**Financial Services Commission of Ontario**

**Commission des services financiers de l'Ontario**

**FSCO A13-000812**

**BETWEEN:**

**JENNIFER MOSER**

**Applicant**

**and**

**GUARANTEE COMPANY OF NORTH AMERICA**

**Insurer**

# REASONS FOR DECISION

**Before:** Edward Lee

**Heard:** June 10-13, and June 17-19, 2014, and in London, Ontario. Written submissions received July 11, 2014

**Appearances:** Kimberley Munro for Mrs. Moser
Rose Bilash and Alexander Neaves for Guarantee Company of North America

## Introduction:

The Applicant, Jennifer Moser, was injured in a motor vehicle accident on August 11, 2009. She applied for and received statutory accident benefits from Guarantee Company of North America ("Guarantee"), payable under the *Schedule*.[1] Ms. Moser now seeks a determination that she was catastrophically impaired as result of the accident. The parties were unable to resolve their disputes through mediation, and Mrs. Moser 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.

## Issues:

1. Is Ms. Moser catastrophically impaired in that she suffers an impairment that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to a mental or behavioural disorder?

2. Is Ms. Moser catastrophically impaired in that she suffers from an impairment or combination of impairments that, in accordance with the *Guides to the Evaluation of Permanent Impairment*, results in 55 per cent or more impairment of the whole person?

3. Is Ms. Moser entitled to the costs of assessments as part of a catastrophic report in the amount of $7,006.00?

4. Is Ms. Moser entitled to attendant care benefits as set out in the agreement dated June 9, 2014, to be awarded should Ms. Moser be determined to be catastrophically impaired?

5. Which party, if any, is liable to pay the other's expenses in respect of the arbitration?

6. Is Ms. Moser entitled to interest for the overdue payment of benefits?

## Result:

1. Ms. Moser does not suffer from an impairment that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to a mental or behavioural disorder.

2. Ms. Moser does not suffer from an impairment or combination of impairments that, in accordance with the *Guides*, results in 55 per cent or more impairment of the whole person.

3. Ms. Moser is entitled to the cost of assessments in the amount of $6,000.00 plus HST (if applicable).

4. Ms. Moser is not entitled to attendant care benefits as set out in the agreement dated June 9, 2014.

5. Guarantee is entitled to its expenses in respect of the arbitration.

6. Ms. Moser is entitled to interest for the overdue payment of the benefits awarded in this arbitration.

## Overview:

Ms. Moser claims she was catastrophically impaired as a result of the injuries she suffered in her car accident. Her impairments are the following: mental and behavioural disorders, closed head injury/cognitive and neuropsychological findings, facial scarring or laceration, dental/oral injuries, nasal fracture, right knee injury, left knee injury, dysphagia/choking, and neck injury.

Her medical experts, Omegamedical Associates ("Omega"), say that she suffers from an impairment that in accordance with the *Guides to the Evaluation of Permanent Impairment*, 4th Edition, 1993, (the "*Guides*"), results in a marked or extreme impairment due to a mental or behavioural disorder. Alternatively, or in addition, her impairment or combination of impairments, in accordance with the *Guides*, results in a 55 per cent or more impairment of the whole person.

Dr. H. Becker MD, and clinical coordinator for Omega, summarized the rating of Ms. Moser's WPI as follows:

> If Dr. Lisa Becker's revised rating as determined for physical impairments (27-58%) is combined with our rating determined by Dr. J. Frank for mental and behavioural impairments as previously outlined in our OCF-19, Ms. Moser demonstrates at least **27-61% WPI** [(27-58)+(0-8)] if cognitive impairment is included strictly under Criterion 7 or, **38-68% WPI** [(27-58)+(15-23)] if cognitive impairment is included in the mental and behavioural rating under Criterion 8.[2]

[2] Page 45, Volume 1 of Joint Brief

Guarantee's medical experts, Benchmark Independent Medical Examinations Inc. ("Benchmark"), contested not only the ratings of Ms. Moser's impairments, but also argued that the car accident was not the cause of some of those impairments.

Dr. W. Gnam, psychiatrist and clinical co-ordinator for the Benchmark, rated Ms. Moser as follows:

> If one were to accept the assumption that (due to the SABS impairment and stability definitions) an impairment rating for Ms. Moser's dental impairment is warranted, and should be assigned based upon her present dental impairment, utilizing the upper bound of Dr. Gryfe's 1-2% WPI range produces a revised total whole person physical impairment score of 17% WPI under Criterion 7 (SABS' Criterion 3.2(e)). Accordingly Ms. Moser's physical impairments do not achieve the catastrophic 55% WPI threshold.
>
> …
>
> Combining physical with mental impairments (after first excluding the brain injury WPI from the total physical impairment score, to prevent double-counting) results in a total combined WPI of 21%. **Ms. Moser's whole person impairment score does not attain the 55% threshold even when physical and mental impairments are combined.**[3]

## EVIDENCE AND ANALYSIS:

### 1. Is Ms. Moser catastrophically impaired in that she suffers an impairment that, in accordance with the *Guides*, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder?

Arbitral caselaw and the jurisprudence have held that an analysis as to whether an applicant is catastrophically impaired under section 3(2)(f) of the *Schedule* involves a three part test.[4] The factors to be assessed are the following:

[3] Page 168, Volume 1 of Joint Brief

[4] *Pastore and Aviva Canada Inc.* (FSCO A04-002496, February 11, 2009), 2012 ONCA 642, *Mujku and State Farm Mutual Automobile Insurance Company* (FSCO A10-002979, January 14, 2013)

1. Did the accident cause the applicant to suffer a mental or behavioural disorder?

2. If it did, what is the impact of mental or behavioural disorders on their daily life (as described in the table at page 301 of chapter 14 of the *Guides*)?

3. In view of the impact, what is the level of impairment (as described in the table at page 301 of chapter 14)?

Further, to be catastrophically impaired, the applicant needs to suffer a marked or extreme impairment in *only one* of the four areas or aspects of functioning listed at page 301 of Chapter 14 of the *Guides.* Those four areas or aspects of functioning are:

(1) Activities of Daily Living

(2) Social Functioning

(3) Concentration, Persistence and Pace, and

(4) Adaption.

In the present case, the assessment of mental and behavioural disorders was conducted by Dr. Frank, psychologist for Ms. Moser (as part of the Omega team); and Dr. Gnam, psychiatrist, for Guarantee (as part of the Benchmark team).

Dr. Frank found that Ms. Moser did not meet DSM-IV diagnostic criteria for a psychological disorder as a result of the accident.[5] He rated her impairments as nil to mild in all four domains of the table at page 301. He determined that Ms. Moser was "not even close to catastrophically impaired under this category alone [mental/behavioural disorders]".

Dr. Gnam came to a very similar conclusion. He did not diagnose a mental or behavioural disorder. He rated her impairments under the four domains as follows: Activities of Daily Living

[5]Page 10, Tab 1A, Volume 1

were nil to mild; Social Functioning was nil to mild; Concentration, Pace and Persistence was mild; and Adaptation was mild.

I agree with their assessments. I find that Ms. Moser does not suffer from an impairment that results in a marked or extreme impairment in any of the four areas of functioning due to a mental or behavioural disorder. Therefore she is not catastrophically impaired under this category.

### 2. Is Ms. Moser catastrophically impaired in that she suffers from an impairment or combination of impairments that, in accordance with the *Guides*, results in 55 per cent or more impairment of the whole person?

