Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Appeal P02-00026

OFFICE OF THE DIRECTOR OF ARBITRATIONS

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

Appellant

and

L. F.

Respondent

BEFORE:	Nancy Makepeace
REPRESENTATIVES:	Linda Matthews for State Farm David F. MacDonald for Mr. F.
HEARING DATE:	November 24, 2003 Written submissions completed by December 29, 2003

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 allowed in part. The arbitration order, dated August 21, 2002, is varied as follows:

   a. Paragraph 1(b) is revoked and replaced with the following:

      > monthly attendant care benefits of $744.18 from January 12 to March 30, 1997, $147.92 from April 1 to August 30, 1997, and $134.68 from August 31, 1997 to January 1, 1999, less payments made to date;

   b. Paragragh 1(c) is revoked.

* Minor error corrected on June 7, 2004, as authorized by the *Dispute Resolution Practice Code* and the *Statutory Powers Procedure Act.*

c. Paragraph 1(m) is revoked and replaced with the following:

a special award in the amount of $200, including interest.

2. The parties may contact me within 30 days if they are unable to agree on appeal expenses.

June 3, 2004

Nancy Makepeace
Director's Delegate

Date

REASONS FOR DECISION

I. BACKGROUND

State Farm appeals from the arbitration order, dated August 21, 2002, which awarded L.F. various benefits under the *SABS–1996*[1] arising out of an accident on January 1, 1997. The Arbitrator made the following order:

> Under section 282 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:
>
> 1. State Farm Mutual Automobile Insurance Company pay L.F.:
>
> (a) weekly income replacement benefits of $185 ongoing from January 24, 2000;
>
> (b) monthly attendant care benefits of $744.18 from January 12 to March 30, 1997, $147.92 from April 1 to August 30, 1997, and $134.68 from August 31, 1997 to January 11, 2000, less payments made to date;
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> (c) $9,737.65 for treatment received at Rosedale Chiropractic & Physiotherapy Centre;
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> (d) $85 for a high back support cushion recommended by Ms. Poon;
>
> (e) a TENS machine in the amount of $488.85;
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> (f) $425 for psychological treatment provided by Dr. R. Davila & Associates;
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> (g) $25 for Dr. Butler's December 8, 1998 report;
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> (h) Dr. Lau's accounts for his December 28, 1998 and November 22, 2000 reports, subject to proof of the amount and any dispute as to the reasonableness of the latter account;
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> (i) $650 for Dr. Chaudri's December 5, 2000 report;
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> (j) $453 for Dr. Kachooie's reports of November 26, 1998 and December 12, 2000;
>
> (k) $50 for Dr. Davila's October 13, 1998 report;

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

(l) $2,632.52 for the reports of Rehabilitation Network Canada Inc., less any portion attributable for Dr. Lau's report;

(m) a special award in the amount of $2,500; and,

(n) interest pursuant to subsection 46(2) of the *Schedule*.

2. The parties may now speak to the question of entitlement to payment of the legal expenses of this arbitration proceeding.

The appeal is wide-ranging. State Farm disagrees with the Arbitrator's factual conclusions about Mr. F's pre-accident employment profile, the severity of his accident-related impairments, his ability to return to suitable work, and his needs for treatment and attendant care. Section 283(1) of the *Insurance Act* restricts appeals to questions of law, and in any event, it is not the role of an appeal adjudicator to second-guess the factual findings of the arbitrator, who had the opportunity to observe the witnesses and consider the detailed evidence in its entirety. Considering the decision as a whole, I am not persuaded the Arbitrator erred in law in his factual findings or inferences. His conclusions were well-supported on the evidence.

Apart from disagreeing with the Arbitrator's assessment of the evidence, State Farm submits that the Arbitrator made several errors of law in applying the post 104 week entitlement test for income replacement benefits under s. 5(2)(b) of the *SABS-1996*. I find that the Arbitrator erred in finding that Mr. F "met his onus of identifying or trying to find potentially suitable employment" by attending a Post 104 Week Disability DAC.[2] However, I am not persuaded this undermines the decision because of the evidence, accepted by the Arbitrator, that Mr. F is completely unable to work as a result of the accident.

With respect to attendant care expenses, I accept State Farm's submission that the Arbitrator misinterpreted s. 70(3) by ordering attendant care benefits ("ACBs") after 104 weeks. State Farm also claims the Arbitrator erred in law by awarding ACBs up to the 104-week mark. It submits that Mr. F

[2] A Designated Assessment Centre ("DAC") assessment pursuant to s. 43 (DAC assessments), s. 37 (refusal or stoppage of weekly benefits) and s. 5(2)(b) (income replacement benefits after 104 weeks).

did not apply within 30 days of receiving the application forms, as required by s. 32(3), and did not "incur" attendant care expenses, as required by s. 16(1), and it argues that attendant care services were not "reasonable and necessary." I am not persuaded the Arbitrator erred in any of these conclusions.

The Insurer submits that the Arbitrator erred in law by awarding medical and rehabilitation expenses, especially the cost of Mr. F's treatment at the Rosedale Chiropractic & Physiotherapy Centre ("Rosedale"). I find that the Arbitrator erred in ordering benefits pending receipt of the report of the Med-Rehab DAC.[3] I am not persuaded the Arbitrator's other medical and rehabilitation benefit orders were in error.

Given my finding on the Rosedale claim, I need not address State Farm's challenge to the Arbitrator's interest order.

Finally, State Farm challenges the special award with respect to medical and ACBs. The award is revoked with respect to post 104 week ACBs and with respect to the Rosedale claim because a special award is only payable on benefits to which the insured person is entitled. In addition, the Arbitrator had no authority to order a special award in relation to occupational therapy sessions which were neither provided nor ordered by the Arbitrator. An award of $200, inclusive of interest, will replace the Arbitrator's order.

The arbitration hearing took place over nine days in December 2000 and August 2001, and written submissions were completed in May 2002. The transcripts and documentary evidence fill three boxes. In a 64-page decision, the Arbitrator gave detailed reasons for his conclusions. He organized his reasons around the benefits claimed, reviewed the main evidence put forward by both sides under each head of benefits, and explained his conclusions with reference to the key evidence. I follow the same format in addressing the parties' appeal submissions.

[3] A DAC assessment under s. 43 (DAC assessments), s. 38 (procedure for claiming medical and rehabilitation benefits) and sections 14 (medical benefits) and 15 (rehabilitation benefits).

II. ANALYSIS

A. Entitlement to Income Replacement Benefits Post 104 Weeks

Introduction

The Arbitrator's factual findings on Mr. F's personal and vocational history are given at pages 6-7 of his decision. They are undisputed on appeal, though State Farm challenges the inferences drawn from them.

An income replacement benefit ("IRB") is payable under s. 5(1) of the *SABS-1996* while the insured person "suffers a substantial inability to perform the essential tasks of the employment in respect of which he or she qualifies for the benefit." Mr. F qualified for IRBs based on his work as a short-order cook at Champs Restaurant & Lounge ("Champs"). He started that job on November 26, 1996, about a month before the accident, and worked four days (about 30 hours) a week, earning $8 an hour.

Section 5(2)(b) limits the IRBs payable. After 104 weeks of disability (January 1, 1999, in Mr. F's case), the insurer is not required to pay an IRB "unless, as a result of the accident, the insured person is suffering a complete inability to engage in any employment for which he or she is reasonably suited by education, training or experience." State Farm terminated Mr. F's IRBs effective January 24, 2000, based on the report of a DAC assessment by Toronto Medical Associates.[4] Mr. F was assessed by Dr. Harold Becker, a general practitioner, Dr. Alborz Oshidari, a physiatrist, Dr. J. Douglas Salmon, a psychologist who prepared a neurovocational assessment report, and Ms. Sandra Wong, an occupational therapist, who did a three-day functional assessment. The DAC assessors identified four occupations as suitable under s. 5(2)(b). Apart from dishwasher, which involves medium strength demands, the assessors identified three occupations that involve only light to limited strength demands –

[4] Arbitration Exhibit 16, Tab 21.

recreational facility attendant, parking lot attendant and restaurant host. They concluded that Mr. F met the strength requirements of the three "limited to light-duty" jobs.

The Arbitrator allowed Mr. F's claim for ongoing IRBs pursuant to s. 5(2)(b). State Farm challenges the order on several grounds.

