



# Accident Benefit REPORTER

## Significant Legal Decisions – Year 2000 in Review

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◆ **Significant  
Legal Decisions –  
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in Review**



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In this issue of the Accident Benefit Reporter, we are pleased to provide a review and summary of significant decisions that were reported during the calendar year 2000. This review consists of cases which are governed by the current legislation, *Bill 59*. They also include decisions that fall under the two earlier regimes - *Bill 164* and the *Ontario Motorist Protection Plan (OMPP)*, where the decision may impact on future *Bill 59* interpretations.

Many will recall that *Bill 59* came into effect on November 1, 1996. As a result there have been relatively few cases that have made their way through the legal system and there are still many unresolved issues surrounding this legislation. These cases highlight the complexity of the law.

We hope that you find this issue helpful in developing this understanding. It is our plan to make the *Decision Review* Issue an annual feature of the Accident Benefit Reporter.

Finally, we are also pleased to announce that effective immediately, we have installed a toll free information line for the purpose of providing ready response to questions from outside of the 416 area code. The number is 1-888-223-0448. Speak to us directly during normal office hours or through voice mail during other times. We will attempt to answer your questions and get the information you require as quickly as possible.

### Year 2000 Decisions

#### Despite pre-existing psychological condition, Applicant entitled to Income Replacement Benefits (Bill 164)

In *K.M. v. General Accident Assurance Company of Canada* (OIC A98-001051), the Applicant claimed entitlement to Income Replacement Benefits. It was established that prior to the accident, the Applicant suffered from psychological impairment. She has a genetic pre-disposition to Affective Mood Disorders; had recently given birth and was suffering from post-partum depression; suffered from marital and family difficulties; and lost her job of many years. The Arbitrator found that the stress associated with the motor vehicle accident hastened and deepened the development of the Applicant's pre-existing condition to a significant degree and as such, awarded Income Replacement Benefits to be paid for approximately one year. At that time, the Arbitrator found that the negative effects linked to the accident would have ameliorated to minor significance. *The insurer was liable for that period of time that the Applicant could show, on a balance of probabilities, that the accident (as a major contributor) hastened or deepened her condition.*

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**A four-year return to the workforce does not disentitle the Applicant from subsequently receiving Income Replacement Benefits (Bill 164)**

In *Gutzke v. Dufferin Mutual Insurance Company* (FSCO A99-000640), the Applicant was a conscientious, hardworking bricklayer who suffered from a condition of severe and chronic pain. Despite this condition, the Applicant was able to work, post-accident, for approximately four years, subject to employment restrictions and a pattern of normal seasonal layoffs. He received significant accommodation from his employer and required increasing levels of medication to dull the effect of his continuing pain. Ultimately, due to his condition, he stopped working. *Notwithstanding a prolonged return to his pre-accident employment, the Arbitrator found that the Applicant suffered from an impairment arising from the accident, and that this impairment prevented him from undertaking the essential tasks of his pre-accident employment.* Accordingly, he was entitled to continuing income replacement benefits.

**Physiotherapy fees in excess of those amounts published within the guideline are not payable (Bill 59)**

In *Mileevski v. General Accident Assurance Company of Canada* (FSCO A99-000740) the Applicant claimed entitlement to in-home physiotherapy benefits. Despite a med/rehab DAC opinion to the contrary, the Arbitrator found that in-home physiotherapy was both reasonable and necessary. The Arbitrator ordered payment for past services, as well as travel time. However, the fees that were charged were in excess of those outlined within the "Professional Fees Guideline in respect of Physiotherapists". *The service being provided did not involve any equipment and consisted entirely of support, encouragement and range of motion exercises. The Arbitrator ordered payment for the services rendered at the low end of the range (\$23.75 per 15-minute unit).*

