

HELPING TO DETERMINE IF YOUR CLIENT IS CATASTROPHICALLY IMPAIRED – THE ROLE OF THE HEALTH CARE PROFESSIONAL

DAVID F. MACDONALD
THOMSON, ROGERS

With anticipated changes to the Statutory Accident Benefits Schedule, it is all the more important for treating health care professionals to determine whether their clients are catastrophically impaired or are likely to be deemed to be catastrophically impaired. Courts and Arbitrators have helped us to understand how the definition of catastrophic impairment may apply to individuals who suffer very severe injuries in motor vehicle accidents. These same decisions have helped us to understand that clinical findings by treating and assessing health care professionals are integral to the process of evaluating whether a person has sustained a catastrophic impairment.

The goal of this paper is to provide health care professionals with further tools to assist them in conducting evaluations and providing detailed reports to assist in Catastrophic Impairment determination. This paper examines the definition of catastrophic impairment, legislative intent and provides a summary of all of the decisions concerning catastrophic impairment determination by the courts and by FSCO Arbitrators.

The paper analyses key chapters in the American Medical Association Guides To The Evaluation Of Permanent Impairment, 4th Edition¹. For each Chapter, we identify key information and assessments by treating and assessing health care professionals that can be used to assist in CAT Impairment designation. The paper analyses the Glasgow Coma Scale and the Glasgow Outcome Scale in light of clinicians' assessments. We then address the legal meaning of causation as it relates to accident benefit impairments. The paper concludes by discussing fair payment for the assessments of treating and assessing health care professionals which form the cornerstone of catastrophic impairment determination.

A. CATASTROPHIC IMPAIRMENT

“Catastrophic Impairment” has been with us since November 1, 1996. The current definition of catastrophic impairment follows:

- (1.2) For the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs after September 30, 2003 is,
 - a) paraplegia or quadriplegia;

¹ AMA Guides To The Evaluation Of Permanent Impairment , 4th Edition, ed. Doege, T.C. © 1995, American Medical Association

- b) the amputation or other impairment causing the total and permanent loss of use of both arms or both legs;
 - c) the amputation or other impairment causing the total and permanent loss of use of one or both arms and one or both legs;
 - d) the total loss of vision in both eyes;
 - e) subject to subsection (1.4), brain impairment that, in respect of an accident, results in,
 - (i) a score of 9 or less on the Glasgow Coma Scale as published in Jennett, B. and Teasdale, G., *Management of Head Injuries*, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or
 - (ii) a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as published in Jennett, B. and Bond, M., *Assessment of Outcome After Severe Brain Damage*, Lancet i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose;
 - f) subject to subsections (1.4), (2.1) and (3), an impairment or combination of impairments that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, results in 55 per cent or more impairment of the whole person; or
 - g) subject to subsections (1.4), (2.1) and (3), an impairment that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioral disorder. O. Reg. 281.03, s.1 (5).
- (1.3) Subsection (1.4) applies if an insured person is under the age of 16 years at the time of the accident and none of the Glasgow Coma Scale, the Glasgow Outcome Scale or the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, referred to in clause (1.2) (e) (f) or (g) can be applied by reason of the age of the insured person. O. Reg. 281/03, s.1 (5).
- (1.4) For the purposes of clauses (1.2) (e), (f) and (g) an impairment sustained in an accident by an insured person described in subsection (1.3) that can reasonably

be believed to be a catastrophic impairment shall be deemed to be the impairment that is most analogous to the impairment referred to in clause (1.2) (e), (f) or (g) after taking into consideration the developmental implications of the impairment. O. Reg. 281/03, s.1 (5).

- (2.1) Clauses (1.2) (f) and (g) do not apply in respect of an insured person who sustains an impairment as a result of an accident that occurs after September 30, 2003 unless,
- a) the insured person's health practitioner states in writing that the insured person's condition is unlikely to cease to be a catastrophic impairment; or
 - b) two years have elapsed since the accident. O. Reg. 281.03, s.1 (7).
- (3) For the purpose of clauses (1.1) (f) and (g) and (1.2) (f) and (g) an impairment that is sustained by an insured person but is not listed in the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993 shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person. O. Reg. 403/96 s. 2 (3); O. Reg. 281/03, s.1 (8).

B. THE DEFINITION: THE DRAFTERS' INTENT

Arbitrators and courts have commented on the Legislature's definition of catastrophic impairment.

One of the seminal decision considering the definition of catastrophic is *Desbiens v. Mordini* a decision of Justice Spiegel of the Ontario Superior Court in 2004.² In *Desbiens*, the Court commented that:

“the legislature's definition of “catastrophic impairment” is intended to foster fairness for victims of motor vehicle accidents and ensure that victims with the greatest health needs have access to expanded medical and rehabilitation benefits.”³

It is also important in interpreting the definition to remember that:

“the SABS are a remedial consumer protection legislation.”⁴

Typically, remedial consumer protection legislation is intended to be interpreted in a manner that assists consumers.

² *Desbiens v. Mordini*, [2004] CanLII 41210 (ON S.C.)

³ *Desbiens*, Supra para 237- 234

⁴ *Smith v. Co-Operators General Insurance Co.*, [2002] 129 S.C.R.

As the court noted again in *Desbiens* at paragraph 238 the text of the regulation itself indicates that the drafters clearly intended the definition of “catastrophic impairment” to be inclusive rather than restrictive.

As a result of *Desbiens* and a number of decisions following *Desbiens*,⁵ when considering section (f) of the definition, Arbitrators and Judges have concluded that it is appropriate to assign a percentage rating to mental and behavioural impairments and to add that percentage, using the applicable tables, to the other percentage ratings of impairment to determine whole person impairment.

Apart from the legislative intention of the drafters, the Financial Services Commission of Ontario (FSCO) created Commission Guidelines dated October 2001 as a guide to Designated Assessment Centre’s (DAC’s) assessing catastrophic impairment.

