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Appeal P01-00002

**OFFICE OF THE DIRECTOR OF ARBITRATIONS**

MARY GLINKA

Appellant/Respondent

and

DUFFERIN MUTUAL INSURANCE COMPANY

Respondent/Appellant

BEFORE: Stewart M. McMahon  
REPRESENTATIVES: Roland Spiegel for Ms. Glinka  
Eric K. Grossman for Dufferin Mutual  
HEARING DATE: September 19, 2002

**APPEAL ORDER**

Under section 283 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, **it is ordered that:**

1. The appeals are allowed in part. Paragraph 2 of the arbitration order dated November 21, 2000 is rescinded and replaced with the following:

Dufferin shall pay \$1,125 in respect of the account of Dr. Harris.

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Stewart McMahon  
Director's Delegate

July 17, 2003

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Date

## **REASONS FOR DECISION**

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### **I. NATURE OF THE APPEAL**

The issues at Arbitration revolved around Ms. Glinka's claims for supplementary medical and rehabilitation expenses claimed pursuant to ss. 14 and 15 of the *SABS-1996*,<sup>1</sup> and assessment expenses claimed under s. 24. The issues at the heart of this appeal relate to process, including: (1) the Insurer's obligation to give reasons for denying a claim, (2) the relationship between the Insured person's right to claim assessment expenses and the Insurer's right to conduct its own medical assessments ("IEs"), and (3) the interaction between the Insurer's obligation to pay interest on "overdue" payments, and the designated assessment centre ("DAC") process. Complicating all these issues is the fact that Ms. Glinka's representative, Mr. Roland Spiegel, also acted as her "rehabilitation case manager" and "accident benefits administrator."

### **II. BACKGROUND**

Ms. Glinka was injured in a motor vehicle accident in September 1998. She sustained soft tissue injuries that resulted in stiffness and soreness in her neck and back, headaches, and mild dizziness. She went on to develop emotional difficulties, including a driving phobia. Ms. Glinka was working at the time of the accident, but had not returned to work at the time of the arbitration hearing in July 2000.

Ms. Glinka was referred to a rehabilitation clinic shortly after the accident. The clinic staff prepared a treatment plan that called for six weeks of chiropractic care, physiotherapy and massage treatment. Dufferin accepted this treatment plan and honoured the account. A second treatment plan was submitted, but Dufferin denied this plan and attempted to arrange a DAC assessment. For reasons that

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

I will explain later, the assessment was not conducted until August 1999. In the interim, Ms. Glinka continued to be treated by the clinic. Ultimately, the DAC reported that the treatment was not reasonable and necessary. Nevertheless, Ms. Glinka continued to attend for treatment for approximately seven months at a cost of roughly \$14,500.

At the same time that Ms. Glinka was being treated, Mr. Spiegel arranged for three assessments and submitted the accounts to Dufferin with a request for payment pursuant to s. 24 of the *SABS -1996*. The first claim related to a multi-disciplinary assessment by DEAHY. The second arose out of a psychological assessment by Dr. Harris. The third was for an in-home assessment by Homereach Community Inc. Dufferin did not respond to any of these claims. When they were ultimately included in the *Application for Arbitration*, Dufferin denied the claims.

The matter proceeded to arbitration on claims by Ms. Glinka for the unpaid portion of her treatment expenses, the cost of the assessments, and a special award. Dufferin claimed cancellation fees related to two aborted insurer examinations and an award pursuant to s. 282(11.2). The arbitration was conducted over three days, with written submissions filed at a latter date. Much of the evidence was in the form of documents, including the records of the rehabilitation centre and various assessment reports.

Ms. Glinka testified, as did a representative from DEAHY, but Mr. Spiegel did not call anyone from the clinic. He indicated that he wanted to give expert testimony himself in his capacity as Ms. Glinka's case manager and accident benefits administrator, but the Arbitrator refused to let him testify. She ruled that Mr. Spiegel could not appear as Ms. Glinka's legal representative and as an expert witness.

The Arbitrator found that Ms. Glinka was entitled to a few weeks of treatment beyond what the DAC stated was reasonable and necessary, but dismissed the claim for the bulk of the treatment because Ms. Glinka had not established the expenses were reasonable or necessary for her treatment or rehabilitation. In addition, the Arbitrator reduced the hourly rate payable for the physiotherapy services.

The Arbitrator did not award interest on the treatment expenses because the DAC had not approved the expenses. She allowed most of the s. 24 expenses together with interest. She dismissed the claim for a special award and Dufferin's claim for an order pursuant to s. 282(11.2), but awarded Dufferin a portion of its legal expenses.

The Arbitrator was very disturbed by what she characterized as the "poor quality of Mr. Spiegel's representation." She devoted two pages of her decision to these concerns, concluding by saying that she did not think Mr. Spiegel was competent to appear before the Commission.

Both parties have appealed. Ms. Glinka asserts that the Arbitrator erred in denying her claim for interest on the limited rehabilitation benefits she allowed. She also claimed that the Arbitrator erred in denying the bulk of her claim for treatment expenses, and seeks an order requiring Dufferin to pay all of these expenses, plus interest. In addition, she appeals the denial of her claim for a special award, and asserts that she, not Dufferin, ought to have been awarded the expenses of the arbitration. Dufferin appeals the rulings with respect to the s. 24 expenses.

