FSCO A09-002443

BETWEEN:

Ms. M.G.

Applicant

and

THE ECONOMICAL MUTUAL INSURANCE COMPANY

Insurer

REASONS FOR DECISION

Before: Susan Sapin

Heard: April 11, 12, 13, 14, 18, 19, 20, 21, 26, 27, 28, and May 19, 2011

Appearances: Wendy Sokoloff and Doug Wright for Ms. M.G.
Nicholas deKoning for The Economical Mutual Insurance Company

Issues:

The Applicant, Ms. M.G., a Registered Nurse, was injured on November 2, 2005 when she was struck and thrown to the ground by a mini-schoolbus as she crossed the street on her way home from the hospital where she worked. She applied for and received statutory income replacement ("IRBs") and other accident benefits from The Economical Mutual Insurance Company Insurance Company ("Economical"), payable under the *Schedule*.[1]

Three years later, in November 2008, after numerous assessments and three unsuccessful attempts to return to work, Ms. M.G. applied to Economical for a determination that she met the

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

criteria for catastrophic impairment as a result of the accident, as that term is defined under clauses 2(1.2)(f) and (g) of the *Schedule*.

If her impairments qualify as catastrophic, Ms. M.G. is entitled to apply for significantly enhanced statutory medical, rehabilitation and attendant care benefits as well as extended housekeeping and home maintenance benefits. Although Economical does not dispute that Ms. M.G.'s impairments prevent her from ever returning to work as a Registered Nurse, it disagrees they are catastrophic.

At the heart of the dispute is whether Ms. M.G.'s impairments meet the thresholds for catastrophic impairment found in the *Schedule* at clause 2(1.2)(f) – an impairment or combination of impairments resulting in 55 per cent or more impairment of the whole person ("WPI"); or clause 2(1.2)(g) – a "marked" or "extreme" impairment due to a mental or behavioural disorder.[2]

Ms. M.G. maintains that she suffers a Class 4 marked mental or behavioural impairment under category (g). Economical says the impairment is mild and does not meet this threshold.

Regarding category (f), Ms. M.G. agrees she does not meet the 55 per cent WPI threshold on the basis of physical impairments alone. She argues that if her mental or behavioural impairments under (g) are combined with her physical impairments, however, she would qualify under (f) as well as (g).

I find Ms. M.G. meets the threshold for catastrophic impairment under both (f) and (g).

Succinctly, the issues in this hearing are:

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[2]To put Ms. M.G.'s claim in context, the other categories of catastrophic impairment are: (a) paraplegia or quadriplegia; (b) total and permanent loss of use of both arms or both legs: (c) or of one or both arms and one or both legs; (d) the total loss of vision in both eyes; or (e) serious brain impairment.

1. Did Ms. M.G. sustain a catastrophic impairment within the meaning of clause (f) or (g) of subsection 2(1.1) of the *Schedule*?

2. Is Ms. M.G. entitled to attendant care benefits beyond 104 weeks after the accident, and if so, in what amount?

3. Is Ms. M.G. entitled to housekeeping and home maintenance expenses beyond 104 weeks after the accident, under section 22 of the *Schedule?*

4. Is Ms. M.G. entitled to the cost of a cellphone as a rehabilitation expense under section 15(5)(i) of the *Schedule*?

5. Is Ms. M.G. entitled to a special award under subsection 282 of the *Insurance Act*?

6. Is Ms. M.G. entitled to interest for the overdue payment of benefits pursuant to section 46(2) of the *Schedule*?

7. Is Ms. M.G. entitled to her expenses of this arbitration proceeding?

Result:

1. Ms. M.G. sustained a catastrophic impairment under paragraphs 2(1.1)(f) and (g) of the *Schedule.*

2. Ms. M.G. is entitled to attendant care in the amount of $1,462.70 per month from May 31, 2008 and ongoing.

3. Ms. M.G. is entitled to housekeeping and home maintenance expenses of $100 per week beyond 104 weeks after the accident, and ongoing, less amounts paid.

4. Ms. M.G. is entitled to $838.22 for the cost of a cellphone for 52 weeks from November 21, 2007 and $1,523.52 as set out in the Treatment Plan dated May 6, 2009, under ss. 15(5)(i) of the *Schedule*.

5. Ms. M.G. is entitled to a special award.

6. Ms. M.G. is entitled to interest in overdue amounts in accordance with the *Schedule*.

7. Ms. M.G. is entitled to her expenses of this arbitration proceeding.

EVIDENCE AND ANALYSIS:

Background and Findings of Fact

The facts of Ms. M.G.'s pre-accident life are not disputed. At the time of the accident, she was a 55 year-old Registered Nurse on the stroke ward at Scarborough General Hospital, where she had worked for the past five years. There was nothing to contradict her evidence that her life before that point was anything but busy, happy and highly productive. She had trained and worked as a nurse in the Philippines for over ten years before coming to Canada in 1993 with her husband Loreto, and their three school-age children, Lester, Lerwin, and Muriele, who are now 32, 28 and 27, respectively. The couple took factory jobs to support their family until they could establish themselves. Ms. M.G. worked as a health care aide in a nursing home until she could qualify as a Registered Nurse (R.N.) in Ontario. Once qualified, the nursing home quickly promoted her to Director of Care.

While at Scarborough General, Ms. M.G. acted as charge nurse and as a "preceptor" in charge of training graduate nurses. She took courses in nephrology, on a part time basis, for two years to qualify for a position in the haemodialysis unit, and was waiting for a transfer to a full-time position in that unit at the time of the accident. She was confident that would eventually lead to

promotion due to her previous managerial experience. Her coworkers testified she was a competent, capable and compassionate nurse, referring to her as the "life of the floor."

According to Lerwin and Muriele, who still live at home, they were spoiled, as their mother did all the cooking, including traditional Filipino dishes; the housekeeping; and all the laundry, refusing assistance from her children because she wanted them to concentrate on their school work. She was also in charge of the family finances.

Ms. M.G. led a busy social life with her extended family, friends and co-workers and was active in her church. She took pleasure in family picnics, parties, dancing, dressing up, sewing, gardening and helping her daughter Muriele with her nursing studies.

Causation is not disputed. A complete physical exam just months before the accident revealed no health issues, apart from a thyroidectomy twenty three years previous and high blood pressure, both controlled with medication.

I find Ms. M.G.'s life changed dramatically after the accident. At first, she was highly motivated and actively engaged in therapy in the hope of a quick and complete return to work. After two failed attempts four and six months after the accident, however, and a brief and unsuccessful effort at volunteering, she lost hope, her condition deteriorated, and depression, anxiety and chronic pain took over her life. She went from functioning at a superior level to barely functioning at all, spending most of her time alone in a basement room in her own house, doing very little of anything.

The accident injuries themselves are well-documented and not seriously disputed. Although it is not clear whether or not she lost consciousness, Ms. M.G. did strike her head on the pavement when struck by the school bus, resulting in a large bruise, and it is agreed that she sustained, at the very least, either a concussion or a mild closed head injury, either of which explain her symptoms of lingering cognitive impairments in the first year or so after the accident (poor memory; inability to concentrate, focus or pay attention to tasks, or "multi-task;" word-finding

difficulties requiring the intervention of a speech language pathologist; and mood disturbance, among others); and headaches, which are constant but vary in severity.[3]

Ms. M.G.'s cognitive symptoms did not improve as expected after a head injury, however, and some have gotten worse. The experts agree that they are most likely being perpetuated by ongoing psychological factors such as depression, anxiety and elements of post-traumatic stress disorder ("PTSD"), as well as chronic pain and interrupted sleep, all very likely due in large part to the devastating realization, for her, that she would never be unable to return to her nursing vocation. Several experts[4] have commented on the mutually reinforcing effects of her symptoms Dr. Levitt perhaps put it best when he characterized the coming together of Ms. M.G's various syndromes as a "perfect storm."

As opined by Dr. Michel Rathbone, who examined Ms. M.G. on November 14, 2006, "both concussion and post-traumatic stress disorder cause similar organic changes within the brain and indeed they may be synergistic."[5]

At the hearing, Ms. M.G. described feelings of frustration, impatience, irritability, lack of motivation, bitterness and anger. She is lost without her work and feels badly about her withdrawal from interactions with her family members and her anger outbursts towards them. The testimony of Muriele, Lerwin and Loreto about these marked changes in her personality and behaviour was consistent, compelling and supported by expert evidence.[6] Ms. M.G. displayed many of these behaviours during her one and a half days of testimony. As well, she was tearful, had difficulty with word-finding, was less able to focus and concentrate as time went on, and did not always answer questions that were specifically asked, or responded with an unrelated answer.

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[3]Ms. M.G. suffered other physical injuries in the accident which will be discussed under (f), below.

[4]Dr. Fiss, neuropsychologist, Exhibit V2 tab 63; Dr. M. P. Rathbone, neurologist, tab 42; Dr. Van Reekum, neuropsychiatrist, tab 70 ; Dr. D. Kurzman, neuropsychologist, tab 56, among others.

[5]Tab 42, paragraph 6

[6]In a report dated February 12, 2007, Dr. Kurzman recommended psychological treatment to deal with emotional and cognitive difficulties, stressing that "issues relating to anger control" were of "extreme" importance.

