Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A12-001079

BETWEEN:

LENWORTH SCARLETT

Applicant

and

BELAIR INSURANCE COMPANY INC.

Insurer

DECISION ON A PRELIMINARY ISSUE

Before: Arbitrator John Wilson

Heard: February 22, 2013, at the offices of the Financial Services Commission of Ontario in Toronto.

Appearances: Nicole Corriero for Mr. Scarlett
Laura Hodgins for Belair Insurance Company Inc.

Issues:

The Applicant, Lenworth Scarlett, was injured in a motor vehicle accident on September 18, 2010. He applied for and received statutory accident benefits from Belair Insurance Company Inc. ("Belair"), payable under the *Schedule.*[1] Belair early on took the position that Mr. Scarlett's injuries were such that he was restricted by the *Minor Injury Guideline, November 2011* (*MIG* or *Guideline*)[2] which provides only for limited accident benefits in the case of a minor injury. A minor injury according to the *Guideline* includes sprains, strains, whiplash injuries and whiplash associated disorders.

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[1] *The Statutory Accident Benefits Schedule - Effective September 1, 2010, Ontario Regulation 34/10, as amended.*

[2] *Superintendent's Guideline No. 02/11*, Financial Services Commission of Ontario

Mr. Scarlett has maintained that although he indeed suffered strains sprains and whiplash related injuries, he also suffered from pre-existing conditions and subsequent psychological disabilities that take him out of the *MIG* constellation.

The parties were unable to resolve their disputes through mediation, and Mr. Scarlett applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

The preliminary issue is:

1. Is Mr. Scarlett precluded from claiming housekeeping, attendant care, as well as medical and rehabilitation expenses, beyond the $3,500 limit because his injuries fall within the *Minor Injury Guideline*?

Result:

1. Mr. Scarlett is not precluded from claiming housekeeping, attendant care, as well as medical and rehabilitation expenses, beyond the $3,500 limit within the *Minor Injury Guideline*.

EVIDENCE AND ANALYSIS:

The parties filed extensive document briefs together with an agreed statement of facts. There is no disagreement as to most of the fundamentals of Mr. Scarlett's claim; that he was in a motor vehicle accident as a passenger in a vehicle insured by Belair which was rear-ended by another vehicle, and that he applied for statutory accident benefits from Belair "as a result of the injuries and impairments sustained in the collision."

In support of his application for benefits Mr. Scarlett submitted a disability certificate dated October 6, 2010 which indicates that he "sustained various sprains and strains to the joints and ligaments of the lumbar and cervical spine as well as headaches and acute stress reaction."

Subsequently, a dental surgeon, Dr. Lewandowski, reported that Mr. Scarlett suffered from "an imbalance of the cranio-mandibular apparatus leading to symptoms of craniofacial pain", or "Temporal Madibular Joint Syndrome" as well as "intra-capsular TMJ syndrome ... characterized by capsulitis/synovitis of the right Temporal Mandibular joints."

On December 12, 2011, an orthopaedic surgeon, Dr. Franco Tavazzani, observed a "depressed affect" and noted "restricted range of motion in the lumbar spine and difficulty transferring from sitting to standing and from standing to supine." He also tested for *Waddell's signs* and noted a positive test indicating "an adverse psychological and emotional response to injury and a poor prognosis for recovery."

On December 8, 2011, Dr. Judith Pilowsky, a psychologist, assessed Mr. Scarlett. In her report of January 19, 2012, she found that he suffered from Pain Disorder, severe depressive symptoms, Chronic Symptoms of a Posttraumatic Stress disorder and driver anxiety.

Dr. Pilowsky prepared a further report on January 17, 2013 in which she also addressed the question of whether Mr. Scarlett's psychological issues fall within the *Minor Injury Guideline*. Dr. Pilowsky administered the Beck Depression and Anxiety Inventory diagnostic tests and noted "severe" endorsements on both.

Mr. Scarlett submits that severe depression, post-traumatic stress disorder, TMJ problems, chronic pain, as well as the predisposition to having a poor prognosis for recovery as indicated by the *Waddell signs* all draw his claim outside of the boundaries of *MIG* and so permit him to access the entirety of the standard benefits contained in his insurance policy.