**The insurer must pay for the cost of your assessment and report (Bill 59)**

In *Sivanesan v. CIBC Insurance* (FSCO A99-000872), counsel for the Applicant obtained a number of reports from treating and non-treating health practitioners. A claim for the cost of these reports was made pursuant to Section 24 of the SABS. The insurer denied the claim and suggested that the reports were "medical/legal reports" and that the cost of the reports ought to have been billed to OHIP, or conversely, submitted to the tort insurer. The arbitrator rejected the insurer's submissions and ordered that the cost of the reports be paid, with interest. *An Applicant is entitled to her own reasonable assessments. The fact that a report is requested with a view to making a claim, or in the course of or in anticipation of a dispute with regard to entitlement, does not take them outside of Section 24, nor does the fact that the reports may be useful in other contexts, such as a tort action.* The critical issues are whether the expenses are reasonable and if the examinations or assessments were undertaken for the purpose of determining an Applicant's entitlement to benefits.

**...More Section 24 authority (Bill 59)**

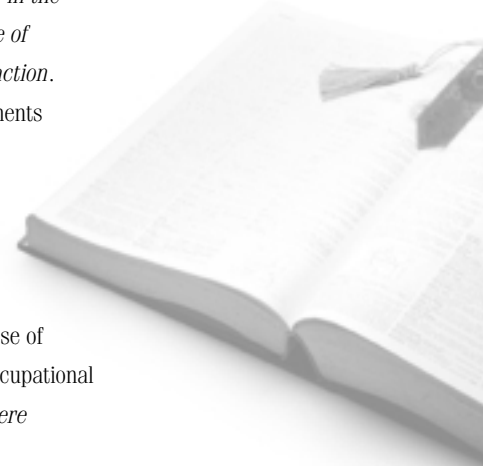
In *Glinka v. Dufferin Mutual Insurance Company* (FSCO A99-000849), the Arbitrator found that a Multidisciplinary Assessment (including an orthopaedic consult, a physiotherapy assessment and an Arcon functional assessment) were undertaken for the purpose of determining the Applicant's entitlement to benefits. Additionally, psychological and in-home occupational therapy assessments were arranged. *The reasonable cost of these assessments and reports were ordered to be paid.*

**Treatment must be reasonable and necessary (Bill 59)**

In *Amoa-Williams v. Allstate Insurance Company of Canada* (FSCO-A97-001864), the Applicant was receiving chiropractic and rehabilitation treatment beyond those dates recommended by a med/rehab DAC. When considering the reasonableness of this treatment, the Arbitrator considered the



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subjective benefit to the Applicant and whether or not the treatment helped to relieve pain. *Pain relief in and of itself can be a legitimate medical and rehabilitative goal, and therefore reasonable and necessary, even if it does not promote recovery.* This statement was qualified in that pain relief measures ought not to encourage an inappropriate or indefinite dependency nor interfere with other aspects of rehabilitation. An applicant who still has residual pain or a limited range of motion, but who is able to resume working and other usual activities, is considered to have a resolved Whiplash Associated Disorder; *however, this does not mean that a patient with "resolved WAD" no longer requires treatment aimed at relieving pain or increasing range of motion.* How to manage a particular injury is not a matter of strict adherence to a particular guideline, but must be a clinical decision in every case. Nevertheless, *be prepared to explain a departure from a particular guideline (both in terms of length of treatment and rate of fee being charged).*

**CPP Benefits are not deductible against weekly benefits. Refusal from the Insurer must be clear within the Notice of Assessment (O.M.P.P)**

In *Field v. State Farm Mutual Automobile Insurance Co.* [2000] O.F.S.C.I.D. No. 7, the issue at arbitration was whether Mrs. Field was time-barred under the Insurance Act and Schedule from challenging the finding that her CPP disability benefits should be deducted from her weekly income benefits. The Arbitrator held that Mrs. Field's application could proceed and that State Farm was not entitled to reduce her benefits by the CPP payments. State Farm appealed that ruling.

