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: Z.K. vs. Allstate Insurance Company Canada, 2020 ONLAT 17-006929/AABS

Released Date: 12/08/2020
File Number: 17-006929/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:

Z.K.

Applicant

and

Allstate Insurance Company Canada

Respondent

REASONS FOR DECISION AND ORDER

PANEL:	**Sandeep Johal, Vice Chair**
APPEARANCES:	
For the Applicant:	Delenthi Warakaulle, Counsel Alfred Kwinter, Counsel
For the Respondent:	Jonathan Schrieder, Counsel Denise Felstead, Adjuster
Court Reporter:	Bruce Porter
HEARD:	**In-person in Toronto**

OVERVIEW

[1] The applicant was injured in an automobile accident on June 6, 2014 and sought benefits pursuant to the *Statutory Accident Benefits Schedule* – Effective September 1, 2010[1] (the "*Schedule*").

ISSUE IN DISPUTE

[2] The following issues are to be determined at the hearing:

I. Has the applicant sustained a catastrophic impairment pursuant to the *Schedule*?

II. Is the applicant entitled to payment for a medical benefit in the amount of $5,905.00 in a treatment plan for chiropractic treatment, recommended by Apex Health Network and denied by the respondent on January 18, 2017?

III. Is the applicant entitled to payment of a cost of examination expense in the amount of $4,520.00 ($14,012.00 less the partially approved amount of $9,492.00) in a treatment plan for a catastrophic neuropsychological and triage assessment recommended by Omega Medical Associates denied by the respondent on June 7, 2016?

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

RESULT

[3] I find that the applicant sustained a catastrophic impairment as a result of the accident.

[4] The chiropractic treatment plan is not reasonable and necessary, therefore the applicant is not entitled to payment.

[5] The applicant is entitled to the cost of examination for a neuropsychological assessment.

[6] The triage assessment is not reasonable and necessary, therefore applicant is not entitled to payment.

[7] The applicant is entitled to interest in accordance with s. 51 of the *Schedule* on the overdue payment of benefits for the neuropsychological assessment.

[1] O. Reg. 34/10.

ANALYSIS

Catastrophic Impairment

[8] For the following reasons I find that applicant has sustained a catastrophic impairment under the *Schedule*, and he is therefore entitled to the enhanced policy limits.

[9] In order to be found to have a catastrophic impairment under the *Schedule*, the applicant must prove on a balance of probabilities that the impairments he suffers from as a result of the accident have a combination of physical and psychological impairment ratings that result in a whole person impairment (WPI) of 55% or more,[2] when rated in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (the "*Guides")*;[3] or in at least one Marked or Class 4 impairment,[4] in any of the four domains as outlined in the *Guides* due to a mental or behavioural disorder. The test to determine whether the applicant has sustained a catastrophic impairment is a legal test and not a medical one.[5]

[10] The classes of impairments are listed in Chapter 14 of the *Guides* and increase in levels of severity from Class 1 (no impairment) to Class 5 (extreme impairment). In order to be found to have a catastrophic impairment, the applicant must present with a Class 4 (marked impairment) in any one of the four domains of either Activities of Daily Living; Social Functioning; Concentration, Persistence and Pace; and Adaptation.

Parties' Positions

[11] The parties disagree on whether the applicant meets the catastrophic impairment test for either Criterion 7 (WPI rating) or under Criterion 8 (Class 4/Marked Impairment).

[12] The applicant's position is that he has a WPI impairment rating of 55% under Criterion 7 and he has a Class 4/Marked Impairment in the domains of Activities of Daily Living; Concentration, Persistence and Pace; as well as Adaptation. As a result, he meets the definition of a catastrophic impairment.

[13] The applicant relies upon the testimony of the applicant, his wife and children who all testified to explain how the applicant has changed as a result of the

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[2] Section 3(2)(e) of the *Schedule* ("Criterion 7").
[3] 4th Edition, 1993 at Chapter 14.
[4] Section 3(2)(f) of the *Schedule* where the applicant has a marked (Class 4) or extreme (Class 5) psychological impairment that affects useful function in any one of the four functional domains. The four functional domains are (1) activities of daily living; (2) social functioning; (3) concentration, persistence and pace and (4) deterioration or decomposition in work or work like settings (also referred to as adaptation). ("Criterion 8").
[5] *See Liu v. 1226071 Ontario Inc. (Canadian Zhorong Trading Ltd.)*, 2009 ONCA 571 at paras. 29-30.

accident, as well as experts who opine that the applicant has met the criteria and has a catastrophic impairment under the *Schedule*.

