Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A10-001364

BETWEEN:

J.M.

Applicant

and

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

Insurer

DECISION ON A PRELIMINARY ISSUE

Before: Judith Killoran

Heard: September 10, 11, and 12, 2012 and November 6, and 7, 2012 at the offices of the Financial Services Commission of Ontario in Toronto.

Appearances: James Leone and Christopher Bialkowski for J.M.
Michael Smith for State Farm Mutual Automobile Insurance Company

Issues:

The Applicant, J.M., was injured in a motor vehicle accident on October 5, 2007. He applied for and received statutory accident benefits from State Farm Mutual Automobile Insurance Company ("State Farm"), payable under the *Schedule*.[1] The parties were unable to resolve their disputes through mediation, and J.M. applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

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

The preliminary issue is:

1. Does J.M. meet the definition of "catastrophic impairment" in paragraphs 2(1.2)(f) and 2(1.2)(g) of the *Schedule*?

Result:

1. J.M. meets the definition of "catastrophic impairment" in paragraphs 2(1.2)(f) and 2(1.2)(g) of the *Schedule*.

BACKGROUND:

J.M. is a 58 year old man who operated a landscaping business before his accident on October 5, 2007. He was travelling north on Highway 400 when he heard a strange noise from his truck and stopped by the side of the road to investigate. While he was examining his truck, he was struck by a minivan from behind pinning him between the two bumpers. He fell backwards onto the minivan and then collapsed on the ground where he was unable to get up. He was taken to the Southlake Regional Health Centre. After the accident, J.M. spent more than five months in a wheelchair before graduating to leg braces with crutches to help him ambulate.

THE LAW

In order to determine whether J.M. meets the definition of "catastrophic impairment", he was assessed under section 2(1.2), paragraphs (f) and (g) of the *Schedule* as follows:

> 2 (1.2) For the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs after September 30, 2003 is,
>
> (f) subject to subsection (1.4), (2.1) and (3), an impairment or combination of impairments that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th Edition, 1993, results in 55 per cent or more impairments of the whole person; or

> (g) subject to subsections (1.4), (2.1) and (3), an impairment that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th Edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.

The catastrophic designation itself does not entitle the insured to any benefits. It merely increases the amount and extent of the benefits to which the insured may be entitled. The insured must still prove entitlement to the enhanced benefits.

J.M. submitted that he meets the definition of catastrophic impairment under the *Schedule* as he was rated as having a whole person impairment (WPI) of 65-69% under paragraph (f) and he was rated as having two marked (Category 4) impairments under paragraph (g). State Farm denied that J.M. meets the definition of catastrophic impairment as its assessors refused to assign a rating to J.M. due to a combination of incomplete testing and unreliable test results.

EVIDENCE:

J.M. testified at the hearing as did his wife and his daughter. Dr. Harpreep Sangha, a physiatrist, Dr. Jeremy Frank, a psychologist, and Dr. Harold Becker testified as medical experts on J.M.'s behalf. Ms. Jane Young-On testified as a witness on behalf of State Farm together with Dr. Oshidari, a physiatrist, and Dr. N.E. Morris, a psychologist, who were qualified as medical experts.

J.M. testified that he was treated in emergency by Dr. H.K.L. Cheah, an orthopedic surgeon, at the Trillium Health Centre, Fracture Clinic. Dr. Cheah arranged for his braces and crutches. His wife helps him put on his braces, washes, and shaves him daily. In his words, she helps with everything, including taking him to the washroom. Physiotherapy helped for a little bit but he found he could not walk without crutches and braces. If he attempts to stand on his own, his legs start shaking. He takes painkillers 3 or 4 times a day, has an ulcer, and his blood pressure is high enough that he requires medication.

