Financial Services Commission of Ontario

Ontario

Commission des services financiers de l'Ontario

Appeal P05-00006

OFFICE OF THE DIRECTOR OF ARBITRATIONS

BELAIR INSURANCE COMPANY INC.

Appellant

and

DAVID MCMICHAEL

Respondent

BEFORE:	Nancy Makepeace
REPRESENTATIVES:	Chris T. J. Blom for Belair Alan L. Rachlin for Mr. McMichael
HEARING DATE:	September 22, 2005 Additional written submissions received in February 2006

APPEAL ORDER

Under section 283 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, **it is ordered that**:

1. The appeal is dismissed and the arbitrator's decision dated March 2, 2005 is confirmed.

2. If the parties are unable to agree on appeal expenses, they may request a hearing in accordance with Rule 79 of the *Dispute Resolution Practice Code*.

March 14, 2006

Nancy Makepeace
Director's Delegate

Date

REASONS FOR DECISION

I. NATURE OF THE APPEAL

Belair appeals from the arbitrator's decision, dated March 2, 2005, that Mr. McMichael is catastrophically impaired as a result of the accident and is entitled to ongoing income replacement benefits and attendant care benefits under the *SABS–1996*.[1] The appeal concerns the method for assessing catastrophic impairment under the *SABS-1996*. In addition, Belair argues that the arbitrator erred in law when he concluded that the accident caused Mr. McMichael's crack cocaine addiction, which was the primary basis for his catastrophic impairment claim. Finally, Belair submits that the arbitrator erred in law by finding that Mr. McMichael is entitled to attendant care benefits plus interest, though no attendant care was provided.

I am not persuaded the arbitrator erred.

II. BACKGROUND

The arbitrator's careful reasons relieve me of the need to review the background in detail. Here are the essential facts.

On June 14, 1998, Mr. McMichael was the backseat passenger in a taxicab that was hit broadside on the passenger side. He was thrown from the car and sustained multiple injuries, including an avulsion skull fracture, a closed head injury, numerous cuts and abrasions on his face, right arm and hand, an open femoral fracture, a broken rib (and perhaps two), a fractured scapula and a pneumothorax on one side. Later investigations also revealed a fractured bone in the left hand, TMJ displacement and fracture of the T9 vertebrae. Mr. McMichael was discharged from hospital after about two weeks. According to the arbitrator, his complaints at the time of the

[1] The *Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996*, Ontario Regulation 403/96, as amended.

hearing included "significant back pain," right thigh pain (the femoral nail installed the night of the accident was removed in April 2001), and "significant" weight loss because of "his inability to continue with his extensive pre-accident sporting activities as a result, in part at least, of his physical limitations."[2]

Most pertinent to the issues in dispute was Mr. McMichael's closed head injury, for which he was first assessed by Dr. Donna Ouchterlony, Director of the St. Michael's Hospital Head Injury Follow-up Clinic, in September 1998. Dr. Ouchterlony referred him to Dr. L. McFadden, a neuropsychologist. Their conclusions are best summed up by the arbitrator:

> [Mr. McMichael's] complaints were of irritability, forgetfulness and decreased concentration, as well as problems with visual focus. . . . . Dr. McFadden noted a number of deficits apparently connected to injuries sustained in the accident – reduced verbal fluency, difficulties with auditory attention and concentration, and poor organization and visual concentration; poor organization and visual constructive tasks; decrease in mental flexibility and a mild degree of impulsive behaviour. In the opinions of Dr. Ouchterlony and Dr. McFadden, these deficits were indicative of left frontal or temporal lobe damage as a result of a mild closed head injury.
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> Mr. McMichael was seen again by Dr. Ouchterlony in November 1998. He reported irritability, forgetfulness, and difficulties with attention and concentration. Assessment at that time revealed "reductions in verbal fluency, difficulties with auditory attention and concentration and poor organization [of] visual and constructive tasks. There was some decrease in mental flexibility noted and a mild degree of impulsive behaviour."
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> The opinions of Dr. Ouchterlony and Dr. McFadden that Mr. McMichael has suffered a mild traumatic brain injury is shared by most of the experts who have assessed him over the years. [footnote omitted] The debate amongst the medical experts is not whether there was a brain injury of some kind, but whether there are significant ongoing sequelae of it. Most importantly for our purposes, the debate centres on whether or not the current cocaine addiction is causally related to the motor vehicle accident. In the opinion of most of Mr. McMichael's expert witnesses, were it not for the cocaine problems, Mr. McMichael would likely not meet the test

[2] Arbitration decision, p. 6.

> for catastrophic impairment. It is also possible, according to these same experts, that he may be able to engage in some kind of employment.[3]

In October 1998, about four months after the accident, Mr. McMichael returned to his pre-accident job as an accounts manager at Cargo Direct. However, he was terminated after half a day because he was unable to work. According to Mr. McMichael, it was after his failed return to work that he began using crack cocaine, eventually becoming addicted to it, though he had used cocaine and other street drugs, as well as alcohol, before the accident. In December 1998, Mr. McMichael started working as a telephone salesman at Canada Water. He was terminated in March 2000 for poor sales. A third and final attempt to return to work lasted only a week. The arbitrator also heard evidence about the effect of Mr. McMichael's substance abuse on his activities of daily living and his family and social life. There was no dispute at the arbitration hearing that crack cocaine abuse and dependence had become Mr. McMichael's most serious problem, and it was the main basis for his catastrophic impairment claim.

The arbitration hearing took place over eight days in 2004, and written and oral submissions were completed later that year. Mr. McMichael testified, as did Ann McMichael (his wife), Douglas Ouderkirk (dispatch supervisor at Cargo Direct), Byron Georgeff (a friend), Earl White (his employer at Canada Water), Dr. Henry Berry (a specialist in neurology, psychiatry and internal medicine who assessed Mr. McMichael for medical-legal purposes), Dr. Shee Bhalerao (treating psychiatrist), Dr. Neville Doxey (vocational rehabilitation psychologist), and Dr. Ouchterlony. Witnesses for Belair were Dr. Arthur Ameis, (a physiatrist who conducts CAT DACs and who testified about the process), Dr. Lawrie Reznek (a psychiatrist who assessed Mr. McMichael for the insurer in February 2002), and Sharon Royer, a claims manager for Belair. The insurer also relied on the reports of Dr. Frank Evans, a psychiatrist and addiction specialist who assessed Mr. McMichael on admission to an inpatient medical detox and drug rehabilitation program, and Dr. Evans appeared for cross-examination by Mr. McMichael's counsel.

[3] Arbitration decision, pp. 7-8.