[14] The respondent's position is that the applicant is not a credible witness as he is malingering and feigning and there is no concrete scientific evidence of an injury.

[15] The respondent relies upon surveillance video of the applicant from 2014 and medical opinions that found the applicant has overstated his injuries and symptoms and is malingering.

Credibility and Surveillance

[16] The respondent relies heavily on the surveillance videos taken three months after the accident from September 2014 where the applicant is seen driving a vehicle, attending a grocery store, taking items out of the shopping cart and placing them in the trunk of the car, as well as attending a park with his family where he was observed to ascend and descend stairs (with both hands on each side of the railings for support). He was further observed to bend at the waist, kneel and crouch and assist his grandchild down a slide.

[17] According to the respondent, the applicant reported to the insurer examination ("IE") assessors around that same time that his back pain was severe and he would rate it as a 10/10 in intensity and his neck pain was a 5/10 in intensity and his headaches were a 10/10 in intensity.[6] It is the respondent's position that the video surveillance was not indicative of his reports of pain to the IE assessors.

[18] During his cross-examination, the applicant testified that his back pain in 2014 after the accident was about a 7/10 in intensity and sometimes 10/10 in intensity and there are often times where he is disengaged from his family and walking off on his own. He testified that he tends to walk gingerly and on his own at times rather than together with the family.

[19] In my view, surveillance is at a moment in time and not illustrative of the overall picture of how the applicant may really be. Although on those days the surveillance took place he did not appear to be in distress as a result of his back pain or headaches, but the applicant's evidence of his self-reports of pain intensity of 7/10 or 10/10 did not mean that he is unable to leave his home or is unable to walk. Furthermore, the surveillance evidence was taken three months after the accident and five years later, during the time of the treatment plans and his request for a catastrophic designation, his condition could have worsened. The applicant testified that he was able to drive shortly after the accident, whereas he is unable to do so now. Furthermore, I do not find the surveillance to be of assistance or indicative of whether the applicant's injuries rise or do not rise to the

[6] Respondent Medical Brief, Volume 5 of 5 at Tabs 26 and 27. IE reports of Dr. Waseem, Physiatrist dated September 29, 2014 and October 15, 2014.

level of a catastrophic impairment as described in the *Schedule*. As a result, I do not find the surveillance significantly impeaches the applicant's credibility.

Applicant's Impairments

[20] The applicant's wife and children testified at the hearing and presented similar testimony that prior to the accident the applicant was running a buy and sell store in Hamilton where he worked long hours from 9:00 a.m. to 8:00 p.m., seven days a week. He ran this business for about twelve years until January 2012 after which, he became a licenced mortgage agent. He was a very outgoing person and also hosted friends at their home on a regular occasion and went to other people's houses as well. He would go for long walks with his wife regularly. He was relatively healthy with no serious illnesses prior to the accident. The family would go for trips to Niagara Falls and also took a trip to Croatia and it was the applicant who did most of the driving.

[21] After the accident the applicant started to complain of back and neck pain as well as headaches. He would be tired constantly, rested more often and he started to have, what his family would call "seizures" where his jaw, hands and legs would start to shake. These "seizures" would last approximately one to two minutes. He went to see a neurologist, Dr. Mitri about his seizures. An MRI and other scans were completed, however there was nothing in the MRI or the scans that would explain the applicant's seizure episodes. He lost over 30 pounds since the accident as he has no appetite and he has to force himself to eat. His concentration and memory were described as "not good". He would forget to turn off the stove and his short-term memory has become quite bad. The applicant testified that his wife has to help with his personal care tasks, including using the washroom, putting his jacket on and clipping his nails.

[22] The applicant's wife and children testified that he is depressed, takes medication to treat his depression as well as pain, and that he is not the same person as before. He usually has a blank stare on his face, and he does not communicate or interact with the family as much as he used to before the accident. His memory is not good as he will forget to eat, or he sometimes forgets why he came into a room. He does not read newspapers or books anymore., He will lie down, walk in the yard and then come back inside and lie down again. He no longer entertains socially or has any get-togethers with his friends. He has not returned to work since the accident, and although he drove on occasion after the accident, his driving has become worse and his family does not let him drive anymore.

