BACK TO SCHOOL with Thomson, Rogers
in collaboration with the Toronto ABI Network

UPDATE - THE EXPERT PANEL'S REPORT TO THE SUPERINTENDENT ON CATASTROPHIC IMPAIRMENT

SEPTEMBER 8, 2011

DARCY R. MERKUR, Partner
Thomson, Rogers
Suite 3100
390 Bay Street
Toronto, Ontario
M5H 1W2

416-868-3176
dmerkur@thomsonrogers.com

PAGE NO.

Introduction

It has taken 15 years of working with a virtually unchanged definition of "catastrophic impairment" to finally get close to having an established legal interpretation of the term.

Only recently have the Ontario Courts provided us with guidance on how to properly apply some of the "catastrophic impairment" tests. These key recent Court cases include:

- *Liu v. 1226071 Ontario Inc.*[1]—the Ontario Court of Appeal made it clear that the GCS test is a bright line legal catastrophic impairment test, meaning that if you have a brain impairment resulting in a GCS of 9 or less immediately post accident you are undeniably catastrophically impaired;

- *Aviva Canada Inc. v. Pastore*[2]—the Ontario Divisional Court ruled that all four areas of function must be accounted for when determining if someone has suffered an overall marked or extreme impairment due to a mental or behavioural disorder (under Chapter 14 of the AMA Guides) and that it is not automatically enough to have a marked or extreme impairment in one of the four areas of function. Note that this decision is being appealed to the Ontario Court of Appeal (leave to appeal having just recently been granted); and,

- *Kusnierz v. Economical Mutual Insurance Company*[3]—a judge of the Ontario Superior Court of Justice ruled that you cannot combine physical and psychological impairments in the 55% WPI test (under the AMA Guides), contradicting an earlier ruling by a different judge of the same Court in *Desbiens v. Mordini*[4] and contradicting the interpretation that continues to be followed by the Financial Services Commission of Ontario. An appeal of the *Kusnierz* decision is being heard by the Ontario Court of Appeal on November 16th, 2011.

Because meeting the legal definition of having suffered a "catastrophic impairment" results in access to approximately $2,000,000 of additional benefits, it is vital that all stakeholders have a clear understanding of the legal definition and its interpretation. The 15 years of litigation surrounding this important definition has lead to increased consistency and predictability.

The importance of consistency within the Statutory Accident Benefit Schedule (the SABS) was highlighted by the Financial Services of Commission (FSCO) in

[1] 2009 ONCA 571 (CanLII)
[2] 2011 ONSC 2164 (CanLII)
[3] 2010 ONSC 5749 (CanLII)
[4] 2004 CanLII 41166 (ONSC)

their 2009 Five Year Review. Recommendation #1 in FSCO's Five Year Review was that consistency should be maintained unless there was a compelling reason for change.

Despite achieving this level of understanding and predictability with the current "catastrophic impairment' definition, a Catastrophic Expert Panel has recommended a complete overhaul of the definition.

It is not that the CAT Expert Panel's Report is completely unfavourable to accident victims, rather that an overhauled definition will lead to uncertainty, complexity and a further backlog to what can only be described as a totally embarrassing one year waiting line for mandatory mediation at FSCO.

Even if some changes were needed to the CAT definition to modernize some of the tests for entitlement, the CAT Expert Panel's Report makes changes to areas where there was never a problem, like modifying the "quadriplegia" criteria.

Moreover, the CAT Expert Panel's Report makes no mention and provides no analysis whatsoever on the financial impacts of the changes, when the September 1, 2010 benefit reductions were all expressly designed to 'stabilize' insurance premiums. The lack of economic analysis leads to confusion over whether the CAT threshold is being raised on lowered and whether insurance premiums will go up or down as a result of the changes, if adopted.

The CAT Expert Panel's Report has lead to some 33 responses from interested stakeholders. Stakeholders have raised a number of concerns with the recommended changes in the Report and those concerns are summarized herein.

From a legal perspective, the most fundamental problem with the CAT Expert Report appears to be a misconception by some of the Panel members about the impact of a CAT designation. **A declaration of CAT does <u>not</u> mean automatic entitlement to benefits! The SABS process, whether CAT or non-CAT, is a <u>needs based system</u>, wherein accident victims are eligible to make claims for reasonable and necessary expenses, up to certain limits.**

This fundamental misunderstanding of the implications of a CAT designation seems to form the basis of many of the Panel's recommendations, including what many consider a positive suggestion of an interim CAT designation.

The idea of labelling someone interim CAT, expressly with the hope that the claimant can get early treatment and avoid being CAT, is fundamentally flawed—the accident victims should be designated CAT, receive early reasonable and necessary treatment and hopefully their condition improves such that they do not require long term access to their CAT accident benefits. A catastrophic

designation is a permanent, not an interim designation, and by being permanent it protects against any unforeseen medical setbacks.