As section 1.1 (f) of the definition indicates that a person with a combination of impairments which results in fifty-five percent or more impairment of the whole person, it is not with any surprise that we note the Guidelines asked the CAT DAC to “ensure it evaluates the whole person”.⁶

The definition of catastrophic was modified for accidents occurring after September 30, 2003 by Bill 198 when it allowed clauses (f) and (g) to be used as a basis for determining catastrophic impairment when two years, as opposed to three years, had elapsed since the accident.

The other modification that occurred in Bill 198 was the inclusion of sections (1.3), (1.4) and (3). Sections (1.3) and (1.4) acknowledged the difficulty of using the Glasgow Coma Scale, Glasgow Outcome Scale and AMA Guides to assess the impairments of a person under the age of sixteen. Sections (1.3) and (1.4) allow assessors who reasonably believe a person under the age of sixteen years to have suffered a catastrophic impairment to analogize that impairment to the impairment referred to in clause (1.2) (e), (f) or (g).

Section (3) allows the assessor evaluating impairments that are not listed in the AMA Guides to deem the impairment to be the impairment in the Guides that is most analogous to the impairment sustained by the insured person.

The net effect of both of these revisions is to allow greater clinical judgment to be used in the assessment of impairments, including consideration of the developmental implications of an impairment.

⁵ *Desbiens*, Supra has been subsequently followed by: *Arts v. State Farm Insurance Company*, Can LII 25055 (ON S.C.), *McMichael and Belair Insurance Company*(2006) Appeal P)5-00006; *Ms. G and Pilot Insurance Company* (FSCO A04-000446, March 16, 2006) affirmed on Appeal (FSCO P06-00004, September 4, 2007); *Augello and Economical Mutual Insurance Company*, (FSCO A07-001204, December 4, 2007 and December 18, 2008); *Pastore v. Aviva*, [2009] O.F.S.C.O. No. 24, February 11, 2009

⁶ Catastrophic Designated Assessment Centre Assessment Guidelines October 2001, FSCO, page 4-2 para 4.5.

C. AMA GUIDES 4TH EDITION – RULES FOR EVALUATION

The Guides themselves recognize a significant role for physician discretion. Section 2.2 of Chapter 1 “Impairment Evaluation” indicates as follows:

“If in spite of an observation of a test result the medical evidence appears not to be of sufficient weight to verify that an impairment of a certain magnitude exists, the physician should modify the impairment estimate accordingly, describing the modification and explaining the reason for it in writing”.

D. ARBITRATION AND COURT DECISIONS

Below you will find a summary of Court and FSCO arbitration decisions which address whether a person has sustained a catastrophic impairment.

Snushall v. Fulsang, [2003] O.T.C. 363, [2003] O.J. No. 1493

The Plaintiff was seriously injured in a motor vehicle accident. She advanced a claim for catastrophic impairment on the basis of impairment of 55% or more of the whole person. Conflicting medical expert evidence was given and Lax J. found that she was not entitled to damages for future health care costs, as the conflicting evidence failed to establish that her injuries resulted in 55% or more impairment of the whole person. Although she suffered significant injuries, her functional abilities were still reasonably good.

Holland v. Pilot Insurance Co., [2004] O.T.C.544, [2004] O.J. No. 2737

The Plaintiff was a 15 year old boy who sustained injuries in a motor vehicle accident after he had been consuming alcohol and marijuana. Medical experts were divided as to whether Plaintiff’s GCS results at 7/15, 8/15 and 4/15 could be considered. Keenan J. found that the results could be considered and found that the status of catastrophic impairment is a creature of legislature. If restrictive meaning is to be assigned to the regulation, it should be clearly cited in the regulation itself.

Desbiens v. Mordini, [2004] O. J. No. 4735

Landmark case in which Spiegel J. articulates the ‘Desbiens approach’ summed up as: **“It is in accordance with the Guides to assign percentages to [the Applicant’s] psychological impairments and to combine them with his physical impairments in determining whether or not he meets the definition of catastrophic impairment under clause (f)”**. Further, Spiegel J. examines the history of the legislative scheme in this area and additionally does an individual assessment of each of the Plaintiff’s impairments.

Lloyd Alison Villers and Pilot Insurance Company, [2005], O.F.S.C.O. No. 46

The Applicant suffered from significant impairments before being injured in a motor vehicle accident. Arbitrator Bayefsky found that not enough had changed in the Applicant's health in order to indicate a catastrophic impairment caused by the accident.

Young and Liberty Mutual Insurance Company, [2005] O.F.S.C.O. No. 76

The Applicant was involved in a car accident in which he was trapped in his car and unable to breath. His GCS was less than 9/15 just after the accident. He suffered from seizures and medical personnel intubated him. The Insurer argued that his GCS should not be considered. Director's Delegate Evans upheld the Arbitrator's decision and found that the legislation only requires that there be a reading of 9 or less. As other factors are not considered in the legislation, they should not be considered determining catastrophic impairment. Therefore, the GCS was considered. The Applicant did meet the threshold to be determined catastrophically impaired.

George and State Farm Mutual Automobile Insurance Company, [2005] O. F.S.C.O. No. 156

The Applicant's appeal of an arbitration decision was overturned in this appeal as the Applicant's WPI did not exceed 30%. Director Delegate Evans reaffirmed the *Desbiens* approach and stated that the *Guides* do allow adding non-structural mental or behavioral impairment to the WPI. Additionally, the Multi Disciplinary Assessment Centre's (DAC's) assessment of the Applicant's level of impairment was found to be binding until an arbitrator determined that it was not.

McMichael and Belair Insurance Co., [2006] O.F.S.C.O. No.17 - 8

The Applicant was injured in a motor vehicle accident. He had a prior history of cocaine use which became cocaine addiction after the accident. Director Delegate Makepeace reaffirmed the *Desbiens* approach. She also upheld the arbitrator's decision and found that:

“whether the [cocaine use] genesis was an effect of the mild traumatic brain injury that Mr. McMichael suffered, a vain and misguided attempt to self-medicate, or some combination of these two, the addiction is a direct consequence of the injuries sustained in the car accident.”

