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TOP 5 PURR-ICELESS CAT CASES OF 2019

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Five decisions in 2019 have significantly shaped the path to a catastrophically impaired ("CAT") designation. These decisions are useful to practitioners and lawyers alike as they clarify when benefit denials can be contested, the source of insurer payments for CAT assessments and what specific information is required for a CAT determination. This paper will discuss five recent Decisions and explain why they are the most influential CAT cases of 2019.

Case #1: *Tomec v. Economical Mutual Insurance Company*, 2019 ONCA 882.

a. The law

The traditional rule holds that an insured has two years to commence an Application at the Licencing Appeal Tribunal following an insurer's clear and unequivocal denial of a benefit. The following hypothetical illustrates this rule in action. The insured sends a denial letter on February 10, 2020 notifying the insured that their Attendant Care Benefit is denied. The insured would typically then have until February 10, 2022 to contest that denial. If a denial is not contested within two years, the insured generally loses their legal right to contest the denial of a benefit pursuant to Section 56 of the SABS.

b. The Decision in *Tomec*

In *Tomec*, the insured was initially classified as non-CAT. At 104 weeks (2 years), after the insured's accident, the insurer sent a standard denial letter notifying the insured that her attendant care and housekeeping and home maintenance benefits had expired.[1] The insured did not contest this denial within two years. Five years after receiving this denial letter, the insured submitted an

[1] *Tomec v. Economical Mutual Insurance Company*, 2019 ONCA 882, at para. 6 [*Tomec*].

OCF-19 (Application for Determination of Catastrophic Impairment) requesting that her Accident Benefit Insurer deem her CAT.[2] According to the LAT Adjudicator and the LAT Vice Chair upon Reconsideration, Tomec should have contested the denial of Attendant Care and Housekeeping and Home Maintenance Benefits within two years of receiving the denial letter. According to the LAT, by waiting five years after receiving the denial letter to make an Application, she had missed her opportunity to challenge the denial by three years.

The Ontario Court of Appeal found that because the insured could not have learned that she was CAT until being classified as such, Tomec had not missed her opportunity to challenge the denial.[3]

The Ontario Court of Appeal went on to explain that Tomec's circumstances changed, and a "new" injury presented itself, the insured should not be prevented from challenging the denial of a benefit on the basis that she was not CAT. The insured learned of her "new" injury only once her impairments worsened to the extent that she was now CAT and entitled to an augmented level of benefits. The time for the insured to bring her Application was now found to be two years from the date of her discovery that she was CAT. The Court of Appeal described the LAT's rule which forces insureds to proceed with claims before knowing whether the benefits are needed and/or available as a "Kafkaesque Regulatory Regime".

c. *Tomec*'s value for the practitioner

Tomec re-establishes the old rule that limitation periods only begin to operate once a person is capable of discovering whether a benefit is available. In a situation where the insured's injuries progress to a new designation (for example from minor injury guideline to non-CAT, or from non-CAT to CAT) an insured may bring an Application for previously denied benefits even if two years have elapsed since the initial denial. The new rule regarding the running of the limitation periods for denials of Accident Benefits is two years from the date an insured discovers they may be entitled to a benefit.

The practitioner must still be careful to track when injuries worsen to the point when a new category or designation of an injury may be required. The point when this new designation is communicated to the insured may be the starting point for a two-year period to challenge a previous denial.

Further, a practitioner should notify both the insured and counsel if they believe that injuries are approaching a point where a new designation may be appropriate. A challenge to an old denial based on a new designation is better planned if it is anticipated.

It is also important to note that there is no limitation period which runs against an insured person when it comes to being designated Catastrophically Impaired.[4] Being found CAT is not a "benefit" *per se*, therefore, no limitation period runs against an insured after a denial of this

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[2] *Tomec, supra* note 1 at para. 7.
[3] *Tomec, supra* note 1 at para. 3.
[4] *Machej* v. *RBC General Insurance Co.* 2016 ONCA 842 (Ont. C.A.) at para 6

designation. However, if a Catastrophically Impaired insured is barred from claiming benefits by a limitation period (such as Attendant Care and Housekeeping and Home Maintenance Benefits) then it would make little sense to apply for Catastrophic Impairment designation at the LAT. If no benefits flow after a finding of CAT, what is the point of making such an Application.