Ms. M.G. also suffered physical injuries in the accident which I accept cause her chronic pain and limit her mobility, and which will be discussed further under category (f), below. Notably, and contrary to Economical's assertions, I find she has complained consistently since the accident of headaches, dizziness, loss of balance, loss of peripheral vision, lost sense of smell, disturbed sleep, chronic pain and incontinence.[7]

Ms. M.G. maintains her impairments so severely limit her function that they meet the catastrophic threshold under the *Schedule*. She feels Economical's assessors did not appreciate their impact on her day-to-day functioning and so failed to rate her impairments appropriately under the *American Medical Association's Guides to the Evaluation of Permanent Impairment,* 4th edition, 1993. For its part, Economical acknowledges the impairments exist, but maintains there is insufficient objective evidence to support a rating of catastrophic, either as a combination of physical and mental impairments under (f), or on the basis of a mental or behavioural disorder under (g).

Catastrophic Impairment under Category (g)

Under clause 2(1.2)(g) of the *Schedule*, a catastrophic impairment is an impairment that, in accordance with the *AMA Guides,* results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to a mental or behavioural disorder.

The *Schedule* defines "impairment" as a loss or abnormality of a psychological, physiological or anatomical structure or function.[8]

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[7]Economical disputes this, claiming this symptom is unrelated to the accident and Ms. M.G. did not complain of it until much later. However, I find she related this symptom to Economical's occupational therapist in the course of an in-home assessment that took place on November 28, 2005, med rehab brief v1 tab 13, as well as to Dr. Michel Rathbone in September 2006 tab 42, and has complained consistently of this distressing symptom ever since.

[8]Subsection 2(1)

The *Schedule* mandates that medical and legal professionals rate impairment under category (g) using the criteria and methods set out in Chapter 14 of the *AMA Guides,* entitled *Mental and Behavioural Disorders.* Under this edition of the *Guides,* mental or behavioural disorders are diagnosed using the *DSM III-R.*[9]

After diagnosis, assessors must rate any resulting impairment according to how it impacts four broad and overlapping areas of function. The four areas of function are:

1. Activities of daily living ("ADLs");

2. Social functioning;

3. Concentration, persistence and pace;

4. Adaptation – "deterioration or decompensation in work or worklike settings."

There are five levels of severity described in Chapter 14, ranging from no impairment (Class 1) to extreme impairment (Class 5).

The Court of Appeal has recently confirmed[10] the interpretation of judges and arbitrators that a finding of marked impairment in *one* of the four areas of function described in the *Guides* is sufficient for a rating of catastrophic under (g). I find the evidence as a whole in Ms. M.G.'s case supports the opinion of her experts that she suffers a marked Class 4 impairment in three of the four spheres of daily functioning: ADL's, Social Functioning, and Adaptability.

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[9]Diagnosis in Ms. M.G.'s case was made using the newer version of this manual, the DSM-IV-TR. However, I do not find that anything turns on this.

[10]*Aviva Canada Inc. vs. Pastore*, [2012] O.J. No. 4508. The court has recently been requested to reconsider.

Overview of Assessments

Dr. Gloria Meneses, Ms. M.G.'s family doctor, applied to Economical for a determination of catastrophic assessment in June 2008, and in August 2008 Dr. R. van Reekum conducted a neuropsychiatric assessment on Ms. M.G.'s behalf, including an interview and comprehensive review of medical records. He concluded it was probable she was catastrophically impaired under (g), based on a number of reported and documented symptoms. These included particularly insomnia and non-refreshing sleep; chronic depression not treated with medication; personality changes in the form of mood swings, irritability, anger difficulties, reduced interest, motivation and participation; and multiple cognitive impairments confirmed on two sets of neuropsychological testing. This was almost three years after the accident.

At Economical's request, Ms. M.G. then underwent a multidisciplinary catastrophic impairment assessment at Custom Rehab & Assessments Canada Ltd. ("Custom Rehab") between January and April, 2009 that included a physiatrist, a psychiatrist, a neurologist and an occupational therapist.

Dr. William H. Gnam conducted the psychiatric component of this Insurer's Examination (IE) in January 2009. Based on his interview with Ms. M.G., a file review, and input about her functioning from Sherry Krushed, an occupational therapist who conducted an in-home visit, Dr. Gnam rated Ms. M.G.'s impairments as moderate in the spheres of ADLs, Concentration, and Adaptation; and mild to moderate in Social Functioning. Dr. Gnam testified at the hearing.

In July 2009, Drs. H. and L. Becker and Dr. R. Rosenblatt, psychiatrist of Omega Medical Associates ("Omega"), assessed Ms. M.G. and prepared a rebuttal report on her behalf dated August 19, with a later addendum November 17, 2009.[11] Dr. Rosenblatt arrived at the same impairment ratings as Dr. Gnam: Class 3 (Moderate) impairment in ADL's, Concentration, and Adaptation and Class 2 (Mild) impairment in Social Functioning, based on similar diagnoses and findings.

[11] The addendum addressed only category (f), discussed below.

A year later in August and September 2010, Dr. S. Garner, physiatrist, and Drs. Brian Levitt and Ronald Kaplan, psychologists, evaluated Ms. M.G. Their conclusions differed substantially from those of Drs. Rosenblatt and Gnam, and they rated Ms. M.G.'s impairments as Class 3 (Marked) in ADL's, Social Functioning and Adaptation, and Class 2 (Moderate) in Concentration, thus meeting the criteria for catastrophic impairment. Dr. Levitt testified at the hearing.

Finally, in February 2011, Dr. Gnam prepared a response to Drs. Levitt and Kaplan outlining his concerns about their methods and interpretation of the data available to them. Dr. Gnam maintained his original moderate/mild impairment ratings were correct.

In addition, I heard evidence from Dr. Meneses; Dr. Laura Cruz, Ms. M.G.'s treating psychiatrist; Billy Mangos, her treating psychologist; Lisa Duffis, treating OT, Dr. D. Kurzman, a clinical psychologist with an interest in neuropsychology, Dr. Levitt, Dr. Van Reekum; and, for the Insurer, Sherry Krushed, OT, and Dr. Dost and Dr. Mathoo. As noted, Ms. M.G.'s husband, son, daughter and mother testified, as well as two of her co-workers.

For the most part, the experts for both sides agree on the diagnoses underlying Ms. M.G.'s mental impairments, which include Major Depression; Anxiety, features of Post Traumatic Stress Disorder (PTSD); and the persisting sequelae of a mild traumatic brain injury.[12] They agree that although chronic pain is a significant focus, the evidence does not support a separate DSM diagnosis of Pain Disorder, and I accept this finding. They also agree Ms. M.G. has undergone negative behavioural and personality changes as a result of her impairments, and her symptoms, taken together, have a "synergistic effect" on her level of function. I find the following excerpt from the report of Kaplan (except for the characterization of her symptoms as severe) accurately captures what everyone acknowledges to be true:

[12] They also agree that the *Guides* make no distinction between mental impairments that arise from traumatic brain injury versus those that are attributable to a psychiatric disorder, as the mental impairments are rated based on evidence of functional impairment, regardless of the cause.

> [Ms. M.G.'s] emotional symptoms appear to be best described as an interaction of posttraumatic distress and depression, complicated by brain injury and chronic pain. As such, distinct diagnostic categories, which are used in the DSM and ICD systems, suggest a compartmentalization of her symptoms that is not reflected in the reality of what is a very complex and mutually reinforcing set of symptoms that remain severe and entrenched."

What the experts do not agree on is the severity of Ms. M.G.'s impairments, and the degree to which her daily functioning is impaired in the four life spheres described above. She claims a complete lack of motivation due to severe depression, cognitive and physical limitations and pain. Although Economical concedes Ms. M.G.'s condition was not static over time, it does not accept that her lack of motivation or deterioration could be as severe as she claims, given the ample evidence that she was very motivated to return to work and engaged in her rehabilitation after the accident. I find this position untenable given the ample evidence of motivational difficulty and Dr. Gnam's admission on cross-examination that if that were the case, he would find a marked level of impairment.[13]

I find there are a number of explanations for the parties' disagreements. I find the evidence supports the fact that Ms. M.G.'s symptoms of depression went untreated pharmacologically for some time after the accident,[14] and that later efforts to treat with medication were not successful, and her psychological condition deteriorated. I find Dr. Gnam did not take into account the devastating effect on her motivation after she realized she would never be able to return to the nursing profession, or the effect over time of the discouraging and unrelieved persistence of her many symptoms despite ongoing efforts at rehabilitation.

Rating Mental and Behavioural Impairments

Under the *Guides*, impairment levels are rated according to how they compare to "useful functioning." In any of the four functional categories, for example, as indicated in the chart from pg. 301 of the *Guides* and entitled *Table: Classification of Impairments Due to Mental and*

[13] Transcript pp 222 – 223

[14] As noted by Dr. van Reekum, (Tab 20) , Dr.Rathbone at tab 42 and Drs. Kurzman and Lubinsky (Tab 102)

Behavioral Disorders, a Class 3, or moderate impairment rating applies where "impairment levels are compatible with *some*, but not all, useful functioning." (See Appendix "A" of this decision) A Class 4, or marked impairment, refers to impairment levels that "*significantly impede* useful functioning." A severe or Class 5 rating would *preclude* useful functioning:[15]

The term "useful functioning" is not defined anywhere in the *Guides,* as such. Instead, it is left to assessors to exercise their clinical judgment and interpret their findings with reference to the qualitative descriptions of each functional area, and examples of impaired functioning, that the *Guides* do provide. The exercise is rendered even more difficult, and allows for variation in ratings, because of the considerable overlap in the four functional categories.