Pre-Accident Employment Profile

State Farm claims that the evidence showed that Mr. F's pre-accident employment profile was "at best, very sporadic, part-time employment, at minimum wage level." In particular, State Farm submits that the Arbitrator erred in finding that Mr. F "was employed full-time at the time of the accident and had a considerable attachment to the labour force, albeit at the lower end of the economic scale."[5]

I agree that the Arbitrator's description of Mr. F's employment as "full-time" is inconsistent with his own finding that Mr. F worked "four days a week (approximately 30 hours)" at Champs.[6] The meaning of "full-time" is somewhat flexible,[7] but few people would argue it extends to 30 hours a week in the case of a cook. In addition, the Arbitrator's statement that Mr. F has "a considerable attachment to the labour force" is difficult to square with his finding that in 1995, Mr. F earned $13,719.75 from three jobs and $10,089 in social assistance, that he earned $6,035 from three jobs in 1996, and received $9,267.44 in social assistance, and that his catering business was "a very casual, infrequent enterprise," for which there was evidence of only two engagements.[8]

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[5] Arbitration decision, p. 22.

[6] Arbitration decision, p. 7.

[7] See, for example, *Moncur and ING Insurance Company of Canada*, (FSCO P03-00024, January 15, 2004), judicial review pending.

[8] *Ibid.*

However, the disputed statement must be placed in context. It followed and qualified the Arbitrator's finding that Mr. F "did not have an especially impressive pre-accident employment history,"[9] suggesting that the Arbitrator was simply recognizing Mr. F's efforts to establish himself as a cook. In any event, the main significance of Mr. F's pre-accident employment profile is with respect to identifying suitable jobs for purposes of s. 5(2)(b). The Arbitrator drew the following conclusion:

> I accept that reasonable employment for which L.F. is suited is semi-skilled employment of approximately 30 hours a week (i.e. four-day full time shifts or five six-hour shifts), at or near minimum wage. I find that the dishwasher, recreational facility attendant, parking lot attendant and host positions identified by the post 104-week DAC meet these requirements.[10]

This statement is consistent with the Arbitrator's findings about Mr. F's pre-accident work.

State Farm submits that in the two years before the accident, Mr. F "worked sporadically, usually on a part-time basis for only a few months of the year." Further, in State Farm's view, Mr. F failed to prove he had the ability or motivation to earn more than $7,000 a year in the year prior to the accident.

The *SABS-1996* does not fix a period for assessment of the insured person's "education, training or experience" for the purpose of identifying suitable employment.[11] The enquiry must be flexible and realistic, considering widely varying employment histories. In this case, the Arbitrator considered Mr. F's entire education and employment history, but ultimately based his assessment of suitable jobs on Mr. F's employment at the time of the accident. As the Champs job was the basis for Mr. F's eligibility for IRBs under paragraph 1 of s. 4(1), I am not persuaded this was an error.

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[9] Arbitration decision, p. 22.

[10] Arbitration decision, pp. 23-24.

[11] The language of s. 5(2)(b) is also found in s. 56(1)(b), which states, "An insured person who is entitled to an income replacement benefit shall make reasonable efforts to, . . . (b) obtain employment for which he or she is reasonably suited by education, training or experience." Employment history is also a factor in determining "personal and vocational characteristics," for purposes of the parties' rehabilitation obligations, described in s.15(4) and s. 55(2)3. Again, no "assessment window" is included in the definition in s. 2(1).

The real issues in the arbitration concerned Mr. F's re-employment efforts, and the severity of his impairment.

Re-Employment Efforts

Mr. F has not worked since the accident. He testified he is unable to work at any job because of his accident-related impairments. He testified, and the Arbitrator found, that he has not looked for a job or investigated options for modified or part-time employment.[12] He did not believe he could do any of the jobs identified by the DAC and accepted as suitable by the Arbitrator, and therefore took no steps to try. This evidence meant the Arbitrator had to decide whether Mr. F was completely unable to engage in suitable work without any positive or detailed evidence from Mr. F as to what he can and cannot do.

The Arbitrator concluded that Mr. F had satisfied his obligation by attending the DAC. He began by referring to several arbitration decisions considering s. 12(5)(b), the "suitable employment" provision of the *SABS-1990*, then stated:

> A significant difference between the [*SABS-1990*] and this *Schedule* [the *SABS-1996*] is the present DAC system. DACs are authorized to conduct independent assessments designed to balance the interests of both insurance companies and claimants. The April 2000 Disability DAC Assessment Guideline states that with regard to income replacement benefits, the "purpose of the DAC assessment is to offer an independent opinion that will assist these two disputing parties to resolve their dispute."
>
> An insurer does not have the ability to require an applicant to attend a DAC in order to assess IRB entitlement. That choice rests with an applicant. I find that an applicant may meet his or her onus of identifying suitable employment by opting for a DAC assessment. This meets the intent of this system being accessible, expert, less expensive, and quicker. I find that L.F., by opting for a DAC assessment, has met his onus of identifying or trying to find potentially suitable employment. L.F. has also met his onus by cooperating with a variety of assessors, including Mr. M. Jean, a vocational evaluation specialist (as well as Dr. G.K. Lau, a psychologist) with Rehabilitation Network Canada Inc. ("Rehabilitation

[12] Arbitration decision, p. 7.

> Network") and with Ms. J. Rosario, a certified evaluator, in their 1998 and 1999 work evaluations, respectively.
>
> The next question is whether L.F. suffers a complete inability to engage in employment which is identified as being reasonably suited for his level of education, training or experience.[13]

Mr. F was referred to Rehabilitation Network (Dr. Lau and Mr. Jean) by his lawyers in 1998, and State Farm required him to be assessed by Choice Rehabilitation Services (including Ms. Rosario) in 1999, pursuant to s. 42 of the *SABS-1996* (insurer examinations).[14] Though no doubt the parties hoped these assessments would help Mr. F identify suitable job alternatives, their main purpose, viewed realistically, was medical-legal. In any event, co-operating with medical and medical-legal assessors does not exhaust an insured person's rehabilitation obligations. Nor does an insurer satisfy its rehabilitation obligations by arranging insurer examinations or paying for the insured person's medical-legal assessments. What the parties did after receiving the reports is more important. Did the insurer implement any rehabilitation recommendations? Did the insured person co-operate or give a satisfactory explanation for not doing so?

The Arbitrator also misstates the role of the DACs.[15] An insured person is not entitled to require a disability DAC at any time. Pursuant to s. 37(3), an insurer's stoppage notice must include notice that the insured person may require a DAC assessment pursuant to s. 43. If the insured person makes a timely request for a DAC, the insurer must arrange the DAC and pay IRBs pending receipt of the report. That is what happened in this case. Once the DAC issues its report, the insurer must continue the benefits pending resolution of the dispute if it is the opinion of the DAC that the insured person continues to suffer from the disability in respect of which the benefit is paid. In this case, the DAC

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[13] Arbitration decision, pp. 8-9.

[14] Arbitration Exhibit 13, Tab 12C and D, Tabs 14C and E.

[15] For a recent review of the decisions and the issues, see *Driver and Traders General Insurance Company*, (FSCO P03-00006, November 18, 2003). See also, for example, *Lowe v. Guarantee Company of North America*, (2003), 67 O.R. (3d) 124 (Ont. S.C.J.).

concluded Mr. F did not meet the s. 5(2)(b) test, and State Farm terminated benefits accordingly, as it was entitled to do.

DACs are part of the claims adjustment and dispute resolution process. They are intended "to take the dispute out of the back-and-forth of competing partisan reports by providing an impartial assessment."[16] Given the expertise, comprehensiveness and impartiality expected of DAC assessors,[17] the parties are well-advised to take seriously a DAC's comments on suitable employment options. However, a DAC does not exhaust the parties' obligations. The issue is whether the parties followed up on the recommendations made in the report, or had good reasons for failing to do so. In this case, Mr. F testified that he did not investigate the occupations the DAC identified as suitable because he believed he could not do those jobs, and it appears State Farm offered no assistance, but simply terminated Mr. F's benefits.

I find that the Arbitrator erred in holding that Mr. F's attendance at a DAC satisfied his rehabilitation obligations, but I am not persuaded the error affected the outcome of the case.

As held in a long line of cases, the best evidence of an insured person's inability to do a job is an honest attempt that fails.[18] In the absence of such evidence from the insured person, how does an arbitrator assess the insurer's claim that the insured person could work if he wanted to? This is a familiar problem:

> . . . . very often the insured person lacks the knowledge or skill to investigate the job market and, in any event, takes the position that he is totally disabled from any work. The insurer, on the other hand, may identify jobs that are of no interest to the insured person or are otherwise unsuitable. The result, in the hearing room, is a deficiency of persuasive evidence about suitable alternative jobs. . . .[19]

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[16] *M.D. and Halifax Insurance Company*, (FSCO P00-00049, May 16, 2001), at p. 6.