For Ms. Moser to succeed under this section, she must prove she suffered an impairment or impairments due to the car accident. The impairments must be rated in accordance with the *Guides*. The ratings for the physical aspects (as I term them) of her impairments must then be combined with a rating for her mental and behavioral impairments to provide a combined or final Whole Person Impairment rating.[6] The final rating must result in 55% or more impairment of the whole person.

The positions taken by the parties in regard to Ms. Moser's impairments are summed up in the following table:

| Impairment | Omega | Benchmark |
|---|---|---|
| Facial Scars | 0-5% | 5% |
| Neck (Cervicothoracic) | 5% | 0% |
| Oral/dental | 5-19% | 2% |
| Nasal Fracture | 0-5% | Not Rated |
| Right Knee | 15% | 6% |
| Left Knee | 2% | 0% |
| Dysphagia | 1-14% | 0% |
| Cognitive | 1-14% | 5% |
| **Total Physical WPI** | **27-58%** | 17% less cognitive rating of 5%= **13%** |

[6]*Kusnierz v. Economical Mutual Insurance Company* [2011] O. J. No. 5908 (C.A.)

| **Mental/Behavioural** | Nil-mild<br>GAF:65 -70 (cognitive excluded)<br>0-8% (cognitive excluded)<br>15 – 23% (cognitive included) | Nil-mild<br>GAF: 64-66 (cognitive excluded)<br>9% |
|---|---|---|
| **TOTAL COMBINED** | 0%-8%+<br><br>27%-58%<br>27%-61%<br>(cognitive included only as a physical impairment)<br>- OR -<br>15% - 23% +<br>27%-58%<br>**38% - 68% WPI**<br>(cognitive included both as a physical impairment and as a mental and behavioural impairment) | **13% + 9% = 21%** |

In the next section, I will rate Ms. Moser's impairments resulting from the following injuries: close head injury/cognitive or neuropsychological findings, facial scarring/lacerations, right knee, neck, left knee, oral/dental injuries, nasal fracturing, and dysphagia (the "physical aspects of her injuries").

In the section after that, I will translate the assessment of Ms. Moser's mental and behavioral impairment to a numerical score (the "mental aspect of her impairment") that can be combined with the physical aspects of her impairments.

Finally, I will combine the physical aspects of her impairments with the mental aspect to provide a combined score for her whole person impairment rating.

### *(I) What are the ratings for the physical aspects of Ms. Moser's injuries?*

#### *(a) Closed Head Injury/Cognitive or Neuropsychological Findings:*

Dr. D. Kurzman, clinical neuropsychologist, assessed Ms. Moser's closed head injury or cognitive or neurological findings on behalf of the insurer.[7] He concluded Ms. Moser had suffered a mild traumatic brain injury with mild residual deficits resulting in pain and mild emotional or psychological distress as it related to cognitive function. Ms. Moser had also undergone a detailed assessment of neurocognitive functions shortly before Dr. Kurzman's assessment,[8] and he applied these results to his analysis.

Dr. Kurzman rated Ms. Moser's mental status impairments under Table 2 of Chapter 4, Page 140 of the *Guides* and placed her in the lower limits of Category I (1-14%). He provided her with a WPI of 1-5% with respect to her mental status impairment, which was finalized at 5% WPI by Dr. Gnam, the Benchmark clinical co-ordinator.

On the Insured's side, Dr. L. Becker, physiatrist, also found Ms. Moser had suffered a closed head injury and was suffering from post-concussive syndrome. She also diagnosed a mild traumatic brain injury, headaches, dizziness, and fatigue. As Ms. Moser performed all her Activities of Daily Living, Dr. L. Becker placed Ms. Moser in the same Category I (1-14%) as Dr. Kurzman.

Based on the consistency in the two completing assessments, and the overall evidence in this matter, I find that placing Ms. Moser in Category I of Table 2 at page 140 is appropriate.
The point of contention between the parties was whether it was appropriate to narrow the range from 1-14%.

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[7]Pages 28-55, and 66-162 of Volume 1

[8]Page 143, Volume 1

### *i. The Application of Wide Impairment Ranges:*

Dr. L. Becker's position (echoed by Dr. H. Becker), was that it was not possible to narrow the range of 1-14% found in Table 2 of Chapter 4 of the *Guides*. When questioned as to whether a refusal to narrow a range was a failure to exercise an evaluator's discretion, Dr. L. Becker responded that it was not a failure, but rather that the *Guides* themselves offered no way to select a number within a range. In fact, she noted several examples where the evaluator was directed to choose the higher number when a range existed.

Nevertheless, I found that an analysis of the examples cited by Dr. L. Becker did not support her contention. For instance, Dr. L. Becker referred first to section 3.2i in the *Guides*, "Diagnosis-based Estimates"[9], and suggested the last paragraph in the right hand column was an example of a *Guides*-based direction to choose a higher impairment rating. On reading that paragraph, it is clear the *Guides* are giving direction when *two* different methods of assessing an impairment are being used, in this case, the rating for arthritic degeneration *or* the rating obtained by using ranges of motion. This example *does not* direct or suggest that an evaluator should choose the higher numerical value when a wide range of impairment values is provided within a *single* category or assessment method.

The same problem is found in the other two examples cited by Dr. L. Becker, at page 99 of the *Guides* in reference to structural inclusions, and at page 140 in regard to the central nervous system (section 4.1). The last paragraph in the section on structural inclusions of the *Guides* directs the evaluator to place the patient in the category with the higher impairment percent, "… [i]f the patient demonstrates the structural inclusions of *two* categories." [Italics mine]

With respect to the central nervous system, the evaluator is tasked with assessing nine different categories of forebrain impairment. "A patient may have more than one of the types of cerebral dysfunction listed above. The most severe of the first five categories shown above should be

[9]Page 84

used to represent the cerebral impairment."[10] Again, the direction is to apply the most severe rating *across* different categories, but not *within* a single category.

Even the wording in section 3.2i of the *Guides* on Diagnosis-based Estimates suggests that narrowing a range may be an appropriate exercise by an evaluator through the use of clinical evaluation. "For most diagnosis-based estimates, the ranges of impairment are broad, and the estimate will depend on *clinical manifestations*."[11] [italics mine]

Both Dr. Gnam and Dr. H. Becker testified at length about the appropriateness of narrowing wide impairment ranges set out in the *Guides*.

Overall, I was convinced that in many cases, it was indeed appropriate and possible to derive a more precise rating from a wide range of possible values listed within a category in the *Guides*. For instance, many references in the *Guides* themselves, especially in the early chapters setting out the meticulous methodology to be used when rating impairments, suggest that wide impairment ranges may be narrowed. The following are directions in the *Guides* to be as specific as clinically possible:

> "The impairment estimate or rating is a *simple* number."[12] [not a range]
>
> "A final estimated whole-person impairment percent, … may be rounded to the nearer of the two nearest values ending in 0 or 5."[13] There is no suggestion here that a WPI should be expressed as a range of values as wide as 1-14.
>
> "A proper medical evaluation accurately documents the individual's *clinical* status."[14] This suggests and underlines the importance of the evaluator's clinical observation and diagnosis.

