CATASTROPHIC IMPAIRMENT - 2016 CHANGES

OVERVIEW

30\(^{th}\) ANNUAL JOINT INSURANCE SEMINAR

Presented by:
The Hamilton Law Association

April 19, 2016

Arbitrator, Dispute Resolution Services Branch
Financial Services Commission of Ontario (FSCO)
CATASTROPHIC IMPAIRMENT - 2016 CHANGES

1. Overview

Starting about a decade ago, insurers were expressing concern that, while the total number of bodily injury claims had been declining, the number of CAT claims was increasing. The number of CAT claims went from approximately 5 per 1,000 bodily injury claims in 2002 to almost 10 per 1,000 bodily injury claims by 2006.

The Government's 2010 automobile insurance reforms included a commitment to consult with the medical community on the definition of “catastrophic impairment” found in the Statutory Accident Benefits Schedule (SABS). The Government directed FSCO to consult with the medical community and make recommendations on amendments to the definition, as well as on the qualifications and experience requirements for health professionals who conduct catastrophic impairment assessments. A Catastrophic Impairment Expert Panel was created and it presented its final report to the Superintendent in early 2011. In December 2011, the Superintendent issued his own report on this issue, urging the adoption of many, but not all, of the recommendations that were contained in the report from the Expert Panel. The stated goal of the recommended changes is to enhance certainty and predictability in the determination of catastrophic impairment and to have decisions based upon up-to-date, evidence-based medicine.

The amendments that are planned to take effect in 2016 are intended to address these concerns and generally follow the Superintendent's 2011 recommendations as to changes to the various definitions of catastrophic impairment and the requisite qualifications of assessors.

2. Monetary Limits

Prior to 2016, the standard coverage for a CAT case was up to $1,000,000 in medical/rehabilitation benefits and up to $1,000,000 in attendant care benefits (i.e., a total of up to $2,000,000). Starting June 1, 2016, the total standard coverage for CAT cases will be reduced to $1,000,000 (i.e., to cover both medical/rehabilitation expenses and attendant care).
3. **Who Can Do CAT Assessments?**

Under s. 45 of the SABS (as amended), CAT assessment can generally only be done by a physician but:

- the physician can be assisted by other registered health professionals as he or she reasonably requires
- if the impairment is a **traumatic** brain impairment only, the assessment or examination may be conducted by a **neuropsychologist** (now defined in s. 3(1) as a "psychologist authorized by law to practise neuropsychology and who has been registered to practice as a neuropsychologist in Canada for a minimum of five years")

4. **New Definitions**

The new definition of catastrophic impairment includes new and/or updated definitions and criteria.

**Highlights**

- More detailed criteria for spinal injury cases
- More detailed criteria based upon the loss of (or loss of use of) one or more limbs
- More detailed criteria based upon the loss (or severe impairment) of vision
- Elimination of GCS test
- More detailed criteria based upon functional impairment as a result of brain injury
- Automatic designation of catastrophic impairment for children with brain injuries (in specified circumstances)
- Two tests based upon whole person impairment (WPI), one of which specifically provides the method of calculating impairment ratings for a **combination** of physical and psychological impairments
- More detailed criteria based upon mental/behavioural disorder

See the Chart for details.
### Definition of “Catastrophic Impairment” — Synopsis of Current Provisions and Pending Amendments

<table>
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<tr>
<th>Current (Sept. 1/10 – May 31/16)</th>
<th>Proposed (to take effect June 1, 2016)</th>
<th>Comments/Notes</th>
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| 1. Paraplegia or quadriplegia    | 3.1 (1) For the purposes of this Regulation, an impairment is a catastrophic impairment if an insured person sustains the impairment in an accident that occurs on or after June 1, 2016 and the impairment results in any of the following: 1. Paraplegia or tetraplegia that meets the following criteria: i. The insured person’s neurological recovery is such that the person’s permanent grade on the ASIA Impairment Scale, as published in Marino, R.J. et al, *International Standards for Neurological Classification of Spinal Cord Injury*, Journal of Spinal Cord Medicine, Volume 26, Supplement 1, Spring 2003, can be determined. ii. The insured person’s permanent grade on the ASIA Impairment Scale is or will be, A. A, B or C, or B. D, and 1. the insured person’s score on the Spinal Cord Independence Measure, Version III, Item 12 (Mobility Indoors), as published in Catz, A., Itzkovich, M., Tesio L. et al, *A multicentre international study on the Spinal Cord Independence Measure, version III: Rasch psychometric validation*, Spinal Cord (2007) 45, 275-291 and applied over a distance of up to 10 metres on an even indoor surface is 0 to 5. 2. the insured person requires urological surgical diversion, an implanted device, or intermittent or constant catheterization in order to manage a residual neuro-urological impairment, or 3. the insured person has impaired voluntary control over anorectal function that requires a bowel routine, a surgical diversion or an implanted device. | ASIA IMPAIRMENT SCALE  
A = Complete: No motor or sensory function is preserved in the sacral segments S4-S5.  
B = Incomplete: Sensory but not motor function is preserved below the neurological level and includes the sacral segments S4-S5.  
C = Incomplete: Motor function is preserved below the neurological level, and more than half of key muscles below the neurological level have a muscle grade less than 3.  
D = Incomplete: Motor function is preserved below the neurological level, and at least half of key muscles below the neurological level have a muscle grade of 3 or more.  
E = Normal: Motor and sensory function are normal.  
MUSCLE GRADING  
0 total paralysis  
1 palpable or visible contraction  
2 active movement, full range of motion, gravity eliminated  
3 active movement, full range of motion, against gravity  
4 active movement, full range of motion, against gravity and provides some resistance  
5 active movement, full range of motion, against gravity and provides normal resistance  
5* muscle able to exert, in examiner’s judgement, sufficient resistance to be considered normal if identifiable inhibiting factors were not present  
NT not testable. Patient unable to reliably exert effort or muscle unavailable for testing due to factors such as immobilization, pain on effort or contracture. |
2./3. Amputation or total, permanent loss of use of one arm or one leg

3.1 (1) 2. Severe impairment of ambulatory mobility or use of an arm, or amputation that meets the following criteria:
   i. Trans-tibial or higher amputation of a leg.
   ii. Amputation of an arm or another impairment causing the total and permanent loss of use of an arm.
   iii. Severe and permanent alteration of prior structure and function involving one or both legs as a result of which the insured person’s score on the Spinal Cord Independence Measure, Version III, Item 12 (Mobility Indoors), as published in Catz, A., Itzkovich, M., Tesio L. et al, A multicentre international study on the Spinal Cord Independence Measure, version III: Rasch psychometric validation, Spinal Cord (2007) 45, 275-291 and applied over a distance of up to 10 metres on an even indoor surface is 0 to 5.

4. Total loss of vision in both eyes

3.1 (1) 3. Loss of vision of both eyes that meets the following criteria:
   i. Even with the use of corrective lenses or medication,
      A. visual acuity in both eyes is 20/200 (6/60) or less as measured by the Snellen Chart or an equivalent chart, or
      B. the greatest diameter of the field of vision in both eyes is 20 degrees or less.
   ii. The loss of vision is not attributable to non-organic causes.

Trans-tibial = below-knee
5. Brain impairment that results in:

**GCS score** of 9 or less within reasonable time of the accident; or

**GOS score** of 2 (vegetative) or 3 (severe disability) more than 6 months post-MVA

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3.1 (1) 4. If the insured person was **18 years of age or older at the time of the accident**, a traumatic brain injury that meets the following criteria:

i. The injury shows positive findings on a computerized axial tomography scan, a magnetic resonance imaging or any other medically recognized brain diagnostic technology indicating intracranial pathology that is a result of the accident, including, but not limited to, intracranial contusions or haemorrhages, diffuse axonal injury, cerebral edema, midline shift or pneumocephaly.

ii. When assessed in accordance with Wilson, J., Pettigrew, L. and Teasdale, G., Structured interviews for the Glasgow Outcome Scale and the Extended Glasgow Outcome Scale: Guidelines for Their Use, Journal of Neurotrauma, Volume 15, Number 8, 1998, the injury results in a rating of,

A. Vegetative State (VS or VS*), **one month or more** after the accident,

B. Upper Severe Disability (Upper SD or Upper SD*) or Lower Severe Disability (Lower SD or Lower SD*), **six months or more** after the accident, or

C. Lower Moderate Disability (Lower MD or Lower MD*), **one year or more** after the accident.

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- GOS/GOS-E take on new importance in absence of GCS
- see Watters decision (A13-006328) for analysis of GOS
3.1 (1) 5. If the insured person was **under 18 years of age at the time of the accident**, a traumatic brain injury that meets one of the following criteria:

i. The insured person is accepted for admission, on an in-patient basis, to a public hospital named in a Guideline with positive findings on a computerized axial tomography scan, a magnetic resonance imaging or any other medically recognized brain diagnostic technology indicating intracranial pathology that is a result of the accident, including, but not limited to, intracranial contusions or haemorrhages, diffuse axonal injury, cerebral edema, midline shift or pneumocephaly.

ii. The insured person is accepted for admission, on an in-patient basis, to a program of neurological rehabilitation in a paediatric rehabilitation facility that is a member of the Ontario Association of Children’s Rehabilitation Services.

iii. **One month or more** after the accident, the insured person’s level of neurological function does not exceed category 2 (Vegetative) on the King’s Outcome Scale for Childhood Head Injury as published in Crouchman, M. et al, A practical outcome scale for paediatric head injury, Archives of Disease in Childhood, 2001: 84: 120-124.

iv. **Six months or more** after the accident, the insured person’s level of neurological function does not exceed category 3 (Severe disability) on the King’s Outcome Scale for Childhood Head Injury as published in Crouchman, M. et al, A practical outcome scale for paediatric head injury, Archives of Disease in Childhood, 2001: 84: 120-124.

v. **Nine months or more** after the accident, the insured person’s level of function remains seriously impaired such that the insured person is not age-appropriately independent and requires in-person supervision or assistance for physical, cognitive or behavioural impairments for the majority of the insured person’s waking day.

- *per new s. 45.1, if a minor meets criteria S.i. or S.ii. (of the CAT definition in subsection 3.1(1)), they can be deemed to be catastrophically impaired without going through the application process set out in s. 45*
6. 55% or more impairment of the whole person according to AMA Guides, 4th ed. ("WPI")

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<th>3.1 (1) 6. Subject to subsections (2) and (5), a physical impairment or combination of physical impairments that, in accordance with the American Medical Association's <em>Guides to the Evaluation of Permanent Impairment</em>, 4th edition, 1993, results in 55 per cent or more physical impairment of the whole person.</th>
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<th>3.1 (1) 7. Subject to subsections (2) and (5) a mental or behavioural impairment, excluding traumatic brain injury, determined in accordance with the rating methodology in Chapter 14, Section 14.6 of the American Medical Association's <em>Guides to the Evaluation of Permanent Impairment</em>, 6th edition, 2008, that, when the impairment score is combined with a physical impairment described in paragraph 6 in accordance with the combining requirements set out in the Combined Values Table of the American Medical Association's <em>Guides to the Evaluation of Permanent Impairment</em>, 4th edition, 1993, results in 55 percent or more impairment of the whole person.</th>
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7. Under the AMA Guides, 4th ed., a class 4 (marked) or class 5 (extreme) impairment due to mental or behavioural disorder in one (per Pasmore) or more of the following areas of function:
(1) activities of daily living;
(2) social functioning;
(3) concentration, persistence and pace;
(4) deterioration or decompensation in work or worklike settings.

3.1 (1) 8. Subject to subsections (3) and (5), 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) in three or more areas of function that precludes useful functioning OR a class 5 impairment (extreme impairment) in one or more areas of function that precludes useful functioning, due to mental or behavioural disorder. O. Reg. 251/15, s. 3.

3.1 (3) Paragraph 8 of subsection (1) does not apply in respect of an insured person who sustains an impairment as a result of the accident unless,

(a) two years have elapsed since the accident; or

(b) a physician states in writing that the insured person’s impairment is unlikely to improve to less than a class 4 impairment (marked impairment) in three or more areas of function that precludes useful functioning, due to mental or behavioural disorder. O. Reg. 251/15, s. 3.
If person is under age of 16 and that prevents typical application of criteria, for criteria nos. 5, 6 and 7 above, take into consideration the developmental implications of the impairment.

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<th>3.1 (4) Subsection (5) applies to an insured person who was under the age of 18 at the time of the accident and whose impairment is not a catastrophic impairment within the meaning of subsection (1). O. Reg. 251/15, s. 3.</th>
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<tr>
<td>3.1 (5) If the insured person's impairment can reasonably be believed to be a catastrophic impairment for the purposes of paragraph 6, 7 or 8 of subsection (1), the impairment shall be deemed to be the impairment referred to in paragraph 6, 7 or 8 of subsection (1) that is most analogous to the impairment, after taking into consideration the developmental implications of the impairment. O. Reg. 251/15, s. 3.</td>
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Criteria Nos. 6 and 7 do not apply unless a physician (or if it is exclusively a brain impairment, a physician or neuropsychologist) states in writing that the person's condition is **unlikely to cease to be catastrophic or two years** have elapsed since the accident.

| 3.1 (2) Paragraphs 6 and 7 of subsection (1) do not apply in respect of an insured person who sustains an impairment as a result of an accident unless, (a) **two years** have elapsed since the accident; or (b) an assessment conducted by a physician **three months or more** after the accident determines that, (i) the insured person has a physical impairment or combination of physical impairments determined in accordance with paragraph 6 of subsection (1), or a combination of a mental or behavioural impairment and a physical impairment determined in accordance with paragraph 7 of subsection (1) that results in 55 per cent or more impairment of the whole person, and (ii) the insured person's condition is unlikely to improve to less than 55 per cent impairment of the whole person. O. Reg. 251/15, s. 3. |

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Watters and the Glasgow Outcome Scale

Arbitrator, Dispute Resolution Services Branch

Facts (cont’d.)

- She was rarely left alone for more than a few hours per day – her husband reduced his hours at work and changed his schedule to be with her as much as possible
- Even when at home alone (during the day), she was in constant contact with husband and teenage daughter, primarily through text messages
- By time of hearing (Feb. 2015), she still could not function independently at home or in the community and required much attendant care

Result

- After a six-day hearing, Ms. Watters was found to be catastrophically impaired based on her GOS score
- This is the first decision on the GOS
- The Insurer appealed the decision but the case settled before the appeal was heard

Watters and State Farm
FSCO A13-006328, June 26, 2015

- Sept. 2011 -- 38-year-old female pedestrian struck by truck and suffered multiple skull fractures and a brain injury (as well as other impairments)
- She sustained few lasting neurological deficits but suffered from severe vertigo, emotional/behavioural changes and cognitive impairments
- Until the vertigo resolved (in summer of 2013), it prevented her from being able to respond to an emergency (at night)

Facts (cont’d.)

- She was assessed for catastrophic impairment and was found (even by her own assessors) not to qualify under:
  1. the GCS,
  2. 55% WPI,
  3. mental/behavioural impairment.
- However, she was found by her own assessors to qualify under the Glasgow Outcome Scale (GOS)
- The Insurer denied that Ms. Watters qualified as catastrophically impaired

What is the GOS?

