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# Home Modification in Accident Benefits Claims

## Guiding Principles and Top Cases

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## Introduction

In Ontario, an individual involved in a motor vehicle accident is usually entitled to Statutory Accident Benefits, a no-fault insurance scheme that provides medical, rehabilitation, and other benefits to injured people.

One of the types of benefits available under Ontario's Statutory Accident Benefits Schedule ("SABS") are home modifications. Falling within the general umbrella of medical and rehabilitation benefits, home modification benefits are meant to cover reasonable and necessary home renovations (such as ramps, widened doorways, accessible bathrooms, etc.) to accommodate accident-related impairments, provided they are recommended by a qualified health professional and pre-approved by the insurer. The legislation also contemplates workplace modifications and vehicle modifications, but the scope of this paper will be limited to home modifications as those are most commonly seen and disputed.

Home modification claims typically come up where an individual has significant or catastrophic injuries, or ongoing mobility concerns following a motor vehicle accident. Their injuries may have required a stay at a rehabilitation facility and now upon discharge, their home may no longer be accessible to them. While an important benefit for catastrophically impaired individuals, there are often disputes over the quantum and types of modifications that are reasonable and necessary given the circumstances. An insurer should not be required to pay for a house to be completely stripped down to its studs and rebuilt. What is proportionate, while still meeting an individual's needs, is tricky and often comes down to competing expert opinions.

## Legislative Provisions in the SABS

The relevant sections of the SABS in relation to housing modifications are as follows:

***Rehabilitation benefits***

> ***16.*** *(1) Subject to section 18, rehabilitation benefits shall pay for all* ***reasonable and necessary expenses incurred*** *by or on behalf of the insured person in undertaking activities and measures described in subsection (3) that are reasonable and necessary for the purpose of reducing or eliminating the effects of any disability resulting from the impairment or to facilitate the person's reintegration into his or her family, the rest of society and the labour market.*

*[…]*

*(3) The activities and measures referred to in subsection (1) are…*

*(i) **home modifications and home devices**, including communications aids, to accommodate the needs of the insured person, or the purchase of a new home if it is more reasonable to purchase a new home to accommodate the needs of the insured person than to renovate his or her existing home;*

This, of course, is subject to further parameters found in the following subsection, reproduced below:

*(4) Despite subsection (1), the insurer is not liable to pay rehabilitation benefits,*

*(a) for expenses related to goods and services described in subsection (3) rendered to an insured person that **exceed the maximum rate or amount** of expenses established under the Guidelines, other than for expenses related to the services described in clause (3) (k);*

*(b) for expenses incurred to renovate the insured person's home if the renovations are only for the purpose of giving the insured person access to areas of the home that are not needed for ordinary living;*

*(c) for the purchase of a new home **in excess of the value of the renovations** to the insured person's existing home that would be required to accommodate the needs of the insured person;*

*[…]*

Note that home modifications are not available for claimants who fall within the Minor Injury Guidelines. This makes sense from both a policy limit perspective and Section 18 of the SABS which dictates that housing modifications must be deducted from the insured's total policy limits for medical and rehabilitation expenses. These are $65,000 for non-catastrophic injuries and up to $1,000,000 for catastrophic impairments, subject to any optional benefits purchased by the insured.

## How Home Modification Benefits Work in Practice

While the process can get more complex in many cases, as a simplified overview if an insured thinks they require home modification benefits, they will likely seek to obtain a home site assessment provided by an occupational therapist or accessibility consultant.

The insurer will generally pay for this assessment, provided it has been approved in advance through a Treatment and Assessment Plan ("OCF-18") completed by a regulated health professional. This home site assessment is meant to provide the rationale for the recommended home modifications, looking at current accessibility features and limitations of the insured's home, with the aim of returning the injured person to their pre-accident level of function as quickly, safely and cost-effectively as possible.

Once the assessments have been completed and the report is received, the insurer will review the recommendations made in the report and decide whether they are reasonable and necessary. In situations with uncertainty or large-scale renovations being recommended, the insurer may request a s. 44 Insurer Examination to review the insured's report and provide another opinion. Depending on the outcome, the parties may agree to a proposed course or action or may bring the dispute to the License Appeal Tribunal ("LAT") for a determination.