Applicant's catastrophic impairment reports

[23] Dr. Lara Davidson, practices in the field of clinical psychology and clinical neuropsychology, conducted an assessment of the applicant and produced a report dated April 26, 2017.[7] Dr. Davidson met with the applicant on four separate

[7] Applicant's Document Brief, Part 3 of 5 at Tab 53.

occasions for the purposes of this report and to complete psychometric testing. She notes that the applicant was struggling with pain, had fatigue and dizziness. Dr. Davidson was concerned about his visual and language issues, so she arranged to have an interpreter present for the assessment She completed numerous psychological and cognitive tests over three days. Six of the tests were for psychological testing and thirty for cognitive testing. The tests covered all four domains of the *Guides* to assess whether the applicant has a catastrophic impairment. Dr. Davidson testified that exaggeration in the testing is something she looks for and considers it vital in forming an accurate opinion. In her report Dr. Davidson found that the applicant performed well on the measures of validity testing during cognitive testing and there was "no evidence of an effortful distortion of cognitive symptomatology." With respect to the validity of the applicant's responses for the psychological testing, she found that the applicant responded consistently and in a reasonably forthright manner and did not attempt to present an unrealistic or inaccurate impression that was either more negative or more positive than the clinical picture would warrant. Overall, she found there was "no evidence of an effortful distortion of an emotional or cognitive symptomatology."

[24] Dr. Davidson diagnosed the applicant with pain disorder, predominant pain severe, depressive disorder—moderate.

[25] Dr. Davidson's conclusion is that the applicant has a moderate (Class 3) impairment in the domain of Social Functioning and a Marked/Class 4 impairment in Activities of Daily Living, Concentration-Persistence and Pace, as well as Adaptation and as a result, she concluded that he met the test for a catastrophic impairment.

[26] Dr. Gerald Young, psychologist, met with the applicant on June 24 and 25, 2019 and produced a report dated July 25, 2019.

[27] Dr. Young is a psychology professor at York University and has written numerous articles and presented at conferences discussing malingering as well as feigning and has been given awards for his work and research on the issue of malingering.[8]

[28] Based on the interview and self-reports from the applicant, the detailed documentation review,[9] as well as the testing and behavioural observations Dr. Young agreed with Dr. Davidson's conclusions that the applicant has a Marked/Class 4 Impairment in three of the four domains: activities of daily living, concentration-persistence and pace as well as adaptation in work or work-like settings. Therefore, the applicant meets the test for a catastrophic impairment.

[29] Dr. Young conducted the Trauma Symptoms Inventory-2-A (TSI-2-A) test and the Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2RF). According to Dr. Young, the TSI-2-A test looks for reliability and validity and on this test the applicant did not score in the exaggerated range. Dr. Young then gave

[8] Applicant's Document Brief, Volume 3 of 5 at Tab 44.
[9] *Ibid* at Tab 45 at pgs. 639-683.

another test for malingering, the MMPI-2-RF and as a result of these tests, Dr. Young did not see any red flags that were raised and did not find any evidence of feigning or malingering.

[30] Dr. Young found the occupational therapy assessments, one from the respondent and one from the applicant to be to compatible with Dr. Davidson's findings. The occupational therapy reports both analyzed the applicant's functionality in the four domains.

Occupational Therapy Assessments

[31] The applicant also relies upon an occupational therapy report by Bani Ahuja who met with the applicant on March 21, 2017 for the purposes of an occupational therapy assessment and produced a report dated April 26, 2017.[10] She provided a functional assessment of the applicant on the four domains from the *Guides* for the purpose of determining catastrophic impairment. After the assessments, she provided an opinion on the functionality of the four domains, however, she did not provide a diagnosis. Ms. Ahuja looked for magnification and exaggeration and, in her opinion, she did not see any signs of magnification and testified that she would have noted it in her report if she did.

Activities of Daily Living

[32] With respect to activities of daily living, Ms. Ahuja noted that the applicant has difficulty initiating and sequencing tasks and difficulty engaging in basic self-care. She noted that he walked slowly, showed difficulty with sit to stand transfers and prolonged sitting. She noted that he experienced a seizure and a possible panic attack during the 3.5 hours of the assessment, indicating safety concerns with being left alone.

[33] Ms. Ahuja noted that the applicant had difficultly planning, organizing information and sequencing as he was not able to complete grocery planning or heat a cup of soup for himself. She noted that he was unable to tidy up after himself in a safe and appropriate manner and during the assessment he showed poor motivation when fatigued. She found him to be limited in his ability to engage in productive activities throughout the day as he spends most of his day resting.