It should be noted that during the claims process, Belair did not merely sit on its hands and ignore the reports and assessments provided by Mr. Scarlett. While it early on articulated a belief that the *MIG* limited Mr. Scarlett's claim, it also sought out experts to validate its opinion.

Following the submission of a treatment plan by Dr. Rahim Jessa, Belair sent the plan to Dr. John Crescenzi, a chiropractor, for a paper review. Dr. Crescenzi concluded that Mr. Scarlett

"sustained soft tissue injuries and notes that there is no evidence on file of any neurological compromise, fracture or dislocation." Consequently, he finds that the injuries "are commensurate with minor injuries as described in the MIG." In fact, his opinion is that "Mr. Scarlett has impairments to which the Minor Injury Guideline (MIG) applies."

Likewise, following an attendant care claim and the TMJ report by Dr. Lewandowski, Belair engaged the services of Dr. Shulamit Mor, psychologist, to assess Mr. Scarlett. Dr. Mor claimed that Mr. Scarlett reported independence in personal care and the intention to play soccer in the upcoming summer, as well as denying depression, cognitive difficulties or the need for psychological treatment. Dr. Mor concluded that "based on his narrative and presentation Mr. Scarlett's symptoms do not meet the criteria for any psychological diagnosis."

Belair also had Dr. Lewandowski's report and recommendation of a TMJ assessment reviewed by Dr. Aviv Ouanounou, a dentist. Dr. Ouanounou did not examine Mr. Scarlett. Dr. Ouanounou reported: "this file documentation does not provide compelling substantive objective evidence or subjective claimant complaints to suggest that the claimant has ongoing concern with their TMJ."

In essence, Mr. Scarlett's attempts to claim certain benefits from Belair were being rebuffed because Belair took the position that he was within the *MIG* and either the benefits were not payable or they were in excess of what was required to be paid under that approach. This appeared to be a major stumbling block since, even when Mr. Scarlett provided further evidence of complicating features of his claim that in his mind took it outside of the *MIG* framework, he was met with the same response.

At the time of the accident, both parties agree that Mr. Scarlett was a new arrival and did not have working status in Ontario. Hence he was not covered by OHIP at the time of the accident. Consequently, the only access Mr. Scarlett had to paid treatment was through the accident benefit system.

It is important then to look at the *MIG* framework that Belair believed itself to be applying.

The *Minor Injury Guideline*, as its name suggests, is a guideline issued by the Superintendent of Insurance pursuant to section 268.3 of the *Insurance Act* which provides context for the use and consideration of such guidelines.

Essentially, according to the legislature which passed the *Insurance Act*, guidelines are informational and non-binding, providing only that they be "considered."

The guidelines however are specifically referenced in the *Schedule*, issued by the executive rather than the legislature pursuant to the *Insurance Act*. Unlike guidelines, the provisions of the *Schedule* are binding, and are read into every policy of automobile insurance issued in Ontario.

As befitting what is essentially a policy document, the *Minor Injury Guideline* presents an overall view of how the Superintendent of Insurance views the statutory accident benefits system, its problems and how they might be rectified. Its point of view is clear:

> The SABS and this Guideline are intended to encourage and promote the broadest use of this Guideline, recognizing that most persons injured in car accidents in Ontario sustain minor injuries for which the goods and services provided under this Guideline are appropriate.
>
> Usage of the Guideline by all stakeholders will be monitored on an ongoing basis, with a view to early identification and response to inappropriate application or interpretation of the SABS and the Guideline.

As guidance for decision-makers, the position seems to be that since the majority of accident-related injuries are minor, any finding to the contrary in a specific matter risks being an inappropriate application of the *SABs* and the *Guideline* "which will be monitored on an ongoing basis."