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[10]Page 140 of the *Guides*

[11]*Ibid*., at page 84

[12]Page 8 of the *Guides*

[13]Page 9 of the *Guides*

[14]Page 8 of the *Guides*

> "The second step in assessing the impairment is analyzing the history and the clinical and laboratory findings to determine the nature and *extent* of the impairment or dysfunction …"[15]
>
> Under Rules for Evaluations: "The physician must utilize the entire gamut of *clinical skill and judgment* in assessing whether or not the results of measurements or tests are plausible and relate to the impairment being evaluated."[16] This underlines once again the importance of clinical judgment and skill on the part of the evaluator.
>
> "If in spite of an observation or test result the medical evidence appears not be of sufficient weight to verify that an impairment of a certain magnitude exists, the physician should *modify the impairment estimate accordingly* …"[17]
>
> "An impairment percentage derived by means of the *Guides* is intended, among other purposes, to represent an informed estimate of the degree to which an individual's capacity to carry out daily activities has been diminished."[18]
>
> "The physician's *judgment and his or her experience, training, skill, and thoroughness in examining* the patient and applying the findings to *Guides* criteria will be factors in estimating the *degree* of the patient's impairment."[19]
>
> "The physician performing an impairment evaluation must provide *more than a number or percentage*. The physician should provide as comprehensive a picture of the patient as possible using the Report of Medical evaluation Form as an outline."[20] [italics mine]

I find these statements in the *Guides* suggest that clinical observation, training, judgment, experience, skill, and thoroughness of evaluation should be used to derive as precise a rating for an impairment as possible. These factors may indeed narrow a wide range of values. I therefore agree with Dr. Gnam, and reject Dr. L. Becker's and Dr. H. Becker's opinion that such ranges may not be narrowed by an evaluator.

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[15] Page 8 of the *Guides*

[16] *Ibid.*

[17] *Ibid.*, at Page 8

[18] Page 2

[19] Page 3

[20] Page 5

Further, even if I am wrong in regard to my interpretation as to how the *Guides* suggest an evaluator might narrow an impairment range, I find that an arbitrator making a determination under the *Schedule* may certainly apply and accept credible, trustworthy, and probative evidence to narrow a wide impairment range. Even Dr. H. Becker recognized this:

> "While clinical judgment may apply, I believe the issue falls under a legal purview rather than a medical one … As in *Liu*, … the issue to be determined with respect to a statutory interpretation falls to a legal determination when an impairment range is provided in the AMA Guides."[21]

Clearly, Dr. H. Becker allows for the exercise of some clinical judgment (on the part of the evaluator), but also agrees that the final answer on narrowing a range falls to the arbitrator. The *SABs* arbitrator is tasked with determining on a balance of probabilities whether the applicant suffers from an impairment or combination of impairment that results in 55 per cent or more of the whole person (the *Guides* themselves suggest the final value might be rounded off to the nearest number ending in zero or five). The arbitrator does not have the luxury of expressing the WPI rating as a wide range of values, all equally possible. As well, it is important to note that an expert may never usurp the function of the trier of fact, which is to decide the issue in dispute.

Although Dr. L. Becker rated Ms. Moser's closed head injury with a WPI of 1-14%, she did not indicate whether the number was closer to 1% or 14%. As with all the estimates the Omega team expressed as wide ranges (including the final totals), she simply testified that it was not possible to obtain a more precise figure. I find that assigning the range of 1-14% to an injury provides little, if any, aid to an arbitrator seeking to arrive at a final WPI rating in a proceeding under the *Schedule*.

In the present case, I find more convincing Dr. Kurzman's opinion that Ms. Moser's neurocognitive profile was generally within normal limits.[22] Although Ms. Moser testified she still experienced some difficulties in cognitive functioning, she nonetheless experienced few

[21]Page 55, Volume 1

[22]Page 143, Volume 1

problems with activities of daily living, and had returned to near full employment. This statement was consistent with all the evidence adduced at the hearing.

Based on all this evidence, I agree with Dr. Kurzman's estimate that Ms. Moser's impairment falls within the lower limits of category one.

I accept, as Dr. Gnam suggested, a WPI rating for the closed head injury/cognitive or neurological findings of 5%.

*(b) Facial Scarring/Facial Lacerations:*

The parties agreed the facial scarring or facial lacerations should be rated at 5% WPI. I am convinced this is an appropriate rating for this impairment.

*(c) The Right Knee:*

The parties agreed Ms. Moser had injured her right knee in the car accident. They disagreed as to the severity of the injury and the extent of the impairment.

Dr. J. Mathoo, physiatrist, assessed Ms. Moser for Guarantee on November 23, 2011.
He examined both knees and found she had full active range of motion, with no instability of ACL, PCL, MCL, or LCL. According to him, the ligamentous complex was fully intact with no give or associated pathology. There was no suggestion of abnormality.

Dr. Mathoo found the injuries to the right knee had largely healed or resolved and he did not assign any impairment rating to the right knee based on laxity of the PCL or MCL. Nevertheless, he did diagnose chondromalacia patella in the right knee and rated her with a WPI of 4 - 6%.

Dr. L. Becker, physiatrist for the Omega team, assessed Ms. Moser on August 9, 2011. In testimony, she stated that she had found severe laxity in the right knee with a high grade tear of the PCL and a high grade tear of the MCL. She then applied Table 64 on Page 85 of the *Guides* and determined that cruciate and collateral ligament laxity led to 15% WPI.

Overall, I found Dr. Mathoo's evidence more probative and convincing than that presented by Dr. L. Becker. Amongst other reasons, the methodology applied in Dr. L. Becker's examination, reflected in her note-taking practices, led me to conclude that her evidence was less reliable than that of other evaluators.

Dr. L. Becker's entire report in regard to her original examination consisted of three pages of handwritten, "fill-in-the-blank" notations and measurements. The eleven-page text analysis at Pages 32-42 of Vol. I, dated May 7, 2013, addressed only subsequent diagnoses of the left knee and dysphasia.

In her handwritten notes on the right knee, Dr. L. Becker used the notation: "++ lachman". She noted "high grade PCL tear—cruciate" and "high grade MCL tear—collateral". She assigned a rating of 15% to the right knee, using Table 64 in Chapter 3 of the *Guides*.

Dr. H. Becker, when reviewing this in his executive summary, made the following comment (at page 27):

> Turning to the further analysis of Dr. Lisa Becker, the following commentary regarding the orthopedic injuries is noted. As a result of the accident, Ms. Moser sustained high grade injury to the posterior collateral ligament and medial collateral ligament of the right knee and also demonstrated findings of moderate chondromalacia patellae. Dr. L. Becker provided a rating of 15% WPI for the knee impairment, noting that this particular combination of injuries was not listed in AMA *Guides* Table 64, Impairment Estimates for Certain Lower Extremity Impairments, page 85. Rather, and in keeping with the "most analogous" directive in the SABS, she chose the *most analogous impairment* being a cruciate and collateral ligament laxity injury, severe, for 15% WPI.[23] [italics mine]

[23] Page 27 of Volume 1 at Tab 1A

It appears Dr. H. Becker assumed Dr. L. Becker's rating of 15% WPI (on the table on page 85 of the *Guides*) was based on analogy, noting the injuries to the PCL and MCL and chondromalacia patellae. Nevertheless, in testimony, Dr. L. Becker contradicted Dr. H. Becker's statement that she had rated by analogy, and stated she had indeed found severe laxity in both the PCL and MCL.

The only notation regarding laxity in Dr. L. Becker's notes is the following:[24]

> -knees-
> I ++lachman –leg laxity
> MCL laxity -[no]effusion

In testimony, she explained that her notation, "++lachman" meant "severe". The words "MCL laxity" appear on the line immediately below. There is no specific reference to PCL laxity whatsoever (severe or otherwise) in her notes.

When asked whether the Lachman test was really a test for the ACL, Dr. L. Becker answered that the Lachman tested the anterior and posterior translation of the tibia and femur. "It could test for both." [the ACL and PCL]

She added that one could perform a Lachman or a "reverse Lachman," which tested for the PCL, and this was what she did in this case. Nevertheless, her notes did not indicate the performance of the "reverse Lachman."

