LICENCE APPEAL TRIBUNAL

TRIBUNAL D'APPEL EN MATIÈRE DE PERMIS

Safety, Licensing Appeals and Standards Tribunals Ontario

Tribunaux de la sécurité, des appels en matière de permis et des normes Ontario

Citation: P.S. vs. Allstate Insurance, 2020 ONLAT 18-012633/AABS

Released Date: 09/28/2020
File Number: 18-012633/AABS

In the matter of an Application pursuant to subsection 280(2) of the *Insurance Act*, RSO 1990, c I.8., in relation to statutory accident benefits.

Between:

P.S.

Applicant

and

Allstate Insurance

Respondent

DECISION

ADJUDICATOR: **Rebecca Hines**

APPEARANCES:

For the Applicant: Chris Clifford, Counsel

For the Respondent: Ryan Kirshenblatt, Counsel

Court Reporter: Laurie Barker, Court Reporter
Greater [City] Area Reporting Group

HEARD: In-Person: **March 2, 3, 4, 5 and 6, 2020**

OVERVIEW

[1] On May 6, 2013, [P.S.] (the "applicant") was involved in a car accident. He applied for accident benefits from Allstate Insurance Company (the "respondent"). A dispute arose with respect to whether the applicant sustained a catastrophic ("CAT") impairment. He applied to the Ontario Licence Appeal Tribunal – Automobile Accident Benefits Service ("Tribunal") for a determination that his accident-related injuries resulted in a CAT impairment as defined in the *Statutory Accident Benefits Schedule* – Effective September 1, 2010, O. Reg. 34/10 (the "*Schedule*"). He also disputes the respondent's denial of his entitlement to three treatment plans for physiotherapy and psychotherapy.

[2] A case conference was held and the parties were unable to resolve the issues in dispute. An in-person hearing took place on March 2, 3, 4, 5 and 6, 2020 in Kingston.

[3] At the hearing I heard evidence from the applicant, the applicant's wife, Ms. Ada Mullet, treating psychologist and Mr. Joseph Stilwell, kinesiologist. The following expert witnesses also testified on behalf of the applicant: Dr. Dory Becker, psychologist, Dr. Giselle Braganza, neuropsychologist and Dr. Harold Becker, general practitioner. The respondent's witnesses consisted of insurer examination ("IE") assessors Ms. Tracie Shaw, occupational therapist, Dr. Julian Mathoo, physiatrist, Dr. William Gnam, psychiatrist and Dr. Kerry Lawson, neuropsychologist.

[4] Unfortunately, there was a delay in rendering a decision in this matter due an administrative error made by the Tribunal as the exhibit list was inadvertently deleted. The Tribunal sent the parties the record of the exhibit list it was able to recover and the parties made submissions regarding the accuracy of the Tribunal's record. A copy of the court reporter's record of the exhibit list was also submitted. A teleconference was held where any discrepancies were discussed. Based on those discussions the Tribunal sent the parties a revised exhibit list and both parties confirmed that they were in agreement that the Tribunal's hearing record was accurate. I commend both parties for their professional conduct during this proceeding.

ISSUES IN DISPUTE

[5] I have been asked to decide the following issues in dispute:

i. Did the applicant sustain a CAT impairment as defined by the *Schedule*?

ii. Is the applicant entitled to a medical benefit in the amount of $3,645.24 for physiotherapy treatment recommended by Joseph Stilwell in a treatment plan (OCF-18) submitted on August 8, 2017 and denied on September 11, 2017?

iii. Is the applicant entitled to a medical benefit in the amount of $2,593.76 for psychological treatment recommended by Dr. Ada Mullett in a treatment plan (OCF-18) submitted on August 3, 2017 and denied on August 16, 2017?

iv. Is the applicant entitled to a medical benefit in the amount of $3,245.47 for physiotherapy treatment recommended by Joseph Stilwell in a treatment plan (OCF-18) submitted on September 5, 2018 and denied September 21, 2018?

v. Is the applicant entitled to interest on any overdue payment of benefits?

RESULT

[6] After considering all of the evidence and for the reasons that follow I find:

i. The applicant did not sustain a catastrophic impairment as a result of the accident.

ii. The applicant is entitled to all three treatment plans plus interest payable in accordance with the *Schedule.*

BACKGROUND

[7] On May 6, 2013, the applicant was riding his motorcycle when a truck made a sudden left-hand turn in front of him resulting in a collision. The applicant maintains he was thrown to the ground and his helmet was split as a result of the impact he had with the truck and the ground. An ambulance was called, and he was transported to the hospital, where x-rays were taken in which the results were normal. He was diagnosed with soft tissue injuries, prescribed pain medication and was discharged the same day.

[8] He followed up with his family doctor following the accident complaining of pain in his left shoulder, back, hip, left leg and reported having problems with his memory.

[9] In January 2015, the applicant underwent surgery (rotator cuff decompression and distal clavicle resection) on his left shoulder. However, this did not result in

any improvement and his impairments developed into chronic pain as well as a psychological impairment. The applicant has also been diagnosed as suffering a mild traumatic brain injury ("TBI") as a result of the accident. Since the accident, the applicant has participated in a chronic pain program and has regularly attended psychotherapy and physiotherapy treatment until the respondent eventually denied the benefits.

[10] The applicant did not have any significant health issues pre-accident. In the sixteen years prior to the accident he was employed as a [tradesperson] working on high-rise buildings. He was the sole breadwinner for his family, working 40 to 45-hours a week and his job involved frequent travel to [City 1], [City 2] and [City 3]. The applicant returned to work following the accident; however, he started to abuse opioids to manage his chronic pain so that he could continue working. His abuse of opioids resulted in his family doctor restricting his driver's licence in July 2016. Consequently, he was unable to work due to the combination of losing his licence, chronic pain and psychological and cognitive issues. The applicant's inability to work and accident related functional limitations has had a serious impact on his psychological status.

