

## **Catastrophic Accident Benefit Claims - The Plaintiffs' Perspective**

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With the enactment of the *Automobile Rate Insurance Stability Act*, commonly known as Bill 59, and with the promulgation of O. Reg. 403/96, a two tiered system of benefits was created with profound consequences to injured persons and their families.

This paper will focus on the plaintiffs' perspective in handling catastrophic accident benefit claims and will discuss, consider and analyse the tactical considerations to employ when acting for the catastrophically injured.

### **I. The Statutory Framework**

“Catastrophic impairment” is defined in subsection 2(1) of the *Statutory Accident Benefits Schedule-Accidents On or After November 1, 1996* as follows:

- (a) *paraplegia or quadriplegia,*
- (a) *amputation or other impairment causing the total and permanent loss of use of both arms,*
- (a) *amputation or other impairment causing the total and permanent loss of both an arm and a leg,*
- (b) *total loss of vision in both eyes,*
- (c) *brain impairment that, in respect of an accident, results in ,*

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1 O. Reg. 403/96, as amended by O. Reg. 403/96, 462/96, 505/96 and 551/96; 303/98 made under the *Insurance Act of Ontario* R.S.O. 1990, c.I.8 as amended (hereinafter the “*Schedule*”).

a) *a score of 9 or less on the Glasgow Coma Scale as published in Jennett, B. and Teasdale G., Management of Head Injuries, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or*

a) *a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as published in Jennett, B. and Bond, M., Assessment of Outcome After Severe Brain Damage, Lancet i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose*

(f) *subject to subsections (2) and (3), any impairment or combination of impairments that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4<sup>th</sup> edition, 1993, results in 55 per cent or more impairment of the whole person, or*

(a) *subject to subsections (2) and (3), any impairment that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment...results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder*

*Subsection 2(3) provides that, for the purposes of clauses (f) and (g) of the definition of "catastrophic impairment" in subsection (1), an impairment that is sustained by an insured person but is not listed in the American Medical Association's Guides to the*

*Evaluation of Permanent Impairment*<sup>2</sup> shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.

The definition of “catastrophic impairment” creates interpretive difficulty because of its utilization of both subjective and objective criteria. Clauses (a) through (d) are objective and there is little interpretive difficulty. These categories are, however, restrictive and, with respect, unfair. Any amputation of a limb should be considered catastrophic. The loss of one or two legs of one arm is catastrophic and, even with the aid of a prosthetic device, results in a significant, if not total, disruption to an injured person’s life. Yet, the legislature requires not only that there be an amputation, but that it be a double amputation - loss of not only a leg, but both arms or an arm and a leg.

Clauses (e) and (f), which involve subjective criteria, are recipes for uncertainty, confusion and litigation. Surprisingly, with the exception of *Unifund Assurance Company v. Michael Fletcher*<sup>3</sup> (discussed in detail below), which was not a court decision, but a decision of a private arbitrator, there have been no cases which have interpreted clauses (e), (f) and (g).

## **II. The Legislative Purpose of the Regulatory Framework and The Importance of Outcome**

The legislative purpose of the Schedule can best be described as the provision of sufficient benefits to enable injured persons to obtain the treatment, rehabilitation and non-medical assistance necessary to carry on day to day and, insofar as possible, reintegrate them into their families, society and the workforce to try and place them in the same position they were in before the accident. In the case of catastrophically impaired persons, their injuries seriously and

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2 (4<sup>th</sup> ed.) American Medical Association (1995).

3 Decision of Bruce R. Robinson, Arbitrator, rendered January 18, 2000 (hereinafter “*Unifund v. Fletcher*”).

continuously impair their functioning and quality of life, such that enhanced benefits are required to enable them to achieve this legislative objective.

Further, sub-section 267.5(4) of the *Insurance Act* also recognizes the enormous costs of rehabilitation and medical care for the catastrophically impaired by permitting such individuals to claim health care costs over and above those paid by their no fault accident benefits insurer in the context of the tort claim.<sup>4</sup> In non-catastrophic cases, such claims are not permitted in the tort action.