[34] The applicant's spouse and daughter also testified that he is forgetful and has forgotten to turn off the stove and he mostly lies down on the couch.

[35] During the occupational therapy assessment, it was noted that he could not efficiently plan the information presented to him during the grocery flyer task and he could not organize rubber bands and cards in order to be able to sort them correctly. It is Ms. Ahuja's opinion that his ongoing pain, fatigue, poor mood, poor sleep hygiene, lack of interest and poor coping mechanisms may have an ongoing impact on his ability to initiate, integrate and execute consistent participation with

[10] Applicant's Document Brief, Part 4 of 5 at Tab 55.

his housekeeping and work-related duties. He requires assistance to access the community as he no longer drives, and he has become dependant on others to assist him when he wants to go out.

Social Functioning

[36] Ms. Ahuja noted that he was pleasant at the onset of the assessment but transitioned into being frustrated, anxious, timid, overwhelmed and tearful as he progressed through the functional tasks. He became fearful after his seizure episode and needed significant pacification and consoling to continue. He stopped talking mid-sentence, interrupted conversations and engaged in significant tangential conversations which impacted his ability to interact with the assessor and the interpreter. Ms. Ahuja noted that based on the applicant's subjective remarks, collateral information received from the applicant's wife as well as the medical documents and observations made during the assessment. It was her opinion that the applicant's ongoing pain, fatigue, low energy and mood, poor motivation and initiation, irritability, frustration, and diminished interest, appear to be interfering with his ability to interact socially, which is contributing to his social withdrawal.

[37] The applicant's wife and children also testified that he is no longer as socially outgoing as he was prior to the accident. He no longer engages socially with anyone else outside the household and even with family members he tends to zone out mentally, does not follow the conversation, or does not participate in any conversation with his family for more than five minutes.

[38] The applicant, his wife and his children testified that prior to the accident, he was able to manage and complete his day to day activities, he worked long hours, he was able to drive, they would go on family vacations and he would host social get togethers with friends and family. Post-accident that is not the case.

Concentration/Persistence/Pace

[39] Ms. Ahuja noted in her report that the applicant showed significant difficulty with concentration as he had difficulty recalling instructions and organizing information that was presented to him. He would be distracted, zone-out and engage in frequent tangential conversations where he had to be redirected to the task every few minutes.

[40] Ms. Ahuja noted that the applicant showed a significantly reduced ability to persist through all tasks presented. He needed encouragement in the grocery flyer task, he could not correct his errors in the list he compiled and left the list incomplete. He was unable to follow through with making soup and could not tidy up after himself in the kitchen. During the tidying/sorting task, he needed a modification of the task in order to continue and he could not follow-up on correcting his errors when they were pointed out to him.

[41] The report notes that with respect to his pace, the applicant had significantly low energy, he had to lie down, took an additional rest break and continued to work at a slow pace even after resting. He could not use his time efficiently to increase his productive output. He took over 20 minutes to complete the grocery flyer task and was observed to have noted irrelevant and additional information in the list. He spent over 20 minutes attempting to make soup from a packet mix. He needed a 35-minute rest break to lie down to take a nap. He moved slowly upon his return from a lunch break and required an additional break. Ms. Ahuja opines that his pain, fatigue, fear of exacerbating symptoms and causing further harm, low mood, and diminished interest, negatively interfered with his performance and overall productive output. (i.e. multiple errors, missing details and refraining from tasks.)

Adaptability/ Deterioration in Work-Like Settings

[42] Based on the assessment and observations, Ms. Ahuja opined that the applicant appears to have a limited ability to adapt to unpredictable or mildly stressful situations and requires cueing and guidance to follow through with routine tasks, which used to be part of his daily life prior to the accident.

Respondent's occupational assessment

[43] The respondent also conducted an occupational therapy assessment by Ms. Nina Munir, occupational therapist, on July 14, 2017.[11]

[44] Ms. Munir observed that the applicant presented with mild to moderate limitations in his neck range of movement. Overall, he was alert and did not require encouragement to maintain his attendance in the four-hour activities of daily living assessment and he completed all presented tasks with the exception of lifting and carrying. Ms. Munir noted the applicant displayed pain behaviour, but she found that it did not interfere with his performance, however, she found his pace was slow overall.