Case #2: *18-004112 v. Belair Direct*, 2019 CanLii 22219 (ON LAT)

18-004112 v. *Belair Direct* gives guidance to practitioners who complete an OCF-19 (Application for Determination of Catastrophic Impairment) under Criterion 6 (55% Whole Person Impairment) and 8 (Chapter 14 Mental or Behavioural) of the *SABS* submitted to an Insurer less than two years post-accident.

a. The Decision in *18-004112* v. *Belair Direct*

In *18-004112* v. *Belair Direct*, the insured applied for a CAT determination 15 months after his accident. The insurer denied this Application on the basis that it was submitted prematurely. The insurer took the position that the application should have been submitted at 24 months, or two years post-accident.

The insured initially applied for a CAT designation under s. 3.1(1)6 of the *SABS.*

An insured can be deemed CAT under s. 3.1(1)6 of the SABS if they sustain a physical impairment or combination of physical impairments that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment ("AMA Guides")[5] results in 55% or more physical impairment of the whole person (also known as Whole Person Impairment or "WPI").

Similarly, an insured can be deemed CAT under s. 3.1(1)7 of the SABS if they sustain a mental or behavioural impairment, excluding traumatic brain injury, determined in accordance with the rating methodology in Chapter 14, s. 14.6 of the AMA Guides[6] that, when the impairment score is combined with a physical impairment described in s. 3.1(1)6 of the SABS in accordance with the combining requirements set out in the Combined Values Table of the AMA Guides[7] results in 55% or more WPI.

Since the insured submitted his application at 15 months, he also had to satisfy the criteria in s. 3.1(2)(b)(i) and (ii) of the *SABS*. Section 3.1(2)(a) precludes an insured from being deemed CAT under 3.1(1)6 and 7 unless the s. 3.1(2)(b)(i) and (ii) of the SABS criteria are satisfied. These additional criteria require the assessor who completes the OCF-19 to find that:

(i) the insured person **has** a physical impairment or combination of physical impairments determined in accordance with s. 3.1(1)6, or a combination of a mental or behavioural

[5] 4th edition, 1993.
[6] 6th edition, 2008.
[7] 4th edition, 1993.

impairment and a physical impairment determined in accordance with s. 3.1(1)7 that results in 55% or more WPI, and

(ii) the insured person's condition is unlikely to improve to less than 55% WPI.

Section 3.1(2)(b) also requires the physician to make this assessment more than three months after the accident.

The physiatrist, orthopaedic surgeon and psychologist who completed and supported the OCF-19 (Application for Determination of Catastrophic Impairment) reports stated that:

> "It is **probable** that [the insured] would be or will be impaired to a Catastrophic extent (55% WPI) in the future.[8]

Adjudicator Paluch found that the practitioner's decision to use the word "probable" suggested an uncertainty about the present value of the insured's WPI. S. 3.1(2)(b)(i) requires a definitive diagnosis about the insured's current WPI. Language about what is probable to occur in the future will not satisfy this criterion.[9] Therefore, the insured was not deemed CAT.

b. *18-004112* v. *Belair Direct's* value for the practitioner

18-004112 v. *Belair Direct* warns the practitioner that an insured who is applying for CAT less than two years after sustaining their injuries under s. 3.1(1)6 or 7 of the SABS must have an assessment that concludes:

(iii) the insured person **has** a physical impairment or combination of physical impairments determined in accordance with s. 3.1(1)6 of the SABS, or a combination of a mental or behavioural impairment and a physical impairment determined in accordance with s. 3.1(1)7 of the SABS that results in 55% or more WPI, and

(iv) the insured person's condition is unlikely to improve to less than 55% WPI.

The assessment must conclude at stage (i) that the insured (is currently suffering) 55% or more WPI due to their physical impairment(s) and or a combination of their physical and behavioural impairment(s). If a practitioner submits an OCF-19 (Application for Catastrophic Impairment) less than two years post-accident, that practitioner should not delve into the future possibility or probability of the insured's WPI. Instead the focus needs to be on how the Insured is doing at the time of the assessment and then state (if the practitioner believes it to be true) that the insured's condition is unlikely to improve to less than 55% WPI.

The insured's practitioner made the mistake of speaking to the likely outcome for the insured instead of focusing on the insureds present condition.

