The Adjusters' Toolbox – Managing Disputed Catastrophic Impairment Claims
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Given the enhanced durations and limits available to those individuals who have been determined to have sustained a catastrophic impairment, it is no surprise that in many scenarios (some involving objectively serious injuries, and some not), plaintiff personal injury lawyers have an interest in attempting to obtain catastrophic impairment status on behalf of an insured person. On the one hand, on any first party insurance claim, insurers have a legal duty of good faith which requires the insurer to act fairly and not to raise unreasonable barriers to a claim being made. On the other hand, the duty is not a fiduciary duty and insurers always have the right to investigate claims and respond to claims if there is a dispute or question about entitlement.

It has been reported[1] that the existing definition of catastrophic impairment has, over time, created considerable uncertainty in the process of determining catastrophic impairment, often leading to inconsistent results, inaccurate diagnoses, and disputes. This comes as no surprise to those who regularly work with these claims. As of 2016, there will be a new catastrophic impairment definition to be applied on a go forward basis, however, there is no question that insurance companies and their defence counsel will be working with the existing definition for some time to come. What follows are some suggestions on how insurance companies can attempt to obtain objectivity in the catastrophic impairment dispute process.

Surveillance

When it comes to the (g) criterion of mental-behavioural impairment, following the Court of Appeal decision in *Pastore v. Aviva Canada Inc.*, it is only necessary to establish a marked or extreme impairment in one of the four domains: activities of daily living; social functioning; concentration, persistence and pace; and deterioration or decompensation in work or work-like settings.

Unfortunately, the *AMA Guides*, Chapter 14, is only about 14 pages long and provides very little commentary as to how a clinician (let alone an insurance company) is supposed to distinguish between the various classes of impairment.

A "moderate impairment" is defined as "impairment levels are compatible with *some*, but not all useful functioning." A Class 4 "marked impairment" is defined as "impairment levels *significantly impede* useful functioning." Chapter 14, however, provides an example but otherwise gives very little commentary as to how to apply these definitions. A great deal is left to "clinical judgement."

Surveillance can be a very useful tool to assess an individual's overall level of functioning over time, and in particular, where a plaintiff medical-legal or section 25 report has been done commenting on catastrophic impairment, to challenge or question the subjective reporting of impairment in such a report.

In a case in which I acted for the insurer, *Kidder and Economical Insurance*[2], Mr. Kidder was seeking a catastrophic impairment designation as well as housekeeping and home maintenance benefits, attendant care benefits and various medical-rehabilitation and section 24 assessment claims. (An IRB claim was withdrawn shortly before the arbitration hearing even though Mr.

[1] Superintendent's Report on the Definition of Catastrophic Impairment in the Statutory Accident Benefit Schedule – www.fin.gov.on.ca/en/autoinsurance/si-report.pdf December 15, 2011.

[2] FSCO file A12-006704, a decision of Arbitrator M. Schnapp of December 19, 2014.

Kidder, by this time, was receiving CPP disability benefits). Most of the claims were dismissed. The arbitrator found that there was some causal (albeit minimal) link between the relatively minor accident of February 7, 2009 and Mr. Kidder's mental health impairments. However, the arbitrator found that the claimant did not have any marked or extreme impairments and was not entitled to any housekeeping and home maintenance or attendant care benefits. The arbitrator found that the claimant basically was not at all credible. The arbitrator found that the extensive surveillance (conducted over 18 days, comprising several reports and about three hours of video) was extremely damaging to the claimant's credibility. The surveillance clearly showed the claimant to be out and about, driving the family vehicle on a regular basis which conflicted both with his testimony during the hearing and also with the expert medical-legal reports filed on his behalf. At the hearing, Dr. Rosenblat, psychiatrist, testified in an apparently reasonable fashion, however, admitted that his report was mainly based on the claimant's subjective self-reporting of impairment and if the claimant's level of self-described impairment was not as reported, then Dr. Rosenblat's own conclusions about diagnosis and the extent of impairment were also called into question.

Among other things, Dr. Rosenblat had reported, and the claimant tried to testify at the hearing, that he had voluntarily determined in the fall of 2010 that he would stop driving due to his allegedly unbelievably fast, aggressive and erratic driving. In fact, Dr. Rosenblat had contacted the Ministry of Transportation to have Mr. Kidder's licence revoked on that basis. Despite that, the surveillance clearly showed that the claimant would take his two school-aged children to extracurricular activities and summer camp while his wife was working. His wife did not appear to be concerned about same.