That said, the *Guideline* optimistically defines its purpose as follows:

> The objectives of this Guideline are to:
>
> a) Speed access to rehabilitation for persons who sustain minor injuries in auto accidents;
>
> b) Improve utilization of health care resources;

> c) Provide certainty around cost and payment for insurers and regulated health professionals; and
>
> d) Be more inclusive in providing immediate access to treatment without insurer approval for those persons with minor injuries as defined in the SABS and set out in Part 2 of this Guideline.
>
> Consistent with these objectives, this Guideline sets out the goods and services that will be paid for by the insurer without insurer approval if provided to an insured person who has sustained a minor injury.
>
> This Guideline is focused on the application of a **functional restoration approach,** in addition to the provision of interventions to reduce or manage pain or disability. [emphasis in original]

While the *Guideline* concedes that some impairments do not come within the *Guideline*, it appears to set a high bar for any exceptions to what is seen as the rule in a situation where "it is intended and expected that the vast majority of pre-existing conditions" will not be seen as an exception.

> **4. Impairments that do not come within this Guideline**
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> An insured person's impairment does not come within this Guideline if the insured person's impairment is predominantly a minor injury but, based on compelling evidence provided by his or her health practitioner, the insured person has a pre-existing medical condition that will prevent the insured person from achieving maximal recovery from the minor injury if he or she is subject to the $3,500 limit referred to in section 18(1) of the SABS or is limited to the goods and services authorized under this Guideline.
>
> Compelling evidence should be provided using the Treatment and Assessment Plan (OCF-18) with attached medical documentation, if any, prepared by a health practitioner.
>
> The existence of any pre-existing condition will not automatically exclude a person's impairment from this Guideline.

The *Guideline* also speaks to the standard of proof required to exclude any particular case from the effects of the *Guideline*. Not only is "compelling evidence" stated to be required but even this appears to be insufficient to meet the *Guideline's* requirements:

> Only in extremely limited instances where compelling evidence provided by a health practitioner satisfactorily demonstrates that a pre-existing condition will prevent a person from achieving maximal recovery from the minor injury for the

> reasons described above is the person's impairment to be determined not to come within this Guideline. Exclusion of a person from this Guideline based on reasons or evidence falling short of this requirement is inconsistent with the intent of the SABS and this Guideline.

Thus, if one takes the *Guideline* at face value, there would appear to be a burden on an insured to demonstrate that there is either "compelling evidence" or compelling evidence that a "pre-existing condition will prevent a person from achieving maximal recovery from the minor injury" or that the impairment is not a minor impairment and that the claim in question is an exception to the general rule in motor vehicle accidents that most impairments are minor, or that the insured has made him or herself out to be one of the "extremely limited instances" where it is appropriate to treat outside of the *MIG*.

In this case, however, Ontario Regulation 34/10 fleshes out the current iteration of the complete accident benefits scheme.

The setup of the scheme is quite conventional. Using the example of Medical benefits, the *Schedule* starts with a general proposition that an insurer is obliged to pay certain benefits:

> 14. Except as otherwise provided in this Regulation, an insurer is liable to pay the following benefits to or on behalf of an insured person who sustains an impairment as a result of an accident:
>
> 1. Medical and rehabilitation benefits under sections 15 to 17.
> 2. If the impairment is not a minor injury, attendant care benefits under section 19. O. Reg. 34/10, s. 14.

Barring exceptions, then an insurer is obliged to make payments of medical and rehabilitation benefits to an insured who sustains an impairment as a result of an accident.

Exceptions have been part of the insurance environment since the first policies were developed. Schroeder, J.A., in *Calverley*, discussed the procedural effect of such exceptions in the context of insurance litigation:

> The effect of exceptions in insurance policies was discussed by this Court in Losier v. St. Paul Mercury Ind. Co., [1957] O.W.N. 97, where reference was made to Cornish v. Accident Ins. Co. (1889), 23 Q.B.D. 453, in which it was held that since exceptions were inserted in the policy mainly for the purpose of exempting the insurers from liability for a loss which, but for the exception, would be covered by the policy, they are construed against the insurers with the utmost strictness.[3]

By applying Schroeder J.A.'s analysis to our examination of Medical benefits under the *Schedule*, then it can be seen that the general provisions of the regulation (and hence the policy) provide for a wide, generalized coverage to insureds who have suffered an impairment subject only to specified exceptions. Thus, once an insured has satisfied the burden of proving that he or she is an "insured" and has suffered an impairment as a result of an accident, it is then incumbent for an insurer to prove that the insured then comes under a specified exception that would justify non-payment either in part or in full.[4]

At first glance, it would appear that the *Minor Injury Guideline* stands this on its head and proceeds with the burden of proving the exception on the insured.