[17] On what is expected of DAC reports, see, for example, *Walker and State Farm Mutual Automobile Insurance Company*, (OIC P96-000036, December 3, 1996) and *Driver and Traders*, note 15 above.

[18] The leading case is *Foden* v. *Co-operators Ins. Assn.* (1978), 20 OR (2d) 728 (Ont.H.C.J.).

[19] *El-Saikali and Co-operators General Insurance Company*, (FSCO P01-00059, March 13, 2003), at p. 17. See also Delegate McMahon's discussion of the issue in the context of determining residual earning capacity under Part VI

The Arbitrator referred to several arbitral authorities about who bears the onus of proof in this situation:

> Under the *1990 Schedule*,[20] arbitrators dealt with an applicant's onus regarding the long-term weekly benefit entitlement test, by accepting that applicants were "not required to prove a negative: that there is no job that they can do."[21] Rather, arbitrators held that applicants might discharge their onus of proof by exploring career options[22] or by identifying some sort of suitable employment (and describing the physical demands of the work and demonstrating with credible evidence that their injuries continuously prevent them from engaging in such employment).[23]

Delegate Naylor has described what I believe to be the correct approach to the "suitable employment" cases. In *Wigle and Royal*, she linked the shifting evidentiary burden at arbitration with the parties' shared rehabilitation obligations:

> The accident benefits scheme places a heavy focus on rehabilitation, including vocational rehabilitation intended to facilitate an injured person's re-integration into the workforce. Early and effective intervention is critical to this goal. I share the view expressed by Arbitrator Palmer in *Camilleri and MIC General Insurance Company* (September 8, 1995, OIC A-008507) that responsibility for rehabilitation planning involves a partnership between the injured person, his or her health care professionals and the insurer.
>
> The notion of shared responsibility also informs the obligations of the parties in relation to paragraph 12(5)(b). While the claimant has the onus of proof, he or she is not required to prove a negative: that they are unable to perform every employment or occupation that

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of the *SABS-1994*, in *DesRoches and Economical Mutual Insurance Company*, (FSCO P99-00062, June 7, 2002).

[20] Prior to January 1, 1994, Ontario Regulation 672 was called the *No-Fault Benefits Schedule*. After that date it became the *Statutory Accident Benefits Schedule — Accidents Before January 1, 1994.* In this decision, the term "*1990 Schedule*" will be used to refer to Regulation 672. [footnote in original]

[21] *Singh and State Farm Mutual Automobile Insurance Company*, (OIC A-005714, May 8, 1995). [footnote in original]

[22] *Gagnon and Jevco Insurance Company*, (OIC A-015357, May 1, 1996). [footnote in original] The appeal was dismissed: (OIC P96-00052, June 9, 1997).

[23] *Wigle and Royal Insurance Company of Canada*, (OIC A-012312, January 12, 1996). [footnote in original] The appeal was dismissed: (OIC P96-000025, April 9, 1998).

> might be suitable.[24] If either party chooses to stand back and wait for the other to come up with alternatives, there are risks involved. In determining whether the parties have met their respective obligations on the particular facts, an arbitrator is left with a substantial margin of judgment. The claimant's own efforts in positioning himself or herself to return to work and the options for alternative work presented by the insurer are an integral part of the factual mix considered in the cases and were both factors in the arbitrator's decision.[25]

Delegate Naylor expanded on her analysis in *H.K. and Canadian Surety Company*, (FSCO P98-00041, February 29, 2000), at pp. 6-7, stating:

> The question boils down to what is reasonable. The cases indicate that neither the insured nor the insurer should be held to unreasonable requirements.
>
> In my view, the arbitration decisions on which Canadian Surety relies simply reflect the longstanding recognition that sincere but unsuccessful rehabilitation efforts go a long way towards proving disability. Conversely, failure to take such steps is likely to work against a claimant unless there is some explanation such as evidence of total disability. I do not view the decisions as establishing a rigid proposition that insureds must "provide evidence of suitable employment" to prove their claim. The appropriate approach is a flexible, fact-based one, in which, while the legal onus always remains on the insured, the sufficiency of the proof depends on what is reasonable in the circumstances. This involves consideration of the evidence presented by both parties, including the nature of the individual's condition and extent of the disability, the efforts the insured has made to position himself or herself to return to the workforce, the vocational assistance made available by the insurer and the options for alternative work that have been put forward.

This has been the prevailing approach in recent "suitable employment" decisions,[26] and I adopt it. Therefore, the issue is whether, considering the entirety of his circumstances, including the nature and severity of his impairments, his efforts to obtain treatment and rehabilitation, his efforts to find suitable work and the assistance provided by the insurer, Mr. F has proven that he is completely unable to do

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[24] *Campbell v. Canadian Life Assurance Company*, [1990] I.L.R. 1-2632 (Man. C.A.). [footnote in original]

[25] At pp. 6-7 of the appeal decision in *Wigle and Royal*, (OIC P96-000025, April 9, 1998).

[26] See also, for example, *Henriques and Motor Vehicle Accident Claims Fund*, (OIC P97-00002, August 21, 1997), confirming (OIC A96-000037, December 12, 1996); *DesRoches and Economical Mutual Insurance Company*, (FSCO P99-00062, June 7, 2002); and *El-Saikali and Co-operators General Insurance Company*, (FSCO P01-00059, March 13, 2003).

suitable work as a result of his accident-related impairments. That Mr. F made no effort to find a suitable job he could do weakens his claim, but other factors must be considered.

This brings us to State Farm's general challenge to the Arbitrator's conclusion that Mr. F is entitled to ongoing IRBs post 104 weeks.

Conclusion on IRB Entitlement Post 104 Weeks

State Farm submits that the Arbitrator failed to apply the "complete inability" test for entitlement under s. 5(2)(b), and erred in several ways. It claims that the Arbitrator applied the less stringent "substantial inability" test that governs entitlement to IRBs for the first 104 weeks, and improperly dismissed the DAC report and the expert evidence put forward by State Farm. The Insurer also claims that the Arbitrator erred in finding Mr. F credible, despite the surveillance evidence and despite the Arbitrator's finding that Mr. F was "cautious" in his evidence. The Insurer likens the case to *Smillie and State Farm Mutual Automobile Insurance Company*, (FSCO A02-000039, September 12, 2003), in which Arbitrator Evans found that the insured person was not entitled to s. 5(2)(b) benefits because, amongst other reasons, he "purposely limited his choices for finding alternative occupations."[27]

The Arbitrator stated the entitlement test correctly, referring to *Lombardi and State Farm Mutual Automobile Insurance Company*, (FSCO A99-000957, April 11, 2001),[28] subsequently confirmed on appeal.[29] Nor did the Arbitrator err in relying on the well-established principle that ability to engage in suitable employment must be assessed realistically and practically, considering the job as a whole,

[27] At p. 13.

[28] Arbitration decision, p. 10.

[29] (FSCO P01-00022, February 26, 2003).

including reasonable hours and productivity in a competitive workplace.[30] There is no error, then, in the Arbitrator's statement of the entitlement test. The real issue is whether he applied it properly.

The Arbitrator clearly stated his reasons for rejecting State Farm's position. He acknowledged that Mr. F was cautious in his evidence, that he sometimes exaggerated, and that his presentation during the hearing differed from how he appears in the surveillance evidence. However, he noted that "a hearing is an artificial environment," and stated he could understand Mr. F's distrust and anger.[31] This would be a troubling statement if it reflected an unwillingness to evaluate Mr. F's credibility, but I do not read it that way. The Arbitrator recognized that the credibility of the insured person is particularly important in cases of chronic (non-organic or unexplained) pain, but preferred to assess Mr. F's subjective pain complaints by considering "all the circumstances, including the consistency of his complaints and apparent functional level." I find no error in this approach. Ultimately, he found Mr. F "credible on the relevant testimony regarding his IRB claim. I accept his evidence of being depressed, stressed, anxious, frustrated and wishing to be alone. I accept that his intimate relationship with his fiancée has been affected, that some days he does not want to even be touched by her."

Similarly, while the Arbitrator's comment that the surveillance evidence was "essentially consistent with a largely non-taxing lifestyle" may have been overly dismissive of the significant discrepancies between Mr. F's observed activity level and his claimed disability, he also found "very noticeable . . . the relative lack of activity performed by this former competitive runner, who attended the 1988 Olympic trials and previously enjoyed a variety of sports."[32] Again, the Arbitrator recognized that Mr. F "has not made any direct effort to return to the labour force," but he noted that Mr. F had been found to be motivated, compliant and co-operative by many of the experts who assessed him, including the DAC assessors.