J.M. testified about how much he liked working for his landscaping business, which he ran for 19 years before the accident. He lives with his wife, daughter and grandson. He expressed feelings of extreme sadness about being so dependent on his wife and daughter for everything. Prior to the accident, J.M. worked long hours, often 12 hours a day, 7 days a week. Now his activities are very restricted. He goes sometimes to his grandson's school with his daughter and sometimes he brings his grandson to and fro on his own. He goes to church sometimes. When he has tried to stand up without crutches, he has fallen. J.M.'s wife had a stroke approximately 18 months ago, which she attributed to the physical and emotional strain which she suffered as a result of her husband's injuries. She also testified about how disoriented and nervous her husband has been since the accident.

There is conflicting evidence about the degree to which J.M. could ambulate the day of the accident. J.M. disputed the ambulance report which stated that he walked away from the accident. He stated that he fell immediately after the accident and that he has never walked again. The Southlake Regional Health Centre report stated that J.M. had bilateral calf pain but he was able to ambulate. He was later treated in the fracture clinic of a second hospital, Trillium Health Centre. J.M. testified that although he was treated by a psychologist for 8 to 10 sessions, he stopped going because he left his sessions feeling worse than when he arrived. In the months following the accident, he was unable to drive even a short distance and he never drove again. This contradicted the information in some of the assessors' reports that he was able to resume driving.

J.M.'s daughter testified that her father is very depressed and is, "not the same person" since his accident. She recounted how her father was so depressed that he tried to kill himself but the arrival of his 5-year old grandson stopped him. J.M.'s daughter also confirmed how much her mother assists him with his activities of daily living. She had observed his attempts to walk which resulted in him falling. Also, she noted that he experienced great pain when he engaged in physical therapy.

I found the evidence of J.M., his wife, and his daughter credible, consistent and convincing. To the extent there are conflicting reports about J.M.'s mobility on the day of the accident and his ability to drive again, I prefer J.M.'s testimony. I also accept the testimony of J.M., his wife, and his daughter that J.M.'s life was dramatically altered after the accident; that is, that he requires daily care and supervision, that he is unable to return to his former employment and perform most of his activities of daily living; that he is sad and chronically depressed; and that he requires the use of crutches due to his experiences with falling and his fear of falling again. I find that the use of crutches contributes to J.M.'s confidence and limited independence.

PHYSICAL IMPAIRMENTS

Dr. Harpreet Sangha, a physiatrist, was qualified as an expert in physical medicine. In his physical impairment evaluation as a component of J.M.'s catastrophic impairment evaluation, he listed J.M.'s injuries as including the following: injuries to both knees, a right fibular head fracture, right ACL, MCL and PCL injury, right medial meniscus tear, left medial meniscus tear, complete left ACL tear, left MCL injury, and lumbosacral strain. During his examination of J.M. on March 29, 2012, J.M. complained of his right knee locking which caused significant pain and of his left knee buckling with posterior cramping into his calf and thigh. J.M. used gait aids of two Lofstrand crutches for safety, particularly as when his left knee buckles he felt it escaped from him anteriorly. J.M. also experienced low back pain with a stabbing quality, together with hand and shoulder pain. As part of his physical examination of J.M., Dr. Sangha observed J.M.'s gait pattern. He concluded that J.M.'s gait is inefficient and unstable with locking and buckling at the knees. J.M.'s left knee had ACL laxity with a medial joint line tenderness and a range of motion of 120 degrees. There were signs of guarding and some self-limitation due to fear and pain. J.M. complained about daily headaches of a throbbing quality associated with photophobia and phonophobia. Although there were neurological symptoms of numbness over his left foot, his reflexes were present and symmetrical. Dr. Sangha noted that J.M. required a daily narcotic and benzodiazepine after the accident.

Dr. Sangha testified that he referred to the American Medical Association's *Guides to the Evaluation of Permanent Impairment* ("*AMA Guides*") and applied the tests for lower extremity impairments.[2] He also heeded the guidance of the *AMA Guides* which specify that the section of the *Guides* which provide the greater impairment estimate be used.[3] Dr. Sangha rated J.M.'s impairments without the use of the Gait Derangement Table as follows: 3% for chronic impairment with musculoskeletal injuries, paraspinal muscle guarding 5%, severe LCL laxity 10%, and right patella/femoral impairment of 2%. The total rating is approximately 24% WPI when applying the Combined Values Chart.