The Arbitrator's comments about Mr. Spiegel's fitness provoked a motion by Dufferin to exclude Mr. Spiegel from appearing on the appeal. I eventually refused the motion, and allowed Mr. Spiegel to continue as Ms. Glinka's representative on the filing of an acknowledgment signed by Ms. Glinka, indicating that she was aware that Mr. Spiegel was not a lawyer; was not a member of the Law Society of Upper Canada; was not subject to the supervision or discipline of a professional body; was not required to carry insurance, and that an order for expenses in favour of Dufferin had been made against her at the arbitration stage.

### **III. ANALYSIS AND DISCUSSION**

I will deal with the issues discretely, starting with Ms. Glinka's appeal, which was filed one day before Dufferin's.

## **A. MS. GLINKA'S APPEAL**

The *Notice of Appeal* filed on Ms. Glinka's behalf contains a 30 page appendix that can best be described as submissions. It is confusing, and sometimes incomprehensible. In addition, it contains a lengthy commentary by Mr. Spiegel that amounts to an attempt to introduce new evidence. I have disregarded the new evidence. Many of the arguments overlap, and a substantial portion focus on complaints about the Arbitrator's handling of the evidence and findings of fact. Because appeals are limited to questions of law, these complaints do not raise legitimate issues for consideration on appeal. I have attempted to organize the remaining issues into themes, concentrating on the ones pursued during oral argument.

### **1. Bias**

Ms. Glinka's written submissions allege that the Arbitrator was biased. More particularly, the submissions state that the Arbitrator was motivated by personal animus directed at Mr. Spiegel. To his credit, Mr. Spiegel withdrew these scurrilous allegations during oral argument and apologized. Beyond recording this apology I would add that there is not even the slightest hint in the record of any impropriety on the part of the Arbitrator. She made a number of harsh comments about Mr. Spiegel's conduct, but there is no reason to suspect that these comments were motivated by anything other than proper considerations and motives.

### **2. Did the Arbitrator ignore relevant evidence?**

Ms. Glinka submits that the Arbitrator erred in failing to consider relevant evidence bearing on her claims for supplementary medical and rehabilitation benefits. I am not persuaded by this argument.

The Arbitrator's decision reveals that she considered the *viva voce* evidence of Ms. Glinka and the records generated by the treatment facility. She also considered and relied on the opinions in

DEAHY's reports, which recommended a few more weeks treatment to be followed by a re-evaluation. However, the Arbitrator noted that beyond this evidence there was virtually nothing to support the need for ongoing treatment.

Mr. Spiegel repeatedly stated that the Arbitrator ignored the abundant evidence that Ms. Glinka needed ongoing treatment during the chronic stage of her illness. However, when pressed, he was unable to point to any specific evidence that was not canvassed by the Arbitrator. Weighing the evidence is the Arbitrator's responsibility. In effect, Ms. Glinka is asking me to review the evidence and to substitute my opinion for the Arbitrator's. That is not my role. This ground of appeal is dismissed.

### **3. Mr. Spiegel's request to testify**

Ms. Glinka submits that the Arbitrator erred when she refused to allow Mr. Spiegel to testify, and that the matter should be remitted for a new hearing. I do not think the Arbitrator erred.

Mr. Spiegel was retained by Ms. Glinka shortly after the accident. He acted in a number of capacities including as a "case manager" responsible for directing and co-ordinating her treatment; an "accident benefits administrator" responsible for securing her benefits; and a legal representative responsible for pursuing her case through the dispute resolution process.

Mr. Spiegel has routinely asserted that insurance adjusters are not qualified to make decisions regarding whether treatment is necessary and appropriate. In contrast, he argues that he is qualified to make such decisions. In this case, as in others, he asked for an opportunity to give expert evidence in his capacity as a "rehabilitation specialist." The Arbitrator refused to allow Mr. Spiegel to testify.

Controlling the hearing is at the heart of an arbitrator's responsibilities. Her decisions in this regard must be given considerable deference, and should only be disturbed if she failed to consider relevant factors,

or exercised her discretion improperly. In this case, the Arbitrator noted that Mr. Spiegel had not complied with Rule 42.3 of the *Dispute Resolution Practice Code (4<sup>th</sup> ed.)* because he failed to: advise Dufferin that he intended to call himself as a witness; provide a copy of his *curriculum vitae* and; file a report or summary of his evidence. These were relevant considerations. I see no error in the way the Arbitrator approached this issue. This ground of appeal is dismissed.

It would appear that in addition to expert evidence Mr. Spiegel also wanted to give evidence about his dealings with the adjuster.

During the appeal hearing Mr. Spiegel relied on Arbitrator Novick's letter decision in *Klerides and Allstate Insurance Company of Canada* (FSCO A00-000169), released on December 12, 2000, for the proposition that there should have been no impediment to his appearing as both a representative and a witness. Mr. Spiegel over-reads the import of this decision. Arbitrator Novick was sitting as a pre-hearing arbitrator who was asked to make an order precluding Mr. Spiegel from acting as the insured person's legal representative because he had given notice that he intended to give evidence. Ms. Novick deferred the matter to the hearing Arbitrator, noting that there may be instances where it will be appropriate for a legal advisor to give evidence.

Our Courts have long recognized that a solicitor should not play the role of witness and counsel in the same proceeding. See Williston and Rolls *The Conduct of an Action*, Butterworths, p. 186 and the cases cited under footnote 30. In my view, there may be instances where it is appropriate for the counsel or representative appearing before an arbitrator to also give evidence, but these will be rare, and should only be allowed where the evidence is necessary to establish a crucial point, and where there is no risk that the credibility of the witness/advocate will be challenged. This was not such a case. If Mr. Spiegel wanted to give evidence he should have retained counsel to argue the matter.