### III. **Subjective Element in the Assessment of Brain Impairment by Use of the Glasgow Coma Scale**

#### ***Reasonableness***

As noted above, subparagraph 2(1)(e)(i) provides for a determination of catastrophic impairment, by use of the Glasgow Coma Scale (hereinafter “GCS”). The GCS is a test comprised of objective measures of verbal, oral, visual and muscular responsiveness, used in the diagnosis of brain damage. Although the GCS is comprised of objective measures, the determination of catastrophic impairment through its administration, in subparagraph 2(1)(e)(i) involves at least one subjective component, namely, the requirement that the GCS be administered “within a reasonable period of time after the accident”. The obvious question arising, as in any “reasonableness” standard, is what constitutes a “reasonable” period of time. Neither the *Schedule* nor the Financial Services Commission of Ontario (hereinafter “FSCO”), which administers the regulatory scheme set out in the *Schedule*, provides any directive in this regard.

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<sup>4</sup> *Henderson v. Parker* (1998), 42 O.R. (3d) 462 (Gen. Div.).

### ***Importance of Timing***

The issue of what constitutes a reasonable period of time was considered in *Unifund v. Fletcher*, a decision of a private arbitrator. The case concerned a 14 year old, Michael Fletcher, who was injured in a motor vehicle accident that occurred on September 30, 1997 while riding his bicycle through an intersection. The ambulance crew responding to the accident took GCS scores at the scene. The initial GCS recording was made at 18:57, 14 minutes after the accident. At that time, Mr. Fletcher's score was 6 out of 15. The second score, recorded at 19:02, was 8 out of 15 and the third, recorded at 19:03, at which time the ambulance arrived at the hospital, was 11 out of 15. Sometime thereafter, Mr. Fletcher was transferred to a second hospital. En route, at 21:44, his GCS score was 10 out of 15 and, on admission to the second hospital, his GCS score rose to 13 at 23:30 and 14 on 00:30 on October 1, 1997. No further GCS scores were obtained.<sup>5</sup>

Counsel for Mr. Fletcher, in an effort to have his client deemed catastrophically impaired, argued that the GCS results of 6 and 8, obtained 14 minutes and 19 minutes after the accident, respectively, should apply on the basis that the GCS evaluations were conducted within a reasonable period of time following the accident. Indeed, the report prepared by the Designated Assessment Centre (hereinafter "DAC") came to the same conclusion.

The arbitrator, however, adopted the approach of the insurer and its expert, neurologist, Dr. Bruce M. Stewart. Dr. Stewart testified that the standard rule of medical practitioners is that 30 minutes is a reasonable time within which to recover to a normal GCS. He further testified that, while the creator of the GCS, Dr. Jennett, did not comment on timing when developing the scale, a neurologist or neurosurgeon would view a "reasonable time" for assessment of the patient's condition and making a prognosis as six hours at a minimum.<sup>6</sup> Finally, Dr. Stewart concluded that, in the Fletcher case, the insured's actual GCS score, which rose from 6 (14 minutes post-accident) to 11 (20 minutes after the accident) and did not drop below 9 at any time thereafter, is inconsistent with a catastrophic brain injury.<sup>7</sup>

It is worth noting that the arbitrator was critical of the DAC assessor's decision to impose his own definition of "a reasonable period of time after the accident" (ignoring the score of 11 at 19:03) rather than accepting the judgment of the clinicians administering the GCS. This, he held, was inconsistent with the erratum issued by the Minister's Committee in June of 1998, which

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5 Ibid at pp.2-3

6 Ibid., at pp.6-7.

7 Ibid., at p.9.

specifies that DAC Committees are not permitted to provide their own definition of what constitutes “a reasonable period of time”.

The *Unifund v. Fletcher* case, although interesting and informative, does not command the same deference that a court or arbitral decision of the Financial Services Commission would. As such, this issue is far from resolved and subsequent decisions will need to address whether Mr. Robinson’s analysis is correct.