Lee and State Farm Mutual Automobile Insurance Co., [2006], O.F.S.C.O. No. 17

The Applicant was in a motor vehicle accident and sustained injuries. Medical experts for the Insurer claimed that the Applicant had a pre-existing history of abusing pain medication and suffered from post traumatic stress and thereby tried to assert that she contributed to her impairment. Arbitrator Ashby made reference to *McMichael*, in which the arbitrator found that the Applicant's pre-existing cocaine habit was not a significant pre-existing factor and that the mild brain injury from the accident materially and

substantially contributed to his post-accident addiction. In this case Arbitrator Ashby decided that there was medical evidence to support that the accident had caused the Applicant's impairments.

Tournay and Dominion of Canada General Insurance Co.,
[2006], O. F.S.C.O. No. 137

The Applicant was injured in a motor vehicle accident during which she was trapped in her car and had to be intubated. Her GCS was less than 9/15. The Insurer claims that because she was intubated her GCS should not be considered. Arbitrator Kominar found that the legislation is not restrictive, her GCS would be considered and therefore she met the threshold for catastrophic impairment.

B.P. and Primmum Insurance Co., [2006] O.F.S.C.O. No. 202

The Applicant was severely injured in a motorcycle accident and his lower right leg was amputated. Arbitrator L. Blackman reaffirmed the *Desbiens* approach and found that the *AMA Guides* state that impairments should not be considered separately in a vacuum but rather it is the unique individual that should be assessed. Additionally, he rejected the argument that the Arbitrator has discretion to find an Applicant suffers a catastrophic impairment on the basis that the cost of future care exceeds the non-catastrophic limit under the schedule. The "whole person" approach was followed and the Applicant was deemed to be catastrophically impaired.

Cordeiro and Wawanesa Mutual Insurance Co., [2007], O.F.S.C.O. No. 64

The Applicant had a pre-existing head injury. In the subject accident, he was injured when his car rolled over him. He suffered serious orthopaedic, cognitive and emotional impairments. Arbitrator Muir found that the motor vehicle accident caused the impairments and thereby determined the Applicant to be catastrophically injured.

Ms. G. and Pilot Insurance Co., [2007] O.F.S.C.O. No. 153

The Applicant was injured in a motor vehicle accident and suffered both physical and mental impairments. Delegate Director Makepeace upheld the previous arbitration decision and found that the WPI percentages of physical and psychological impairments should be combined. Therefore the Applicant met the threshold for catastrophic impairment. Additionally, she also found that the trier of fact, and not medical experts, have the responsibility under paragraph 2 (1)(f) of the *Schedule* to capture and accurately estimate all of the impairments. Further, she noted that an impairment that is not listed in the *Guides* shall be deemed to be the impairment that is listed that is most analogous to the sustained impairment.

H. and Lombard General Insurance Co. of Canada, [2007] O.F.S.C.O. No. 193

David Payne, Thomson, Rogers for Applicant

The Applicant sustained physical and mental impairments in a motor vehicle accident. Arbitrator Renahan applies *Desbiens* approach. Arbitrator cites Spiegel J. in *Desbiens* and finds that because the *Guides* are referenced by the *Schedule*, it becomes an integral part of the incorporating instrument as if reproduced therein. The CAT DAC assigned a WPI of 1%. The arbitrator assigned a WPI of 79% based upon a rating of 52% for physical impairments and a rating of 55% for mental and behavioural disorders.

Arts (Litigation Guardian of) v. State Farm Insurance Co., (2009), 91 O. R. (3d) 394, [2008] O.J. No. 2096

The Plaintiff was involved in a motor vehicle accident that caused both physical and mental impairments. The Plaintiff argued that if his physical and psychological impairment WPI percentages were combined he would qualify as catastrophically impaired. McKinnon J. accepted this argument and found that it is permissible to assign percentage ratings in respect of a person's psycho-emotional impairments and to combine them with percentage ratings in respect of the person's physical impairments for the purpose of determining whether the person is catastrophically impaired to pursuant to section 2(1)(f).

Augello and Economical Mutual Insurance Co., [2008] O.F.S.C.O. No. 189

The Applicant was injured in a motor vehicle accident that caused both physical and mental impairments. The Applicant argued that if her physical and psychological impairment WPI percentages were combined she would qualify as catastrophically impaired. Arbitrator John Wilson found that the *Desbiens* approach of permitting the combination the WPI percentages of physical and psychological impairments more closely corresponds with the underlying principles of the accident benefits scheme and that the approach that favours the insured should prevail.

B. and RBC General Insurance Co., [2009] O.F.S.C.O. No. 5

The Applicant was injured in a motor vehicle accident and made an application for determination of catastrophic impairment. Arbitrator Murray assessed each of the areas of impairment and found that they do not equal a WPI of 55% or more. Therefore the application was refused. Additionally, Arbitrator Murray finds that the Applicant's failure to obtain testimony or reports from some of her attending physicians calls the Applicant's credibility into question. Further Arbitrator Murray found that one of the Applicant's medical experts was evasive and unresponsive and this called his credibility into question.

Pastore and Aviva Canada Inc., [2009] O.F.S.C.O. No. 24

The Applicant was injured in a motor vehicle accident and sustained both physical and mental impairments. Arbitrator Nastasi reaffirmed the *Desbiens* approach but found that:

“*Desbiens* did not specifically decide or comment on the use of one prevailing methodology in assigning percentage ratings to psychological impairments... I find that given the lack of guidance offered in the 4th edition of the *Guides* that adopting a more holistic and flexible approach will result in the most fulsome and true picture of an individual's impairments.”

She accepted that Table 3 in Chapter 4 of the *Guides* provides the most accurate assessment of the Applicant's psychological impairment.

Further she concluded:

“I find that one marked impairment is adequate to meet the definition of catastrophic impairment under clause (g) [mental/behavioural disorder].”