[11] In March 2017, the applicant applied for a determination that his accident-related injuries resulted in impairments that met the statutory threshold for a CAT impairment under Criterion 7 of the *Schedule*. However, he was assessed for a CAT impairment under both Criteria 7 and 8. Under Criterion 7, he must prove that he has a combination of physical and psychological impairment ratings from medical professionals that meet the 55% whole person impairment ("WPI") threshold as outlined in Chapter 4 of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (the "*Guides*"). Both parties agree that the applicant does not meet the CAT threshold solely under Criterion 8, which provides that an individual must sustain a Class 4 (marked) impairment as a result of the accident in any of the four spheres of functioning[1] outlined in Chapter 14 of the *Guides* due to a mental or behavioural disorder.[2]

[12] The respondent commissioned North York Rehabilitation Centre Corp. ("NYRC") to complete a series of CAT insurer examinations ("CAT IEs") which ultimately determined that the applicant's physical WPI was 17% under Criterion 7, which does not meet the 55% threshold. NYRC's assessments under Criterion 8 determined that the applicant sustained a mild to moderate impairment in all four

[1] The four spheres of functioning in the *Guides* are (1) Activities of Daily Living; (2) Social Functioning; (3) Concentration, Persistence and Pace; (4) and Adaptation.

[2] Since the accident occurred prior to the 2016 amendments to the *Schedule*, a finding of one marked impairment is sufficient to meet the CAT threshold under Criterion 8.

domains from a mental and behavioural disorder, which also does not meet the CAT threshold. NYRC's CAT summary rating report determined that the applicant's combined physical and psychological WPI under Criterion 7 was at most 35 to 37%.

[13] By contrast, assessments on behalf of the applicant conducted by OMEGA Assessment Centre ("OMEGA") completed CAT assessments under both Criterion 7 and 8. OMEGA concluded that the applicant's physical impairment was 23% and his psychological impairment was 40%. [40 +23] equals 54% WPI, which was rounded up to 55%, which would meet the CAT threshold. If it is determined that the applicant has suffered a CAT impairment, he is entitled to the extended tier of benefits that accompanies this designation.

ANALYSIS

[14] For the reasons that follow I find that the applicant did not sustain a 55% WPI under Criterion 7 due to a combination of physical and psychological impairments as a result of the accident.

[15] Under Criterion 7, both parties accept the physical ratings assigned by the respondent's assessor, Dr. Mathoo, physiatrist. Dr. Mathoo determined that the applicant had a physical impairment with a total WPI rating of 17%. Since the parties agree, I accept this impairment rating.

[16] The crux of this dispute centered around the difference of opinions, WPI% ratings (and methods used to assign those ratings) by the parties' neuropsychological experts, Dr. Braganza (OMEGA) and Dr. Lawson (NYRC) as well as by the experts who diagnosed the applicant's psychological impairment Dr. Gnam (NYRC) and Dr. D. Becker (OMEGA). I will first address which neuropsychological opinion I prefer and my findings regarding the appropriate WPI% rating.

Mental Status Impairment

[17] Dr. Braganza's neuropsychological CAT report determined that the applicant sustained a mild TBI as a result of the accident which resulted in a cognitive impairment and functional limitations. The cognitive tests administered by Dr. Braganza revealed that the applicant performed within impaired ranges on immediate and delayed memory. He also performed poorly on tests involving language and attention.

[18] Dr. Braganza indicated that somatic factors such as fatigue, pain, emotional distress, and possible side effects of medication may have exacerbated the applicant's cognitive symptoms. Dr. Braganza highlighted that the findings of her assessment were consistent with the applicant's self-reported symptoms, his test results, as well as an earlier neuropsychological assessment completed by Dr. Day, neuropsychologist. Dr. Braganza opined that a WPI% would be appropriate within the first tier of Table 2 of the Guides which provides a range of 1 to 14 WPI% for a mental status impairment. In her report, she explained that the Guides do not provide a methodology for further narrowing this range. Dr. Braganza left it up to Dr. H. Becker who completed the CAT rating summary report on behalf of OMEGA to select the appropriate WPI%. In his CAT summary rating report, Dr. H. Becker selected the highest range of 14% in calculating the applicant's total WPI%, which I will address later.

[19] By contrast, Dr. Lawson opined that any neurocognitive impairment the applicant sustained in the accident had resolved and he assigned 0 WPI%. For the reasons that follow, I prefer the opinion of Dr. Braganza over Dr. Lawson's.

[20] I find Dr. Braganza's opinion more reliable when compared to the rest of the medical evidence before me. The applicant has consistently reported problems with memory and cognition since the date of the accident to his family doctor and to almost every assessor who has seen him since the accident. These self-reported complaints have resulted in functional limitations. The following are some examples which highlight the applicant's cognitive difficulties:

a) The ICAN OT report dated April 6, 2016 assessed the applicant's functional abilities within the home environment. The report supports that the applicant displayed cognitive difficulties carrying out three simple projects. The authors of the report indicated that the applicant had functional difficulty with developing a plan, changing plans when required, solving problems and demonstrated no flexibility in thought. Significantly, the authors mentioned that the applicant's home did not have running water, which is odd for a licenced [tradesperson];

b) Dr. Day's neuropsychological CAT assessment dated July 5, 2016[3] revealed that the applicant performed poorly on cognitive tests which Dr. Day attributed to the accident. Dr. Day opined that "there were clear signs of compromised memory, signs of weaker frontally mediated abilities (poor flexibility and problem solving)." Dr. Day also indicated that

[3] This CAT assessment was not completed in relation to the OCF-19 which forms the basis of this dispute. Neither party addressed this at the hearing.