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[30] The Arbitrator cited *Terry and Wawanesa Mutual Insurance Company*, (FSCO A00-000017, July 12, 2001). This principle has been adopted in any number of arbitral and appellate decisions. For example, see *Kota and Wawanesa Mutual Insurance Company*, (FSCO P96–00075, July 13, 1998).

[31] Arbitration decision, p. 21.

[32] Arbitration decision, p. 23.

State Farm also takes issue with the Arbitrator's dismissal of the DAC report. I agree the Arbitrator may have been overly dismissive of the DAC report, but I am not satisfied he placed the burden of proof on State Farm. I am satisfied his IRB order was reasonably supported by the evidence. Both parties to the appeal reviewed, in their written submissions, the main evidence they advanced before the Arbitrator. I do not find it necessary or appropriate to review the evidence in detail because the evidence the Arbitrator relied on supported his conclusions. There was a great deal of expert evidence, which the Arbitrator accepted, that Mr. F has a pain disorder as a result of a combination of physical and emotional factors."[33] But the dispute was not just about the severity of Mr. F's impairment; his limited vocational options played a very important part in the Arbitrator's decision. The Arbitrator accepted the findings of several assessors that Mr. F was "a man of limited intellect." He concluded that Mr. F had tried to rehabilitate himself, but was now "overwhelmed by this accident by factors beyond his control." In short, this was a fairly typical chronic pain case involving an insured person who had limited adaptive resources. State Farm would have preferred that the Arbitrator take a different view of the evidence, but that is not a basis for an appeal on a question of law.

B. Attendant Care Benefits

Introduction

Mr. F claimed monthly ACBs, under s. 16 of the *SABS-1996*, from the date of the accident and ongoing. By the time the arbitration hearing started in December 2000, his claim totalled $21,168.65, less the $4,754.46 State Farm paid in February 2000. He also claimed ongoing ACBs of $134.68 per month.

The Arbitrator allowed the claim in part. He ordered State Farm to pay Mr. F monthly ACBs of $744.18 from January 12, 1997 (when he was discharged from hospital and moved in with his parents) to March 30, 1997; $147.92 from April 1, 1997 (when he moved to Thunder Bay and was cared for

[33] Arbitration decision, p. 22.

by his fiancée) to August 30, 1997; and $134.68 from August 31, 1997 (when they moved to Toronto) to January 11, 2000, less payments made to date. He did not order ongoing benefits.

The Arbitrator decided four sub-issues in making this award. (i) State Farm claimed that Mr. F was disentitled from claiming ACBs because he failed to comply with the 30-day time limit for submitting an application under s. 32(3). The Arbitrator rejected this because he concluded State Farm failed to provide Mr. F with the appropriate application forms, information and explanatory materials required under s. 32(2). (ii) State Farm argued that Mr. F had not "incurred" attendant care expenses, as required under s. 16(2) of the *SABS-1996*, because he had not paid his parents and fiancée for looking after him and they had no expectation he would do so. The Arbitrator rejected this based on previous Commission decisions. (iii) The Arbitrator concluded that the 104-week limit on ACBs under s. 18(2) did not apply to Mr. F because of s. 70(3), a transitional provision. (iv) Finally, the Arbitrator concluded that the ACBs ordered were "reasonable and necessary expenses" resulting from the accident, as required under s. 16(2).

State Farm disputes each of these points on appeal. I find that the Arbitrator erred in law on the transitional provision, and the order will be revoked with respect to benefits after January 1, 1999. There are no other errors.

The Temporal Limit on Attendant Care Benefits

Attendant care benefits, provided under Part V of the *SABS-1996*, are subject to temporal and monetary limits.

Section 18(2) imposes the temporal limit. It says, "no attendant care benefit is payable for expenses incurred more than 104 weeks after the accident." The limit does not apply if the insured person was catastrophically impaired as a result of the accident, or if he had purchased optional benefits, but neither exception applies in this case.

There are two monetary limits on ACBs. Section 16(5) sets a limit of $6,000 per month for the catastrophically impaired, and $3,000 per month for others. Section 19(2) states that the attendant care benefit in respect of an insured person for any one accident shall not exceed $1,000,000 if catastrophically impaired, and $72,000 otherwise. Again, this overall monetary limit does not apply if optional benefits were purchased.

The *SABS-1996* also puts temporal limits[34] and monetary limits on medical and rehabilitation benefits. There is no monthly limit on these benefits, but s. 19(1) gives an overall maximum of $100,000, unless the insured person was catastrophically impaired, in which case the limit is $1,000,000.

As the Arbitrator pointed out, the overall monetary limit of $72,000 corresponds to the maximum amount of ACBs an insured person would receive in the 104 week period prescribed in s. 28(2) on the basis of $3,000 per month over 24 months (two years). Since Mr. F's accident occurred on January 1, 1997, these provisions mean he could not receive ACBs after January 1, 1999, and that he could receive no more than $3,000 per month during that time, for a maximum of $72,000. Mr. F would also be eligible for a maximum of $100,000 of medical and rehabilitation benefits for 10 years after the accident.

If this were all, the matter would be straightforward, but it is complicated by s. 70, the transitional provision. The parties agree that s. 70(1) applies to Mr. F, but they disagree on the interpretation of s. 70(3). The two provisions read as follows:

> 70. (1) Despite anything else in this Regulation, if a motor vehicle liability policy is in effect on the day this Regulation comes into force, subsections (2) and (3) apply until the earlier of the following:
>
> 1. The first expiry date under the motor vehicle liability policy.
>
> 2. The date on which the motor vehicle liability policy is terminated by the insurer or the insured.
>
> . . . .

[34] Section 18(1), but it does not apply in respect of a catastrophically impaired insured person or one who has purchased optional benefits.

> (3) The sum of the medical, rehabilitation and attendant care benefits paid under the motor vehicle liability policy for any one accident in respect of an insured person who does not sustain a catastrophic impairment as a result of the accident shall not exceed $1,000,000, and the limits set out in clauses 19 (1) (a) and (2) (a) do not apply.

To understand the legislative intent underlying s. 70, it is necessary to consider the limits on medical, rehabilitation and attendant care benefits under the *SABS-1994*, which the *SABS-1996* replaced. The *SABS-1994* was introduced alongside changes to the tort rules that precluded recovery of pecuniary damages in tort.[35] In a notional "trade-off," more generous accident benefits were made available than had been available under the *SABS-1990*. Section 46(1) of the *SABS-1994* imposed a $1,000,000 limit on the total of all medical and rehabilitation benefits "in respect of an insured person . . . in respect of any one accident." There was no monthly maximum or temporal limit. Section 47(4) set a monthly maximum of $3,000 for attendant care, but higher limits applied for more seriously-injured claimants under sections 47(5)-(7). There was no temporal limit and no overall maximum amount that could be received.

With the *Automobile Insurance Rate Stability Act*, which applies to accidents on or after November 1, 1996, the right to sue for pecuniary damages for health care expenses was restored, subject to a verbal threshold. At the same time, the accident benefits available for medical, rehabilitation and attendant care were reduced, except for the catastrophically impaired or those who had purchased optional benefits, as a cost-saving measure. The legislative evolution clarifies the objective underlying s. 70: it was intended to limit the retroactive operation of the *SABS-1996* to already existing policies.

How s. 70(3) affects the overall monetary limit set out in s. 19(2)(a) is clear. The attendant care limit of $72,000 paid in respect of an insured person for any one accident does not apply to this claim, which is

[35] Section 267.1 of the *Insurance Act*, which applies to accidents after December 31, 1993 and before November 1, 1996. The complete bar on recovery of pecuniary damages replaced the verbal threshold for both pecuniary and non-pecuniary damages under s. 266 of the Insurance *Act*, which applies to accidents after October 23, 1989 and before January 1, 1994.

governed by the transitional provisions. Instead, there is an overall limit of $1,000,000 for "the sum of all medical, rehabilitation and attendant care benefits paid under the
. . . policy for any one accident in respect of an insured person."