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[8] *18-004112 v. Belairdirect*, 2019 CanLii 22219 (ON LAT), at para. 24 [*18-004112*].
[9] *18-004112*, supra note 8 at para. 28.

Case #3: *Applicant v. Unica Insurance Company*, 2019 CanLii 101494 (ON LAT)

Applicant v. *Unica* comments on the minimum level of detail a practitioner must provide in an OCF-19 and assessment report when completing an Application for Determination of Catastrophic Impairment.

a. The Decision in *Applicant* v. *Unica*

In *Applicant* v. *Unica*, the insured submitted an application for CAT designation. The application consisted of an OCF-19 which was filled out by a family physician. The physician checked off the box on the OCF-19 indicating that the physician believed that the insured was CAT.[10] The insured further submitted the treating family physician's clinical notes and records in support of the Application for Catastrophic Impairment.[11] Lastly, the insured submitted a psychiatric assessment report consisting of 6 pages detailing the insured's symptoms and only 1 page explaining that the insured met CAT criteria 7 and 8.[12] However, the report did not outline how or why the insured met CAT criteria 7 and 8.

At the LAT, Adjudicator Ferguson found that the insured was not CAT. Upon reconsideration at the LAT, Vice-Chair Lester upheld the adjudicator's finding.[13]

Vice-Chair Lester commented that simply filling out the OCF-19 along with a treating physician's clinical notes and records is not sufficient evidence for the LAT to determine in the insured's favour. Vice Chair Lester suggests that reports (in addition to the OCF-19) are required by the practitioners standing up for the insured in order for the LAT to understand the assessors thought process leading to their opinion. A simple conclusive report without digging into the nitty-gritty of the AMA Guides is not good enough. Further a report which details symptoms and then states a belief that the insured is CAT is also insufficient.[14]

However, Vice-Chair Lester stated that clinical notes and records do provide some evidence that an insured is CAT.[15]

b. *Applicant* v. *Unica*'s value for the Practitioner

Unica is a cautionary tale of how a CAT Application and assessment report can fall short. The practitioner must do more than simply fill out the OCF-19 and provide their notes and records. An assessment report appears to be mandatory. Further, an assessment report cannot merely state the conclusion that an insured is CAT. The report must outline **how** and **why** the insured is

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[10] *Applicant v. Unica Insurance Company*, 2019 CanLii 101494 (ON LAT), at para. 12. [*Unica*].
[11] *Ibid.*
[12] Ibid.
[13] *Unica*, supra note 10 at para. 14.
[14] *Unica*, supra note 10 at para. 12.
[15] *Ibid*.

CAT. A practitioner should explain how the insured's injuries and impairments meet the CAT criteria and why they believe the insured is CAT by referring to the AMA Guides.

Unica is a warning to practitioners that boiler-plate or half-hearted efforts to deem an insured CAT are not likely to be successful at the LAT.

Case #4: *J.M. v. Aviva*, 2019 CanLII 51309 (ON LAT)

a. The decision in *J.M.* v. *Aviva*

The question in the LAT Reconsideration Decision in *J.M.* v. *Aviva* is whether the cost of an insured's own CAT assessments should be drawn from an insured's medical/rehabilitation residual limits of coverage.

b. Decisions concurring with *J.M.* v. *Aviva*

The LAT upheld the finding that CAT assessments are not paid from the insured's medical/rehabilitation and attendant care coverage limits in three other 2019 cases:

a) *[L.G.] v. Unifund*, 2019 CarswellOnt 17975 (Adjudicator Victor);

b) *N.S. v. Scottish & York*, 2019 CarswellOnt 20570 (Vice-Chair Flude on reconsideration); and

c) *V.K. v. Unica Insurance Inc.*, 2019 CarswellOnt 7826 (Adjudicator Ferguson).

c. *J.M.*'s value for the practitioner

J.M. v. Aviva is useful for a practitioner and lawyers who are confronted with an insurer refusing to pay for a CAT assessment because medical/rehabilitation coverage has run out. *J.M.* is also useful for lawyers who learn that an insurer has previously deducted CAT assessment costs from their client's medical/rehabilitation coverage limits. A request should be made in these circumstances to reverse these charges and restore the insured's available medical/rehabilitation coverage.