When questioned further about the use of the "other test for the PCL", (the Drawer Test — another diagnostic tool to test for laxity in the PCL), Dr. L. Becker responded that she was familiar with that test, and her "usual practice" would be to perform the Drawer Test, "if she sensed laxity." Nevertheless, here too, she admitted that she "did not recall" if she had performed the Drawer Test. Further, there was no mention of the use or application of such a test in her notes.

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[24] Page 12, Tab 1A, Volume 1

Finally, Dr. L. Becker stated that she did not recommend follow-up procedures or that Ms. Moser recommence her use of a knee brace despite the diagnosis of severe laxity in both ligaments, and any concern that Ms. Moser's knee might "blow out".

I found that Dr. L. Becker's note-taking was insufficient and did not withstand the questioning she received on cross-examination. It was unclear from her testimony where she had noted severe laxity in both the PCL and MCL. She had no present memory or recollection of her examination of Ms. Moser. Also unclear was the testing protocol Dr. L. Becker had performed on Ms. Moser to arrive at her conclusions, and why she had not documented their execution, despite her assertions that she had performed them. All these deficiencies detracted from the general reliability, credibility, and probative value of her evidence.

In contrast, Dr. Mathoo's testimony in regard to how he positioned Ms. Moser's leg, knee, and body to conduct his tests for laxity was very convincing. Dr. Mathoo stated that the "reverse" Lachman test was not known in the literature. Instead, the Lachman test was a test for the ACL. Not only did Dr. Mathoo not discover "severe" laxity, but no other imaging evidence or examinations revealed this finding. According to Dr. Mathoo, "severe" laxity, as described by Dr. L. Becker, would have suggested the need for bracing or surgery (Ms. Moser had previously been prescribed with and wore a knee brace, but was no longer using this device at the time of this examination).

Further, nothing in Dr. Mathoo's cross-examination caused me to doubt his conclusions, testing, and note-taking protocols. As well, the preponderance of the evidence in the record supported Dr. Mathoo's findings.

An MRI of the right knee taken on September 8, 2009, stated the following: "mild PCL laxity, with moderate thickening of proximal third of MCL. There is approximately 50% disruption of MCL fibers. High grade II-III proximal MCL tear, high grade partial PCL tear."[25]

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[25] Page 84, Volume 1

Dr. Haider examined Ms. Moser's right knee on November 18, 2009. He found she had "slight laxity, but better than when I saw her last time."[26]

Dr. Haider did a follow up examination on January 3, 2010. This time, he made this comment: "There is no instability on gross examination."[27]

Another MRI was performed on March 9, 2010. It made no mention of the "50% disruption of MCL fibers" noted in the earlier MRI of September 2009. With regard to the PCL, this comment was made: "Intact, there is thickening and signal abnormality in the PCL near the femoral insertion in keeping with moderate strain. The appearance is similar to previous."[28]

According to Dr. Mathoo, the second MRI was objective evidence of internal change and healing. There was no longer reference to a 50% disruption of MCL fibers. Further, the earlier MRI mentioned both MCL and PCL tears. The later MRI made no such mention. There was mention of mild laxity in the PCL in the first MRI. The second MRI made no such mention. Dr. Mathoo testified that protection of the knee, and the use of a brace would aid the normal progression of healing. Collagen would be laid down between the ends of the ligament to restore strength and stability. The more severe findings would be present earlier in the diagnostic history. These imaging results corroborate Dr. Mathoo's opinion that ligaments can, and do heal, with time and rehabilitation.

Dr. Karabatsos, orthopedic specialist, examined Ms. Moser on August 12, 2010. In regard to her right knee, he stated the following: "Examination of both knees revealed no swelling. She had full range of motion. There was no crepitus. *There was no ligamentous instability*. There were no effusions."[29] [italics mine]

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[26]Page 93, Volume 2

[27]Page 94, Volume 2

[28]Page 97, Volume 2

[29]Tab 2A at Page 21

The only other examiner who reported laxity was Dr. K. Willits, (orthopedics specialist). He examined Ms. Moser on March 2, 2011 and made the following comment: "Physical exam today reveals grade 2 PCL laxity with no other ligamentous injury. *Her knee is quiet on exam today and good and strong*."[30] [italics mine]

Very importantly, Dr. G. Delaney, a second physiatrist who conducted another examination on behalf of Ms. Moser on November 29, 2011, did not report findings of laxity in Ms. Moser's right knee.[31] Her explanation for the lack of such a finding was simply unconvincing. She testified that sometimes a patient could resist the manipulations of the knee during an examination for laxity. Dr. Mathoo's explanation was much more credible. He stated that proper placement and application of the test at this time, more than two years post-accident, would reveal laxity, if it existed.

Given the overall evidence, I reject the suggestion of Dr. L. Becker that the right knee be rated 15% WPI under Table 64 of Page 85 of the *Guides* because of severe laxity in the two ligaments.

Nevertheless, I note that Dr. Mathoo diagnosed Ms. Moser with severe chondromalacia patellae in the right knee, evidenced by patella femoral crepitus. Dr. Mathoo applied table 62 on page 84 of the *Guides* and determined this resulted in a WPI of 4-6% for the right knee. Dr. Gnam, in his executive summary, rated the right knee with 6% WPI.

Based on the evidence, I agree with this rating of 6% WPI for the right knee.

### *(d) The Neck:*

Guarantee did not dispute that the accident caused an injury to Ms. Moser's neck. Ms. Moser argued that the injury caused an impairment of 5% WPI. Guarantee argued that the neck should be rated 0% WPI.

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[30] Page 1, Tab 18

[31] Delaney Report, Volume 1, Tab 3A

Dr. L. Becker determined Ms. Moser demonstrated a non-uniform range of motion on examination. Her notes indicate the following in regard to the neck:

> "good ROM—mild decreased ext [denoted by a downward arrow]
> —mild tender
> no spasm no neuralgia [denoted by a null symbol]

In testimony, Dr. L. Becker stated she saw limitations of the extension of the neck. She diagnosed the neck impairment using Table 73 at Page 110 of Chapter 3 of the *Guides*, and placed Ms. Moser in DRE II – non-uniform loss ROM and assigned a rating of 5% impairment to the neck.

Dr. Mathoo's opinion was the neck injury had fully resolved at the time of his examination. He used an inclinometer to take his measurements and found no residual spinal impairment. Further, Ms. Moser demonstrated full range of motion through all planes, without radiculopathy or loss of ROM segment integrity. She displayed no tenderness, spasms, or trigger points, and palpitation of the neck elicited no complaints of pain. Her X-ray and CT scan of August 2009 on discharge were normal. The palpitation allowed him to examine the muscle along its entire length. The lack of problems with ROM and palpitation suggested a full resolution of the injury. Based on these findings, he placed her in DRE I and rated her 0% WPI for the neck.

The other medical evidence in the file tended to echo Dr. Mathoo's findings in regard to neck extension. Dr. Karabatsos observed a full range of motion of her cervical spine.[32]

Dr. Delaney, in November 2011, determined Ms. Moser's neck extension to be normal, although she found abnormalities in the range on motion in other planes.

When asked about the differences between his and Dr. L. Becker's findings in regard to non-uniform loss of range of motion ("dystmetria"), Dr. Mathoo testified that the *Guides* directed the examiner to use the Range of Motion Model as a differentiator to determine the most appropriate

[32]Tab 2A, Page 21

category for the impairment. Based on Table 75 at Page 113, Ms. Moser would fall into Line A of Category II ("Unoperated on, with no residual signs or symptoms"), which would result in a WPI of 0%.