#### 4. Estoppel

Ms. Glinka submits that the Arbitrator erred when she allowed Dufferin to challenge the number of treatment sessions she attended. She argues that because Dufferin did not identify this concern at the time it rejected the second treatment plan, it cannot raise the issue now. In my view, it was implicit in Dufferin's refusal to pay for treatments beyond the first treatment plan that it was challenging the number of sessions claimed by Ms. Glinka.

Ms. Glinka also argues that Dufferin should not have been allowed to challenge the s. 24 claims at the arbitration hearing because it did not respond to these claims at the time they were submitted. This is a more serious issue.

I categorically reject Dufferin's argument that in the *SABS-1996* context, the insurer's obligation to give reasons for denying a claim is not very significant, and there should not be any consequences attached to a deficient response. If anything, in the context of the *SABS-1996*, which is premised on the prior approval and assessment of medical and rehabilitation expenses, the need for reasons is more important. The Insurer's reasons may very well set the stage for everything else that follows, including: the insured person's decision to accept or challenge the decision; the nature of the inquiry undertaken by the DAC; the scope of disclosure by both parties; and the length and breadth of any ultimate trial or arbitration hearing. In appropriate circumstances, significant consequences should attach to a failure to comply with the statutory duty to give reasons for denying a claim.

However, I am not prepared to grant the relief sought by Mr. Glinka in this case because there is no evidence in the record that Ms. Glinka or her representative ever took issue with the absence of a response. Nor was any evidence of prejudice presented to the Arbitrator. When Mr. Spiegel was asked during the appeal hearing to point to such evidence, he replied that he was continuously pressing insurers for proper reasons, and consistently took the position that they did not have a basis for denying

his clients' claims. This harks back to my earlier comments about the difficulties inherent in Mr. Spiegel's attempts to wear too many hats at once. Comments made by a representative during the course of oral argument on appeal cannot be treated as evidence. This ground of appeal is dismissed.

**5. Did the Arbitrator err in reducing the amount payable with respect to Dr. Harris's account on the basis that Ms. Glinka should have submitted it to her collateral insurer?**

Ms. Glinka was referred to Dr. Harris for a psychological assessment. As a result of that assessment, Dr. Harris began to treat her. The treatment accounts were submitted to Sun Life which paid them pursuant to a supplementary medical policy connected to Ms. Glinka's employment. For reasons that were not explained, the account for the initial assessment was not sent to Sun Life. Instead, it was sent directly to Dufferin with a demand for payment pursuant to s. 24. The Arbitrator found the assessment expenses should have been submitted to Sun Life and reduced the amount payable by Dufferin to correspond with the hourly rates that were allowed by the Sun Life policy. However, on a review of Sun Life's policy, it is evident that Ms. Glinka had exhausted the limits with respect to psychological care. In these circumstances, the fact that Ms. Glinka had not submitted the expenses to Sun Life, or that she did not provide a reason at the arbitration hearing for failing to do so, was moot. No more benefits were payable by Sun Life. Apart from the question of the Sun Life policy, the Arbitrator found that the amount of Dr. Harris's account would have been payable. Therefore, the Arbitrator's order is varied and Dufferin is responsible for payment of an additional \$990.00, representing the unpaid portion of Dr. Harris's account.

**6. Did the Arbitrator err in refusing to order interest on the additional supplementary medical and rehabilitation benefits she awarded Ms. Glinka?**

The Arbitrator awarded Ms. Glinka a few additional sessions at the clinic, beyond what the DAC report stated was reasonable and necessary. Based on a plain reading of s. 46, the Arbitrator concluded that in light of the negative DAC report, these additional expenses were not overdue and hence did not

attract interest. Ms. Glinka challenges this ruling. For the reasons set out below, I agree with the Arbitrator's conclusions.

### **When do benefits become overdue?**

I disagree with the suggestion made by some insurers that a benefit can never be overdue in the event of a dispute, because the claimant has not yet proven the benefit is "due." However, I also reject the suggestion that a finding by an adjudicator that a benefit is owing, necessarily means the unpaid benefit was overdue, and therefore attracts interest.

### ***The SABS-1996***

At the risk of seeming to over-simplify an issue that has engendered a lot of debate, s. 46(1) of the *SABS-1996*, defines overdue. It states "[a]n amount payable in respect of a benefit is overdue if the insurer fails to pay the benefit *within the time required under this Part*" [emphasis added]. Part X, which is entitled "Procedures for Claiming Benefits," contains the rules governing payment of the various benefits contained in the *SABS*. The specific rules relating to medical and rehabilitation benefits are found in s. 38. Therefore, for our purposes, s. 46 (1) can be read as follows:

An amount payable in respect of a medical benefit is overdue if the insurer fails to pay the benefit within the time required by s. 38.

In light of this, the first step in establishing a claim for interest pursuant to s. 46(2) is identifying the applicable payment obligation imposed by s. 38. The second step is to ascertain if the insurer has fulfilled that obligation within the stipulated time. I have highlighted the words "within the time required," because they suggest to me that careful attention must be paid to the point at which the insurer is obliged to make a payment. This temporal connection is reinforced by the wording of s. 46(2), which states that interest is payable "from the date the amount became overdue."

With one exception, I discuss below, if a disputed expense is submitted to a DAC assessment, and the report does not state the expense is reasonable and necessary, s. 38 does not impose any payment obligations, short of a finding by an adjudicator that a benefit is owing.<sup>2</sup> In the absence of an obligation to pay in advance of the order, there is no foundation for a finding that the amount was payable prior to the order.