the applicant's chronic pain and depression were likely contributing to the clinical picture and recommended that he be reassessed at a later date to see if psychological treatment resulted in any improvement. Despite this fact, Dr. Day diagnosed the applicant with a mild cognitive disorder due to TBI (possible post-concussive effects);

c) Dan Fyke's OT housekeeping and home maintenance assessment dated August 10, 2017 states that the applicant has difficulty with the cognitive completion of tasks that require planning, preparation, executing complex tasks and tasks that require patience, several steps and problem solving.[4]

d) Ms. Jane Wong's CAT OT report dated February 8, 2017 highlights that the applicant had problems completing functional tasks with cognitive elements within a reasonable time frame. He displayed an inability to follow instructions and did not complete the assignments within the allotted time. One assignment involved running errands in the community. Ms. Wong indicated that the applicant followed 1 out of 7 rules, evidencing difficulties with multi-tasking, reduced problem-solving skills and problems processing written instructions.[5]

e) A Ministry of Transportation form titled "Cerebrovascular Diseases Traumatic Brian Injury/Tumour or other Neurological Diseases" completed by Dr. Pitre, family doctor, dated August 4, 2018 indicates that the applicant sustained a mild TBI which is stable. The second page indicates that the applicant's impairment has resulted in ongoing cognitive functional limitations. Dr. Pitre notes that the applicant's prognosis is permanent.

[21] The applicant did not have any problems with memory or cognitive functioning pre-accident. I find the applicant to be a credible witness and I accept his testimony regarding how the accident has impacted his memory and cognition. The applicant testified that since the accident, he is unable to navigate to familiar places. For example, he has gotten lost in the woods on his own property which he knows like the back of his hand. Further, he forgets to take his medication and frequently misplaces things. Post-accident, he has difficulty focusing and following through on tasks that would have been simple pre-accident. The applicant's problems with memory and cognition post-accident were also

[5] Ms. Wong did not render an opinion regarding the cause of the applicant's functional limitations and indicated that pain and motivation could have played a part.

corroborated through his wife's testimony, who I also find to be a credible witness.

[22] Much was made by the respondent about an incident on December 3, 2016, in which the applicant got intoxicated at a funeral and fell and hit the right side of his head on a steel bar. The hospital emergency record states, "Fall with minor head trauma. No loss of consciousness. Was ambulatory at the scene. Patient vomited." The ambulance call report notes "patient has pain all over – but it is the same/normal since a motorcycle accident 5 years ago."

[23] The respondent contends that the applicant's symptoms with poor memory and cognition were more than likely caused by the December 2016 fall, not the accident, as the CAT assessments took place after this incident. Further, the MRI completed post-accident did not show any significant findings.

[24] I disagree as I find the applicant's complaints about his memory predate this incident, which is reflected in the CNRs of his family doctor and Dr. Day's neuropsychological report. Further, the hospital record does not indicate that the applicant sustained a concussion and no imaging or follow ups were recommended. In my view, if the applicant sustained a more serious injury, the doctor at the hospital would have recommended further investigation. The applicant testified that, other than suffering some embarrassment due to the fall, this incident was not the cause of his past and current complaints. The applicant's wife also confirmed that this incident had little impact on the applicant's cognitive symptoms or function.

[25] During cross-examination, the respondent challenged Dr. Braganza's opinion because she did not have the hospital records relating to the December 2016 fall and did not have the updated CNRs of the applicant's family doctor when she completed her CAT assessment report. Of significance was the fact that the applicant's family doctor supported the reinstatement of his driver's licence in a form completed on August 9, 2018. In my view, the fact that the applicant's family doctor supported the reinstatement of his licence after the CAT assessments were completed does not refute the fact that he was diagnosed with a mild TBI as a result of the accident. In fact, the form completed by his family doctor supports that he still has ongoing cognitive impairments. Dr. Braganza was asked whether having these records would have changed her opinion and she indicated that it would not. In addition, Dr. Braganza testified that just because the MRI did not reveal any significant findings does not mean that the applicant did not sustain a brain injury which has caused resulting cognitive limitations.

[26] Dr. Lawson testified that symptoms of traumatic brain injuries usually heal within three to six months. Dr. Braganza agreed with Dr. Lawson that in 85% of cases they do; however, in 15% of cases they do not. Dr. Braganza explained that in the applicant's case, recovery has been delayed likely because of pre-morbid factors such as his history of substance abuse. I find the applicant's post-accident symptoms and limitations more compatible with the 15% scenario and that these symptoms have interfered with his ability to function in his daily activities.

[27] As already noted, Dr. Lawson determined that any neurocognitive impairment the applicant sustained had resolved and he assigned a WPI of 0%. Dr. Lawson's assessment revealed validity issues with the applicant's neurocognitive and psychometric test results as a result of poor test engagement. Dr. Lawson also opined that the applicant's cognitive difficulties likely reflect the applicant's emotional distress, pain and somatic symptoms.

[28] I assign Dr. Lawson's opinion less weight because I find it inconsistent with the rest of the evidence before me. Unlike every other medical practitioner who has assessed the applicant, Dr. Lawson is the only doctor whose assessment had validity issues. In addition, Dr. Lawson challenged the applicant's credibility as he determined that the applicant over-reported his accident-related symptoms of depression. In my view, this was inconsistent with every other assessor's opinion including the CAT psychiatric IE of Dr. Gnam, who described the applicant as honest and credible in his presentation. Dr. Gnam did not have any problems with validity.