Mr. McMichael claimed income replacement benefits from November 24, 2002, when they were terminated by the insurer based on a disability DAC. In order to be entitled under s. 5(2)(b) of the *SABS-1996*, he had to prove that he suffered a "substantial inability to engage in any employment for which he . . . is reasonably suited by education, training or experience." He also claimed attendant care benefits of some $5,000 per month from April 2002 based on a report and Form 1 by Ms. Beverly Cott, an occupational therapist. This claim required Mr. McMichael to establish that he was catastrophically impaired, as defined under s. 2(1.1) of the *SABS-1996*, because otherwise attendant care benefits are limited to $3,000 per month for 104 weeks (24 months) after the accident, for a maximum of $72,000.[4] A key factual issue underlying both benefit claims was "the causal relationship, if any, between the car accident and Mr. McMichael's current difficulties, in particular his addiction to crack cocaine."[5] The arbitrator found that Mr. McMichael suffered a catastrophic impairment caused by the accident, and that he is entitled to the income replacement benefits and attendant care benefits claimed.

Belair appeals on three grounds. It submits that the arbitrator erred in law by finding that Mr. McMichael's crack cocaine addiction was a catastrophic impairment under paragraph (g) of s. 2(1.1) of the *SABS-1996* (impairment related to a class 4 mental or behavioural disorder) though he found the same impairment did not qualify Mr. McMichael under paragraph (f) of s. 2(1.1) (55 percent whole person impairment). Second, it submits that the arbitrator erred in law by finding that Mr. McMichael's crack cocaine addiction was caused by the accident, relying on *Correia and TTC*. Belair submits the arbitrator's decision is inconsistent with the decisions of the Ontario Court of Appeal in *Chisholm* and *Greenhalgh*. Finally, the insurer submits that the arbitrator erred in law by finding that Mr. McMichael is entitled to the attendant care benefits he claimed though attendant care was not provided.

[4] Subsections 16(5),18(2)-(3), and 19(2) of the *SABS-1996*.

[5] Arbitration decision, p. 2.

III. ANALYSIS

A. Catastrophic Impairment

Mr. McMichael claims that he has suffered a catastrophic impairment as defined under paragraphs (f) and/or (g) of the definition in the *SABS-1996*:

> 2(1.1) For the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs before October 1, 2003 is,
>
> . . . .
>
> (f) subject to subsections (2) and (3), an impairment or combination of impairments that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, results in 55 per cent or more impairment of the whole person; or
>
> (g) subject to subsections (2) and (3), an impairment that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.

In May 2002 a CAT DAC assessment was conducted by Dr. H. Becker, Dr. A. Oshidari (physiatrist), Dr. J.D. Salmon (neurologist), Susan Wong (occupational therapist who conducted an in-home assessment), and Dr. H. Rosenblat (psychiatrist). The consensus opinion was that Mr. McMichael did not satisfy the requirements of either paragraph (f) or (g). At the arbitration hearing, Mr. McMichael questioned "both the methodology and the results of that assessment."[6]

The arbitrator first considered paragraph (g). The *Guides* calls for assessment of four functional areas: (i) activities of daily living, (ii) social functioning, (iii) concentration, persistence and pace, and (iv) adaptation in work or work-like settings (deterioration or decompensation under stress). In each functional area, the severity of impairment is assessed under five classes: class 1,

[6] Arbitration decision, p. 30.

no impairment; class 2, mild impairment (impairment levels are compatible with most useful functioning); class 3, moderate impairment (impairment levels are compatible with some, but not all, useful functioning; class 4, marked impairment (impairment levels significantly impede useful functioning); and class 5, extreme impairment (impairment levels preclude useful functioning).

The arbitrator rejected Dr. Salmon's conclusion, which was as follows:

> All things considered, in terms of the impact of strictly neurogenic/psychogenic disorders on his daily functioning, Mr. McMichael: (a) remains functionally independent in all *daily living tasks* (Class 1: No impairment), although some impairment is recognized with regard to some non-CNS physical issues (e.g. back pain); (b) demonstrated sound *concentration*, *persistence* and *pace* upon interview, with minimal difficulties with same upon psychometric testing, but some concerns upon OT home assessment, suggesting a rating in the Class 2: Mild Impairment range in this criterion; (c) appears capable of *social* involvement compatible with Class 3-4: Moderate to Marked Impairment, with suggested fluctuations in behaviour contingent upon the social context and environmental demands (with minimal impairment noted in the context of a quiet but lengthy personal interview); The final domain of "*work adaptation* was not formally assessed at this time in light of the above noted ratings. From the overall perspective, Mr. McMichael would appear to fall into Class 2-3: Mild to Moderate Impairment based upon the AMA Guides Mental and Behavioral Disorders classification. As such, Mr. McMichael does not appear to meet Catastrophic Impairment status under this criterion. [Class 4 or 5].[7]

The arbitrator rejected the conclusions of the CAT DAC, noting, amongst other problems, the assessors' failure to consider Mr. McMichael's adaptation to work, which he found inconsistent with both the AMA *Guides* and the CAT DAC Assessment Guidelines;[8] unexplained differences in their assessments of his impairment in other functional areas (especially activities of daily living and social functioning);[9] their over-reliance on clinical testing without considering other available information about Mr. McMichael's crack cocaine binges and deteriorating substance

[7] Arbitration decision, p. 32.

[8] Arbitration decision, p. 41.

[9] Discussed at p. 33 of the arbitration decision.

abuse problems over the years since the accident;[10] and their failure to consider addiction *per se* as a disabling impairment. He preferred the opinions of Dr. Ouchterlony, Dr. Bhalerao and Ramona Bray (a treating social worker), ultimately concluding that Mr. McMichael suffered a class 4 impairment in three of the four functional areas (social functioning; concentration, persistence and pace; and adaptation to work), as well as a class 3 impairment in activities of daily living.

This raised a further question: how many functional class 4 or 5 impairments are required for a global class 4 or 5 catastrophic impairment score based on mental or behavioural disorder? The *Guides* states that "in the ordinary individual, extreme impairment in only one class would be likely to preclude the performance of any complex task, such as one involving recreation or work. Marked limitation in two or more spheres would be likely to preclude performing complex tasks without special support or assistance, such as that provided in a sheltered environment."[11] However, the arbitrator noted that in *Desbiens v. Mordini*, the parties agreed that a class 4 or 5 impairment was required in only one functional area.[12] Mr. McMichael satified the requirements of paragraph (g) on either basis because the arbitrator found he suffered a class 4 impairment in three of the four functional areas.