The practical value of this Decision cannot be overstated. Lawyers counselling their injured clients whether to use up their likely needed and scarce resources to pay for Catastrophic Impairment Assessments have a tough decision to make if the cost of CAT assessments are drawn from the Insured's residual medical/rehabilitation limits. The difficulties associated with drawing the cost of the CAT Assessments from an insured's residual medical/rehabilitation limits was nicely summarized by Vice-Chair Flude at paragraph 29 of his Decision which stated the following:

> "Section 18(5) … To interpret Section 18(5) in a manner urged on me by Aviva, a seriously injured Applicant may have to hold a large percentage of their medical and rehabilitation budget in reserve. In the current case, the assessment of approximately $21,000.00 represents 42% of the amount available for treatment.
>
> The percentage that might need to be held in reserve must be considered in light of the provisions of the Schedule setting out the definition of catastrophic impairment. In cases where Section 3(5) applies, an Applicant may have to wait two years from the date of the accident to apply for Catastrophic Determination. To be denied 40%of available reasonable and necessary treatment may have a devastating impact on potential recovery. Given that the purpose of the Schedule is to bring treatment resources to bare expeditiously, it runs in the face of that purpose to include a large percentage of available funds in reserve.

In practice, this ruling will significantly increases the opportunity for an insured person to move forward with an Application for Catastrophic Impairment. Many lawyers and their clients would either be handcuffed or cautious in using the last available medical and rehabilitation reserves to make this Application. Few, if any, insureds will pay out of their pockets for these costly assessments. It also allows insured person's CAT impairment assessors to prepare thoughtful and comprehensive reports which are demanded from the LAT if the matter goes to a Hearing.

Case #5: *A.G. v. Allstate Insurance*, 2019 CanLii 125858 (ON LAT)

A.G. v. *Allstate* informs the practitioner that a material change in an insured's condition may warrant additional CAT Insurer examinations even if a full CAT IME has already been completed.

a. The decision in *A.G.* v. *Allstate*

The insured initially applied for CAT only under Criterion 7(55% WPI). The insurer then set up a full slate of CAT IE assessments, including assessments to determine whether the insured met the test for CAT under Criterion 8 (Mental or Behavioural Impairment). The CAT IE's conducted by the insurer found that the insured had not suffered a CAT impairment under Criterion 6/7 and 8. Over a year after the CAT insurer IE's were conducted, the insured submitted a report prepared by two psychologists indicating that the insured's mental, behavioural and cognitive state deteriorated. The insured's counsel conveyed this information to the insurer.[16]

The Insurer scheduled two new Insurer exams with a psychiatrist and a neuropsychologist in order to respond to the insureds new report on mental or behavioural impairments, which the

[16] *A.G. v. Allstate Insurance*, 2019 CanLii 125858 (ON LAT), at para. 10 [*A.G.*].

insured refused to attend. Adjudicator Boyce found that the material change in the insured's condition warranted further IMEs.[17] The insured's new CAT application argued that his mental condition deteriorated in the year and a half since his initial CAT application. Adjudicator Boyce held that if the insured's condition had deteriorated to the extent that was alleged, it was reasonable to allow the insurer to evaluate the insured in light of this alleged material change in circumstances.[18]

b. *A.G.*'s value for the Practitioner

A.G. v. *Allstate* is useful for a practitioner who is informed of, or notices a decline in the insured's condition. *A.G.* provides authority for further IME's or CAT assessments in response to a material change in the insured's condition.

Also of note was the Adjudicator's finding that in the circumstances, it was not necessary to submit a new OCF-19 because the initial Insurer IE evaluated the insured under Criterion 8 (Mental and Behavioural impairment) and both parties agreed that Criterion 8 was an issue in dispute at their upcoming LAT Hearing. As a result of the foregoing, a new OCF-19 was not required.

Honourable Mention - Case #6: *18-000169 v. TD Home and Auto Insurance Company*, 2019 CanLii 22189 (ON LAT)

18-000169 provides examples of evidence which may be useful to an Adjudicator charged with making a CAT determination under Criterion 8 (Mental or Behavioural Impairment).

a. The decision in *18-000169* v. *TD Home and Auto*

The insured was struck by a passing motorist while riding his bicycle on October 28, 2014. He was knocked from his bicycle to the pavement, splitting his head open. The insured sustained the following injuries and impairments:

- physical injuries to his head;
- physical injuries to his upper body;
- physical injuries to his knees;
- a fractured neck;
- concentration issues;
- irritability;
- anxiety;
- stress;
- depression; and
- uncontrollable and sometimes violent outbursts.