- The GOS was an attempt (in 1975) to create a common, normative description of the level of functional outcome achieved by those who sustained brain damage
- There are five categories on the scale: (1) death; (2) persistent vegetative state; (3) severe disability; (4) moderate disability; (5) good recovery
- There is likely to be little debate about categories 1, 2 and 5
- The focus of litigation will be on the difference between 3 & 4
What is the GOS?

- According to the current SABS, the assessment must be done by someone qualified at least 6 months after the accident
- Vegetative (Score of 2) or Severe Disability (Score of 3) = CAT
- Moderate Disability or Good Recovery ≠ CAT

What is the GOS?

"Severe Disability" (conscious but disabled) – 1975 definition
This is used to describe patients who are dependent for daily support by reason of mental or physical disability, usually a combination of both. Many will be in institutions, but this should not be a criterion, because exceptional family efforts may enable such patients to be looked after at home. It is important to recognize that severe mental disability may occasionally justify this classification in a patient with little or no physical disability.

What is the GOS?

"Moderate Disability" (disabled but independent) – 1975 definition
Such patients can travel by public transport and can work in a sheltered environment, and are therefore independent in so far as daily life is concerned. The disabilities found include varying degrees of dysphasia, hemiparesis, or ataxia, as well as intellectual and memory deficits and personality change. These may produce considerable family disruption. Notice that independence is of a greater degree than that commonly described by geriatric physicians and others under the title “activities of daily living”, which usually refer only to ability to maintain self-care within the patient’s room or house; those able to do only that would be judged as severely disabled on the present scale.

Lessons from Watters

- GOS is not just about neurological deficits -- it is more about functional impairments in the real world (including those based on personality/behavioural changes and cognitive impairments)
- Any medical professional who is trained can give an opinion on GOS score
- Collateral interviews are critical
- Independence is the key factor in distinguishing between “severe” and “moderate” disability

Lessons from Watters

- A neurologist is not necessarily the best expert on GOS
- There can be overlap between CAT categories
- This decision will likely remain important after the new CAT definitions come into effect as many of the conclusions also apply to analysis of CAT impairment under GOS-E
The GOS-E is a refinement of the GOS, dividing each of the broad categories of "severe disability", "moderate disability" and "good recovery" into LOWER (i.e., less recovery) and UPPER (i.e., greater recovery).

Under the regulations that come into effect on June 1, 2016, an insured person who is 18 years of age or older at the time of the accident can be considered to have sustained a catastrophic impairment if he or she sustains a traumatic brain injury as a result of the accident that:

1. Is objectively proven by medically recognized brain diagnostic technology; and

2. When assessed in accordance with Wilson, J., Pettigrew, L. and Teasdale, G., Structured Interviews for the Glasgow Outcome Scale and the Extended Glasgow Outcome Scale: Guidelines for Their Use, Journal of Neurotrauma, Volume 15, Number 8, 1998, the injury results in a rating of:
   A. Vegetative State one month or more after the accident;
   B. Upper Severe Disability or Lower Severe Disability six months or more after the accident; or
   C. Lower Moderate Disability one year or more after the accident.

Things to think about

- When is the best time to do the GOS/GOS-E assessment? Can you do more than one?
- Who is the best professional to do the assessment?
- Did that professional have the best information available to them about the Applicant’s level of function and independence at home and in the community and did they actually consider and weigh all of the relevant information?
- Was the structured questionnaire employed? Correctly?
BETWEEN:

DENISE WATTERS

Applicant

and

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

Insurer

REASONS FOR DECISION

Before: Richard Feldman

Heard: February 17, 18, 19, 23, 24 and 26, 2015, at the offices of the Financial Services Commission of Ontario in Toronto.

Appearances: David Preszler for Ms. Watters
Aldo Picchetti for State Farm Mutual Automobile Insurance Company

Background:

The Applicant, Denise Watters, was a pedestrian who was struck by a motor vehicle on September 29, 2011. As a result of this accident, she sustained multiple skull fractures and a significant brain injury (as well as numerous other impairments). At the time of the accident she was 38 years old, a wife and mother of two teenaged children and she worked over 50 hours per week as a manager at two Tim Horton restaurants. She enjoyed her job and her family. She was described by her husband as active, happy, outgoing and healthy (with the exception of some asthma).
It is uncontroverted that the impairments that the Applicant sustained as a result of this accident have had a profound impact upon her life. She has not returned to any employment and has been largely housebound, relying heavily upon her husband and daughter for support, supervision and care. She only occasionally leaves her home, usually to attend medical appointments, engage in physical rehabilitation (such as swimming and aqua fitness) or go shopping. When she leaves the home, she is almost always accompanied by a family member or other attendant.

After the accident, Ms. Watters applied for and received statutory accident benefits from State Farm Mutual Automobile Insurance Company (“State Farm”), payable under the Schedule. ¹ Disputes arose between the parties concerning certain accident benefits claimed by the Applicant. The parties were unable to resolve their disputes through mediation and Ms. Watters applied for arbitration at the Financial Services Commission of Ontario under the Insurance Act, R.S.O. 1990, c.I.8, as amended.

The central issue in this case is whether the Applicant’s impairments are sufficient to meet the definition of a “catastrophic impairment.” State Farm has taken the position that the Applicant has not suffered a catastrophic impairment and, as a result, has refused to pay more than $50,000 ² in medical and rehabilitation benefits. State Farm also takes the position that the Applicant requires much less attendant care than she has claimed and, in any event, cannot be entitled to more than $36,000 in total attendant care benefits unless she is found to be catastrophically impaired. To date, the Insurer has paid no attendant care benefits at all.

During the hearing, the parties focused on these two main issues and adduced little evidence concerning the individual treatment plans that are also the subject of this proceeding (listed below).

¹The Statutory Accident Benefits Schedule — Effective September 1, 2010, Ontario Regulation 34/10, as amended.
²$50,000 is the maximum amount payable under the Schedule for medical/rehabilitation benefits in cases where a person’s impairments do not fall within the Minor Injury Guideline but also do not meet the definition of a catastrophic impairment (and where optional benefits have not been purchased). As will be discussed later, the Applicant has argued that State Farm had not even paid (or approved) a total of $50,000 when these benefits were “cut off” by the Insurer.
Issues:

The parties agreed that the issues in this arbitration proceeding are as follows:

1. Did Ms. Watters sustain a catastrophic impairment within the meaning of clause 3(2)(d)(ii) of the Schedule as a result of the accident?

2. Is Ms. Watters entitled to attendant care benefits at the rate of $4,988.08 per month from September 29, 2011 to date and ongoing for the services provided by the Applicant’s spouse, Derek Gordon Watters?³

3. Is Ms. Watters entitled to receive the following medical/rehabilitation benefits:

   a. $1,278.01 for out-of-pocket expenses submitted to the Insurer on October 31, 2012?

   b. $2,081.51 for out-of-pocket expenses submitted to the Insurer on December 31, 2012?

   c. $1,834.13 for the cost of a mental health assessment pursuant to a plan dated March 2, 2012 by Dr. Judith Pilowsky?

   d. $2,415.00 for the cost of a total body assessment pursuant to a plan dated September 18, 2012 by Dr. Jason Wen-Shyang-Su?

   e. $2,773.22 for occupational therapy services pursuant to a plan dated February 8, 2012 by Julie Fajertag?

   f. $4,539.83 for occupational therapy services pursuant to a plan dated February 15, 2012 by Julie Fajertag?

   g. $1,255.50 (partially approved for $855.50) for a nutrition assessment pursuant to a plan dated June 6, 2012 by Julie Fajertag?

   h. $310.00 for the cost of aquafit admission pursuant to a plan dated July 13, 2012 by Julie Fajertag?

³In closing arguments, counsel for the Applicant sought to amend this claim to $6,000.00 per month from September 29, 2011 onwards for all attendant care services reasonably required by the Applicant. This shall be discussed further in my analysis of the attendant care claim.
i. $3,719.06 for the cost of occupational therapy pursuant to a plan dated July 13, 2012 by Julie Fajertag?

j. $3,719.06 for the cost of occupational therapy pursuant to a plan dated December 6, 2012 by Julie Fajertag?

k. $531.00 for the cost of assistive devices pursuant to a plan dated October 18, 2012 by David Surette?

l. $2,050.00 for the cost of massage therapy pursuant to a plan dated October 31, 2012?

m. $1,550.00 for the cost of chiropractic services and massage therapy pursuant to a plan dated March 11, 2013?

4. Is State Farm liable to pay a special award because it unreasonably withheld or delayed payments to Ms. Watters?

5. Is Ms. Watters entitled to interest for the overdue payment of benefits?

6. Is State Farm liable to pay Ms. Watters expenses in respect of the arbitration?

7. Is Ms. Watters liable to pay State Farm's expenses in respect of the arbitration?

Result:

1. Ms. Watters has sustained a catastrophic impairment within the meaning of clause 3(2)(d)(ii) of the Schedule as a result of the accident.

2. Ms. Watters is entitled to attendant care benefits as follows:
   - $4,988.08 per month from October 5, 2011 through March 31, 2012;
   - $3,980.77 per month from April 1, 2012 through August 31, 2013;
   - $1,698.82 per month from September 1, 2013 through August 31, 2014;
   - $2,315.87 per month from September 1, 2014 onwards.
3. Ms. Watters is entitled to receive the following medical/rehabilitation benefits:

- $1,278.01 for out-of-pocket expenses submitted to the Insurer on October 31, 2012 (less any amounts that are related to the Applicant's asthma medication);

- $2,081.51 for out-of-pocket expenses submitted to the Insurer on December 31, 2012 (less any amounts that are related to the Applicant's asthma medication);

- $2,773.22 for the cost of occupational therapy services recommended in a plan dated February 8, 2012 by Julie Fajertag;

- $3,632.57 for the cost of occupational therapy services recommended in a plan dated February 15, 2012 by Julie Fajertag;

- $1,225.50 for the cost of a nutrition assessment pursuant to a plan dated April 24, 2012 by Julie Fajertag;

- $310.00 for the cost of aquafit therapy pursuant to a plan dated July 13, 2012 by Julie Fajertag;

- $2,773.22 for the cost of occupational therapy pursuant to a plan dated July 13, 2012 by Julie Fajertag;

- $3,719.06 for the cost of occupational therapy pursuant to a plan dated December 6, 2012 by Julie Fajertag;

- $531.00 for the cost of an assistive device pursuant to a plan dated October 18, 2012 by David Surette.

4. State Farm is liable to pay a special award because it unreasonably withheld or delayed payments to Ms. Watters. The issue of the quantum of the appropriate special award is deferred.

5. Ms. Watters is entitled to interest for the overdue payment of benefits set out above in accordance with section 51 of the Schedule.

6. The issue of expenses is deferred.
EVIDENCE AND ANALYSIS:

Catastrophic Impairment

Introduction

Ms. Watters claims that, as a result of the accident on September 29, 2011, she sustained a catastrophic impairment within the meaning of clause 3(2)(d)(ii) of the Schedule. To succeed on this issue, Ms. Watters must prove (on a balance of probabilities) that, as a result of the September 29, 2011 accident, she sustained a brain impairment that results in a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale (“GOS”), 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.

With respect to the first part of this test (i.e., proof that the accident caused brain impairment), there is really no dispute. “Impairment” is defined in the Schedule as a “loss or abnormality of a psychological, physiological or anatomical structure or function”. The evidence is clear that, as a result of the September 29, 2011 accident, the Applicant sustained, in addition to other injuries, multiple skull fractures with subdural and subarachnoid bleeding. She sustained traumatic brain injury, including residual encephalomalacia in the inferior right frontal lobe of her brain. I find that the Applicant sustained a brain impairment as a result of the September 29, 2011 accident.

Similarly, I am satisfied that the experts who testified concerning this issue administered the GOS test more than six months after the accident and were trained for that purpose. This does not appear to be in dispute.

The real issue to be determined here is whether that brain impairment resulted in 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.
**Glasgow Outcome Scale**

According to the parties, this is the first case to deal with this issue. Thus, no case law was presented in which clause 3(2)(d)(ii) of the Schedule (or any similar provision) has been interpreted by the courts or an arbitrator at FSCO.

In 1975, two professors from the University of Glasgow, Dr. Bryan Jennett (neurosurgeon) and Dr. Michael Bond (psychiatrist), wrote a paper entitled, “Assessment of Outcome After Severe Brain Damage -- A Practical Scale”. Before analysing the scale suggested by these authors (what is now referred to as the Glasgow Outcome Scale or “GOS”), I think it is important to consider what these authors had to say about the context in which it was created and the perceived need for such a scale.

The article begins with the following summary:

Persisting disability after brain damage usually comprises both mental and physical handicap. The mental component is often the more important in contributing to overall social disability. Lack of an objective scale leads to vague and over-optimistic estimates of outcome, which obscure the ultimate results of early management. A five-point scale is described -- death, persistent vegetative state, severe disability, moderate disability, and good recovery...

The authors go on to explain:

...when the brain is the organ affected, the persisting disability usually comprises both mental and physical handicaps which can seriously impair the quality of life. This makes the assessment of outcome after brain damage a matter of some complexity, calling for the exercise of considerable effort and skill. In practice the state of health of survivors is often described in vague terms which make it difficult to judge what degree of recovery has really occurred.

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The outcome of serious illness concerns not only the patient and his family but therapeutic teams and the whole community. As medicine becomes more expensive, and major illness increasingly the corporate concern of society rather than a private contract between patient and physician, there is growing awareness of the need to assess the results of different types of management. In cases of brain damage, not only is the initial treatment dependent on the use of scarce resources, but the outcome may be permanent disablement which requires continuing social support. If measures of the efficacy of health services are to take account of humanitarian benefits, as well as economic costs and benefits, then some attempt must be made to measure the quality of life.6

Different medical professionals from different disciplines provide treatment to those with brain damage at different stages of recovery and tend to use different measures of success and different terminology to describe outcomes. Thus, Drs. Jennett and Bond concluded that there was a need for a common language to describe outcomes so that various treating health practitioners could compare and evaluate the efficacy of different types of treatment for patients with brain damage. Also, at the time this article was written (1975), many of the existing outcome scales were extremely crude. For example, one scale placed all patients into one of two categories: (1) vegetative existence; or (2) recovery. Doctors Jennett and Bond felt that two- or three-point scales were simply too crude to be helpful and, as a result, suggested a five-point scale instead.

The authors also recognized that the assessment of outcome in brain damage cases is complicated by two additional characteristics: (1) the combination of mental and physical features; and (2) the prolonged time scale during which recovery appears to continue. They write (at p. 481-2):

> The combination of mental and physical handicap not only complicates assessment but also tends to make the total disability greater than the sum of its parts. This seems likely to be due to the interaction between the two components of disability; either the mental or the physical symptoms alone might be well compensated for, but when occurring together the capability of coping with each is reduced. Clinicians are apt to underestimate the mental sequelae in these patients, for one or more reasons. Some such patients are euphoric and make little of their disability, whilst the extent of personality change, the commonest and most disabling sequel, may emerge only when relatives or close associates are

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questioned. Intellectual and cognitive deficits may be overlooked in a brief clinical interview, but may be revealed by formal psychometric testing...