Therefore, the arbitrator concluded Mr. McMichael is catastrophically impaired as a result of the accident in that he suffers a class 4 impairment due to a mental or behavioural disorder as defined in chapter 14 of the AMA *Guides*.

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[10] Subsection 2(2) contemplates impairments that change over time. It states that clauses (f) and (g) do not apply unless the insured person's health practitioner states in writing that the insured person's condition has stabilized and is not likely to improve with treatment, or three years have elapsed since the accident.

[11] *Guides*, chapter 14, pp. 14/300-301, Arbitration exhibit 15, tab 4. The arbitrator also considered a document entitled "Mental and Behavioural Impairments Assessments Guideline" found on the old FSCO website, "but never precisely identified beyond that." This document also required a class 4 or 5 impairment in two or more functional areas. At p. 48, the arbitrator concluded, "Whatever the import of this document, it is not binding on me, and I cannot find support for the need for at least two scores of Marked Impairment in the language of paragraph (g)." That an arbitrator is not bound by DAC Guidelines was reaffirmed, most recently, in *Villers and Pilot,* (FSCO P05-00010, January 30, 2006), at p. 26.

[12] *Desbiens et al. v. Mordini et al.*, [2004] O.J. No. 4735 (Ont. S.C. J.), at para.129, discussed at p.48 of the arbitration decision.

However, turning to paragraph (f), the arbitrator was not satisfied that Mr. McMichael met the 55 percent whole person impairment ("WPI") criterion.[13] Mr. McMichael did not take issue with the CAT DAC assessors' conclusion that he suffered an 8 percent impairment as a result of his orthopedic injuries sustained in the accident. At issue was the impairment resulting from his brain injury, assessed under Chapter 4 of the AMA *Guides*, which deals with injuries to the nervous system.

The CAT DAC concluded Mr. McMichael sustained a 29-31 percent impairment due to his brain injury, insufficient to qualify for catastrophic impairment status under paragraph (f). To score a 55 percent WPI based on the combined values chart set out in the AMA *Guides*, Mr. McMichael had to have sustained at least a 51 percent impairment, described as "severe limitation of all daily functions requiring total dependence on another person," as a result of his brain injury. Though Dr. Henry Berry concluded Mr. McMichael met this criterion, the arbitrator was not persuaded. Instead, the arbitrator implicitly accepted ratings in the 30-49 percent range, described as "severe limitation impeding useful function in almost all social and interpersonal daily functions." As noted by Belair's counsel on appeal, even a 49 percent rating for neurological impairment, combined with an 8 percent rating for musculoskeletal impairments, results only in a 53 percent score, just under the 55 percent required for a catastrophic impairment rating.

As a result, Mr. McMichael satisfied the requirements of paragraph (g) but not paragraph (f) of s. 2(1.1). The arbitrator considered the implications, and stated:

> That Mr. McMichael meets the criteria for catastrophic impairment under one set of criteria and not another is not surprising even where they are, on the face of it, related to some degree. The various sets of criteria are in the alternative.[14]

This statement is the basis for the insurer's appeal. Belair does not challenge the arbitrator's findings of fact, which it concedes are beyond the scope of an appeal under s. 283(1) of the

[13] Arbitration decision, pp. 49-58.

[14] Arbitration decision, p. 54.

Insurance Act. Nor does it challenge the arbitrator's analysis under each paragraph. Belair's position is that the AMA *Guides* are intended to ensure consistency of results, and therefore the arbitrator's different conclusions with respect to paragraphs (f) and (g) are irreconcilable, amounting to an error of law.

I reject this. I agree with the arbitrator that the definitions of catastrophic impairment in s. 2(1.1) are alternatives. For one thing, the use of the word "or" after paragraph (f) suggests this is a disjunctive list. Indeed, Belair concedes that a claimant is catastrophically impaired if he satisfies any one of the definitions in paragraphs (a) through (g). It is easy to see that this must have been within the contemplation of the drafters, since, for example, a claimant who qualifies as a quadriplegic under paragraph (a) may have no visual or brain impairments, thus "failing" paragraphs (d) and (e).

Underlying Belair's argument is the observation that while paragraphs (a) through (e) describe specific types of impairment, paragraphs (f) and (g) take a different approach, offering different ways of assessing global impairment. However, the same analysis applies. It is easy to see that a claimant may satisfy paragraph (f) because of a combination of orthopedic injuries, for example, without suffering any impairment due to a mental or behavioural disorder – or vice versa. Another claimant may have a visual impairment that does not qualify under paragraph (d) ("total loss of vision in both eyes") but does qualify under paragraph (f) when combined with other injuries. I am persuaded these outcomes were intended by the drafters.

Further support for an expansive reading of s. 2(1.1) is found in s. 2(3), which provides for an assessment by analogy to impairments listed in the AMA *Guides*.

> 2(3) For the purpose of clauses (1.1) (f) and (g) . . . , an impairment that is sustained by an insured person but is not listed in the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993 shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.

As stated by Justice Spiegel in *Desbiens v. Mordini*, the statutory direction that impairment be evaluated "in accordance with" the AMA *Guides* should be given "a fair, large and liberal interpretation so as to ensure the attainment of the object of the *Act* according to its true intent, meaning and spirit."[15] "Impairment" is broadly defined in the *SABS* as "a loss or abnormality of a psychological, physiological or anatomical structure or function." But there are many different ways of being impaired – or, by extension, catastrophically impaired. A broad definition of "catastrophic impairment" ensures that the most seriously impaired claimants may qualify for enhanced attendant care or other benefits, whatever the nature of their impairments.[16] I think it likely that the drafters created alternative ways of satisfying this definition so as to avoid under-inclusiveness and ensure that impairments of equal seriousness are treated equally in the *SABS*.

Nor is this conclusion inconsistent with anything in the AMA *Guides*, which, while aiming for improved standardization, objectivity and reproducibility in the evaluation of impairment, recognize that it "does not and cannot provide answers about every type and degree of impairment," and cannot displace the clinical judgement of the evaluator or the role of an adjudicator.[17]

Similar interpretive considerations led to Justice Spiegel's conclusion, in *Desbiens v. Mordini*, that impairments due to mental or behavioural disorder described in paragraph (g) could be assigned a percentage and combined with other impairments in the assessment of whole body impairment under paragraph (f). That decision was released after the close of evidence in the arbitration hearing and the arbitrator limited himself to a discussion of the issues without making a finding on the combined rating. The issue was not squarely addressed by either party on appeal, and I need not consider it further.

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[15] Paragraph 243.

[16] A catastrophic impairment determination does not, by itself, entitle a claimant to any specific benefits. Its effect is to remove a limitation on the benefits for which the claimant may qualify.