[17] *A.G.*, *supra* note 16 at para. 31.
[18] *A.G.*, *supra* note 16 at para. 29.

Adjudicator Boyce summarized the test for CAT by virtue of Criterion 8 as follows. Four domains are assessed on a continuum. These domains are: activities of daily living; social functioning; concentration persistence and pace; and adaptation. The continuum contains 5 levels of impairment which range from class 1 (the lowest) to class 5 (the most impaired). These classes of impairment are outlined in Chapter 14 of the AMA Guides. If an insured is found to have a Class 4 impairment of any one of the four domains, they are deemed CAT. A Class 4 impairment is defined as a "marked impairment".[19]

Evidence of the insured's impairments did not demonstrate a Class 4 impairment in the domains of activities of daily living, concentration, persistence and pace and social functioning. It was clear at the Hearing that the insured could complete his activities of daily living, socializes and for the most part, could concentrate in most situations. Surveillance showed him going into the community, driving, squatting, bending and looking over his shoulders without demonstrated pain.[20]

However, the insured's lack of emotional and psychological regulation, which resulted in irregular moods and behaviour, as well as private and public outbursts pushed him into a Class 4 impairment in the domain of Adaptation. This impairment could be traced directly to a traumatic brain injury he suffered as a result of the accident and the trauma and stress that ensued.[21]

Adjudicator Boyce therefore found that the insured suffered a marked (Class 4) impairment in the domain adaptation due to a mental or behavioural disorder resulting from his psychological impairments.

b. *18-000169* v. *TD Home and Auto's* value for the Practitioner

18-000169 v. *TD Home and Auto* highlights the type of evidence which can sway an Adjudicator in the direction of CAT finding for an insured.

Adjudicator Boyce commented that the insured's treating psychologists and occupational therapist assessors interacted with him over four years post-accident, allowing them to form an "appropriate sample size" to accurately assess his complaints.[22] The more time spent with an insured lent support and weight to a treating practitioner's conclusions.

Further, the three treating practitioners called as witnesses reported similar symptoms which were supported by the documentation filed.[23] Congruency in symptom reporting over time and with different medical specialists is persuasive.

Adjudicator Boyce was also convinced by reference to specific episodes of the insured's lack of psychological and emotional regulation.[24] Reference to real examples of an impairment manifesting in the insured's daily life are very persuasive.

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[19] *18-000169 v. TD Home and Auto Insurance Company*, 2019 CanLii 22189 (ON LAT), at para. 11 [*18-000169*].
[20] *18-000169, supra* note 19 at para. 12.
[21] *18-000169, supra* note 19 at para. 13.
[22] *18-000169, supra* note 19 at para. 14.
[23] *Ibid.*

Finally, Adjudicator Boyce also noted that Chapter 14 of the AMA Guides does not require a specific psychological diagnosis to be found CAT, and further noted that brain injuries are difficult to accurately diagnose.[25]

[24] *18-000169, supra* note 19 at para. 16
[25] *18-000169, supra* note 19 at paras. 17-19.

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Michael L. Bennett was admitted to the Law Society of Ontario in 2000. Since that time, he has worked exclusively in the field of Personal Injury Law. In his first two years of practice, Michael represented several insurance companies and the Office of the Public Guardian and Trustee. Michael has now restricted his practice to the representation of injured persons and their families.

Michael has appeared before the Ontario Court of Appeal, Superior Court of Justice of Ontario, Financial Services Commission of Ontario, the Licencing Appeals Tribunal and other regulatory bodies on subjects concerning insurance coverage, benefit entitlements, the rights and responsibilities of insurers and, of course, Catastrophic Impairment issues.

Michael is a caring yet fearless advocate on behalf of his clients. He is willing to go the extra mile to see clients receive the treatment they require and deserve with a special interest in complicated orthopaedic injuries, brain injuries and spinal cord injuries.

Michael Bennett has worked at Thomson Rogers since 2002 and has been a partner there since 2008 where he continues to practice.