I agree with the ratings of Kaplan and Kaplan in each functional area and have set out my reasons for each below.[16]

Overall, I preferred the evidence of Drs. Levitt and Kaplan over that of Dr. Gnam, despite the latter's criticism of their methodology and findings, for two main reasons. The first was that I found their evidence was more consistent with the first-hand accounts of family members and treating practitioners who have interacted with Ms. M.G. regularly over time. The second was that I found Drs. Levitt's and Kaplan's analyses of the criteria for each level of impairment in the *Guides*, and the application of the criteria to the facts, to be more thorough and accurate than that of Dr. Gnam, and to be more in keeping with the intent of the *Guides,* particularly with regard to the interpretation of "useful" function.

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[15] A copy of the chart from page 301 of the *Guides* is included as Appendix "A" to this decision.

[16] For ease of reference I have included each assessor's impairment rating and the description from the *Guides* at the beginning of each section.

Activities of Daily Living

Under this functional category, the *Guides* provide the following description:[17]

> *Activities of daily living* include such activities as self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, and social and recreational activities . . . the quality of these activities is judged by their independence, appropriateness, effectiveness, and sustainability. It is necessary to define the extent to which the individual is capable of initiating and participating in these activities independent of supervision or direction. . .

Dr. Gnam opined that, "All information considered, mental impairment in this domain appear [sic] to preclude some but not all useful functioning, consistent with Moderate (Class 3) impairment." [18] The "information considered" consisted of previous medical reports, his interview with Ms. M.G., in which she "reported diminished capacity to engage in leisure activities due to impaired motivation and anxiety, and an inability to manage financial matters;" and two neurocognitive screening tests.

Dr. Gnam stated that "All mental impairment ratings incorporate the functional data and opinions summarized in the Occupational Therapy in-Home Assessment Report of Ms. B. Sherry Krushed, OT. . ." Dr. Gnam adopted Ms. Krushed's opinion that Ms. M.G. had "functional independence in most self-care and household productivity tasks, with some restrictions in self-care tasks due to pain and physical impairments."[19]

I disagree with this assessment for a number of reasons. I find Dr. Gnam based his conclusion on limited and inaccurate information. Limited, because neither he nor Ms. Krushed interviewed any family members for insight into what she could, or would, actually do on her own on a daily

[17] I have excerpted a brief description from the Guides at the beginning of each functional category, for ease of reference.

[18] Tab 76 pg. 9

[19] Ibid., Pgs. 8-9

basis, without cueing, unlike Dr. Levitt, who interviewed Ms. M.G.'s mother for collateral information. I also find it inaccurate because I find Ms. Krushed's report failed to consider the effect of pain, diminished capacity and lack of motivation on the effectiveness and sustainability of Ms. M.G.'s ADLs.

Ms. Krushed concluded Ms. M.G. was "functionally independent" on the basis of her observations of Ms. M.G.'s ranges of motion and the fact that Ms. M.G. was able to "prepare a simple meal" – i.e. put rice in an automatic rice cooker and chop vegetables, a task Ms. M.G. had to stop to carry on a conversation with Ms. Krushed, and which she was in the end too tired to actually finish. Although she documented all of Ms. M.G.'s difficulties and complaints, including the fact that she required assistance and/or supervision with most household tasks, Ms. Krushed provided no opinion on how her impairments would affect how much she could actually initiate or accomplish independently, a key component of rating "useful" function. She also was not very thorough in finding out about Ms. M.G.'s recreational activities. For example, Ms. M.G. had long given up sewing due to dizziness.[20]

In relying on Ms. Krushed's inaccurate report, I find Dr. Gnam's opinion was based on misleading information.

Secondly, Dr. Gnam failed to consider, compare and differentiate the criteria for moderate, marked and severe impairment before arriving at his conclusion. His statement, that mental impairment that appears to "preclude *some* but not *all* useful functioning" [emphasis added] is consistent with Moderate impairment, is not accurate. If one looks at the three descriptions of Class 3, 4, and 5 (Moderate, Marked and Extreme Impairment), they clearly describe a continuum. In between 3 ("impairment levels are compatible with *some*, but not all, useful functioning,") and 5 ("impairment levels *preclude* useful functioning"), there is category 4: "impairment levels *significantly* impede useful functioning." I find there is no evidence that the changes to Ms. M.G.'s ADL's have been anything less than significant.

[20] As related to Dr. Kurzman during his assessment on November 30 and December 7, 2006.

Her sex life non-existent, her family had moved Ms. M.G. to a room in the basement. As she and her family testified, Ms. M.G. had completely lost interest in and did not engage in any of her pre-accident social and recreational activities, was unable to concentrate sufficiently on cooking, housekeeping and entertaining.

As reported by her family, unless cued or prompted to do something, she would simply sit in her room alone all day. As pointed out by Dr. Levitt, "My understanding is that most of her daily activity when she is actually doing things was under the watchful eye of a family member, a child, her husband, her mom. When they left her alone she would do next to nothing."

For any of the activities canvassed, there was no evidence she did, or could, initiate, participate or persist indedpendently without discontinuing due to pain, headache, fatigue, dizziness, irritability and frustration with her cognitive and physical limitations. These complaints have been consistent since the accident. and lack of interest and motivation.

Social functioning

> *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, such as family members, friends, neighbors, grocery clerks, landlords, or bus drivers. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation . . .

Dr. Gnam considered Ms. M.G.'s function in this area to be mildly to moderately impaired, on the basis that ". . . [she] continues to have meaningful relationships, was observed (during the OT and Psychiatry assessments) to have adaptive and appropriate social interactions with others, but nonetheless has reduced social motivation related to sleep and mood impairment, as well as self-reported embarrassment due to her persistent disabilities."

I find this assessment underrates Ms. M.G.'s situation and does not begin to encompass the complete shut-down in her social and family life and intimate relationships since her failed

attempts to return to work. Her role in her family has completely changed. Instead of being the caretaker in charge to whom everyone at work and at home turned to for support, advice and direction, not to mention that she ran her household single-handed, Ms. M.G. is now dependent on her husband and children, needs them but resents them for it, is argumentative, angry and impatient with them, and no longer desires or is able to tolerate their companionship. She has moved out of the bedroom she shared with her husband and sleeps alone in the basement. In fact the evidence is that she now pretty much *lives* there. She has no interest in, derives no pleasure from, and actively avoids social interactions unless they are forced upon her by her family and, increasingly rarely, her friends. I do not find that any of her family and social relationships can any longer be described as "meaningful," either to her or to her family.

I agree with Dr. Levitt, that demonstrating appropriate social interactions in limited structured settings such as during an assessment, is not the same thing as initiating or participating meaningfully in a wide range of interpersonal and social activities.

I find Dr. Gnam's basis for a Moderate rating - that Ms. M.G. has appropriate social interactions in limited structured settings, best fits the descriptor for a Marked rating, as, to my mind, on the evidence as a whole, including her family, it is more accurate to say Ms. M.G.'s impairment levels significantly impede useful function, rather than being "incompatible with some, but not all, useful functioning."

Concentration, Persistence and Pace

> *Concentration, persistence, and pace* . . . refer to the ability to sustain focused attention long enough to permit the timely completion of tasks commonly found in work settings. In activities of daily living, concentration may be reflected in terms of ability to complete everyday household tasks. . .

Drs. Levitt and Kaplan found Ms. M.G. to be "at least moderate" in this domain, whereas Drs. Gnam and Becker classed her impairments as mild. Again, I prefer the evidence of Drs. Levitt and Kaplan. Even Ms. Krushed acknowledged Ms. M.G.'s inability to multi-task in

her presence, and to be able to do only one thing at a time, and slowly at that. She also noted Ms. M.G.'s need to talk herself through simple activities, her forgetfulness, her reliance on a PDA to organize herself, and how sustained effort brought on headaches and fatigue. These observations were consistent with the whole of the evidence that was put before me, from the date of the accident until the hearing, about how little Ms. M.G. actually accomplished in any given day.

Adaptability

> *Deterioration or decompensation in work or worklike settings* refers to repeated failure to adapt to stressful circumstances. In the face of such circumstances the individual may withdraw from the situation or experience exacerbation of signs and symptoms of a mental disorder; that is, decompensate and have difficulty maintaining activities of daily living, continuing social relationships, and completing tasks. Stresses common to the work environment include attendance, making decisions, scheduling, completing tasks, and interacting with supervisors and peers .

Even Dr. Gnam agreed that Ms. M.G.'s mental status " almost certainly would deteriorate if subjected to repeated exposures to work-like stresses and environments," and that his opinion was "consistent with [her] history of repeated attempts to return to work that ultimately could not be sustained."