The easiest way to establish that the insurer is not under an obligation to pay, prior to adjudication, is to walk through s. 38 highlighting the instances in which the insurer is obliged to pay.

Subsections 38(1) and (2) require the insured person to submit an application and treatment plan before expenses are incurred. Subsection 38(8) states that within 14 days of receiving these documents, the insurer must deliver a notice to the insured person stating whether it will pay for some, all, or none of the proposed treatment.

The insurer's acknowledgment that it will pay for at least some of the treatment triggers the first obligation to pay an expense. Subsection 38(11) states that the insurer shall pay for these services within 30 days of receiving the invoice. A failure to honour this obligation will result in a finding that the amount payable is overdue. Pursuant to s. 46(2) the insurer will be obliged to pay interest on this amount from 30 days after receipt of the invoice.

Subsections 38(12) and (13) provide that the insurer must arrange a DAC assessment if it has not agreed to pay for all of the proposed treatment. However, in keeping with the fact that this takes time, and the prevailing medical view is that soft tissue injuries respond best if treated promptly, s. 38(16) provides that even though the insured person is to be assessed by a DAC, the insurer must pay for the lesser of the first 15 sessions with a chiropractor or physiotherapist, or the total of such expenses

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<sup>2</sup> For ease of reference, I shall refer to a DAC report that states the expense was reasonable and necessary as a "positive" DAC report. Similarly, I shall refer to a DAC report that does not state the expense was reasonable and necessary as a "negative" DAC.

incurred within six weeks after the accident.<sup>3</sup> Section 38 does not contain any explicit statement about when these expenses must be paid. Counsel for Allstate in the

*Amoa-Williams* case suggested that to be consistent, the insurer should pay for these services within 30 days of receipt of the invoice. This makes sense to me. This represents the second instance in which s. 38 imposes an obligation on the insurer to pay an expense. If an insurer fails to pay for these limited services within 30 days of receiving the invoice, the amount payable is overdue, and hence the insurer would also be responsible for the payment of interest pursuant to s. 46(2).

The insurer's obligations on receipt of the DAC report are set out in s. 38(14). Subject to a determination by an adjudicator, if the DAC reports that "an expense is reasonable and necessary for the insured person's treatment or rehabilitation, the insurer shall pay for the expense." Section 38(14) is silent on when this benefit must be paid. Again, to be consistent, the most apparent time is within 30 days of receipt of an invoice. This represents the third instance in which s. 38 imposes an obligation on the insurer to pay a benefit. Accordingly, these expenses are overdue if the insurer fails to pay them within 30 days of receipt of the invoice. It follows that interest is payable on these overdue payments in accordance with s. 46(2).

However, s. 38(14)(b) states that, subject to adjudication, if the DAC report is negative, the insurer is not required to pay for the expenses. The insured person can decide to pursue the treatment and commence legal proceedings, but the insurer is under no obligation to pay the expenses until there is a positive decision from a judge or arbitrator that the treatment was reasonable and necessary. This finding will oblige the insurer to pay for the expenses incurred by the claimant. The question remains, does it also trigger an obligation to pay interest pursuant to s. 46(2)? To my mind, the answer is no.

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<sup>3</sup> It was not dealt with by any of the parties, but for completeness sake, I note that s. 38(16) is subject to s. 38(14) and, accordingly, an argument can be made that the insurer is obliged to pay for any of these initial 15 sessions that pre-date the DAC, irrespective of the outcome of the DAC, but its obligations for any of these sessions that post-date the release of the DAC report are determined by the outcome of the assessment.

When considering the interest provisions found in the *SABS*, it is important to keep in mind that they are not the same as the pre-judgement interest provisions in s. 128 of the *Courts of Justice Act*, which provide (with some exceptions) that pre-judgement interest is payable whenever a party is entitled to an order for the payment of money. The event that triggers an obligation to pay interest in a civil proceeding is a finding that money is payable. In contrast, the event that triggers an obligation to pay interest pursuant to s. 46(2) of the *SABS-1996* is not merely the determination that a benefit is owing – it requires an additional finding that the insurer failed to pay the benefit within the time required by s. 38. In the event that a matter is referred to a DAC, and the DAC releases a negative report, there is no obligation to pay until there has been a determination after trial or arbitration. Accordingly, I can see no basis for a finding that the insurer's failure to pay, in advance of the adjudicator's ruling, can be characterized as a failure to pay the benefit within the time required by s. 38.

This conclusion can be bolstered by asking when the insurer should have paid the benefit (in other words, when would the benefit be overdue on the grounds that the insurer had failed to pay in a timely fashion)? The only real option is 30 days from receipt of the account. But that is the date that applies in the event of a positive DAC. Clearly, the legislature intended a different result in the event of a positive DAC versus a negative DAC.

The evolution of the interest provisions in the 1990 and 1994 versions of the *SABS* supports this reading of the *SABS-1996*.

### ***The SABS-1990***

The 1990 version of the *SABS* was quite straightforward. It contained a general section that governed the payment of all benefits. Weekly benefits were defined as overdue if not paid within 10 days of receipt of a completed application. Medical and rehabilitation benefits were overdue if not mailed within 30 days of receipt of the application. With some minor exceptions, that are not relevant for our

purposes, there were no provisions that displaced or nullified the insurer's obligation to pay benefits merely because of the existence of a dispute. Section 24(4) stated that "[t]he insurer will pay interest on overdue payments from the date they become overdue at the rate of 2% per month."

