



## Ask a Lawyer

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### What level of attendant care benefit is payable when catastrophic status is in dispute?

Health practitioners involved in the completion of Form 1 (assessment of attendant care needs) under the Insurance Act Regulations are entering a new era of confusion and contradiction. There are two diametrically opposed sections in the March 1, 2006 amendments relating to the level of attendant care to be paid to a person whose status is under review.

#### Recall a few of the basics:

1. Attendant care benefits are payable only after Form 1 is completed;

2. Attendant care benefits are payable at two different levels: up to \$3000 per month for two years if one is not catastrophically impaired, but if one is catastrophically impaired, it jumps to \$6,000 maximum per month for life.

3. Many impairment levels are known essentially from the time of the collision. In particular a Glasgow Coma Score of 9 or less within a reasonable time of the collision meets the criteria.

4. A significant number of impairments are not known until some time after the collision. For example, orthopaedic injuries and behavioural impairments may have to await prognosis and maximum medical recovery.

The new Regulation provides for potentially different treatment of this last group.

#### Payment rules when Catastrophic Impairment is in issue:

- If the application for catastrophic impairment is made not more than 104 weeks after the accident, and, immediately before the application the insured was receiving an attendant care benefit then

- The insurer must continue to pay benefits while a determination is being made

- It must be made on the assumption that the person will be considered catastrophic (s. 40)

#### Payment rules when level of attendant care payable is in issue:

- If a new assessment (Form 1) is required, the insurer shall continue to pay the insured person attendant care benefits at the same rate as they were paid before the insurer gives notice of the required reassessment (s. 39)"

#### How will this play out in real cases? Let's look at two examples:

1. An injured person is considered catastrophically impaired from the date of the collision because of a GCS of 8. The first form 1 prepared post hospital discharge does not take into account any need for supervision except while cooking and out in the community. The form presents a value of \$3500 per month. A neuropsychological examination is conducted 12 months post discharge. The evaluator finds that there are serious concerns about judgment and opines that the person needs 24 hour super-

vision. The new Form 1 has a value of \$6000. Assume the insurer disputes the new amount.

**Q.** What does the insurance company have to pay to the insured person while the dispute is resolved?

**A.** \$3500 per month.

Section 39 clearly applies. This has nothing to do with determining the insured's impairment level, just the level of attendant care needed.

2. Psychiatric difficulties associated with a diagnosis of post traumatic stress disorder and anxiety are not fully apparent following the crash. There is also a brain injury, but the GCS was not taken until 3 hours post collision and at hospital it fluctuated above 9. A form 1 suggested 24 hour care due to concerns over the insured harming himself. It is completed as if it is \$6000 per month but only \$3000 is payable under the non-catastrophic limit.

Increasing anxiety and agoraphobia rendered the insured person housebound and unable to work, participate in family or social activities. A Catastrophic designation application is made 18 months after the collision based on a severe mental and behavioural impairment.

**Q.** What does the insurance company have to pay to the insured person while the issue of catastrophic impairment is resolved?

**A.** \$6000 per month

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Section 40 applies to essentially deem the insured person to be catastrophic during the dispute period. This results in a payment of \$6000 per month. It would also permit the retention of a case manager. The level of payment is controversial, since this result is not consistent with s. 39. I would argue that section 39's limitation is not triggered until there is a request for an assessment by the insurer under that section. That would usually only follow the catastrophic assessment application, so the s. 40 rule would apply.

For health practitioners there is a lesson to be learned from these examples: do not complete the Form 1 for a non-catastrophic impaired insured on the assumption that your client will never get over \$3000 so any need over that does not need to be reported. You may be cutting him or her off from an entitlement later. And remember, recover in tort is still available.

*Send your questions about the new Regulations or other legal matters to me at [blegate@leggate.ca](mailto:blegate@leggate.ca).*