Despite this, Dr. Gnam concluded; "However, functional testing indicates that [Ms. M.G.] is not completely unable to engage and maintain some restricted work-like stresses and activities, implying that impairment in this domain should be rated as Moderate (Class 3).[21]

I do not believe Dr. Gnam's opinion to be either correct or reasonable for two reasons. The first is that Ms. M.G. testified, and I find, that even simple volunteer efforts such as calling out bingo numbers or helping visiting family members at the hospital were overwhelming for her, and she quickly became fatigued, confused, irritable and unable to cope. I find the facts indicate Ms. M.G. has not been able to "maintain some restricted work-like stresses or activities" as Dr. Gnam claims.

[21] Tab 76, pg. 9.

The second reason I reject Dr. Gnam's opinion is that, even if he were not wrong on the facts, his application of the impairment rating system set out in the *Guides* is not correct in this case. His conclusion, that Ms. M.G.'s impairment is Moderate because she is "not completely unable to engage and maintain some restricted work-like stresses and activities," applies the wrong test. The test for Moderate impairment, or even Marked impairment, is not, as he suggests, "complete inability." That would be more akin to the threshold for Extreme of class 5 impairment, where "impairment levels *preclude* useful functioning.

Rather, the test for Moderate Class 3 impairment is an impairment that is "compatible with *some,* but not all, useful function." The next level up, Marked or Class 4 impairment, is one that "*significantly impede[s]* useful functioning." Of the two, the better fit with the facts, even as they were described by Dr. Gnam, would be the Marked, and not the Moderate level. There is, after all, a huge qualitative and quantitative difference between working full time as a nurse and volunteering a few hours a week to call out bingo numbers at a senior centre or help out at the information booth at the hospital.

I find Dr. Gnam failed to consider and compare all of the relevant impairment levels and correctly apply them to the facts and his conclusion was flawed as a result.

I find that the evidence from Ms. M.G.; her family; Lisa Duffis, her treating OT from March 2007 to date; and her co-workers about her many and persistent, but unsuccessful, attempts to return to her nursing job, and, later, volunteer work, are ample evidence of a marked impairment in this domain. Ms. M.G. described in great detail how she was completely unable to manage her job due to her cognitive impairments, pain and distress. She was "buddied" with a co-worker at first, but could not be left to manage patients alone. She was unable to remember medications or to calculate the proper intravenous doses and ratios – something she used to be able to do easily in her head. She finished each shift in more pain than when she started; her co-workers had to put her in a room to rest. Ms. Duffis, her treating occupational therapist, eventually advised Ms. M.G. to stop working because it was not safe for her to do so and it was "too much for her."

In a report dated February 24, 2011,[22] prepared as a rebuttal report to the Kaplan and Kaplan report of September 9, 2010, Dr. Gnam attempted to explain the substantial differences between his and Drs. Kaplan's and Levitt's mental impairment ratings. Dr. Gnam was most critical of the fact that Drs. Kaplan and Levitt administered psychometric validity tests which indicated extreme exaggeration of symptoms, but then disregarded the findings and diminished the significance of those measures. According to Dr. Gnam, the only possible explanations for the test results were that Ms. M.G. was either malingering, or unconsciously exaggerating her symptoms for some other unknown motive such as a "cry for help." Either way, the logical conclusion would be that Ms. M.G.'s symptoms and impairment could not be accurately assessed, and therefore Drs. Levitt's and Kaplan's mental impairment ratings were invalid.
I reject Dr. Gnam's critcisms and prefer the evidence of Drs. Levitt and Kaplan. I find the latter's explanation for why they discounted their invalidity findings in their report is a reasonable one:

> [Ms. M.G.] produced an invalid profile, which on first blush suggests extreme exaggeration. We followed up during clinical interviewing to ascertain her understanding of the test items, and in particular her understanding of critical items endorsed. When we did this, it became clear that her understanding of the items was coloured by language and cultural issues. She often responded to related thoughts, rather than to the items themselves, interpreting the questions very loosely at time. When she explained her understanding of each item, it was clear that she was not attempting to exaggerate or mislead. Regardless, we are unable to provide a normative interpretation of her profile.[23]

I find this description of Ms. M.G.'s behaviour when answering questions is remarkably consistent with how she answered questions in her testimony at the hearing. It was evident that Ms. M.G. does not always understand more abstract or complex ideas the way others do and she is a rigid and concrete thinker. I do not find this to be inconsistent with her occupation as a nurse, as Dr. Gnam suggests. But I find it reasonable that these peculiarities would affect her responses

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[22]Exhibit 1, tab 108

[23]Tab 108, pg. 3

to verbal tests. I note that Dr. Kurzman also reported that questions had to be repeated for Ms. M.G. due to her "borderline" verbal comprehension and language skills.[24]

In my view, when weighed against the medical and lay evidence as a whole, not all of which was available to Dr. Gnam, Drs. Levitt's and Kaplan's conclusions about impairment levels are sound despite Ms. M.G.'s performance on the validity tests. I note that, unlike Dr. Gnam, Drs. Levitt and Kaplan interviewed Ms. M.G.'s mother, and had an additional source of pertinent collateral information as well.

Catastrophic Impairment under Category F

Under clause 2(1.2)(f) of the *Schedule*, a catastrophic impairment is an impairment or combination of impairments that, in accordance with the *Guides* more impairment of the whole person (WPI). The WPI for physical impairment is arrived at by first rating each individual, rateable physical impairment as a percentage. The percentages are then combined (not an exercise in straight addition) according to the "Combined Values Chart" found at pages 322 – 324 of the *Guides*, to arrive at a percentage impairment of the whole person.

As confirmed by the Court of Appeal in *Kusnierz v. Economical Mutual Insurance Company*[25], mental impairments can also be combined with physical impairments to arrive at a WPI under category (f), using the same Combined Values Chart. First, though, mental and behavioural impairments under (g) must be converted to a numerical scale so that they too can be rated as a percentage. They can then be combined in a like manner with physical impairments to arrive at a

[24]Report dated April 12, 2010 Exhibit 1, tab 102

[25][2011] O.J. No. 5908

combined WPI using the Combined Values Chart. [26]

Included as Appendix "B" to this decision is a chart illustrating the percentage WPI ratings for Ms. M.G.'s physical and mental impairments, as determined by each assessor, with the total combined WPI in the very last row. The percentage WPI, for mental impairments only, ranges from a low of 27% (Custom Rehab, Dr. Rosenblatt) to a high of 40% (Drs. Levitt and Kaplan).

For the reasons explained above, I find the opinion of Drs. Levitt and Kaplan, that Ms. M.G. suffers marked impairment in three spheres of function, to be the most accurate. For the same reasons, I find their WPI rating of 40% for mental impairments is also the most accurate, representing as it does a greater degree of impairment than the other assessments.

I further find that the 40% figure represents the most reasonable conversion of a marked impairment rating in three functional categories to a percentage WPI rating, because it correlates well with the rating charts for two methods of converting qualitative mental impairments to WPI percentages referenced in the *Guides* at pp. 142 and 301. Drs. Levitt and Kaplan referred to these methods in their analysis, and, as noted in *Jaggernauth,* these are among the methods that have been considered with approval by triers of fact. I find this was a reasonable approach to take in this case.[27]

A 40% WPI for mental impairment would require a further (combined) physical WPI of at least 25% to amount to a catastrophic rating of 55% under the Combined Values Chart.

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[26] As neither the *Guides* nor the Court in *Kusnierz* provide a specific methodology for converting qualitative mental/behavioural ratings to percentage values, assessors have devised a number of options for doing this. In *Jaggernauth and Economical Mutual Insurance Company* (FSCO A08-001413, December 20, 2010 - settled before appeal heard), Arbitrator Feldman reviewed in detail the pros and cons of the six methodologies considered so far by assessors, arbitrators and judges. All incorporate a certain degree of imprecision and subjectivity, such that no single one, needless to say, is entirely satisfactory. The particular "conversion methodologies" used by Ms. M.G.'s assessors are not themselves in dispute in this case, however, and so there is no need to review them in this decision.

[27] I make no comment on whether Dr. Gnam's method, of his own devising, is any more or less reliable, despite its complexity, than the approach used by Drs. Levitt and Kaplan or Dr. Rosenblatt, other than to say that Dr. Gnam's starting point – a rating of Ms. M.G.'s functioning on the Global Assessment of Function (GAF) scale - was higher than every other assessor's, and, in my opinion, too high. Had he used a lower GAF score to start with, the end result would likely have been a WPI for mental impairments similar to that of Drs. Levitt and Kaplan.

For the reasons below, I find Ms. M.G.'s combined physical WPI should range from 23 – 34 per cent, as follows:

Neck	5%
Back	5%
Both knees	4%
Elbow (ulnar nerve)	6%
Sleep	1 – 9%
Headaches	2%
Urinary Incontinence	1 – 9%
Total Combined	**23 – 34%**

This excludes any rating for neurocognitive impairments, which I find Kaplan and Kaplan captured in their mental and behavioural rating. It also excludes any consideration of dizziness and balance issues, which Ms. M.G. complained of consistently since the accident, and for which there was no evidence that those symptoms are not physical, as opposed to mental. Even considering only the lowest scores[28] in two disputed categories, sleep and urinary incontinence, the total combined WPI is 23%, which, when combined with the 40% WPI for mental impairment, yields 53%. 53%, "rounded to the nearest value ending in 0 or 5," as permitted by the *Guides*, takes Ms. M.G. to the 55% catastrophic threshold.