## I. **Determination of Catastrophic Impairment - Procedural Requirements**

### *Insurer’s Determination of Catastrophic Impairment*

Pursuant to subsection 40(1), an insured person may apply to the insurer for a determination of whether the impairment is a catastrophic impairment as defined in the *Schedule*. After receiving the application, the insurer has 30 days to do one of the following:

- (a) determine that the impairment is catastrophic and give the insured person notice of the determination;
- (b) determine that the impairment is not catastrophic and give the insured person notice of the determination, including the reasons for the determination; or
- (c) give the insured person notice that the insurer requires the insured person to be assessed by a designated assessment centre.<sup>8</sup>

It is clear from the wording of subsection 40(1) that the onus is on the insured to apply for a determination as to whether the impairment is catastrophic and counsel must so advise. In cases of injuries falling into the categories set out in clauses 2(1)(a)-(d), this step will generally be a mere formality. The opposite is true where evaluation of the injuries is more complex and

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<sup>8</sup> The details of the assessment process are set out in s.43 and apply equally to the determination of a non-catastrophic impairment.

involves a subjective component, for example, injuries falling into the categories set out in clauses 2(1)(e)- (g). In these latter cases, a catastrophic DAC will be conducted, at the request of either the insurer or the injured person.<sup>9</sup>

As has been pointed out,<sup>10</sup> in the case of injuries falling within the category set out in clause 2(1)(f), it is essential that the client be fully briefed with respect to the nature of the DAC assessment and the importance of reporting all injuries and limitations to the assessor, regardless of their significance to the injured person. If the client fails to do so,

he or she may not meet the 55% “whole-body impairment” even though his or her injuries truly justify the finding of such impairment.

In all cases where a catastrophic DAC has been conducted, counsel for the injured person should carefully review the report of the DAC assessor to determine whether anything was overlooked. Further, counsel should obtain an expert addendum to the DAC report, if necessary. The determination of the DAC is not the final answer. Any party may mediate, then arbitrate or litigate this issue.

The complexity in determinations of catastrophic impairment under paragraph 2(1)(e), (f) and (g), and the scope for plaintiffs’ counsel to argue for or against a given medical assessment, is evident from the Glasgow Outcome Scale’s five page article on head injury evaluation and the fact that the AMA Guide attempts to list every possible impairment an injured person may have, with an associated percentage rating of “whole-body impairment”.<sup>11</sup> In the latter case, each percentage is combined according to a set of tables to determine the percentage of whole-body impairment that the person has sustained. It is important that all counsel dealing with serious injuries understand the list of impairments and calculation tables in the AMA Guide.

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9 See subparagraph 40(2)(c), subsection 40(3) and section 43 of the *Schedule*.

10 See Howie and Wagman, “How Bill 59 Will Impact Plaintiffs and Their Counsel in the Management of Their Claims” The Canadian Institute Conference re: Bill 59 (March 20 & 21, 1997).

11 *Supra* note 2.

***Catalogue of Benefits for Catastrophic Impairment -Neutralizing the DAC Assessment.***

As previously mentioned, the determination of the “DAC” as to whether or not an injury or impairment is catastrophic is not final. Each insured person has the right to arbitrate or litigate his dispute with the insurer. Counsel must retain a suitably qualified expert to review, consider and analyze the report of the DAC and to provide a critique and criticism of the methodology employed and the findings reached. The issue in *Unifund v. Fletcher* as to what constitutes “a reasonable period of time” is as much more a legal issue than a medical issue. The neurologists, neurosurgeons and other experts may disagree, but it will be up to a judge or an arbitrator to determine what is reasonable. One can anticipate that there will be divergence of opinions between judges and arbitrators and, ultimately, it may be for the Court of Appeal to resolve this controversy.

Realistically, whether there is \$100,000.00 or \$1,000,000.00 of medical/rehabilitation funding available may not be always of practical significance. If the injured person does not have ongoing medical and rehabilitation needs beyond the \$100,000.00 limit, whether the claim is or is not catastrophic may not change anything. However, if the injured person suffers from chronic pain, fibromyalgia, or from mild or moderate brain injury, one could anticipate the need for ongoing medical and rehabilitation care needs which normally would exceed the \$100,000.00 limit.

Consider this example. Smith, is injured in a car accident in which his car was broad sided by a tractor trailer. Smith was not wearing a seatbelt and he struck his head on the windshield. Smith suffered a loss of consciousness and his Glasgow Coma Scale score was 7 out of 15. One hour later at the hospital it was 15 out of 15. Is this claim catastrophic? As a result of the accident, Smith is no longer able to work. He suffers from memory loss, depression, personality change, irritability, anxiety, poor concentration, nightmares and has developed a phobic reaction such that he cannot be with people or in cars. One can easily anticipate that he would require in excess of

\$100,000.00 in medical/rehabilitation services. He will require the services of a psychologist, social worker, vocational counselor, job coach, occupational therapist, chiropractor, message therapist, acupuncturist and physiotherapist.