[29] I also find Dr. Lawson did not provide a fulsome explanation regarding the validity issues he encountered with the applicant's test results in his CAT IE report. For example, Dr. Lawson states that the applicant's test results should be interpreted with caution. However, a closer review of the test results demonstrated that there were validity issues on only one out of approximately twenty-four tests administered. Further, no explanation was provided regarding the fact that the applicant performed poorly on the remainder of the tests with no validity issues. I find Dr. Lawson did not properly explain this in his report and that he ignored other medical evidence that challenged his findings. Dr. Lawson also admitted that he did not administer the psychometric tests himself. Instead, he has a group of psychologists that do that for him. He could not recall which psychologist in his office administered the tests on the date of his assessment. I find that this also leads me to question his ultimate conclusions.

[30] During cross-examination Dr. Lawson indicated that the applicant sustained a mild TBI but that it had resolved because that is what the scientific literature supports. I find Dr. Lawson's reasoning weak as he did not refer to what scientific literature he was relying upon in reaching this conclusion. The applicant submitted decisions of the Ontario College of Psychologists (OCP) which reflect that Dr. Lawson has been disciplined in the past for unethical practices. Therefore, Dr. Lawson's findings cannot be trusted as these complaints reflect negatively on his neutrality as an assessor. I agree with the applicant that Dr. Lawson's findings on this file were inconsistent with the opinions of all of the other medical assessors on this file. However, whether Dr. Lawson's CAT IE complied with the ethical standards of the OCP is not before me. Moreover, for the other reasons already provided, I have assigned his opinion less weight.

Method of Achieving WPI Rating

[31] As highlighted above, in her initial CAT assessment and rebuttal report, Dr. Braganza provided a range of impairment of 1 to 14% and declined to select a number within that range. She left it up to Dr. H. Becker to select the appropriate range in doing his CAT assessment summary report. Dr. H. Becker then selected the highest range and assigned a WPI of 14%. Dr. H. Becker testified that neither the *Schedule* nor the *Guides* provide medical experts with the proper tools to assign a total WPI% within a range. Therefore, he always selects the highest percentage as a person is no better than their worst impairment.

[32] I agree with the respondent that this method of assigning WPI% is not helpful. While I respect Dr. H. Becker's expertise in the *Guides* and experience in conducting CAT assessments, I do not accept this practice as the *Guides* specify that medical experts should assign as precise a rating as possible using their clinical judgment. Dr. H. Becker is not a neuropsychologist, nor did he personally meet with the applicant or conduct the assessment. In my view, the task of assigning a WPI% was Dr. Braganza's and she should have used her clinical judgment to select a number within the range and then provide her medical reasons to justify that number in her report.

[33] At the conclusion of her testimony I asked Dr. Braganza that if she had to assign a WPI rating for a mental status impairment, where would the applicant be within the range and she indicated he would be in the range of 12 to 14%. Since Dr. Braganza provided a range of 12 to 14%, I accept 12% for the applicant's mental status impairment. I do not accept the maximum of 14% as I do not find that Dr. Braganza sufficiently justified the higher number in her CAT assessment or fully

articulated her clinical rationale during her testimony. However, as already indicated I prefer her opinion over Dr. Lawson's based upon the other evidence before me. I find that the applicant sustained a mild TBI which has resulted in cognitive limitations and that these limitations warrant a mental status impairment rating of 12%.

Psychological Impairment

[34] Dr. Gnam's and Dr. D. Becker's diagnoses of the applicant were very similar. Dr. Gnam diagnosed the applicant with major depressive disorder, single episode, mild, chronic as well as somatic symptom disorder, with predominant pain, persistent, moderate. Dr. D. Becker diagnosed the applicant with major depressive disorder, likely recurrent episode, moderate to severe, chronic; and somatic symptom disorder with predominant pain, moderate to severe.

[35] The doctors also came to slightly different ratings under Criterion 8. These impairments are assessed under Chapter 14 of the *Guides*.[6] Mental and behavioural impairments are rated according to how seriously they affect a person's useful daily functioning. The below chart sets out the four spheres assessed for functioning and class levels of impairment.[7]

Area or Aspect of Functioning	**Class 1:** **No Impairment**	**Class 2: Mild Impairment**	**Class 3:** **Moderate Impairment**	**Class 4:** **Marked Impairment**	**Class 5:** **Extreme Impairment**
Activities of Daily Living	No impairment is noted	Impairment levels are compatible with most useful functioning	Impairment levels are compatible with some, but not all useful functioning	Impairment levels significantly impede useful functioning	Impairment levels preclude useful functioning
Social Functioning					
Concentration, Persistence and Pace					
Adaptation (Deterioration in a work-like setting)					

[6] American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, Ch.14.7: Mental and Behavioural Disorders.
[7] *Ibid,* pg. 301, Table 1

[36] Dr. D. Becker determined that the applicant had a moderate impairment in all four spheres of functioning. Dr. Gnam agreed that the applicant had a moderate impairment in Activities of Daily Living and Adaptation, however, determined that the applicant had a mild impairment in Social Functioning and a mild to moderate impairment in Concentration, Persistence and Pace. I will not address the two spheres in which the doctors agreed. However, I will discuss whose opinion I prefer in the spheres of Social Functioning and Concentration, Persistence and Pace as it is relevant to the WPI% rating.

Social Functioning

[37] I find that the applicant has a moderate impairment in Social Functioning as a result of his accident related psychological impairment.

[38] According to the *Guides*, this area of functioning refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. It is not only the number of aspects in which social functioning is impaired that is significant, but also the overall degree of interference with a particular aspect or combination of aspects.

[39] In her psychological CAT assessment Dr. D. Becker determined that the applicant has a moderate impairment in social functioning. By contrast, Dr. Gnam determined that the applicant had a mild impairment. For the reasons that follow, I agree with Dr. Becker and find the applicant has a moderate impairment in the sphere of social functioning.

