ACCESSING FIRST AND THIRD PARTY FUNDING FOR IN-HOSPITAL MEDICAL, REHABILITATION AND ATTENDANT CARE NEEDS FOR SEVERELY INJURED ADULTS AND CHILDREN

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ACCESSING FIRST AND THIRD PARTY FUNDING FOR IN-HOSPITAL MEDICAL, REHABILITATION AND ATTENDANT CARE NEEDS FOR SEVERELY INJURED ADULTS AND CHILDREN

The majority of the context for this paper will be drawn from the first party provisions of the SABS. These provisions will be considered in light of the *Health Insurance Act* and case law to identify instances when mainly first party payors are able to be called upon to fund in-hospital services. The key to the approach to entitlement to all benefits is understanding "attendant care".

DEFINING "ATTENDANT CARE"

The process of identifying what is meant by attendant care and what is or is not attendant care will help us determine whose responsibility it is to pay for/provide attendant care.

An assessment of attendant care needs is now defined under the post March 1, 2006 SABS to mean:

> "a written assessment of attendant care needs that satisfies the requirements of section 39."

Section 39(16) indicates:

> "an assessment of attendant needs under this section in respect of accidents occurring on or after March 1, 2006 shall be in the form of and contain the information required in the "Assessment of Attendant Care Needs" dated December 31, 2005 and available on the website http://www.fsco.gov.on.ca/."

Under the SABS: "attendant care benefits" means the benefit provided by section 16. Section 16 indicates:

> "16(1) the insurer shall pay an insured person who sustains an impairment as a result of an accident an attendant care benefit. …
>
> (2) the attendant care benefit shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person for,
>
> (a) services provided by an aide or attendant; or [read "and"]

(b) services provided by a long term care facility, including a nursing home, home for the aged or chronic care hospital. …

(4) the monthly amount payable by the attendant care benefit shall be determined in accordance with the Form 1."

As such, the definition of "attendant care" includes:

> "services provided by an aide or attendant" and "services provided by a long term care facility, including a nursing home, home for the aged or chronic care hospital."

In leading towards a greater understanding of what is meant by attendant care under the SABS, before we look at the wording in the Form 1, we may take a clue from the fact that attendant care is defined to be a separate benefit to medical benefits. Medical benefits include nursing. By inference, attendant care and nursing may have two different meanings.

For the most part however, we must look to the Form 1 to determine what is attendant care.

THE FORM 1

Section 39(16) mandates that the Assessment of Attendant Care Needs "shall"… "contain the information required" by the Form 1.

Section 13 of Ontario Regulation 547/05, which became law March 1, 2006, makes following an "Unfair or Deceptive Act or Practice" under Section 438 of the *Insurance Act*:

> "any examination … that does not comply with the requirements under the [*Insurance Act]* or the [SABS] regulations."

What then is the "information required" by the Form 1?

The Form 1 preamble is the instruction to the user as to how to complete the Form 1. The preamble directs us initially as to what the "information required" is for the purposes of section 39(16). Its instruction is therefore mandatory and its meaning central to the Form 1 requirements. The preamble begins:

> "Use this form to report the future needs for attendant care required by the applicant as a result of an automobile accident on or after March 1, 2006."

What is plain on the face of the Form 1 from the first words of the preamble is the obligation to placed upon the assessor to "report the future needs for attendant care".

Interpreting the word "needs" is fundamental. It is to be given its everyday meaning: to "need" = to "require". To comply with this instruction, the assessor completing the Form 1 need only look at each of the sections, for instance, "dress – upper body" and indicate in his or her opinion whether the person needs, or requires help in performing this personal care activity, and if so, how much.

The word "future" can mean going to happen or expected to happen. The time frame encompassed by "future" can be in the next minute, hour, week, weeks, month, year, lifetime or eternity. Considering the assessment is being done in the moment (now), the future being referred to is the immediate future rather than the distant future. Also consider the Section 43(13) language:

> (13) If the designated assessment is required under section 39 in respect of a claim for an attendant care benefit, the report shall include,
>
> (a) an assessment of attendant care needs; and See: *O. Reg. 546/05, ss. 22, 32.*
>
> (b) recommendations on the future provisions of attendant care services to the insured person. *O. Reg. 281/03, s.21.*

Plainly, when a DAC assesses need, it does an assessment of attendant care needs – Form 1 - to determine what the current needs are, and then makes recommendations on future needs in the narrative report.

The preamble asks the assessor to report the future needs for attendant care required by the applicant <u>as a "result" of an automobile accident</u>. As such, the assessor, (having knowledge of the person's impairment(s) which form(s) the basis of the need for attendant care) is thus responsible to assess the care needs which arise as a result of the impairments resulting from the accident.

"As a result" is an important phrase. "Result" means "consequence" or "outcome". So for instance, "as a result" does not mean "directly caused". The causal link between the impairment and the need is less where the attendant care is required "as a result of the impairment" than if the need for attendant care was required to be directly caused by the impairment arising from the accident.