Assume that the \$100,000.00 limit will be exhausted in less than 3 years. Are Mr. Smith's impairments considered catastrophic? Much depends on what the term "reasonable means". Cases like this will have to be litigated and guidelines set by the courts to fill in the gaps created by the regulations in order to help resolve these interpretational difficulties. Smith's impairments could be considered catastrophic either because his GCS was below 9 within a "reasonable period of time" or because his impairments constitute a 55% impairment of the whole person within the meaning of Section 2(1)(f) of the Schedule.

These cases will be expensive to litigate, but it is absolutely critical that counsel for the injured victim must be able to marshal on his or her client's behalf, pertinent, credible and compelling expert evidence.

#### V. **The "Catch All" 55% Impairment of the Whole-Person**

The American Medical Association's Guide to Permanent Impairment sets out a difficult test for permanent impairment. Few people understand what is required. Indeed the guide to Permanent Impairment is not a guide, but a lengthy book in

which every human activity is weighed, analyzed and considered. Every activity is carved up into discrete percentages.

For example, does a person suffering from a mild brain injury, chronic pain, fibromyalgia, or post-traumatic stress disorder suffer a catastrophic impairment? Much depends on whether the person is capable of carrying on a normal life. It will be extremely difficult to persuade any trier of fact that a person suffering from impairments common to chronic pain or fibromyalgia meets the rigorous and restrictive test found in the American Medical Association's Guides to the Evaluation of Permanent Impairment. However, there will be cases where the extent of the depression, post-traumatic stress, or pain is so disabling and debilitating as to constitute a total

disruption of the person's life, that he or she may qualify under this heading. The effect on the activities of daily living, self care, personal hygiene, communication, travel, sexual function, sleep and social recreational activities are so profound and limiting that the impairments could very well constitute a 55% impairment of the whole person.<sup>12</sup> There will be few cases that meet this requirement.

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<sup>12</sup> Chapter 14: "Mental and Behavioral Disorder" to the American Medical Association's Guides to the Evaluation of Permanent Impairment, *supra* note 2.

I. **Cashing-Out Catastrophic Claims**

In previous articles<sup>13</sup>, Richard Bogoroch has written about some of the considerations involved in negotiating “cash-outs” of statutory accident benefit claims. Catastrophic claims present a host of difficulties in this regard. While the claims are substantial, different considerations apply. Timing and the discount rate to employ are among the most important factors to consider. Counsel would be doing his or her client a disservice if the claim is cashed-out too soon after the initial injury, or if too great a discount to present value is accorded to the insurer.

***Timing***

In the early stages of catastrophic injury, the insurer generally devotes a great deal of time, resources and energy to properly adjust the claim.<sup>14</sup> Adjusting techniques mean not only reviewing the claim and arranging for medical assessments, but ensuring that capable, experienced claims personnel are placed on the file.<sup>15</sup> A Case Manager is retained and coordination of medical and rehabilitation treatment is planned, organized and implemented. The insured person, in the early stages, is provided with a panoply of services generally from highly qualified service providers. It would be a mistake obviously, at this stage, to even contemplate a “cash-out”. As your client’s condition stabilizes, or if it is determined that no further improvement is contemplated, it is reasonable to start considering a “cash-out” of benefits.

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13 R. M. Bogoroch, “Cashing Out Accident Benefits Claims Under the Statutory Accident Benefits Schedule” The Law Society of Upper Canada Conference on Personal Injury Litigation (June 11, 1997); and

14 See also in this regard, Joseph J. Sullivan’s comments in his paper, “The Defence Perspective.”

15 See Sullivan, *supra*.

Prior to negotiating a “cash-out” you should do the following:

0. Obtain copies of the complete file to ensure that your brief is similar to the insurers’;
2. Retain a highly qualified occupational therapist or other experienced experts to prepare a future care cost report outlining the goods and services that your client will require. See Appendix “A” for a sample report;
1. Obtain a list from the insurer of all the benefits paid to date to know how much of the policy limit remains;
1. Retain an actuary or chartered accountant and calculate the present value of the future care costs as well as the income replacement benefits to which your client is entitled; and
1. Ensure that you are in receipt of a report regarding your client’s life expectancy.