Among a series of adult survivors of severe head injury treated in the acute stage in the department of neurosurgery in Glasgow, we found that most who were disabled had a combination of mental and physical disability; mental disability was usually dominant and was sometimes unaccompanied by neurological signs... Using a scale of social disability, one of us (M.B.) showed that mental symptoms were more closely related to the social outcome than was physical disability. And among mental symptoms it was personality change or cognitive deficits which were the main sources of difficulty, whereas symptoms of mental illness (depression or anxiety) seldom contributed significantly to a patient’s difficulties.

It is in this context that the authors described the five categories of their Glasgow Outcome Scale: (1) death; (2) persistent vegetative state; (3) severe disability; (4) moderate disability; and (5) good recovery.

In this case, the first two categories are not relevant. Obviously the Applicant did not die as a result of her injuries and she is not in a persistently vegetative state. She is claiming that she has sustained a “severe disability” (a score of 3 on the GOS) so I will focus on the definitions of categories 3, 4 and 5 (set out in their entirety, below):

(3) Severe disability (conscious but disabled) -- This is used to describe patients who are dependent for daily support by reason of mental or physical disability, usually a combination of both. Many will be in institutions, but this should not be a criterion, because exceptional family efforts may enable such patients to be looked after at home. It is important to recognise that severe mental disability may occasionally justify this classification in a patient with little or no physical disability.

(4) Moderate disability (disabled but independent) -- Such patients can travel by public transport and can work in a sheltered environment, and are therefore independent in so far as daily life is concerned. The disabilities found include varying degrees of dysphasia, hemiparesis, or ataxia, as well as intellectual and memory deficits and personality change. These may produce considerable family disruption. Notice that independence is of a greater degree than that commonly described by geriatric physicians and others under the title “activities of daily living”, which usually refer only to ability to maintain self-care within the patient’s room or house; those able to do only that would be judged as severely disabled on the present scale.
(5) Good recovery -- This implies resumption of normal life even though there may be minor neurological and psychological deficits. Return to work is regarded as an unrealistic index of recovery, because it may lead to false impressions in either direction. Local socioeconomic circumstances may make it difficult for anyone who has been seriously ill to return to work, even though fully recovered. On the other hand, some patients with considerable disability may be fully employed, either because their work is compatible with their particular disability, or because their employers are showing generosity by providing what really represents sheltered employment. Other aspects of social outcome should be included in the assessment, such as leisure activities and family relationships.

**Expert Opinions**

The Insurer relies upon the opinions of Dr. David Kurzman and of Dr. Garry Moddel.

Dr. Kurzman (neuropsychologist) and Dr. Lubinsky (psychologist) assessed the Applicant in February 2012 and then again in February 2013. These assessors were chosen by the Applicant (i.e., these were not insurer’s examinations) but these were not assessments for the purpose of determining whether the Applicant sustained a catastrophic impairment. The overall opinion of Dr. Kurzman was that Ms. Watters’ difficulties in the areas of headaches, fatigue, cognitive impairment, and mood symptoms (i.e., irritability, poor frustration tolerance, sadness) are suggestive of a Persistent Post-Concussion Syndrome and that she likely meets the diagnostic criteria for a Chronic Adjustment Disorder Unspecified, with irritable mood. He noted that this was a serious accident with significant and documented neurological sequelae and that the Applicant’s premorbid history of being a victim of abuse (as a youth) undoubtedly “placed her at increased risk for developing emotional/psychological sequela following the onset of any additional stressor” (which includes this motor vehicle accident).

With respect to her GOS score, however, Dr. Kurzman concluded that the Applicant did not (as of February 2013) meet the criteria for a “severe disability” score. Dr. Kurzman explained this conclusion as follows:

Ms. Watters manages her own medications independently and she has been able to resume engaging in light household chores being limited from heavier chores because of dizziness and bodily pain. She is also able to assist with meal
preparation (although she does not use the stove on her own as there was one recent reported instance where she almost burned herself). She is independent for her self-care activities including dressing, bathing, and grooming. She currently spends most of the day at home and on her own and is able to manage her hygiene and dressing activities, basic meal preparations, and basic household tasks. Her level of socialization is reduced; however, this was attributed to a deterioration in relationships with co-workers with whom she primarily socialized secondary to being unable to return to work. In fact, Ms. Watters expressed a desire to socialize more often than she does at present. Thus, it is our opinion that Ms. Watters does not meet the criteria for Catastrophic Impairment based on her GOS.7

Neither Dr. Kurzman nor Dr. Lubinsky testified at this proceeding.

The opinion of Dr. Moddel (a neurologist) on this issue (as of May 2013), as contained in the Insurer’s initial Catastrophic Impairment Evaluation, consists of twelve words, “At this time, her Glasgow Outcome Scale was neither severe nor vegetative.” His report contains no explanation for this conclusion. Dr. Moddel testified at this hearing and had the opportunity to provide an explanation.

Dr. Moddel sees the GOS as being exclusively a neurological test, best understood and applied by neurologists and neurosurgeons. He is also of the opinion that the only evidence that should be considered in assigning a GOS score is objective results from formal neurological testing. Given this approach, not surprisingly, Dr. Moddel focused primarily on his own neurological assessment of the Applicant and upon previous neurological assessments of the Applicant and he paid little attention to the other medical documentation provided to him. Dr. Moddel points out that on formal testing, other than a decreased sense of smell, the Applicant has consistently demonstrated few, if any, neurological deficits. Finally, since the “severe disability” category is just below “persistent vegetative state”, it suggests to him that to qualify as having a “severe disability”, a person must demonstrate significant disability, characterized by such features as:

- significant difficulty communicating
- difficulty eating
- partial paralysis requiring assistance with transferring, walking, toileting, etc.

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significant dementia (affecting the ability to make rational decisions)

Dr. Moddel met with the Applicant for about 45 minutes and administered a mini-mental status test (to look for signs of dementia) and asked the Applicant to draw a clock (which, according to Dr. Moddel, is a task with which people may have difficulty if they have impaired executive functioning). The results of these tests were within the normal range. Dr. Moddel concluded that, if the only neurological deficit demonstrated by the Applicant is some loss of the sense of smell, this cannot possibly meet the definition of “severe disability” on the GOS.

The Applicant relies upon the opinion of Dr. Chantal Vaidyanath. Dr. Vaidyanath is a physiatrist with expertise in physical medicine and rehabilitation. She has experience in brain injury rehabilitation. Her medical career has been both clinical and academic in nature and, until recently, she was involved in teaching and research at the University of Toronto. She testified that she is familiar with the GOS as it is used more in research than in clinical practice. Dr. Vaidyanath was also able to provide considerable insight into how the GOS has been used and interpreted since the article of Drs. Jennett and Bond was first published in 1975.

According to Dr. Vaidyanath, the GOS has not always been interpreted and used consistently by different medical practitioners. Whether this might reflect systemic bias that might exist within certain medical communities or areas of specialization or might be due to differences in methodology and the lack of a prescribed protocol, GOS scores for the same patient could vary significantly depending upon who was doing the assessment. To address these issues and attempt to clarify the definitions and criteria for the five points on this scale, the original authors of the 1975 paper, together with two colleagues from the University of Glasgow, wrote a follow-up article in 1981.8

In the 1981 article, Dr. Jennett et al. provided the following definitions:

(3) Severe disability: This indicates that a patient is conscious but needs the assistance of another person for some activity of daily living every day. This may range from continuous total dependency (for feeding and washing) to the

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need for assistance with only one activity -- such as dressing, getting out of bed or moving about the house, or going outside to shop. More often dependency is due to a combination of physical and mental disability -- because when physical disability is severe after head injury there is almost always considerable mental deficit. But a few patients who have little or no physical deficit are unable to organise their day-to-day lives effectively, and must be classified as severely disabled. The worst of these requires the care and protection which only a mental hospital can provide, while others cope at home with the support of attentive relatives, but could not be left overnight because they would be unable to plan their meals or to deal with callers, or any domestic crisis which might arise. The severely disabled are described by the phrase “conscious but dependent”.

(4) Moderate disability: These patients may be summarised as “independent but disabled,” but it is perhaps the least easily described category of survivor. Such a patient is able to look after himself at home, to get out and about to the shops and to travel by public transport. However, some previous activities, either at work or in social life, are now no longer possible by reason of either physical or mental deficit. Some patients in this category are able to return to certain kinds of work, even to their own job, if this happens not to involve a high level of performance in the area of their major deficit.9

According to the 1981 article, in a study involving 150 brain-injured patients, about two-thirds had a marked personality change, with little or no cognitive deficit. According to this study, marked neurological deficit was found to be relatively uncommon, even for those who sustained severe brain damage (more than six hours in coma). Personality change, on the other hand, was determined to be the most consistent finding; the authors note that personality change can constitute an appreciable deficit even in patients without significant cognitive or physical sequelae. The authors also conclude that mental deficits contribute more significantly to social disability than do persisting neurological signs and contribute more to the burden reported by caring relatives than do physical handicap.10

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The study also revealed that interviewing relatives and others close to the patient often yielded useful information about behavioural, emotional and cognitive changes that might not be captured through formal testing:

The Glasgow Outcome Scale ... allows the overall social outcome of most patients to be assessed reliably on the basis of a structured interview which concentrates on social and personal functioning, without the need for detailed neurological and psychological evaluation.\textsuperscript{11}

In 1998, other professors from the University of Glasgow and the University of Stirling developed standardized structured interview questionnaires to promote consistency in methodology amongst practitioners attempting to determine a score under the GOS (or the Extended GOS).\textsuperscript{12} The structured interview requires the assessor to interview the patient as well as family members or other close associates in order to ascertain the extent of disruption to the patient’s relationship with family and friends and to determine the patient’s ability to independently:

- perform activities of daily living within the home;
- travel;
- shop and carry on business transactions outside the home;
- work; and
- return to weekly participation in usual pre-accident social and leisure activities outside of the home.

The structured interview provides a standardized methodology for gathering the necessary information and for converting that information into a GOS score.

Dr. Vaidyanath acknowledges that, when assessing a person and assigning a GOS score, it is not strictly required that one consider the 1981 article (in which the creators of the GOS expand


upon and elucidate their 1975 article). She also acknowledges that nowhere in the Schedule does it require a person who is determining a GOS score to utilize the structured interviews referenced in the 1998 article. She suggests, however, that knowledge of this literature, developments in this field since 1975 and current best practices ought to at least inform one’s interpretation of the Glasgow Outcome Scale. She was, therefore, critical of Dr. Moddel’s methodology and his conclusion.

Other insurer assessors also found that the Applicant’s true level of disability as a result of her brain and other impairments was not accurately captured by focusing exclusively on the failure of formal testing to reveal evidence of neurological deficits.

Dr. Ellen Margolese (a psychiatrist who examined the Applicant in late 2013 at the request of State Farm to assess her claim to post-104-week income replacement benefits) found that the Applicant had greatly impaired cognitive function, despite the lack of abnormal results on formal neurological testing. She found that the Applicant cannot function independently, cannot multi-task and that she needs constant cueing, assistance and support. She also found that the Applicant cannot navigate independently in the community. Dr. Margolese suggested that for a person like the Applicant (i.e., a person who sustained a closed-head injury), neuropsychological testing would likely reveal a more accurate picture of the level of impairment than neurological testing.

The Insurer then had the Applicant examined by another psychiatrist of its choice, Dr. Rosenblat, as well as a neuropsychologist, Dr. Zakzanis, as part of its continuing catastrphic impairment assessment. Despite these assessments being part of the Insurer’s investigation into whether the Applicant had sustained a catastrophic impairment, neither Dr. Rosenblat nor Dr. Zakzanis comment upon the Applicant’s GOS score or upon the opinion of Dr. Moddel with respect to that issue.

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13 Some of the insurer’s “CAT” assessments were conducted earlier but the assessments by Dr. Rosenblat and Dr. Zakzanis had to wait until two years had elapsed since the accident.
Dr. Rosenblat did find that the Applicant had a major neurocognitive impairment which is likely multifactorial in origin and due to a combination of issues including traumatic brain injury, chronic pain, headache, fatigue and mood disorder.

Dr. Zakzanis agreed with Dr. Margolese that neuropsychological testing would be more appropriate in this case than neurological testing as a neuropsychological assessment evaluates the impact of a brain injury and/or psychological symptomatology and other factors on an individual’s cognitive functioning, with particular reference to the extent to which daily functioning has been interrupted. Dr. Zakzanis explained that the difference between formal test results and reported levels of function may “reflect both the transitory nature of Ms. Watters’ cognitive impairment and the manifestation of executive dysfunction in her real world outside of an examiner directed, distraction free and controlled office setting…”

Unlike Dr. Moddel, Dr. Zakzanis also conducted a collateral interview of the Applicant’s spouse. Based upon all of the information he gathered, Dr. Zakzanis concluded that:

- Ms. Watters’ level of cognitive functioning was abruptly and continuously altered following the unequivocal moderate traumatic brain injury she sustained as a direct result of the subject motor vehicle accident;

- the September 29, 2011 accident is at least materially related to her present cognitive difficulties and is therefore one causative factor;

- the Applicant requires constant reminders concerning her medication;

- she rarely leaves the home to socialize;

- she is not independent and requires assistance with public transportation, shopping, cooking, housework and finances;

- in general, as a result of her neurocognitive impairment (and not depression), she requires direction and supervision of daily living activities and cannot function independently.
State Farm did not request Dr. Moddel to provide a follow-up report or comment on the opinions of Dr. Vaidyanath, Dr. Margolese, Dr. Rosenblat or Dr. Zakzanis.

When he testified, Dr. Moddel said that none of this would have changed his opinion because he still believes that the GOS score ought to be based solely on the results of formal neurological testing. To the extent that multiple factors (physical, neurological, mental, psychological, etc.) may all contribute to the Applicant’s reported functional limitations, Dr. Moddel stated that he believes that the “Whole Person Impairment” test for catastrophic impairment would be the more appropriate test to use since, in his opinion, the GOS score is strictly meant to be a measure of neurological deficits that result from brain impairment.

Unlike Dr. Moddel, Dr. Vaidyanath had the benefit of being able to review the reports of Dr. Margolese, Dr. Rosenblat and Dr. Zakzanis (in addition to all of the other medical documentation listed in the index to the CAT report from Omega Medical Associates). She also had the benefit of being able to conduct a structured collateral interview of Ms. Watters’ husband, Derek. Finally, she had the benefit of being able to review the report of occupational therapist Erin Sesel.

Erin Sesel conducted a thorough (4 hour) in-home assessment of the Applicant in May 2014, specifically for the purpose of determining her GOS score. She finds that, as of May 2014, as a result of a combination of physical, emotional and cognitive difficulties, the Applicant, “has not been able to resume many of her former life roles and duties and she continues to require regular supervision and support, which in turn, would prevent her from living independently.”

Due to this lack of independence, she concludes that the Applicant’s GOS score is 3 (severe disability).