Section 70 is silent as to whether it affects the monthly monetary limit described in s. 16(5) or the temporal limit set out in s. 18(2). The transitional application of s. 18(2) was the issue before the Arbitrator. He concluded that the 104-week limit no longer applied because if it did, the transitional provision would have no effect on the overall maximum of $72,000, assuming the monthly $3,000 maximum. Of course, since s. 70 is equally silent about the monthly maximum, an alternative explanation might be that the legislature intended only to affect the 104-week rule. But since most claimants were only eligible for $3,000 a month in ACBs under the *SABS-1994*, and nothing in the *SABS-1996* suggests "any intent to liberalize the available monthly amount for attendant care," the Arbitrator concluded that the only way to give meaning to s. 19(2) was to assume that the legislature intended to suspend the 104 week limit by suspending the overall maximum on ACBs:

> If effect were to be given to both subsection 18(2) (the durational limits) and paragraph 16(5)(a) (the monetary maximums) of the present *Schedule* [the *SABS-1996*], then the maximum amount available for attendant care would remain at $72,000, despite the transitional provision of section 70.[36]

The Arbitrator did not find this to be "a reasonable and just outcome," relying on *Bapoo v. Co-Operators General Insurance Co.* (1997), 36 O.R. (3d) 616 (Ont.C.A.), as cited in *Tustin and Canadian General Insurance Group*, (FSCO P99-00004, August 13, 1999):

> Rather, I find that a "just and reasonable outcome" is obtained only by interpreting subsection 70(3) of the *Schedule* regarding paragraph 19(2)(a) as continuing a $3,000 monthly maximum (now enshrined in paragraph 16(5)(a) of the *Schedule*) and thus consequentially setting aside the subsection 18(2) durational limit and continuing the indefinite availability of attendant care benefits.[37]

[36] Arbitration decision, p. 26.

[37] Arbitration decision, p. 27.

I agree that s. 70(3) is less than crystal clear. Although ACBs are treated separately from medical and rehabilitation benefits in both the *SABS-1994* and the *SABS-1996*, s. 70(3) creates a transitional overall maximum for "the sum of the medical, rehabilitation and attendant care benefits paid." Second, it refers to s. 19(2)(a) – the overall maximum for ACBs – but not to the monthly maximum and temporal limit.

The Arbitrator considered two possible interpretations of the transition provision – that it removes the monthly limit on attendant care benefit, but applies the temporal limit; or that it removes the temporal limit, while leaving the monthly limit in place. He rejected the third alternative – that s. 70(3) affects neither the temporal limit nor the monthly maximum on ACBs, and effectively leaves in place the $72,000 overall maximum for ACBs – because he concluded this would make the transitional provisions redundant as applied to ACBs. This assumes that the legislature meant to suspend the application of the ACB provisions of the *SABS-1996* considered as a distinct category of benefits. It is not the most plausible reading of s. 70, which expressly applies to "*the sum of* the medical, rehabilitation and attendant care benefits paid" [emphasis added]. Considering the substantial reduction in these benefits under the *SABS-1996*, I conclude s. 70 was intended to provide a middle ground during the transitional period. Accordingly, Mr. F is eligible for up to $1,000,000 in medical, rehabilitation and ACBs, though he would otherwise be entitled only to a maximum of $72,000 of ACBs and $100,000 in medical and rehabilitation benefits under the *SABS-1996*. This interpretation does not make s. 70 redundant, though the monthly maximum, temporal limit and (effectively) the overall maximum on ACBs in the *SABS-1996* apply to him as if there were no transitional provision.

This interpretation is most faithful to the legislative text and its underlying objective. The stark difference in the maximum medical, rehabilitation and ACBs available in the *SABS-1994* and the *SABS-1996* reflects the significant restoration of tort rights in the 1996 amendments to the *Insurance Act*. I am not persuaded this is an unreasonable or unjust outcome.

As Justice Doherty, writing for a five-member panel of the Ontario Court of Appeal, stated in *Hope v. Canadian General Insurance*, [2002] O.J. No. 1643:

> Ambiguity cannot be determined by examining words in isolation from the text in which they appear. Nor is ambiguity established by demonstrating that if the legislature had intended a particular meaning, it could have used different language that would have expressing that meaning more clearly. Not all language that falls short of crystal clarity is properly labeled ambiguous. (para. 14)

Though s. 70(3) could have been drafted more clearly, I am not persuaded this justifies departing from the plain words of the text in the way the Arbitrator did. I think it more likely that the omission of any reference to s. 16(5) or s. 18(2) was deliberate, and reflected the legislature's focus on the overall maximum for medical, rehabilitation and ACBs.

I find the Arbitrator erred in law by finding that Mr. F was entitled to ACBs after January 1, 1999. The order will be varied accordingly.

Procedure for Claiming Attendant Care Benefits

Section 32 of the *SABS-1996* creates a three-step process for initiating an accident benefit claim. Section 32(1) requires an insured person to give the insurer notice that he wishes to apply for a benefit within 30 days of the circumstances giving rise to entitlement, "or as soon as practicable thereafter." The next step, described in s. 32(2), is for the insurer to provide the appropriate forms and information for the application for benefits. Section 32(3) requires the claimant to submit "an application for the benefit" within 30 days of receiving the materials described in s. 32(2).

There was no dispute that Mr. F gave State Farm timely notice of the accident and his wish to claim accident benefits. Further, there appears to have been no dispute that Mr. Jeffrey Kope, a State Farm representative, sent Mr. F the standard accident benefit application package,[38] plus some explanatory

[38] The "application package" was approved by the Superintendent under s. 69 of the *SABS-1996*, which states that the application forms referred to in s. 32(2)(a) shall be in a form approved by the Superintendent. The *SABS-1996* accident benefit application package was published in Bulletin A-10/96, dated October 23, 1996. The cover page indicates that the package includes: the application for accident benefits (OCF-1/59), activities of normal life form (OCF-12/59), employer's confirmation of income (OCF-2/59), permission to disclose health information (OCF-5), disability certificate (OCF-3/59), and treatment plan (OCF-18/59). At the foot of the cover page is stated: "After the insurance company reviews your complete application package, you will be contacted about the benefits you are entitled to receive. If your insurance company needs any additional information in order to process your application, they will contact you."

material, in January 1997,[39] and visited Mr. F within a few weeks of the accident.[40] Nor was it disputed that Mr. F, through his former counsel, completed and submitted an application for accident benefits and an activities of normal life form in January 1997, and later submitted the other standard documents.

However, though Mr. Kope and Mr. F's counsel corresponded on a number of matters in the following months,[41] Mr. F did not request ACBs until October 22, 1998, when the matter was raised in Mr. MacDonald's letter advising State Farm that Mr. F had retained him.[42] In response, State Farm asked for an attendant care certificate and retained an occupational therapist, Ms. Rosemarie Lai, to complete an attendant care assessment and Form 1.[43] Mr. F provided details of his claim for past and ongoing ACBs in a letter dated December 29, 1998, almost two years after the accident.[44]

State Farm claimed that Mr. F was disentitled from claiming ACBs because he failed to comply with the 30-day period described in s. 32(3), and did not have a "reasonable explanation" for the delay.[45] Mr. F claimed that State Farm cannot rely on s. 32(3) because it failed to comply with its obligations under s. 32(2), which are as follows:

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[39] Arbitration Exhibit 10, Tab 18A. I agree with Mr. F that there was no State Farm letter dated January 24, 1997 in evidence. It appears State Farm's counsel may be referring to the letter of January 17, 1997. The Arbitrator made no explicit finding on point, but appeared to accept that the standard package had been provided (arbitration decision, p. 57). The parties addressed this dispute in their appeal submissions, but I do not need to consider this factual issue. If the package was provided, the question remains whether State Farm provided the forms and information pertaining to ACBs, and I am not persuaded the Arbitrator made an error of law in finding that this did not occur.

[40] The Recorded Statement Summary prepared by Mr. Kope on January 28, 1997 (Arbitration Exhibit 7) does not indicate any discussion about attendant care needs. Mr. F. testified that Mr. Kope did not tell him he could claim ACBs (Arbitration Transcript, December 20, 2000, p. 130, question 615).

[41] Arbitration Exhibit 10, Tab 18.

[42] Arbitration Exhibit 10, Tab 18ttt.

[43] Arbitration Exhibit 10, Tabs 18uuu. and xyzxyzxyz. The use of Form 1 is mandated in s. 16(4).

[44] Arbitration Exhibit 11, Tab t. According to State Farm's letter to Dr. E. Duncan, dated January 14, 1999, the total at that time was $26, 645.00. Arbitration Exhibit 11, Tab v.

[45] Section 31(1) states: "A person's failure to comply with a time limit set out in this Part does not disentitle the person to a benefit if the person has a reasonable explanation."

> The insurer shall promptly provide the person with,
>
> (a) the appropriate application forms;
>
> (b) a written explanation of the benefits available under this Regulation;
>
> (c) information to assist the person in applying for benefits; and
> (d) information on any possible elections relating to income replacement, non-earner and caregiver benefits.