Dr. Mathoo also referenced Table 76 at page 118 of the *Guides* dealing with "cervical region impairment." According to this table, a 4% WPI impairment would be appropriate if the decrease in extension amounted to 40 degrees or two-thirds of the total range of motion. Dr. Mathoo stated that this decrease would have been evident and discernable to any medical professional. In Ms. Moser's case, Dr. L. Becker's only noted observation was that there was a "mild" decrease in extension. For Ms. Moser to experience a 5% WPI, Dr. L. Becker would have had to have observed something in the neighbourhood of a two-thirds decrease of total extension (40/60 degrees). There was nothing in Dr. L. Becker's notes or testimony to suggest that the "mild" decrease she observed amounted to a two-thirds loss. In fact, Dr. L. Becker's notes made no mention of any numerical measurement of the decrease in extension.

Further, Dr. Mathoo's discussion in regard to the mechanism of the injury and its impact on the neck was very convincing. There was no dispute that Ms. Moser had suffered an injury to her right sternoceidomastoid muscle. According to Dr. Mathoo, that injury would have been associated with right-side neck pain and the rotation of the head, but not with limitations in extension. Therefore, there was no pathological connection between the mild decrease in extension observed by Dr. L. Becker and the actual injury itself.

In the present case, three physiatrists evaluated the range of motion of Ms. Moser's neck within a four-month period at or shortly after the two-year mark.[33] Dr. Mathoo's examination in November 2011 was the most recent. He found no limitations in range of motion in any plane. Two examiners found no limitations in extension; only Dr. L. Becker noted a mild decrease in extension. Two examiners found no limitations whatsoever in the other planes. Only Dr. Delaney

[33] I noted the submissions of Ms. Moser at paragraph 150, where it was argued that the ROM findings of L. Farrell and C. Merton should be considered. I gave little or no weight to those findings simply because they were recorded on her discharge from the hospital and within several months of the accident.

noted limitations in rotation and bending, but she did not comment further apart from making this note: "Ongoing chronic neck pain, likely soft tissue in origin."[34]

Based on all the evidence, I found the analysis made by Dr. Mathoo to be the most convincing. I find the appropriate category to place Ms. Moser's neck is DRE I at page 106 of the *Guides*. I assign 0% WPI to Ms. Moser's neck.

*(e) The Left Knee:*

*i. Preliminary Matter:*

At the onset of the hearing, Ms. Moser sought to enter an X-ray of the left knee. Guarantee objected to this document on the grounds that it had not been part of the joint document brief, and that it was being tendered outside of the 30 days permitted by the *Dispute Resolution Practice Code.*[35]

Ms. Moser argued that the document should not be excluded. Not only was it very relevant, but it had been obtained but recently. Thus it had not been possible to submit it within the time frames set out in the *Code*.

I rejected the arguments of Ms. Moser. The test for entering the document was not relevance, but whether "extraordinary circumstances" existed wherein I might allow its entry outside the normal delays.[36] In the present case, the fact that the document had not been obtained until recently was not in and of itself, an "extraordinary circumstance." X-rays are a very ordinary and everyday part of modern medical science. There was no evidence that Ms. Moser had somehow been unable or prevented from obtaining the x-ray in a timely manner. Nor was the need for the x-ray a new development or discovery. The potential probative value of such an

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[34]Volume1, Tab 3A, Page 16

[35]Rule 39 of the *Dispute Resolution Practice Code Fourth Edition Updated — August 2011*

[36]Rule 39.2 *Dispute Resolution Practice Code*

x-ray had been known to Ms. Moser since at least as early as May 2013, when Dr. L. Becker issued her report.[37]

### *ii. Causation:*

Both sides agreed there was chondromalacia patella in the left knee. They disputed whether the car accident had been the cause of this pathology. Dr. L. Becker testified the left knee had been overused in compensating for the right knee injury. The left knee symptoms were more slowly revealed because Ms. Moser had been initially non-weight bearing in a wheelchair, and then wore a right knee brace because she could not use shoulder crutches.

Dr. Mathoo did not agree with this theory. He stated that the effect of the wheelchair and brace would have been to protect the left knee. Because there was no initial weight bearing and a curtailment of activities such as running or stair-climbing, the gradual development of the left knee problem was counter-intuitive. Further, neither he nor Dr. L. Becker had identified the left knee as a problem in either of their examinations.

Nonetheless, the left knee problem had been identified in a report of Dr. Lubinsky and Dr. Kurzman as early as August 2010. In that report, Ms. Moser stated she had developed pain in her left knee as a result of compensating for the right.[38]

Dr. Mathoo also suggested that because there had not been direct trauma to the left knee, the footnote under Table 64, at Page 83 of the *Guides* could not be applied to rate the knee.

In the present case, Ms. Moser was found face down after being struck by the car. She had abrasions on both knees. On the balance of probabilities, I conclude she had experienced some trauma to the left knee. On cross-examination, Dr. Mathoo agreed that some impact would have been sufficient.

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[37] Tab 1A, Volume 1, Page 32-42

[38] Tab 2A, Volume 1, Page 39

The arbitral test for causation is one of material contribution.[39] Here it is reasonable, that after her injury to her right knee, Ms. Moser overcompensated or overused her left knee which led her to develop or exacerbate her chondromalaica patella. The accident materially contributed to this injury.

### *iii. The Rating for the Left Knee:*

Because no x-ray imaging was available, Dr. L. Becker applied the footnote at Table 62, Page 83 of the *Guides* and rated the left knee at 2% WPI.

That footnote reads as follows: "In a patient with a history of direct trauma, a complaint of patellofemoral pain, and crepitation on physical examination, but without joint space narrowing on roentgenograms, a 2% whole-person or 5% lower-extremity impairment is given."

I have already determined that Ms. Moser had a history of direct trauma to that knee and that the accident materially contributed to this injury. She certainly complained of patellofemoral pain, and no roentgenogram evidence was available.

In regard to crepitation, there was no mention of this symptom in Dr. Delaney's report, but she noted crepitation in her personal notes which she presented at the hearing. These notes had not formed part of the joint brief, but Dr. Delaney referred to them in her testimony. Guarantee did not immediately object to the use of the notes and only objected after she had testified about her findings.

I did not exclude her notes or her evidence, because Guarantee's objection was made too late and came only after she had completed her evidence. Although Dr. Delaney did not mention it in her report, I am convinced that there was crepitation in the left knee, as shown in her personal notes. Nonetheless, this omission and deficiency in her report detracted from the overall reliability of her evidence.

[39] *Monks v. ING Insurance Company of Canada*, 2008 ONCA 269

Dr. Delaney suggested the left knee might be rated as high as 3-20% WPI, but her own evaluation noted that Ms. Moser *usually* felt 0/10 pain in her left knee [no pain at all], and at worst, it was 4-5/10, lasting *for a few seconds only* on squatting or doing deep knee bends.[40] I find her suggestion that the WPI could be as high as 20% unsupported by any evidence. Based on the footnote at Table 62, Dr. L. Becker suggested the WPI could be 2%, and I accept this rating for the left knee.

*(f) The Oral/Dental Injuries:*

Guarantee did not contest that Ms. Moser had suffered injuries to her mouth and jaw in the accident. The injuries led to the loss of six upper and two lower teeth, a maxillary fracture, intra-oral and facial lacerations, and some chin numbness.