[45] With respect to the domain of Concentration, Persistence and Pace, Ms. Munir noted that the applicant took several prolonged breaks to lie down during the assessment and he complained of being fatigued and in pain. Ms. Munir noted the applicant had reduced tolerance and persistence as he made numerous errors during cognitive tasks, he displayed pain behaviours and signs of visible distress and fatigue. He declined to participate in physical tasks of lifting and carrying in anticipation of pain. His work pace was highly inefficient, disorganized and poorly executed for both cognitive and physical based tasks.

[46] Ms. Munir noted that the applicant did not demonstrate the functional abilities required for organizing practical information, planning and sequencing events in a logical and formal manner. He did not demonstrate the functional abilities for applying critical thinking and practical reasoning abilities. He did not present with the tolerance to sustain his concentration and focus long enough in order to work

[11] Respondent Medical Brief, Volume 5 of 5 at Tab 33 (2)

in a productive and focused manner. She noted these barriers to have an ongoing impact on his ability to multitask as evidenced by reduced accuracy, difficulty alternating attention in a dynamic setting, the need for repeated instructions and cueing, and difficulty clustering information for task completion.

[47] With respect to the domain of Work Adaptation, Ms. Munir noted that the applicant demonstrated the tolerance to sustain his concentration on a reasonably continuous basis, however his work performance was poor and not conducive to achieving reasonable results. His self-awareness, understanding or ability to reflect, observe and or shed introspective comment regarding his functional abilities were questionable. She found his work behaviours to be unproductive, disorganised and haphazard. She opined that the applicant did not demonstrate the mental, emotional and physical reserve to participate in a series of work-like activities with or without the presence of task modification based on direct assessment findings.

[48] With respect to the domain of Social Functioning, Ms. Munir noted that the applicant displayed signs of helplessness and dependency on others for fulfilling tasks that fell within his functional abilities. She noted that he appeared anxious and hesitant during the community outing and asked for direction on what to do next and requested the language interpreter to read information for him. He often approached others in a peculiar and intrusive manner for information rather than investing the time to search and scan his immediate environment. She found that the applicant did not demonstrate acceptable social behaviours required to effectively relate to others, and to build and maintain work relationships with peers in a work-like setting.

Respondent's psychological assessment

[49] Dr. Wiseman conducted a psychological assessment of the applicant on behalf of the respondent on July 10, 2017,[12] and found that the current objective data from her assessment indicated high levels of distress, and likely over-reporting pain related disability. She found a discrepancy between the applicant's behaviour during the assessment and the reported level of emotional distress on the questionnaires. Dr. Wiseman noted that the applicant's participation in the occupational therapy assessment with Ms. Munir was not sufficiently consistent or comprehensive to enable Ms. Munir to gather evidence of any legitimate difficulty the applicant may have with adaptation in work-like settings. As a result, she found that the applicant did not meet the burden of evidence necessary for concluding that he has a Class 4/Marked impairment in any of the four domains from the *Guides*.

[50] I place less weight on the opinion of Dr. Wiseman and prefer the opinions of the applicant's assessors for the following reasons.

[12] Respondent Medical Brief, Volume 5 of 5, at Tab 33A1.

[51] Dr. Young noted that one of the tests Dr. Wiseman used was a DASS test, which is a test that he has not heard of, and he had to do research on it to understand what the test measured. According to Dr. Young, the test is standardized for a college and university population and in his opinion, the DASS test is not useful for the purpose of validity or the clinical status of a patient. Furthermore, he opines that the PSR-1 test Dr. Wisemen used is an outdated test and not commonly used for this type of case.

[52] Dr. Davidson also opined that the PSR-1 test is not an appropriate test to use as the scale is not an appropriate measure when looking at credibility. She also opines that that there are no peer reviewed or published papers in support of this test. Dr. Davidson also agrees with Dr. Young that the DASS test is not an appropriate test as there are no measures of validity for it.

[53] Dr. Wiseman also testified that she acknowledged the bulk of the criticism she has received from the applicant's doctors is based on her use of the PSR-1 test and she agreed that it has not been peer reviewed. Furthermore, she agreed that there is not much testing on it and that is a weakness of the PSR-1 test.

[54] Dr. Wiseman agrees that people present differently on different days and the applicant responded differently during his assessment with Dr. Davidson.

[55] Dr. Davidson and Dr. Young both state that Dr. Wiseman changed the "goalposts" on the Personality Assessment Inventory (PAI) test she conducted as the applicant's score fell within the valid range as per the manual for that test however, Dr. Wiseman used the average score which would place the applicant's score at the cut-off point which allowed Dr. Wiseman to opine that he was overreporting as a result.