If this indeed is the case, then to understand the extent of this burden it is necessary to explore the meaning of "compelling evidence" in the context of this *Guideline*.[5]

The phrase is not defined either in the *Guideline* or the *Schedule*. However, traditionally in Canada there have been only two standards of proof, one civil, and one criminal. The former is on a balance of probabilities while the latter is beyond a reasonable doubt.

Although there have been suggestions, perhaps inspired by Lord Denning's comments in *Bater v. Bater*, [6] that although in civil matters proof was required on a reasonable balance of probabilities, where conduct is alleged of a criminal or quasi-criminal nature, then there must be a degree of

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[3] *Calverley v. Gore District M.F. Ins. Co.* [1959] O.J. No. 662 ON C.A.

[4] It is important to differentiate this from the procedure with regard to catastrophic impairment where the wording of the section makes it clear that the burden is on an insured to show entitlement to enhanced benefits - standard benefits being the policy default.

[5] The requirement of "compelling evidence" is also inserted into the *Schedule* at section 18(2) dealing with provision by the health practitioner of evidence relating to a pre-existing condition.

[6] [1950] 2 All E.R. 458

probability which is commensurate with the occasion. To Denning such circumstances would require a clear preponderance of proof. Such a position was echoed by the Supreme Court in *Hanes v. Wawanesa.*[7] However, as R.C. Boswell J. noted recently in *MacIntosh*[8]:

> More recently, in *F. H. v. McDougall*, 2008 SCC 53, the Supreme Court took the opportunity to revisit the issue of the degree of proof required in civil cases and to comment upon the decision in *Hanes* and those that followed. The Court confirmed that "in civil cases there is only one standard of proof and that is proof on a balance of probabilities": para. 49. There is no intermediate standard of proof between balance of probabilities and the higher standard of proof beyond a reasonable doubt applicable in criminal cases. The Court disagreed with the assertion that a greater degree of scrutiny must be applied by a trial judge to evidence in more serious cases. Justice Rothstein remarked, at para. 45:
>
>> To suggest that depending upon the seriousness, the evidence in the civil case must be scrutinized with greater care implies that in less serious cases the evidence need not be scrutinized with such care. I think it is inappropriate to say that there are legally recognized different levels of scrutiny of the evidence depending upon the seriousness of the case. There is only one legal rule and that is that in all cases, evidence must be scrutinized with care by the trial judge.

Whatever the obligation on health practitioners with regard to furnishing evidence as to pre-existing conditions that could affect the outcome of accident-related injuries, it is not at all clear that the requirement of "compelling evidence"[9] translates directly into any enhanced burden of proof when adjudicating whether an insured falls inside or outside of the *MIG.*

I am not convinced that the *MIG* does create an extra evidentiary burden for an insured. Firstly the French version which is equally authoritative uses the phrase "La preuve convaincante devrait être fournie" in relation to the provison of information supporting an exception to the *MIG*. Any proof that is accepted by an adjudicator can always be called "convincing" since it persuades the adjudicator to make a certain decision. As a word it lacks the potential force of the word "compelling" in the English version and suggests to me that the authors intended that credible evidence be submitted to take an insured out of the *MIG.*

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[7] [1963] S.C.R. 154
[8] *MacIntosh v. Manulife Financial* [2012] O.J. No. 386
[9] « La preuve convaincante » in the French version of the *Guideline*

Likewise, the use of the conditional "devrait" departs from the usual legislative convention where in the words of the federal *Interpretation Act*, "L'obligation s'exprime essentiellement par l'indicatif présent du verbe porteur de sens principal et, à l'occasion, par des verbes ou expressions comportant cette notion." Thus it is hard to see the French version as mandating the provision of compelling evidence, instead of merely encouraging it.