Dr. Vaidyanath considered all of the information available. Based upon the Applicant’s lack of independence and need for daily assistance with some activities of daily living, Dr. Vaidyanath concluded that, as a result of the September 29, 2011 accident, the Applicant sustained a brain impairment that resulted in a score of 3 (severe disability) on the Glasgow Outcome Scale, as

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**Analysis**

Based upon my review of the relevant literature and having considered the testimony of both Dr. Vaidyanath and Dr. Moddel concerning this issue, I prefer the approach taken by Dr. Vaidyanath, which I find to be more reasonable and more consistent with the intent and spirit of both the Glasgow Outcome Scale and the *Schedule*.

In the 1975 article referenced in clause 3(2)(d)(ii) of the *Schedule*, the authors make it clear that the goal of the GOS is to accurately reflect a brain-injured person’s level of function in the real world, after the person has had some time to recover from the original trauma. The authors recognize that many people with traumatic brain injuries will often sustain neurological as well as other physical and psychological impairments.

They also found that a patient who has suffered brain damage “often lacks insight and may even deny disability, especially in the mental sphere”.\(^\text{15}\) That is why, in their subsequent papers, they warn practitioners about the shortcomings of a brief clinical interview with just the patient (who may have poor insight into his/her own limitations) and recommend conducting collateral interviews (with close family members, etc.) in order to get a better idea of the patient’s impairments, including cognitive and personality/behavioural changes that are often missed by speaking only to the patient.

The GOS was designed to provide a standardized description of a person’s level of recovery after some time has elapsed since the trauma occurred (typically 6 to 12 months). That description is to be based upon the person’s actual functional abilities, taking into consideration all impairments (although, typically, cognitive, mental and behavioural impairments tend to dominate over physical impairments). The creators of the GOS state that the assessor, in

\(^{15}\)Jennett, B. and Bond M., *Assessment of Outcome After Severe Brain Damage*, The Lancet, March 1, 1975, pp. 480-484 at 482.
attempting to determine the appropriate score on the GOS, should focus on the extent to which
the person who sustained a brain injury has been able to return to their usual pre-accident
activities, with special emphasis on the person’s level of independence, inside and outside of the
home. The authors found that personality changes were the most common and most disabling
sequelae of a brain injury. It is obvious from the 1975 article that such changes to the
personality or behaviour of a brain-injury victim ought not to be ignored when determining the
appropriate score under the GOS.

Dr. Moddel admitted on cross-examination that, at the time he formed his opinion concerning the
Applicant’s GOS score, he had not recently reviewed the 1975 article and he was unfamiliar with
the 1981 article or the standardized structured interview questionnaires referenced in the 1998
article. He refused to consider or give any weight to reports (that were provided to him) by
occupational therapists and others who observed the Applicant in real-world settings and that
contained relevant information concerning the Applicant’s level of function and independence
with respect to various activities of daily living, inside and outside of her home. He also failed to
conduct collateral interviews of the Applicant’s husband or other close associates that might shed
light on personality, behavioural and cognitive changes of the Applicant as well as information
about her daily activities and level of independence.

Dr. Moddel focused exclusively on neurological test results (his and earlier neurological test
results referenced in the documents provided to him) and his observations and communications
with the Applicant during his assessment of her. This is because Dr. Moddel, incorrectly, sees
the GOS as simply a measure of the severity of any neurological deficits caused by brain
impairment. Since he found virtually no neurological deficits (other than an impaired sense of
smell), he concluded that the Applicant had not sustained a “severe disability” under the GOS
and felt that no further explanation was needed. I find this interpretation and application of the
GOS to be far too simplistic and I reject it.

I also reject Dr. Moddel’s suggestion that such a narrow interpretation of the GOS is appropriate
because brain-injured persons with multi-factorial impairments can always fall back on the “55%
whole person impairment test” (what is now clause 3(2)(e) of the Schedule). Dr. Moddel seems
to suggest that there can be no overlap between the various tests for catastrophic impairment. A similar argument was previously advanced with respect to the whole person impairment test. It was argued that since there was another category (what is now clause 3(2)(f) of the Schedule) that dealt with mental and behavioural impairment, such impairments ought not to be included in the rating of whole person impairment. This idea (that there can be no overlap) has been rejected both by FSCO and by the Ontario Court of Appeal.\footnote{16}{For example, Kusnierz v. Economical Mutual Insurance Company, 108 O.R. (3d) 272 (C.A.).}

In my view, the common purpose behind the various tests for determination of catastrophic impairment is to identify those persons who have been involved in a motor vehicle accident and who are likely to require substantially more assistance (or assistance for a longer period of time) than is available under the Schedule for non-catastrophic cases. It is unrealistic to expect that there will not be some overlap between tests for catastrophic impairment since different impairments tend to interact with each other and magnify the overall level of a person’s impairment.\footnote{17}{Jennett, B. and Bond, M., Assessment of Outcome After Severe Brain Damage, The Lancet, March 1, 1975, pp. 480-484 at 481-482.}

For these reasons, I cannot accept either the approach or the conclusion of Dr. Moddel. The question remains, “What GOS score is appropriate for the Applicant?”

The creators of the GOS recognized that some of the categories they created would “include patients with a range of different degrees of disability”.\footnote{18}{Jennett, B. and Bond M., Assessment of Outcome After Severe Brain Damage, The Lancet, March 1, 1975, pp. 480-484 at 482.} “Severe disability” is a broad category, covering persons with impairments ranging from just slightly better than catatonic to just slightly worse than a “moderate disability”. Similarly, “moderate disability” is also a very broad category covering persons who range in ability from those who are slightly more functional than those labelled “severely disabled” to those who are effectively fully recovered. There are going to be cases, like this one, where a brain-injured person may fall on the GOS somewhere near the boundary between “severe” and “moderate” disability.
The primary distinction on the GOS between severe and moderate disability appears to be the level of independence achieved by the brain-injured person by the time of the assessment: independence in activities of daily living; independence in mobility within and outside of the home; independence in organizing, initiating and completing daily activities; independence in initiating and responding to opportunities for social interaction; and, independence in returning to work and participating in the person’s usual, pre-accident leisure activities.

Dr. Kurzman and Dr. Lubinsky adopted an approach to the GOS that is similar to that recommended by Dr. Vaidyanath. In deciding whether the Applicant fell within the “severe disability” category, they focused on her level of independence inside and outside of the home. This was appropriate. They relied upon what the Applicant and her husband reported that the Applicant was able to do independently: prepare coffee; manage her own medications, assist with meal preparation, watch television; shower; dress; and exercise. For some reason, they concluded that the Applicant was at home, alone, for most of every day. The Applicant also apparently reported that she did not need or want much assistance. Based upon the information they had available, their conclusion that she did not reach the level of a severe disability is understandable.

Nevertheless, I give greater weight to the opinion of Dr. Vaidyanath for the reasons that follow.

First, Dr. Vaidyanath had the benefit of reviewing several reports that were written after the February 2013 report of Drs. Kurzman and Lubinsky. Many of these subsequent reports\textsuperscript{19} comment on the Applicant’s lack of independence, her inability to return to her usual pre-accident activities as a result of her brain injury and her need for daily assistance (with public transportation, shopping, cooking, housework and finances).

Second, while Dr. Lubinsky interviewed the Applicant’s husband, it is unclear what methodology, if any, she employed. There is no suggestion in the report itself that the

\textsuperscript{19} Including the Insurer’s psychological report of Dr. Margolese dated October 3, 2013, the follow-up neurological report of Dr. Gladstone dated November 26, 2013, the attendant care and future care needs analysis of occupational therapist Bonnie Koreen dated December 30, 2013, the Insurer’s assessments in January 2014 by Dr. Zakzanis (neuropsychologist) and Dr. Rosenblatt (psychiatrist) and the in-home occupational therapy report of Erin Sesel from 2014.
recommended structured interview was employed. Therefore, it is unclear what questions were asked or what methodology was used to convert the answers obtained into a GOS score.

Third, the information provided to Dr. Lubinsky by the Applicant appears to have created a false impression that she was more independent than was, in fact, the case. From my review of the report of Drs. Kurzman and Lubinsky, I believe that they did not appreciate the true level of the Applicant’s dependence. For instance, from their report, they seem unaware that:

1. the Applicant’s family members adjusted their schedules to ensure that the Applicant was rarely home alone for longer than a few hours;

2. the Applicant required constant cuing to initiate and remain on task and her husband and daughter were communicating with her (by telephone and text messages) throughout the day (up to 20 times per hour) whenever they were not physically present to assist her;

3. the Applicant’s husband assisted her in managing her medications throughout the day and she was not doing this independently;

4. she has had several mishaps where she has burned food and her clothing while attempting to assist her husband in meal preparation; and

5. all of the evidence demonstrates that the Applicant is incapable of using public transportation independently or shopping independently.

Finally, I had the benefit of hearing Dr. Vaidyanath testify about her opinions during the course of this proceeding. Her evidence was tested through cross-examination. I did not have a similar opportunity to hear from Dr. Kurzman or Dr. Lubinsky.

As will be further described in the next section on attendant care, the evidence clearly shows that while the Applicant has made some gains since the accident, she still requires a substantial amount of attendant care and requires daily assistance. While she can be left alone in her home for several hours without undue risk of harm, she is not truly independent either inside or outside of her home.
She requires constant monitoring and cueing to ensure that she is eating properly, changing into clean clothes, properly caring for her dog and taking the right medication at the right time. She only occasionally leaves her home, usually to attend medical appointments, engage in physical rehabilitation (such as swimming and aqua fitness) or go shopping. When she leaves the home, she is almost always accompanied by a family member or other attendant. Based upon the overwhelming weight of the evidence presented, I am satisfied that she cannot independently use public transportation or go shopping. There have been times when the Applicant has been unable to remember where she is going or why and when she has been unable to follow a shopping list, even if she helped to prepare it. Past incidents described by Derek Watters demonstrate that the Applicant can become confused and overwhelmed when out in the community and that she needs to have an attendant with her when she leaves her home. In short, the Applicant is dependent upon daily support. This ongoing need for daily support is, in large part, due to the brain impairment she sustained as a result of the September 29, 2011 accident.

**Conclusion -- Catastrophic Impairment**

For all of the foregoing reasons, I find that, as a result of the September 29, 2011 accident, the Applicant sustained a brain impairment that has resulted in a score of 3 (severe disability) on the Glasgow Outcome Scale (“GOS”), 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. I therefore find that Ms. Watters has sustained a catastrophic impairment within the meaning of clause 3(2)(d)(ii) of the *Schedule* as a result of the accident of September 29, 2011.

**Attendant Care**

**The Law**

Pursuant to section 19 of the *Schedule*, attendant care benefits shall pay for all reasonable and necessary expenses that are incurred by or on behalf of an insured person as a result of an accident for services provided by an aide or attendant. The amount of a monthly attendant care
benefit is determined in accordance with a duly completed “Assessment of Attendant Care Needs” (Form 1). For a person who has not sustained a catastrophic impairment (and who has not purchased optional benefits), the maximum amount payable is $3,000 per month (up to an aggregate total of $36,000) and no attendant care benefits are payable more than 104 weeks after the accident. For a person who has sustained a catastrophic impairment, the maximum amount payable is $6,000 per month (up to an aggregate total of $1,000,000) and the 104-week time limit does not apply (s. 20 of the Schedule).

By the definitions set out in paragraph 3(7)(e) of the Schedule, an aide or attendant for a person includes a family member (or friend) who acts as the insured person’s aide or attendant, even if the family member (or friend) does not possess any special qualifications. However, for the expense to be considered to have been incurred, where the aide or attendant does not provide attendant care in the course of their usual employment, occupation or profession, it must be proven that the person who provided the goods or services has sustained an economic loss as a result of providing the goods or services to the insured person.

**Amount Claimed**

The claim for attendant care benefits, as originally framed by the Applicant, was as follows:

Is Ms. Watters entitled to attendant care benefits at the rate of $4,988.08 per month from September 29, 2011 to date and ongoing for the services provided by the Applicant’s spouse, Derek Gordon Watters?

On the last day of this hearing, in closing arguments, counsel for the Applicant sought to amend this claim by seeking $6,000.00 per month in attendant care benefits from September 29, 2011 onwards. While I agree with the Applicant’s position that an arbitrator retains the power to award whatever amount of attendant care is reasonable and necessary (based upon the proven facts and calculated in accordance with the Form 1), I will not permit the requested amendment to this claim in this case for three reasons. First, it was completely unfair to the Insurer for Applicant’s counsel to attempt to amend this claim at the conclusion of the hearing. Second, with respect to past attendant care expenses, there is no evidence that the Applicant **incurred** any expense greater than that claimed in the Expense Forms she signed and submitted to the
Insurer.\textsuperscript{20} Third, even if I were to permit this amendment, as I will discuss later, it would have no practical effect since I am not satisfied on the evidence before me that such a level of attendant care is reasonable and necessary.

\textbf{Form 1’s}

There have been five formal assessments of the Applicant’s need for attendant care that have resulted in the completion of a Form 1. They are listed in the chart below.

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<tr>
<th>Date</th>
<th>Prepared By</th>
<th>Prepared For</th>
<th>Monthly Amount</th>
</tr>
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<tbody>
<tr>
<td>November 1, 2011</td>
<td>Julie Fajertag, OT</td>
<td>Applicant</td>
<td>$4,988.08</td>
</tr>
<tr>
<td>March 5, 2012</td>
<td>Julie Fajertag, OT</td>
<td>Applicant</td>
<td>$4,597.82</td>
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<tr>
<td>April 24, 2012</td>
<td>Nancy Lok, OT</td>
<td>Insurer</td>
<td>$493.27</td>
</tr>
<tr>
<td>August 9, 2013</td>
<td>Nancy Lok, OT</td>
<td>Insurer</td>
<td>$97.33</td>
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<tr>
<td>October 9, 2013</td>
<td>Bonnie Koreen, OT</td>
<td>Applicant</td>
<td>$2,315.87</td>
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</tbody>
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None of these occupational therapists testified at this proceeding. I must therefore rely upon the Form 1’s and reports that they prepared and consider those documents in light of all of the other evidence tendered in this proceeding.

\textbf{Denial of the Claims for Attendant Care}

The accident occurred on September 29, 2011. Within one month, the Insurer issued a letter and Form OCF-9 (Explanation of Benefits Payable) indicating that no attendant care would be paid to the Applicant because she had sustained only a “minor injury” (within the meaning of the Minor Injury Guideline).

\textsuperscript{20}Pursuant to subparagraph 3(7)(e)(ii) of the Schedule, as part of proving that an expense has been “incurred”, an insured person must prove that she has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense.
On November 1, 2011, the first Form 1 for attendant care was submitted to State Farm along with a report by the occupational therapist, Julie Fajertag, explaining the Applicant’s need for monthly attendant care in the amount of $4,988.08. On November 2, 2011, the Applicant’s lawyer wrote to State Farm pointing out that the Applicant had sustained multiple skull fractures and a brain injury and asking how that could possibly fall within the Minor Injury Guideline (“MIG”).

On November 4, 2011, State Farm issued a new OCF-9 in which it seems to have retreated from its original position (re the MIG) but now indicated that attendant care expenses would not be paid unless there was proof that such expenses had been incurred. State Farm also asked the Applicant to identify who was providing the attendant care services since the Expense Forms (OCF-6) did not provide this information (they only refer to an “assistant”). State Farm continued to request the name of the service provider(s) and proof of economic loss from November 2011 through April 2013.