There are a variety of finer points that have been adjudicated at the LAT, including which home is to be assessed, whether the purchase of a new home is reasonable and necessary, or how to address renovations in the case of rental homes. The following are some of the top cases on home modifications that provide helpful guidance to parties seeking or deciding on home modification benefits.

## Top Housing Cases

***Mirzaie v. Wawanesa Mutual Insurance Company*, 2021 CanLII 104417 (ON LAT)**

The Applicant was involved in a motor vehicle accident and was found to be catastrophically impaired as a result. Based on a Housing Accessibility Report prepared by Jeffrey Baum, he applied for a rehabilitation benefit in the amount of $1,277,130.00 for the purchase of a new home. The Respondent denied the benefit, claiming it was not reasonable or necessary. The dispute was brought to the LAT, to determine whether the Applicant was entitled to a medical and rehabilitation benefit to the maximum amount remaining under the SABS (given the million-dollar policy limits) for the purchase of alternative housing.

The LAT determined that the Applicant was **not** entitled to benefits for the purchase of a new home. In coming to its decision, the LAT considered the Applicant's circumstances, injuries, and the options presented to address his needs.

The Applicant lived in a one-bedroom rental condominium. His occupational therapist recommended a single-level detached home so he could have a therapy dog to help with

his psycho emotional difficulties, a backyard, natural sunlight and open space. The Applicant's evidence was that living in a dark and closed off apartment was creating emotional difficulties, he lacked access to the community and the outdoors, faced issues with his use of medical marijuana, and did not have access to safe emergency exits being in a high-rise building.

Mr. Baum's report investigated housing options that could fulfill the recommendations but notably did not conduct a fulsome assessment as to whether the Applicant's needs could be accommodated by modifying his rental apartment. Instead, the options presented included either renting a detached home with necessary home modifications being made or purchasing and modifying a suitable house. Given difficulties with modifying rental properties and reversion costs of restoring a rental to its original form, as well as the fact that the Applicant required a long-term housing solution, the purchase of a new home was the recommended option Mr. Baum and the Applicant pursued.

The Respondent's position was that the housing benefit sought was not reasonable and necessary given it was twice the cost of the remaining medical and rehabilitation limits and would leave no money for the Applicant's ongoing treatment. The Respondent also argued that the housing benefit sought failed to consider the option of a ground floor apartment, or modifying the applicant's current rental apartment.

The LAT reiterated that the Applicant bears the onus of establishing, on a balance of probability, that the disputed benefit is reasonable and necessary. In this case, they found the Applicant failed to meet his onus. The LAT also confirmed that the insurer is not obligated to pay the cost of the purchase of a new home in excess of the cost of renovating the Applicant's existing home. As a result, one must determine what it will cost to modify or renovate the Applicant's current premises even though that premises may never actually be modified or renovated. This was not undertaken, because Mr. Baum opined that *"changing a multi-unit apartment into a single level house would have resulted in all of the tenants being evicted, changes to zoning and millions of dollars incurred. Thus given Mr. Tamir's recommendations, an assessment of Mr. Mirzaie's pre-accident unit was not completed."* The LAT did not find this explanation reasonable.

This case serves as a reminder that Applicants are not entitled to a 'windfall' as a result of an accident. Adjudicator Gosio adopted the principle articulated by FSCO Arbitrator Makepeace in 1994 in the oft referenced decision of *MacMaster v Dominion of Canada General Insurance Co.,*[1] that the purpose of Section 16 of the Schedule is **to enable the applicant to return to their pre-accident level of function**, as opposed to providing a windfall. The Applicant is not entitled to hold out for a multi-million-dollar house and accept

[1] [1994] OICD No 122, 1994 CarswellOnt 4976

nothing less. Instead, Section 16 of the Schedule requires the Applicant to cooperate with the insurer to reach a solution that, while it may not be ideal, is workable and reasonable.

***Douglas v Wawanesa Mutual Insurance Company*, 2025 CanLII 3853 (ON LAT)**

The Applicant was found to be catastrophically impaired following a motor vehicle accident on August 11, 2018. She was receiving post-104-week income replacement benefits and had received $343,740.88 in medical and rehabilitation benefits at the time of the dispute. The disputed benefits were for home modifications and devices in the amount of $334,363.41 ($579,163.41 total less $244,800.00 previously approved).