[17] Arbitration exhibit 15, tab 1, pp. 2-3 of chapter 1. The *Guides* recognizes that a number of limitations may affect any given evaluation, including changing medical knowledge, the variability of "normal" functioning, the variety of human disease, the need for clinical judgement, and the difficulty of determining how an impairment affects functioning in everyday life, which requires consideration of non-medical factors. Additional factors complicate assessment of impairments due to mental or behavioural disorders (see the discussion at pp. 300-301 of chapter 14).

B. Causation

Belair submits that the arbitrator erred in law when he concluded that Mr. McMichaels' addiction to crack cocaine "is a direct consequence of the injuries sustained in the car accident."[18] Belair submits this conclusion is inconsistent with the Ontario Court of Appeal decisions, *Greenhalgh v. ING Halifax Insurance Company* (2004), 72 O.R. (3d) 338, and *Chisholm v. Liberty Mutual Group* (2002), 60 O.R. (3d) 776. In Belair's submission, these decisions effectively overruled *Correia and TTC Insurance Company Limited*, (FSCO A00-000045, October 27, 2000), confirmed, (FSCO P00-00061, July 16, 2001), with which the arbitrator agreed.

The arbitrator introduced the dispute at the outset of his decision:

> A key factual issue in this case is the causal relationship, if any, between the car accident and Mr. McMichael's current difficulties, in particular his addiction to crack cocaine. Mr. McMichael states that, as a result of the accident, he has become a crack cocaine addict. It is this addiction, primarily, that forms the basis of his position that he is catastrophically impaired and therefore entitled to attendant care and equally, that he is unable to work. Belair states, on the contrary, that Mr. McMichael was a cocaine abuser before the car accident and therefore his addiction to crack cocaine did not arise from the accident. In that case, states Belair, there is no entitlement to either benefit.

Before considering the evidence about Mr. McMichael's drug use, the arbitrator clarified some important terms:

> A note about the use of terminology regarding cocaine use and abuse. During the course of the hearing, the terms, "use", "abuse" and "addiction" in relation to cocaine and crack cocaine were used somewhat interchangeably. Despite this usage by some during the hearing, cocaine abuse and cocaine dependence are diagnoses found in the *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders.* [footnote omitted] How these DSM-IV diagnoses relate to the terms "use", "abuse" and "addiction" as they were used by some witnesses is not clear. However, Belair alleges, based largely on the opinion of Dr. Reznek, that Mr. McMichael suffered from cocaine abuse prior to the car accident. Mr. McMichael

[18] Arbitration decision, p. 25.

> denies this, but does state that as a result of the accident he is addicted to crack cocaine (cocaine abuse, or cocaine dependence). In coming to the conclusions I have about Mr. McMichael's pre-accident health and level of function, I have considered the diagnostic criteria for cocaine abuse as set out in the DSM-IV Manual. There is no dispute that he now suffers from cocaine abuse and/or cocaine dependence.[19]

Dr. Lawrie Reznek, a psychiatrist, examined Mr. McMichael at Belair's request on February 18, 2002. It was his opinion that the accident did not cause Mr. McMichael's cocaine abuse because, in Dr. Reznek's view, he abused drugs before the accident. This conclusion was based, in part, on Dr. Reznek's assumption that Mr. McMichael underestimated his cocaine use before the accident because there was evidence that he underestimated his alcohol use. Therefore, Dr. Reznek reasoned, "because cocaine is highly addictive and can often lead to serious social and functional problems, Mr. McMichael must have also met these other criteria for the diagnosis of cocaine abuse as described in the DSM-IV."[20]

The arbitrator rejected Dr. Reznek's conclusion. He found that while Mr. and Mrs. McMichael "may have underestimated the frequency of his drug use in the years immediately prior to the accident," it did not follow that Mr. McMichael suffered from cocaine abuse or dependency before the accident.[21] Moreover, the arbitrator heard a great deal of evidence about Mr. McMichael's deterioration since he first used crack cocaine in October 1998. For example, while Dr. Reznek noted that Mr. McMichael "was well presented," he declined to consider other evidence about Mr. McMichael's functioning at the time. A little more than a month later (and a week after leaving a similarly positive impression on Beverly Cott, an occupational therapist), Mr. McMichael was admitted to hospital twice (on March 25-26 and then again on March 30-April 8, 2002) after crack cocaine binges.

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[19] Arbitration decision, pp. 2-3.

[20] Arbitration decision, pp. 9-10.

[21] Arbitration decision, p. 10.

The arbitrator accepted that Mr. McMichael "had a long history of cocaine use, beginning in his late teens and continuing sporadically to the time of the accident."[22] However, he concluded the evidence did not support a finding of pre-accident cocaine abuse. The main basis for the "use but not abuse" finding was evidence about Mr. McMichael's ability to function at work, at home with his family, and in sporting and social activities before the accident, evidence that came from Mr. and Mrs. McMichael, Mr. Georgeff (a friend), and Mr. Ouderkirk (a dispatch supervisor with his pre-accident employer), supported by pre-accident income tax and medical records. The arbitrator concluded that Mr. McMichael's cocaine use had peaked in his early twenties, and that he was "a recreational user" in the years leading up to the accident:

> The most critical factor in arriving at my conclusion that Mr. McMichael did not meet the DSM-IV criteria for cocaine abuse is the complete lack of evidence that Mr. McMichael's substance use ever interfered in his day-to-day life. Prior to the accident he was an active family man, enjoyed sports on a regular, almost daily basis. He was actively involved in his birth family's life, with regular visits to his mother and his three sisters. He may have downplayed work and career in favour of other things in his life, such as sports and an active social life in the Beaches. Nonetheless, he maintained steady employment and met his sales targets. In short, he lead an active, productive and by all accounts a complete life in the years prior to the car accident. [Arbitration decision, p. 14, footnote omitted]

In contrast, "[t]here is no dispute that Mr. McMichael currently meets the criteria for cocaine abuse. He likely also meets the criteria for cocaine dependence."[23]

It was not enough for Mr. McMichael to show that he abused and became addicted to crack cocaine after the accident and not before; he had to prove these impairments were causally connected to the accident. He testified that he first used crack cocaine after his failed attempt to return to work in October 1998 in an attempt to self-medicate. The arbitrator accepted the causal connection:

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[22] Arbitration decision, p. 12.

[23] Arbitration decision, p. 15.