Dr. L. Becker stated that Ms. Moser had significant dental injuries and eating problems due to the accident. Because the *Guides* did not specifically address the issue of dental injuries, she applied chapter 9 on Mastication and Deglutition by analogy as required under the *Schedule*.[41]

According to Dr. L. Becker, an impairment of 5-19% for a "diet limited to semisolid or soft foods" was appropriate, based on Table 6 at Chapter 9 on page 231 of the *Guides*. Dr. L. Becker repeated that nothing in the *Guides* suggested how that range could be narrowed.

Dr. J. Gryfe, Guarantee's expert, was an oral and maxillofacial surgeon. His opinion was that oral and dental impairments are not mentioned in the *Guides* because full functionality after a dental injury could now be recovered after complete prosthodontic and surgical treatment. Given that Ms. Moser had no dietary restriction and her diet was neither limited to semisolid nor liquid foods, there was no functional impairment on which a WPI rating could be obtained under Table 6.

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[40] Tab 3A, Page 41, Volume 1

[41] Section 3(4)

At the hearing and again in her submissions, counsel for Ms. Moser sought to exclude all of Dr. Gryfe's explanations as to how he rated Ms. Moser because Dr. Gryfe had not been recognized as an expert in the use of the AMA *Guides* to calculate impairments.

I dismissed this objection when it was made and permitted Dr. Gryfe's testimony for the following reasons.

First of all, Dr. Gryfe was qualified as an expert witness in the field of oral and maxillary medicine. As such, he was eminently qualified to testify on these matters and had more expertise than Dr. L Becker, Dr. H. Becker, or any other evaluator who testified in this domain.

Secondly, unlike Dr. H. Becker, Dr. Gryfe had conducted a personal clinical evaluation and examination of Ms. Moser. Dr. Gryfe's rating and evaluation was not based solely on reports, documents, and examinations performed by others. Instead, Dr. Gryfe had a personal knowledge of the facts to which he testified. There is no requirement to be qualified as an expert to testify about facts within one's personal knowledge.

Third and most important, nothing in the *Guides* suggests an evaluator needs to be qualified as an expert or to have undergone a particular course of study or learning to rate or evaluate a patient using the *Guides'* rating system.

Chapters One (Impairment Evaluation) and Two (Records and Reports) of the *Guides* provide the evaluator with an extensive and detailed overview of procedure and methodology. Meticulous instruction is given as to how an evaluator should record, evaluate, assess, weigh, diagnose, and finally, rate a patient. The following unequivocal direction is found in section 2.1, Medical Assessment of Impairment:

> The third step is comparing the results of the analysis with the criterion specified in the guides for the particular body part, system, or function. This comparison is distinct from the preceding clinical evaluation and need not be performed by the physician who did that evaluation; rather, *any knowledgeable person* can compare

> the clinical findings with the Guides criteria and determine whether or not the impairment estimates reflect those criteria. [italics mine][42]

Clearly, no other expertise, lecture attendance, or course work in the *Guides* is required. Further, the *Guides* were neither written nor conceived with the *Schedule* in mind. I was satisfied Dr. Gryfe had adequately applied the procedures required by the *Guides* to rate Ms. Moser. As I stated at the hearing, Ms. Moser's objections to the testimony delivered by Dr. Gryfe about his thought processes, analysis, and how he himself evaluated and rated Ms. Moser go to the probative weight of that testimony, rather than its admissibility.

In the present case, I found Dr. L. Becker's evidence more convincing than that of Dr. Gryfe. Ms. Moser is currently almost five years post- accident. Under the *Schedule,* determinations of catastrophic impairment are routinely sought at the two-year mark. An impairment is defined at section 3(1) of the *Schedule* as a "… loss or abnormality of a psychological, physiological or anatomical structure or function."

I accept Ms. Moser's testimony that as a result of injuries to her mouth, teeth, and jaw, she sometimes has trouble closing her mouth, keeping things in, and swallowing when eating. Sometimes she experienced drooling and leaking. I find this is an impairment and it is appropriate to rate it at this time. This falls clearly within the realm of Chapter 9.3(b) of the *Guides* on mastication and deglutition (chewing and swallowing).

Nevertheless, based on the overall evidence, the impact of this impairment on Ms. Moser was minimal. Ms. Moser reported no dietary restrictions. She was not on a semisolid or liquid diet. She generally ate the same diet she had before the accident. Her problem was that her mouth did not remain closed the way it had before. Ms Moser's only behavioural change was to modify her eating by biting things and eating smaller pieces. She was not afraid to use her teeth.

Under the *Guides*, when mastication and deglutition are impaired, the impairment may be rated by examining the person's diet. The minimal level of impairment (5-19%) requires the person to be restricted to semisolid or soft foods. Here, Ms. Moser had no such restrictions. She had no

[42] *Guides,* Page 9

dietary problems. The evidence simply does not support or allow for the rating suggested by Dr. L. Becker and Dr. H. Becker (5-19%). Ms. Moser's impairment would necessarily be less than 5%.

I find that an appropriate rating for this impairment is 2%.

*(g) Nasal Fracturing:*

Ms. Moser claimed she suffered an impairment due to nasal fracturing. Table 4 at page 230 of the *Guides* discusses "Facial disfigurement and Impairments", and is a guide as to how "specific, prominent facial disfigurements"[43] are to be estimated. The note beneath the table suggests: "With these guidelines, reasonable impairment values can be placed on other facial disfigurements."

Using this table, Dr. L. Becker rated this impairment as 0-5% WPI, placing Ms. Moser in the category "Nasal distortion in physical appearance". In her report she had the following note: "minimal nasal distortion".[44] On cross-examination, Dr. L. Becker was asked "What was the distortion?", and her response was this: "Specifically I could not describe it: there was a distortion in the appearance of the nose."

Dr. H. Becker (who had no specific medical expertise in this field), suggested the nasal distortion might alternatively be categorized as a class two impairment of the whole person (5% to 10%). "A person belongs in class 2 when there is loss of the supporting structure of part of the face, with or without a cutaneous disorder. Depressed cheek, nasal, or frontal bones constitute class 2 impairments."[45]

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[43]See paragraph immediately preceding Table 4 at Page 230

[44]Page 14. Volume 1

[45]Page 229 of the *Guides*

I rejected the suggestion of Dr. H. Becker as it was unsupported by any evidence. No evaluator who actually examined Ms. Moser suggested she be rated in this category, and further, there was no evidence that Ms. Moser had suffered “depressed cheek, nasal, or frontal bones.”

Ms. Moser’s own testimony was that her nose had been fractured in the accident. In regard to deformity of the nose, she had been asked by her plastic surgeon if she wished to take out the “bump”, but she declined.

The overall evidence suggests that the effect of this distortion on Ms. Moser was minimal. Even Dr. L. Becker used this word in her description. It was unclear whether it was a “specific prominent facial disfigurement,” but using the footnote to Table 4, I find it appropriate to rate the nasal fracturing as 1% WPI.

*(h) Dysphagia:*

Ms. Moser testified that some time after the accident, she began to experience periodic choking while trying to swallow food. Sometimes when speaking, she felt a choking sensation in her throat. In June 2012, she was examined by Dr. McKenna, an ear, nose, and throat specialist, who had her undergo a barium swallow. The results of the test were inconclusive, and Dr. McKenna stated that the examination of the base of tongue, and all laryngeal structures was “normal”.[46] No cause of the swallowing difficulties or choking sensation was identified.

Dr. L. Becker testified that dysphasia (defined as difficulties with swallowing, a choking sensation), was a known complication of intubation from undergoing surgeries. Ms. Moser had undergone many surgeries for her oral and dental work and it was very plausible the dysphasia was a result of those intubations. Dr. L. Becker rated it by analogy using page 147 of *Guides*, under Table 12, impairments of medulla and posterior hindbrain (1-14%).