Pre-accident

[40] In assessing the degree to which an accident has interfered with something, it is necessary to compare the applicant's pre- and post-accident activities. I find that the applicant consistently reported his pre-accident social functioning to all assessors as well as throughout his testimony at the hearing. Pre-accident, the applicant was out-going and had a large network of male friends which he enjoyed spending regular time with. The applicant reported that he would play darts with these men twice a week, go for drinks, go to hunting camps and he enjoyed many other activities such as ATV-ing, fishing and snowmobiling. He testified that he was hardly ever at home and I got the impression from him that he very much valued the time he spent with his friends and that this was a very important part of his pre-accident life.

Post-accident

[41] I also find the applicant consistently reported his post-accident social activities. Post-accident, the applicant is a homebody and is socially isolated. The applicant testified that he will get together with friends occasionally, but it is not the same as he will sit there quietly drinking water while everyone else has a good time. He is not the fun, outgoing guy he used to be. Post-accident, the applicant's large network of friends has dissipated. The applicant's wife testified that the applicant's brother will visit once a week and a neighbour will drop by occasionally. The loss of the applicant's social life has also contributed to his psychological status as he feels sad, isolated and alone. The applicant has done some hunting and fishing post-accident but does so at a reduced capacity and by himself on his own property with activity modifications.

[42] The respondent argued that the applicant has a mild impairment in social functioning as the majority of the assessors have indicated that the applicant is able to interact appropriately and communicate effectively with people in the community. Further, despite the fact that the applicant has lost his male companions, his relationships with his wife and children have improved because he now spends more time at home. This was confirmed by the applicant and his wife. Moreover, the applicant has shown the ability to make new friends as he met a friend at the chronic pain program he attended and was described by the facilitator of the program as "having wit and a great sense of humour." In addition, the applicant has gone out on social outings to Canada's Wonderland, the Aquarium and to the casino.

[43] The applicant's wife corroborated her husband's testimony about his pre- and post-accident social functioning. She testified that, pre-accident, her husband was very social and had many friends and was barely at home. Post-accident, he spends most of his time at home and rarely socializes with friends. Further, she confirmed that her husband did make a friend through the chronic pain program; however, this relationship was short lived, and they only got together on a few occasions. She also stated that although her and husband's relationship has improved in some ways, he is often angry and irritable, which is difficult to deal with.

[44] In analyzing the applicant's impairment within this domain, Dr. Gnam determined that the applicant's impairment was mild because he was polite and cooperative during the assessment and was observed to socialize with other patients in the waiting area. While I agree with the respondent that the above are examples of the applicant socializing and going on social outings, the applicant is also

described in many reports as having a short fuse with his wife and kids and being frequently irritable. I also witnessed the applicant's irritation and lack of coping skills when he was being cross-examined by the respondent. The fact that the applicant has gone out on some social outings post-accident does not mean that he has a mild impairment. I also find that Dr. Gnam observed the applicant's behaviour over one day which is a snapshot in time and does not factor in the overall impact of the accident on the applicant's social functioning.

[45] A moderate impairment is defined as an impairment level compatible with some, but not all useful functioning. The *Guides* do not just specify social functioning as having the ability to interact and communicate effectively in the community. The *Guides* also note that impaired social functioning may also include avoidance of interpersonal relationships or social isolation. When I compare the overall social activities of the applicant's pre- and post-accident life, I find he has a moderate impairment as a result of his accident-related psychological impairment. The *Guides* provide that in conducting this analysis it is not just the number of aspects in which social functioning is impaired that is significant. Instead, it is the overall degree of interference with a particular aspect.

[46] I find that the accident has had a serious impact on the applicant's social functioning as his social life has drastically changed post-accident. I believe that the social aspect of male companionship was an important part of the applicant's life pre-accident. Post-accident, he spends much of his time at home and has become socially withdrawn because of his depression and chronic pain. In my view, this change qualifies as a moderate versus mild impairment.

[47] Dr. Gnam testified that the applicant's decrease in social functioning with his male peers is not all connected to his psychological impairment. Instead, Dr. Gnam contributed it to the applicant not working as a man's social network shrinks when he is not working. Further, the loss of the applicant's driver's licence has also likely had an impact on the applicant's decreased social functioning. In Dr. Gnam's opinion, it was unusual for the applicant to socialize with other patients in the waiting room. These are some of the examples that drove Dr. Gnam's rating.

[48] I disagree with Dr. Gnam. In my view, the applicant losing his licence, then losing his job and most of his friends are all connected and is a combination of his accident-related chronic pain and psychological impairment. Dr. Day's psychological report highlights that some of Ms. Mullet's psychotherapy sessions focused on getting the applicant motivated to initiate social interactions because he had become so isolated because of his depression. The applicant's wife

testified that post-accident they have run into her husband's old work friends in the community. She has witnessed her husband's mood change because his self-esteem is so diminished because he feels useless because he is not working. In my view, these examples support the fact that the applicant's psychological impairment has contributed to his inability to function in this domain which in my view is compatible with a class 3 moderate impairment.

Concentration, Persistence and Pace

[49] I find that the applicant has a class 3 moderate impairment in the sphere of Concentration, Persistence and Pace.

[50] According to the *Guides*, this area of functioning refers to an individual's capacity to sustain focused attention long enough to permit the timely completion of tasks commonly found in work settings. In activities of daily living, this may be reflected in terms of ability to complete everyday household tasks.

[51] Dr. D. Becker determined that the applicant had a moderate impairment in this sphere of functioning. In her CAT assessment, she opined that factors including pain, significant depressive symptomatology, a tendency to ruminate, worry, disturbed sleep, and the effects of medication contribute to reported cognitive difficulties and problems sustaining focused attention and persisting with tasks. To the contrary, Dr. Gnam opined that the applicant was in between a mild and moderate impairment in this sphere of functioning. For the reasons that follow, I agree with Dr. D. Becker and find that the applicant has a moderate impairment within this sphere of functioning.