> As indicated earlier, the consensus of medical opinion is that Mr. Michael's addiction to cocaine is as a result of the car accident. In addition to Mr. McMichael's experts (Dr. Ouchterlony, Dr. Berry and Dr. Bhalerao), the Med-Rehab DAC, considering the reasonableness and necessity of a drug rehabilitation program, agreed that it was. Dr. Salmon, a neuropsychologist who assessed Mr. Michael on two occasions in both a Med-Rehab and Catastrophic DAC assessment (CAT DAC), considered that the accident had materially contributed to Mr. McMichael's substance abuse problem.
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> Whether as a result of marginally impaired impulse control as suggested by some [footnote omitted], or as a misguided attempt to self-medicate, I accept those opinions as well as the evidence of the McMichaels' that the drug addiction was a direct consequence of the accident.[24]

On appeal, Belair does not take issue with the arbitrator's treatment of the evidence, but submits that he erred in law in failing to apply the *Chisholm* and *Greenhalgh* tests in assessing the causal connection between the accident and Mr. McMichael's cocaine abuse, and instead relying on *Correia*.

As I have reviewed the evolution of the law in this area in several cases, including the arbitration decision in *Correia,* which was confirmed on appeal, and most recently in *Sohi and ING Insurance Company of Canada*, (FSCO P04-00026, May 5, 2005), there is no need to review the authorities in detail.

In summary, Belair submits that the definition of "accident" in s. 2(1) of the *SABS-1996* – "'accident' means an incident in which the use or operation of an automobile directly causes an impairment. . . " – requires Mr. McMichael to prove that his cocaine abuse was *directly caused by* the accident, a test Belair submits he has failed to satisfy. I need not address the *Chisholm*/*Greenhalgh* analysis because I agree with the arbitrator that it does not apply in this case:

[24] Arbitration decision, p. 18.

> the issue here is not whether there was an accident, in the sense of whether there were impairments caused by the use or operation of an automobile, but rather with tracing the chain of causation from impairments suffered in an accident to other causally linked sequelae.[25]

In *Correia*, there was no dispute the claimant was injured in an accident. The issue was whether she was entitled to benefits in relation to different injuries she suffered during a functional capacity evaluation required by her treatment provider. I concluded that the extent of her coverage was determined by the "as a result of" language of the various benefit entitlement provisions, not the "directly causes" language of the "accident" definition of the *SABS-1996*. As noted by the arbitrator, my conclusion was based on analysis of the statutory language and objectives:

> Important policy considerations also favour this approach. Accident benefits are intended to be payable on a non-adversarial, expedited basis. Requiring an insured person to trace the "chain of causation" with precision is inconsistent with this policy. Early rehabilitation is another important objective of the accident benefits scheme. For this reason, the *SABS* places special emphasis on prompt payment of medical and rehabilitation benefits, and requires insurers to pay certain benefits pending resolution of any dispute about entitlement.[26]

The arbitrator concluded:

> To my mind the facts of this case point to at least as strong a causal connection between the accident and Mr. McMichael's current problems as those found in *Correia*. Indeed, this case is not unlike the circumstance where apparently minor injuries sometimes lead to debilitating psychological problems in the months after the accident and initial physical injuries.
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> The question becomes whether the primary impairment at issue here, an addiction to a debilitating medication, is within the types of risks associated with the injuries sustained by Mr. McMichael early in the morning of June 14, 1998. Again I find, whether its genesis was an effect of the mild traumatic brain injury that Mr. McMichael suffered, a vain and misguided attempt to self-medicate, or some

[25] Arbitration decision, p. 22.

[26] At pp. 38-39 of the arbitration decision in *Correia*.

> combination of these two, the addiction is a direct consequence of the injuries sustained in the car accident.[27]

Belair submits that Ms. Correia's case is distinguishable because she suffered her new injury while engaged in an accident-related rehabilitation program, whereas Mr. McMichael's post-accident addiction was a natural progression of his pre-accident drug use. Though Mr. McMichael may present a less sympathetic claim, I am not persuaded the arbitrator erred in his assessment of its legal merits.

A similar approach was taken in *McIntyre v. TTC Insurance Co.*, [2006] O.J. No. 201 (OSCJ), released shortly before this decision was to be released. (The parties were given a brief time to comment.) Somers J. accepted the plaintiff's claim that she was entitled to income replacement benefits for a period of about 15 months while she was a patient in a drug rehabilitation program. Though the plaintiff had been addicted to narcotics before the accident, she had recovered and was functioning well at home and at work at the time of the accident. Justice Somers found that *Chisholm* and *Greenhalgh* were unhelpful to the defence because he had "no difficulty in finding that there was an accident, which resulted in injuries to the plaintiff." Instead, Somers J. referred to *Monks v. ING Insurance Co.*, [2005] O.J. No. 2526, which adopted *Correia* and accepted the distinction between the "directly causes" analysis required by the definition of "accident" and the "as a result of an accident" analysis required under the income replacement benefits entitlement provision.

In *McIntyre,* Somers J. concluded that the plaintiff was

> particularly vulnerable, because of her past history, to slip back from her pre-accident position to her former drug dependency existence. That she did so is in my mind no different than if she had had a pre-existing back condition which was exacerbated by the accident and eventually led to be more serious back trouble. I am of the view that the defendant, like a tortfeasor defendant, must take the plaintiff as it finds her. There was an accident and the outcome of it was not just an aching neck and back for a lengthy period of time, but a fit of depression which upset the general

[27] Arbitration decision, pp. 24-25, footnotes omitted.

> tenor of the plaintiff's day-to-day existence and put her into her former drug dependency. It is quite true that the drug dependency situation did not arise immediately following the accident, but it certainly did arise during the period of time prescribed by section 4(1) of the regulation.[28]

The arbitration decision in *Sohi and ING Insurance Company of Canada*, (FSCO A03-001125, July 15, 2004) was one of the decisions Justice Lalonde referred to in *Monks* in noting that the *Correia* arbitration decision has been followed. The decision was revoked on appeal and the matter remitted for rehearing: (FSCO P04-00026, May 5, 2005). That decision is of some interest because of the facts in that case: three weeks after his automobile accident, Mr. Sohi set himself on fire in the living room of his apartment. It can be argued that the chain of causation in this case, as in Mr. Sohi's case, is attenuated by the claimant's life choices after the accident. However, the problem in *Sohi* was the arbitrator's failure to address significant gaps and inconsistencies in the evidence. I was not persuaded Mr. Sohi's claim must fail in law, and I reaffirmed my analysis in *Correia*.

In short, the arbitrator's analysis is consistent with a number of decisions that deal not with whether an incident was an "accident" but with "the unfolding consequences of an injury sustained in an accident."[29] I agree with the arbitrator that this case falls to be decided under the same principles. He concluded:

> whether its genesis was an effect of the mild traumatic brain injury that Mr. McMichael suffered, a vain and misguided attempt to self-medicate, or some combination of these two, the addiction is a direct consequence of the injuries sustained in the car accident.[30]

[28] At para. 22.