Dr. Gnam testified that the examination and barium swallow test performed on Ms. Moser had given normal results. There was no direct evidence that Ms. Moser’s throat had been damaged by

[46] Page 9, Volume 3, Tab 21A

intubation. He also suggested that the table used by Dr. L. Becker to rate this impairment was inappropriate as there was no evidence that the nerves of the medulla and hindbrain had been injured. He did not rate this impairment as it had been based on a review of a single document file and there was no evidence that the car accident had caused this injury, even if there was one.

*i. Causation:*

There was no evidence rebutting Dr. L. Becker's testimony that it was very plausible that Ms. Moser's multiple intubations had caused the dysphagia. I find that the car accident was a material contributor to the dysphasia Ms. Moser now experiences.

*ii. The Rating for Dysphagia:*

I also accept the suggestion of Dr. L. Becker that this impairment be rated using Table 12 at Page 147 of the *Guides* by analogy. The impairment is exactly what is listed in the tables, -- dysphasia.

Nevertheless, once again, I find it appropriate to narrow the wide range she suggested. (1-14% WPI).

Dr. L. Becker did not include this impairment in her initial examination Ms. Moser testified that the problem was "intermittent" and "periodic". It did not occur "everyday", and happened more of the time with solids, but not liquids. All this convinces me that Ms. Moser's dysphagia is in the mildest end of the suggested range. Based on the evidence, I rate the impairment at 3% WPI.

*(i) Combining the individual ratings for the physical aspects of her impairments:*

**The total obtained by combining the individual ratings for the physical aspects of her impairments is 22% WPI** (5% facial scarring + 5% for closed head injury/neuropsychological findings + 6% right knee + 2% left knee + 0% the neck + 2% oral/dental injuries + 1% nasal fracturing + 3% dysphagia).

### ***(II) What is the rating for Ms. Moser's impairments due to mental and behavioural disorders?***

The next step in formulating a final WPI is to translate the impairment based on an individual's mental and behavioural disorders to a WPI rating so it can be combined with the physical aspects of the individual's WPI.

#### *(a) Translating the impairment based on mental and behavioural disorders to a WPI rating*

Dr. Gnam testified that nothing in the *Guides*, legislation, or policy in the province of Ontario provided guidance as to how mental impairment was to be calculated and expressed as a WPI rating.[47] There was no direction as to how to translate the word descriptors of Chapter 14 of the *Guides* into the numerical values required under the *Schedule*.

Both Dr. Gnam and Dr. Frank advocated the use of the California Scale to translate a Global Assessment of Functioning score (GAF) to a WPI rating. This method has been variously accepted and rejected by arbitrators and the courts, but I find its use was appropriate in the present case. Both Ms. Moser's and Guarantee's expert applied the same method to arrive at a very similar WPI.

Dr. Frank scored Ms. Moser as 65-70 on the GAF scale and translated this to a 0-8% WPI. Dr. Gnam scored Ms. Moser at 65 (mild), or 64-66 of the GAF scale, and determined she had a WPI of 6-9%.

Based on the overall evidence in this case, including Ms. Moser's own testimony, I am convinced that this consistent result, arrived at by both sides, is an appropriate assessment of her WPI based on mental and behavioural disorders alone. I accept the higher number rated by Dr. Gnam, and find Ms. Moser's WPI based on mental and behavioral disorders is 9%.

[47]Page 158, Volume 1 of Joint Brief

### *(b) Dr. Frank's Second GAF Rating*

I noted Dr. Frank assigned a second GAF score of 55-60 to Ms. Moser, when "cognitive effects as per her reports are considered," even though he himself performed no formal neurocognitive assessment or testing.

In his report, he made this statement: "I understand that Ms. Moser suffered a *brain injury* in the subject accident and that cognitive deficits have been identified and documented in a comprehensive neuropsychological exam".[48] [italics mine] Taking into consideration the effects of this brain injury, Dr. Frank arrived at his second GAF score, which he translated to a WPI of 15-23%.

In his executive summary, Dr. H. Becker suggested Dr. Frank's second GAF score (translated to a WPI of 15-23%) might be used to obtain a final WPI rating for Ms. Moser.[49] I reject this suggestion in its entirety.

I give no weight to Dr. Frank's second WPI range of 15-23% based on reports of cognitive problems. First, Dr. Frank had not been tasked with performing this assessment and he had not done any formal testing. Second, he deferred to Dr. Kurzman, the neuropsychologist, who only rated her at 1-5%. Third, Dr. Frank did not himself diagnose any cognitive disorder (apart from a "rule out" diagnosis of cognitive disorder [not otherwise specified], which he again deferred to the neuropsychologist). Fourth, his rating of 15-23% impairment would place Ms. Moser squarely in Category II of Table 2, Mental Status Impairments, on Page 140 of the *Guides*. This would suggest Ms. Moser had an impairment that "require[d] direction and supervision of daily living activities". This conclusion is completely untenable and contradicted by all evidence in this matter, including Ms. Moser's own testimony.

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[48] Page 10, Tab 1A, Volume 1

[49] Page 23, Tab 1A, Volume 1

More importantly, it appears that two different members of the Omega assessment team, Dr. Frank and Dr. L. Becker, both rated the brain injury and each assigned an impairment value for this *same* item. From their testimony, neither Dr. Frank nor Dr. L. Becker had read the other's report, and Dr. H. Becker did not clarify in testimony why he suggested using both Dr. L. Becker's and Dr. Frank's values to calculate a final WPI. In doing so, it appears he actually counted the same impairment (closed head injury/cognitive or neuropsychological findings) twice. Even the applicant's own submissions concede that Dr. Frank's second rating should be discarded to reduce the likelihood of double-counting.[50] I agree and I have discarded this second rating, although the issue of double-counting must still be addressed. I will do so in the next section.

### *(III) What is Ms. Moser's final WPI rating when the ratings from the physical aspects of her impairments are combined with the rating for her impairment due to mental and behavioral disorders?*

Dr. H. Becker combined the 27-58% whole person impairment (the total from the physical aspects of her impairments to the neck, closed head injury, right knee, left knee, facial lacerations, nasal fractures, dental injuries, and dysphagia) with the impairments obtained from Dr. Frank's assessment of mental and behavioral disorders (0-8%). This resulted in a final score of **27%-61%.**

I have already detailed why I rejected the second rating of 15-23% from Dr. Frank. I have also stated that I agreed with Dr. Gnam's rating of 9% WPI for mental and behavioural disorders alone; as well as Dr. Kurzman's and Dr. Gnam's rating of 5% WPI for the closed head injury/ cognitive or neuropsychological findings over the suggested rating of 1-14% given by Dr. L. Becker.

I must now address double-counting. Both sides agreed that the possibility arose for double-counting when combining the values for the physical aspects of the WPI with the mental aspects.

[50]Paragraph 180 of Applicant's Submissions

Dr. H. Becker stated the following:

> Ms. Moser demonstrates at least **24-53% WPI** [(24-49)+(0-8)] if cognitive impairment is included strictly under Criterion 7 or at most **35-61 WPI** [(24-49)+(15-23)] if cognitive impairment is included in the mental and behavioural rating under Criterion 8. In the later case, *we acknowledge the potential for "double-rating" mental status impairment under table 2, page 142, and concentration, persistence and pace under table 1, page 301.* However, the degree of overlap is unknown and no method for determining this is provided in the AMA Guides or SABS.[51] [italics mine]

In testimony, Dr. H. Becker added that a person with both a brain injury and psychological injuries might even have a higher impairment rating because of "synergy." Double-counting was a "vague concept" and there was "no way to understand what it might be."