Dr. Sangha reviewed Dr. Oshidari's Report of March 11, 2011,[4] where he declined to use the gait derangement table in the *AMA Guides*, which is used rarely. Dr. Sangha testified that this is an appropriate case for the use of the gait derangement table due to the extent of the pathology, including the bilateral knee impairment. There is no doubt that it should be used if there are multiple fractures, dislocation or ligament ruptures. The meniscus is inoperable, and there is a macerated meniscal tear. There is a Grade 3 instability of the knees coupled with strains and sprains of all three other ligaments. Dr. Sangha testified that the medial joint line tenderness was consistent with abnormality. The MRI comments on medial meniscal tears which lead to an ongoing pathology where the knee does not absorb shock or causes the femur to intermittently catch or lock. Due to the ACL disruption, J.M. had an ACL brace for instability.

Dr. Sangha testified that he chose the gait derangement table[5] based on experience/judgement and the underlying pathological processes. The *AMA Guides* specify that a diagnosis is based on estimates where the final lower extremity estimate must not exceed the estimate for an amputation which is 100% or 40% with the whole person.[6] Due to the pathological processes at

[2] *AMA Guides*, page 3/85

[3] *ibid*, pg. 3/84

[4] Exh 5, Tab 6 , pg. 3

[5] Table 36, Chapter 3, page 76

[6] *AMA Guides*, pg. 3/84

play with J.M., the gait impairment table is an appropriate tool to speak to the underlying pathology. Bilateral gait aids are appropriate in the circumstances and gait is the main impairment.[7] J.M. routinely uses two crutches which results is a moderate severity rating and a whole person impairment rating (WPI) of 40% when using the Gait Derangement Table. However, gait cannot be combined with other values in the lower extremity. Dr. Sangha combined the rating for the use of daily medications results which was 3% with the rating for lumbosacral strain which was 5%. After applying the Combined Values Chart[8], Dr. Sangha concluded that J.M.'s WPI is rating 45%.

Dr. Alborz Oshidari was qualified as an expert in physiatry and performing CAT assessments. He conducted an assessment of J.M. for State Farm on March 11, 2011. His findings did not correlate with the weaknesses displayed by J.M. and he was unable to provide a rating. If he were to provide a rating of impairment based on the *AMA Guides*, he stated that he would have to rate impairment based on weakness of the group of muscles in the lower extremity. However, he found "no specific neurological condition or orthopaedic condition, which can explain this amount of weakness. Therefore, based on the *AMA Guides*, he concluded that J.M.'s impairment is not ratable and he does not meet catastrophic impairment for this criteria."[9]

Dr. Oshidari found inconsistent findings on examination of J.M. Due to the pain experienced by J.M. during the testing, he could not make a thorough assessment. Although he observed significant weakness in the lower extremities consistent with nerve injury in the back there appeared to be no nerve injury in the back with no structural abnormality. Two MRIs of the knees revealed that the left knee has a tearing of the posterior medical meniscus with damage to the anterior cruciate ligament. Dr. Oshidari testified that the right knee has an emulsion at the fibular head with no organic cause for an instability of the knee. Also, he stated that the medial meniscus tear is not addressed by the brace which cannot unload the knee but only stabilizes it. Dr. Oshidari testified that J.M. used crutches from habit or fear of causing harm to himself.

[7] *AMA Guides*, pg. 3/76

[8] *AMA Guides*, page 322

[9] Exhibit 5, Tab 6, page 13

He thought that J.M.'s presentation was disproportionate to his injury. He also commented that J.M. had a neck complaint which he did not raise with Dr. Sangha.