The CAT Expert Panel's Report is a bold attempt to modernize the definition of CAT with the goal of trying to design a definition that will provide a CAT designation only to those with the most severe injuries and that are likely to have long term medical needs. However, that goal is a policy goal that is outside the Panel's mandate and there is no justifiable reason for the Panel to narrow the CAT definition given that the system is a needs based system and given that the Panel was not considering economic implications.

Background and Overview

A Catastrophic Impairment Expert Panel (the "Panel") was assembled by the Ontario Government in order to address Recommendation #10 of the FSCO's Five Year Review of Automobile Insurance dated March 31, 2009 (the "Five Year Review").

Recommendation #10 of the Five Year Review had stated that:

> "Further consultation with experts in the field is needed to amend the definition of "catastrophic impairment'. The goal for this review should be to ensure that the most seriously injured accident victims are treated fairly."[5]

The Five Year Review had stated that most stakeholders supported the two tiers of benefits based on severity of injury, but that the "integrity of the model is dependent on a clear and fair definition of 'catastrophic impairment'".[6]

Notably, Recommendation #1 of the Five Year Review stated that:

> "When determining the merits of any future regulatory changes, consideration should be given to whether the change would increase complexity and regulatory burden. There should be a compelling reason for making a change that would add complexity to the accident benefit system."[7]

The CAT Panel consisted of 8 experts, 3 of whom had been consultants to the Insurance Bureau of Canada.

The CAT Panel had two mandates:

1) Phase I-Considering Changes to the Definition of CAT; and,

[5] See page 30 of the Five Year Review
[6] See page 29 of the Five Year Review
[7] See page 20 of the Five Year Review

2) Phase II-Considering the Credentials for CAT assessors.

This paper will:

1) Review the CAT Expert Panel's Phase I Report on suggested changes to the CAT Definition;

2) Review of the Concerns raised by Stakeholders to the Phase I Report;

3) Review of the CAT Expert Panel's Phase II Report on suggested credentials of CAT assessors; and,

4) Provide a Status Update on Where We Are At.

1) PHASE I REVIEW

On April 8, 2011, the Panel released its report entitled "Recommendations for Changes to the Definition of Catastrophic Impairment".

The Phase I Report (without appendixes) is at Tab A.[8]

Summary

The Panel's recommendations were stated to have been designed to ensure that individuals who were most seriously injured in traffic accidents received appropriate treatment.

The Panel attempted to revise the CAT definition to improve its accuracy, relevance and clarity. As a result, the Panel tried to recommend assessment systems with acceptable validity, reliability and predictive ability.

Specifically, the Panel recommended the following:

1) ASIA classification be used to assist with determination of CAT subsequent to spinal cord injury;
2) GOS-E be used to assist with the determination of CAT subsequent to TBI in adults;
3) Spinal Cord Independence Measure be used to assist with the measurement of CAT with ambulation dysfunction; and,
4) GAF be used to assist with the determination of CAT subsequent to psychiatric disorders.

8 The full report with all appendixes is at http://www.thomsonrogers.com/news-catastrophic-impairment-expert-panel.

The Panel took the position that these assessment systems, particularly when combined with clinical anchors, would considerably compensate for recognized ambiguities and limitations found within the AMA Guides, 4th edition.

Notably, the Panel concluded that combining physical and mental/behavioural conditions cannot be achieved in a valid and reliable way with the currently available methods of impairment cross-rating.

The Panel stated that they had difficulty understanding how combinations of physical impairments and psychological conditions that independently did not meet the criteria in the revised 2(e) and 2(f) could be equated to a severe injury to one's brain or, spinal cord, or to blindness. But the Panel noted that further investigation in this area was needed, including defining a clinically comparable combined psycho-physical whole personal impairment threshold that corresponded to the currently accepted physical threshold.

In their Report, the Panel took the position that fairness would be improved if insured persons with a catastrophic impairment received benefits without undue delay and, therefore, the Panel recommended that a designation of interim CAT status be allowed for insured adults with TBI and for those with major physical impairments who unequivocally required intensive and prolonged rehabilitation. The stated purpose of the interim status was to ensure that these individuals have access to the rehabilitation services that are necessary to maximize their chances of achieving a lower final impairment level, and potentially one that is less than CAT.

The Phase I Mandate

The Panel's Phase I mandate was to review the definition of 'catastrophic impairment' and make recommendations for changes to the definition "to ensure that the most seriously injured accident victims are treated appropriately."