[29] Arbitration decision, p. 20.

[30] Arbitration decision, p. 25.

This was a strong finding, and one that was well-supported on the evidence and consistent with previous decisions.[31] I am not persuaded the arbitrator erred.

C. Attendant Care Benefits

The arbitrator ordered Belair to pay "an attendant care benefit of $5,056.80 per month from April 2002, to date and ongoing, pursuant to section 16 of the *Schedule* [the *SABS-1996*], less amounts credited to Belair for time when [Mr. McMichael] was otherwise supervised." He remained seized "in the event that there are any unresolved disputes respecting the quantum of attendant care benefit."

Though Belair initially challenged the arbitrator's finding that Mr. McMichael needed attendant care 24 hours a day, this argument was withdrawn at the start of the appeal hearing. Belair submits that the arbitrator erred in law by awarding benefits though no attendant care expenses were "incurred" and by ordering ongoing benefits though Mr. McMichael's need for attendant care may change from time to time.

I am not persuaded the arbitrator erred.

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[31] This conclusion made it unnecessary for the arbitrator to consider the significance, if any, of the October 2003 amendment of the "catastrophic impairment" definition: paragraphs (f) and (g) continue to apply to accidents before October 1, 2003, but the beginning words of the subsection were changed from "'catastrophic impairment' means, . . ." to: "[f]or the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs before October 1, 2003 is, . . ."

Though counsel discussed the change at the conclusion of oral submissions in the arbitration hearing, it appears the arbitrator was not asked to decide whether the change is substantive or merely formal and whether it has retrospective application. Belair's position was that *Correia* was wrongly decided and that *Chisholm* and *Greenhalgh* governed the case. Discussing the issue in the context of paragraph (f), the arbitrator stated:

> In respect of entitlement to most benefits under the *Schedule,* where there may have been pre-existing health issues, arbitrators have determined that the accident must have made a contribution to the disability – the usual formulation is that the injury sustained in the accident made a "material contribution" to the impairment.
>
> It is not clear from the language of the definition in subsection 2(1.1) why a determination of catastrophic impairment would be treated so dramatically different by the Legislature. However, I need not decide the question in this case, because I find that Mr. McMichael's impairments are all causally related to the car accident. As noted a number of times, Mr. McMichael was in good health prior to the accident, leading an active family, work and social life. He was for our purposes impairment free prior to the accident. (p. 58)

The significance, if any, of the amendment to the definition was not argued on appeal, and I draw no conclusions.

(i) "Incurred"

Belair submits that the arbitrator erred in his interpretation of s. 16(2) of the *SABS-1996*, which provides 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 an aide or attendant" or "services provided by a long-term care facility, including a nursing home, home for the aged or chronic care hospital." Belair's position is that Mr. McMichael did not "incur" attendant care expenses because he did not receive attendant care, pay for attendant care, or incur a debt or obligation to pay for attendant care.

Mr. McMichael submits that Belair's refusal to pay attendant care benefits was the reason he did not receive the attendant care the arbitrator found he needed. Allowing the insurer to avoid paying the overdue benefits creates a moral hazard in the accident benefit system, according to Mr. McMichael, and this should be avoided on public policy grounds.

The arbitrator dealt with the issue summarily, relying on previous decisions:

> It is well established that an applicant need not actually receive the items or services claimed in order to be entitled to an expense.[32] To do otherwise would allow the insurer to set up the inability of an insured to pay for a benefit 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.[33]

However, in *Stargratt*, one of the decisions relied on by the arbitrator, there was no dispute that the claimant was attended by her sister and parents after the accident, though she had not paid or promised to pay for her care. The insurer knew Ms. Stargratt needed help but failed to tell her she could pay her family for looking after her, instead implying that she could claim benefits

[32] *Wawanesa Mutual Insurance Company v. Smith*, 42 O.R. (3d) 441; *Stargratt and Zurich Insurance Company* (FSCO A99-000521, October 4, 2001) [footnote in original] The decision was confirmed on appeal on this point, (FSCO P01-00045, March 31, 2003).

[33] Arbitration decision, pp. 66-67.

only by providing receipts from a third-party attendant.[34] Other decisions have suggested that entitlement follows upon proof that attendant care services were provided.[35]

However, benefits were awarded in *Persofsky and Liberty Mutual Insurance Company*, (FSCO A99-000598, June 23, 2000) (caregiver and housekeeping services) and *Fehringer and Zurich Insurance Company*, (FSCO A99-000699, February 28, 2002) (chiropractic and massage treatment), for periods when no services were obtained because the insurer denied the claim. Both arbitrators relied on *Kennelly and Wawanesa Mutual Insurance Company*, (FSCO A99-000139, January 21, 2000), at pp. 18-19, where the arbitrator ordered the insurer to pay for speech therapy the claimant had stopped receiving when the insurer terminated her benefits:

> Wawanesa submits that even if it is obliged to pay for ongoing speech therapy, it should not have to pay for any missed treatments. It argues that Ms. Kennelly cannot be said to have "incurred" expenses for treatments she did not receive and can no longer obtain; although Ms. Kennelly can *resume* speech pathology treatments, she cannot *replace* missed treatments. I agree with Wawanesa that in this sense these benefits are forever lost and can never be recouped.
>
> This, however, does not mean the expenses were not incurred. Ms. Kennelly established the reasonable necessity of these services, along with their amounts, and properly presented them to Wawanesa.
>
> Wawanesa maintains that it would be unfair to make them pay for a service which can no longer be provided, and which therefore provides no benefit to Ms. Kennelly. This is not only wasteful, it argues, but it amounts to a windfall for Ms. Kennelly.
>
> While at first glance there is some logic to this argument, if allowed it would undermine the statutory goal of prompt and timely payment for necessary medical services. Insurers might deny payment of needed services with impunity, believing that an arbitrator will not later order them to pay for the treatments, however

[34] Similarly, see *Horvath and Allstate Insurance Company of Canada*, (FSCO A02-000482, June 9, 2003) and *L.F. and State Farm Mutual Automobile Insurance Company*, (FSCO P02-00026, June 3, 2004), at pp. 24-26.

[35] See, for example: *S.D. and TTC Insurance Company Limited*, (FSCO A00-000206, May 13, 2002), at p. 44; *McKnight and Guarantee Company of North America*, (FSCO A02-000299, October 28, 2003), at p. 5; and *Michalski and Wawanesa Mutual Insurance Company*, (FSCO A03-001363, December 13, 2005), under appeal, released subsequent to the hearing in this appeal. In *Da Rosa and Allstate Insurance Company of Canada*, (FSCO P01-00007, May 16, 2002), at pp. 20-23, I revoked the arbitrator's order for attendant care and medical and rehabilitation benefits that were neither incurred nor claimed.