[52] Dr. Gnam's CAT IE report reflects that his class rating under this sphere was heavily influenced by Dr. Lawson's neuropsychological assessment. Dr. Gnam did not have problems with validity testing and found that the applicant presented honestly. However, in his report he highlights the validity issues encountered by Dr. Lawson in the cognitive testing in analyzing the applicant's impairment under this sphere. In his report, Dr. Gnam concludes that because the applicant had the capacity to complete the testing during all of the IE assessments, he has the capacity to do things. However, significantly, Dr. Lawson concluded that the applicant showed a lack of engagement in completing the battery of neuropsychological and psychometric tests. Therefore, in my view it does not make sense that Dr. Gnam used this to justify that the applicant's impairment under this domain was in between mild and moderate as he was unable to complete the battery of neurocognitive tests in a meaningful way.

[53] I also preferred Ms. Wong's CAT OT assessment over Ms. Shaw's as I find Ms. Shaw's assessment heavily focused on the applicant's physical ability to complete tasks versus from a psychological and emotional perspective. During cross-examination, Dr. Gnam acknowledged that Ms. Shaw's assessment could have had more cognitive and psychological components. In her IE report, Ms. Shaw referred to several physical examples where the applicant exhibited physical challenges in completing tasks in an efficient manner. For example, pre-accident, he could mow his lawn in half a day. Post-accident, he completes this task over three days. Ms. Shaw also referred to the applicant as being sad throughout the entire assessment and expressing irritation and becoming easily fatigued. In my view, this supports that there is a psychological element which impacts the applicant's ability to complete tasks in a timely and efficient manner.

[54] I find Ms. Wong's OT report more well balanced from both a physical, emotional and cognitive perspective. During Ms. Wong's assessment the applicant frequently exhibited self-deprecating behavior and became angry, sad and frustrated during the tests administered. Ms. Wong describes the applicant as breaking down into tears during her assessment because he became so frustrated with completing a task. Further, the applicant did not properly follow instructions and did not complete any of the tasks within the time allotted. In my view, Ms. Wong's assessment supports that the applicant has a moderate impairment in concentration, persistence and pace from a psychological perspective.

[55] During cross-examination, Dr. Gnam was asked whether he considered the findings of Ms. Wong's report in completing his assessment. He indicated that he considered Ms. Wong's assessment and gave it some weight but not much because he was unable to speak with her about it. However, in the file review section of his report, Dr. Gnam does not discuss Ms. Wong's report in any detail. In my view, this was an oversight. Moreover, during his testimony Dr. Gnam agreed that the applicant was closer to having a moderate versus mild impairment in this sphere.

[56] Finally, Ms. Wong's OT assessment and Dr. D. Becker's class rating of moderate in this domain is more consistent with the evidence before me. As already explained Dr. Day's neuropsychological assessment, the ICAN evaluation and Dan Fyke's OT housekeeping and home maintenance assessment clearly demonstrate that the applicant has difficulty completing tasks within a timely manner due to a lack of attention, inability to process instructions and a lack of problem-solving skills. The combination of the applicant's psychological diagnoses, the impact of his TBI and suffering from chronic pain have all

impacted the applicant's ability to concentrate and maintain persistence and pace in his daily activities. I find that these limitations have had an impact on some, but not all useful functioning in this domain.

Method of Assigning and Converting WPI% Rating for Psychological Impairment

[57] Neither the *Schedule* or the *Guides* provide a set method for medical experts to convert psychological impairment ratings under Chapter 14 to a WPI%. However, the two most popular approaches include a) using the "Global Assessment of Functioning Scale" (GAF); or b) using Table 3 of Chapter 4 of the Guides. This Table provides ranges of percentages for mild (1-14), moderate (15-29) and marked impairments (30-49). In this case, Dr. D. Becker and Dr. Gnam both used only the GAF scale and California Method[8] in reaching their respective impairment ratings.

[58] The GAF scale is used to estimate an individual's overall psychological, social and occupational functioning on a scale of 0 to 100 - the higher the score, the better the function. The California Method is then used to convert the GAF score into a WPI% for the purpose of combining physical with psychological impairments under the *Guides* to get a final WPI for the purpose of determining catastrophic impairment under the *Schedule*.

[59] Dr. Gnam determined that the applicant's GAF score was between 54 to 56 which he converted into a WPI rating of 21 to 24%. In justifying the GAF score Dr. Gnam indicated that this number was consistent with the fact that he found two moderate impairments in the four spheres of functioning.

[60] Dr. D. Becker opined that the applicant's GAF score was between 45 to 50 which she converted into a WPI range of 30 to 40%. Dr. D. Becker testified that she came to a higher GAF score because her psychological diagnosis of the applicant was more severe than Dr. Gnam's. In his closing submissions the applicant maintains that Ada Mullet, his treating psychologist agrees with Dr. D. Becker that the applicant's psychological impairment is severe as opposed to mild. However, this point was contradictory as Ms. Mullet testified that applicant's depression was in the middle of moderate versus severe. I accept Ms. Mullet's opinion as she has treated the applicant over a longer period of time.

[61] In his CAT IE, Dr. Gnam was critical of Dr. D. Becker's method of rating the applicant's psychological impairment. First, Dr. Gnam took issue with Dr. D. Becker's GAF score as, in his view, the GAF score and the WPI% assigned was

[8] Schedule for Rating Permanent Disabilities, Labor Code of the State of California: January 2005.

more compatible with a marked verses moderate impairment rating. Second, Dr. Gnam challenged Dr. H. Becker's practice of picking the highest number within the range of 30-40% in calculating the applicant's total WPI% under Criterion 7. In his view, this practice is not accepted anywhere in the *Guides*, is not a reliable method and challenges the integrity of the rating process. Dr. Gnam testified that since Dr. D. Becker determined the applicant had a moderate impairment in all four domains then the applicant's total WPI% would not be more than 29%. I find Dr. Gnam's opinion in relation to this made sense.