In *Sebastian and Canadian Surety Company*, (FSCO P96-00032, July 28, 1998), Director's Delegate Naylor considered a claim for interest on an award of weekly benefits. The principal dispute related to the amount of the benefit. The insurer argued that interest should only be awarded from the time Mr. Sebastian produced all the documents necessary to allow it to calculate the amount of his benefit. The Director's Delegate rejected this submission. She held that the obligation to pay interest pursuant to s. 24(4) of the *SABS-1990* was mandatory and that there is "no residual authority or discretion." She then asked the question – when were the payments overdue? To answer that question she went directly to the payment obligations set out in s. 24. Because the insurer had failed to pay the full amount of the benefit within the time set out in s. 24(1) she concluded the benefit was overdue, and hence attracted interest from that date forward. This direct tie between an examination of the payment obligations set out in the *SABS* and the obligation to pay interest, is consistent with the approach I have adopted in the cases before me.

In *Sebastian*, the insurer argued that at 2% per month, the interest provisions were designed to punish the insurer for reprehensible conduct, and therefore, interest should not be awarded short of this kind of wrongdoing. The Director's Delegate rejected this submission. However, she acknowledged that the interest provisions in the *SABS* had a dual component. In addition to compensating the claimant for the value of the money withheld, she concluded that it was designed "to further the system's fundamental goal of ensuring prompt payment of benefits..." I had made the same observation a few months earlier in an arbitration decision dealing with caregiver benefits. See *Urquhart and Zurich Insurance Company*, (OIC A96-000368, February 26, 1998).

### ***The SABS-1994***

When considering the significance of these “prompt payment” comments, in the context of the 1994 and 1996 versions of the *SABS*, it is important to note that in *Sebastian* the Director’s Delegate observed that “[t]he emphasis at the outset is on speedy payment with a minimum of formality.” Both the *SABS-1994* and the *SABS-1996* contain a significant amount of process and formality, including detailed rules about when payments must be made, and when they do not have to be made. In light of these changes it is too simple to say that the interest provisions are part of a larger scheme designed to encourage prompt payment. Instead, it is now more accurate to say that the interest provisions are part of a larger scheme designed to encourage the insurer to pay in accordance with the rules and time-frames set out the in the *SABS*.

Bill 164 removed the right to sue for pecuniary losses. Accordingly, the statutory accident benefits contained in the *SABS-1994* were significantly expanded. There was a corresponding increase in the amount of process that attached to the application and payment provisions. For our purposes, the most important change was the introduction of the DAC system that was designed to provide the parties with an independent assessment of the claim. The DAC opinion is not the final word on the parties’ rights and obligations – that is reserved to the judge or arbitrator – but the outcome of the DAC generally defines their rights and obligations pending adjudication. See *M.D. and Halifax Insurance Company*, (FSCO P00-00049, May 16, 2001).

The provisions governing the payment of all the principal benefits contain sections, similar to those found in the *SABS-1990*, that stipulate the insurer must pay on receipt of an application. In most cases, these obligations are accompanied by corresponding statements that the amount payable is overdue if the insurer fails to comply with these obligations. For example, the payment provisions governing weekly benefits are found in s. 62. Subsections 62(1) and (2) state that the insurer shall start paying these benefits within 14 days of receipt of an application, and every second week thereafter. Section 62(4) states that the amount payable is overdue if the insurer fails to comply with these obligations.

Section 68 states that “the insurer shall pay interest on the overdue amount for each day the amount is overdue from the date the amount became overdue at the rate of two per cent per month compounded monthly.”

All of the decisions considering the interest provisions in the *SABS-1994* deal with weekly benefits. The first decision to consider these provisions in any detail was *Bajic and Pafco Insurance Company Limited and Zurich Insurance Company*, (FSCO P00-00050, June 5, 2001). On appeal, the Director upheld an order that the insurer was responsible for the payment of interest on IRBs found to be owing after an arbitration hearing. The insurer argued interest should not accrue until the arbitration, and any appeals therefrom, were completed. The Director stated that overdue must be given some meaning, but was not prepared to go as far as the insurer urged. To ascertain if interest was owing, the Director examined the payment provisions in s. 62 and determined that the insurer was obliged to start paying IRBs within 14 days of receipt of an application, and to continue paying every two weeks thereafter, for as long as the insured was entitled to benefits. In light of these provisions, the Director found that the payments were overdue and awarded the insured person interest pursuant to s. 68. It is worth noting that the claimant did not request a DAC, and consequently, the case does not consider the interaction between the DAC rules and the definition of overdue.

*Faraj v. Prudential of America General Insurance Co.*, [1999] O.J. No. 4574, did involve a consideration of the interaction between the DAC provisions and the payment of interest on IRBs. Mr. Faraj requested a DAC which reported he was no longer eligible for benefits. In accordance with the applicable provisions, the insurer terminated benefits following the release of the DAC report. However, while preparing for the ensuing litigation the insurer obtained a report from one of its own experts that contradicted the DAC. A few months later the insurer reinstated benefits and ultimately paid the arrears, but refused to pay interest pursuant to s. 68. Justice Thompson rejected the insurer’s argument that the benefits were not overdue prior to reinstatement because there was still a dispute about causation up to that point. However, he also rejected the insured’s argument that the amount was overdue as of the date of termination. Justice Thompson concluded that until the insurer’s own expert

contradicted the DAC assessment the insurer had “done everything it was required to do and nothing was overdue until someone said it was overdue.” In the circumstances, he ordered interest, pursuant to s. 68, from the date of the report forward.