Dr. Oshidari testified that for a diagnosis-based impairment, the rating would be higher because of neck pain. However, he stated that would require a true structural abnormality, which J.M. does not have. No surgical treatment was necessary and a brace only supports the front and back of his knees. In his opinion, the gait derangement table was not applicable as there was no structural abnormality in the right knee or right leg with no ligament rupture and no brace or crutches needed. The fracture to J.M.'s fibula bone he diagnosed as nothing major.
He commented that the Gait Derangement Table is used rarely as it requires multiple fractures, dislocations, and ligament ruptures. He insisted there were no dislocations and only a fractured fibula head which did not meet the requirement for multiple bilateral lower limb injuries.
Dr. Oshidari testified that the right medial meniscus tear would result in pain but not instability. He was of the opinion that there was no physical reason for J.M. to use braces and crutches.

MENTAL AND/OR BEHAVIOURAL DISORDER

Dr. Jeremy Frank, psychologist, was qualified as an expert. He testified about psychological impairment under the *AMA Guides*. He conducted a clinical interview of J.M. and a review of the medical briefs as part of his mental/behavioural evaluation on March 29, 2012 as a component of the catastrophic impairment evaluation. The *AMA Guides* suggest that an analysis of mental and behavioural impairments should be reviewed under the following four major categories: activities of daily living; social functioning; concentration, persistence, and pace; and adaptation.

In his report, Dr. Frank summarized the psychological assessments of J.M. which were conducted after the accident. In November 2007, Drs. K. Keeling and I. Gladshteyn diagnosed an Adjustment Disorder with Depressed Mood and rated J.M. with a Class 3: Moderate Impairment. In May 2008, Dr. Keeling issued a psychological discharge report which noted "The client is still anxious and depressed and states that his memory and concentration still doesn't reach the pre-accident level ... extended psychological treatment would be advisable with reassessment." In September 2008, Dr. K. McCutcheon noted that J.M. had memory problems and that pain

interfered with his concentration. She concluded that he might be dealing with mild psychological turmoil related to the accident but that no further treatment was warranted. A number of disability certificates submitted in 2009 noted sleep disturbances and depression. In December 2009, Dr. Gladshteyn diagnosed a major depressive disorder and specific phobia (situational) and documented a Class 4: Marked Impairment. In September 2010, Dr. C. Heusser conducted a psychological insurer's examination and found that J.M. was:

> severely depressed, anxious and very frustrated by his circumstances. Given his physical and psychological impairments, it is my opinion that he suffers a substantial inability to engage in his pre-accident occupation as well as the housekeeping and home maintenance activities he used to perform. In fact, given his current psychological impairments, I think it doubtful that [J.M] could be competitively employed even if a suitable sedentary alternate occupation was identified for him.[10]

Dr. Frank observed that J.M. was sad and tired, did not smile and offered no spontaneous information. He was low in energy and could not recall details. Pre-accident, J.M. stated that he was sociable, worked at his own business, had experienced no trauma and had good family relationships. He denied having experienced depression or anxiety in the past but he was taking anti-depressants after the accident. J.M. told Dr. Frank that his sessions with the psychologist made his problems worse and he left with a headache. He rated his pain at 6 out of 10 which is greater somedays but he could not identify the triggers. He does not cope well with his pain and he cries from pain at times. He only sleeps 4 hours a night with broken, restless sleep. While suicidal ideation is common, suicidal intent and attempts are more severe. J.M. recalled trying to hang himself after persistent sadness, loss of appetite, and feelings of guilt, worthlessness and hopelessness. However, he had no recent suicidal intent or attempts although there was a level of depression and feelings of hopelessness. In Dr. Frank's opinion, J.M. was experiencing coping problems with possible Post Traumatic Stress Disorder. There was an intrusive memory of what happened and flashbacks where he lost sight of his surroundings. He did not want to talk about the accident and he had a hypervigilance and fear of falling. He has not driven a car since the accident and suffers from passenger anxiety. He drives a mobility scooter, worries about being hit and has a score of 7 out of 10 for anxiety. He continues to have problems with reading,

[10]Exhibit 2, Tab 66, Page 13, September 20, 2010

locking doors, multi-tasking and he is unable to dress himself. He is afraid of falling and he does no housework or cooking.