As such, the preamble to the Form 1 directs the person completing the form to assess the attendant care needs required as an outcome of the accident.

As a mandatory instruction, the preamble is just as important for what it doesn't say as it is for what it does say. What is not stated in the preamble and therefore not permitted in the completion of the Form 1, is that the person completing the form should only indicate the net need. That is, the preamble does not ask and does not permit the person completing the Form 1 to subtract from the "needs for attendant care" any time for services that are being provided to meet those needs. This conclusion can be strengthened by looking at the various parts of the form.

For instance, under Part 1:

> "Grooming – face: wash, rinse, dry, morning and evening."

In completing that section, the assessor must either reach the conclusion that the applicant can wash, rinse and dry his or her face or that s/he needs attendant care to assist in this activity. If s/he has a need for an attendant to assist with this grooming activity, the form asks the "number of minutes" required to assist in this activity. The form <u>does not ask</u>:

> "number of minutes less number of minutes already being provided by family member, nurse, physiotherapist, physician."

As such it is evident that, regardless if the need is being met by one of the above persons, the Form 1's direction to the assessor is that the assessor identify the amount of time which the person needs to complete the listed activity - nothing more and nothing less.

The assessor who completes the Form 1 is to fully indicate within the assessment of attendant care needs Form 1 what those needs are in order to have met the section 39(16) requirements that it "shall contain" the information required by the Form 1.

Once those needs are identified on the Form 1, reimbursement for the person who provides the services to meet those needs can be sought. Equally, there may be other services being provided for which reimbursement is not available under the Form 1. At the end of the preamble, the following paragraph exists:

> "Please Note: Users of Form 1 should also review other accident benefits available under the Statutory Accident Benefits Schedule for possible reimbursement of other losses and expenses (such as housekeeping and home maintenance, transportation, home modifications and other medical and rehabilitation expenses)."

Willie Handler, Senior Manager for the Auto Insurance Division with the Financial Services Commission by letter on July 31, 2006, provided his interpretation of this section. Mr. Handler indicated:

> "The Form 1 statement referred to in your letter advises users to review other benefits available under the SABS for possible reimbursement of other losses and expenses. It was added to remind Form 1 users to check for other benefits, such as housekeeping and home maintenance, that are not reimbursed as part of the attendant care benefit. **The statement is not intended to imply that any amount be deducted from the overall attendant care benefit calculations**." **[my emphasis]**

Consider the example "housekeeping". If a Form 1 allocates an amount for "extra laundering", the last part of the preamble reminds the assessor to take this amount of time allocated for "extra laundering" into consideration when assessing the appropriate housekeeping benefit.

This interpretation is consistent with the benefit types mentioned in the preamble. For instance, considering the reference to "home modifications", the attendant care provider is not entitled to attendant care payments for any home modification activities not yet undertaken. Nevertheless, if the injured person requires home modifications as a result of the automobile accident related impairments sustained by the applicant, the user of the Form 1 is reminded to review the availability of these benefits with the applicant. Further, there is no question that once home modifications are completed it may be necessary to re-evaluate attendant care needs in a new environment. What Mr. Handler makes plain is that one should not deduct from need in anticipation of any benefits available.

The attendant care benefit is the benefit most closely connected to maintaining the safety and well being of the applicant. If a person is unable to attend to the activities of daily living, requires assistance with walking, is unable to get in and out of a wheelchair independently, is cognitively impaired and/or unable to respond to an emergency, that person's life or at least that person's physical, cognitive and/or emotional health are in jeopardy unless they are provided access to the attendant care which they require. It is primarily this reason that attendant care has remained through successive iterations of the Statutory Accident Benefits Schedule, a benefit which is to be paid first even if the insurer disputes it.

One of the reasons that no permission is required from the insurer for an occupational therapist to proceed to assess attendant care needs and complete a Form 1 is the concern. In many ways, identifying and meeting the attendant care needs of a motor vehicle accident victim are preeminent and of a greater priority than the other benefits.

When one requires attendant care to offset a danger to personal health and safety caused by the accident related impairment, it does not seem right, just or supported by the provisions of the Form 1 to subtract from the identified need for attendant care, any services may or may not be provided to address the person's attendant care needs. Consumer Protection concerns of the SABS require that the consumer be entitled to timely access to necessary attendant care.

Given that the Form 1 assesses need for attendant care, a completed Form 1 represents the maximum amount payable by an insurer towards attendant care required by the applicant. The Form 1, on its face, does not attest to the provision of services by anyone; it simply identifies the need for those services.

The insurer will want information to help it confirm the provision of services in order to issue appropriate payment to those service providers. That concern is not the subject of the Form 1. Further, there is nothing within the SABS which directs the person completing the Form 1 to consider payment to service providers in the process of completing the Form 1 to identify the needs for attendant care required by the applicant.