State Farm wrote to the Applicant on September 11, 2012 to advise that, based upon the various Form 1’s and expense forms submitted to it, upon being provided with confirmation of the identity of the service provider and proof of economic loss, State Farm would pay the Applicant attendant care benefits as follows:

1. For the period from September 29, 2011 to June 4, 2012, the non-catastrophic maximum amount of $3,000.00 per month;

2. For the period from June 5, 2012 to August 31, 2012, $493.27 per month, in accordance with the Form 1 from Nancy Lok dated April 24, 2012.

Presumably, State Farm intended to continue to pay incurred attendant care expenses at the rate of $493.27 per month until a new Form 1 was completed or until 104 weeks had elapsed since the accident.

The Applicant’s lawyer wrote to State Farm in May 2013 to advise that it was the Applicant’s husband, Derek, who was providing the attendant care services. Enclosed was also a letter from
Derek Watters’ employer who estimated his loss of income (as a result of reduced hours) at between $2,300 and $2,500 from December 2012 to April 2013. State Farm was not satisfied with this information (as it only related to a limited period of time and did not include pay stubs from before and after the accident).

In August 2013, State Farm was provided with pay records from Derek Watters’ employer from August 2011 to August 2012. State Farm responded that it wanted all pay records for 2010 and 2011 and Mr. Watters’ income tax returns for 2009, 2010 and 2011.

In February 2014, State Farm was provided with the income tax returns for Derek Watters from 2009 through 2012. In April 2014, State Farm was provided with the additional pay stubs it had requested and other proof of economic loss. Yet, as of the last day of the hearing of this matter, State Farm had still paid no attendant care benefits whatsoever to Ms. Watters.

To summarize, from November 2011 through September 2013, State Farm refused to pay any attendant care benefits because it was taking the position that it had not been provided with adequate evidence as to who was providing the attendant care services and evidence that that person had sustained economic loss as a result of providing those services. State Farm also refused to pay any attendant care benefits related to any services provided after September 2013 (i.e., more than 104 weeks after the accident) because it was taking the position that the Applicant had not sustained a catastrophic impairment as a result of the accident.

**Economic Loss**

By the end of this hearing, the Insurer conceded that the Applicant had proven that Mr. Watters was providing attendant care services to his wife and that, in each month since the accident, he had sustained an economic loss in order to provide those services to her. In any event, I find that this was proven, on a balance of probabilities, by the uncontroverted evidence of Derek Watters, his employers, his pay records and his income tax returns. Mr. Watters modified and reduced his hours of work so that Ms. Watters would be alone as little as possible. In late 2014, he further reduced his days of work (from 3-4 days per week to 1-2 days per week) in order to be at home
more to assist his wife. Based upon the evidence presented in this hearing, I find that the Applicant has proven that in each month since the accident, Derek Watters sustained an economic loss in order to provide attendant care services to the Applicant.

**Nature of Attendant Care Services Provided**

I think that it is important to note, at this stage, that the Applicant, her husband (Derek) and her daughter (Emily) were all very credible witnesses. They all attempted to give honest and straightforward answers to the questions that were put to them, to the best of their recollection. Both Derek and Emily Watters have described in clear and convincing detail how the accident has changed the Applicant and impaired her ability to function independently. The testimony of the Applicant and the members of her family during the hearing was consistent with what they are reported to have told assessors over the last few years. The testimony of each of them withstood cross-examination and was often corroborated by documentary evidence. I have no hesitation in relying upon their testimony.

The impairments/injuries that the Applicant sustained as a result of the September 29, 2011 accident include the following:

- multiple intracranial injuries
- traumatic subarachnoid hemorrhage
- fracture of base of skull, closed
- potential left subdural, subarachnoid blood
- complex base of skull fracture, extending through the occipital bone on the left with pneumocephaly through the mastoid air cells, sphenoid sinus, and the clivus
- fracture through the left maxillary sinus
- hemorrhagic contusion involving the basal right frontal lobe
- trace subarachnoid blood at the vertex
- nondepressed fracture involving the left occipital bone

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21 and I acknowledge that there may be some duplication within this list.
nondisplaced fractured clivus with extension into the left sphenoid sinus filled with blood
oblique fracture involving the left temporal mastoid bone which involved the temporomandibular joint with blood in the left middle ear and mastoid air cells
left maxillary sinus that appeared to be filled with blood with medial wall fracture
soft tissue swelling on the left scalp
amnesia
chronic headaches
sprains, strains and contusions
postconcussion syndrome
adjustment disorder with irritable mood

One of the more troubling impairments experienced by the Applicant following the accident was vertigo (a sense that the room was spinning). The episodes of vertigo were very severe and made it unpredictable as to whether the Applicant could safely and reliably walk from one point to another for either routine activities (such as going to the bathroom) or in response to an emergency (especially at night, when she would have to rouse herself from sleep and then quickly move from a horizontal to a vertical position). As a result of vertigo, the Applicant has fallen numerous times (but only required medical attention as a result of one such fall -- in March 2013).

Numerous assessors of the Applicant have also noted difficulties with attention, memory, headaches, mental fatigue and mood (irritability). She has difficulty initiating action and remaining focused on the task at hand (especially in the presence of distractions). She was also having difficulty coping with her chronic pain and keeping track of all of her medications.

For the first week after the accident, due to her serious injuries, the Applicant was in hospital. Derek was absent from work that week in order to be with his wife in the hospital as much as possible.\textsuperscript{22} Derek felt he needed to be in the hospital because the Applicant was combative and

\textsuperscript{22}Derek sustained no economic loss during this week, however, as his employer paid him up to October 2, 2011 even though he was absent for part of that time.
non-compliant with hospital staff. She would, however, listen to Derek. He would assist her in
going to and from the bathroom, in showering and in feeding.

Against the advice of her treating doctors, the Applicant insisted on being discharged and she returned home on October 5, 2011. She was given medication for pain and for constipation.

Emily has assisted her mother primarily by providing emotional support -- being home as much as possible to keep her mother company and to ensure her comfort and safety. When away from home, Emily would also frequently communicate with her mother through text messages in order to provide support and cueing. Emily, however, was a full-time student and there is no evidence that she sustained any economic loss as a result of assisting her mother. Therefore, to the extent that she provided some attendant care services, there is no evidence that the Applicant incurred any expenses with respect to those services and there is no obligation on the Insurer to pay for such services.

In any event, the bulk of the attendant care responsibilities have fallen on Derek.

Derek changed his hours at work in order to be available to assist the Applicant as much as possible. As the sole income earner after the accident, he could not stop working altogether or the family would risk, amongst other things, losing their home. He reduced his hours of work and, with the co-operation of his employer(s), arranged those hours of work so that he would be working mostly on days when the Applicant would be away at therapy or when he knew his children would be at home to assist the Applicant (such as on weekends). In this way, Derek tried to ensure that the Applicant would rarely be left alone for more than a few hours at a time and he could maximize his time with her. However, even when not physically present with the Applicant, Derek was in contact with her (primary through frequent text messaging) and was providing supervision, guidance and support throughout the day, even while he was at work. While such “remote” attendant care services would not be appropriate in all cases (especially where an insured person is likely to be unsafe if left alone), it seems to have been a practical and
effective (even if not ideal) method of providing some of the necessary attendant care services in this case.\textsuperscript{23}

Although the Applicant’s need for physical assistance has greatly diminished over time, her need for basic supervision (cueing, guidance and support) has remained relatively constant. In the next section, I shall analyze the amount of attendant care reasonably required by the Applicant since the accident.

\textbf{Amount of Attendant Care Reasonably Required}

Virtually every assessor (including those retained by the Insurer) who has considered the Applicant’s functional abilities has confirmed her need for some type of attendant care -- that is, her need for daily assistance with activities of daily living and her inability to function independently due to a combination of physical, cognitive and psychological/behavioural impairments. Many of these opinions have already been referenced in the previous section of this decision dealing with the determination of whether the Applicant sustained a catastrophic impairment as a result of the September 29, 2011 accident.

The primary source of disagreement appears to be not whether the Applicant requires attendant care but, rather, the amount of attendant care she reasonably requires. The Insurer conceded that, pursuant to the Ontario Court of Appeal’s decision in \textit{Henry v. Gore},\textsuperscript{24} the Applicant is entitled to the amount of attendant care that was reasonable and necessary and is not restricted to claiming only an amount equal to the economic loss sustained by Derek Watters as a result of providing those services.

As the Applicant’s impairments have changed over time, so too has her need for attendant care. I will therefore consider her needs over four separate periods (described below). In setting the start and end dates for each of these periods, I have attempted to reflect when there was a

\textsuperscript{23}The idea of “indirect” or “remote” attendant care was also approved of by a judge of the Ontario Superior Court of Justice in \textit{Shawnoo v. Certas Direct Insurance Company}, 2014 ONSC 7014 (CanLII) at paras. 65-81.

material change in the circumstances of the Applicant (in terms of her need for attendant care) as well as when new attendant care assessments were conducted, while striving to keep the time periods as simple as possible.

(a) October 2011 to March 2012

During the first six months following the accident, the Applicant required much assistance. She needed help with walking, toileting, bathing, grooming and so on. She also required help with meal preparation, hygiene and needed basic supervision to remind her to eat, to take her medication and to attend her medical appointments.

Derek would assist the Applicant with all of these tasks. He would help her bathe/shower and clean up afterwards. He would help support her when she needed to walk from one part of the house to another (especially when she needed to go to the bathroom). He would do all meal preparation. He would ensure her safety and comfort and change the linens in the bedroom. He would assist her with her exercises and in the use of the TENS machine. He would also provide support, monitoring and cueing through telephone calls and text messages when he was not at home.

This is all appropriately reflected in the Form 1 from Julie Fajertag dated November 1, 2011 and the accompanying report dated November 7, 2011. She recommends total monthly attendant care benefits in the amount of $4,988.08. Of this total, reasonable amounts have been attributed to providing assistance through such services as: meal preparation (90 minutes each day); assistance with mobility; monitoring medication intake and effect; and assistance with bathing and grooming. The largest areas of need identified by Julie Fajertag relate to “hygiene” and “basic supervisory care”; these categories require further discussion.

Under the heading “hygiene” on the Form 1, the largest single item identified by Ms. Fajertag is 3 hours each day ($925.58 per month) to “ensure comfort, safety and security in this environment” (i.e., the bedroom). In her report, Ms. Fajertag explains that this is really meant to
reflect the fact that family members would “call and text often to check-in and provide cues and reminders as needed (i.e., to ensure she is eating and resting, to organize her schedule)”. Although this item on the Form 1 is intended to be used for services related to ensuring comfort, safety and security in the bedroom, Ms. Fajertag obviously concluded that there was nowhere else in the Form 1 that was more appropriate to capture this particular type of supervisory care. In coming to this conclusion, she relied upon Ontario Society of Occupational Therapist (“OSOT”) guidelines (described at page 21 of her report). I note that the occupational therapist retained by the Insurer, Nancy Lok, adopted a similar approach with respect to this issue. Bonnie Koreen did as well. Thus, all the occupational therapists who assessed the Applicant’s attendant care needs agreed that this was appropriate. I also agree that this approach is appropriate and I find to be reasonable Ms. Fajertag’s conclusion as to the Applicant’s need for reassurance and comfort, both in person and through telecommunications.

With respect to “basic supervisory care”, neither Ms. Fajertag nor any other medical professional who has assessed the Applicant’s need for attendant care has ever suggested that she requires round-the-clock care or that she requires basic supervisory care because she lacks the ability to respond to an emergency due to changes in behaviour or needs custodial care due to changes in behaviour.

Ms. Fajertag does allot 8 hours per day ($2,468.20 per month) for basic supervisory care as, in her opinion, the Applicant physically lacked the ability to be self-sufficient in an emergency. In her report, Ms. Fajertag explains this is some detail. Due to the medications the Applicant was taking at night and her severe episodes of vertigo (often brought on by quickly moving from a horizontal to vertical position), the Applicant reported that she was often disoriented when woken at night and would likely experience a severe episode of vertigo if she attempted to rise quickly from bed. Ms. Fajertag writes (at pages 21-22 of her report):

The client would benefit from supervisory care during the night (8 hours) as she wouldn’t be self-sufficient in an emergency during this time period. She is unable to move quickly when first awakened and she has to get up slowly and in stages otherwise her dizziness would be triggered which would affect her balance and could potentially lead to a fall. When resting during the day she tends to sit on

primarily Mr. Watters, although this is not specified in Ms. Fajertag’s report.
her living room couch with pillows for support, from which she can transfer independently, with more ease and more quickly compared to getting up from a full lying position in her bed which she reserves for sleeping in at night or when others are home.

This is consistent with the testimony I heard from the Applicant and members of her family. I find this proposal also to have been reasonable and necessary.

In short, I find the attendant care recommended by Julie Fajertag in the Form 1 dated November 1, 2011 to be reasonable and necessary and that the expenses related to these services were incurred. For the period of October 5, 2011 through March 31, 2012, I find that the Applicant is entitled to attendant care benefits in the amount of $4,988.08 per month.

(b) April 2012 to August 2013

In a follow-up attendant care assessment of March 2012, Ms. Fajertag found that the Applicant’s needs had changed very little. She recommended total monthly attendant care benefits in the amount of $4,597.82 (about $400 less than was recommended in the previous report). The main differences between this and her earlier report are that, according to Ms. Fajertag, by March 2012, the Applicant:

- no longer required assistance with grooming
- required less assistance (60 minutes per day instead of 90) by way of meal preparation since the Applicant could make herself a simple breakfast or lunch (without using the stove or oven, which appliances everyone agreed the Applicant could not operate safely) and only required someone to make dinner for her
- required less assistance bathing
- required increased support and supervision (4 hours per day instead of 3)

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26No attendant care is payable for the period from September 29 to October 4, 2011 as no attendant care expenses were incurred during that period.
With respect to the Applicant’s ongoing need for support and supervision (a total of 4 hours each day), Ms. Fajertag writes as follows (at pages 8-9 of her March 13, 2012 report):

She [the Applicant] continues to struggle with adjusting to her change in function and her cognitive and emotional challenges are significant. She requires support and regular cueing during her waking hours to organize herself, complete planned activities, keep her on track and follow her daily schedule. She can be left alone in a structured environment with her needs set up for her for short periods at a time and she does go out in the community for limited and specific tasks on her own (i.e. PT [physiotherapy] appointments with designated taxi driver), however remote supervision is available to her which enables her to do so. Her husband recognizes her challenges and sets her up for success to promote improved mood, confidence and participation. This includes calls and texts throughout the day to check in, ensure she is taking her medication and eating, to see how she is feeling and assist with dealing with her children as needed. She reports that her husband “constantly checks in on me ... sometimes I really need it, such as days I have trouble focusing”. Whenever she is leaving the house (i.e. for her PT appointments by taxi) and returning he will check in. If she doesn’t respond her husband will worry and has left his work on more than one occasion to return home to check on her (for example on one occasion she was in the bathroom and didn’t answer the phone). He tracks her schedule on his own phone so that he is aware of where she is. She reports that she is frustrated and discouraged by her change in function and limitations and it is her husband that keeps her positive and on track. He encourages her to go out together to improve her mood. She reports “I get depressed a lot and he helps me feel better ... it is like a full time job for him I think ... I get very frustrated over my progress and when I can’t do things, persistent pain, when I get discouraging news from the doctor ... he lets me vent on him”. She also reports that it is reassuring to know he is there at night which helps her to fall asleep. Her children also come straight home after school to make sure she is ok when they would otherwise tend to do other social activities after school. She benefits from the encouragement, reassurance and emotional support from her family which is key in helping her cope, keeping her mood positive and promoting her recovery.