Dr. Frank administered psychometric testing which he believes showed an invalid profile due to the extreme responses which did not take into consideration cultural background or language. There was a profile distortion on the validity scales because J.M. did not engage. J.M. threw his hands up in frustration and had problems with persistence which speaks to motivation. Dr. Frank stated that J.M.'s inability to speak English and his limited education only allowed for a provisional diagnostic opinion of major depressive disorder. Dr. Frank based his diagnosis on J.M.'s presentation which was very depressed, his behaviour, his psychometric data and a review of the file. He referred to Dr. Heusser's report of September 20, 2010. In her report, Dr. Heusser observed that J.M. was casually dressed, unshaven, quite anxious, and needed to take breaks. However, J.M. cooperated and displayed minimal pain behaviour when he was assessed by Dr. Frank. Again, due to the level of negativity and hence, distortion in testing, the test results were invalid.

Dr. Frank testified that overreporting is a component of Psychological Pain Disorder. This is where judgment is required on the part of the assessor as you cannot rely on the test results which are often invalid. It is important to contextualize the lack of psychometric evidence and use some caution when you are unable to find evidence upon which to rely. There is no way to assess someone scientifically if you are dealing with a different culture and language. Dr. Frank emphasized that you must do the best you can with what you have and consider how J.M. looks to different people over time by reviewing other reports. It is a challenge to come up with degrees of impairment which requires a "clinical confidence". The test data is not thrown out and there is not exclusive reliance on self reporting. A screening assessment helps with an estimate and a provisional diagnosis based on observation which can help move to CAT impairment ratings. Dr. Frank's estimate of functioning in J.M.'s case was 43% to 47%. He did not test his concentration but concluded that his limitations in his activities of daily living reflected mental and behavioural impairments.

In his report, Dr. Frank concluded that J.M. "does experience physical injuries that do impact upon his functioning but based on available information, it also appears that psychological factors, including significant depression, kinesiophobia (i.e. fear of falling) and high levels of pain focus and pain catastrophizing result in high levels of perceived disability and self-limiting behaviour which is beyond his conscious control." According to Dr. Frank, J.M. exhibited Marked (Class 4) impairment in Activities of Daily Living and Marked (Class 4) impairment in concentration, persistence and pace. J.M. also exhibited Moderate (Class 3) impairment in social functioning as he has the ability to engage meaningfully with friends and to socialize while affected by his depression, pain focus and activity limitations. In consideration of his level of depression and pain coping difficulties, Dr. Frank predicted that J.M. would deteriorate significantly from an emotional perspective in the face of repeated work-like stressors and that his psychological functioning would result in Moderate to Marked (Class 3 to 4) impairment in Work Adaptation.

Dr. Norman Edward (Ted) Morris was qualified as an expert in psychology. He assessed J.M. on April 19, 2012. The assessment was scheduled originally for March. He reviewed the documents in advance from a large file box which he passed on to his associate, Jane Young-On. They had a discussion before the originally scheduled assessment. The assessment did not go ahead as J.M. could not ascend or descend the stairs to the office.

Ms. Jane Young-On is a psychological associate who is on the temporary register of the College of Psychologists. She has worked with Dr. Morris for eight years and under his direct supervision for two years. Dr. Morris testified that Ms. Young-On is capable of conducting independent assessments. He was unable to attend at the beginning of the assessment on April 19, 2012 but he joined later and stayed only for 10 minutes or so, rather than his regular 1 hour attendance. J.M.'s tolerance was limited due to his high blood pressure and anxiety. Part way through the psychometric assessment by Ms. Jane Young-On, J.M. claimed he could not continue.