It will be very important to both insurer and applicant alike for the occupational therapist who assesses attendant care needs to provide a narrative report. The narrative report is the appropriate document and location for all comments available to be made by the occupational therapist concerning the assessor's knowledge as to the services being provided to support the injured person's needs.

It will also be important in the narrative report for the assessor to identify any manner other than the by the attendant care provider whereby the needs for attendant care are being met (i.e.: supervisory need being met by physiotherapist or rehabilitation support worker or teacher or educational assistant during the period of intervention). This information will help the insurer to determine the appropriate payment to make for attendant care to the appropriate attendant care provider.

SABS PROVISIONS RELATED TO COMPENSATION OF ATTENDANT CARE PROVIDERS

Now Section 39(4) of the SABS states:

> "The insurer shall begin payment of attendant care benefits within 10 business days after receiving the assessment of attendant care needs and, pending receipt by the insurer of the report of any examination under section 42 required by the insurer, shall calculate the amount of the benefits based on the assessment of the attendant care needs."

Section 16(4) indicates:

> "The monthly amount payable by the attendant care benefit shall be determined in accordance with Form 1."

Section 33(1) states:

> "A person applying for benefit under this Regulation, shall within 10 business days after receiving a request from the insurer, provide the insurer with the following:
>
> 1. any information reasonably required to assist the insurer in determining the person's entitlement to a benefit."

Ontario Regulation 547/05, Unfair Deceptive Acts or Practices, Section 3(2) 1. prescribes as an "unfair deceptive act or practice:"

> "3(2) 1. Charging an amount in consideration for the provision of goods or services to or for the benefit of a person who claims statutory accident benefits or who otherwise claims payment under a contract of insurance, if the goods or services are not provided."

As such, on receipt of a narrative report and accompanying Form 1, it may be appropriate for an insurer to request information from an identified service provider of attendant care benefit to confirm the provision of attendant care services in order that appropriate payment can be issued.

PRIORITY BETWEEN MINISTRY OF HEALTH AND STATUTORY ACCIDENT BENEFIT INSURER

Section 16 indicates:

> "16(1) the insurer shall pay an insured person who sustains an impairment as a result of an accident an attendant care benefit. …
>
> (2) the attendant care benefit shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person for,
>
> (a) services provided by an aide or attendant; or *[read "and"]*
>
> (b) services provided by a long term care facility, including a nursing home, home for the aged or chronic care hospital. …"

Section 58 of the SABS states:

> "(1) The insurer shall pay benefits under this regulation even though the insured person is entitled to, or has received, benefits under an *Act* administered by the Ministry of Community and Social Services for Ontario or under similar legislation in another jurisdiction."
>
> "(2) For the purposes of subsection (1) a service, benefit or entitlement provided under an *Act*, the administration of which was transferred from the Ministry of Community and Social Services to the Ministry of Health by Order in Council, shall be deemed to be provided under an *Act* administered by the Ministry of Community and Social Services for Ontario so long as the nature of the service, benefit or entitlement remains substantially the same as it was before the transfer."

LEGISLATIVE HISTORY TO SABS SECTION 58

By Order in Council in 1993, the Ministry of Community and Social Services transferred to the Ministry of Health its responsibilities under *The Long Term Care Act* which was reconstituted *The Long Term Care Act,* 1994 S.O. 1994 c.26. This Act applies to CCACs and some nursing homes. *The Act* does not apply to hospitals defined under *The Health Insurance Act* or *The Public Hospitals Act.*

Through that shifting of responsibilities, the Ministry of Health came to have certain obligations when a resident of Ontario living in the community or in some nursing homes applied to an approved agency (usually CCAC) for community services that the agency provides. The responsibility under section 22 of *The Act* placed on the agency is to assess the person's requirements and determine the person's eligibility for the services. Following assessment, if a person was determined eligible, the agency is then responsible to develop a plan of service. Obviously there are a number of qualifying factors which need to be met before a person can gain any entitlement to any form of publicly funded benefit under *The Long Term Care Act.*

Under *The Long Term Care Act*, a distinction is made between personal support services and professional services. Both, or either type of services may be provided by an agency under *The Long Term Care Act* to someone who is residing in the community and not in the hospital.

Attendant care services are available under *The Long Term Care Act* to a person who qualifies after an assessment. Only a person residing in the community or a nursing home may apply for an assessment. Section 58 says, in essence,

notwithstanding that a person is entitled to or has received attendant care (personal support worker) benefits under *The Long Term Care Act*, the accident benefit insurer is responsible to pay attendant care benefits, regardless of the entitlement the person has under *The Long Term Care Act*.

The effect of Section 58(1)(2) of the SABS is to make the accident benefit insurer the first payor for any services which may be similar to services an Ontario resident may be entitled to if deemed eligible for same under *The Long Term Care Act.* Under the language of Section 58, the accident benefit insurer remains fully responsible to pay benefits under the Regulation even though the insured person has received benefits under *The Long Term Care Act*.