**Knechtel and Royal & Sunalliance Insurance Co., of Canada,
[2009] O.F.S.C.O. No. 70**

The Applicant sustained injuries in a motor vehicle accident. Medical expert for the Applicant claimed she suffers from psychological impairments. Arbitrator Sampliner concluded after considering surveillance evidence of the Applicant conducting normal daily activities that the nature and degree of psychological impairments that would lead to a determination of CAT status must be more substantial than the Applicant's.

**Liu v. 1226071 Ontario Inc. (c.o.b. Canadian Zhorong Trading Ltd.),
2009 O.N.C.A. 571, [2009] O.J. No. 3014**

Appeal by the Plaintiff from a trial decision that he had not sustained a catastrophic impairment as a result of a motor vehicle accident and as such was not entitled to the jury award of damages of \$865,000.00 for health care expenses. He lost consciousness; the initial GCS administered by the paramedics was less than nine (9). MacFarland J. found that the fact that there might have been other higher GCS scores also within a reasonable time after the accident was irrelevant. It was a legal definition to be met by a claimant and not a medical test. As such the Plaintiff was deemed catastrophically impaired and was entitled to the jury award of health care damages.

E. CHAPTER 3 OF THE AMA GUIDES – MUSCULOSKELETAL SYSTEM – CATASTROPHIC IMPAIRMENT ASSESSMENT AND THE ROLE OF THE TREATING OR ASSESSING HEALTH CARE PROFESSIONAL

Chapter 3 of the Guides includes sections which address the upper extremities, the lower extremities, the spine and the pelvis. These sections describe and recommend methods and techniques of determining impairments due to amputation, a restriction of motion, sensory motor deficits, peripheral nerve disorders and peripheral vascular disease.⁷

The upper extremity, lower extremity, the spine and the pelvis are each to be considered as a unit of the whole person. The upper extremity is four parts – hand, wrist, elbow and shoulder, the lower extremity is six sections – the foot, hind foot, ankle, leg, knee and hip, the spine is twenty-four vertebrae.

As the Guides note “examinations for determining musculoskeletal system impairments are based on traditional approaches for recording the medical history and performing a physical examination.”

As Chapter 3 notes: “Evaluating the range of motion of an extremity or of the spine is a valid method of estimating an impairment.”

A Clinician’s assessment of musculoskeletal system impairments will likely include an evaluation of motion impairments and range of motion measurements. Historical range of motion measurements obtained through clinical records of treating physiotherapists and occupational therapists are of significant assistance to assessors evaluating impairment in this section.

Equally, notes with respect to vascular disorder, bone and joint deformities including crepitation in joint motion and joint swelling observations provide important information for the purposes of evaluating the degree of impairment of musculoskeletal system. Musculotendinous impairments, tightness, grip and tension strength measurements help evaluate upper extremity impairments.

Notations of limb length discrepancy, gait derangement, muscle atrophy, joint crookedness or stiffness of joints also assists in evaluating the impairment.

In assessing persons who have suffered musculoskeletal impairments including amputations, the “whole person” approach leads to a multi system assessment of impairment. Ratings would be completed inside chapter 3 (Musculoskeletal System impairments) Chapter 13 impairments (The Skin) and Chapter 14 (Mental and Behavioural Disorders) and Chapter 4, (The Nervous System).

As the Guides note, the evaluation of an amputee’s impairments should be undertaken without the use of a prosthesis. Exacerbations caused by weather, stressful situations,

⁷ Chapter 3 of the musculoskeletal system AMA Guides, fourth edition

humidity and sweating should also be taken into consideration. In the case of amputation, redness, rashes, blisters, skin peeling, affect a broad range of activities of daily living from the type of clothing to be worn to the ability to walk with prosthesis.

F. CHAPTER 4 OF THE AMA GUIDES – THE NERVOUS SYSTEM – CATASTROPHIC IMPAIRMENT ASSESSMENT AND THE ROLE OF THE TREATING OR ASSESSING HEALTH CARE PROFESSIONAL

Chapter 4 is an extremely important chapter in evaluating whole person impairment, especially in light of the *Desbiens* decision. The *Desbiens* decision used Chapter 14 to evaluate the mental and behavioural impairments a person has. By virtue of the fact that Chapter 14 does not assign mental or behavioural impairments a percentage of whole person impairment, in accordance with the *Desbiens* methodology, assessors rely upon tables contained within Chapter 4, to assign the appropriate percentage.

Chapter 4 is also an important chapter in relation to aphasia and communication disturbances, sensory disturbances and motor disturbances. Health Care Professionals such as psychologists, speech language pathologists and social workers will be able to provide helpful comment in relation to impairments related to aphasia and dysphasia.

Table 1 from Chapter 4 provides a description of the impairment and the correlating percentage impairment of the whole person, is included below (Chapter 4, page 141).

TABLE 1. IMPAIRMENTS RELATED TO APHASIA OR DYSPHASIA.

Description	% Impairment of the whole person
Minimal disturbance of comprehension and production of language symbols of daily living	0 – 9
Moderate impairment in comprehension and production of language symbols of daily living	10 – 24
Inability to comprehend language symbols; production of unintelligible or inappropriate language for daily activities	25 – 39
Complete inability to communicate or comprehend language symbols	40 – 60

In relation to the *Desbiens* methodology, Chapter 4.1 (c) Emotional or Behavioural Disturbances, provides two extremely important tables to help evaluate whole person impairment. Chapter 4 itself encourages use of Table 3 in that Chapter to assign percentage whole person impairment ratings to Mental and Behavioural Impairments.

As page 4/142 of the Guides state:

“These types of disturbances illustrate the interrelationships between the fields of neurology and psychiatry. The disturbances may be the result of neurological impairments but may have psychiatric features as well which may range from irritability, outbursts of rage or panic and from aggression to withdrawal. These illnesses may include depression, manic states, emotional fluctuations, socially unacceptable behaviour and involuntary laughing or crying and other kinds of central nervous system responses. **The criteria for evaluating these disturbances (Table 3, below) relate to the criteria for mental and behavioural impairment (Chapter 14, page 291).**”

Table 3 is repeated below.