Composition of Panel

The Panel was comprised of:

1) Dr. Pierre Cote (as the chair of the Panel)
2) Dr. Arthur Ameis
3) Dr. Linda Carroll
4) Dr. J. David Cassidy
5) Dr. Ronald Kaplan
6) Dr. Michel Lacerte
7) Dr. Patrick Loisel
8) Dr. Peter Rumney

The Phase I Objective

The Panel's stated Phase I objective was to identify ambiguities and gaps in the current SABS definition of CAT in order to reflect emerging scientific knowledge and judgment, and then make recommendation for changes to the definition of CAT.

The Phase I Literature Review

The Panel conducted non-systemic reviews of the recent scientific literature to identify ambiguities and gaps in the current SABS definition of CAT. However, the Panel acknowledged at the outset of their Report that a **systematic review of the literature was not possible given the resources and timeline available to the Panel.**

The Development of Recommendations

Consensus of the Panel was deemed to have been reached when 75% (6 of 8 members) agreed with a recommendation.

THE PROPOSED REVISIONS TO THE SABS CAT DEFINITION

In the initial stage of the Panel's deliberations, the Panel discussed the meaning of CAT. The Panel was asked some basic questions on their perspective of a "catastrophic impairment" and whether certain injuries should qualify as CAT.

It is notable that some members of the Panel had an extremely controversial initial perspective on what should be CAT (for example, 2 of the 8 members did not agree that someone suffering from paraplegia or quadriplegia ought to qualify as CAT).

In considering changes to the CAT definition, the Panel took the position that, in their view, a catastrophic impairment was 'an extremely serious impairment or combination of impairments that is expected to be permanent and which severely impacts an individuals' ability to function independently." This initial viewpoint by the panel is the subject of much criticism by Lawyers Associations as it appears to encroach on policy considerations that are outside the Panel's mandate.

Despite this stated viewpoint, the Panel rightfully noted that CAT is "not a medical entity; rather, it is a legal entity which defines a point along the medical spectrum of impairment severity."

In the end, the **Panel agreed that <u>all</u> current SABS definitions required significant revisions, except 2(d) regarding GCS which the Panel concluded should be eliminated** since the Panel felt it had questionable ability to predict long term outcomes.

A chart summarizing all of the proposed revisions is at Tab C.

A chart comparing the proposed revisions with the current SABS CAT definition is attached at Tab D.

Adult versus Paediatric Definition

The Panel noted that an adult was anyone 18 or older.

The Panel suggested that the new 2(a), 2(b) and 2(c) should apply to all age groups but that there be a specific paediatric TBI definition.

Due to time constraints, the Panel was unable to adequately address adaptations to definition 2(e) and 2(f) for the paediatric population and recommended an Expert Paediatric Working Group to address this issue as soon as possible.

Interim CAT

The Panel suggested that an interim CAT designation be provided for the new 2(d) and 2(e) criteria.

The Panel was of the view that interim CAT status would ensure that certain insured individuals have access to the rehabilitation services that are necessary to improve their health and maximize their chances of achieving a final impairment that is less than CAT.

The Panel also stated that they believed an interim CAT designation was necessary to balance access to higher levels of funding necessary for early rehabilitation with the need to minimize the risk of patients being permanently designated CAT where there is a reasonable chance that they will cease to be CAT.

2(a) — Paraplegia/Tetraplegia

The Panel suggested the use of ASIA and noted the following:

- ASIA classification has become the standard in medical practice.
- Asia classifies patients in five mutually exclusive severity categories that range from Complete (Grade A) to normal (Grade E).

- Review of literature suggests that its reliability and validity is adequate.
- Ability of ASIA to predict the ambulatory capacity of patients with spinal cord injuries provides a useful system for tracking the evaluation of these injuries in the first year after the trauma.
- Recent scientific literature suggests that the majority of Grade D patients will be able to ambulate independently one year after the injury.
- There was a consensus opinion of the Panel that those patients with Grade E, and those patients with Grade D injuries who successfully recover their ability to ambulate independently, are not CAT.
- The Panel agreed that transient paralysis (spinal shock) is an acute condition with favourable outcomes, and is not a CAT and that the ASIA grade must not be made until the neurological recovery is such that the permanent ASIA Grade can be determined with reasonable medical certainty.

In conclusion, the Panel strongly supported ASIA classification because it is commonly used in routine spinal cord injury care, requires the use of standardized examination protocol and removes some of the subjectivity and other limitations associated with the use of the related sections of the AMA Guides. The Panel felt that the ASIA system provided a more structured formula to rate impairment, and could be expected to both increase inter-rater reliability and more effectively identify CAT impaired spinal cord injured patients.