Under *The Long Term Care Act*, if an assessment has been completed and a person is determined to be eligible for personal support services, homemaking services, community support services or professional services, they may be provided. The accident benefit insurer retains the responsibility to pay the attendant care services under the SABS regulation as first payor.

MEANING OF SABS SECTION 60 "OTHER COLLATERAL BENEFITS"

First and foremost, we should clarify that Section 60 has nothing to do with the protocol to be used in assessing attendant care or how to complete a Form 1. Whether a person is in a hospital, is receiving PSW support or in a nursing home or PSW support at home from a CCAC does not impact on how the Form 1 is to be completed. It is to be completed by identifying and quantifying all attendant care needs, regardless of whether or how they are being met or by whom. Section 60 only has to do with the amount the insurer needs to pay.

As it relates to attendant care benefits, Section 60(2) states:

> "(2) Payment of a medical, rehabilitation or attendant care benefit or a benefit under Part VI is not required for that portion of an expense for which payment is reasonably available to the insured person under any insurance plan or law or under any other plan or law."

Section 60(2) is similar to all other portions of section 60 which speak to benefits paid to or "for which payment is reasonably available to the insured person".

As such, if a group medical policy or a private medical policy purchased by the insured person provides the opportunity for payment to be issued to the insured person for attendant care, the accident benefit insurer is not required to pay for that portion previously paid or for which payment is "reasonably available ***to the insured person."***

Unfortunately, there is no law, other than the SABS, which provides payment of the expense of attendant care or which makes payment of the attendant care expense "reasonably available to the insured person."

Under the wording of section 60(2) unless payment of the attendant care expense is available ***to the insured person***, the accident benefit insurer must make payment of the attendant care benefit.

The obligation placed upon the SABS insurer to pay the attendant care benefit is reinforced by section 58(1) and (2). Statutes and regulations are to be interpreted with certain rules. If one section, for instance Section 60, speaks of general language about rights to deductions and another section, Section 58, speaks about a specific situation – namely that the insurer is responsible to pay when a person may be entitled to benefits under *The Long Term Care Act*, the rule is that the specific meaning informs us of the appropriate interpretation to be given to the general language.

Interpreting Section 60(2) in light of Section 58, the insurer does not have the right to deduct from its obligation to pay attendant care benefits, any benefit available to or being received by the insured under *The Long Term Care Act*, since *The Long Term Care Act* does not make payment of any benefit available ***to the insured person***. Section 58 would have no meaning if any other interpretation were made of Section 60(2).

Last, there can be no debate that services being provided by the provider of personal support services under *The Long Term Care Act* in the community are not services for which the insured has incurred an expense. If there has been no expense incurred by or on behalf of the insured person, then, pursuant to section 16(2) requirements for payment of the attendant care benefit have not been met. As there is no expense incurred by the insured, there is no payment available to the insured.

ATTENDANT CARE IN HOSPITAL

We have seen from consideration of the above provisions that the insurer is the first payor for attendant care benefit related to attendant care in a nursing home or in the community. Is it any different when the insured person is in hospital?

I enclose a letter on the subject from Anne Utley who is a Senior Subrogation Manager with the Ministry of Health on the subject. I attach it to this paper for reference.

Under section 16(2), the insurer is responsible to pay an attendant care benefit for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for "services provided by a long term care facility, including a nursing home, home for the aged or chronic care

hospital." The insurer is also required pursuant to section 16(2) to pay for the services provided by an aide or attendant.

In the recent case of Bellavia and Allianz Insurance, Arbitrator Killoran concluded that the insurer's responsibility is to pay for services by an aide or attendant and for services provided by a hospital which is a long term care facility where the insured person required both.

Section 16(2) does not mention acute care or rehabilitation hospitals. As such, for acute care hospitals and rehabilitation hospitals, we must consider whether section 60(2) applies. If it applies, the insurer may deduct attendant care from the portion of the benefit for which payment is reasonably available to the insured person.

In order to determine whether there is any deduction available to the insurer, we must first determine whether or not the Ministry of Health provides attendant care services in hospital. To do so, we must look to the enabling legislation. The enabling legislation is the *Health Insurance Act*. The *Health Insurance Act* tells us the services to which residents of Ontario are entitled in hospital. These are known as "insured services" under the *Health Insurance Act*.

Regulation 552 to the *Health Insurance Act* identifies insured hospital services in Canada as including the following:

> "7. Subject to section 10, the inpatient services to which an insured person [insured under the *Health Insurance Act*] is entitled without charge are all of the following services:
>
> 1. accommodation and meals at the standard or public ward level.
> 2. necessary nursing service, except for the services of a private duty nurse who is not engaged and paid by the hospital.
> 3. laboratory, radiological and other diagnostic procedures …
> 4. drugs, biologicals and related preparations that are prescribed by an attending physician.
> 5. use of operating room …"

In contrast to *The Long Term Care Act,* which makes attendant care available to residents of nursing homes or living in the community through personal support workers, there is no inclusion of personal support worker as an insured service under the *Health Insurance Act*. As such, there is no law or plan that makes attendant care available to a person who is in hospital and who is entitled to an attendant care benefit from his/her car insurer under the SABS.