In April 2012, State Farm had the Applicant assessed by Nancy Lok to obtain its own opinion as to the Applicant’s need for attendant care. It is perhaps worth noting, once again, that State Farm appears to have accepted the opinion of Ms. Fajertag and (upon condition of being provided with evidence that the attendant care expenses were incurred) agreed to pay attendant care benefits to the Applicant of $3,000.00 per month up to June 4, 2012 (around the time that State Farm
delivered the attendant care report of Nancy Lok)\(^{27}\) and, thereafter, to pay attendant care benefits in accordance with the recommendations of Ms. Lok.

Ms. Lok agreed that the Applicant required attendant care, but at a much lower rate than had been suggested by Ms. Fajertag only a month earlier. Whereas Ms. Fajertag had recommended total monthly attendant care benefits in the amount of $4,597.82, Ms. Lok was recommending only $493.27 per month.

There are three main areas of disagreement that explain the difference between the total attendant care being recommended by these two occupational therapists.

First, Ms. Lok concluded that the Applicant was able to prepare or assist in preparing most of her meals so she allotted less than 2 hours per week to this type of attendant care (i.e., 2 hours per week versus the 7 hours per week recommended by Ms. Fajertag). It is true that the Applicant could make simple meals, particularly breakfast and lunch that did not require use of the stove or oven (cereal and milk, a sandwich, etc.) and this was also recognized by Ms. Fajertag in her assessment. The real question is the extent of assistance the Applicant required to prepare dinner. Since she would often skip breakfast or lunch and was not maintaining a healthy diet when alone, Derek (who is a cook) testified that he tried to ensure that a healthy dinner was prepared each night. Sometimes the Applicant would assist with some part of the meal preparation but Derek would have to be present to supervise and having the Applicant participate would actually increase the time it took to prepare the meal. On average, this would take about an hour each night, seven days per week. Given this evidence, I find that Ms. Fajertag’s estimate of the time required for Derek to prepare dinner was more accurate than that of Ms. Lok.

Secondly, Ms. Lok concluded that the Applicant’s vertigo was not a serious safety concern. She felt that, even if the Applicant were awoken suddenly at night, she would be capable of being self-sufficient in an emergency. According to the report of Ms. Lok, the Applicant told her that she had only had dizzy spells when she got up at night to use the washroom one or two times

\(^{27}\)See State Farm’s Form OCF-9 dated September 11, 2012.
in the month preceding the assessment. Accordingly, Ms. Lok found that there was no need for basic supervisory care at night.

I cannot reconcile this conclusion with the other evidence available to me concerning the Applicant’s problems with vertigo and dizziness around this time. The Applicant testified that her serious problems with vertigo did not subside until the summer of 2013. This is confirmed by the medical records.

Dr. Richard Gladstone, in his neurological report of April 21, 2012, notes ongoing complaints of dizziness. The clinical notes and records of the Applicant's family physician (Dr. Betty Ballard), also reveal numerous ongoing complaints of vertigo/dizziness including entries in March, May, June, July, August and October 2012. Dr. Ballard's records from May 15, 2012 note that the “spinning sensation” had recurred and that the Applicant had ongoing vertigo she was living with “pretty much daily”. In Dr. Ballard's record from October 23, 2012, she notes that the Applicant “had a lot of falls since the accident due to dizziness”. In her clinical notes, Dr. Ballard also makes several references to the need to refer the Applicant to an ear, nose and throat specialist to deal with the complaints of vertigo. This finally did occur when the Applicant was referred to Dr. Kassel around April of 2013.

Vertigo appears to have remained a serious problem for the Applicant until after she received treatment by Dr. Kassel. Based upon the Applicant's testimony and the medical records, I find that, by the summer of 2013, although the Applicant still had occasional dizzy spells (which were manageable), she no longer suffered the severe episodes of vertigo that she had been experiencing up to that point. Since an episode of vertigo was more likely to occur if the Applicant were forced to suddenly awaken and try to get out of bed quickly, I accept the opinion of Ms. Fajertag that this could render the Applicant incapable of being self-sufficient in an emergency and that she required basic supervisory care during the hours that she would normally sleep at night. The need for such assistance, however, ended with the cessation of the vertigo in the summer of 2013.
The third major area of disagreement between these two occupational therapists is in the amount of support that the Applicant reasonably required (for “comfort, safety and security”) and that was being provided in person or remotely (by telephone) during the course of a typical day. Ms. Lok recommended only 15-30 minutes per day of such assistance whereas Ms. Fajertag recommended 4 hours per day.

Ms. Fajertag was not just an occupational therapist hired to conduct one or two attendant care assessments; she was the Applicant’s treating occupational therapist. She therefore had more contact with the Applicant than Ms. Lok and likely had a better understanding of the Applicant’s day-to-day challenges. I tend to give greater weight to the opinion of Ms. Fajertag.

On this issue, however, having heard the testimony of the Applicant, her husband and her daughter, I find that about half of these services (i.e., ensuring the Applicant’s “comfort, safety and security”) were being performed during this period by Emily Watters, who did not sustain an economic loss in so doing. Emily was assisting both through text messaging and telephone calls (although not to the same degree as her father) and by proceeding straight home after school to provide comfort and support to her mother on weekdays (in addition to staying home with her mother on weekends). In order to reflect the attendant care expenses incurred with respect to this category, I shall reduce the amount payable for this category to 2 hours per day (which will reduce the total monthly attendant care benefit by $617.05\(^2\)).

I find that the Applicant reasonably required the attendant care services recommended in March 2012 by Ms. Fajertag; I also find that the Applicant incurred all of the expenses related thereto, with the exception of expenses related to an average of two hours per day of assistance provided by Emily Watters. Therefore, for the period of April 1, 2012 through August 31, 2013, I find that the Applicant is entitled to attendant care benefits in the amount of $3,980.77 per month.

\[^2\] (120 minutes per day x 7 days per week ÷ 60 x 4.3) x $10.25 per hour = $617.05 per month
In August 2013, the Insurer had Ms. Lok re-assess the Applicant’s need for attendant care. She concluded that the Applicant required 10 minutes of assistance each day with her exercises. Other than that, she felt that the Applicant was completely independent and required no other support, cueing, supervision or any other type of attendant care whatsoever. She recommended attendant care benefits in the amount of $97.33 per month.

I reject Ms. Lok’s conclusions. Her opinion is completely at odds with all of the other evidence before me, including the testimony of the Applicant, her husband and her daughter (all of whom I found to be very credible witnesses) as well as virtually all of the medical evidence from around the same time period, including the opinions of numerous experts retained by the Insurer (e.g., Drs. Rosenblat, Margolese and Zakzanis).

The Applicant had improved physically by the summer of 2013. Most of her physical injuries had healed and she was growing stronger and more steady on her feet. Significantly, she was no longer suffering from vertigo and, as a result, did not require supervision throughout the night (i.e., she could now be self-sufficient in an emergency, even if woken from a deep sleep and required to quickly rise from bed and exit the house).

Her cognitive and psychological problems persisted, however. She still required constant cueing and monitoring for almost all tasks, including taking her many medications. Emotionally, she was suffering from depression, chronic pain and adjustment disorder, combined with a mood disorder. If anything, she was declining psychologically as almost two years had elapsed from the accident and she was losing hope of returning to a “normal” life. She remained impatient, irritable, easily confused and distractible and had difficulty organizing, initiating, persevering and completing any tasks.

She developed some strategies for working around her cognitive limitations. For example, she would remain at the door while the dog was outside so as not to forget to bring the dog back in. She would use her cell phone alarm to remind her when to take medication. She would use a
dosette to help manage her many medications and, each week, she and Derek would fill the dosette together.

The overwhelming weight of evidence demonstrates, however, that despite these and other strategies employed by the Applicant, she still required a considerable amount of attendant care, particularly monitoring and supervision to ensure that she was eating, taking her medication, attending various appointments and to ensure her comfort and safety both inside the home and when she needed to go out into the community.

All of this is much better captured in the attendant care assessment by Bonnie Koreen.

On October 9, 2013, Bonnie Koreen conducted an attendant care assessment of the Applicant at the Applicant’s home. With respect to the Level 1 and Level 3 attendant care, the total amount recommended by Ms. Koreen was fairly consistent with what had been recommended by Ms. Fajertag in March 2012. The focus of the parties has really been on the Applicant’s need for Level 2 care.

With respect to ensuring comfort, safety and security, Ms. Koreen recommends the same amount of assistance as did Ms. Fajertag in her last Form 1 -- that is, 4 hours each day. For the previous period (April 2012 through August 2013), I found this amount of assistance to be reasonable but I reduced the amount payable because I found that Emily Watters was providing about half of this service. For the same reason, although I accept Ms. Koreen’s opinion as to the amount of attendant care reasonably required by the Applicant, I shall reduce by $617.05 the total monthly attendant care benefit payable by State Farm for the period of September 2013 through August 2014.

With respect to basic supervisory care, as I previously indicated, the Applicant no longer required basic supervision while she slept at night. Ms. Koreen was advised, however, that the Applicant desired and needed to go out into the community about three times each week and required an attendant to go with her on these outings. She writes (at page 31 of her report of December 30, 2013):
When attending medical appointments, Mr. Watters always tries to accompany her to ensure information is heard accurately and that follow up recommendations will be carried through as directed.

At the present time, Ms. Watters does not use public transit independently and only infrequently goes into the community by herself and then only for short distances, such as to walk to the bus stop to meet her husband after work. When in the community accompanied by others, it is not uncommon for her to become disoriented and confused as to where she is despite RSW training and subsequent practice with her husband. Her husband expressed concern regarding her inconsistency with safely crossing intersections noting that she does not always look around prior to crossing streets.

It is noteworthy that as per the Form 1 guidelines put out by the Ontario Society of Occupational Therapists “attendant care within the basic supervisory care will be relevant to clients who have sustained injuries affecting their safety in the community due to physical, cognitive or behavioural changes”. The guidelines provide examples of clients who get lost in the community or who need assistance with remembering information provided during medical appointments including acting on follow through recommendations.

Based on the above it is reasonable to account for three trips into the community per week, inclusive of any medical appointments, for which Ms. Watters requires basic supervisory care to ensure her safety in light of her cognitive impairments.

Ms. Koreen therefore recommends 3 hours per week for this type of supervisory care in the community and, in light of the evidence available and the explanation provided by Ms. Koreen in her report, I accept that this is both reasonable and necessary. In total, Ms. Koreen recommends a monthly attendant care benefit of $2,315.87. After making the appropriate adjustment, I find that the Applicant is entitled from September 1, 2013 through August 31, 2014 to monthly attendant care benefits in the amount of $1,698.82.

(d) September 2014 onwards

Based upon the evidence presented, I find that the Applicant’s need for attendant care has not changed since September 2013. In September 2014, however, Emily Watters began going to college and her hours changed considerably. She could no longer be counted on to be home in

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29 i.e., deducting $617.05 to reflect two hours per day of attendant care services provided by Emily Watters, for which the Insurer is not obliged to pay as there is no evidence that any expense was “incurred” by the Applicant in relation to the services provided by her daughter.
the mid-afternoon. Derek wanted to ensure that the Applicant would not be left alone for too long so he further reduced his hours at work (down to two days per week) so that he could be at home more often with his wife and replace the services that had formerly been provided by Emily. Since Derek increased the amount of attendant care services he was providing to the Applicant as of September 2014 (to replace the services previously provided by Emily), I have no difficulty in permitting the full attendant care benefit recommended by Ms. Koreen ($2,315.87 per month) for the period from September 1, 2014 onwards as the evidence satisfies me that (from September 1, 2014 to the conclusion of the hearing) this is the amount of attendant care that was reasonable and necessary and that was incurred by the Applicant.

**Conclusion -- Attendant Care**

For all of the preceding reasons, I find that Ms. Watters is entitled to attendant care benefits as follows:

- $4,988.08 per month from October 5, 2011 through March 31, 2012;
- $3,980.77 per month from April 1, 2012 through August 31, 2013;
- $1,698.82 per month from September 1, 2013 through August 31, 2014;
- $2,315.87 per month from September 1, 2014 onwards.

**Medical/Rehabilitation Expenses**

**Overview**

Pursuant to sections 14 of the Schedule, an insurer is liable to pay for reasonable and necessary medical and rehabilitation benefits (under sections 15 to 17 of the Schedule) to or on behalf of an insured person who sustains an impairment as a result of an accident.

For a person who is not subject to the Minor Injury Guideline, the total sum of the medical and rehabilitation benefits (unless optional benefits were purchased) shall not exceed $50,000 or, if the insured person sustained a catastrophic impairment as a result of the accident, $1,000,000 (subsection 18(3) of the Schedule).
By July 2012, State Farm took the position that it had already paid the maximum non-catastrophic limits ($50,000) for medical/rehabilitation benefits and, thereafter, denied any treatment plan submitted to it on this basis alone. No other reason was given for State Farm for denying any of the treatment plans (related to medical and rehabilitation benefits) that it denied after July 2012.

The Applicant submits that if I find that the Applicant is found to have sustained a catastrophic impairment as a result of the September 29, 2011 accident, then State Farm should automatically have to pay all of the denied plans (that are the subject of this proceeding) since the Insurer’s only basis for denying those plans (the non-catastrophic monetary limit of $50,000) would have been found not to be valid.

The Insurer takes the position that there remains an onus upon the Applicant to prove that the expenses being claimed are reasonable and necessary. I agree. Using an admittedly unlikely scenario, I can demonstrate why this is the case.

Imagine that a plan was submitted on behalf of an applicant for a solid gold walker (assume that there is no valid medical reason why the walker must be made of gold -- it just looks nicer) and that the insurer denied the plan because it believed that the total maximum medical/rehabilitation benefits had already been exhausted. If it were later found that the limits had not been exhausted or were much higher (due to a finding of catastrophic impairment), does it make sense that the insurer should now automatically have to pay for a solid gold walker, without regard to whether that expense is reasonable and necessary? I think not. Furthermore, I think it would offend the principles enunciated by the Ontario Court of Appeal in Stranges.30

Counsel for the Applicant submitted that all of the expenses in question have been incurred by the Applicant and that for many, she had to borrow the money (at exorbitant interest rates) in

order to afford to pay for the goods and services. It is submitted that she must therefore have honestly believed they were reasonable and necessary.

I find that the Applicant’s belief is not determinative of this issue. The applicant in my fictional scenario might honestly have believed that the solid gold walker was reasonable and necessary but that does not make it so.

I also note that some of the expenses in dispute were submitted before the Insurer was alleging that the monetary limits had been reached for medical/rehabilitation benefits. Such a plan may well have been denied for reasons unrelated to the issue of whether or not the purported cap of $50,000 had been reached.