In his testimony, Dr. Morris pointed to the variance in responses of J.M. when he was assessed by Drs. McCutcheon, Gladshteyn and Heusser. Dr. Morris testified that, in his opinion, J.M. was overstating his physical impairment and amplifying his symptoms. Dr. Morris believed that he could not, with confidence, come up with a defensible whole person impairment rating under the *AMA Guides*. He reviewed Dr. Frank's ranked impairment in two areas but he declined to provide a rating because of the invalid profile he had to work with after testing. In his assessment, he concluded that, "it is difficult to determine with reasonable confidence [J.M.'s] psychological condition in light of compromised effort and challenged validity ..."[11] Later, he and his associate stated the following: "While it is acknowledged that [J.M.] may be experiencing intrusive psychological/emotional symptomatology, under the circumstance of this evaluation (questionable effort and reliability) I cannot ascertain with clinical confidence the true degree of any diagnosable psychological condition ... I am unable to offer reliable and defensible impairment classification ratings due to mental and behavioural disorders to the four aspects or areas of functionality."[12]

Dr. Morris testified that he thought the test which he was required to apply when determining ratings was that of "preponderance of evidence". He placed importance on consistency across the evidence and questions are raised when there is poor effort and significant variations. In the second last paragraph of his report, he stated that it was difficult to determine but that J.M. appeared to be in pain. There was an asterisk that stated J.M. was at high risk of suicide after he acknowledged one event of self destructive behaviour. In the Beck Depression Inventory, J.M. admitted suicidal ideation but stated that he would not act on it. However, Dr. Heusser in her report stated that he was at high suicide risk.

With respect to activities of daily living, J.M. stated that he could not do any cooking or vacuuming which he enjoyed doing pre-accident. This was corroborated by his daughter who attended the assessment and talked about her father's suicide attempt. Dr. Morris had difficulties with recall and could not say either way whether his daughter confirmed the information as there

[11]Exhibit 5, Tab 7, page 15

[12]Exhibit 5, Tab 7, page 16

was no rating on the activities of daily living. There was no evidence with respect to social functioning, concentration, or adaptation. He was referred to his colleague's notes[13] where there were comments about J.M.'s bad memory and concentration. Dr. Morris testified that it was the degree of change in J.M.'s social functioning which was difficult to rate. Although J.M. goes out rarely, he does sometimes use his mobility scooter.

Dr. Morris outlined the process involved in assessing J.M. He reviewed and discussed Jane Young-On's findings with her, where she had provided provisional conclusions but they could not arrive at a rating because the testing was not complete. There were no efforts to reschedule as that was the responsibility of the insurer.

Ms. Jane Young-On testified that J.M.'s scores showed a lack of effort. She drafted the psychological assessment of J.M. after several discussions with Dr. Morris. Her assessment of J.M. which started at 10 a.m. concluded at 1 p.m. when J.M. asked to stop the assessment. Usually, a complete assessment is six hours long. She found the testing results for pain were invalid as there was too high a level of endorsement or reporting. Due to the inconsistencies, high endorsement and lack of completion of testing, it was not possible to provide a rating for J.M. There was no disagreement between she and Dr. Morris that they were unable to arrive at a rating with any confidence. She conceded that J.M. had challenges with his activities of daily living but she was not confident about the amount of his impairment. With respect to social functioning, she did not believe she had enough information.

WHOLE PERSON IMPAIRMENT

Dr. Harold Becker testified as an expert in rating impairment under the *AMA Guides* (4th Edition). On April 4, 2012, he conducted a file review from the date of the accident. He reviewed Dr. Sangha's findings for a catastrophic impairment rating under criterion 7 (physical impairments) which concluded that J.M. demonstrated a 45% whole person impairment (WPI) based on *AMA Guides* 4th edition analysis and use of the Combined Values Guide to add his

[13]Exhibit 5, Tab 7, pages 6 & 12

neuro-musculoskeletal impairments including medication side effects (3% WPI), DRE II lumbo-sacral spine impairments (5% WPI) and gait derangement – routine use of two canes or two crutches (40% WPI).