Returning, however, to the English version of the *Guideline*, while it remains a possible interpretation that the Superintendent intended to override the normal practice and create a higher evidentiary burden for an insured, that interpretation must not be judged in isolation, but rather in the context of the entire legislative scheme.

I am unable to see an integrated scheme in the *Insurance Act*, the *Schedule* or indeed the *Guideline* that would support such a radical transformation.

There is no question however that a legislator can, with respect to matters in its jurisdiction, override the common law and amend statutory provisions that would otherwise apply. To do so, however, there must be a clear statement by the legislature to that effect. As Riddell J.A. summarized the question:

> In short, the Legislature within its jurisdiction can do everything that is not naturally impossible, and is restrained by no rule human or divine... [10]

Likewise, the Legislature can delegate authority to the executive, or to a subordinate authority the power to make delegated legislation or regulations, as is the case in the *Schedule*. The *Insurance Act*, however, does not provide for a "Henry VIII clause" which "delegates to a subordinate authority the power to make legislation that prevails over its enabling statute."[11]

In the absence of other legislative guidance, I would find that the only way to reconcile the English and French versions of the *Guideline* with regard to the provision of "compelling evidence" would be to interpret both provisions as an exhortation to medical practitioners and other *stakeholders* to

[10] *Florence Mining Co. v. Cobalt Lake Mining Co.* [1909] O.J. No. 196
[11] *Construction of Statutes 5th edition* Ruth Sullivan Lexis Nexis Markham 2008

provide credible, or convincing evidence if they wish to ensure that an insured is to be treated as being outside of the *MIG*.

While the *Minor Injury Guideline* is not legislation, it is incorporated by reference into the *Schedule*. It is long established[12] that the effect of incorporation by reference is that the material incorporated becomes part of the legislation or, in this case, the regulation that is the *Schedule*.

Accepting that the *Guideline* has been properly incorporated in the *Schedule*, then it would appear that the document should be interpreted conventionally as with any other legislative enactment.

Cronk J.A., in *Summers*, has reiterated the correct approach to statutory interpretation in Ontario:

> Second, it is now clear that there is only one approach to statutory interpretation in Canada, in both the civil and criminal law domains. In *Re Rizzo & Rizzo Shoes Ltd.*, [1998] 1 S.C.R. 27, at para. 21, the Supreme Court endorsed this formulation of the preferred approach, articulated by Elmer Driedger in *Construction of Statutes* (2nd ed. 1983), at p. 87:
>
> Today there is only one principle or approach, namely, the words of an Act are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament.[13]

It may be more difficult parsing a document such as the *Guideline*, and integrating it into its entire context when it is written in such an unconventional manner; incorporating policy, procedure and prognostication, at times in the same provision. It is not impossible however and is helped by the active choice of the "guideline" format by the legislator which specifically allows one to look at the spirit and weigh the practicability of the measures outlined in the document before choosing to implement them or not.

Section 1 of the *Guideline* specifically provides that it is "issued pursuant to s. 268.3 of the *Insurance Act* for the purposes of the *Statutory Accident Benefits Schedule.*" As noted earlier, section 268.3 provides that "a guideline shall be considered in any determination involving the

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[12] *R. v. St. Lawrence Cement Inc.* 60 O.R. (3d) 712. C.A.

[13] R. v. Summers, 2013 ONCA 147

interpretation of the *Statutory Accident Benefits Schedule.*" Once again, the jurisprudence tells us, in the words of Hennessy J.[14], that this means that the guidelines are "non-binding."

Hence, although the *Guideline* is incorporated by reference into the *Schedule*, it remains a non-binding interpretative aid in deciding specifically whether Mr. Scarlett comes within the *MIG*. This conclusion is reinforced by the manner in which the legislators chose to bring forward the *Minor Injury Guideline.* Although in other statutory schemes guides or guidelines may be mandatory, in the statutory accident benefits scheme they are not.

Indeed, if it was supposed that the incorporation into a regulation changed the nature of this *Guideline*, then there would necessarily be some tension between the regulation and the parent *Insurance Act*, which itself clearly expressed the intention of the legislature in providing for guidelines to be non-binding.