Ms. Ruth Rawsthorne, a State Farm representative, testified that the *SABS-1996* explanatory booklet prepared by the Insurance Bureau of Canada was probably what was given to Mr. F. Under the heading "Attendant Care Benefit," the IBC booklet states, "This benefit will pay for reasonable and necessary expenses for a caregiver or attendant that you require as a result of the accident."[46] As the Arbitrator noted, this "very brief entry" included no further particulars.[47] He concluded, "I do not find that to be meaningful compliance with section 32."

The three-step procedure prescribed in s. 32 makes a great deal of practical sense because at each step, the obligation is placed on the party in the best position to provide the information and documents needed. At the first stage, the insured person is required to give the insurer sufficient particulars of the claim or potential claim to allow it to commence its claims handling procedures. In response, the insurer is obliged to provide sufficient information, explanation and forms to enable the claimant to apply for benefits. That means providing the application package approved by the Superintendent. The claimant must complete and submit the pertinent forms within 30 days of receiving them.

As the claim progresses, the insurer may require the claimant to provide additional forms and information in response to new information received. Section 32(4) provides for this possibility:

> If a person is required by an insurer to submit an additional application in respect of a benefit that the person is receiving or may be eligible to receive, the person shall submit the additional application to the insurer within 30 days after receiving the additional application forms from the insurer.

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[46] Arbitration Exhibit 31.

[47] Arbitration decision, p. 57.

An insured person may make a number of applications for various benefits – medical and rehabilitation benefits and travel expenses, for example – throughout the claims period. His disclosure obligations do not end with the application for benefits. Additional information may be required after the application process is complete – a statutory declaration (s. 33); disability certificate (s. 34); election (s. 36); treatment plan (s. 38(2)); insurer examination (s. 42) or DAC assessment (s. 43). As well, an insurer may require additional documentation (with respect to income, for example) beyond what an insured person must provide with the initial application.

In this case, the only information State Farm provided about ACBs was the single sentence quoted by the Arbitrator from the Insurance Bureau of Canada booklet. This was helpful, but not sufficient, on its own, to inform an unsophisticated claimant about the nature of the benefit or the process for making a claim. The standard application package does not include an application for ACBs, and the application for accident benefits does not ask the insured person what benefits are claimed. Instead, the initiating documents, including the application, activities of normal life form, disability certificate, and employer's confirmation of income, require certain basic information from the insured person, his doctor and employer. The insurer is expected to adjust the claim and determine what benefits may be available based on the information received. The process is designed to ensure that an unsophisticated claimant receives the appropriate benefits.

The standard package includes the forms required at the initiating stage of every claim. Beyond the "package," it is left to insurers to provide "the appropriate application forms," pursuant to s. 32(2)(a), based on the information received from the claimant. The *SABS* is clear about this. The insurer bears the obligation to provide sufficient information to enable the consumer to claim benefits. There is no exemption from this rule where the insured person is represented.[48]

[48] For example, see *Kuchiak and Wawanesa Mutual Insurance company*, (OIC P97-00025, December 8, 1997), at p. 8: "The [*SABS-1994*] mandates that information be forwarded to applicants for benefits. It does not create an exception for applicants who are represented by counsel". Recently, *Smith v. Co-operators*, 2002 SCC 30, has reinforced the "consumer protection" orientation of the accident benefit scheme. In at least three recent cases – *Horvath and Allstate Insurance Company of Canada*, (FSCO A02-000482, June 9, 2003); *C.R. and Lombard General Insurance Company of Canada*, (FSCO A02-001057, December 22, 2003); and, most recently, *McIntosh and Allstate Insurance Company of Canada*, (FSCO A02-001277, April 23, 2004), under appeal – arbitrators have applied *Smith* in the s. 32 context, holding that an insurer will not be able to rely upon the 30-day time limit for submitting an application for

In any event, Mr. F's activities of normal life form, provided as part of the package and filed within 30 days of the accident, indicated that he needed help with bathing, grooming, dressing and undressing, walking, climbing stairs, sitting, standing and finding words to express thoughts, and that he could not drive or ride in a car or transit or participate in social activities. I agree with the Arbitrator that this was sufficient to alert State Farm to the need to provide the appropriate forms and additional information about ACBs. Yet Ms. Rawsthorne conceded that the Insurer's claim log does not indicate this was ever considered.

State Farm's file indicates that Mr. Kope spoke with Mr. F's previous counsel about ACBs on August 15, 1997: "Wants to know why attendant care not paid . . . never claimed or requested by lawyer, send IRB to lawyer. Time for an IME in accordance with s. 42." Ms. Rawsthorne conceded the file does not indicate that a Form 1 was provided or an assessment done in response to this expressed concern. Nothing was done to assess Mr. F's need for ACBs until mid-November 1998, in response to Mr. MacDonald's letter.

State Farm's failure to provide the appropriate application forms and sufficient explanatory information to allow Mr. F to make a meaningful decision about attendant care means it cannot rely on the 30-day time limit. The Arbitrator did not err.

"Incurred"

Section 16 of the *SABS-1996* requires an insurer to pay for all reasonable and necessary attendant care expenses *incurred* by or on behalf of the insured person as a result of the accident. State Farm submits the Arbitrator erred in awarding any ACBs, given his finding that Mr. F has not paid his parents and fiancée for their services, and they were not told they would be paid.

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benefits unless it has given notice of the time limit and the consequences of non-compliance.

State Farm's submissions do not persuade me to depart from my lengthy analysis of this issue in *Stargratt and Zurich North America Canada* (FSCO P01-00045, March 31, 2003). In State Farm's view, that decision "is not a correct application of the Court of Appeal decision of *Monachino v. Liberty Mutual Fire Insurance Company* (2000), 47 O.R. (3d) 481, as the Director's Delegate admittedly prefers the dissent of Mme Justice Weiler." However, I recognized that the decision of the majority in that case meant that Ms. Stargratt "would not have been eligible for benefits under s. 7 of the *SABS-1990*, absent a finding that her sister or her parents lost income in caring for her."[49] I concluded that Justice Finlayson's statement that "a cost must be incurred" must be understood in context of the issue in that case – whether the *SABS-1990* provided reimbursement for care provided by non-professional family members who did not lose income in providing care. That issue has now been resolved by s. 2(7) of the *SABS-1996*, which expressly allows for attendant care provided by a non-professional family member or friend. In any event, Justice Finlayson's statement did not resolve the meaning of "incurred," the very issue in dispute in *Stargratt* and in this case.

In *Stargratt*, I placed some weight on the legislature's decision to retain that word, in light of the consistent Commission case-law on point. I also considered Hope v. Canadian General Insurance,[50] a *SABS-1990* decision, in which the Ontario Court of Appeal rejected the analysis of the Divisional Court in *Smith (Committee of) v. Wawanesa Mutual Insurance Company* (1998), 42 O.R. (3d) 441. The issue in both decisions was whether benefits were payable for future medical and rehabilitation needs that are identified within the benefit period, but provided afterwards. That is not the issue in this case.

Nor am I persuaded that *Stargratt* is in conflict with *Moons and Co-operators General Insurance Company*, (FSCO P00-00033, May 28, 2001). The issue in *Moons* was a claim for income lost by a family member visiting the injured person in hospital. The claim was brought as a claim for visitors' expenses under s. 21 of the *SABS-1996*. The key to Director Draper's analysis was his finding that

[49] At p. 9.

[50] Above, p. 21

"lost income is not viewed as an expense in either ordinary usage or legislation" (para. 9). He specifically left open the possibility that Mr. Moons might be eligible for ACBs for the value of services provided (para. 34).

As in *Stargratt*, the real issue here was whether an obligation was incurred. State Farm has not given me any basis for finding that the Arbitrator erred in his conclusion. The Arbitrator's decision makes it clear that State Farm's position was seriously undermined by its failure to explain to Mr. F what documentation would suffice to prove an attendant care claim, in accordance with s. 32 of the *SABS-1996,* its failure to arrange an attendant care DAC assessment in accordance with s. 39(4), and its failure to pay benefits pending receipt of the DAC report, in accordance with s. 39(6). As the Arbitrator stated, these procedural rules "provide at the disposal of an insured an immediate interim monetary benefit where a neutral examiner has determined the need for attendant care, so that insureds, while in pain and disability following an accident, do not have to scramble for assistance, relying essentially on the voluntary kindness of family and friends."[51] I agree.

State Farm took the position that Mr. F was not entitled to ACBs because he failed to submit sufficient documentation that attendant care expenses were incurred, but it could not establish that it notified Mr. F as to what was required. I am not persuaded the Arbitrator erred in rejecting this defense.

"Reasonable and Necessary"

State Farm submits that the Arbitrator erred in finding that Mr. F. needed attendant care as a result of the accident. This was not an important focus of either party's submissions, probably for the very good reason that s. 283(1) of the *Insurance Act* restricts appeals to questions of law.

