BEARDWINTER LLP
Defender
Vol.1 | Issue 2
July, 2007

# Why a WAD II Injury is not a WAD II Injury

In an effort to both simplify and streamline claims, one of the changes to the Schedule of Accident Benefits may have had the unintended effect of creating a significant trap for unsuspecting insurers.

Section 5(2)(e) of the Schedule states as follows:

> 5(2) The insurer is not required to pay an income replacement benefit…
>
> > (e) for any period longer than 16 weeks after the accident, in the case of an insured person whose impairment comes within the *Grade II Whiplash Guideline*, if the accident occurred after April 14, 2004.

On the face of it the language is simple enough. If the claimant is diagnosed with suffering from a WAD II injury, she is entitled to receive income replacement benefits to a maximum of 16 weeks. So, rather then conducting an insurer examination, the most obvious approach is to pay the insured income replacement benefits for the maximum allotted period and deny payment thereafter based on the clear wording of the statute. Unfortunately, it is not so simple.

In the May 9, 2006 FSCO preliminary issue hearing decision of *Kieffer v. Economical* it was found that Ms. Kieffer was entitled to benefits beyond the 16 week period, despite the fact that she suffered WAD II injuries. There was no dispute that she suffered WAD II injuries. The Arbitrator found that the question was not merely whether a claimant has suffered a WAD II injury, but whether the claimant=s impairments come within the WAD II Guidelines. Ultimately, it was concluded the WAD II guidelines are in fact just that - a guideline as opposed to a rule.

A claimant could be excluded from the WAD II restrictions if (1) he suffers from radicular back symptoms, (2) has "other" significant impairments (distinct from the WAD II), and (3) has additional symptoms associated with the WAD II injury that required separate treatment from that provided under the guideline. Furthermore, section 3 of the Grade II Whiplash Guideline sets outs exceptions in which an individual who suffers from a WAD II injury does not come under the *Grade II Whiplash Guidelines* if there are specific pre-existing occupational, functional, or medical conditions that significantly distinguish the insured's needs from that of others with similar impairments.

So, if a claimant suffers from pre-existing back pain complaints, then she may fall outside of the *Grade II Whiplash Guidelines*. If subsequent to the accident the claimant develops psychological problems or chronic pain, (as in the case of *Kieffer*), then he may fall outside of the *Grade II Whiplash Guidelines*. It is not difficult to imagine circumstances in which the claimant would be unanimously

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diagnosed with suffering from a WAD II injury, but not subject to the WAD II Whiplash Guidelines.

The problem is how do you address this?

If an insurer relies on the initial disability certificate in which the claimant is diagnosed with suffering a WAD II injury and dutifully advises the insured that income replacement benefits will be terminated at the 16 week mark then this is being done at the insurer's potential peril. An insurer may not receive the pre-accident clinical notes and records of the treating physician for greater then one year after the denial (if at all) at which point it is determined that the claimant has a significant health history. Psychological problems often do not manifest themselves for months or years post accident and it is clear that chronic pain cannot be properly classified as chronic until at least six months post-accident. At that point, income replacement benefits have been terminated and the insurer has not had the benefit of an insurer examination report to address these issues.

The claimant may serve her own assessment just prior to the expiry of the 104 week period in which a conclusion is reached by the doctor that the claimant suffers from a disability that falls outside of the WAD II Whiplash Guidelines. The insurer would not have any medical assessments to respond and it is far from certain that an insurer would be allowed to conduct its own section 42 assessments (if the matter were commenced in Superior Court then you would at least have the right to proceed with a defence medical assessment). To say the least, this would be a difficult case to win at Arbitration.

The *Kieffer* decision was not appealed and at present there are no other decisions in FSCO or in Superior Court that address this issue. I expect that this will become a key and pivotal issue into the future. At the end of the day, it is always best to obtain an insurer examination report in order to deny payment of income replacement benefits. In order to address the issues raised in the *Kieffer* decision, it would also be wise to ask the assessor to provide an opinion as to whether the claimant's WAD II injuries fall within the WAD II Whiplash Guidelines (and provide the doctor a copy for his reference).

Good claimant's counsel will find ways to thwart the supposedly clear intentions of the Schedule. Good adjusters will recognize the pitfalls in the Schedule and take a proactive way to strengthen the denial.

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