Further, the SABS insurer is fully responsible to pay for the services of a private duty nurse if required in hospital. This claim may be made successfully under section 14 (2) (a) for "nursing".

In trying to identify whether the services provided by a nurse in hospital are attendant care services, just as the SABS differentiates between nursing services (Section 14(2)(a)) and attendant care services (16(2)), so too does the *Long Term Care Act, 1994* differentiate between the closest descriptor for attendant care in that Act "personal support services" (Section 2(6) and "professional services" (2(7)) which include nursing services, occupational therapy services, physiotherapy services, social work services, speech-language pathology services, dietetic services …".

Given that acute care hospitals and rehabilitation hospitals do not provide attendant care as an insured service, nor do they provide personal support services as an insured service under the *Health Insurance Act* or under any other enabling "law" and given that there is no payment available or reasonably available to the insured person for attendant care expense, <u>section 60(2) does not apply to reduce the insurer's obligation to pay attendant care benefits to family members or private sitters who provide attendant care services to motor vehicle accident victims in hospital.</u>

Secondly, in Canada, it is by virtue of the *Health Insurance Act* that the residents of Ontario <u>do not incur any personal expense</u> when they are admitted to an acute or rehabilitation hospital. The costs of the "insured hospital services" are borne by the Government of Ontario and Government of Canada. There is no expense of those listed above "for which payment is reasonably available <u>to the insured person"</u> under Section 60(2) of the SABS.

Also, in accordance with the principles of statutory interpretation, words which are included in a regulation are presumed to be included with reason. If Section 60(2) had meant to allow the insurer a deduction so long as payment of an expense was available to any one, then the words "to the insured person" would not have been placed in the section. By using the phrase "for which payment is reasonably available to the insured person, the Ontario Legislature has plainly indicated that no deduction for attendant care benefits is available to the insurer under any law or plan unless that law or plan makes payment reasonably available "<u>to the insured person"</u> for the expense of attendant care services.

The *Health Insurance Act* is the only law relating to the potential care available to a person in hospital. Plainly it:

1. does not make attendant care services available to car accident victims in hospital; and

2. it does not make any payment for attendant care services "to the insured person".

It is the position of the Government of Ontario, as expressed in the attached letter by Anne Utley, that the Government of Ontario does not provide attendant care services in hospital.

There is no express indication within the *Health Insurance Act* or any other enabling legislation which relates to acute care or rehabilitation hospitals that allows for any interpretation that attendant care is required to be supplied or is an insured service which is to be supplied by a acute or rehabilitation hospital.

LAW – INCURRED EXPENSE

The decisions listed below confirm that the accepted meaning of incurred expenses is as follows (from *Smith v. Wawanesa* 42 O.R. (3d) 77, (Divisional Court) 1998):

> "An insured, to incur an expense … need not actually receive the items or services or spend the money or become legally obliged to do so. It is sufficient if the reasonable necessity of the service or item and the amount of the expenditure are determined with certainty." [1][2][3][4][5]

BELAIR AND MCMICHAEL, DECISION MARCH 14, 2006

David McMichael was injured in a motor vehicle accident on June 14, 1998. he was hospitalized in 2002 and sought payment of attendant care benefits beginning after his hospitalization in March/April 2002. A Form 1 was completed on March 27th, 2002. A narrative report prepared by Beverley Cott who completed the Form 1 accompanied the Form 1.

The Form 1 allowed for ongoing supervisory care found that as a result of his mild brain injury he continued to be at risk for making poor choices and remained at risk in returning to drug usage, possible overdosing or at the very least risking his relationships with family and friends and as well as facing financial ruin.

Ms. Cott's report stated that one week after her visit to assess his attendant care needs that he had relapsed and again returned to drug usage. The therapist concluded:

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[1] Smith v. Wawanesa 42 O.R. (3d) 77 (Divisional Court) 1998
[2] Stargratt and Zurich, Arbitration Decision: October 4, 2001, Appeal P02-00045
[3] L.F. and State Farm, P02-00026
[4] McMichael and Belair [2006] Appeal A02-001081
[5] S.D. and TTC Insurance Co., Arbitration Decision: May 23, 2002

> “He remains in crisis and is at great risk [therapist’s emphasis] for returning to drug usage, particularly in view of his history and his poorly structured daily routine. In an effort to assist Mr. McMichael to remain drug free, he requires immediate intervention via ongoing supervision either by family, friends and/or attendants…given that Mr. McMichael this therapist supports the provision of attendant care at least until such time he is admitted to an in-patient drug rehabilitation program.”

The approach taken by the occupational therapist in assessing the need for attendant care arising as a result of the accident is accepted as the appropriate approach by the arbitrator. The arbitrator accepts the appropriate attendant care figure that is identified in the Form 1. In this case, the insurer declined to pay the attendant care. The insurer did not request particulars of attendant care services provided nor did it adopt Plaintiff counsel’s recommendation that it pay the attendant care “without prejudice”. The insurer denied the attendant care.