2(b) — Severe Impairment of Ambulatory Mobility

The Panel recommended significant changes to 2(b). The changes were motivated by three factors:

1) The Panel found no scientific evidence to assist its deliberation on the determination of CAT secondary to severe physical injuries;
2) The current CAT definition does not accurately describe the range of injures that can lead to CAT—as the current definition focuses on amputation and does not include other injuries such as burns or crush injuries; and,
3) The definition offers no specific criterion for determination of CAT.

The Panel concluded that:

- Separate definitions were needed to determine the presence of CAT related to upper limb versus lower limb.
- The AMA Guides should be used for determining CAT relating to upper extremity injury. The Panel found any extensive impairment to an upper extremity would result in 55% or more WPI and could therefore be determined using the revised 2(e) definition.
- The Panel proposed a different approach for CAT related to ambulatory mobility as the AMA Guides only provide 40% WPI for hip disarticulation and even two below knee amputations do not result in a 55% WPI.

- The revised 2(b) definition should be used for CAT related to ambulatory mobility.

2(c) — Blindness

The Panel was of the view that this definition only required a minor clarification.

The Panel made it clear that non-organic visual loss was excluded from the definition because it was not associated with actual physical damage to the visual system.

2(d) — TBI in Adults

The Panel suggested the use of GOS-E (along with the elimination of the GCS test!) and noted the following:

- Panel recommended GOS-E for CAT secondary to brain injury in adults.
- GOS-E has strong psychometric properties and is particularly reliable when a structured interview, standard scoring algorithm and a quality control system are used to monitor its administration and scoring.
- GOS-E allows for grading TBI into one of eight categories that range from death to good recovery.
- Panel set the threshold for CAT status at Moderate Disability Lower (MD-), as the Panel found that it best approximates the Severe Disability level that is in use with the GOS under the current SABS. However, the Panel recognized that this finding, made in isolation, might be problematic and consequently stipulated that any finding other than Vegetative must be associated with a preceding period of inpatient neurological rehabilitation. The Panel felt that the requirement of a preceding period of inpatient rehabilitation would also ensure that the patient had been exposed to and has engaged in an appropriate level of expert rehabilitation before a determination is made. Finally, the Panel felt that precluding final assessment of the patients with MD- until one year after onset would ensure that the condition has stabilized or is close to a final plateau.
- The Panel was of the view that the natural history of TBI suggests that a significant proportion of patients with initially moderate or severe levels of disability will improve during the year following their injury but the Panel felt that these patients would require substantial rehabilitation during this period to optimize their recovery. Accordingly, the Panel recommended an interim CAT status to allow these patients to access the necessary level of medical and rehabilitation care.

2(e) — Other Physical Impairments

With respect to Other Physical Impairments, the Panel stated as follows:

- The Panel found little literature on validity and reliability of the AMA Guides to support their continued use. There was no literature found to support the use of 55% WPI as the threshold for CAT although the Panel noted that the 55% WPI is the score given to a paraplegic. The Panel felt that the AMA Guides were moderately reliable at best for low back pain or major trauma. The Panel felt that there was no evidence that the AMA Guides were valid for upper extremity injures and fractures to lower limbs.
- The Panel recommended that Chapters 3-13 of the AMA Guides, 4th edition, be used for CAT definition in patients with physical impairments not covered under the other definitions.
- The Panel recommended interim CAT status for individuals who meet the 55% WPI three months posts accident. The Panel felt that interim status would provide necessary resources to those who need prolonged and substantial rehabilitation services and assistance with re-integration into the community, in hopes that the services would improve the probability of making a significant recovery, perhaps to a non-CAT level. The stated goal of the interim CAT status was to provide extended access to rehabilitation and attendant care services and thus promote maximal medical recovery, for patients at high risk of a permanent CAT.
- The Panel agreed that physical and mental or behavioural impairments cannot be combined in any consistent manner using the AMA Guides 4th edition. The Panel stated that, in their view, the impairment rating systems for physical and mental/behavioural impairment are not compatible and cannot be combined.
- The Panel had difficulty understanding how combinations of physical impairments and psychological conditions that independently did not meet the criteria outlined in the revised 2(e) and 2(f) could be equated to a severe injury to the brain or, spinal cord or to blindness. The Panel also had difficulty understanding that combining impairments is a simple additive process.
- Finally, the Panel acknowledged that they did not have the resources to conduct a comprehensive literature review to determine whether a valid and reliable method of combining physical and psychological impairment existed and the Panel concluded that research was needed into identifying the most appropriate threshold WPI scores for various psycho-physical combinations.