In *Mercier v. Royal and Sun Alliance Company of Canada*, [2003] O.J. No. 1233, Justice Quinn rejected the reasoning in *Faraj*, stating that in his view, the court put “too sharp a point on the meaning of ‘overdue.’” He expressed the view that “[w]here it has been adjudged that benefits have been improperly withheld from a plaintiff, I can see no reasons in law or logic why those benefits should not attract interest.” With respect, I disagree. I do not think it is possible to put too fine a point on the definition of overdue. To the contrary, a determination of entitlement to interest pursuant to s. 68 turns on a finding of overdue. I harken back to my earlier comment about the differences between the interest provisions in the *Courts of Justice Act* and the *SABS*. However, I note with interest that, after making these general comments, Justice Quinn embarked on the type of analysis that I have suggested is essential to an assessment of any claim for interest pursuant to the *SABS*. He looked at the insurer’s obligations in s. 62(1) and (2) and the definition of overdue. Unfortunately, for our purposes, he did not go on to inquire into what, if any, effect the DAC provisions have on the issue of whether a payment is overdue.

The Court of Appeal has considered the question of interest on weekly benefits awarded after trial. In *Attarvar v. Allstate Insurance Company of Canada*, [2003] O.J. No. 213, the Court upheld a decision that interest was payable on the difference between the loss of earning capacity benefit (“LECB”) paid by the insurer, which was based on the outcome of a DAC assessment, and the amount ultimately determined at trial. The payment of LECBs is also governed by s. 62 and, accordingly, the insurer is under the same obligation to begin paying these benefits within 14 days of receipt of an application, and every two weeks thereafter, and these payments are overdue if the insurer fails to comply with this obligation. Justice Laskin rejected the insurer’s argument that the shortfall in the LECBs was not overdue because it had followed the DAC’s recommendations. He noted that if the legislature had intended this result there would have been a statement to this effect in s. 62.

The common thread in all of these decisions is the link between the insurer's failure to meet its statutory obligation to pay the amount owing on receipt of the application, and a finding that the payment was overdue and hence attracted interest. The Court of Appeal took the matter one step further in the context of LECBs when it determined that a reading of s. 62 did not support the contention that the DAC rules were intended to supplant the obligation to pay the full amount of the benefit on receipt of the application.

These cases are important because they reinforce the link between the payment provisions contained in s. 62 and the interest provisions in s. 68. However, ultimately, the provisions governing the payment of medical and rehabilitation benefits are far more important to our deliberations because these sections contain direct links between the DAC rules and the definition of overdue.

The sections governing these benefits start with the universal obligation to pay on receipt of an application. However, from this starting point the insurer is given a number of sequential options governing the response to the claim. As the insurer moves through these options, the previous rules that define when it must pay are displaced by a fresh set of rules, and statements defining when the amount payable is overdue.

The most straightforward example of this sequence is found in the rules governing rehabilitation benefits. Section 45.1(1) states that the insurer shall mail or deliver benefits within 14 days of receipt of an application, and s. 45.1(2) stipulates that payments are overdue if the insurer fails to comply with this obligation. However, if the insurer asks for a certificate from a medical practitioner attesting to the reasonableness and necessity of the treatment, s. 45.1(3) states that ss. 45.1(1) and (2) do not apply. Instead, a new rule takes effect that obliges the insurer to pay within 14 days of receipt of the certificate, and the payment is overdue if the insurer fails to comply. Similarly, s. 45.1(4)(a) states that if an insurer refers a rehabilitation claim to a DAC, ss. 39.1(1)(2) and (3) no longer apply. The net effect of this sequence is that once the matter is referred to a DAC, the previous rules that define the insurer's payment obligations and the corresponding statements about when a payment is overdue, become

irrelevant. In large measure, this sequence does what the Court of Appeal said was absent in the LECB context.

The rules governing payment on receipt of the DAC report are set out in s. 45.1(4)(b) and (c). They provide that the insurer must pay the disputed expense within 14 days of receipt of a positive DAC report, and the payment is overdue if the insurer does not comply. Therefore, if the insurer arranges a DAC assessment, but then fails to pay for any expenses the DAC states are reasonable and necessary, it will also be responsible for the payment of interest from 14 days after receipt of the report.

Can interest be payable pursuant to s. 68 in the event of a negative DAC report? A plain reading of s. 45 and 45.1 suggests the answer is no. It is clear from the opening words of s. 45(11) that the insurer's ultimate obligation to pay for treatment is determined by the adjudicator, not the DAC. However, interest pursuant to s. 68 only attaches to that award if the payment became overdue at some point in time. In the absence of any requirement to pay on receipt of a negative DAC, the benefit ultimately awarded by the adjudicator is not overdue prior to adjudication.

The provisions with respect to the payment of medical benefits under the *SABS-1994* are a little more complicated. The provisions governing the payment of some types of medical expenses track the rehabilitation provisions. In other cases, a referral to a DAC does not automatically displace the insurer's obligation to pay on receipt of the certificate. However, on my reading of these provisions, once the DAC report is released, the insurer's prior obligations are displaced, and its ongoing obligations, pending adjudication, are determined by the outcome of the DAC.