Dr. Sangha provided alternate ratings for severe right LCL laxity (10% WPI), left moderate ACL impairment (7% WPI), bilateral medial meniscal injury (0% WPI) and right patellofemoral syndrome (2% WPI). However, he stated that instead of using the ratings for individual lower extremity impairment, it was more appropriate to use the gait derangement table. Dr. Becker agreed that as J.M. suffered multiple injuries with a fibular head fracture and ligament damage coupled with a pain disorder and as he is in Axis 1, the Gait Derangement Table works best. Dr. Becker concluded that with respect to physical impairments, J.M. demonstrates a 45% whole person impairment, a score which does not independently meet the catastrophic impairment threshold. With respect to mental and behavioural impairments, J.M. meets the catastrophic definition independently with two Marked (Class 4) impairments in Activities of Daily Living and Concentration, Persistence and Pace and a whole person impairment rating of [(45) + (36-44)] or 65-69% WPI. In other words, J.M. crosses the catastrophic threshold without providing the 40% WPI rating for the use of two canes or two crutches; that is using the Combined Values Guide [3 + 5 +10 + 7 + 2] + [(36-44)] or [(24)]+[(36-44)] = 51-57%WPI. Consequently, Dr. Becker submitted an application finding that J.M. met the catastrophic threshold under both criteria.

Dr. Becker testified that the *AMA Guides* rate impairment and do not provide a diagnosis. J.M. has experienced a loss of function with an injury to his knee resulting in an inability to bend it properly. His major problems relate to walking. The Gait Derangement Table rates impairment but does not provide a diagnosis. A medial meniscal injury is not rated unless surgery is required. However, a meniscus is the cartilage between joints. Dr. Oshidari restricts the use of the gait table to a situation where there are multiple fractures, ligament damage or dislocation. Dr. Becker testified that if there are a lot of injuries to the lower extremity, including both legs, the result is more impairment.

Dr. Becker reviewed Dr. Morris's report where his methodology resulted in a 0% rating. Dr. Becker is not a psychologist and he is restricted to using the *AMA Guides* to determine the impairment rating. While he does accept that Dr. Morris found that J.M. was unrateable according to Dr. Morris, he does not accept that the result is equal to zero as J.M. has an impairment.

CONCLUSION

J.M. relied on the decision in *Fournie and Coachman Insurance Company*[14] which is similar to the case before me. The arbitrator found that Mr. Fournie met the definition of catastrophic impairment as found in both paragraph 2(1.2)(f) and paragraph 2(1.2)(g) of the *Schedule*. Mr. Fournie had injuries to his left heel and ankle as a result of an accident. Coachman submitted that in order for Mr. Fournie to surpass the 40% maximum WPI, he must have sustained bilateral impairments to his lower extremities. Also, the use of a brace and bilateral arm crutches was not sufficient and even if his psychological impairments were to be combined with his physical impairments, his WPI would not meet the 55% threshold. However, the arbitrator found that the Gait Derangement Table was the most appropriate way to assess his injuries. He also found that Mr. Fournie required the use of two crutches for his safety, to promote his independence and to improve his quality of life. When reviewing the evidence of mental and/or behavioural impairment, the arbitrator found that a Class 4 impairment was required in only one area of functioning in order to have an individual declared catastrophically impaired. In the case before me, J.M. was found to have two Class 4 (marked) impairments in the area of mental and/or behavioural impairment. J.M. also relies on the Court of Appeal decision in *Pastore*[15] where one marked impairment was found to be sufficient for a catastrophic impairment designation.

State Farm submitted that it agrees that J.M. is impaired but disagrees about the extent of his impairment. State Farm relied on its orthopedic examinations by Drs. Wolfson, Dipasquale, Esmail, French, Kwok and Oshidari. These examinations found varying degrees of impairment

[14](FSCO A07-000297, February 12, 2010)

[15]*Pastore and Aviva Canada Inc. and Financial Services Commission of Ontario and Ontario Trial Lawyers Association, Insurance Bureau of Canada and the Attorney General of Ontario,* 2012 ONCA 642

involving the right and left knees with some instability but no atrophy in the legs which raised a question about J.M.'s need for crutches. State Farm insisted that the Gait Derangement Table should not be used to rate J.M.'s impairment when there is evidence of symptom magnification. I disagree.