[51] Arbitration decision, p. 31.

With respect to ACBs, the main factual dispute was between Ms. Lai's reports of November 23, 1998 and January 19, 2000, on which State Farm relied, and the report of Ms. E. Poon, another occupational therapist, on which Mr. F relied. The Arbitrator broke the claim down into three periods that related to his changing domestic arrangements, and considered the differing opinions of Ms. Lai and Ms. Poon with respect to his attendant care needs for each period. In each case, he preferred the opinion of State Farm's expert, Ms. Lai.

State Farm submits that the Arbitrator erred in awarding ACBs despite his finding that Mr. F failed to prove the reasonableness of the benefits claimed. As I understand it, State Farm's concern arises from the Arbitrator's focus on his reasons for not awarding the very high level of benefits Mr. F claimed, supported by Ms. Poon, rather than his reasons for accepting Mr. F's need for the lower level of benefits supported by Ms. Lai. In this situation, where the factual dispute revolves around the competing opinions of the parties' experts, it may be tempting to see the two reports as "either/or" options. Failing to consider whether the insured person has proven entitlement to *any* level of benefits would be an error of law. Reading the Arbitrator's reasons in context, I am satisfied he accepted that Mr. F needed some amount of attendant care, and concluded that Ms. Lai's report offered the best evidence of what was needed.

I am not satisfied the Arbitrator erred in reaching the conclusions he did.

C. Medical Benefits

The Rosedale Claim

State Farm challenges the Arbitrator's award of medical benefits in the amount of $9,737.65 for "active rehabilitation/physiotherapy" ($5,678.00), chiropractic ($1,319.65), massage ($2,660.00) and behavioural therapy ($80.00) given by Rosedale Chiropractic & Physiotherapy Centre ("Rosedale") between November 30, 1998 and June 2, 1999.

Rosedale submitted a treatment plan, dated December 11, 1998, on Mr. F's behalf. State Farm refused the claim, by letter dated January 6, 1999, based on insurer examinations by Dr. Michael Ford, an orthopaedic surgeon, and Dr. R. Hershberg, a psychiatrist. State Farm arranged a Med-Rehab DAC, which was performed at West Park Hospital, in Toronto, over three days in April 1999. By that time, Rosedale had submitted two more treatment plans, dated January 13, 1999 and March 1, 1999, and these were also considered by the DAC. (A fourth treatment plan, dated April 5, 1999, was not considered.) In a report dated May 3, 1999, the DAC assessors recommended no further passive treatment. As a result, Rosedale terminated Mr. F's treatment.

State Farm argues that the Arbitrator erred by dismissing the reports on which it relied.[52] He dismissed the insurer examination reports of Dr. Ford (November 30, 1998) and Dr. Hershberg (December 8, 1998) because these doctors saw Mr. F before Rosedale's first treatment plan was submitted, and therefore did not have an opportunity to comment on it. In addition, the Arbitrator was not persuaded that Dr. Hershberg, a psychiatrist, had the expertise to comment on the treatment provided by Rosedale.

The Arbitrator queried whether an insurer should be able to rely on a report when it has not complied with its obligations under the *SABS*, specifically the requirement, stated in s. 42(7), that an insurer examination report be provided to the insured person within seven days. There is no question State Farm failed to comply with this requirement or its obligation to give adequate reasons for refusal. The refusal letter of January 6, 1999 stated simply, "Based on Dr. M. Ford and Dr. R. Hershberg, State Farm Insurance does not approve the following goods and services" without further explanation.[53] This was not meaningful notice.

[52] Arbitration decision, p. 42.

[53] Arbitration decision, p. 38 and 60; Exhibit 11, Tab U.

In a letter date-stamped by State Farm on January 25, 1999, Mr. F requested copies of the reports.[54] He did not receive them. Instead, State Farm's response was to send the reports to Mr. F's family doctor "for comment," while explaining to Mr. F that the doctors had found "no objective evidence" of disability, recommended no further treatment and thought he would benefit from a gradual return to work.[55] This was not compliance with the *SABS*.

I need not decide whether the Insurer's non-compliance precluded its reliance on the report, because I am not persuaded the Arbitrator erred in finding Dr. Hershberg's report unhelpful or in dismissing Dr. Ford's report. I agree with the Arbitrator that the underlying basis for Dr. Ford's opinion that Mr. F needed no "further formal medical rehabilitation" was "his view that there are no objective determinants for [Mr. F's] subjective report of pain."[56] The Arbitrator did not err in concluding that this "cannot be the end of the analysis."[57]

The Arbitrator was also very critical of State Farm's reliance on the Med-Rehab DAC report.[58] He identified a number of deficiencies in the report, and concluded it was "of little assistance in trying to determine the reasonableness and necessity of the Rosedale treatment."[59] Although the Arbitrator gave scant recognition to the strengths of the DAC assessment, I am not persuaded this was an error of law.

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[54] Arbitration Exhibit 11, Tab Y.

[55] Arbitration Exhibit 11, Tab B.

[56] Arbitration decision, p. 60.

[57] A long line of FSCO decisions have affirmed the approach set out in *Quattrocchi and State Farm Mutual Automobile Insurance Company*, (OIC A-006854, September 29, 1997), the case cited by the Arbitrator.

[58] Arbitration Exhibit 15, Tab 20.

[59] Arbitration decision, p. 42.

However, State Farm's discomfort with the result is well-founded, because the Arbitrator also rejected the evidence put forward in support of Mr. F's claim. He found Dr. Sher "of little assistance,"[60] criticized the last three Rosedale treatment plans for failing to identify the purpose or progress of treatment, and implicitly rejected Mr. F's evidence that he improved while being treated at Rosedale and deteriorated after treatment was terminated. What, then, was the basis for his award?

The Arbitrator's reasons make it clear that timing was the most important element in his decision:

> A fundamental purpose of the DAC system is to allow a quick independent opinion as to the merits of a proposed treatment plan so that an insured can make an educated choice whether to proceed with recommended treatment. It does an insured little good to read, after the fact, why the treatment was not reasonable or necessary. In this case, there was a considerable delay in L.F.'s DAC assessment. The longest delays were in arranging the DAC (January 29th to March 11th) and sending the DAC reports (April 19th to, at the earliest, May 26th). Treatment ended shortly thereafter.
>
> This is a first-party claim. It can seldom be reasonable to give a blanket refusal to any and all future medical treatment. Nor is it reasonable to tell an applicant, who has been attending treatment for more than half a year (and when the insurer has also been in receipt of the initial treatment plan for more than half a year), only at the end of the treatment that it was unreasonable. The rights of examinations given to insurers contemplate equally, certain responsibilities. The very existence of DACs restricts the discretion of an insurer.
>
> Therefore, the threshold of requisite reasonableness and necessity should reflect, if applicable, that an applicant has, in effect, been denied the benefit of what is intended to be a timely independent medical opinion. While an objective standard remains in such cases, a significant factor must be whether the treatment was reasonable from the perspective of what the applicant knew or ought to have known during the course of the treatment.
>
> L.F. went to Rosedale seeking assistance to relieve his accident-related symptoms. His treating specialist, Dr. Kachooie, recommended such treatment in correspondence with L.F.'s family doctor, Dr. Chaudri. The treatment provider, Rosedale, recommended continuing treatment. I find that it was reasonable for L.F. to commence and pursue treatment at Rosedale. I do not find that it was reasonable for L.F. to postpone treatment for months until the DAC assessment was arranged, this system being predicated on quick independent assessments, specifically so as not to delay an insured's access to treatment.
>
> I also find that it was necessary for L.F. to pursue such treatment. Section 55 of the *Schedule* requires an insured person who is entitled to weekly benefits to obtain such

[60] *Ibid.* Dr. B. Sher is a chiropractor and the manager of Rosedale, and he testified at the arbitration hearing about the treatment provided at his clinic.