[56] I further place less weight on Dr. Wiseman's report and testimony as she testified that she believes her role is that of a "detective, to flush out malingering." In my view, an insurer examination assessor's role is to provide a medical opinion that is related only to matters that are within the doctor's area of expertise. In this case, Dr. Wiseman's expertise is in the field of Neuropsychology,[13] and not that of a detective. She further agrees that the other doctors did proper tests and that the results from Dr. Davidson's testing are valid.

[57] Furthermore, in Dr. Wiseman's report at page 15 Tab 33A1, for activities of daily living, she notes that the *Guides* require investigation of the extent to which an individual's mental and behavioural difficulties impact performance of self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, social activity and recreational activity. During her interview with the applicant she noted that he: has had erectile dysfunction since the accident; reports problems with sleeping due to awakening at 2:00 a.m. and not being able to fall back asleep; and she had to redirect him three times to move on to discuss the next activity. The

[13] *Ibid* at Tab 33(5) (c) at pg. 26.

sleep issues and having to cue or redirect him are also what other assessors and his family have testified to and are in support of him having these mental and behavioural difficulties that impact the performance of self-care, personal hygiene, sexual function, sleep and social activity as noted in the *Guides*.

[58] Furthermore, Dr. Wiseman opines that the applicant's participation in the concurrent occupational therapy assessment conducted by Ms. Munir was limited, Ms. Munir observed numerous behavioural inconsistencies, and Ms. Munir did not provide an impairment rating as a result. Dr. Wiseman opines that because the applicant's participation was not sufficiently consistent or comprehensive, Ms. Munir was unable to gather objective behavioural evidence of any difficulty the applicant may have had with respect to all four domains. Dr. Wiseman also notes that the questionnaires Ms. Munir administered indicated the applicant perceived himself to have a complete disability in the area of family and home responsibility and a mild to high disability in self-care. Furthermore, all of the questionnaires did not have validity scales. However, in my view an occupational therapist is not qualified or trained in assessing validity on testing. Their job is to assess the applicant's function and, in this case, the applicant's function on the four domains to determine whether he may or may not have a Class 4 or Marked impairment in any one of the domains.

[59] Upon review of Ms. Munir's assessment she noted the applicant participated in the activities of daily living assessment for four hours and the community functional assessment for four hours as well. She goes on to state that he did not terminate the assessment and completed all presented tasks with the exception of lifting. Furthermore, she noted carrying and pain behaviours.[14] She also noted that he demonstrated "some minor reduction in participation".[15] As a result, I do not agree with Dr. Wiseman that the applicant's participation was not sufficiently consistent or comprehensive during the occupational therapy assessment with Ms. Munir.

[60] As a result of the above, I find that the occupational therapy reports from the respondent's assessor, Ms. Munir and from the applicant's assessor, Ms. Ahuja find similar functional abilities which note difficulties in Activities of Daily Living; Concentration, Persistence and Pace as well in Adaptation.

[61] Furthermore, for the reasons outlined above, I agree with and place more weight on the reports of Dr. Davidson and Dr. Young that found the applicant has a Class 4/Marked impairment in the domains of Activities of Daily Living; Concentration, Persistence, and Pace; and in Adaptation in work or work like settings.

[62] As a result of finding that the applicant has a catastrophic impairment in accordance with the *Schedule*, I will now turn to discuss the chiropractic treatment plan in dispute and the cost of examination expense.

[14] Respondent's Medical Brief Volume 5 of 5 at Tab 33A2 at pg. 14.
[15] *Ibid* at pg. 20.

Is the chiropractic treatment reasonable and necessary?

[63] For the following reasons I find that the chiropractic treatment plan in the amount of $5,905.05 is not reasonable and necessary.

[64] The treatment plan was submitted by chiropractor, Kevin Cherbonneau and lists the applicant's injury and sequelae as cervicalgia, radiculopathy, headache, low back pain, fatigue, mixed anxiety and depressive disorder as well as sleep disorder.[16]

[65] The goals of the treatment plan are for pain reduction, increase strength, increased range of motion, return to activities of normal living through a registered support worker who would help the applicant with his social and recreational needs. However, when turning to part 12 of the treatment plan under the "Proposed Goods or Services" there are ten items listed. Only one session is for physical treatment to be provided by the chiropractor. The second is for counselling and promoting health and preventing disease. The third is for education to promote health and prevent disease. The remainder of the treatment plan is for travel, planning, brokerage, progress report and documentation support.