TABLE 3. EMOTIONAL OR BEHAVIORAL IMPAIRMENTS.

Impairment Description	% Impairment of the whole person
Mild limitation of daily social and interpersonal functioning	0 – 14
Moderate limitation of some but not all social and interpersonal daily living functions	15 - 29
Severe limitation impeding useful action in almost all social and interpersonal daily functions	30 - 49
Severe limitation of all daily functions requiring total dependence on another person	50 – 70

Review of Table 2, Mental Status Impairments, below suggests the interrelationship between assessment of attendant care, activities of daily living and Whole Person Impairment. A person who suffers “impairment that requires direct daily care under continued supervision and confinement in home or at a facility” suffers a Whole Percent Impairment of thirty to forty-nine percent (30 – 49%). Table 2 is repeated below.

TABLE 2. MENTAL STATUS IMPAIRMENTS.

Impairment Description	% Impairment of the whole person
Impairment exists, but ability remains to perform satisfactorily most activities of daily living	1 – 14
Impairment requires direction and supervision of daily living activities	15 – 29
Impairment requires directed care under continued supervision and confinement in home or other facility	30 – 49
Individual is unable without supervision to care for self and be safe in any situation	50 – 70

Chapter 4 is also the chapter which deals with impairment criteria for sleep and arousal disorders. The observations of clinicians treating and assessing the candidate for catastrophic impairment may helpfully include within their observations and narrative their comments on the degree to which fatigue interferes with the person’s day-to-day activities. That information should assist catastrophic assessors in assigning appropriate percentages. Table 6 – Impairment Criteria for Sleep and Arousal Disorders is repeated below.

As the Guides note:

“The categories of impairment that may arise from sleep disorders (Table 6 below) relate to (1) the Nervous System, with reduced daytime attention, concentration and other cognitive abilities; (2) Mental and Behavioural factors including depression, irritability, interpersonal difficulties and social problems;...”.

TABLE 6. IMPAIRMENT CRITERIA FOR SLEEP AND AROUSAL DISORDERS

Impairment Description	% Impairment of the whole person
Reduced daytime alertness with sleep pattern such that patient can carry out most daily activities	1 – 9
Reduced daytime alertness requiring some supervision in carrying out daytime activities	10 – 19

Reduced daytime alertness that significantly limits daily activities and requires supervision by caretakers	20 – 39
Severe reduction of daytime alertness that cause the patient to be unable to care for self in any situation or manner	40 – 60

A review of the tables in Chapter 4:

- Table 1 - Impairments Relating To Aphasia
- Table 2 - Mental Status Impairments
- Table 3 - Emotional Behavioural Impairments and
- Table 6 - Impairment Criteria for Sleep and Arousal Disorders

reveals that observations by clinicians assessing all elements of physical, motor, emotional, psychological, behavioural function and activities of daily living, can provide helpful information to assist in the determination of Whole Person Impairment under Chapter 4.

Assessments by psychologists, social workers, neuropsychologists, physiotherapists, and occupational therapists may address the need for supervision, a person's ability to comprehend and communicate, the degree of limitation in daily functions and the presence of fatigue. These assessments provide extremely helpful information for the purposes of evaluating catastrophic impairment and assigning Whole Person Impairment under Chapter 4.

Obviously neurological functions associated with paraplegia or quadriplegia can also be evaluated under Chapter 4 of the AMA Guides.

Impairments resulting from spinal cord injuries include those related to station and gait, use of upper extremities, respiration, urinary bladder function, and sexual function.

It is important to note that those who have sustained diagnoses of incomplete paraplegia or incomplete quadriplegia do satisfy the criteria for catastrophic impairment under Section (1.2) (a) of the Definition of Catastrophic Impairment in the SABS. Whether the descriptor is "complete" or "incomplete", catastrophic assessors have accepted the conclusion that by virtue of the fact that there are no qualifying adjectives which modify the term "paraplegia" or "quadriplegia" within the definition of catastrophic impairment, a claimant is catastrophically impaired whether or not his or her paraplegia or quadriplegia is complete or incomplete.

Once all of the impairments have been evaluated and assigned percentage ratings, the combined values chart is used to add the percentage values of whole person impairments to arrive at a total WPI for the individual.

G. CHAPTER 13 OF THE AMA GUIDES – THE SKIN – CATASTROPHIC IMPAIRMENT ASSESSMENT AND THE ROLE OF THE TREATING OR ASSESSING HEALTH CARE PROFESSIONAL

As the chapter indicates, the functions of the skin include providing a protective covering, participating in sensory perception, temperature regulation, fluid regulation, electrolyte balance, immunobiologic defences and resistance to trauma, and regenerating the epidermis and its appendages.

Permanent impairment of the skin is defined as any anatomic or functional abnormality or loss that persists after medical treatment and rehabilitation. In evaluating skin impairment, health care professionals can assist catastrophic impairment assessors by helping in characterization of disfigurement, ie. altered or abnormal appearance, scar, impairment of function and/or amputation. When clinicians comment on the effect that skin related impairments have upon ADL's this information can assist in determining whole person impairment.

In accordance with the Guides, there is impairment of the whole person from 0% – 10% when signs and symptoms of a skin disorder are present or are only intermittently present and there is no limitation or limitation in the performance of activities of daily living, and no treatment or intermittent treatment is required.

A person suffers a Class 2 skin impairment of the Whole Person from 10% to 24% in relation to a skin impairment when a person has signs and symptoms of a skin disorder that are present or intermittent and there is a limitation in performance of *some* of the activities of daily living and intermittent to constant treatment may be required.

A person suffers Class 3 skin impairment of Whole Person from 25% - 55% when the person has signs and symptoms of the skin disorder that are present or intermittently present, and there is limitation in the performance of *many* of the activities of daily living and intermittent to constant treatment may be required.