> reasonable, because they can no longer be of benefit to the applicant. As Arbitrator Palmer noted in *Pintucci*,[36] "it does not behove an insurer to deny the process of the *Schedule* and ask to be relieved from payment at arbitration." Although an aggrieved applicant can recover a special award if the hearing arbitrator finds that an insurer unreasonably withheld benefits, this penultimate remedy cannot substitute for prompt, regular treatments during the period of entitlement.
>
> Nor am I persuaded that this amounts to a windfall for Ms. Kennelly. She was deprived of a service that she was entitled to by statute. The termination of therapeutic support delayed her recovery, increased her frustration over her impairments, and caused her to lose some of the gains she had made over the previous year. Moreover, the insurer has had the benefit of these monies throughout the time that they should have been dispensed to Ms. Kennelly.
>
> For all these reasons, I find that the expenses in question were incurred.

This appeal, like *Kennelly*, raises the question whether an arbitrator can award benefits in relation to a specific past period when no services were provided. The same problem does not arise where *goods* claimed were not obtained because the claim was refused, but can be obtained once the claim is paid in accordance with the arbitrator's order.[37] Similarly, when a claim for *treatment* is allowed, the treatment can often be obtained, albeit over a different and later period, once the claim is paid in accordance with the arbitrator's order, and despite the delay, the treatment may benefit the claimant. But Mr. McMichael, like Ms. Kennelly, cannot obtain the attendant care *services* the arbitrator found he was entitled to from April 2002 to the date of the hearing.

Belair submits that the word "incurred" indicates that 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 incurred. However, the accident benefits scheme is consumer protection

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[36] *Pintucci and Jevco Insurance Company* (FSCO A97-000755, January 7, 1999) [footnote in original]

[37] See *Stargratt* for a discussion of medical and rehabilitation benefits decisions considering the meaning of "incurred." In several decisions, insurers have been ordered to pay for goods claimed but never received because of the insurer's refusal: *Plows and Jevco Insurance Company*, (OIC A-000175, A-000588, January 16, 1992) (paraplegic entitled to modified van), and *Quarrington and Jevco Insurance Company*, (OIC A-010804, July 17, 1995) (dental implants) are the leading *SABS-1990* decisions. Though I dismissed the claim for an orthopedic mattress and pillow in *Caruso and General Accident Assurance Company of Canada*, (OIC A06-000644, March 27, 1997), I rejected the insurer's submission that the *SABS-1994* changed the law.

legislation, and this sometimes requires "bright-line boundaries" that produce anomalous results in certain circumstances.[38] Belair's position has serious implications for the claims process. *Kennelly* illustrates the problem: 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.

The procedural rules described in section 39 of the *SABS* were intended to ensure that the claimant does not bear the health risk of forgoing needed services or the financial risk of paying for them out of pocket without any assurance of compensation.[39] To avoid this, s. 39(6) of the *SABS-1996* requires attendant care benefits to be paid pending receipt of the DAC report, and s. 39(7) requires payment pending resolution of any dispute if the DAC report supports the claim. No attendant care DAC was arranged in this case because the claim, brought in April 2002, depended on a catastrophic impairment determination, and the CAT DAC assessors, reporting in May 2002, concluded Mr. McMichael was not catastrophically impaired. The arbitrator was not asked to consider whether the *SABS* requires an attendant care DAC in this situation, or whether the pay pending dispute rules continue to apply, and the issue was not put to me either.

Nonetheless, the arbitrator's order must be understood in the statutory context and particularly the pay pending dispute rules in s. 39. Consider the clearest case, where an attendant care DAC is conducted and a "negative" report released. In that case, the insurer is entitled to refuse payment, and the claimant's recourse is to prove his claim before a judge or arbitrator. But 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.

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[38] *Smith v. Co-operators General Insurance Co.*, [2002] 2 S.C.R. 129, 2002 SCC 30 (CanLII), at para. 16.

[39] The third option – accepting unpaid care from family and friends in the hope of being able to pay for it in the future – is available to some claimants but not all, and cannot be assumed. It appears not to have been available to Mr. McMichael.

Mr. McMichael's attendant care claim was not an afterthought intended to bolster his position at arbitration. As required by the *SABS*, Mr. McMichael applied for pre-approval of his claim immediately after his hospitalization in March-April 2002 and subsequent decline. In his correspondence with Ms. Royer at that time, Mr. Rachlin was clear about the seriousness of the situation, and expressly asked the insurer to provide the recommended attendant care on a without prejudice basis pending the outcome of the CAT DAC.[40] Ms. Royer conceded she understood from Mr. Rachlin that Mr. McMichael's family felt "he was at self-risk and harm due to his cocaine addiction."[41] The arbitrator accepted Mr. McMichael's position 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."[42] 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*.

(ii) Order for Ongoing Benefits

Belair submits that the arbitrator's order for ongoing payment of attendant care benefits in a fixed amount leaves the insurer with no recourse should Mr. McMichael's attendant care needs change – for example, if he recovers from his crack cocaine addiction.

The factual basis for the arbitrator's order was a report and Form 1 prepared by Beverly Cott, an occupational therapist, on March 27, 2002, about three years prior to the date of the decision. Ms. Cott stated that Mr. McMichael "remains in crisis and at great risk of returning to drug usage, particularly in view of his history and his poorly structured daily routine."[43] She

[40] Arbitration exhibit 24, tabs 13 and 15.

[41] Arbitration transcript, June 10, 2004, p. 14-15, questions 57-58.

[42] Arbitration decision, p. 67.

[43] Arbitration exhibit 7, report dated March 27, 2002, at p. 24.

concluded he "requires ongoing supervision" to ensure his safety and prevent an overdose: "Given that Mr. McMichael continually finds himself in crisis, this therapist supports the provision of attendant care, at least until such time as he is admitted to an in-patient drug rehabilitation program." Similarly, Dr. Ouchterlony testified about the risks to Mr. McMichael if he did not stop abusing crack cocaine and other substances. According to the arbitrator, their recommendation for attendant care "is not necessarily open ended, but for both Ms. Cott and Dr. Ouchterlony, it is recommended as an interim step in a comprehensive drug treatment program."[44] As to the ongoing effect of the order, the arbitrator summed up the issue this way:

> It is impossible not to note the significant divergence in the views of the experts relied upon by Mr. McMichael, as regards the length of time and circumstances during which Mr. McMichael may need attendant care. Despite these divergences of view, I am required to determine whether or not he is entitled to the benefit based on the evidence before me.
>
> Having considered all of the evidence, I am persuaded that Mr. McMichael was in need of attendant care at the time that Ms. Cott authored her report and, given Mr. McMichael's proven inability to stay clear of crack cocaine since that time, notwithstanding further treatment recommended by her and others, he remains entitled to the benefit.[45]

This issue is a familiar one for the accident benefits scheme, where claims adjustment and dispute resolution depend on assessments made at specific times, but benefits are paid on an ongoing periodic basis.