### ***Conclusion***

Interest is not payable in the *SABS-1994* context because the initial obligation to pay is displaced once a referral is made to a DAC, and because the only obligation to pay imposed by the DAC provisions is tied to the release of a positive DAC report. The *SABS-1996* is even more straightforward because

there is no initial obligation to pay. In the absence of an obligation to pay, there is no statutory basis for saying that the insurer failed to pay the disputed expense “within the time required by s. 38.” In light of this, there can be no basis for a finding that the benefit was overdue, and hence no basis for the imposition of interest pursuant to s. 46(2).

In addition to a plain reading of the provisions, I think that the rationale for the interest provisions in the *SABS* also supports a conclusion that interest should not be payable in the event of a negative DAC report.

Modern theories of pre-judgement interest suggest that it is designed to compensate the successful party for the loss in the value of money that occurs in the interval between the time they became entitled to the money, and the date of judgement. At the same time, it deprives the unsuccessful party of any benefit they may have gained from holding onto the money. See M.A. Waldron, *The Law of Interest in Canada* (Scarborough: Carswell, 1992) at p.127. In this sense, pre-judgement is designed to be neutral. These theories were developed in the context of pre-judgement interest rates tied to commercial rates. However, at 2% per month (either simple or compound), the interest payable pursuant to the *SABS* is not neutral. It does more than compensate the insured for the delay, or deprive the insurer of any benefit gained from the use of the money pending judgement. It represents a penalty that is imposed in the event of an overdue payment.<sup>4</sup> This penalty component is the incentive designed to encourage the insurer to pay within the time-frames set out in the parts of the *SABS* that define the insurer’s payment obligations. Imposing interest in the event of non-compliance encourages the insurer to meet its obligations. However, this incentive is negated if the interest is payable in any event.

This interpretation of the interest provisions means that a claimant will not be compensated for the loss in the value of benefits that are not paid until after judgement. This is an important consequence that cannot be ignored. However, any consideration of the relationship between the obligation to pay

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<sup>4</sup> This consequence must be distinguished from the notion of punishment that is imbedded in a special award or punitive damages. See *Sebastian*. It is imposed in the event a payment is overdue, and does not require an additional finding that the payment was unreasonably withheld.

interest and the DAC provisions must consider all the consequences that flow from the release of a DAC report. A positive DAC report triggers an obligation to pay for disputed benefits pending the outcome of the litigation. This is a significant departure from traditional contract principles, and represents a significant advantage in favour of the claimant. The inability to claim interest after a negative DAC is part of the balancing integral to this system. In addition, if the claimant is ultimately unsuccessful at trial or arbitration, they will be obliged to repay the benefits that post-date the DAC, but it is not obvious to me that the insurer is entitled to demand interest on the repayment. In this respect, the interest provisions following a DAC report work in tandem.

For all of these reasons, I am satisfied that if the insurer refers a dispute over medical benefits to a DAC, which delivers a negative report, but a judge or arbitrator later finds that the treatment is reasonable and necessary, the insurer will be responsible for payment of the treatment, but will not be responsible for the payment of interest pursuant to s. 46(2), prior to adjudication because the amount awarded was not overdue before that time.

Having said this, the question of whether interest is payable will often be complicated by the fact that it is not uncommon for the DAC to assess the person after most of the treatment contained in the initial treatment plan has already been undertaken. This problem can be exacerbated by the fact that the DAC reports often comment only in prospective terms, and it can be difficult to determine what, if any, opinion they are proffering on the past treatment. All of the cases before me exhibit these difficulties. However, for the purposes of these appeals, counsel have largely ignored these elements and with one significant exception, have argued the matter on the basis that the DAC rejected the proposed treatment, but the insured person chose to pursue the treatment anyway, and ultimately succeeded in establishing entitlement to the benefits in issue. One significant wrinkle in the *Khaledi* and *Langdon* cases is the existence of a dispute over the hourly rate charged by the treatment centres. I will deal with this issue in the individualized portions of the affected decisions.

**7. Did the Arbitrator err in denying Ms. Glinka’s request for the expenses of the arbitration?**

The expenses of the Arbitration hearing are a matter within the Arbitrator’s discretion and should not be lightly interfered with. The Arbitrator considered all the relevant criteria. There is no basis for interfering with her exercise of discretion.

**8. Did the Arbitrator err in failing to order Dufferin to pay a special award?**

This ground of appeal could only succeed if Ms. Glinka succeeded on the other grounds of appeal, most of which have been dismissed. The Arbitrator did not err. This ground of appeal is dismissed.

**B. DUFFERIN’S APPEAL**

**1. The significance of the finding that Mr. Spiegel was the true source of the referral to DEAHY and Homereach.**

The Arbitrator found that the referrals to DEAHY and Homereach were signed by Ms. Glinka’s family doctor, but that he did so at Mr. Spiegel’s request. She also found that Mr. Spiegel had some form of undisclosed relationship with these two organizations. Dufferin argued on appeal that in the face of these findings, the Arbitrator should have also found that the assessments were not reasonable or, alternatively, were not conducted for the “purposes of the Regulation,” and hence were not payable pursuant to s. 24. Although I understand Dufferin’s concerns, I am not convinced that the Arbitrator’s ruling can be disturbed.

The Arbitrator found that Mr. Spiegel arranged for the s. 24 assessments, but she did not find, as suggested by Dufferin, that Mr. Spiegel arranged for the family doctor to sign the referral forms, to hide his involvement. More importantly, there is no evidence to suggest that Dufferin was operating under a misguided sense of who the true source of the referral was, or that it would have responded to the claim

any differently if the referral had been signed by Mr. Spiegel. In this regard, Dufferin's failure to give any reason for its refusal to pay the s. 24 expenses operates against it.