A person suffers a Class 4 skin impairment of the Whole Person from 55% - 85% when the person has signs and symptoms of a skin disorder that are constantly present and there is limitation in the performance of *many* of the activities of daily living which *may include intermittent confinement at home or other domicile*, and intermittent to constant treatment may be required.

A person suffers a Class 5 skin impairment of the Whole Person from 85% - 95% when the person has signs and symptoms of a skin disorder that are constantly present and there is limitation in the performance of *most* of the activities of daily living which *may include intermittent confinement at home or other domicile*, and intermittent to constant treatment may be required.

**H. CHAPTER 14 OF THE AMA GUIDES -
MENTAL AND BEHAVIOURAL DISORDERS -
CATASTROPHIC IMPAIRMENT ASSESSMENT AND THE ROLE OF THE
TREATING OR ASSESSING HEALTH CARE PROFESSIONAL**

Mental impairment must be evaluated in accordance with each of the four categories provided in the Mental and Behavioural Disorder table on page 301, Chapter 14 of the Guides, which are:

1. Activities of daily living;
2. Social functioning;
3. Concentration, persistence and pace;
4. Adaptation to work or work-like settings.

In order to qualify as having sustained a “marked impairment”, the applicant must establish that:

“impairment levels significantly impede useful functioning“.

A rating of “marked impairment” in one of the four categories is sufficient to be deemed Catastrophically Impaired.⁸

Occupational therapists, physiotherapists, psychologists, social workers and other health care professionals often evaluate one or more activities of daily living in the course of their assessments.

In the context of an occupational therapist’s assessment of function for a person suffering any impairment, consideration of all of the listed activities of daily living - and even those not listed - is critical to determine the extent of a person’s impairment.

Various chapters incorporate by reference the need to evaluate all ADL’s to determine impairment. Use of the ADL Table is central in evaluating Mental and Behavioural Impairments under Chapter 14 of the Guides. The Activities of Daily Living Table from page 317 of the Guides is reproduced below.

⁸ *Pastore and Aviva* [2009] O.F.S.C.O. No. 24

Table - ACTIVITIES OF DAILY LIVING, WITH EXAMPLES

Activity	Example
Self-care, personal hygiene	Bathing, grooming, dressing, eating, eliminating
Communication	Hearing, speaking, reading, writing, using keyboard
Physical Activity	<i>Intrinsic:</i> Standing, sitting, reclining, walking, stooping, squatting, kneeling, reaching, bending, twisting, leaning <i>Functional:</i> Carrying, lifting, pushing, pulling, climbing, exercising
Sensory function	Hearing, seeing, tactile feeling, tasting, smelling
Hand functions	Grasping, holding, pinching, percussive movements, sensory discrimination
Travel	Riding, driving, travelling by airplane, train or car
Sexual function	Participating in desired sexual activity
Sleep	Having a restful sleep pattern
Social and recreational activities	Participating in individual or group activities, sports, hobbies

An occupational therapist who considers activities of daily living in light of each of the impairments can provide helpful information for the purposes of accurate assessment of catastrophic impairment.

Narrative reports which identify the degree to which the individual is capable, or incapable, of initiating or participating in these activities or any other activities of daily living which are part of that unique individuals daily activities, independent of supervision or direction, will be instrumental in assisting counsel, evaluators, arbitrators and judges to determine whether the person has suffered impairments which significantly impede useful functioning in their activities of daily living.

In the course of their assessment, Occupational therapists, physiotherapists, psychologists, social workers, neuropsychologists routinely consider activities of daily living, social functioning, concentration, persistence and pace in adaptation to work-like settings.

To the extent that records and reports from these treating professionals reveal impairments in these areas, it is important for those evaluations to include an indication as to *whether the impairment levels significantly impede useful functioning together with any examples which illustrate such a conclusion*. Should that be the case, whether it be in one or more of the spheres of activity of daily living, social functioning, concentration, persistence and pace or adaptation to work-like settings, the clinician's evaluation will assist in determining that the person has suffered a *marked impairment in one or more of the four spheres*.

Should the evaluation of the four spheres result in the assessor's conclusion that the person has suffered less than a marked impairment, such an evaluation will still enable catastrophic assessors, arbitrators and judges to assign percentage Whole Person Impairment using Chapter 4, The Nervous System's Table 3 – Emotional or Behavioural Impairments. The percent will be 0% - 14% if there is a mild limitation of daily, social and interpersonal functioning. 15% to 29% if there is a moderate limitation of some but not all social and interpersonal daily functions and 30% to 49% if there is a severe limitation impeding useful action in almost all social and interpersonal daily functions.

Equally, evaluation of the attendant care requirements of a client will assist catastrophic assessors, arbitrators and judges to use Table 2 – Mental Status Impairments from Chapter 4 of the Guides, to evaluate whether the person requires direction and supervision of daily living activities, directed care or continued supervision in the home, or suffers an inability to be safe in any situation without supervision. When those determinations are made pursuant to Table 2 - Mental Status Impairments, the catastrophic assessor, judge or arbitrator may then assign the percentage of Whole Person Impairments between 1% and 70% under each of the four categories listed in Table 2.

(1.) Social Functioning

As the Guides state, Social functioning refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. It includes the ability to get along with others, family, friends, neighbours, grocery clerks, landlords and bus drivers.

Social functioning may be demonstrated by a history -- ordinarily obtained through review of clinician's reports -- of altercations, social isolation, avoidance of interpersonal relationships and other examples of impaired functioning. It is also important to give context to the social traits which are exhibited. For instance, a hostile and uncooperative person may be tolerated by family but that person may have marked restriction and trouble functioning because antagonism and hostility are not acceptable in the work place or in a social context.

(2.) Concentration, Persistence and Pace

According to the Guides, this refers to the ability to sustain focused attention long enough to permit timely completion of tasks, commonly found in work settings.

Activities of daily living and a person's ability to complete everyday household tasks should be considered. Where there are previous work attempts or observations in work-like settings, a person's concentration, persistence and pace may be evaluated in light of his or her success or impairment in the work setting.