The insurer argued at first instance and on appeal that Mr. McMichael is not entitled to attendant care because it was not incurred and that no services were provided.

The Arbitrator and the Director’s Delegate on appeal both accept in accordance with the prevailing case law identified earlier in this paper that:

> “It is well established that an applicant need not actually receive the items or services claimed in order to be entitled to an expense. To do otherwise, would allow the insurer to set up the inability of an insured to pay for an expense as a shield from its obligation under the policy of insurance. It is sufficient that the reasonableness and necessity of the service be established and that the amount of the expenditure can be established with certainty.”

At page 67 of the Arbitration, the Arbitrator summarizes the evidence that was before him at the time he made his decision on the appropriate amount of attendant care to be payable. Apart from the Form 1, the narrative report of the occupational therapist completing same, there were the opinions of several other experts familiar with his circumstances:

> “who supported with some qualifications, his need for this kind of attendant care. **There is no evidence to the contrary.** I find therefore that Mr. McMichael is entitled to an attendant care benefit as calculated in the Form 1 appended to Ms. Cott’s report, subject to the comments below.”

Ms. Cott commented in her narrative report accompanying the Form 1,

> “this therapist supports the provision of attendant care, at least until such time as he is admitted to an in-patient drug rehabilitation program.”

This statement was adopted by the Arbitrator.

Belair sought a credit for times when it claims Mr. McMichael would have been under supervision and therefore not entitled to the benefit. The Arbitrator agreed to some degree. In his Order, Arbitrator Muir indicated that during the period that Mr. McMichael was an in-patient at Bellwood, “He would be supervised and not in need of additional attendant care or notionally already in receipt of the benefit”.

The Arbitrator left it to the parties to resolve the fine details of the issue and indicated that he remained seized of the matter in the event that there was an unresolved dispute concerning the precise quantum of the attendant care benefit.

In essence, the decision by the Arbitrator at first instance in *McMichael,* stands for the proposition that where there is a Form 1 indicating need, supplemented by the opinions of several experts familiar with the circumstances who support the need for attendant care, and where there is no evidence to the contrary, Mr. McMichael is entitled to attendant care benefits as calculated in the Form 1 with the exception that a credit to that amount would be available during periods when he was an in-patient at Bellwood and was supervised and not in need of additional attendant care to that being provided by the Bellwood institution.

In McMichael, attendant care needs were identified in the Form 1. The evidence before the Arbitrator from a family member, assessing occupational therapists and several other medical experts supported the need for the attendant care at the amount indicated and there was no countervailing evidence provided by the insurer to suggest that the assessed amount of need for attendant care was inappropriate. Presumably, that evidence would follow in an appropriately managed case by an insurer who had knowledge that there were periods of time when Mr. McMichael “was otherwise supervised”. Even though such evidence was not offered at the hearing itself, the Arbitrator allowed the hearing to remain open for the purposes of resolving any dispute between the parties as to when Mr. McMichael “was otherwise supervised.”

The Arbitrator’s Order was that Belair should pay attendant care benefits in the amount of $5,056.80, per month, pursuant to Section 16 of the Schedule, less the amount credited to Belair for the time when Mr. McMichael was otherwise supervised. The Arbitration Decision on the attendant care issue in McMichael upholds the appropriateness of the manner by which the Form 1 had been completed. This Arbitration Decision reflects the approach that is mandated by the SABS and recommended by your Association.

The decision is a lesson to insurers who are enjoined by the finding to take steps to determine what attendant care is being provided and to obtain opinions to determine whether or not the attendant care needed as identified in the Form 1, is reasonable and necessary according to their Section 42 examiners.

From a claims-handling perspective, if an adjuster were to adopt the approach taken by the Arbitrator in McMichael an adjuster would:

1. receive the Form 1; and

2. then request information concerning the services provided by the family members if the narrative report accompanying the Form 1 did not provide a plain indication of same.

If the family members were unable to provide the services, it does not change the need. The need should then be met by appropriately trained providers.

BELAIR AND MCMICHAEL – APPEAL DECISION MARCH 12, 2006

The comments with respect to attendant care begin on page 19 of the Appeal decision.

Belair initially challenged the Arbitrator's finding that Mr. McMichael needed attendant care twenty-four hours; however, it eventually withdrew this argument. In so doing, the insurer accepts the Arbitrator's decision which confirmed the appropriateness of the approach taken and the content of the Form 1 that was completed by the treating occupational therapist at first instance. The therapist assessed need in that Form 1, not whether or how the need was met.

On Appeal, Belair argued that the Arbitrator erred by awarding attendant care benefits even though they were "not incurred" and by ordering ongoing benefits even though Mr. McMichael's need for attendant care may change from time to time. The decision by the Arbitrator was upheld on Appeal by the Director's Delegate.