The Ontario Financial Services Commission found that in determining whether a claimant's application is time-barred "the onus is squarely on the Insurer to show that a limitation period has started to run and has expired". Moreover, the regulation is intended to ensure that those decisions that trigger the time-bar are unambiguous, so that an Insured may act to protect his or her rights. Therefore, *the notice requirements in s. 24(8) would only apply when it was clear that State Farm turned down Mrs. Field's demand for repayment of the portion of the CPP that was deducted; CPP benefits are not deductible against weekly benefits.*

**A minor Applicant was found to have no "ownership" interest in her parents vehicle and was entitled to transportation expenses for automobile travel to medical appointments of less than 50 kilometres (Bill 59)**

In *Daniels v. Lumbermens Mutual Casualty Co.* [2000] O.F.S.C.I.D. No. 105, the Applicant applied for, and received, statutory accident benefits from Lumbermens Mutual Casualty Company, payable under the Schedule. Lumbermens refused to pay transportation expenses for medical treatment. The parties were unable to resolve their disputes through mediation and the Applicant applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c. I.8, as amended. It was found that the Applicant is entitled to transportation expenses for automobile travel to medical appointments of less than 50 kilometres. The Applicant was a minor at the time of the original dispute. The issue was whether the Schedule excluded the payment of medical benefits related to the first 50 kilometres of transportation and the Insured person's automobile to and from the treatment session. *The Financial Services Commission of Ontario interpreted an "insured person's automobile" to mean an automobile in which the Insured has an interest, such as an ownership or leasehold interest. The Applicant was found to have no interest in her mother's or her father's automobiles and was therefore excluded under subsection 14(6) of the Schedule. As such, the Applicant was entitled to transportation expenses for automobile travel to medical appointments of less than 50 kilometres.*

**An unprotected defendant is jointly and severally liable for the entire amount of damages, regardless of his proportional liability (Bill 59).**

In *Sullivan Estate v. Bond* [2000] O.J. No. 3714 (O.S.C.J.), the court considered whether section 267.7 of the *Insurance Act*, under *Bill 59*, entitles a plaintiff to recover the whole amount of damages against a joint defendant, or whether it is restricted to the proportion of the defendant's liability.

In this case the defendant, a tavern, was an unprotected defendant, in that it was not insured under any valid Ontario automobile insurance policy. *The court found that an unprotected defendant is responsible to a motor vehicle accident victim on the basis of joint and several liability.* Under Bill 59, the unprotected defendants are jointly and severally liable for the entire amount of damages, regardless of their proportional liability. This case is currently under appeal.

**Where an offer to settle at mediation is fair, and the plaintiff's counsel fails to reject the offer, the plaintiff is bound by their solicitor's actions (Bill 164)**

In *Jimenez et al v. Markel Insurance Company of Canada* [2000] O.J. No. 2193 (S.C.J.), the plaintiffs were injured in a motor vehicle accident. The parties participated in a mediation before the Financial Services Commission of Ontario and a settlement was reached. The following day, counsel for the defendant Insurer wrote to counsel for the plaintiffs enclosing a full and final release and a written notice of settlement. The plaintiffs had instructed their counsel to reject the offer, but counsel failed to communicate this rejection to the Insurer. *The court found that the Insured would not be bound by the settlement if it did not clearly set out his or her entitlement.* However, in this case the settlement was fair. As such, the settlement was enforceable since the lawyer failed to reject the offer within the prescribed time.

**An application for arbitration must be filed within 2 years of receiving a Notice of Assessment which clearly advises that benefits will cease from the Insurer (O.M.P.P)**

In *Antunes v. Allstate Insurance Co. of Canada* [2000] O.F.S.C.I.D. No. 6, the Applicant was injured in a motor vehicle accident on October 25, 1991. The Insurer terminated weekly income benefits on October 28, 1994. The Applicant subsequently applied for a mediation in November 1998 and for arbitration in February 1999. The issue in this case was whether the Applicant was precluded from proceeding to arbitration because his application for arbitration was filed beyond the two-year limitation period set out in subsection 281(5) of the Act and subsection 26(1) of the Schedule. The Financial Services Commission of Ontario found that *the limitation period starts when the Insurer sends a Notice of Assessment which clearly advises that benefits will cease on a specified date, because otherwise the Insured does not meet the criteria in the policy.* As such, the application for arbitration was denied because it was filed beyond the two-year limitation period set out in subsection 281(5) of the Act and subsection 26(1) of the Schedule.