2(f) — Psychiatric Impairment

The Panel recommended the use of GAF and stated:

- The Panel found no scientific evidence supporting the reliability and validity of mental/behavioural impairment ratings using the AMA Guides 4th edition (chapter 14). Moreover, the Panel felt that chapter 14 relied heavily on functional limitations experienced by a patient in four complex

spheres of life to derive its ratings rather than specifically addressing psychological impairments.
- The Panel did not find a valid and reliable assessment tool to measure overall psychiatric impairments.
- The Panel recommended that the Superintendent assemble an independent panel of experts to develop a comprehensive list of disorders to be included under 2(f)(i). The Panel recommended that the definition incorporate the GAF as one of the necessary criteria.
- The GAF has good reliability and face validity. Panel selected a GAF cut-point of 40 as a threshold for CAT because it would likely capture individuals with severe psychiatric impairment, whose capacity for living safely within the community is tenuous in the absence of substantial mental health support services.

Use of Most Analogous Impairment for AMA Guides

The Panel unanimously agreed that this definition can be eliminated because of redundancy with 2(e).

TBI in Children

With respect to TBI in children, the Panel stated:
- The final outcome for a brain injured child may not become apparent for years or even decades after injury. The Panel was aware of the inadvisability of substantially delaying a final determination of CAT in children, on the sole basis of achieving a reasonable certainty of outcome.
- The Panel noted that a long period of waiting for a final determination could impose medically unnecessary stressors on parents and families already challenged with coping with a child suffering from a serious TBI.
- The Panel stated that false positive determinations of CAT were not in the best interest of the child, or a reasonable burden for the Insurer. But the Panel concluded that the problems associated with a false-positive determination through early identification of CAT were far outweighed by the benefits to all catastrophically impaired children and their families.
- The Panel noted that radiological features of serious brain injury, in association with admission to a Level I hospital are good clinical predictors of a prolonged recovery and poor outcome. Similarly, given the careful screening of patients at paediatric rehabilitation centres, the Panel believed that admission for brain injury rehabilitation is a sensitive and specific indicator of high risk of poor outcome. The Panel concluded that using these criteria for automatic determination of CAT will provide injured children with access to early and necessary health care.
- For those not within the automatic determination criteria, the Panel stated an early determination based upon clinical status would still be important,

especially since the natural course of the condition suggests that most improvement occurs early.

- The Panel agreed that the standard tools used to evaluate TBI in adults (GCS, GOS and AMA Guides) are not appropriate for head injuries in children.
- The Panel considered recommending the King's Outcome Scale for Childhood Head Injury (KOSCHI), a modified GOS adapted to children. However, the Panel stated that scientific evidence on the psychometric properties of KOSCHI was preliminary, and the Panel did not support its use as the sole basis of determination at this time.
- The Panel recommended than an inter-examiner reliability study be conducted with experienced paediatric neurologists and rehabilitation medicine specialists in Ontario.
- The Panel recommended that until the inter-examiner reliability study is completed, the Vegetative and Severe Categories of KOSCHI be used, with the time threshold of 3 months and 6 months respectively.
- Lastly, the Panel stated that for those few children with subtle injuries that will become serious sources of impairment only with the fullness of time, the direct paediatric evaluative route should remain available, along with the adult criteria pertaining to TBI, until age 21, but noted that this was a question of policy and was outside the Panel's mandate.

The Challenges to be Resolved

The Panel acknowledge a number of areas where the Report was incomplete, including:

1) Combining physical and psychological impairments—The Panel acknowledged that it didn't have the resources to do a comprehensive literature review on this issue and recommended an Expert Panel of clinicians and scientists to systematically review the literature and determine whether a valid and reliable methodology is available to rate and combine physical and psychological impairment ratings;

2) Method to rate physical and psychiatric impairments in the paediatric population—Panel recommended a Paediatric Expert Panel;

3) Classification of traumatic head injury in the paediatric population—inter-examiner reliability study recommended by the Panel; and,

4) Premorbity and Age—The Panel recommended that the Superintendent consider the development of criteria or means of adjusting criterion to address special circumstances or issues about prior impairment, etc.

2) SUMMARY OF STAKEHOLDER CONCERNS

A total of 33 submissions were submitted to the Superintendent in response to the release of Phase I of the Panel's Report.

Below is a summary of the General Concerns with the Report and the Specific Concerns with the Report that have been raised in the various submitted responses.

General Concerns:

1) Composition of Panel:
    a. Bias—Various Brain Injury Associations took great issue with the fact that three of the eight Experts on the Panel had been consultants for the Insurance Bureau of Canada.

    b. Panel Members Lacked Treatment Experience—the Alliance of Community Medical and Rehabilitation Providers raised concern that the composition of the Panel did not include enough treatment providers.