I therefore find that I must analyze each of these claims to determine whether the Applicant has met her onus with respect to each one. However, in the absence of any evidence to the contrary, it may not be that difficult for the Applicant to meet her onus where:

(a) the plan is recommended by someone who was in a good position to know if the goods and/or services in question were reasonable and necessary at the time, especially if that person’s expert opinions concerning the Applicant have already been tested and found by me to be worthy of being given considerable weight (such as the Applicant’s treating occupational therapist, Ms. Fajertag, whose opinions I accepted with respect to the issue of attendant care);

(b) where the person making the recommendation has the support of other medical professionals familiar with the Applicant’s circumstances; and/or

(c) where the nature of the goods and/or services being recommended is consistent with the other evidence as to the Applicant’s needs at the time the plan was submitted.

I shall now consider each of the expenses being claimed.
$1,278.01 for out-of-pocket expenses submitted to the Insurer on October 31, 2012

These expenses were related to transportation and the cost of prescription medication.

With respect to the transportation expense, $626.95 is claimed for the cost of the Applicant taking a taxi to and from medical appointments. Details and dates are provided. The Insurer has not challenged whether these expenses were incurred. The Applicant did not own a vehicle at the time and could not take public transportation. I find this expense to be reasonable and necessary.

With respect to the cost of prescription medication, the Applicant provided details, copies of prescriptions and receipts. The total claimed is $651.06 and I find all of this to be reasonable and necessary except with respect to such portion of the expense that may be related to the Applicant’s asthma medication (Symbicort), which condition was neither caused nor exacerbated by this motor vehicle accident. I trust that the parties can determine the correct amount without my assistance.

The Applicant is entitled to receive $1,278.01 towards these expenses, less any amounts that are related to her asthma medication.

$2,081.51 for out-of-pocket expenses submitted to the Insurer on December 31, 2012

These expenses were related to transportation (taxis and expenses related to a rental car), prescription medication, assistive devices and the cost of obtaining medical documentation. The total amount claimed is $2,081.51.

With respect to the transportation expense, particulars have been provided and, once again, the nature and amounts of these expenses appear to me to be reasonable.
With respect to the cost of prescription medication, the Applicant provided details, copies of prescriptions and receipts. I again find all of this to be reasonable, necessary and payable by the Insurer except with respect to such portion of the expense that may be related to the Applicant’s asthma medication.

The expenses related to devices includes $504.61 for a filing cabinet, filing supplies, ergonomic chair, chairmat and pill organizer (dosette) that were approved by the Insurer on July 12, 2012 (by fax back). Other devices purchased by the Applicant were intended to assist and ensure her safety in the bathroom (bath seat, clamp-on tub rail, rubber bath mat, etc.). I find that these expenses were reasonable and necessary.

The Applicant is entitled to receive $2,081.51 towards these expenses, less any amounts that are related to her asthma medication.

- **$1,834.13 for the cost of a mental health assessment pursuant to a plan dated March 2, 2012 by Dr. Judith Pilowsky**

I am unsure of the purpose for this mental health assessment by Dr. Pilowsky (a psychologist). The Applicant had just been assessed by a neuropsychologist (Dr. Kurzman) and a psychologist (Dr. Lubinsky) in February 2012 and the Insurer had approved and paid for that assessment. During this proceeding, there was no testimony and no specific submissions concerning Dr. Pilowsky’s plan. The Insurer had this plan reviewed by Dr. Mark Watson (by way of paper review) and he found that it was not reasonable and necessary in light of the assessment that had just been concluded by Dr. Kurzman. On the basis of the evidence before me, I find that the Applicant has failed to prove that this expense was reasonable and necessary. The Applicant is not entitled to $1,834.13 for the cost of a mental health assessment by Dr. Judith Pilowsky pursuant to a plan dated March 2, 2012.
➢ **$2,415.00 pursuant to a plan dated September 18, 2012 by Dr. Jason Wen-Shyang-Su**

This plan relates primarily to a proposal for botox injections for the Applicant, for the stated purpose of pain reduction (and increased function). During this proceeding, there was no testimony and no specific submissions concerning this plan or this type of treatment. Thus, the only evidence to support that this was reasonable and necessary is the Treatment Plan itself. I find that this is not sufficient to satisfy the Applicant’s evidentiary burden. On the basis of the evidence before me, I find that the Applicant has failed to prove that this expense was reasonable and necessary. The Applicant is not entitled to $2,415.00 for the cost of treatment recommended by Dr. Jason Wen-Shyang-Su in a plan dated September 18, 2012.

➢ **$2,773.22 for occupational therapy services pursuant to a plan dated February 8, 2012 by Julie Fajertag**

This plan proposed that an occupational therapy assistant (or rehabilitation support worker) attend on the Applicant to provide twelve two-hour sessions to improve her function and confidence at home and in the community. It was approved by the Insurer (as per the fax back of February 21, 2012) so it is unclear to me why this is listed as an issue in dispute. The Applicant is entitled to $2,773.22\(^{31}\) for the cost of occupational therapy services recommended in a plan dated February 8, 2012.

➢ **$4,539.83 (partially approved for $3,632.21) for occupational therapy services pursuant to a dated February 15, 2012 by Julie Fajertag**

This plan proposes, amongst other services (including preparation and travel time), ten 1.5-hour sessions (over 16 weeks) of in-home occupational therapy. The reasons for the proposed treatment are more fully explained in the progress report of Ms. Fajertag dated February 15, 2012 and which accompanied this treatment plan.

\(^{31}\)Of course, if the Insurer can prove that it has already fully paid this expense to or on behalf of the Applicant, it will have fulfilled its obligation.
The Insurer had this plan independently assessed by its occupational therapist, Nancy Lok. She conducted an in-home assessment in April 2012 and then issued a report on May 3, 2012. In this report, Ms. Lok considered each of the proposals made in the February 15, 2012 plan from Ms. Fajertag. In particular, she found that there was duplication of some of the services that were being proposed by Functionability Rehabilitation Services and those that were being provided to the Applicant through other programs. Consequently, she deemed 8 (not 10) sessions over 16 weeks to be reasonable and necessary and partially approved the plan in the amount of $3,632.57. For some reason, this was shown as $3,632.21 in the OCF-9 dated May 30, 2012. Thus, it is really the difference of about $900 that is in dispute.

I did not have the benefit of hearing testimony from either Ms. Fajertag or Ms. Lok. Although I tended to prefer the opinion of Ms. Fajertag on the issue of attendant care, on the issue of this particular treatment plan, I prefer the reasoning contained in the report of Ms. Lok. The Applicant is entitled to $3,632.57\(^{32}\) for the cost of occupational therapy services recommended in a plan dated February 15, 2012.

➢ \$1,225.50 (partially approved for \$855.50) for a nutrition assessment pursuant to a plan dated April 24, 2012 by Julie Fajertag

There was a concern that the Applicant was gaining a lot of weight (she gained over 50 pounds in about 6 months) and that she may not be eating nutritionally balanced meals. Ms. Fajertag, together with Aimee Hayes, registered dietician, submitted a plan for a nutrition assessment at a total proposed cost of \$1,225.50. This consists of \$165.00 for an assessment, \$110.00 for an hour of planning time, \$440.00 for four hours of documentation time, \$150.00 for documentation support, \$245.30 for travel time and \$115.20 for mileage.

The Insurer had the Applicant examined by Dr. Craig Winsor with respect to this plan on July 5, 2012. Dr. Winsor agreed that a nutritional assessment was reasonable and necessary. He also agreed with \$165.00 for the assessment, \$110.00 for planning time, \$245.30 for travel time and \$115.20 for mileage. He felt, however, that \$590.00 for documentation was excessive and that a

\(^{32}\) Again, if the Insurer can prove that it has already fully paid this expense to or on behalf of the Applicant, it will have fulfilled its obligation.
more reasonable figure would be $220.00. Thus he concluded, in his report dated July 5, 2012, that a reasonable cost for the nutritional assessment would be $855.50. In accordance with the opinion of Dr. Winsor, the Insurer approved the treatment plan by Form OCF-9 dated July 23, 2012, but only in the amount of $855.50.

It is not immediately obvious to me why a general medical practitioner like Dr. Winsor, whose experience appears to be primarily in the fields of occupational and environmental medicine and aviation medicine (according to his report), would be the right person to opine on the proposed nutritional assessment or why he needed to conduct a “musculoskeletal examination” of the Applicant in order to render a second opinion. In any event, he does not explain why the proposed documentation time is excessive and I see no reason to prefer his opinion over that of the Applicant’s treating occupational therapist and the nutritionist who would actually be doing the work described in the plan.

On the basis of the evidence presented, I find that the Applicant is entitled to $1,225.50 for the cost of a nutrition assessment pursuant to a plan dated April 24, 2012.

$310.00 for the cost of aquafit admission pursuant to a plan dated July 13, 2012 by Julie Fajertag

On July 13, 2012, Ms. Fajertag recommended the Applicant participate in an aquafit class at a local community centre once per week. The cost to have the Applicant and an aide participate in such a program was estimated at $240.00 ($20.00 per week for 12 weeks). An additional $70.00 was requested to cover the cost of necessary documentation. Thus, the total estimated cost of this twelve week program was $310.00.

The reasons for this recommendation are detailed in the Occupational Therapy Assistant Progress Report of Jennifer Jones, dated July 8, 2012. The Applicant had already started participating in aquafit classes and using the hot tub at the recreation centre and found them to be helpful in terms of pain relief and increased mobility and strength. This is consistent with the Applicant’s testimony concerning the benefits she has derived from this type of therapy.

33Less any amounts that the Insurer can prove it has already paid towards this expense.
Ms. Watters also reported to Ms. Jones that the “social aspect is a big part” and that she was meeting new people and talking with them. Ms. Jones felt that the social aspect of getting out into the community and interacting with others was also another reason to have the Applicant continue with the aquafit program.

The Insurer provided no reason why this plan was not approved. It was around this time (July 2012), however, that State Farm advised the Applicant that no further plans for treatment would be considered as the medical/rehabilitation “limits” under the policy had been exhausted.

Based upon this evidence, I find the plan of Julie Fajertag dated July 13, 2012 related to participation of the Applicant in an aquafit program to have been reasonable and necessary and I find that the Applicant is entitled to $310.00 for the costs associated therewith.

- $3,719.06 for the cost of occupational therapy pursuant to a plan dated July 13, 2012 by Julie Fajertag

There is no plan dated July 13, 2012 in the amount of $3,719.06. There is, however, a plan from Ms. Fajertag dated July 13, 2012 in the amount of $2,773.22, primarily related to the cost of having an occupational therapy assistant (Ms. Jones) continue to work with the Applicant once each week, for two hours at a time, for another 12 weeks. Detailed reasons for this recommendation are provided in the Occupational Therapy Assistant Progress Report of Jennifer Jones, dated July 8, 2012 and are supplemented by additional reasons provided in the treatment plan of Ms. Fajertag. The Applicant’s need for such assistance is supported by the preponderance of the evidence, including the testimony of the Applicant and her spouse.

The Insurer provided no reason why this plan was not approved. It was around this time (July 2012), however, that State Farm advised the Applicant that no further plans for treatment would be considered as the medical/rehabilitation “limits” under the policy had been exhausted.

Based upon this evidence, I find the plan of Julie Fajertag dated July 13, 2012 to provide the Applicant with continued support by an occupational therapy assistant to have been reasonable.
and necessary and I find that the Applicant is entitled to $2,773.22 for the costs associated therewith.

- $3,719.06 for the cost of occupational therapy pursuant to a plan dated December 6, 2012 by Julie Fajertag

On December 6, 2012, Ms. Fajertag submitted a plan for occupational therapy (biweekly 1.5 hour sessions -- 8 sessions over 16 weeks) in the amount of $3,719.06 (which included time for therapy, travel and documentation). The goals of this therapy were to:

1. optimize safety and promote independence in personal care and housekeeping tasks;
2. improve physical function, reduce pain and improve comfort;
3. implement memory and organizational strategies and aids to improve cognitive function;
4. support the Applicant in return to productive and meaningful activities.

At the time this plan was proposed, the Applicant continued to have significant physical, cognitive and emotional impairments. She was still suffering from episodes of severe vertigo and was falling frequently. She had put on quite a lot of weight since the accident and was not always eating well. Although gaining in strength, by late 2012 the Applicant was still not independent in many activities.

The Applicant’s need for ongoing occupational therapy was supported not only by Julie Fajertag, but also by Nancy Lok and Drs. Kurzman and Lubinsky.

The Insurer provided no reason why this plan was not approved. No explanation of benefits (Form OCF-9) was provided to the Applicant (at least, I have no evidence that such a form was delivered by State Farm).
Based upon this evidence, I find the plan of Julie Fajertag dated December 6, 2012 to provide the Applicant with continued occupational therapy to have been reasonable and necessary and I find that the Applicant is entitled to $3,719.06 for the costs associated therewith.

- $531.00 for the cost of assistive devices pursuant to a plan dated October 18, 2012 by David Surette

On October 31, 2012 (not October 18, 2012), chiropractor David Surette submitted a plan for the cost ($531.00) of a Nexus Rollator. Such a device was recommended by the Applicant’s family physician as the Applicant was still suffering from bouts of dizziness and vertigo. It was hoped that a rollator would help ensure the safety and stability of the Applicant, especially when outside the home, as well as increase her ability to engage in activities of daily living. The Applicant testified that this device did assist her in mobility and stability. Based upon this evidence, and in the absence of any evidence to the contrary, I find that this plan was reasonable and necessary and that the Applicant is entitled to $531.00 for the cost of this device.

- $2,050.00 for the cost of massage therapy pursuant to a plan dated October 31, 2012

On October 18, 2012 (not October 31, 2012), Claudia Casella, chiropractor, submitted a plan in the total amount of $2,050.00 for physical rehabilitation and massage therapy. By fax back on November 9, 2012, State Farm denied this plan on the basis that the monetary limit for medical/rehabilitation benefits had been exhausted.

Other than the plan itself, there is no evidence before me to explain the exact nature of the services being recommended and no explanation as to why it was reasonable and necessary at the time it was proposed. I find that this is insufficient to meet the onus upon the Applicant.

- $1,550.00 for the cost of chiropractic services and massage therapy pursuant to a plan dated March 11, 2013

On March 11, 2013, Claudia Casella submitted a further plan for physical rehabilitation and massage therapy in the total amount of $1,550.00. By fax back on March 20, 2013, State Farm
denied this plan on the basis that the monetary limit for medical/rehabilitation benefits had been exhausted.

Other than the plan itself, there is no evidence before me to explain the exact nature of the services being recommended and no explanation as to why it was reasonable and necessary at the time it was proposed. Again, I find that this is insufficient to meet the onus upon the Applicant.

**Special Award (entitlement only)**

**The Law**

Special awards are authorized under subsection 282(10) of the *Insurance Act*, which states as follows:

> If the arbitrator finds that an insurer has unreasonably withhold or delayed payments, the arbitrator, in addition to awarding the benefits and interest to which an insured person is entitled under the *Statutory Accident Benefits Schedule*, shall award a lump sum of up to 50 per cent of the amount of which the person was entitled 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 cent per month, compounded monthly, form the time the benefits first became payable under the *Schedule*.