**The test for a "complete inability" to carry on a normal life is stricter than a "substantial inability". Complete inability encompasses substantially all of the activities in which a person would normally engage before the accident (Bill 59).**

In *Morelli v. Zurich Insurance Co.* [2000] O.F.S.C.I.D. No. 5 (O.F.S.C.), the Applicant was injured in a motor vehicle accident on December 4, 1996. The insurance company denied non-earner benefits on January 31, 1997. The parties were unable to resolve their dispute through mediation, and applied for arbitration at the Financial Services Commission of Ontario. The issue was whether the Applicant was completely or substantially unable to carry on a normal life. *The test for a "complete inability to carry on a normal life" is strict. It represents a higher degree of disability than "substantial inability". "Complete inability" basically encompasses substantially all of the activities in which a person would normally engage in before the accident.* The Applicant was denied the benefits on the grounds that she had not met the "complete inability test" in section 12, and there was no significant difference between her physical ability to carry out her daily activities before the accident and after the accident.





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Where pre-accident earnings cannot be substantiated because a claimant shows losses on his/her Income Tax Return, the approach is to strike a balance between the pre-accident earning capacity and his/her post-accident residual earning capacity (Bill 164).

In *Angolano v. Liberty Mutual Insurance Co.* [2000] O.F.S.C.I.D. No. 47, the insurance company appealed from an arbitration order awarding loss of earning capacity benefits ("LECBs") to the insured. The Director's Delegate outlined the proper procedure for calculating the pre-accident earning capacity ("PEC") and residual earning capacity ("REC"), taking into account the Insured's personal vocational characteristics. Among other injuries, the Insured separated a shoulder in an automobile accident on December 9, 1994. As a result, he was unable to return to his pre-accident work as a self-employed installer of aluminum window siding and aluminum products. The Insurer accepted that he was entitled to income replacement benefits ("IRBs") under the Statutory Accident Benefit Schedule - SABS (*Bill 164*), but paid him the minimum amount of \$185 per week because his income tax returns showed losses for the three years before the accident. It was found that while previous decisions expressed legitimate concerns about claims for weekly benefits that are unsupported by documentation, the approach to PEC should be somewhat more flexible as the calculation is meant to represent earning "capacity" rather than actual earnings. While an insured person must be able to establish his or her pre-accident earnings on some verifiable basis, PEC differs and should be treated more leniently. *The equation should compare the insured person's pre-accident earning capacity with his or her post-accident residual earning capacity. The outcome should be one that balances these two equations, and other evidence beyond income tax returns will be considered in determining a proper PEC.*

**The limitation period for applying for mediation after the denial of payment of a Statutory Accident Benefit begins only where the letters from the Insurer denying the benefits is clear. (OMPP).**

In *Randisi v. AllState Insurance Co. of Canada* [2000] O.J. No. 3549 (O.S.C.J.), the insurance company brought a motion for summary judgment to dismiss the Insured's claim for failing to commence the action within the limitation period provided by section 281(5) of the *Insurance Act*. The Act states that the claim must be commenced within two years of the Insurer's refusal to pay the statutory accident benefits. The Insured was involved in a motor vehicle accident on March 17, 1993. The Insurer paid weekly income benefits for a period in excess of 156 weeks. The issue at trial was whether the date of limitation begins two years from the date of denial of such benefits or on the cessation of such benefits. *The court concluded that the limitation commences when the denial to payment of continued weekly benefits by the Insurer is clear. There is an onus on the Insurer to be clear since it is the words of the Insurer in section 281(1) of the Insurance Act that sets the date of commencement.* If the contents of the Insurer's letter expresses an invitation to discuss their denial, then the court will conclude that there was not a clear message of denial, and as such, the limitation period will not start.