It is entirely possible that without the surveillance evidence, which not only contradicted the claimant but also his key medical witnesses (who, again, had to rely on Mr. Kidder's self-report), the arbitrator may have given Mr. Kidder the benefit of the doubt and found a marked impairment in one or more of the domains.

Funding of Assessments

With the reforms introduced that were effective September 1, 2010, there is no question that the ability of the claimant, whether allegedly catastrophically impaired or not, to obtain medical assessments (under what is now section 25) funded by the insurer has been significantly circumscribed. The same package of reforms also appears to have been intended to abolish the right of a claimant to seek funding of a "rebuttal" assessment report under what used to be section 42.1 of the 1996 Schedule.

It appears to be fairly commonly accepted, although not unanimously so, that the September 1, 2010 reforms abolished the ability of claimants to seek funding for "rebuttal" reports after September 1, 2010, even on claims involving accidents that happened prior to September 1, 2010. However, a few plaintiff personal injury lawyers are taking the position that claimants whose accident happened prior to September 1, 2010, may still seek funding under section 42.1 on the basis that this provision is still in force. There is a decision of Arbitrator Wilson in *R.J. and Dominion of Canada General Insurance Company*[3] that rules to this effect (this particular interpretation has not been tested at the FSCO Appeal or Divisional Court level). However, the decision indicates that at least one arbitrator was willing to make an interim expenses award pursuant to section 279(4.1) of the *Insurance Act,* to require funding of catastrophic impairment assessments, presumably at a point in time where the claimant's assessors would get the last word.

[3] FSCO file A12-001233, a decision of September 17, 2013.

Although not commonly seen, section 279(4.1) also permits an arbitrator to make an interim order, not just for accident benefits, but also for legal expenses, pending a final order in any matter before FSCO. As such, funding for a catastrophic assessment report could be sought through that avenue. This provision is in force for the time being, at least until April 1, 2016, at which time it is anticipated that the Licence Appeal Tribunal will take jurisdiction of accident benefits disputes. Presumably, any interim order for legal expenses will be subject to the maximum cap on medical-legal reports of $1,500.00, however.

Insurers should give careful thought as to the timing of any funding for medical assessment reports being claimed. It is not unusual to see requests for funding of several "catastrophic impairment" assessments (by way of an OCF-18) at or around the same time as an OCF-19 Application for Determination of Catastrophic Impairment being submitted. Insurers might consider whether it is better to have such assessments take place at a relatively early stage and then, in some sense, have the ability to have the insurer's own insurer's examinations have the last word in the assessment process, rather than have to face a later request while in the dispute resolution process of requests for further assessments, be they contemplated as expert medical-legal reports (under either the *Dispute Resolution Practice Code* or the *Rules of Civil Procedure*) or under section 25.

Obtaining Relevant Medical and Employment Documentation

The importance of gathering up all of the relevant medical and other (i.e. employment, financial) documentation cannot be overlooked in terms of having objective insurer's examinations done. This is particularly true when evaluating catastrophic impairment in relation to mental-behavioural impairments under category (g), but is also very true in terms of the other categories, such as Whole Person Impairment criterion, category (f).

It is not unusual, for example, for individuals who claim to have mental-behavioural impairments as a result of an accident to have also had a pre-existing mental health history, possibly quite significant. With the relevant background information and documentation in hand, assessors are better equipped to come to accurate conclusions about causation and overall impairment ratings.

It is my experience that insurance companies often do, at a relatively early stage, obtain relevant documentation such as the clinical notes and records of a family doctor and/or a decoded OHIP summary. This documentation is certainly important, but the request for information and documentation should not stop there. Where mental health problems are alleged, insurance companies are well advised to obtain clinical notes and records of other professionals that have seen the individual. For example, in Ontario, the services of a psychiatrist (who is a medical doctor) are usually funded through the public OHIP system so the existence of a history with a psychiatrist should be disclosed in an OHIP summary. Psychologists are not usually funded through the public OHIP system so a history of past encounters with a psychologist would not necessarily be evident from a decoded OHIP summary, although it might be from the family doctor's records.

Employment files are often helpful in determining whether an individual has had any type of disability claim or been seen, for example, through an EAP type program. If the insured person has returned to work in some capacity (whether allegedly successful or not), the employment file will contain useful information that may be highly relevant to overall function in a broad sense, and in particular, in regards to Adaptation to Work and Work-Like settings.