Thus, to establish entitlement to a special award, an applicant must prove that payments have been *unreasonably* withheld or delayed by the insurer. It is well established that an insurer can be wrong in withholding or delaying payments without necessarily being unreasonable. It is also well established that, while bad faith on the part of an insurer can be considered as an aggravating factor in determining the appropriate size of a special award, there is no requirement upon an applicant to show that an insurer has acted in bad faith in order to establish entitlement to a special award (i.e., to prove that payments have been unreasonably withheld or delayed).
**Grounds for this Claim**

The Applicant has advanced seven alternative grounds for her claim of a special award. I find that two of these grounds have merit. Each is discussed below.

1. **Inappropriate Placement in MIG**

The Applicant submits that, given the nature of her injuries, it was inappropriate for the Insurer to initially place her within the Minor Injury Guideline (“MIG”). I agree.

Nevertheless, the Insurer quickly (i.e., within a few weeks) took the Applicant out of the MIG and there is no evidence that any payments were unreasonably withheld or delayed as a result of this conduct on the part of the Insurer.

2. **Denying IRBs without an Insurer’s Examination (“IE”)**

According to documentation filed, on July 24, 2013 State Farm purported to terminate payment of income replacement benefits (“IRBs”) until the Applicant could demonstrate “active participation” in a “community-based rehabilitation program”. State Farm was relying upon subsection 57(2) of the Schedule, which requires an insured person who is eligible for IRBs (amongst other benefits) to participate in such rehabilitation as is “reasonable, available and necessary”. State Farm relied upon its psychiatry assessment of November 2012, in which Dr. Joan Tucker commented that the Applicant had not yet been referred to an acquired brain injury comprehensive program and that she was not yet receiving regular psychotherapy to help her cope with functional and family changes. There is no evidence before me as to what

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34Six grounds set out in detail in the letter from David Preszler to Aldo Picchetti dated February 5, 2015 (Ex. 19) and one additional ground raised by Mr. Preszler in his closing arguments concerning the Insurer allegedly ignoring medical reports that were favourable to the Applicant. Note that I have not used the same numbering in the next session as is used in Mr. Preszler’s letter of February 5, 2015.

35Ex. 18, Tabs 41 and 42.

36Of course, by July 2012, the Insurer terminated all medical and rehabilitation benefits (on the basis that the monetary limits had been exhausted) so, while State Farm seemed to be insisting that the Applicant actively participate in a community-based rehabilitation program as a condition of her continuing to receive IRBs, State Farm was clearly not offering to assist her in paying for any costs associated with her participation in such a program.
community-based rehabilitation program was reasonable, available and necessary as of July 2013.

The Applicant takes the position that the Insurer’s purported termination of IRBs in July 2013 was not in accordance with the provisions of the Schedule and that it demonstrates bad faith on the part of State Farm in the handling of this case.

I find that I have insufficient information concerning the details of the Applicant’s claim for IRBs, the merits of that claim or particulars of how that claim was handled by State Farm. This issue was not addressed at all during the hearing. I am advised that, ultimately, the parties settled the Applicant’s claim for IRBs on a full and final basis. I have no documentation related to that settlement. I do not know how much was paid to the Applicant in total or how much of that total amount was related to past IRBs, future IRBs or interest. I also have no evidence as to whether, when the IRB claim was settled, the Applicant specifically reserved the right to pursue a claim for a special award based upon any unreasonable withholding or delay in payment of IRBs.

Based upon the scant information provided, I find that I cannot grant any special award based upon the alleged improper termination of income replacement benefits on July 24, 2013.

3. Refusal to Provide Productions

Counsel for the Applicant alleged in his letter of February 5, 2015, that the Insurer failed to provide adequate disclosure. Although the letter indicates that a motion would be brought at the commencement of the hearing to deal with this issue, no such motion was brought before me. There is no evidence of a breach by State Farm of any undertakings or orders. There is also no evidence before me that any delay by State Farm in providing requested documentation has resulted in an unreasonable withholding or delay in payment of any accident benefits.37

37This, however, can be relevant to a determination of the issue of a party’s reasonable expenses if it can be shown that the other party’s failure to fulfill undertakings or comply with orders tended to prolong, obstruct or hinder the proceeding.
4. Updated OCF-19

About one month before the hearing commenced, the Insurer requested an “updated OCF-19”. If the Applicant had complied, this may well have given State Farm an opportunity to conduct further catastrophic impairment assessments. The Applicant declined to provide an “updated OCF-19” for reasons provided by Mr. Preszler in his letter of February 2, 2015 (Ex. 18, Tab 46).

Again, this seems to be an attempt by the Applicant to demonstrate bad faith on the part of the Insurer. There is no evidence that this conduct resulted in an unreasonable withholding or delay in payment of any accident benefit that is currently in issue before me. As such, this conduct cannot form the foundation of a claim for a special award. On the other hand, as previously indicated, evidence of bad faith conduct on the part of the Insurer may be relevant to a determination as to the appropriate quantum of any special award.38

5. Ignoring Reports Favourable to the Applicant

The Applicant alleges that the Insurer ignored reports that were favourable to her and that this was unreasonable. Based upon the evidence presented, I am not satisfied that the Applicant has proven that payment of any benefit in dispute was unreasonably withheld or delayed as a result of such conduct. Proof of such conduct, however, could be relevant to the determination of the appropriate quantum of a special award.

6. Failure to Pay Attendant Care

On the facts of this case, I do not find it unreasonable for the Insurer to have taken the position that the Applicant was not catastrophically impaired. This is a novel area of law and there were conflicting opinions with respect to the Applicant’s GOS score. Even the Applicant’s own assessors, Dr. Kurzman and Dr. Lubinsky, supported the Insurer’s position on this issue. As such, although I have found that the Applicant did sustain a catastrophic impairment as a

38Alternatively, there are other avenues through which one may seek to have an insurer disciplined for engaging in unfair or deceptive acts or practices.
result of the September 29, 2011 accident, the Insurer’s position on this issue was not unreasonable.

As a result, I do not find to be unreasonable the Insurer’s refusal to: (1) pay more than $3,000.00 per month in attendant care; (2) pay more than $36,000 in attendant care during the first 104 weeks of disability; and (3) pay any attendant care benefits related to services provided more than 104 weeks after the accident.

I also do not find to be unreasonable the Insurer’s withholding of attendant care benefits until the Applicant clarified who exactly was providing attendant care services to her as well as details of the services being provided. The expense forms sent by the Applicant to State Farm did not identify the service provider(s) and the Form 1’s and report from the Applicant’s assessors left it a bit vague as to which family members were providing which services.

Furthermore, once the Applicant made it clear that she was seeking expenses related to services provided by her husband, it was reasonable for State Farm to demand documentation to prove that he had sustained an economic loss in each month for which attendant care benefits were being claimed. Those records were not provided to State Farm until April 2014.

At that point, however, State Farm should have honoured its obligations under the Schedule and its Form OCF-9 of September 11, 2012. That was the form in which State Farm advised the Applicant that, based upon the various Form 1’s and expense forms submitted to it, upon being provided with confirmation of the identity of the service provider and proof of economic loss, State Farm would pay the Applicant attendant care benefits as follows:

1. For the period from September 29, 2011 to June 4, 2012, $3,000.00 per month; and

2. For the period from June 5, 2012 to August 31, 2012, $493.27 per month, in accordance with the Form 1 from Nancy Lok dated April 24, 2012.
I do not find it unreasonable for the Insurer to have relied upon the opinion of Ms. Lok. While Ms. Lok’s opinion conflicted with that of Ms. Fajertag, it was not so obviously flawed that the Insurer ought to have ignored it.

I find that by April 2014, the Insurer had all of the documentation and information necessary to properly assess the Applicant’s attendant care claims. By that point, State Farm ought to have been satisfied that the Applicant required attendant care and that the service provider, Derek Watters, had sustained an economic loss as a result of providing attendant care services to the Applicant. In April 2014, even if the Insurer was relying on the reports from Ms. Lok, it ought to have at least paid to the Applicant:

1. $3,000.00 per month in attendant care for October 2011 through May 2012 ($24,000.00);

2. $493.27 per month for June 2012 through August 2013 (approximately $7,400.00);

3. $97.33 for September 2013.\(^{39}\)

In other words, by April 2014, the Insurer should have paid to the Applicant about $31,500.00 in attendant care benefits even if the Applicant was seeking greater amounts for the period up to September 2013 and even if there was a dispute regarding the Applicant’s entitlement to attendant care benefits for services provided after September 2013 (i.e., more than 104 weeks after the accident).

During closing arguments, I provided Insurer’s counsel with an opportunity to provide an explanation as to why the Insurer had not paid to the Applicant any attendant care benefits. In particular, I asked why State Farm did not at least pay what it had promised to pay once it had received (by April 2014) all of the documents that it had requested from Mr. Watters concerning his economic loss. State Farm adduced no evidence on this issue and Mr. Picchetti was unable to offer any explanation for the Insurer’s continued withholding of attendant care benefits after April 2014.

\(^{39}\)pursuant to the Form 1 of Nancy Lok dated August 9, 2013.
I find that State Farm’s withholding of attendant care benefits (in the total amount of approximately $31,500.00) after April 2014 was unreasonable.\(^{40}\) As a result, a special award is warranted.

### 7. Medical/Rehabilitation Limits Not Reached

On July 25, 2012, State Farm advised the Applicant by way of Form OCF-9 that the $50,000 non-catastrophic medical/rehabilitation limit had been reached. It denied every subsequent treatment plan for that reason.

When the Applicant’s counsel pushed for details of all amounts that had been paid and/or approved, State Farm eventually conceded that only a little over $43,000.00 had been approved in medical/rehabilitation benefits (including the cost of any assessments requested by the Applicant).\(^{41}\) By June 2014, State Farm advised that a total of $43,549.89 had been paid in medical/rehabilitation benefits. State Farm adduced no other evidence with respect to this issue.

Thus, based upon the evidence before me, it appears that State Farm paid $43,549.89 in total medical/rehabilitation benefits to or on behalf of the Applicant (inclusive of amounts paid for assessments requested by the Applicant). There is no evidence before me that State Farm had approved more than it had paid. Thus, when State Farm advised the Applicant that it had reached the non-catastrophic monetary limits for medical/rehabilitation benefits in late July 2012, this was incorrect. State Farm discovered this error within 6 months (if not sooner) since it acknowledged by letter dated January 24, 2013 that it had only paid $43,421.67 in medical/rehabilitation benefits (including the cost of assessments requested by the Applicant). From July 2012 onwards, State Farm denied all treatment plans solely on the incorrect premise that the monetary limit had been reached. Yet, when State Farm discovered that this was wrong and that there was actually approximately $6,500 that remained available for reasonable and necessary

\(^{40}\)Although I have ordered the Insurer to pay more than this amount in attendant care benefits for the period of October 2011 through September 2013, it is only the withholding of about $31,500 of these benefits that was \textit{unreasonable} and only from May 2014 onwards.

\(^{41}\)Exhibit 18, Tabs 39 and 40. As of January 2013, about $5,500.00 of the amount that had been approved remained unpaid.
medical and rehabilitation expenses, it took no steps to reconsider these treatment plans. It is this conduct, in particular, that was unreasonable.

During the period of July through December 2012, numerous treatment plans were submitted that ought to have been approved and probably would have been but for State Farm’s unreasonable conduct. Treatment plans that ought to have been approved during this period include:

- $310.00 for the cost of aquafit therapy pursuant to a plan dated July 13, 2012 by Julie Fajertag;
- $2,773.22 for the cost of occupational therapy pursuant to a plan dated July 13, 2012 by Julie Fajertag;
- $531.00 for the cost of an assistive device pursuant to a plan from David Surette dated October 18, 2012; and
- $3,719.06 for the cost of occupational therapy pursuant to a plan dated December 6, 2012 by Julie Fajertag.

Thus, approximately $6,500.00 in medical/rehabilitation benefits were unreasonably withheld by State Farm. This also merits a special award.

**Conclusion – Special Award**

For the reasons set out above, I find that State Farm is liable to pay a special award because it unreasonably withheld or delayed payments to Ms. Watters. The issue of the quantum of the appropriate special award is deferred.

**REMAINING ISSUES:**

There are a number of issues that I cannot properly adjudicate without further evidence and submissions. Such issues include (but are not necessarily limited to):
• the amount of interest owing on accident benefits awarded in this order;
• the quantum of the special award to which the Applicant is entitled;
• entitlement to and quantum of expenses related to this proceeding.

I am hopeful that the parties will be able to resolve any such outstanding issues on their own, without the need for further adjudication. If, however, after reasonable efforts, the parties are unable to resolve any remaining issues on their own, either party may deliver a written request that the hearing be resumed so long as that request is made to FSCO (on notice to the other party) within 90 days of the date that this order is issued.

____________________________________________________________________
Richard Feldman  June 26, 2015
Arbitrator                  Date
BETWEEN:

DENISE WATTERS

Applicant

and

STATE FARM MUTUAL AUTOMOBILE 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. Watters has sustained a catastrophic impairment within the meaning of clause 3(2)(d)(ii) of the Schedule as a result of the accident.

2. Ms. Watters is entitled to attendant care benefits as follows:
   - $4,988.08 per month from October 5, 2011 through March 31, 2012;
   - $3,980.77 per month from April 1, 2012 through August 31, 2013;
   - $1,698.82 per month from September 1, 2013 through August 31, 2014;
   - $2,315.87 per month from September 1, 2014 onwards.

3. Ms. Watters is entitled to receive the following medical/rehabilitation benefits:
   - $1,278.01 for out-of-pocket expenses submitted to the Insurer on October 31, 2012 (less any amounts that are related to the Applicant's asthma medication);
   - $2,081.51 for out-of-pocket expenses submitted to the Insurer on December 31, 2012 (less any amounts that are related to the Applicant's asthma medication);
$2,773.22 for the cost of occupational therapy services recommended in a plan dated February 8, 2012 by Julie Fajertag;

$3,632.57 for the cost of occupational therapy services recommended in a plan dated February 15, 2012 by Julie Fajertag;

$1,225.50 for the cost of a nutrition assessment pursuant to a plan dated April 24, 2012 by Julie Fajertag;

$310.00 for the cost of aquafit therapy pursuant to a plan dated July 13, 2012 by Julie Fajertag;

$2,773.22 for the cost of occupational therapy pursuant to a plan dated July 13, 2012 by Julie Fajertag;

$3,719.06 for the cost of occupational therapy pursuant to a plan dated December 6, 2012 by Julie Fajertag;

$531.00 for the cost of an assistive device pursuant to a plan dated October 18, 2012 by David Surette.

4. State Farm is liable to pay a special award because it unreasonably withheld or delayed payments to Ms. Watters. The issue of the quantum of the appropriate special award is deferred.

5. Ms. Watters is entitled to interest for the overdue payment of benefits set out above in accordance with section 51 of the Schedule.

6. The issue of expenses is deferred.

7. If, after reasonable efforts, the parties are unable to resolve any remaining issues on their own, either party may deliver a written request that the hearing be resumed so long as that request is made to FSCO (on notice to the other party) within 90 days of the date that this order is issued.

June 26, 2015
Date