[62] Dr. D. Becker testified that the applicant had serious symptoms according to his GAF score which does not correspond with a moderate category in the AMA Guides. I found this explanation to be weak as if the applicant's functioning was more severely impaired then Dr. D. Becker would have determined that the applicant had a marked impairment. However, she did not. Further, she did not select a number within the range and provide her clinical rationale to back it up in her initial report. Instead, she left it up to Dr. H. Becker to select the appropriate WPI% when he completed his CAT summary rating report. Dr. H. Becker selected the highest range of 40% for the applicant's psychological impairment in combining the applicant's total WPI.

[63] Dr. H. Becker testified that he always chooses the highest percentage rating within a range on the basis that "you are no better than your worst impairment." In his report, Dr. H. Becker justified his philosophy based on case law which supports that the *Schedule* is consumer protection legislation and that it and the *Guides* should be interpreted broadly and inclusively in favour of the insured. While I agree with Dr. H. Becker that the tools and processes for assigning impairment ratings for psychological impairments are less than perfect, I do not find Dr. H. Becker's practice helpful. Further, I do not find Dr. H. Becker's rationale to justify his practice particularly neutral.

[64] Ultimately, I find it was up to Dr. D. Becker to select the appropriate range for the psychological impairment in her initial CAT assessment report using her clinical judgment and provide the medical rationale to justify her number. Dr. D. Becker authored a rebuttal report in response to Dr. Gnam's critique. In that rebuttal, Dr. D. Becker selects the maximum range of 40%. She testified that sometimes the applicant could be a 30 and sometimes he could be a 40. I agree with Dr. Gnam and find Dr. D. Becker's impairment rating was inflated. I agree with the respondent that Dr. D. Becker's conversion of the GAF to a WPI% rating is consistent with a marked impairment rating. I also find OMEGA's method of calculating the WPI% was inconsistent with Dr. Day's method. Dr. Day's assessment determined that the applicant had a moderate impairment in 3

spheres and a marked impairment in one and he provided a total WPI of 33%. While I agree that you need to look at a person as a whole and that percentages when it comes to psychological impairments is a grey area, there needs to be consistency and at the very least a valid explanation to justify ratings.

[65] I asked the parties to submit case law focussing on the conversion of GAF scores under the California Method into WPI% ratings under the *Guide*s. The applicant submitted case law from the Financial Services Commission of Ontario ("FSCO") in support of the preposition that the *Schedule* is consumer protection legislation which should be given a broad, liberal and inclusive interpretation. Further, any ambiguities should be resolved in favour of the insured. In some of those decisions the arbitrators accepted the practice of accepting the highest number within a range to calculate the total WPI% for CAT impairment ratings. To the contrary, the respondent submitted case law from this Tribunal which rejected this practice altogether as the *Schedule* and the *Guides* support that medical experts should come to as precise a rating as possible using their clinical judgment. It is important to note that I am not bound by the decisions of FSCO or this Tribunal.

[66] I did not find the case law relied upon by the applicant relevant to the present case as the decisions did not focus on the conversion of GAF scores into WPI% ratings using the California Method. Further, in the few decisions that dealt with psychological impairments the doctors determined that the insureds had a marked impairment under Criterion 8. In the applicant's case, Dr. D. Becker has not determined that he has a marked impairment, yet the numerical rating assigned is in the range of a marked impairment. Even though I agree with the applicant that the *Schedule* is consumer protection legislation which should be given a liberal and inclusive interpretation I do not accept the WPI% rating assigned by Dr. D. Becker as the WPI% assigned was inconsistent with her moderate impairment rating. Further, I do not find Dr. D. Becker's rating is supported by the evidence, the instructions in the *Guides* to assign a rating as precise as possible or the case law relied upon by the applicant.

[67] In conclusion, I find that Dr. Gnam underestimated the applicant's overall impairment rating. However, I also find that Dr. D. Becker's impairment rating to be inflated. During cross-examination Dr. Gnam explained that he came to his GAF score rating and WPI% rating based on the fact that he determined the applicant had two moderate impairments under the four domains of functioning. However, as established I find that the applicant has a moderate impairment in all four spheres which according to the conversion table would be equal to a WPI of 29%.

[68] While I acknowledge that the applicant sustained serious physical and psychological impairments as a result of the accident when you add [17+12+29] the total is 48% WPI. Therefore, the applicant does not meet the 55% threshold required under Criteria 7. The applicant has not met his onus on a balance of probabilities that he suffered a CAT impairment pursuant to the *Schedule.*

Is the applicant entitled to the treatment plan for psychotherapy recommended by Ada Mullet?

[69] I find the treatment plan for psychotherapy is reasonable and necessary in the amount of $2,593.76 for the following reasons.

[70] Sections 14 and 15 of the *Schedule* provide that an insurer is only liable to pay for medical expenses that are reasonable and necessary as a result of an accident. The applicant bears the onus of proving on a balance of probabilities that any claimed medical expenses are reasonable and necessary.

[71] At the conclusion of the hearing I asked the respondent to confirm whether the medical and rehabilitation limit had been exhausted as it did not direct me to any evidence regarding the denial of the treatment plans in dispute. The respondent was not sure if the medical and rehabilitation limit had been exhausted and I asked counsel to confirm in writing following the hearing. Following the conclusion of the hearing, the respondent confirmed that it has approved $43,172.52 in medical and rehabilitation benefits leaving a balance of $6,827.48 left available under the policy limit.