The Director's Delegate indicated:

> "In these circumstances, given Mr. McMichael's serious situation and his clear, contemporaneous and well documented request for funding, the Arbitrator's Order was, in my view, the only Order that preserves any procedural integrity to the process under the SABS".

The Arbitrator examined the evidence concerning the need for attendant care and referred to the fact that the Arbitrator at first instance, had accepted that:

> "Mr. McMichael had demonstrated over the course of more than four years (now six) a complete inability to stay off crack cocaine for any significant period of time",

and therefore required attendant care during that period of time.

Except for a period of two weeks and the times during which Mr. McMichael was under the supervision of institutions, Mr. McMichael lived with his family who cared for him as best they could. Mrs. McMichael testified that even simple tasks would often require prompting about the next step.

The uncontroverted evidence before the Arbitrator was that:

> "Mrs. McMichael has had to take over much of the management of the household, both in terms of the physical doing of the tasks required but equally significant the executive functions of a responsible homemaker and family partner."

As such, there is evidence of need for attendant care and there is the evidence of the wife of her attempts to assist him with respect to his injury-related impairments. There was no evidence given to contest either the need for the attendant care nor was there evidence to dispute the provision of assistance by Mrs. McMichael.

However, Mrs. McMichael had to work and there were periods of time that he was left without supervision. As a result, the evidence accepted at the Arbitration was that he had "demonstrated over the course of more than four years (now six) a complete inability to stay off crack cocaine for any significant period of time".

The Director's Delegate notes that:

> "The procedural rules described in Section 39 of the SABS were intended to ensure that the claimant does not bear the health risk of foregoing needed services or the financial risk of paying for them out-of-pocket without any assurance of compensation."

The Director's Delegate then referenced the pay-pending resolution of dispute provisions of the previous version of the SABS to avoid the health risk of foregoing the needed services or the financial risk of paying for them.

In relation to Belair's submission that the word "incurred" indicates:

> "That the attendant care benefits provide indemnity coverage only, and therefore no benefits are payable for any period when the service was not obtained or the expense not incurred".

The Director's Delegate indicates:

> "The accident benefit scheme is consumer protection legislation, and this sometimes requires 'bright-line boundaries' that produce anomalous results in certain circumstances. Belair's position has serious implications for the claims process…if benefits for a given period are not payable unless the services were received, the insurer stands to benefit from refusing to pay for services claimed whether for medical, rehabilitation, attendant care, housekeeping or other services…"

In conclusion, the Director's Delegate upheld the Arbitrator's Order indicating:

> "It must be understood in the statutory context and particularly the pay pending dispute rules in Section 39…Belair's position would mean that an Arbitrator has no authority to order payment of benefits to which the claimant has proven entitlement, unless the claimant has obtained the services without the insurer's approval. **This is an absurd result that would render the dispute resolution process meaningless."**

In the result, the Order was upheld for payment of attendant care benefits to include periods when the insured person had a need for attendant care but was not receiving services at that time to address the need. This seems appropriate given that the very reason for the absence of services to address the need was the insurer's failure to agree to pay for same.

Arbitrator Muir also made an Order for ongoing benefits. The Director's Delegate upheld that order and referred to Section 284 of the *Insurance Act* which allows the insured person or the insurer to apply to the Director to vary or revoke an Order of the Director or an Arbitrator based upon:

> "a material change in the circumstances of the insured or that evidence not available at the time of the Arbitration or the Appeal has become available or that there was an error in the Order…"

Thereupon the Director's Delegate or Arbitrator may:

> "vary or revoke the Order and make a new Order if he or she considers it advisable to do so".

Under Section 284, an Order made, varied or revoked under subsection (3) may be prospective or retroactive (Section 284 (4)).

To date, Belair has continued to pay the benefits owing for attendant care and has not applied to the Director's Delegate under Section 284 to vary the Order.

The Divisional Court also upheld the decisions on the arbitration and on the appeal.

WHAT NOW?

If:

1. the insurer chooses to ignore a claim for attendant care; or

2. refrains from obtaining assessments to address the need which is being advanced for attendant care; or

3. refrains from requesting information to support the provision of services for the attendant care;

then the insurer is at risk of having an Arbitrator or Judge make an order for payment of past benefits, similar to that which occurred in McMichael.

ATTENDANT CARE SINCE MARCH 1, 2006

The Form 1 rates have changed. The replacement of the DAC by section 42 evaluation is significant.

Section 39(1) states that an Application for Attendant Care Benefits:

> "Must be in the form of an Assessment of Attendant Care Needs for the insured person that is prepared and submitted to the insurer by a member of a health profession who is authorized by law to treat the person's impairment."

Since an insurer "may but is not required to pay an expense incurred before an Assessment of Attendant Care Needs," it is all the more important to have all attendant care needs recognized and assessed at a very early stage.

On receipt of the Application for Attendant Care Needs, the insurer's obligation is to begin payment of the benefits within 10 business days.