Under the *Schedule*, double-counting addresses how an evaluator might properly reconcile the ratings obtained from the neurologic impairments of Chapter 4 of the *Guides* with the impairments arising from mental and behavioural disorders obtained in Chapter 14 of the *Guides*.

According to Dr. Gnam, the *Guides* never contemplated the combining of the rating from Chapter 14 (mental and behavioural disorders) with the rating for whole person impairment, which already includes the neurologic impairments rated in chapter 4. Both Dr. Frank (psychologist) and Dr. Gnam (psychiatrist) spoke of how difficult it was to separate or differentiate the effects of brain injury or neurological deficits from those emanating from mental or behavioural disorders.

Barring any physical evidence of brain injury (such as imaging or other clinical diagnostic techniques), the evaluator applies much the same tests and criterion to rate the impairments due to mental and behavioural disorders (Chapter 14) as he or she uses to rate neurological or cognitive impairments (Chapter 4).

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[51] Page 23 Tab 1A, Volume 1

In Chapter 4, the evaluator assesses activities of daily living, daily social, and daily interpersonal functioning. In Chapter 14, the evaluator assesses activities of daily living, social functioning, concentration, persistence and pace, and adaptation (at page 320). The wording, descriptors, and text anchors suggest that the assessment of Chapter 14 is indeed wider than that of Chapter 4.

Dr. Gnam testified that a thorough mental and behavioral examination under chapter 14 would capture all impairments, whether related to brain injury, cognitive impairment or mental and behavioral disorders. *As the criterion under chapter 14 reflect composite impairments from these causes, and it was not appropriate to include a rating under chapter 4 for mild brain injury. This would be actual "double-counting."*

In the present case, Dr. Gnam suggested subtracting or "backing out" the entirety of the 5% impairment due to Ms. Moser's closed head injury/neuropsychological findings from her whole person WPI before combining the remainder with Ms. Moser's WPI rating based solely on her mental and behavioural disorders.

I agree that double-counting is a distinct possibility when combining the closed head injury/ neuropsychological findings with impairments due to mental and behavioural disorders. Nonetheless, in the present case, Ms. Moser suffered amnesic effects following her accident. She had no memory of the incident itself. She also has post-concussive disorder, manifested in problems with memory, concentration, multitasking, and other symptoms. Certainly, some part or much of her impairment might be attributable to mental and psychological disorders developed since the accident, but I am not convinced that the entirety of her presentation is due to mental or psychological disorders alone.

Although I agree in large part with Dr. Gnam, instead of subtracting the entirety of the 5% impairment due to her closed head injury/neuropsychological findings, I find it appropriate to subtract 2% from that component, and then combine the remainder with the WPI based solely on her mental and behavioural disorders.

If I subtract 2% for closed head injury/neuropsychological findings, the result is 21% for the physical aspects of her WPI.

**I then combine this 21% with the 9% rating for her mental and psychological disorders. The final WPI rating is 28%.** Even rounding this number up to thirty (**30% WPI**), the result falls far below the 55% threshold set out in the *Schedule*.

I find Ms. Moser does not have an impairment or combination of impairments that, in accordance with the *Guides*, results in 55% or more impairment of the whole person.

### 3. Is Ms. Moser entitled to the costs of a catastrophic assessment and report in the amount of $7,006.00?

Ms. Moser submitted a treatment and assessment plan (OCF-18) dated June 29, 2011, which recommended a review of "Medical records to determine Catastrophic Impairment and if applicable complete an OCF-19", a physiatry assessment, a mental and behavioral assessment, an overall assessment summary, and miscellaneous costs for completing forms. The actual incurred cost of the catastrophic impairment report was $7,006.00.

Guarantee submits that this catastrophic assessment report was not reasonable and Ms. Moser should not be entitled to the costs of this report. They make this argument for the following reason:

The treatment and assessment plan in question was sent to an insurer examination conducted by Dr. Gelman.[52] He reviewed the medical documentation that was in the file at the time, and concluded that all of her treatment, especially in the realm of her dental restoration, was not yet complete. The reports by an orthopaedic surgeon, an oral and maxillofacial surgeon, a neurologist, a functional assessment, and an in-home assessment, led him to conclude that Ms. Moser was not catastrophically injured. He therefore concluded that the assessment was neither reasonable nor necessary.

[52] Gelman Report August 9, 2011 at Volume 1, Tab A Page 56-65

I do not agree with this opinion. All the reports upon which Dr. Gelman formulated his opinion pre-dated the two-year anniversary of Ms. Moser's accident. Most were completed within the first year of her accident. None of those reports was a comprehensive summary or analysis in regard to whether or not Ms. Moser had been catastrophically impaired. Further, even the possibility of further treatment in regard to Ms. Moser's dental injuries was not an automatic bar to her undergoing the assessment. Nor was the fact that the insurer had "always" held the position that Ms. Moser was not catastrophically impaired.

The catastrophic assessment undergone by Ms. Moser addressed relevant issues disputed at length at this hearing. It was reasonable and necessary for Ms. Moser to undergo the assessments in question.

The quantum of what may be awarded is set out in section 25(5)(a) of the *Schedule*. That section limits that amount to a total of $2,000.00 for any one assessment or examination. In the present case, Ms. Moser is entitled to the costs of three assessments. Therefore, she is entitled to $6,000.00 plus HST (if applicable).

### 4. Is Ms. Moser entitled to attendant care benefits as set out in the agreement dated June 9, 2104, to be awarded should Ms. Moser be determined to be catastrophically impaired?

I have determined that Ms. Moser is not catastrophically impaired. Therefore, she is not entitled to the attendant care benefits sought.

### 5. Which party, if any, is liable to pay the other's expenses in respect of the arbitration?

The parties provided written submissions in regard to entitlement to expenses. I agree with most of Guarantee's submission. Guarantee had the far greater degree of success in the outcome of the proceeding. No novel issues were raised at the hearing. No conduct prolonged, obstructed, or hindered the proceeding. No other factors were relevant to this analysis. Guarantee is entitled to their expenses of this proceeding, and the parties may seek an assessment of expenses before an arbitrator pursuant to section 79 of the *Dispute Resolution Practice Code*, should they desire.

## 6. Is Ms. Moser entitled to interest for the overdue payment of benefits?

Ms. Moser is entitled to interest for the overdue payment of the benefits she was awarded at this hearing.

| ___________________________ | September 26, 2014 |
|---|---|
| Edward Lee<br>Arbitrator | Date |

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

**FSCO A13-000812**

**BETWEEN:**

**JENNIFER MOSER**

**Applicant**

**and**

**GUARANTEE COMPANY OF NORTH AMERICA**

**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. Moser does not suffer from 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 a mental or behavioural disorder.

2. Ms. Moser does not suffer from an impairment or combination of impairments that, in accordance with the *Guides*, results in 55 per cent or more impairment of the whole person.

3. Guarantee shall pay to Ms. Moser the costs of assessments in the amount of $6,000.00 plus HST (if applicable).

4. Ms. Moser is not entitled to attendant care benefits as set out in the agreement dated June 9, 2014.

5. Ms. Moser shall pay to Guarantee their expenses in respect of the arbitration.

6. Guarantee shall pay interest to Ms. Moser for the overdue payment of the benefits awarded in this arbitration.

| ______________________________ | September 26, 2014 |
|---|---|
| Edward Lee<br>Arbitrator | Date |