Both Elmer Driedger and his successor, Ruth Sullivan,[15] underline that there is a hierarchy of legislation with laws enacted by the legislature itself being at the pinnacle, with subordinate legislation presumed to be coherent with the enabling statute, in this case the *Insurance Act.* Given both the provisions of section 268.1 and the fact that it forms part of the *Guideline* itself when incorporated in the *Schedule*, I have no doubt that the advisory nature of the *Guideline* has not been altered by its incorporation in the *Schedule.*

How then does this *Guideline* relate to Mr. Scarlett's claim for accident benefits?

It is my understanding that the critical elements of the *Guidelin*e, as it affects Mr. Scarlett's claim, are as follows:

- Persons who suffer minor injuries (as defined) should be treated appropriately, with early, quick and limited intervention to assist in recovery.

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[14] *Ligocki v. Allianz Insurance Co. of Canada* [2010] O.J. No. 672

[15] *Construction of Statutes*, supra

- The decision or not to treat an insured either within the *Minor Injury Guideline* or not should be made on the basis of credible medical evidence and not on speculation.

- Even those persons who otherwise might be within the *MIG* can be treated outside of the *Guideline* if there is credible medical evidence that a pre-existing condition will prevent the insured person from achieving maximal recovery from the minor injury.

As noted in the agreed statement of facts, Belair has paid out $1,582.34 towards medical and rehabilitation expenses and a surprising $3,658.50 for medical assessments for a total of $5,240.84 "or $2,740.84 above the $3,500 limit prescribed for minor injuries."[16]

Mr. Scarlett's ongoing claim includes the costs of a mental health assessment, a TMJ assessment, an orthopaedic assessment and a further $1,067.30 for incurred physiotherapy.

I accept that in the absence of clear legislative direction that would override the existing jurisprudence as to burden of proof, it remains the Insurer's burden to prove any exception to or limitation of coverage on the civil balance of probabilities. In this case, that burden has not been met.

Leaving aside the issue of whether Belair's payments beyond the $3,500 limit implicitly recognized that Mr. Scarlett was not restricted by the *MIG*, I find that Belair has not met its burden of showing that Mr. Scarlett's claim is restricted to the parameters of the *Minor Injury Guideline*.

I make this finding in light of the *Guideline's* own first principle that provides as a goal to "speed access to rehabilitation for persons who sustain minor injuries in auto accidents."

Once again, Belair has claimed that Mr. Scarlett's injuries were minor soft tissue injuries and consequently he suffered a minor injury which is defined by the *Guideline* as follows:

a) minor injury means a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and any clinically associated sequelae.

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[16] Agreed statement of facts.

> This term is to be interpreted to apply where a person sustains any one or more of these injuries.[17]

While there is no doubt that Mr. Scarlett suffered soft tissue injuries, it is not at all clear that he also did not suffer from any other conditions that were neither soft tissue injuries nor the sequelae thereof, or that the sum of his injuries from the accident was minor in nature.

The reports of chronic pain by Dr. Tavazzani are evidence of symptoms separate from Mr. Scarlett's soft tissue injuries, presenting as a psychological, neurolocognitive and emotional impairment.

Dr. Pilowsky's psychological reports, taken with the comments of Dr. Tavazzani, provide credible evidence that Mr. Scarlett suffered serious depressive symptoms and PTSD consequent to the accident. While the Insurer's reports may disagree with that conclusion, that is the very sort of conflict that is meant to be resolved in court or by arbitration, on the issue of reasonableness of the particular treatment proposed, not by a unilateral veto of benefits by the Insurer.

It is important to note, however, that the negative conclusions in the Insurer's psychological report clearly turned on an alleged admission by Mr. Scarlett that he had no psychological issues and did not require psychological treatment. While the factual matrix of these alleged statements is dealt with in Dr. Pilowsky's second report, the Insurer's conclusions raise questions as to whether section 233 of the *Insurance Act* was taken into account by the Insurer when it relied on Mr. Scarlett's alleged statements in refusing benefits.