As such, on receipt of the Form 1 and the narrative report, if the insurer requires any clarification as to who is providing the services, a letter requesting that information should be sent immediately. The information can certainly be requested pursuant to section 33(1).

One of the conceivable responses that the insurer will receive in relation to its request is something like: "We are unable to provide the attendant care without the funding by the insurer." If that is the nature of the response then McMichael

helps the insurer to understand they are required to provide the funding in order that the services can be arranged.

Section 39(4), preserves the “pay pending” responsibility of the insurer concerning attendant care benefits. The insurer has the obligation to pay the attendant care, having calculated the amount of the benefits based on the Assessment of Attendant Care Needs, while it arranges and waits for a report from its section 42 evaluator.

Pursuant to section 40(3), if an application is made within 104 weeks of the accident to have the person deemed catastrophically impaired and immediately before the application the insured person was receiving attendant care benefits, the insurer is obliged to continue to pay attendant care benefits to the insured person until it receives its section 42 examination determining CAT status. The amount of the attendant care benefit is determined on the assumption that the person is catastrophically impaired ($6,000.00).

If a section 42 evaluation concludes no attendant care is payable or that some amount less than the applicant’s Form 1 amount is payable for attendant care, then a dispute as to the appropriate amount of attendant care benefits can arise.

Whenever there is a dispute as to the appropriate amount of attendant care benefits because of the denial of the applicant’s Form 1, the applicant has the right to proceed to mediation and arbitration to seek an order for payment of the appropriate attendant care benefit.

In the absence of DACs, where there has been a denial or a reduction of attendant care as a result of S.42, the applicant’s health and safety is placed into jeopardy. Counsel for the injured person will apply for mediation and fail the mediation. S/he will then issue an application for arbitration and apply for an interim order for payment of attendant care benefits to be made by an arbitrator.

This process can take place quickly even where an Attendant Care DAC has been the basis for a denial of benefits. A motion for interim benefits can be brought, heard and decided successfully, within 8 weeks of that denial.[6]

It’s apparent by the Keyes decision that arbitrators will scrutinize the approach taken by the DAC or section 42 evaluator and will not hesitate to call an approach taken by such an evaluator “partisan” if the section 42/DAC assessment process and report is not in accordance with the SABS or guidelines for persons completing Form 1 Section 42/DAC assessments.[7]

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[6] See Keyes and The Personal Insurance Company of Canada, Arbitrator Muir, FSCO decision A06-001156

[7] Keyes and The Personal Insurance Company of Canada, Arbitrator Muir, FSCO decision A06-001156, page 11

Regardless of the finding of the section 42 evaluator, section 39(7) makes it plain that, within the first 104 weeks new assessments of attendant care needs may be submitted to an insurer "anytime there are changes that would affect the amount of the benefits".

After 104 weeks, neither the insurer nor the insured can submit an Assessment of Attendant Care Needs unless the person is catastrophic and at least 52 weeks have elapsed since the last section 42 examination.

INTERIM MOTIONS FOR BENEFITS

Haimov and Ing Insurance

Marcus Haimov suffered catastrophic brain injuries rendering him comatose as a result of a motor vehicle accident on February 22nd, 2005. He was placed at Sunnybrook, Toronto Rehabilitation Institute and Baycrest Hospital. The insurer had received Form 1s identifying his attendant care needs but had declined to pay same indicating that they believed that the attendant care which he required was the responsibility of the Ministry of Health.

The applicant brought a motion for interim benefits in the context of a pending arbitration at the Financial Services Commission of Ontario in September of 2006 and was successful in demonstrating a prima facie entitlement to attendant care benefits payable by the insurer, at various rates during the various hospitalizations, culminating with an Order of payment of the amount of $6,000.00 per month from May 31st, 2006 to present and ongoing, plus interest and costs in accordance with the Dispute Resolution Practice Code.

In the decision, the Arbitrator evaluated the need of Mr. Haimov and agreed that he had a twenty-four hour a day need for attendant care. The Arbitrator referred to OHIP's position that attendant care is not an insured hospital service under the *Health Insurance Act.*

The Arbitrator also dealt with the insurer's submission that the co-payment to Baycrest of $1,500.00 per month, was in satisfaction of attendant care or a credit to his attendant care payments. The Arbitrator rejected the position of the insurer and found that the payment of $6,000.00, was owing above and beyond the co-payment requirement as it was a contribution towards accommodation and meals and not a payment on account of attendant care.

ADVANCE PAYMENTS IN TORT

Ordinarily section 258 of the *Insurance Act* may be used for the purposes of securing an advance payment from the tort feasor for loss of income. Section 258.5 (2) indicates:

> "If the insurer admits liability in respect of all or part of a claim for income loss the insurer shall make payments to the person making the claim pending determination of the amount owing."

Motions for summary judgment may also secure advance payments for services required in or outside of hospital; however, in the context of motor vehicle litigation, motions for summary judgment – partial judgment under Rule 20 include an onus for the plaintiff to satisfy the court that the plaintiff meets the applicable threshold.

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