[72] The treatment plan authored by Ms. Mullet dated August 3, 2017 in the amount of $2,593.76 recommended 12 sessions of counselling at a total cost of $1,795.32, $200.00 for form completion and $299.22 for planning services and $299.22 for documentation support activity. The duration of the treatment plan was to cover a period of 24 weeks. Under activity limitations, the plan states the applicant's chronic pain and depressed mood prevent him from continuing to work as a [tradesperson]. Further, he is unable to drive, has poor stamina, and cognitive limitations impair his ability to engage in activities of normal life. The goal of the treatment plan is for pain reduction and to provide him with the skills to cope with role losses associated with the accident, emotional coping, managing his anxiety, depression and suicidal ideation.

[73] First, I find the goals of the treatment plan to provide the applicant with the skills to cope with his depression and other symptoms to be a fair objective. In addition, the evidence overwhelmingly supports that the applicant sustained a serious psychological impairment as a result of the accident as both Dr. Gnam

and Dr. D. Becker diagnosed the applicant with major depressive disorder in their respective CAT assessments. In my view, the applicant requires additional psychological treatment to address his ongoing accident-related psychological impairment.

[74] Second, the applicant testified that he has benefitted from his past psychological sessions with Ms. Mullet. He indicated that Ms. Mullet could talk him down when he feels depressed and she has given him strategies to cope with his suicidal thoughts. The fact that the applicant benefits from psychological treatment was also corroborated by the applicant's wife. In Ms. Mullet's report dated November 30, 2017, she recommends the applicant receive ongoing psychological intervention to grieve the many role losses he has sustained as a result of the accident. As already noted above, the applicant's accident related impairments have interfered with his employment, his independence to navigate within the community and his social functioning.

[75] Third, Ms. Mullet testified that she has treated the applicant since 2016 and that the applicant continues to require ongoing treatment. The applicant relied upon Ms. Mullet's progress reports which outline the applicant's psychological limitations and progress from treatment in support of the need for ongoing psychotherapy.

[76] Finally, the respondent did not direct me to any evidence or provide any explanation to support its reason for denying the treatment plan.

[77] Based on the above-noted reasons the applicant has met his onus in proving on a balance of probabilities that the treatment plan is reasonable and necessary as a result of his accident related impairments.

Is the applicant entitled to the two treatment plans for physiotherapy (hydrotherapy) recommended by Joseph Stilwell?

[78] I find the first treatment plan in the amount of $3,645.24 is reasonable and necessary. I find the second treatment plan in the amount of $3,245.47 to be reasonable and necessary up to the medical and rehabilitation policy limit.

[79] Both treatment plans authored by Mr. Stilwell are practically identical as far as noting the applicant's accident-related impairments. The goals of both plans are to reduce the applicant's pain and improve his ability to function in his daily activities. Under evaluation both plans note that massage and water therapy has really helped with the applicant's levels of pain. In my view, I find the goals of the plans to be reasonable. Further, the applicant has been diagnosed with chronic

pain so there is a clear link between the applicant's accident-related impairment and the treatment being sought.

[80] It is well accepted law that a medical benefit is reasonable and necessary if the treatment meets the objective of reducing an individual's pain which improves their ability to function in their daily activities.

[81] As of the date of the hearing, the applicant was still suffering from chronic pain which was affecting his ability to function in his daily activities. In addition, the applicant has consistently reported to his family doctor and other assessors that he found physiotherapy beneficial as it reduced his pain which enabled him to function. The applicant testified that he has attempted to do the exercises at home but could not remember how to do them properly. In addition, he does not have the equipment at home because the therapy involves him using a treadmill in a pool. The applicant's wife also testified that she observed her husband's condition improve post-therapy.

[82] The applicant also relied on the report of Dr. Cooke, orthopedic surgeon, dated October 16, 2018 who supported the applicant's ongoing need for physiotherapy. I also heard the testimony of Mr. Stilwell, the applicant's service provider who supported the applicant's ongoing need for therapy. In the absence of a competing opinion, I accept the opinion of Dr. Cooke and Mr. Stillwell and find the treatment plans to be reasonable and necessary.

[83] The applicant also submits that physiotherapy is so important in relieving his pain that he started paying out of pocket when his treatment was denied by the respondent. The applicant submitted invoices from Hydrathletics to support same. These invoices demonstrate that the applicant continued to attend therapy at a reduced frequency from August 27, 2017 to October 31, 2018.

[84] The first treatment plan dated August 1, 2017 recommended 36 sessions of physiotherapy at a cost of $2,094.34 and 18 sessions of massage at a cost of $931.04 plus form completion and taxes for a total cost of $3,645.24. The duration of the treatment plan was for nine weeks. The second treatment plan dated August 18, 2018 recommended 24 sessions of physiotherapy at a cost of $2,137.68 and 6 sessions of massage in the amount of $534.42. This treatment plan also covered a duration of nine weeks. Since neither party addressed the quantum of the treatment plans, I do not find the proposed amounts excessive.

[85] The applicant has met his onus on a balance of probabilities in proving that the treatment plans for physiotherapy (hydrotherapy) and massage are reasonable and necessary.

[86] The applicant is entitled to the full amount of the first treatment plan in the amount of $3,645.24. I find the second treatment plan in the amount of $3,245.47 to be partially reasonable and necessary up to the medical and rehabilitation policy limit.

Is the applicant entitled to payment of interest on overdue payment of benefits?

[87] Section 51(1) provides that "an amount payable in respect of a benefit is overdue if the insurer fails to pay the benefit within the time required under this regulation".

[88] Since I have determined that all of the three treatment plans are reasonable and necessary, I find interest is payable pursuant to s.51 of the *Schedule*.

ORDER

[89] For all of the above noted reasons, I issue the following order:

i. The applicant did not sustain a catastrophic impairment as a result of the accident.

ii. The applicant is entitled to all three treatment plans plus interest payable in accordance with the *Schedule.*

Released: September 28, 2020

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Rebecca Hines
Adjudicator