[66] I do not find this chiropractic treatment plan, which lists the applicant's physical and psychological impairments, to be reasonable and necessary because, it would be beyond the scope of practice for a chiropractor to opine on an applicant's psychological impairments or to provide psychological counselling.

[67] Second, it is not clear what role the registered support worker (RSW) would be conducting as the only item left for the proposed goods and services is the education portion to promote health and prevent disease.

[68] Lastly, despite the physical impairments listed, there is only one small portion of this treatment plan that is directed to physical treatment.

[69] As a result of the above, I find that the treatment plan for chiropractic treatment in the amount of $5,905.05 is not reasonable and necessary.

Is the applicant entitled to the cost of examination in the amount of $4,520.00?

[70] For the following reasons I find that the applicant is entitled to payment for the cost of examination for a neuropsychological assessment in the amount of $2,000 plus HST as it is reasonable and necessary. However, the triage cost of examination is not reasonable and necessary.

[71] The treatment plan was in the amount of $14,012 and the respondent partially approved it in the amount of $9,492, leaving the amount in dispute of $4,520 which

[16] Respondent Document Brief, Volume 6 of 8 at Tab 82.

is for the cost of examination for the neuropsychological assessment and the triage assessment for $2,000 each plus HST.

[72] The treatment plan proposes numerous assessments for the purposes of determining whether the applicant has a catastrophic impairment. The respondent approved all the assessments and expenses except for a neuropsychological assessment and a triage assessment as it determined both to be not reasonable and necessary. The respondent's denial of the neuropsychological assessment was because the applicant listed an intracranial injury however the respondent takes the position that there is no objective evidence of a diagnosis of an intracranial injury.[17]

[73] Upon review of the treatment plan, the proposed assessments are listed as:

a) Physiatry assessment

b) Psychology assessment

c) Cognitive screening assessment

d) Occupational therapy (in-home) assessment

e) Triage assessment

f) Overall assessment-summary, analysis, final rating

[74] It is not clear if the neuropsychological assessment the respondent is referring to is the psychological assessment or the cognitive screening assessment.

[75] In my view, the request for an assessment is to show that there is a reasonable possibility that the applicant has the condition that the assessment is proposing to investigate. The applicant does not need to show or prove that he has the condition in order for an assessment to be deemed to be reasonable and necessary. The purpose of the assessment would be to prove whether the applicant does or does not have the impairment.

[76] A review of the contemporaneous medical evidence shows that the applicant had complaints of psychological symptoms and was prescribed medication and counselling. The applicant further had physical pain which included headaches and back pain and was prescribed pain medication from August 2015 to February 2016, when the treatment plan was submitted.[18]

[77] The applicant, his wife and children testified that since the accident the applicant has complained of constant headaches that would require him to lie down and sleep. Furthermore, he has complained of seizure like episodes which have been

[17] Respondent Document Brief, Volume 5 of 8, at Tab 73, pg. 3.
[18] Applicant's Document Brief, Part 2 of 5 at Tab 28 pgs. 301-311.

noted by the applicant's assessors in their medical reports as well as in the respondent's IE report by Dr. Wiseman.

[78] As a result, I find that on a balance of probabilities the applicant's headaches and seizure like episodes warrant a neuropsychological or cognitive assessment and I find it to be reasonable and necessary.

Triage Assessment

[79] The onus is on the applicant to prove why each assessment is reasonable and necessary and I have not been persuaded on a balance of probabilities of why a triage assessment is reasonable and necessary. I have not been presented with any evidence or submissions on why a triage assessment would be required and what assessment of the applicant it would provide.

[80] In my view, a triage assessment is not an assessment of the applicant that will investigate any condition that the applicant has and as a result, I find that it is not reasonable and necessary.

ORDER

[81] For the above-noted reasons, I find that the applicant sustained a catastrophic impairment as a result of the accident.

[82] The chiropractic treatment plan is not reasonable and necessary.

[83] The applicant is entitled to the cost of examination for a neuropsychological assessment.

[84] The applicant is not entitled to a triage assessment.

[85] The applicant is entitled to interest in accordance with s. 51 of the *Schedule* on the overdue payment of benefits for the neuropsychological assessment.

Released: December 8, 2020

Sandeep Johal, Vice Chair