As can be seen from the chart above, the only assessment of physical impairments that falls short in this case is that of the Custom Rehab team. I did not find their assessment and rating to be as reasonable or as persuasive as those of Dr. Garner or the Drs. Becker for a number of reasons. The first reason is that I do not find the Custom Rehab team had a realistic or accurate grasp of Ms. M.G.'s actual functional abilities for her activities of daily living. As discussed above, I did not find Ms. Krushed's extrapolations from her observations of Ms. M.G.'s abilities to complete

[28] I have considered only the lowest scores to avoid double-counting. However, although sleep impairment in Ms. M.G.'s case is also related to her mental and behavioural impairments, she is awakened by bed-wetting, which is considerably disruptive. For that reason I do not believe her sleep impairment is entirely accounted for in the mental/behavioural category. As for incontinence, it is not clear that it is entirely a question of anxiety or other mental impairment.

daily living tasks and engage in social activities to be realistic or reasonable. Consequently, to the extent Dr. Mathoo and Dr. Dost relied on Ms. Krushed's faulty statements and conclusions, their reports are similarly inadequate.

The second reason I prefer the evidence of Kaplan and Kaplan and Omega over that of Custom Rehab, is that I find the Custom Rehab team's approach resulted in their under-rating of Ms. M.G.'s physical impairments. There appear to be a number of reasons for this. One is that the team members did not consult with each other, or even exchange their reports; each simply conducted his or her own assessment and prepared a report, and the team leader, Dr. Mathoo, included their findings in his Executive Summary. I find this lack of communication impeded the exercise of clinical judgment or interpretive analysis by team members - essential components of assessing the impact of impairments on daily functioning.

The effect of this compartmentalized approach can be seen in how the Custom Rehab team members accounted, or rather, failed to account, for the effects of pain on daily functioning. Dr. Mathoo's position is that, according to the *Guides,* the effect of pain is accounted for in the percentage rating for each physical impairment. Although this statement is true, it does not go far enough. The result is that, despite recording Ms. M.G.'s undisputed complaints of persistent neck and back pain, if an assessor does not assign a percentage WPI to a particular body part, any associated pain and resulting inhibition of function is not accounted for. For example, Dr. Mathoo consistently recorded, and, I find, accepted Ms. M.G.'s pain complaints over several assessments he himself conducted. But his approach resulted in 0% ratings for Ms. M.G.'s neck and back pain and dysfunction, and 0% for her elbow pain.[29]

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[29]The *Guides* provide for two models of rating spinal impairments (neck and back); the Injury or "DRE" (Diagnosis-Related Estimates) model, and the "ROM" (Range of Motion). Dr. Mathoo chose the former; Drs. Becker and Garner, the latter. Drs. Becker and Garner rated Ms. M.G.'s neck impairment at 5% on the basis that previous assessors had noted spasms and she said she had them, and because they noted asymmetrical range of motion. These findings would reasonably result in a 5% WPI rating regardless of which model was used, as the DRE II level assigns a 5% rating where one of the findings has been "intermittent or continuous muscle guarding observed by a physician." Dr. Mathoo assigned a WPI of 0% because there was no radiculopathy and he did not find any spasm or asymmetrical range of motion when he examined Ms. M.G.. I find Dr. L. Becker's November 3, 2009 rebuttal of Dr. Mathoo's Sept 5, 2009 critical rebuttal of her July 23, 2009 CAT assessment, and her 5% WPI finding for neck and back impairment, is a reasonable and fairer application of the principles and methods found in the *Guides* in Ms. M.G.'s case and more the more persuasive opinion.

This would not necessarily be a problem if the effects of pain on function were accounted for elsewhere. However, I find they were not. Dr. Gnam, while acknowledging that chronic pain (as well as depression) was a significant factor in affecting motivation and function for Ms. M.G., ruled out a diagnosis of pain disorder under the DSM-IV. This is a reasonable finding — Drs. Levitt and Kaplan also agreed with it — but in this case there is no evidence to show that Dr. Gnam's WPI rating for mental impairment included an appropriate component for the effects of pain. Given that I have found his WPI rating for mental impairment too low, in part because I find Dr. Gnam underrated the severity of Ms. M.G.'s depression, I find it also likely that pain was not given the appropriate weight. Had the Custom Rehab team members communicated with each other and coordinated their efforts, they could have addressed their concern about "double-counting" directly and transparently, and perhaps not erred in the opposite direction.

Similar difficulties arose regarding Custom Rehab's view that Ms. M.G.'s complaints of incontinence were not rateable. As noted, I find the evidence indicates she complained consistently after the accident of this condition, which did not exist before, and, on a balance of probabilities, these symptoms were caused by the accident. Dr. Mathoo and Dr. Dost acknowledged Ms. M.G.'s complaints but dismissed them, concluding on their review of the evidence available to them, that her incontinence was merely a coincidence, not significant, and not neurologically or physically based, and, therefore, not rateable. Although I agree there may be insufficient medical evidence that the symptom is *neurologically-based*, I do not agree the condition is not rateable. The symptoms are physical, real, intrusive and distressing. There is no evidence they were adequately taken into account by Dr. Gnam in his mental WPI rating. The condition should, and I find, can be accounted for under the physical impairment category. Dr. Becker considered it to be an impairment and rated it by analogy, as permitted under the *Schedule*. I find this approach is fair and reasonable, as is the range of 1 - 9% impairment assigned by Dr. Becker.

I note that, unlike the Custom Rehab team members, Drs. Levitt and Garner discussed and compared their findings to arrive at a consensus opinion. This meant they dealt directly with the issue of double-counting and worked together to determine which functional impairments should

be captured under (f) or (g), to avoid, as much as possible, either over- or under-rating them. This was evident in their reports and testimony, and, in my view, resulted in a more thorough and accurate assessment overall.

Attendant Care:

Ms. M.G. claims attendant care in various monthly amounts ranging from $1,020 to $5,723.07 from 2007 and ongoing based on a series of Form 1's completed by Lisa Duffus, Ms. M.G.'s treating occupational therapist who began working with her in 2007. Two of her Form 1's purport to allot attendant care on a "retroactive" basis. A Form 1 dated March 19, 2009 includes 9 hours under the category of "Basic Supervisory Care." The most recent Form 1 dated January 19, 2011 recommends round-the-clock care under that category.

Economical paid for attendant care at the rate of $1,020 per month for two years after the accident,[30] stopping the benefit only because there is no ongoing entitlement beyond 104 weeks unless an insured person is catastrophically impaired, a designation Economical was entitled to dispute, and did, in accordance with the *Schedule.* Ms. M.G. did not claim amounts for Basic Supervisory Care during that period.

Economical disputes Ms. M.G.'s claims on two grounds; firstly, it disagrees that attendant care can be assessed or allocated retroactively; and secondly, it submits neither the 9 nor the 24 hours per day allotted under "Basic Supervisory Care," are either reasonable or necessary in this case.

On the first point, I agree that the wording of the *Schedule* supports Economical's position. Section 39 of the *Schedule* requires that attendant care needs are assessed using the standard Form 1. Under s. 39(3) of the *Schedule*, "An insurer *may*, but is not required to, pay an expense incurred *before* an assessment of attendant care needs . . . is submitted to the insurer." [emphasis

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[30]It appears that Economical actually paid attendant care and housekeeping benefits up to May, 2008, and terminated them by letter and OCF-9 dated July 21, 2008. Accident Benefits Brief, Exhibit 2, tab 186. The maximum period for which this benefit is available absent a designation of catastrophic impairment is 104 weeks, or, in this case, up to November 2, 2007. The maximum entitlement for a catastrophically impaired person is $6,000 per month.

added]. I was not persuaded in this case that I have the jurisdiction to require Economical to do what the *Schedule* has explicitly said it is not required to. My jurisdiction is limited to determining whether the recommended attendant care is reasonable and necessary going *forward* from the date of each Form 1.

On the second point, I find, on the evidence as a whole and considering the extensive medical and rehabilitation benefits available to Ms. M.G. elsewhere under the *Schedule*, that the 9 hours per day claimed in March 2009 for Basic Supervisory Care were not necessary or reasonable at that time. I further find that the 24-hour attendant care claimed in June 2011 is not necessary or reasonable.

There are a number of reasons for this. One is that I find Ms. Duffus' recommendations are not consistent with the purpose of the Form 1. Another reason is that Ms. Duffus failed to include many basic care needs in any of her Form 1's. I also did not find her to be objective or particularly knowledgeable about completing the form.

The *Schedule* requires attendant care to be paid in accordance with From 1, which is a standard form. Other than that the benefit requested must be reasonable and necessary, there do not appear to be any other guides to assist in "interpreting" the form.[31] Regarding the purpose of the Form, one is left for guidance with what the Form itself says, and relevant jurisprudence.

The Form 1 outlines three "levels" of care, differentiated by and paid according to the kind of skill required to perform the type of care. The time devoted to each care activity is allotted in minutes. The Levels are: Level 1, Routine Personal Care; Level 2, Basic Supervisory Care; and Level 3, for complex health/care and hygiene functions.