2) Panel's Assumptions—various Lawyers' Associations raised issues with the Panel's assumptions, namely:
    a. While the Panel confirmed that CAT is a 'legal term', the Panel then attempts to make the term 'scientific', and while a scientific approach is helpful to establishing objective protocols for assessment and testing, putting scientific evidence into a Regulation results in confusion and undue complexity, and allows for significant interpretive issues.

    b. A preconceived notion and an invalid premise by the Panel about what a CAT ought to be fundamentally undermined the entire report (the Panel starts off by stating that CAT is an "extremely serious impairment that is expected to be permanent and which severely impacts an individual's ability to function independently" and then the Panel crafts regulations that it believes are in accordance with this presumed definition).

    c. The amendments proposed are not truly based on matters of medicine but are rather medicine designed to fit within a particular policy objective determined by the Panel, and the Panel stepped outside the arena of medicine and into policy when doing so.

3) The Comprehensiveness of the Report and Timing of Regulatory Changes:
    a. Report was Rushed—numerous stakeholders complained that the report was admittedly completed without enough time to complete a comprehensive literature review and that there were a number of references in the report to areas requiring further research.
    b. Report Incomplete—numerous stakeholders noted that the Report admittedly refers to a number of areas where more research is required (such as whether you can combine physical and psychological ratings).
    c. Changes Premature—both the Brain Injury Associations and the Lawyer Associations highlighted the fact that it would be premature to proceed with the recommended changes given that the report contemplates further research.

4) Lack of Costing and Other Analysis—the Lawyers Associations pointed out that:
    a. No costing or analysis was completed to assist stakeholders in understanding what effect the recommendations would likely have on price stability.
    b. There was no attempt made to determine whether the changes will increase or decrease the CAT threshold.
    c. No effort was made to determine whether the changes would lead to increase litigation and claims costs.
    d. Changes should not be made without a full analysis as to how it will affect coverage and costs.
    e. No effort was made to determine the increased cost to the publically funded health care system.
    f. The Report does not address important policy and fiscal considerations that are essential to the analysis.

5) Increased Complexity, Uncertainty and Confusion:
    a. Introduction of GOS-E, ASIA and GAF to Regulations adds unnecessary complexity and confusion.
    b. The body of jurisdiction since the largely unchanged CAT definition was introduced in 1996 has led to predictability and drastic changes to the definition would destabilize and complicate matters.
    c. Failure to identify problems needing correction (for example, why change simple and understandable definitions like paraplegia and quadriplegia into a test that adds complexity, increased litigation and delay without an analysis of the need to change that definition).

Specific Concerns:

1) Recommendation regarding requirement for Inpatient Rehab—stakeholders noted the following *(also see Inpatient Rehab Data Summary at Tab E regarding the ridiculous wait times and limited number of rehabilitation beds)*:
    a. The Panel relied on a false assumption that all seriously injured individuals go to inpatient rehabilitation.
    b. A number of patients are not admitted to inpatient rehabilitation because their needs are too complex.
    c. Would result in regional disparity.
    d. Would increase waiting times for an already stressed system.
    e. The insurance companies raised the issue that this requirement could lead to self-serving determinations to recover SABS and would be open to abuse.

2) The conclusion not to allow the combining of physical and psychological ratings—various stakeholders noted the following:
    a. Victim advocates supported ensuring that the whole person evaluation take into consideration both the physical and mental/behaviour impairments and disabilities, while the insurance companies applauded the conclusion that they cannot be combined.
    b. The Legal Associations noted that preventing a combination could be discriminatory against those with psychological injuries and chronic pain.
    c. Since the issue is being addressed by the Ontario Court of Appeal in November, 2011 (appeal of *Kusnierz v. Economical Mutual Insurance Company*, 2010 ONSC 5749 (CanLII)), no changes should be made until that decision is released.

3) Notion of Interim CAT—stakeholders made the following comments:
    a. The interim CAT designation recognizes the benefits of early intervention.
    b. The Insurance Companies and some of the Lawyers Association raised concerns over how benefit entitlement would work in cases where the person was later determined to be non-catastrophic and highlighted the reality that this interim designation would lead to increased disputes, complexity, litigation and the potential for increased costs that have not been analyzed.

4) Elimination of GCS—Lawyers Associations and Thomson, Rogers advocated for the continued use of GCS, since:
    a. It is simple and straightforward to apply.
    b. It is extensively used by and relied on by ambulance attendants and trauma units post-accident.

c. It provides important immediate access to CAT benefits as of right.
d. It has been dealt and interpreted extensively by the Courts.
e. It is believed to be the most common means of accessing CAT benefits.