Persons with catastrophic impairments, not always, but frequently, have reduced life expectancies. It is essential if you are going to negotiate settlement of your client’s claim that you know what his or her life expectancy is. Invariably, the insurer will have a report with the most pessimistic view of your client’s life expectancy. That report must be reviewed, analyzed and critiqued by an expert of your choosing. You should never accept the insurer’s opinion of life expectancy without having that opinion vetted by your own expert.

### ***How Much Discount is Appropriate in a Catastrophic Case?***

The insurer is not required to “cash-out” benefits. They are required to adjust the case and to pay benefits to its insured in accordance with the *Schedule* and the arbitral and court decisions which have interpreted the *Schedule*. A “cash-out” or “lump-out” is a monetization of its contractual

obligations under the Schedule and is of tremendous benefit to the injured person. The insurer, therefore, quite properly seeks a discount from the net present value of the injured person's entitlement. The discounts should not be significant. The catastrophically injured person requires the money for life. He or she will also require continuous and regular medical and rehabilitation and attendant care. A 25% discount is more than reasonable. A discount of more than 25% under the circumstances, may not be in the best interest of the injured person. The "cash-out", therefore, may not be in your client's best interest. If the discount sought is too significant do not "cash-out".

### ***The Advantages to Cashing Out***

Most clients wish to be free of the overarching supervision and direction of the insurer. They want the insurer out of their lives. They want to be free to control their medical treatment and rehabilitation without having to seek permission for funding approval from the insurer and without having to constantly seek reimbursement for any and all expenses. There are psychological and very real advantages to terminating the relationship between the insured and the insurer. As indicated above, if the price is too high it is not worth it. Nonetheless if clients wish to embark on "cash-outs" after making fully informed decisions and considering carefully the advantages and disadvantages of "cashing-out", counsel must abide by his or her client's instructions. I have attached a sample form, as Appendix "B", which I trust will provide counsel with assistance.

### **VII. Representing the Mentally Incapable Client**

Practicing law in the millennium is difficult, often times complex and always challenging. Representing persons under disability creates a host of difficulties for even the most experienced counsel. Mentally incapable clients must have a guardian appointed pursuant to the *Substitute Decisions Act*<sup>16</sup>. *Even if no such guardian is appointed, any settlement must be court approved*

*pursuant to Section 7 of the Rules of Civil Procedure.* Court approval documentation should be explicit, detailed and should also contain a clear description of the fees proposed to be charged as the court must approve the client's account. This protection is not just for the benefit of the client, but for the benefit of the insurer as well. Any settlement not so approved is open to be attacked and set aside if it is determined that the insured person lacked capacity to instruct counsel.

## I. Reversionary Interests

One of the interesting features of "cashing-out" benefits is the use of reversions in structured settlements. The reversion simply provides that, if the insured person does not live beyond a certain period of time, the structure reverts to the insurer.

For the longest time some of us have had an aversion to reversions. We simply would not settle a case if the insurers sought a reversionary interest. Because we have utilized "cash-outs" as a way to monetize settlements and to provide for the injured person's family in the event of his or her demise, there is something jarring about giving that money back to the insurer in the event of death. In theory, however, there should be no such theoretical obstacle. If the purpose of the "cash-out" is to provide for the future care, future medical and future income needs and if those requirements need not be funded because of the death of the insured, there is nothing wrong in principle with the funds reverting back to the insurer. However, everything is a question of negotiation. Much depends on the "cards" you have drawn, the nature of the case, the facts underlying the case and the way the insurer has behaved from the inception of the file. All of these are the levers to be utilized in the negotiation with the insurer.

There are numerous combinations and permutations to employ. Reversions can be granted for only a portion of the principal amount of the settlement, or you can share in the reversion with the insurer. If the insured dies within the guaranteed period, half the money or a quarter of the

money, or whatever percentage you arrive at would then revert back to the insurer. As stated earlier, much depends on negotiation.

I. **Conclusion**

In the years to come, case law and arbitral decisions will, we expect, resolve some of the interpretive difficulties arising from the definition of a catastrophic impairment. Few cases will present much difficulty. For those that do, it is hoped that this paper will shed some light on a difficult and complex task, will enable counsel who represent the catastrophically injured to have a better understanding of the issues involved in catastrophic impairments, and to illuminate some of the tactics and considerations involved in negotiating “cash-outs”.