The *SABS-1996* provides some of the answers by prescribing a detailed mandatory step-by-step process, which I described, in relation to attendant care benefits, at pages 20-24 of *L.F. and State Farm Mutual Automobile Insurance Company*, (FSCO P02-00028, June 3, 2004). The main point, for present purposes, is that the *SABS* contemplates assessment of attendant care claims on a prospective basis, subject to periodic review.

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[44] Arbitration decision, p. 65.

[45] Arbitration decision, p. 66.

This is clear from sections 39 and 43 of the *SABS*, and from Form 1, the prescribed Assessment of Attendant Care Needs form, which instructs: "[u]se this form to report the future needs for attendant care." Subsection 39(1) allows an insurer to require the claimant to furnish a health professional's certificate stating that the expenses described are reasonable and necessary for the person's care. Subsection 39(2) allows this to be done "as often as is reasonably necessary" if the expenses are "of a continuing nature." Section 39(4), which allows an insurer give notice to the claimant that he or she "is not entitled or is no longer entitled" to receive an attendant care benefit, also implies that an insurer may allow an attendant care claim initially, then give a stoppage notice later based on new information. A claimant can also require a review: s. 39(8) allows a claimant to submit a new application if he or she requires an increased level of attendant care.

An attendant care DAC must be arranged if the claim is disputed, and multiple DACs are contemplated, subject to the limitations in s. 39(5). Subsection 43(7) requires the DAC to determine the amount payable for "future provision of attendant care services." The prospective orientation of the process is reaffirmed by the Attendant Care DAC Assessment Guideline (December 2000).

The determination of the DAC is binding on the claimant and insurance company, "subject to the determination of a dispute, in accordance with sections 279-283 of the *Insurance Act*, related to the attendant care benefit:" s. 39(7). An insurer can refuse or terminate attendant care benefits in accordance with a "negative" DAC report, but must pay benefits in accordance with a "positive" DAC report. Can an insurer reduce or terminate attendant care benefits because of new information or changed circumstances after a "positive" DAC report? I am not aware of any attendant care benefit decisions on point, but in *Sivaloganathan and Liberty Mutual Insurance Company*, (FSCO P03-00035, September 23, 2004), which concerned income replacement benefits, the Director confirmed the arbitrator's decision rejecting the argument that an insurer, after paying benefits in accordance with a "positive" DAC, could reassess the claim and

"re-start" the stoppage process, leading potentially to another DAC assessment. The arbitrator rejected this approach, and the Director confirmed his decision that the insurer must pay benefits subject to the dispute resolution process, with one exception: the Director agreed with the arbitrator's finding that an insurer can re-start the process at 104 weeks because a pre-104 week disability DAC would not have considered the stricter post-104 week test.[46] I need not decide the issue in this case.

In any event, the situation is different again once an arbitrator orders benefits to be paid. An arbitrator's order is final and binding on the parties, subject only to appeal on a question of law. Absent a stay, the order is payable pending the appeal decision. An arbitrator's order for payment of ongoing periodic benefits does not, however, leave the insurer without recourse. Section 287 of the *Act*, "Protection of Benefits," applies:

> An insurer shall not, after an order of the Director or of an arbitrator appointed by the Director, reduce benefits to an insured person on the basis of an alleged change of circumstances, alleged new evidence or an alleged error, unless the insured person agrees or unless the director or an arbitrator so orders in a variation or appeal proceeding under section 283 or 284.

Section 284 allows either the insured person or the insurer to apply to the Director to vary or revoke an order of the Director or an arbitrator based on "a material change in the circumstances of the insured or that evidence not available on the arbitration or appeal has become available or that there is an error in the order. . . " The Director or arbitrator may "vary or revoke the order and may make a new order if he or she considers it advisable to do so": s. 284(3). Significantly, "[a]n order made, varied or revoked under subsection (3) may be prospective or retroactive:" s. 284(4).

The arbitrator's order in this case was consistent with established arbitral practice to award benefits from the start of entitlement and ongoing from the date of the decision, where the claim

[46] See also *Sellathamby and Allstate Insurance Company of Canada*, (FSCO P02-00009, December 17, 2002), confirming (FSCO A01-000313, March 21, 2002), amended May 8, 2002.

is for ongoing periodic benefits and the arbitrator concludes that the claimant continues to meet the entitlement test on the date of the hearing. The issue has received little attention, though the few references to it support the arbitrator's approach. See, for example, *C.L. and Zurich Insurance Company*, (FSCO P98-00043, March 24, 1999), at p. 3, and *Hernandez and Zurich Insurance Company of Canada*, (FSCO A98-00045, April 12, 1999), at p. 3. Any other approach would produce endless disputes in a periodic benefits system.

Section 284 describes a relatively open-ended process that can, it appears, be invoked whenever circumstances change. For example, if Mr. McMichael recovers from his addiction and no longer requires attendant care, Belair can apply for revocation or variation of the order. If a relapse follows, Mr. McMichael can apply to have his attendant care benefits reinstated. An in-patient program of fixed duration may call for attendant care benefits to be stopped for a certain period of time, then reinstated. While this may seem rather a lot of process for what might be repeated changes in the order, I am persuaded this was the intention of the legislature, since Mr. McMichael has already satisfied an arbitrator of his entitlement to ongoing benefits. In any event, s. 287 expressly allows the parties to agree on a change in the benefits paid pursuant to an arbitrator's order.

I note, as well, that the arbitrator remained seized of any disputes about the amount of attendant care benefit owing. Though it appears he intended to address disputes about periods where Mr. McMichael was an in-patient in the past, nothing prevents the parties from asking that the hearing be re-opened to address any *current* disputes about the quantum of benefits payable for any particular period. If the arbitrator concludes he has exhausted his jurisdiction, Belair would be entitled to bring a s. 284 application.

IV. EXPENSES

Appeal expenses may now be decided in accordance with Rule 79 of the *Dispute Resolution Practice Code*. I may be contacted if the parties are unable to agree.

March 14, 2006

Nancy Makepeace
Director's Delegate

Date