As such, assessments and daily notes by those working closely with the injured person, including rehabilitation support workers, social workers, psychologists, attendant care providers, occupational therapists and physiotherapists, may assist in providing examples of the patient's incapacities, focus, fatigue or cognitive impairments. While psychological testing can also measure these impairments, the AMA Guides remind us that it is important to remember that concentration during psychological testing can be significantly different from the requirements for concentration in work-like settings.

(3.) Deterioration and Decompensation in Work or Work-Like Settings

As the Guides indicate, this refers to a person's impairment and inability to adapt to stressful circumstances. Individuals may withdraw from the situation or express exacerbation of signs and symptoms of mental disorder – decompensation. This decompensation may come in the form of having difficulties in activities of daily living, continuing social relationships and or completing tasks. It is extremely useful to determination of mental and behavioural disorders for clinicians to provide examples of decompensation and stresses that might have occurred.

As a side note, there are several arbitration decisions that note the lack of formal occupational therapy situational assessments. These assessments assist catastrophic assessors, judges and arbitrators in determining Catastrophic Impairment. Clinicians who evaluate activities of daily living or perform situational assessments should also include within their report information which they have concerning the fall-out or effect of the assessment upon the person, emotionally, physically and behaviourally, following the situational assessment.

Consider the example of a person who is able to work four hours but then must sleep for an hour and one half in his truck before returning to work for a further two hours. On return home at the end of the day, the person is unable to perform household functions or interact with his family but instead must go to sleep to recover energy sufficient to work. The person in this example exhibits decompensation that is relevant in consideration of his adaptation in a work-like setting. Such a person, for example may even require attendant care if that person cannot be aroused during the night as a result of the extreme fatigue caused by overexertion. That need for attendant care may be relevant when considering Chapter 4, Table 2 – Mental Status Impairments and Table 6 – Sleep Disorders to determine Whole Person Impairment.

Situational assessments and those impairments that become apparent with situational assessment of activities of daily living, social interactions and adaptation to work-like settings are central to the evaluation of the depth and degree of mental or behavioural disorder. The person may be suffering decompensation apparent in these assessments whether it be as a result of physical, cognitive and/or purely psychological impairments.

If a person has attempted a return to work, it is important to obtain an occupational therapy assessment of her function in the work-place through contact with co-workers and supervisors in order to determine performance in those settings. This information can be pivotal in allowing assessors to determine the extent to which the person suffers mental/behavioural impairments in the work-like setting. A physical demands analysis of the work place is also integral to this evaluation in providing a baseline to compare the extent to which a person's impairments prevent a person from fully achieving her capacity in and/or the responsibilities of her work.

If a person has pre-existing psychological symptoms, the onus is on the applicant to prove that it is more probable than not that the contribution of the accident was more than minimal and thereby made a material contribution to the development of the person's present mental and behavioural condition.

I. GLASGOW OUTCOME SCALE - CATASTROPHIC IMPAIRMENT ASSESSMENT AND THE ROLE OF THE TREATING OR ASSESSING HEALTH CARE PROFESSIONAL

Six months after the accident, brain injury survivors can be assessed using the Glasgow Outcome Scale which was developed in 1975 by Jennett, B. and Bond, M. The Scale is based on overall social compatibility or dependence of the client. It takes into account the combined effect of mental and neurological deficits without listing them as part of the definition.

There are four categories of survival:

- Vegetative State
- Severe Disability
- Moderate Disability
- Good Recovery

A person is Catastrophically Impaired if his or her score on the Glasgow Outcome Scale (GOS) is 2 (vegetative) or 3 (Severe Disability).

A person with Severe Disability is able to follow commands but is unable to live independently at the time of the evaluation. The survivor is conscious but needs the assistance of another person for some activities of daily living every day. Need for daily

attendant care of some amount is likely required. A 1981 paper by Jennett, Bond and Snoek⁹ provided a helpful definition of severe disability.

As noted within the article, Severe Disability:

“May range from continuous total dependency (for feeding and washing) to the need for assistance with only one activity – such as dressing, getting out of bed or moving about the house, or going outside to a shop. Often dependency is due to a combination of physical and mental disability. [example]...the patient cannot be left overnight because they would be unable to plan their (*sic*) meals or deal with callers or any domestic crisis which might arise.”

In Chapter 13 of the text, Management of Head Injuries, by Bryan Jennett and Graham Teasdale,¹⁰ the authors provide further elucidation of the meaning of Severe Disability. Comments within that definition include the following:

“The least affected of those in the category of severe disability are patients who are communicative and sensible, though usually with marked impairment of cognitive and memory function on testing, who are dependent for only certain activities on others – perhaps dressing, feeding, or cooking their meals [consider all ADL’s from previous tables] Such a person could not be left to fend for himself even for a weekend. **“He is not independent and must therefore be regarded as severely disabled on our classification.”**

Ready knowledge of this definition by treating and assessing health care professionals including psychologists, neuropsychologists, social workers, speech language pathologists, occupational therapists and physiotherapists and evaluation of the client in view of their ability to carry on activities of daily living, attendant care needs, and/or their complete or incomplete independence, will assist insurers, lawyers, judges and arbitrators in determining whether or not a person has suffered a Severe Disability under the Glasgow Outcome Scale.

The need which a person has for attendant care is extremely relevant to the determination of whether the person is “not independent” and as such is “severely disabled”.

⁹ Jennett, B. Snoek, J. Bond Mr, Brooks N., Disability After Severe Head Injury: Observation On The Use Of The Glasgow Outcome Scale, J Neurol, Neurosurg, Psychiat 1981;44:285-293

¹⁰ Jennett, B, Teasdale, Management of Head Injuries 1981, F.A. Davis Company, USA

J. THE MEANING OF “CAUSATION” IN DETERMINING CATASTROPHIC IMPAIRMENT

At page 316 of the 4th Edition of The American Medical Association Guides to the Evaluation of Permanent Impairment, causation is defined:

“Causation means that a physical, chemical or biologic factor contributed to the occurrence of a medical condition. To decide that a factor alleged to have caused or contributed to the occurrence or worsening of a medical condition has, in fact, done so, it is necessary to verify both of the following:

- “(a) The alleged factor ***could have caused or contributed to worsening of the impairment***, which is a medical determination.
- (b) The alleged factor did cause or contribute to worsening of the impairment, which is a non-medical determination.”