Section 233, of course, is the provision that forbids an insurer from relying on any statement by an insured in defence of a claim for benefits unless that statement is contained or embodied in the written and signed application for benefits.

Likewise, the TMJ issue would not appear to arise as a sequala to a soft tissue injury.

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[17] This definition is repeated at section 3(1) of the *Schedule*.

It makes no sense if the Insurer is positioned to veto access to benefits on the basis of the delivery of a single report, in the face of credible evidence to the contrary, when the resulting delay in treatment could last for years. This runs contrary both to the spirit of the accident benefit scheme and the stated purpose of the *Guideline* itself.

As for the *Waddell's signs* as a pre-existing condition that would also take Mr. Scarlett out of the *MIG*, on the limited evidentiary record I am not prepared to accept that they are more than just some corroboratory evidence of propensity or vulnerability, albeit evidence that would bolster the findings of chronic pain and other unfavourable independent outcomes.

Nonetheless, I find that the TMJ, the chronic pain diagnosis and the psychological impairments are separate and distinct from the soft tissue injuries, and are supported by credible evidence.

In doing so I reject the Insurer's view of the *MIG*, which might well be summarized by Dr. Crescenzi's conclusion that Mr. Scarlett's injuries "are commensurate with minor injuries, as described in the MIG." In fact, his opinion is that "Mr. Scarlett has impairments to which the Minor Injury Guideline (MIG) applies."

Mr. Scarlett does not deny that he has some minor injuries, and injuries that come within the *MIG*. He also has significant other problems arising from the accident that are not necessarily consequent to soft tissue injuries. When the totality of his injuries is assessed, they come outside of the *MIG*.

To find otherwise would not, in Mr. Scarlett's case at least, speed access to rehabilitation or improve utilization of health care resources, since at the time of the accident he had no access to OHIP to pay for any treatments arising from the accident.

I find that Mr. Scarlett provided timely and credible information to Belair that taken by itself would have justified considering that he was outside of the *MIG* and that he should not be considered as having received only a minor injury as a result of the accident.

Admittedly, there are the opinions of the Insurer's experts who, after a brief review, issued reports contradicting Mr. Scarlett's treatment providers. We have already looked at how Dr. Crescenzi's report likely misinterpreted the *MIG* provisions. The only way to fully reconcile the conflicting reports with any certainty would be to undertake a full trial of the issue with all experts subject to cross-examination. At the early stages in the claim process where the *MIG* is situated, such would be neither desirable nor possible.

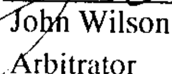
The insurer is in effect mandated to make an early determination of an insured's entitlement to treatment beyond the *MIG*. In essence, because of the necessarily early stage of the claim when the *MIG* is applied, the determination must be an interim one, one that is open to review as more information becomes available.

What it is not is the "cookie-cutter" application of an expense limit in every case where there is a soft tissue injury present. Such does not respond either to the spirit of the accident benefits system or the policy enunciated in the *Guideline* of getting treatment to those in need early in the claims process.

While it is quite possible that the majority of claimants can be accommodated within the *MIG*, averages are misleading when applied to individual cases. Each case merits an open-minded assessment, and an acceptance that some injuries can be complex even when there are soft tissue injuries present amongst the constellation of injuries arising from an accident.

EXPENSES:

If the parties are unable to agree on the issue of expenses, I may be spoken to briefly on that issue.



John Wilson
Arbitrator

March 26, 2013
Date

Financial Services
Commission
of Ontario

Commission des
services financiers
de l'Ontario

FSCO A12-001079

BETWEEN:

LENWORTH SCARLETT

Applicant

and

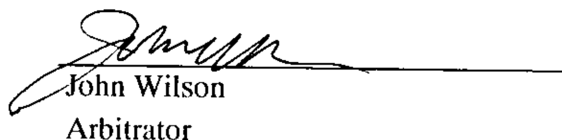
BELAIR INSURANCE COMPANY INC.

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. Mr. Scarlett is not precluded from claiming housekeeping, attendant care, as well as medical and rehabilitation expenses, beyond the $3,500 limit within the *Minor Injury Guideline.*



John Wilson
Arbitrator

March 26, 2013
Date