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[31] I am not aware of any guidelines under the *Schedule* that assist in using the Form 1. Apparently, according to Lisa Duffus, there exist guidelines for occupational therapists produced by their governing body. However, these were not entered into evidence nor were any submissions made about them. Occupational therapists are one of the few health care professions considered competent under the *Schedule* to assess care needs using the Form 1. Although their professional guidelines would not be binding on me, they might have been helpful in understanding how OT's address the issue of reasonableness and necessity of care, and whether their guiding principles are consistent with the intent of the *Schedule*.

Level 1 includes assistance with Dressing, Grooming, Feeding, Mobility and Extra Laundering. Level 2 includes Hygiene, Basic Supervisory Care as noted above, and Co-ordination of Attendant Care (to a maximum of 1 hour per week). Level 3 contains provisions relating to assistance with exercise, administering and monitoring medication, and "Skilled Supervisory Care", among others.

In addition, a note on the first page of the form states that attendant care needs should be considered together with other available statutory accident benefits:

> Users of Form 1should also review other accident benefits available under the Statutory Accident Benefits Schedule for possible reimbursement of other losses and expenses (such as housekeeping and home maintenance, transportation, home modifications and other medical and rehabilitation expenses.

This is an important statement as I find it is designed to ensure the Form 1 is used in the context of the statutory accident benefits scheme as a whole, and that benefits are coordinated, maximized, and not duplicated.

An overview of the care categories on the form indicates it is designed for the most part to address care needs arising from physical, cognitive or behavioural impairments that require the physical presence of an attendant - for help with dressing, grooming, feeding, hygiene, mobility, exercise, medication, etc. – the categories specified on the Form. In some cases where cognitive or behavioural impairment is an issue, the physical presence of an attendant may be required to cue, remind or prompt the person to perform necessary activities of daily living they would not otherwise initiate on their own.

As stated on Form 1, Level 2 "Basic Supervisory Care" is for basic supervisory functions. It is in this category that Ms. Duffus recommended 9 hours of care in 2009 and 24-hour care in 2011, under the heading, "applicant lacks [sic] ability to respond to an emergency or needs custodial care due to changes in behaviour." Based on the Form itself, I find that inability to respond to an emergency and the need for custodial care are the <u>only</u> two categories of the Form 1 where supervisory attendant care up to 24-hours a day can even be contemplated for someone in Ms. M.G.'s circumstances.

This is also the most contentious area of disagreement between the parties. Ms. M.G. maintains that her physical impairments (poor balance, dizziness and difficulty negotiating stairs), coupled with her cognitive impairments (forgetfulness, distractibility, confusion) and mood impairments (depression, lack of motivation, anxiety, agoraphobia) render her unable to respond to an emergency or to be safe at home or in the community, such that 9 hours of care was required as of March 2009, and 24 hours per day from 2011 onwards.

Economical, while not discounting Ms. M.G.'s cognitive and emotional impairments, acknowledges she needs help with certain physical activities such as meal preparation, grooming and hygiene.[32] However, it disagrees that Ms. M.G.'s cognitive, emotional or behavioural impairments prevent her from responding to an emergency, or that they require the presence of an attendant 24 hours per day.

For the most part, I agree. I do not find Ms. Duffus' recommendations for supervisory care in the March 19, 2009 or January 7, 2011 Form 1's to be necessary or reasonable.

Ms. Duffus' March 19, 2009 Form 1 recommended monthly benefits of $2,471.30, of which $2,099.30, or nine hours daily, was allocated to Basic Supervisory Care on the basis that Ms. M.G. "lack[ed] the ability . . . to be self-sufficient in an emergency." To the standard form wording, Ms. Duffus added, "*during the day with cell phone, and Night time*." The remaining $371.82 comprised an hour a day for assistance with meals, and 3 minutes twice a day for supervision using the stairs at night.

In an addendum to this Form 1, Ms. Duffus explained that the 9 hours Basic Supervisory Care included 8 hours at night "to continue assuring her in-home safety [in case of fire or flood] . . . and emotional well-being." She allocated the remaining hour during the day, because ". . . the ongoing emotional support that Ms. M.G. has been receiving from her relatives, friends and

[32]As per in-home assessments conducted by Ms. Alison Wills and Ms. Krushed in 2011. As discussed below, I find their recommendations are too low.

family during the day via the use of her cell-phone while in the community continues to provide her comfort and safety."[33]

While assuring a person's emotional well-being and providing emotional support are helpful for rehabilitative purposes, I do not agree that they are appropriate uses of the type of attendant care services intended under the Basic Supervisory Care category in Form 1. Where accessing the community safely is a concern, rehabilitation benefits to pay for an attendant under ss 15(2) and (5)(k) of the *Schedule* would be better suited, as these two sections provide specifically for a wealth of reasonable and necessary measures to reduce or eliminate the effects of impairments or to facilitate the reintegration of an insured person into her family or the rest of society. These measures include transportation for an aide or attendant to accompany a person to treatment or counselling sessions, and, where warranted, might include other means to encourage independent participation in the community. One example is as a cell phone which, as explained below, I find to be a necessary and reasonable rehabilitation expense.

With respect to 8 hours overnight care on the basis that Ms. M.G. was not self-sufficient in an emergency, I do not find that was the case at that time. I note that in an in-home OT assessment prepared during the same time period,[34] Ms. Alison Wills of Custom Rehab reported that Ms. M.G. was able to describe appropriate plans when posed emergency situational questions such as fire, flood or someone breaking in, despite her reported difficulties with concentration, memory and multi-tasking. Regarding Ms. M.G.'s reported difficulty negotiating stairs due to pain, dizziness and balance issues, Ms. Duffus had already accounted for that by allotting 3 minutes twice per night for assistance using the stairs.

On the question of self-sufficiency in an emergency, I prefer Ms. Wills' evidence over that of Ms. Duffus. I find it was apparent from her testimony and the tenor of her reports, that Ms. Duffus was overly emotionally involved in Ms. M.G.'s case to the extent that she

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[33]Exhibit 12, pg. 106

[34]Report dated May 28, 2009, Tab 90.

compromised her impartiality and ability to objectively assess Ms. M.G.'s needs from an occupational therapy viewpoint. She burst into tears at one point when describing how Ms. M.G.'s psychological condition had deteriorated. She overlooked basic and obvious attendant care needs in her Form 1's, needs that even Economical's assessors recommended (dressing, bathing, grooming, extra laundering), attributing her errors to "clinical oversight" and inexperience. She openly challenged the recommendations of Ms. M.G.'s treating psychiatrist, Dr. Cruz, and treating psychologist, Dr. B. Mangos, that Ms. M.G. should be encouraged to overcome her fears and anxieties and become more independent by taking the bus by herself to an appointment, something a surveillance video showed Ms. M.G. was able to do on at least one occasion.[35] I find Ms. Duffus' concerns for Ms. M.G.'s financial worries, for which both women blamed Economical, also affected her impartiality.

Despite these overall concerns, however, I find the one hour during the day recommended by Ms. Duffus, when I understand someone would be available periodically at the other end of a cellphone to monitor Ms. M.G. while she was at home or in the community, could be reasonable on the grounds of safety and/or cuing. The difficulty of course would be in separating time spent ensuring safety and providing necessary cueing, from time spent providing emotional support to an emotionally vulnerable person, which is not, in my view, what attendant care under Form 1 is for.

The above concerns also apply to Ms. Duffus' third and final Form 1 completed on January 7, 2011. Although I find there is ample evidence to indicate that by then Ms. M.G.'s emotional condition had deteriorated considerably,[36] I do not agree that 24-hour a day Basic Supervisory Care as allotted by Ms. Duffus, at a cost of $5,337.55 of the $5,723.07 total claimed per month, is a necessary or reasonable response to this situation.

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[35]Exhibit 8

[36]Dr. Cruz, Dr. Kurzman, Ms. Duffus, Dr. Meneses

In an addendum to the Form 1, Ms. Duffus elaborated on her reasons for recommending 24-hour supervision:

> [Ms. M.G.] has suffered a considerable worsening of her psychosocial status since the date of this writer's last assessment (via continuing to express and demonstrate signs of heightened depression, decreased initiative and motivation, frustration and irritability) stemming from the noted difference between her pre vs. post-accident productivity level and overall quality of life. In addition to this, are her persisting physical functional limitations (which continues [sic] to compromise her safety with mobility via untimely falls, particularly when negotiating stairs), with ongoing cognitive functional deficits (particularly with memory, abstract reasoning and visual processing speed); all of which, **increases her need for monitoring, emotional support and comfort assurance, and maintain concerns and doubts surrounding Ms. M.G.'s ability to timely [sic] and appropriately respond to a realistic probability of an imminent, yet unforeseeable emergency scenario (i.e. fire or flood).**[37] **[emphasis added]**

By this time, the evidence was that Ms. M.G. was living a fairly isolated existence, mostly sitting alone at home and not doing much of anything, including, according to her daughter, getting up in the morning, dressing, or eating without prompting or assistance from family members. She cried a lot and expressed thoughts of suicide, which was, understandably, of great concern to her family, who, along with Ms. Duffus, were worried Ms. M.G. would act on these thoughts. Although Ms. Duffus was concerned for Ms. M.G.'s safety, I find her concerns about Ms. M.G.'s emotional state and suicidal thoughts played a predominant role in her recommendation for 24-hour care.