> treatment and participate in such rehabilitation as is reasonable, available and necessary to permit the insured to engage in the applicable tasks and shorten the period during which the benefit is payable. This, as I understand it, was the whole intent of the treatment provided by Rosedale.
>
> Upon receipt of the DAC reports, L.F. had some information indicating that the treatment was no longer reasonable or necessary, neither Dr. Ford nor Dr. Hershberg having addressed the Rosedale treatment plan. The DAC reports pointed out concerns that it was reasonable for L.F. and Rosedale to address, i.e. what were the specific incremental goals and were those goals being met
>
> I cannot, however, discern when L.F. received the DAC reports. The DAC summary report is dated May 3, 1999. State Farm, however, sent portions to Rosedale on May 26, 1999, leaving the impression in the letter that they only recently received the report. Dr. Oshidari's 16-page typed single spaced report is dated the same date as the assessment date. Curiously, so are those of Dr. Salituro, C. Stadnik and I. Oliver. I am persuaded that one or more of the authors back dated their report. Therefore, it seems more likely that the DAC reports came to the attention of L.F. and/or Rosedale more or less the same time as they appear to have come to the attention of State Farm, that is on or about May 26, 1999 which is close to the end of the treatment.
>
> The contemporaneous medical notes are mixed as to whether the Rosedale treatment was assisting, overall, the Applicant's condition. I think, however, that the Applicant is to be credited for pursuing treatment, on the basis of the medical advice he was receiving, even though, perhaps on at least a periodic short-term basis, his symptoms may not have improved and may, in fact, on occasion have worsened. I think, however, based on the DAC reports, that it was reasonable, after May 26, 1999, to wind down the treatment. Treatment at Rosedale ended June 2, 1999. Accordingly, the account of $9,737.65 is allowed.[61]

Section 38 does not include a clause like s. 37(3)(c), which states that where an insured person requests a disability DAC, the insurer must continue to pay weekly benefits until the DAC report is received. It does include limited pay-pending-dispute provisions (in s. 38(16)), but it was not suggested that section applied to the Rosedale claim. The *SABS-1996* places the risks on the insured person in this situation, and whether that is a wise or a fair policy is not for the Arbitrator or me to decide.

Nor am I persuaded that the delays in obtaining the DAC report justified the Arbitrator in awarding benefits on the basis that it was reasonable for Mr. F to continue treatment at Rosedale at the time. The *SABS* requires a different analysis. The first question is whether Mr. F was entitled to the benefits

[61] Arbitration decision, p. 44.

claimed. If so, a second question arises: whether the insurer unreasonably withheld or delayed the benefits, justifying a special award not to exceed 50 percent of the amounts owing. There is no authority in the *SABS* or the *Insurance Act* to order the benefits claimed based only on delay in obtaining a DAC report. By dismissing the evidence led in support of the claim and terminating benefits on receipt of the DAC report, the Arbitrator left little doubt that his order essentially required State Farm to pay the claim until it provided the DAC report to Mr. F. This was an error of law. The order will be revoked accordingly.

Other Medical and Rehabilitation Benefits

State Farm also challenges the Arbitrator's award of $85 for a high back chair support cushion under s. 14(2)(h) of the *SABS-1996*, and $488.85 for a TENS machine and $425 for psychological treatment provided by Dr. R. Davila, under s. 15. Though State Farm disagrees with the Arbitrator's assessment of the evidence, it did not identify any error of law. The Arbitrator heard conflicting evidence about Mr. F's need for medical and rehabilitation assistance, and his decision was well within his authority based on the evidence.

D. Interest

The arbitrator ordered payment of interest on the medical and rehabilitation benefits awarded pursuant to s. 46(2) of the *SABS-1996*. On appeal, State Farm submits this was an error in law. In the Insurer's view, "pre-judgment" interest is not payable where an insurer refers a dispute about medical benefits to a DAC and the DAC gives a negative report – that is: one that does not require the insurer to pay benefits pending resolution of the dispute. In that situation, State Farm argues that interest only begins to accrue after the date of the Arbitrator's order, because only then was the insurer required to pay the benefits.[62]

[62] State Farm relies on *Amoa-Williams and Allstate Insurance Company of Canada*, (FSCO P01-00052, July 17, 2003).

State Farm's interest appeal relates only to its appeal of the Arbitrator's award of medical benefits for Mr. F's treatment at the Rosedale clinic. Given my conclusion that the Arbitrator erred in making that order, I need not decide the interest issue. Considering the complexity, importance and relative novelty of the issue, it is more appropriately addressed in the context of a live dispute.

E. Special Award

Mr. F claimed a special award on numerous grounds. The Arbitrator accepted only three.

He found that State Farm unreasonably denied Mr. F's claims for treatment at the Rosedale clinic. Given my finding that the Arbitrator erred in law by awarding these benefits, there is no authority for a special award.[63] The arbitration order will be varied accordingly.

The Arbitrator also found that State Farm unreasonably delayed payment of ACBs. State Farm did not pay any ACBs until February 2000. For the reasons given above, I am not persuaded the Arbitrator erred in finding that the Insurer cannot rely on s. 32(1) of the *SABS-1996* because it failed to provide a written explanation of the benefits available and information to assist Mr. F in applying for ACBs, as required by s. 32(2). The Arbitrator also relied on State Farm's failure to follow the attendant care recommendations of Ms. Lai, the expert it had retained to prepare a Form 1, its failure to arrange an attendant care DAC assessment as required by s. 39(4), and its failure to pay the benefits claimed pending receipt of the DAC report pursuant to s. 39(6).[64]

The Arbitrator concluded that "State Farm unreasonably withheld payment of ACBs, upon receipt of Ms. Lai's Form 1 in 1998, and certainly no later than receipt of Ms. Poon's report early the next

[63] Section 282(10) of the *Insurance Act* requires an arbitrator to order a special award "in addition to awarding the benefits and interest to which an insured person is entitled under the [*SABS*]" if the arbitrator finds that the insurer has unreasonably withheld or delayed payments.

[64] Arbitration decisions, pp. 56-58.

year."[65] I find no error in the Arbitrator's conclusion that State Farm unreasonably withheld ACBs to January 1, 1999 (the 104-week point), but because the Arbitrator erred in awarding ACBs after 104 weeks, that part of the special award must be revoked. State Farm paid ACBs of $4,764.46 in February 2002. By my rough estimate, the amount left owing is very nominal – in the order of a few hundred dollars plus interest.

Finally, the Arbitrator found that State Farm unreasonably withheld or delayed benefits by not providing the assistive devices recommended by Ms. Lai, in her insurer examination report of November 23, 1998, until January 14, 2000, and failing to provide the two occupational therapy follow-up visits she recommended. At the arbitration, the Insurer submitted that the expenses were not "incurred." The Arbitrator noted, correctly, that a long line of cases supports the proposition that expenses need not be incurred to be payable, and found that the Insurer's position on this point did not sit well with its failure to provide Mr. F with a copy of the report, as required pursuant to s. 42(7). He also relied on Commission cases holding that a special award may be ordered in relation to benefits that were unreasonably delayed, but were paid before the start of the hearing.[66] I am not persuaded this was in error. However, while State Farm paid for the assistive devices, costing $190, in January 2000,[67] it appears the educational sessions were neither provided nor ordered by the Arbitrator. In the absence of a finding that Mr. F was entitled to these benefits, there was no authority to order a special award in that regard. As a result, the only possible basis for a special award was $190 plus interest.

The Arbitrator's conclusion on the special award is as follows:

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[65] Arbitration decision, p. 59.

[66] Arbitration decision, pp. 54-5. Authority for this proposition is found in, for example, *Lopez and State Farm Mutual Automobile Insurance Company*, (FSCO P98-00031, September 20, 1999); *Jensen and GAN Canada Insurance Company*, (FSCO P96-00079, March 31, 1999); *Rocca and AXA Insurance Company*, (FSCO A97-000903, March 10, 1999); *Quarrington and Jevco Insurance Company*, (OIC A-010804, July 17, 1995); *Chafe-Moote and Prudential of America General Insurance Company (Canada)*, (FSCO P99-00044, September 8, 2000); and *Graper and Liberty Mutual Fire Insurance Company*, (FSCO A00-000133, July 20, 2001).

[67] Arbitration Exhibit 9, Tab 6B, p. 4, Arbitration decision, p. 55.

> I find that the Insurer, after taking advantage of its rights of examination under section 42, unreasonably withheld medical and attendant care benefits recommended by its own expert. I also find that State Farm failed to provide a reasonable basis for refusing to pay the Rosedale treatment plan. I find that a special award of $2,500 is warranted.[68]

The Arbitrator did not explain how much of the $2,500 award relates to each head of benefits he found were unreasonably withheld or delayed. By my estimate, the benefits in respect of which there is authority for a special award total no more than $500, plus interest. Rather than referring this matter back for rehearing, I find it more appropriate to vary the award, in the interest of putting an end to an extended dispute. The Arbitrator's order for a special award of $2,500 will be revoked and replaced with an order for payment of $200, including interest.

IV. EXPENSES

If the parties are unable to agree on appeal expenses, they may contact me within 30 days of this decision.

June 3, 2004

Nancy Makepeace
Director's Delegate

Date

[68] Arbitration decision, p. 64.