**Monthly Long Term Disability Benefits are not "temporary benefits", and are deductible against weekly benefits under s. 75(4) of the SABS (Bill 164)**

In *Laporte v. Dominion of Canada General Insurance Co.* [2000] O.J. No. 818 (O.S.C.J.), this action arose out of a single motor vehicle accident on October 18, 1994. The Insured applied for weekly benefits, which was granted by the Insurer, and subsequently terminated on March 15, 1996. The Insured had been receiving Monthly Disability Benefits (prior to the motor vehicle accident) since December 1986 under a group Long Term Disability (LTD) Plan in relation to impairments which prevented him from continuing employment. The Monthly Disability Plan will terminate no later than July 31, 2002 (the month the Plaintiff attains the age of 65). Subsection 75(4) of the SABS (*Bill 164*) states that an Insurer may deduct "any temporary disability benefits being received by the Insured person in respect of a period following the accident and in respect of an impairment that occurred before the accident". The insurance company brought a motion as to whether the Monthly Disability Benefits being received by the Insured

under the LTD Plan constitute "temporary disability benefits" within the meaning of subsection 75(4) of the SABS (Bill 164). *The court found that LTD benefits are comparable to Canada Pension Plan Disability Benefits with respect to the degree of disability necessary to qualify for benefits, as well as the duration of benefits. Since Canada Pension Plan Disability Benefits are not considered "temporary disability benefits", neither are monthly LTD payments. As such monthly LTD benefits are not deductible under section 75(4) of the SABS (Bill 164).*

**An accident need not be the sole or main cause of an individual's condition. The accident only has to make a significant contribution to the disability (Bill 164)**

In *Alves v. Commercial Union Assurance Co.* [2000] O.E.S.C.I.D. No. 139, the Applicant appealed an arbitration order, dated May 13, 1999, rejecting his claim for further income replacement benefits beyond May 5, 1995, and for payment of expenses for chiropractic treatment. He also argued that the Arbitrator failed to deal with the outstanding rehabilitation expenses. The primary issue, which dealt with income replacement benefits, considered whether the Applicant sustained an impairment as a result of the accident and if he suffered a substantial inability to perform the essential tasks of his pre-accident employment for the period claimed. According to the facts set out in the decision, the Applicant had a previous back injury, which he sustained while at work, along with two successive motor vehicle accidents. The Arbitrator found that the Applicant was not back to work as normal at the time of the accident, because of the continuing back and shoulder problems. On appeal it was found that "*it is well-established that the accident need not be the sole or main cause of the individual's condition. It need be shown only that the accident made a significant or material contribution to the disability*". It was concluded that if the Applicant's disability resulted from the cumulative effect of his problems (pre-existing and accident-related) he is still entitled to benefits, even if his pre-existing problems are far more significant.

**Even plaintiffs who abuse alcohol and drugs are entitled to compensation if the Insurer fails to notify them that treatment is a requirement of obtaining benefits (Bill 164)**

In *M.A. and State Farm Mutual Automobile Insurance Company* [2000] F.S.C.O. A98-001289, the Insured was involved in two motor vehicle accidents on June 3 and October 18, 1996. She applied for and received Statutory Accident Benefits from State Farm Mutual Automobile Insurance Company. The Insured admitted that she only sustained soft tissue injuries and that she was unable to return to her pre-accident caregiver, housekeeping and self-care activities due to chronic pain and substance abuse problems she has experienced since, and as a result of the accidents. The Insurer argued that benefits should not be paid on the grounds that the Insured failed to mitigate her losses, that she was a malingeringer, and that she failed to deal with her drug and alcohol problems. The court found that while the Insured had attempted to conceal her February 1996 accident, and to exaggerate her limitations following the motor vehicle accidents, and even to implicate other areas of her body (right ankle) not injured in those accidents, she was still, entitled to benefits. In addition, while the evidence was clearly consistent with the allegation of malingering made by the Insurer, the court found that it did not prove such an allegation by the preponderance of the evidence. Finally, it was decided that even if the Insured failed to seek treatment with respect to her abuse of drugs and alcohol, the Insurer is still required to pay until they have notified her that she is required to seek treatment, and she refuses the treatment.

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