I do not find Ms. Duffus' recommendation reasonable in the circumstances, however. With respect to physical safety, the evidence was that several measures were in place to ensure this. When at home, Ms. M.G. would stay on one floor during the day so as not to have to use the stairs, which in any event were equipped with railings for her safety. The washroom was fitted with grab bars for her. She used a kettle with an automatic shut-off, did not use the stove without family supervision, and used an electric rice cooker to make rice. She was able to use taxis for

[37] Addendum to Form 1 #4 - Re-Assessment, January 19, 2011, Exhibit 12. The remaining $385.52 per month was for 7 hours per week for meal preparation, 35 minutes a week for supervision using the stairs at night, and 15 minutes a week for "maintains and controls medication supply."

transportation. Ms. M.G. testified that a door directly to the street was installed for her. I do not find that it was unsafe for Ms. M.G. to be home alone on the basis of physical or cognitive impairments or that 24-hour care would be required to ensure her safety.

With respect to Ms. M.G.'s depression, anxiety and suicidal thoughts, I find her emotional state did not constitute the type of "emergency" that would require 24-hour care contemplated under the category of "Basic Supervisory Care" on the Form 1. Even if it did, then the appropriate course of action would be for Ms. Duffus to seek, and defer to, the opinion of a mental health professional such as a psychiatrist or psychologist, preferably someone who was treating Ms. M.G., or even the family doctor.

Ms. Duffus did review the March 18, 2011 report of Mr. Billy Mangos, Ms. M.G.'s treating psychologist, who stated that, "Although Ms. M.G. is not actively suicidal and has no history of suicidal plan(s) or intent, her emotional vulnerability and high level of anxiety does warrant vigilance in monitoring Ms. M.G. for suicidal ideations."[38] A year previously, in June 2010, Mr. Mangos assessed Ms. M.G. and reported there was no evidence of "risk of imminent harm to self or others." [39] Mr. Mangos agreed on cross-examination that he did not at any time feel Ms. M.G.'s situation was so serious that he would consider sending her to the emergency department or committal to a hospital, an opinion shared by Dr. Laura Cruz, Ms. M.G.'s treating psychiatrist. I find that at no time could Ms. M.G.'s psychological condition or cognitive impairments be considered to require the basic supervisory care under Form 1 on the basis that she was not self-sufficient in or able to respond in an emergency.

Ms. Krushed, Economical's OT, also conducted an in-home assessment and prepared a Form 1 during the same period, on March 2, 2011. She, too, acknowledged Ms. M.G.'s deteriorated psychological condition, but felt she should defer the need for supervisory care to a psychologist at that time ". . . due to reported feelings of depression, fear of being alone and suicidal

[38]Exhibit 13, p. 2

[39]Exhibit 12, Report dated June 8, 2010, at p. 11

thoughts." I find this is the correct approach to take, as the point at which a person's psychological condition becomes an emergency that may or may not require attendant care (or appropriate treatment) is something that most properly should be determined by a psychologist or psychiatrist. [40]

As noted in her Addendum Report, above, and as she explained in her testimony, Ms. Duffus recommended 24-hour supervision because she was primarily concerned with Ms. M.G.'s safety and comfort at home and in the community and her emotional well-being, noting that her client needed "monitoring, emotional support and comfort assurance."

These are all very real and valid concerns. However, for the reasons noted above, I am not persuaded that 24-hour attendant care is the necessary, reasonable or even appropriate response in this case.

Ms. M.G. also relied on the evidence of Dr. Kurzman, a psychologist who reviewed Ms. Duffus' March 2009 Form 1 and endorsed the latter's recommendations for overnight supervisory care. However, it was clear from his testimony that Dr. D. Kurzman simply accepted Ms. Duffus' recommendations at face value. I did not find his evidence helpful on that point.

However, I did find his April 12, 2010 report, co-authored with Dr. Tobi Lubinsky, very valuable for the treatment recommendations found in the last two pages. These include psychological counselling in the form of cognitive behavioural therapy; sleep hygiene; a comprehensive facility – based multidisciplinary chronic pain rehabilitation programme; perhaps more effective pharmacological pain management; stress, pain and anger management strategies; a community-based activation/rehabilitation programme to get her back out into the community; a rehabilitation support worker to assist her to resume "various activities of daily living including meal preparation, household chores, grocery shopping, and self-care tasks; and, finally, a Mindfulness-Based Cognitive Therapy (MCBT) programme for better insight into her mood

[40] There does not appear to have been a further psychological or psychiatric assessment on behalf of Economical, something I find ought to have been done, particularly once Ms. Krushed alerted them to the issue.

disorders, and hopefully, in the words of Drs. Lubinsky and Kurzman, “ to develop a new relationship to them.”

Although Ms. M.G. has had a great deal of treatment in the years since the accident, none of it appears to have been as targeted, coordinated or comprehensive as that suggested by Drs. Lubinsky and Kurzman, and none of it would appear to have had any lasting positive effect. All of these suggested treatments are well within the scope of the medical and rehabilitation benefits sections of the *Schedule,* and I find them to be necessary and reasonable, if not overdue. I would strongly urge the parties to give them serious consideration.

How much attendant care is reasonably necessary?

As noted above, Ms. Duffus failed to include in her Form 1’s of March 2009 and June 2011 many basic care needs that could and should have been included. Other OT’s, such as Ms. Krushed and Ms. Wills, for example, did include some of these care needs, but not to an extent that reflected Ms. M.G.’s actual needs.

Considering all of the evidence presented to me, including that of Ms. M.G. herself, her family members, her treating physicians, psychologists, and other therapists; and the expert opinions on both sides, and having reviewed the various Form 1’s and functional assessments in evidence, I have determined the amounts of attendant care that I find to be reasonable and necessary according to the specific Form 1 categories and have set out the amounts in a chart at Appendix “C” to this decision.

Economical shall pay monthly attendant care benefits of “1,462.70 from May 2008 and ongoing.

Housekeeping

As I find Ms. M.G. was entirely responsible for housekeeping before the accident and the evidence as a whole (much of it discussed above) consistently indicates she is not up to most of

the tasks she previously undertook, I find she is entitled to the maximum weekly housekeeping benefit of $100 from 104 weeks after the accident and ongoing.

Rehabilitation Benefit: Cell phone

Economical approved a Treatment Plan from Ms. Duffus for a cell phone on November 21, 2007, for a trial period of 52 weeks, together with a taxi account for the same period, for a total cost of $838.22. Ms. Duffus submitted a second Treatment Plan for "Continued cell phone plan, to ensure that she can contact family member when needed to ensure her receipt of comfort and safety during her community-based rehab activity sessions." [41] The plan was for three years at a cost of $1,523.52.

Economical had the Treatment Plan assessed by its own OT, Ms. H. Ksenyck, under s.42 of the *Schedule*. Ms. Ksenyck found the cell phone necessary and reasonable for Ms. G's safety and security while in the community. She based this opinion in part on the medical diagnoses of Dr. Gnam. However, as Ms. M.G. had owned a cell phone before the accident, Ms. Ksenyck deducted what Ms. G paid before the accident for her cell phone, from the $1,523.52 claimed, and approved $963.72 for the cost of the three-year plan.

I agree that the cell phone is a necessary and reasonable rehabilitative measure. However, the uncontradicted evidence of Ms. G and her family is that Economical never paid for the cell phone. There was no explanation forthcoming from Economical for why this approved benefit was not paid. I find Ms. G is entitled to the cell phone and also to a moderate special award of 25% for this inexplicable and unreasonable conduct. The amount of the special award should be calculated based on the overdue amount for the cell-phone, in the same manner as the special award is calculated in relation to the IRB claim, as explained below.

[41] Treatment Plan dated May 6, 2009, Exhibit 1, Tab 89

Special Award:

Under ss. 282(10) of the *Insurance Act*, if an arbitrator finds that an insurer has unreasonably withheld or delayed payments, he or she may award a lump sum of up to 50% of the amount of benefits found owing at the time of the award, "together with interest on all amounts then owing to the insured (including unpaid interest) at the rate of 2% per month compounded monthly, from the time the benefits first became payable under the *Schedule.*"

If I understand her submission correctly, Ms. M.G. claims a special award on two grounds. The first is that Economical did not pay for a cell-phone for Ms. M.G. despite approving one. I have dealt with this ground above.

The second ground is that it was unreasonable for Economical to stop her income replacement benefit ("IRB") under s. 55 of the *Schedule* on November 1, 2009, alleging that she did not respond to Economical's request for a Treatment Plan based on treatment recommendation made by Dr. K. Suddaby, one of Economical's post-104 IRB assessors, as part of his psychiatric assessment on August 24, 2009. The adjuster's notes at the time appear to verify that this was in fact the reason the IRB was stopped.[42]

Under section 55 (1) and (2) of the *Schedule*, an insured person entitled to an IRB is required to obtain such treatment and participate in such rehabilitation as is reasonable, available, and necessary to permit the person to "engage in employment . . . that [he or she] would be able and qualified to perform the essential tasks of . . . **if the . . . person obtained treatment and participated in rehabilitation that is reasonable, available and necessary to permit the person to engage in the employment."[**emphasis added].