On June 12th, 1996 The Supreme Court of Canada released its decision in *Athey v. Leonati*.¹¹ The Plaintiff suffered a disc herniation while working out following an accident. The Court stated:

“it is not now necessary, nor has it ever been, for the Plaintiff to establish that the Defendant’s negligence was the sole cause of the injury.”

Further from *Athey*:

“As long a Defendant is part of the cause of an injury, the Defendant is liable, even though his act alone was not enough to create the injury.”

In 2001 Director’s Delegate Naylor spoke in detail about principals of causation and adopted *Athey* in the *Correia and TTC* Arbitration Appeal.¹² Ms. Correia suffered an injury when bus doors closed on her. After physiotherapy sessions she felt ready to return to work. Her therapist wouldn’t allow her to return to work without a functional capacity evaluation. She was injured in the functional capacity evaluation. The Arbitrator found that Ms. Correia’s original injuries had substantially resolved and were not disabling but that her treatment-related injuries disabled her from work on an ongoing basis.

On Appeal, the Director’s Delegate Naylor upheld the conclusion that the injury related to the functional capacity evaluation was directly caused as a result of the accident and that the ongoing benefits were payable in relation to the disability arising therefrom.

¹¹ *Athey v. Leonati*, [1996] 3 S.C.R. 458 S.C.C.

¹² *Correia and TTC*[2001] O.F.S.C.O. No. 106

The Ontario Court of Appeal released the decision *Monks v. Ing*¹³ on April 15th, 2008. The Plaintiff was injured in three accidents. After the third accident, she became a complete quadriplegic. The Defendant did not dispute that the plaintiff was catastrophically impaired but claimed that her impairment was caused by a combination of the first and second accidents and said she was “a crumbling skull plaintiff”. The phrase “Crumbling skull” is used at law to describe a person who suffers impairments before an accident which would continue to worsen whether or not the accident occurred.

The Ontario Court of Appeal noted:

“The trial judge did not err in finding that there is no room for the crumbling skull theory in accident benefit cases. Where, as here, a benefit claimant’s impairment is shown on the “but – for” or material contribution causation tests to have resulted from an accident...the insurer’s liability for accident benefits is engaged...”¹⁴

Finally the Court of Appeal noted:

“The case law related to accident benefit claims is clear – that the principals enumerated in the Supreme Court of Canada decision of **Athey** are equally applicable in the context of an accident benefit claim.”¹⁵

In conclusion, if the accident made a material (more than minimal) contribution to the impairment or to the worsening of the impairment, then the impairment was directly caused by the accident and should be an impairment evaluated under one or more of the categories in the definition of catastrophic impairment.

¹³ *Monks v. Ing* (2008), 90 O.R. (3d) 689 C.A.

¹⁴ *Ibid*, *Monks*, *Supra*.

¹⁵ *Ibid*, *Monks*, *Supra*

K. Fair Payment for Assessments by Health Care Professionals Which Assist in Determining Catastrophic Impairment

Section 5.2 of the Financial Services Commission of Ontario (FSCO) Report on the Five Year Review of Automobile Insurance dated March 31st, 2009 is entitled "Assessments and Examinations". FSCO has indicated a concern with respect to assessment costs. They have made a number of recommendations in this regard. One is that Section 24 assessment expenses should be subject to the same maximum monetary and time limits that apply to medical and rehabilitation benefits under Section 19 of the SABS.

FSCO further suggests under its Recommendation 12 that the fee for completing the forms should be capped at \$200.00 and the cost of all other assessments should be capped at \$2,000.00.

In Recommendation 14 FSCO indicates the availability of in-home assessments should be limited to seriously injured claimants and should only be used to evaluate their need for attendant care and home modifications.

FSCO has considered the family physician as a potential gate-keeper for assessment requests:

"Consider having assessment requests completed only after a referral is made by the health professional primarily responsible for the claimant's rehabilitation (in most cases a family physician). Assessment requests will continue to be submitted by providers following a referral."

However, on page 36 of its report, FSCO notes:

"Some stake holders suggested that FSCO develop guidelines to cover best practices for insurer examinations, standardized reports and assessor qualifications. FSCO is of the view that some stake holders would like to see FSCO regulate the provision of third party medical examinations. FSCO believes that this is neither an appropriate role for a Regulator of Financial Services nor is it an area that requires the involvement of another Regulator since all assessors are already regulated by one of the Health Regulatory Colleges."

FSCO Recommendation 16 is that the Health Care Professional Associations and the Insurance Industry should jointly develop standards for the delivery of third party medical examinations as well as qualifications for assessors. FSCO would facilitate this process.

In response to concerns about assessors who are assisting with respect to conducting catastrophic impairment assessments, FSCO indicated in Recommendation 17:

“restrict ability to conduct catastrophic impairment assessments to practitioner’s with appropriate training and experience.”

Whether accident benefit insurers adopt a practice of restricting the amount that they will pay for first party assessments for reports which comment on activities of daily living, work adaptation, functional testing, psychological and neuropsychological testing, remains to be seen. At present time however, there is no restriction on the availability to a third party of an assessment which it may chose to pay for in its agreement with the assessor.

In that regard, law firms are in a position to seek reports addressing impairment and dysfunction – cognitively, neurologically, musculoskeletally and mentally or behaviourally – and are in a position to pay the full costs of same.

© **David F. MacDonald**

Partner

Thomson, Rogers

Barristers & Solicitors

390 Bay Street, Suite 3100

Toronto, Ontario M5H 1W2

Telephone 416-868-3155

Cell 647-290-7291

Fax 416-868-3134

E-mail dmacdonald@thomsonrogers.com