The LAT determined that the Applicant was entitled to the proposed treatment plan in part – specifically with respect to the relocation of the fridge. She was **not** entitled to the remaining rehabilitation benefits, which included new flooring, drywall, and rewiring throughout the home, construction of an addition at the rear of the home be used as a therapy room, kitchen renovations, garage rebuild, and a hardwired alarm system.

This case goes through the reasonableness and necessity of various specific benefits. However, it also emphasizes a few key principles when dealing with home modifications.

First, this decision reiterates that **reasonable and necessary modifications must be connected specifically to the Applicant's accident-related impairments**. In this case, the Applicant's home was quite old. In fact, it was built in 1904. As such, it is expected that many items such as rewiring or replacing fuse panels, would be reasonable because these old items pose safety of fire hazards. However, they are wholly unrelated to the accident and would require replacement irrespective of the Applicant's injuries.

The Applicant did not support the connection between the proposed recommendations and her accident-related impairments. They also did not provide an opinion of how the proposed recommendations are required as a result of any accident-related impairment.

The proposed modification of creating an additional 'therapy room' was found by the LAT to be excessive. The cost of $170,000.00 was recommended because the Applicant had a recumbent bike in the middle of her living room, which was deemed not to be an acceptable solution. However, it was noted that the Applicant's home had 5 rooms (a primary bedroom, secondary bedroom, office, open concept living room and dining room) that could be used for this gym area instead. There was no explanation as to why a separate room was required.

Second, this decision **weighs the impact of partial approvals on outstanding items in dispute.** The LAT compared various renovations and devices approved, and how they may already address other recommendations of the rationale for same. For example, one of the home modifications requested in this case was to replace flooring in the entire home due to a safety/tripping hazard. However, the insurer had already approved installation of non-clip ceramic time flooring for the foyer and bathroom, which previously had slippery tile that the Applicant had fallen on in the past.

Similarly, the insurer had already approved a stair lift so the Applicant could access her basement. In light of this, the recommendation that the Applicant's furnace and water heater be moved upstairs from the basement was no longer reasonable and necessary. This is encouraging for insurers who make partial approvals based on their determinations and can be helpful for situations where some recommendations become redundant due to items already approved.

Finally, this decision serves as a reminder that **the LAT can only weigh in on submissions within its jurisdiction.** One of the renovations in dispute was the Applicant's garage. Both parties agreed that a garage needed to be constructed. The Respondent's assessor recommended building a garage at the front of the house, which was most cost effective. The Applicant's assessor, however, recommended that the garage be built at rear of the house because building it at the front would encroach upon municipal property.

The LAT reported that this was not within its jurisdiction to determine per s. 280 of the *Insurance Act.* The LAT can only determine whether building the garage at the rear of house was reasonable and necessary based on Applicant's accident-related impairments. In this case, there were no submissions based on the Applicant's impairments and therefore the LAT found it was not reasonable and necessary that the garage be placed at the rear of the property.

The Applicant brought a request for reconsideration on June 16, 2025, which was dismissed.[2]

## ***Sorrentino v. Certas Home and Auto Insurance Company*, 2026 ONSC 1578 (CanLII)**

The Applicant was 83 years old when she was involved in an accident on April 26, 2016, wherein she sustained catastrophic injuries. She lived in her own apartment at the time and continued to do so after the accident with attendant care services. However, she subsequently decided to move in with her daughter because of her functional and care

[2] *Douglas v Wawanesa Mutual Insurance Company*, 2025 CanLII 58812 (ON LAT)

needs. The Applicant sought $388,082.53 for modifications to her daughter's home. The Respondent denied the claim and instead agreed to provide $22,825.53 for modifications to her own apartment instead. This dispute has a long procedural history and boils down to the question of what constitutes an "existing home" for the purposes of SABS.

The Applicant initially brought a dispute before the LAT, which was dismissed on December 9, 2024. On September 23, 2025, the Divisional Court overturned the LAT decision.[3] The final decision from the Superior Court of Justice Divisional Court forms the basis of the within discussion.