With respect to the more general argument that the Arbitrator erred in finding that the assessments were for the purpose of the *Regulation*, she turned her mind to this requirement and considered a number of factors, including the true source of the referral. Her findings of fact in this regard are not reversible on appeal.

The Arbitrator also considered the significance of the undisclosed relationship between Mr. Spiegel and the assessment companies. She noted that there is no statutory prohibition against an individual making a referral to an entity he has a relationship with. She contrasted this with the provisions governing referrals for treatment which include conflict of interest rules. However, the Arbitrator also noted that the existence of a relationship between the referrer and the assessor may "raise questions about the legitimacy of the need for the assessment." This statement makes it clear to me that the Arbitrator was aware of Dufferin's concerns. The evidence might have tipped the scales differently for another arbitrator, but that does not make her findings reversible on appeal. She considered the relevant evidence and applied the appropriate legal principles. This ground of appeal is dismissed.

**2. The relationship between the claims for s. 24 assessments and Ms. Glinka's refusal to co-operate with Dufferin's attempts to arrange IEs and DAC assessments.**

At the same time that Mr. Spiegel was arranging for assessments at DEAHY and Homereach, Dufferin was attempting to arrange an IE. On the first occasion, Mr. Spiegel asked Dufferin at the last moment to reschedule the appointment as Ms. Glinka had other obligations. Dufferin agreed to reschedule the appointment but, again, at the last moment Mr. Spiegel advised that Ms. Glinka could not attend due to a conflict. The Arbitrator was not convinced that Ms. Glinka's excuses were genuine, and found that she was intentionally being "uncooperative." To make matters worse, prior to the third appointment,

Mr. Spiegel advised Dufferin that Ms. Glinka would not attend the upcoming IEs on the basis that they were no longer necessary because he had obtained reports from DEAHY and Homereach.

Dufferin asserted in its written submissions that Ms. Glinka's "subversive" behaviour in relation to IEs and a subsequent DAC should have prevented a finding that the s. 24 assessment expenses were reasonable. Ms. Glinka responded that this amounted to a "tit for tat" approach that was inappropriate. She argues that the reasonableness of the s. 24 assessments must be judged on their own merits and should not be influenced by any wrongdoing (which was not admitted) with respect to Dufferin's attempts to arrange its own assessments or a DAC.

Sections 42 and 24 are inextricably linked – both are designed to allow the parties to undertake the assessments necessary to present and assess a claim. Beyond a theoretical link, Mr. Spiegel linked the two sets of assessments when he informed Dufferin that Ms. Glinka would not attend the IEs because they were redundant in the face of the assessments he had arranged.

The Arbitrator's findings regarding Mr. Spiegel's successful attempts to thwart Dufferin's legitimate efforts to arrange IEs are found in an earlier part of the decision, and it does not appear that she considered this evidence when she dealt with the s. 24 claims. In my view, this evidence was crucial to the s. 24 claims, and the Arbitrator erred by failing to consider it. The Arbitrator left the Commission to pursue other employment and, therefore, it is not practical to return the matter to her. In the circumstances, I will deal with the matter.

In this case, I do not think that it was reasonable for Ms. Glinka to invoke the authority of s. 24 to embark on a series of assessments designed to support her claim for benefits, while at the same time effectively blocking the Insurer's attempts to arrange assessments designed to assess the validity of those same claims. The appeal is allowed, and the order for the payment of the expenses incurred in relation to the assessments by DEAHY and Homereach is rescinded.

The same considerations do not apply to the assessment undertaken by Dr. Harris, which was suggested by Ms. Glinka's family doctor because of concerns about her emotional health.

**3. Did the Arbitrator err in awarding interest on the expenses awarded pursuant to s. 24?**

Dufferin argues that s. 24 "expenses are not benefits and hence do not attract interest pursuant to s. 46.

I do not agree. The Arbitrator dealt with the matter succinctly as follows:

such expenses are specifically referred to as other "benefits" under section 41 of the *Schedule*. Section 41 provides that "benefits" under Part VI (which includes costs of examinations under section 24(1)) are payable within 30 days after the insurer receives the application for the benefit.

I agree. In light of the dismissal of the claims related to the assessments by DEAHY and Homereach, this only applies to the assessment by Dr. Harris. The payment became overdue 30 days after receipt of the application and hence, attracted interest from that date onward.

**IV. EXPENSES**

Ms. Glinka enjoyed limited success on her appeal. In addition, I note that her written materials were lengthy and frequently did not raise appealable issues, putting Dufferin to unnecessary expense. However, she was successful in defeating a motion brought by Dufferin to remove her representative of choice. I have also considered the fact that her appeal contained unfounded allegations of bias directed at the Arbitrator, although this is ameliorated to some extent by Mr. Spiegel's apology.

Dufferin enjoyed mixed success on its appeal. It was successful in relation to the s. 24 claims, but unsuccessful in relation to the interest issues.

Considering all of these factors, each party shall bear their own expenses in relation to the main appeal. However, I confirm my earlier ruling, dated November 13, 2001, that Ms. Glinka must pay Dufferin's

expenses of \$500 in relation to the adjournment of a motion alleging institutional bias. I also confirm my subsequent decision, dated December 24, 2001, dismissing the institutional bias motion and awarding Dufferin its expenses of the motion in any event of the cause. Those expenses were later assessed at \$2,507.33, inclusive of disbursements.

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Stewart M. McMahon  
Director's Delegate

July 17, 2003

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Date