If the insured person does not comply, the insurer is entitled to notify the person that it will stop the benefit.

[42]Exhibit 4, Tab 8

There is no question that Dr. Suddaby's treatment recommendations were necessary and reasonable. However, I find Ms. M.G. did seek appropriate treatment in a timely manner, and the adjuster's notes clearly indicate Economical was aware of this.

In his report, Dr. Suddaby, opined that the cognitive impairments that so distressed Ms. Gubatan were "consistent with the level of severity of an untreated major depressive illness;" [43] an opinion, as we have seen, shared by the medical experts. Serious depression has been a large part of Ms. Gubatan's problem all along and continues to be a significant component of her difficulties. Dr. Suddaby was unable to determine at that time, from reports provided or from Ms. Gubatan herself, the nature of any previous treatment for her depression. He noted that Dr. van Reekum in his July 2008 report had also noted the depression appeared to have gone untreated, and that Dr. van Reekum had recommended a trial of antidepressant medication. I note that at the hearing, Dr. van Reekum expressed surprise that no medication had been prescribed for Ms. Gubatan's depressive symptoms.

Dr. Suddaby recommended Ms. M.G. be "aggressively treated to guideline treatments with anti-depressant medications," laying out a comprehensive and specific suggested treatment plan. He also recommended referral to a psychiatrist for ongoing medical care and to a psychologist for cognitive behavioural therapy to focus on major depression and pain management. However, he pointed out that Ms. G's depression-related cognitive impairments would "likely interfere with her significantly benefitting from cognitive behavioural therapy" until they had responded to medical treatment.

Importantly, Dr. Suddaby also felt that a significant recovery could be possible with treatment.

Ms. M.G. acted promptly on Dr. Suddaby's recommendations. Her family doctor referred her to Dr. Cruz, a Filipino psychiatrist. An entry in the adjuster's file dated January 14, 2010 indicates the adjuster received a fax from Ms. M.G.'s previous counsel dated November 5, 2009 advising

[43] Tab 93, Pg. 14

Economical that Ms. M.G.'s first appointment with Dr. Cruz was scheduled for December 11, 2009.[44] Ms. M.G. attended this appointment. Dr. Cruz prescribed Cymbalta, which she described as an anti-anxiety and anti-depressant used mainly for depression and pain. A year later, Dr. Cruz referred Ms. Gubatan to a number of different types of cognitive behavioural programmes, which Ms. M.G. attended. I find that Ms. Gubatan complied with the requirements of section 55 of the *Schedule* in a timely manner by seeking and participating in necessary and reasonable treatment very similar to that recommended by Dr. Suddaby. Consequently, I find Economical had no valid reason to purport to stop her IRBs under s. 55, or any other section of the *Schedule.*

Although Ms. M.G. complied with her obligations, and despite requests from her counsel, Economical did not reinstate Ms. M.G.'s IRBs until just before the start of this hearing, two and a half years after stopping them. Economical did not provide any explanation for the delay.
I find both the delay and the lack of any explanation to be completely unacceptable. As it is well-established that an insurer cannot avoid a special award simply by paying an overdue benefit just before the issue is to be adjudicated, I find Economical's conduct merits a special award in this case.

Under ss. 282(10), a special award is calculated according to "the amount to which the person was entitled at the time of the award." Had the IRB claim proceeded to arbitration, I would have issued an award in Ms. M.G.'s favour. Instead, Economical has paid the full amount owing, with interest. As Economical cannot avoid the consequences of a special award by simply "paying up" on the eve of arbitration, I find the "time of the award" is the time an award on the merits and the special award would have been made, which is the date of this decision. The "amount to which the person is entitled" is the amount Economical paid.

I did not hear submissions on the amount of the special award and am not in a position to calculate the amount at this time. I would ask the parties to calculate and agree on the maximum amount of the special award that *could* be awarded in this case according to ss 282(11) of the

[44] Adjuster's notes, Exhibit 4, tab 8

Schedule and as set out in *Liberty Mutual Insurance Company and Persofsky*,[45] which is: 50% x (benefits that were unreasonably withheld or delayed + interest on these benefits calculated under the SABS) +compound interest calculated according to ss. 282(10).

The parties may contact the Case Administrator to schedule submissions on the amount of the special award including, if necessary, a determination of the maximum amount that could be awarded.

EXPENSES:

As Ms. M.G. has been entirely successful in this proceeding, she is entitled to her arbitration expenses. If the parties are not able to agree on the amount of expenses, either party may request, in writing, under Rule 79.1 of the *Code*, an appointment before me to determine the matter.

______________________________	November 23, 2012
Susan Sapin Arbitrator	Date

[45] *Liberty Mutual Insurance Company and Persofsky et al.* (FSCO P00-00041, January 31, 2003), Appeal

FSCO A09-002443

BETWEEN:

Ms. M.G.

Applicant

and

THE ECONOMICAL MUTUAL INSURANCE COMPANY

Insurer

ARBITRATION ORDER

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

1. Ms. M.G. sustained a catastrophic impairment under paragraphs 2(1.1)(f) and (g) of the *Schedule.*

2. Ms. M.G. is entitled to attendant care in the amount of $1,462.70 per month from May 31, 2008 and ongoing.

3. Ms. M.G. is entitled to housekeeping and home maintenance expenses of $100 per week from November 2, 2005 and ongoing, less amounts paid.

4. Ms. M.G. is entitled to $838.22 for the cost of a cellphone for 52 weeks from November 21, 2007 and $1,523.52 as set out in the Treatment Plan dated May 6, 2009, under ss. 15(5)(i) of the *Schedule*.

5. Ms. M.G. is entitled to a special award.

6. Ms. M.G. is entitled to interest on overdue amounts in accordance with the *Schedule*.

______________________________	November 23, 2012
Susan Sapin Arbitrator	Date

APPENDIX "A"

Area or aspect of functioning	**Class 1: No impairment**	**Class 2: Mild impairment**	**Class 3: Moderate impairment**	**Class 4: Marked impairment**	**Class 5: Extreme impairment**
Activities of daily living Social functioning Concentration Adaption	*No* impairment is noted	Impairment levels are compatible with *most* useful functioning	Impairment levels are compatible with *some*, but not all, useful functioning	Impairment levels *significantly impede* useful functioning	*Impairment levels preclude* useful functioning

APPENDIX "B"

Chart Summarizing Ms. M.G.'s WPI, adapted from the report of Kaplan and Kaplan.

Impairment	**CAT IE Custom Rehab April 22, 2009 Dr. J. Mathoo, Dr. R. Dost & Dr. W. Gnam**	**CAT Rebuttal - Omega July 23, 2009 Drs. H. & L. Becker & Dr. Rosenblatt**	**CAT Rebuttal – Addendum-Omega November 17, 2009**	**Kaplan and Kaplan — Dr. Scott Garner August 2010**
Cervicothoracic Spine	0%	5%	5%	5%
Lumbrosacral Spine	0%	5%	5%	5%
Bilateral Knee Pain	*2% (attributed to right knee only)	4% (both knees)	4% (both knees)	4% (both knees)
Right Ankle	Not Rateable	Not Rateable	Not Rateable	Not Rateable (no current symptoms)
Gait/ Balance	0%	No Rating	No Rating	5% (falls frequently)
Shoulders	No Rating	1%	1%	Not Rated
Elbow/ Ulnar Nerve	No Rating	6%	6%	6% (ulnar never injury)
Neurocognitive Impairment/Neuro-emotional rating	No Rating	1-14%	1-14%	Defer to Psychology
Sleep	No Rating	1-9%	1-9%	Defer to Psychology
Headaches	No Rating	No Rating	4%	2%
Smell/ Taste	3%	No Comment	3%	0%
Genitourinary/ incontinence	No Rating	No Rating	1-9%	10%
Vision	0%	No Comment	No Comment	Not rated
WPI – physical impairments only	5%	25-40%	28-47%	31%
Mental & Behavioural Rating if provided	27-31%		30-34%	40%
Comprehensive WPI Rating	31-34%	48-60%	50-65%	59%

APPENDIX "C"

Attendant Care deemed to be reasonable and necessary.[46]

		# of Minutes	**Times/wk.**	**Minutes/wk.**	**Hourly Rate**	**Weekly Amt.**
Level 1	Assistance with dressing/ undressing a.m. and p.m.	30	7	210	$11.23	$137.94
	Grooming	5	7	35		
	Feeding	60	7	420		
	Supervision using stairs at night	3	14	42		
	Extra laundering	60	5	30		
Level 2	Hygiene	10	7	70	7.00	65.87
	Clothing Care	30	2	60	7.00	
	Basic Supervisory Care	60	7	420	7.00	
	Coordination of A/C	60	1	60		
Level 3	Exercise	60	7	420		$1,462.70
	Medication	5	7	35		
TOTAL MONTHLY AMOUNT						$1,462.70

[46] As the hourly rate for each level of attendant care on the Form 1 increases over the years, the parties may wish to re-calculate the above amounts according to the version of the Form 1 that was in place for each year since 2008.