5) Specific Concerns with New Tools—various stakeholders raised concerns with the merits, standards and validity of the new testing tools proposed by the Panel. While the scope of those substantive concerns are beyond the scope of this paper, the concerns included:
   a. Other physical impairments—the Alliance suggested that other physical impairments should be based on an assessment of the whole person, not artificially separating mental and physical, and should consider non-psychiatric symptoms and syndromes, like chronic pain, chronic fatigue and fibromyalgia.
   b. GAF—the Alliance suggested using a GAF of 50 or less for CAT, rather than 40.
   c. Spinal Cord—stakeholders supported the continued inclusion of unmodified terms like paraplegia and tetraplegia as part of the CAT definition and Lawyers Associations took the position there was no reason to remove these simple criteria that would normally not lead to dispute or litigation.

3) PHASE II REVIEW

The second phase of the Panel's mandate was to make recommendations to the Superintendent of the Financial Services Commission of Ontario about the training, qualifications and experience of assessors who conduct CAT assessments under the SABS.

On June 21, 2011, the Panel released their Phase II report, entitled "Recommendations for Training, Qualifications and Experience for Catastrophic Impairment Assessors".

The Phase II Report is at Tab B to this paper.

The Phase II Expert Panel included the same eight clinical and scientific experts as Phase I, but also included Dr. Loretta Howard.

Panel's View of Strengths and Weaknesses of current CAT assessment system

At the outset of Phase II, the Panel was asked to comment on their view of the strengths and weakness of the current CAT assessment system.

The Panel noted:

Strengths:

- It provides timely and geographically diverse access to CAT assessments; and,
- It allows for flexibility in selecting assessors.

Weaknesses:

- The absence of assessment guidelines, standardized methodologist and lack of quality control do not promote consistency in assessments;
- A significant potential for bias is related to the assessors being dependent on referral sources to ensure a steady volume of work; and,
- The absence of mandatory training in impairment evaluation and medico-legal expertise is an important source of variation in the quality of assessments.

Expert Baseline Survey

At the outset of their discussions the Panel agreed that assessors eligible to conduct CAT assessments should have the following characteristics:

1) A minimum level of experience in their area of specialization;
2) Completed training in the required measurement tools; and,
3) Completed formal training in a university program that teaches impairment evaluation and medico-legal expertise.

Summary of Recommendations:

The Panel made the following recommendations:

1) Requirement for Lead Evaluator—CAT assessments should be under the responsibility of a Lead Evaluator who conducts assessments within their scope of practice. The Lead Evaluator would be:
    a. Qualifications:
        i. a medical doctor who has been licensed/registered for a minimum of five years in Canada, or
        ii. a doctorate-level neuropsychologist (in cases of TBI) who has been licensed/registered for a minimum of five years in Canada; and,
    b. Required to have formal training in a university-based course to acquire competencies in impairment evaluation and medico-legal expertise.

2) Training for Clinicians—All clinicians involved in the assessment of a catastrophic impairment be trained, depending on their scope of practice, in:
   a. The use of the American Spinal Injury Association (ASIA) classification for spinal cord injury;
   b. Extended Glasgow Outcome Scale (GOS-E) for TBI in adults;
   c. The Spinal Cord Independence Measure for ambulation disorders;
   d. The Global Assessment of Functioning (GAF) for psychiatric disorders; and/or,
   e. The American Medical Association's (AMA) Guides to the Evaluation of Permanent Impairment, 4th edition for the assessment of physical impairments.

3) Transitional Period—Panel suggests a Guideline from the Superintendent would be needed to direct the transition.

Lead Evaluator

The Panel recommended that a Lead Evaluator be responsible for overseeing the CAT assessment process.

The Lead Evaluator would be a regulated health professional who would be responsible for advising and guiding the assessment team. Specifically, the Lead Evaluated would be responsible for:

1) Reviewing the application and the clinical file;
2) Assembling a team of Evaluators (regulated health professionals) that meet the needs of the assessment;
3) Ensuring that the CAT assessments follows the tests described in the SABS;
4) Reviewing all forms and/or reports and ensuring that they are accurate; and,
5) Preparing and submitting a final form and/or report that synthesizes the clinical evidence and describes the presence/absence of a catastrophic impairment.

The Qualifications of the Lead Evaluator

The Panel recommended that an assessment or examination in connection with a CAT determination and the preparation of a final report regarding CAT shall be done by a medical doctor, unless the impairment is a brain impairment only in which case it may be done by a neuropsychologist who holds a doctorate degree (PH.D., Psy.D. or Ed.D).

However the medical doctor may be assisted by other regulated health professionals as may be reasonably required in order to conduct a comprehensive review and/or clinical assessment in connection with the preparation of the report. Lead Evaluator shall conduct assessments and prepare reports consistent with their practice and expertise in CAT analysis.