The Court maintained that authorities hold that "existing home" has been given a broad and flexible interpretation, often encompassing a residence the insured intends to occupy. The Court determined that it was an error of law to require the Applicant to prove that the modifications under the (OCF-18) could not be made to her own apartment before considering the new substantive modifications to her daughter's home under the disputed treatment plan. The Court concluded that the Applicant's appeal was allowed, and in the interest of efficient access to justice and the Applicant's significant age and safety concerns, ordered the Respondent to pay $365,527 plus $10,000 in costs.

The key legal point is **that the Court rejected a narrow interpretation of "existing home."** It held that "existing home" should not be limited to the residence occupied by the insured at the time of the accident. The Court accepted that the claimant was entitled to decide where she would live after the accident, particularly where that choice was connected to her care needs. The proper question was not whether the claimant had proven that her condo could not be modified before considering the daughter's home. Rather, the question was whether the proposed modifications to the daughter's home were reasonable and necessary to accommodate the claimant's accident-related needs.

In light of this, insurers may need to exercise caution where denying modification requests to a home that is different from the Applicant's pre-accident residence. That being said, this case does not mean any preferred residence becomes compensable. The proposed modifications still need to be tied to accident-related functional needs and shown to be reasonable and necessary.

### ***Trottier-Plante v Economical Insurance,* 2023 CanLII 65749 (ON LAT)**

The Applicant was involved in a motor vehicle accident on May 30, 2019, and sought multiple SABS benefits, including catastrophic impairment status, treatment, occupational therapy, home accessibility costs, rent, a wheelchair-accessible van, and home

[3] *Sorrentino v. Certas Home and Auto Insurance Company,* 2025 ONSC 5518 (CanLII)

modifications. The home-modification issue concerned an (OCF-18) in the amount of $252,413.75.

The Applicant argued that she required a walker at all times because of the accident and that her house was not accessible. She submitted that modifications were required to accommodate her changed mobility needs. The Respondent denied the treatment plan. Its position was that the accessibility report provided in support of the home modifications was premised on wheelchair accessibility even though the Applicant did not actually require a wheelchair at the time. The Respondent argued that there was no medical documentation supporting a current need for wheelchair-related modifications.

The LAT agreed with the Respondent and found that the proposed modifications and devices were not reasonable and necessary. The central issue was that the **recommendations were not tied to the applicant's current level of function.** The accessibility consultant and occupational therapy evidence contemplated the Applicant's potential future wheelchair needs, including the possibility that she might require a wheelchair earlier in life because of the accident. The LAT found that this was not enough. The proposed modifications were based on anticipated future accessibility requirements, not current accident-related functional needs. The insurer's occupational therapist testified that there was no medical recommendation for a wheelchair or wheelchair accessibility, and that providing a prognostic opinion about future wheelchair use was outside the scope of the occupational therapist's role.

A second issue dealing with home modification raised in this case was that the proposed modifications related to a property where the Applicant no longer lived and no longer had access. The Applicant had moved from the residence after it was condemned and she was evicted. No expenses had been incurred, and no modifications had been completed. The LAT held that if the Applicant wanted accessibility modifications, she would need to propose a new accessibility plan for a new property.

The practical significance of this case is that it is **strong authority against speculative, future-oriented home modification plans.** It supports the proposition that home modifications must be grounded in current, medically supported, accident-related functional needs. It is also useful where the proposed work is attached to a stale or unavailable residence. claimed.

## Conclusion

Home modifications are a category of benefits that typically and expectedly see large figures and therefore come with added scrutiny. The cases referred to above illustrate that thorough investigations and assessments need to be conducted to properly assess what modifications can adequately accommodate an insured's needs. The purpose of Section 16 of the Schedule is to enable the applicant to return to their pre-accident level of function, as opposed to providing a windfall. Reasonable and necessary modifications must be connected specifically to the Applicant's accident-related impairments, and the impact of partial approvals on other items in dispute needs to be considered. The Court is still mindful that the SABS is consumer protection legislation and, where wording is being interpreted too narrowly, such as in the case of an "existing home", there may be cost consequences. However, recommendations still must be tied to an Applicant's current level of functioning and cannot be future-oriented in the absence of medical evidence.

We spend a great deal of time in our homes, and they should be an accessible space for someone who has been significantly or catastrophically impaired by a motor vehicle accident. However, there are important guiding principles and limitations in place to determine what is reasonable and necessary in the circumstances.