I prefer the reasons articulated by Drs. Sangha and Becker for using the Gait Derangement Table in the case before me. J.M.'s primary physical impairment involves his lower extremities and bilateral instability. He suffers from a constellation of injuries which include a right fibula fracture, a left ACL tear, and a left and right medial meniscus tear coupled with major depression and pain disorder. Also, I do not accept that J.M. is unrateable for physical impairment. None of his medical assessors disagreed that he suffered from a physical impairment. While it may have been challenging to assess J.M., it is reasonable to consider all of the information, as Dr. Sangha did in order to rate the degree of his impairment.

The flaw in Dr. Oshidari's methodology is that no consideration is given for J.M.'s knee problems as surgery is not required. However, the sole reason surgery is not required is because it would not correct J.M.'s impairment issues. In these circumstances, the Gait Derangement more accurately captures and rates J.M.'s disability. J.M.'s injuries are consistent with his experiences with instability and falling which were corroborated by his family members. As a result, he routinely relies on the use of crutches to ambulate. I prefer Dr. Sangha's approach to rating J.M.'s impairments to that of Dr. Oshidari. Even if Dr. Oshidari had inconsistent test results, I do not find it reasonable that he concluded that it was impossible to rate J.M.'s physical impairments when it was evident from all of the assessment reports that J.M. has a physical impairment.

State Farm disputes Dr. Frank's findings of two Class 4 Marked impairments in the area of mental and/or behavioural impairments on the basis that there was only a brief screening with invalid test results as J.M. was not a reliable historian. According to State Farm, there was no accurate basis for Dr. Frank's opinion. I disagree. I find that Dr. Frank's scores and ratings of J.M.'s impairments are founded on reliable evidence. I was impressed with Dr. Frank's report and his testimony which was balanced and considered. State Farm offered little to counter

Dr. Frank's evidence as it chose not to request that the assessment of J.M. by Dr. Morris and Ms. Jane Young-On be rescheduled and completed. Although Dr. Morris and Ms. Jane Young-On arrived at a rating of 0% for J.M., I do not find that an acceptable approach in the circumstances. A more reasonable conclusion might have been that it was impossible to rate J.M. until the testing was concluded. It would then have been the responsibility of State Farm to reschedule the assessment for the purpose of completing the testing. I also find that it was unrealistic to expect J.M. to complete six hours of psychological testing in one day.

I accept the ratings calculated by Drs. Sangha, Becker, and Frank. With respect to physical impairments, J.M. demonstrates a 45% whole person impairment, a score which does not independently meet the catastrophic impairment threshold. However, when calculating a true whole person impairment rating, he crosses the catastrophic threshold with a whole person impairment rating of [(45) + (36-44)] or 65-69% WPI. With respect to mental and/or behavioural impairments, J.M. meets the catastrophic definition independently with two Marked (Class 4) impairments in Activities of Daily Living and Concentration, Persistence and Pace. While I believe there is merit to Dr. Becker's suggestion that J.M. may cross the catastrophic threshold without using the gait derangement table, I find that the gait derangement table is the most appropriate means for rating J.M.'s physical impairments. As an alternative, Dr. Becker used the Combined Values Guide and individual ratings to arrive at the following calculation: [3 + 5 +10 + 7 + 2] + [(36-44)] or [(24)]+[(36-44)] = 51-57%WPI.

I find that J.M. meets the catastrophic impairment definition with a WPI of 65-69% under the whole person impairment rating. I also find that J.M. meets the catastrophic impairment definition independently under mental and behavioural impairments as he has been assessed with two Marked (Class 4) impairments. Consequently, I find that J.M. meets the definition of catastrophic impairment in paragraphs 2(1.2) (f) and 2(1.2)(g) of the *Schedule.*

January 24, 2013

Judith Killoran
Arbitrator

Date

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A10-001364

BETWEEN:

J. M.

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. J.M. meets the definition of "catastrophic impairment" in paragraphs 2(1.2)(f) and 2(1.2)(g) of the *Schedule*.

January 24, 2013

Judith Killoran
Arbitrator

Date