Experience of the Lead Evaluator

Doctor shall be Licensed by Canadian Colleges of Physicians and Surgeons for at least five years and neuropsychologists with a doctorate degree in psychologist shall have at least five years of licensing or registration in Canada.

Training of the Lead Evaluator

Panel recognizes that the level of knowledge and skill necessary to lead a CAT assessment goes beyond clinical training of medical doctors or neuropsychologists. Therefore, the Panel recommended that all Lead Evaluators have specialized competencies acquired through formal training in a university-based program specializing in impairment evaluation and medico-legal expertise. The program must be sufficiently comprehensive and must include evaluation of proficiency in the competencies. Other members of the assessment team would not need to acquire the specialized competencies to contribute to the assessment of an injured claimant.

Lead Evaluator Competencies

In addition, the Lead Evaluator must be able to demonstrate all of the following nine competencies:

1) Ability to act effectively for the purpose of determining the presence of CAT including liaising with relevant parties and coordinating a multidisciplinary approach, as required;
2) Ability to maintain current knowledge of the medico-legal context and process with regard to application for, and determination of, CAT entitlement in Ontario including legislative framework, relevant regulations, FSCO Guidelines, forms and reporting requirements;
3) Ability to conduct an intake review including identifying the mandate of the assessment, obtaining the informed consent, and reviewing relevant documentation, which includes the claimants' comprehensive file and health claim statements;
4) Ability to work collaboratively in a team-based manner to organize and implement the assessment process by communicating effectively, managing conflict, developing consensus, and dealing effectively with challenging assessment processes;

5) Ability to apply a comprehensive causal analysis within the context of the SABS;
6) Ability to formulate an evidence-based opinion on CAT founded on the critical appraisal of the findings;
7) Ability to write a well formulated, comprehensive report to current independent examination professional standards for submission to relevant parties;
8) Ability to behave in an ethical and professional manner with sensitivity to vulnerable populations and minorities and with respect for fiduciary obligations; and,
9) Ability to provide expert testimony, as required.

Training of ALL Evaluators

The Panel recommended that ALL Evaluators conducting CAT assessments be regulated health professionals who have formal training in the use of the measurements tools that are directly relevant to their scope of practice. The purpose of the training would be to improve the quality of assessments and standardize assessments.

Transitional Phase

A Transitional period would be required for the Lead Evaluators to attain the competencies and qualifications recommended by the Panel. The Panel recommended a Superintendent Guideline be issued to direct the transition period.

The Panel recommended that the Guideline include the following three phases:

1) **Phase I**—Upon the approval of recommendations by the Government, all Lead Evaluators, must be either a medical doctor or doctorate-level neuropsychologist with a minimum of five years of licensing/registration in Canada.

2) **Phase II**—One year from the date the recommendations are approved by the Government, all Evaluators must have completed training in the use of the applicable assessment tools. Similarly, all Lead Evaluations must be enrolled in a general, university-based program in insurance medicine and medico-legal expertise or its equivalent.

3) **Phase III**—three years from the date the recommendations are approved, all Lead Evaluators must have completed a full certification in a university-based training program in insurance medicine and medico-legal expertise or its equivalent.

Other Recommendations - Standardized Data Collection Forms

The Panel recommended that standardized forms designed to collect the data necessary to assist the Lead Evaluator be used. The Panel recommended that the Superintendent convene a sub-panel of experts to develop a concise and comprehensive set of evaluation forms for the assessments of CAT.

4) STATUS UPDATE ON WHERE WE ARE AT

As of the end of August, 2011, the Government has not taken any further public steps to initiate or adopt the recommended changes.

While any changes can be made by Regulation without the need for Cabinet approval, because the announcement of changes could turn into an unwanted election issue for the upcoming Provincial election this October, **it is highly unlikely that any changes will be made in 2011.**

Lawyers Associations and Rehab Organizations have done an impressive job at combating the insurance company lobbyists by meeting with various politicians and raising concerns about the possibility of Regulatory changes that would have a negative impact on the rights of innocent accident victims. In fact, Lawyers Associations, like the Ontario Trial Lawyers Association, have put together a media war chest fund to raise public awareness of this important issue if necessary.

With that backdrop and having regard to the history of SABS changes, it is more likely that any changes would be announced in draft in early 2012 with a September 1, 2012 implementation date. But given some of the unexpected recommendations by the Panel, such as an interim CAT designation it is possible that the Report will be scrapped altogether and will simply be revisited as a cornerstone to the next five year review.

DARCY MERKUR, Partner
Thomson, Rogers
Suite 3100, 390 Bay Street
Toronto, ON M5H 1W2

416-868-3176
dmerkur@thomsonrogers.com