2017 CarswellOnt 21129
Financial Services Commission of Ontario (Arbitration Decision)

Czombos and Wawanesa Mutual Insurance Co., Re

2017 CarswellOnt 21129, [2017] O.F.S.C.D. No. 332

LEIGH CZOMBOS (Applicant) and WAWANESA MUTUAL INSURANCE COMPANY (Insurer)

Marvin J. Huberman Member

Heard: January 23, 2017; January 24, 2017; January 25, 2017; April 5, 2017; April 6, 2017; April 7, 2017; April 27, 2017; April 28, 2017; May 1, 2017; July 10, 2017; July 11, 2017; July 12, 2017; July 13, 2017; August 11, 2017
Judgment: December 28, 2017
Docket: FSCO A13-012754

Counsel: Allan S. Blott, Q.C., Julia De Carli, Eda Bardhi, for Applicant, Leigh Czombos
Patrick C. Ho., for Insurer, Wawanesa Mutual Insurance Company

Subject: Insurance
Headnote
Insurance --- Automobile insurance — No-fault benefits — Medical and rehabilitation benefits — Chiropractic and massage
Insurance --- Automobile insurance — No-fault benefits — Medical and rehabilitation benefits — Miscellaneous
Insurance --- Automobile insurance — Catastrophic impairment — General principles

***Marvin J. Huberman Member*:**

ISSUES:

1 The Applicant, Ms. Leigh Czombos, was injured in a motor vehicle accident on June 29, 2009 (the "accident"). She applied for and received statutory accident benefits from Wawanesa Mutual Insurance Company ("Wawanesa"), payable under the applicable *Schedule*. [1] Issues arose between the parties concerning the Applicant's entitlement to certain statutory accident benefits. The parties were unable to resolve their disputes through mediation, and the Applicant applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c. I.8, as amended.

2 The issues in this Hearing are:

> 1. Did the Applicant sustain a catastrophic impairment as a result of the accident, as defined in clauses 2(1.2) (f) and (g) of the *Schedule*?
>
> 2. Is the Applicant entitled to payment for the following benefits totaling $83,417.90, pursuant to the *Schedule*, and described as follows:
>
> > (a) Mental Health Assessment Treatment Plan, submitted by Dr. Gaskovski, in the amount of $1,925.00, dated May 28, 2013;
> >
> > (b) Chiropractic treatment plan for spinal decompression, submitted by Mississauga Pain & Decompression Centre, in the amount of $2,438.06, dated January 16, 2012;
> >
> > (c) Chiropractic treatment plan for spinal decompression, submitted by Mississauga Pain & Decompression Centre in the amount of $2,000.00, dated October 11, 2013;

(d) Chiropractic treatments provided by Norfolk Chiropractic Wellness Centre in the amount of $4,720.00, submitted on February 27, 2014 and denied on February 27, 2014;

(e) Therapeutic Injections provided by Dr. Mordy Levy in the amount of $1,875.00, submitted on April 3, 2012 and denied on April 3, 2012;

(f) Chiropractic treatments provided by Norfolk Chiropractic Wellness Centre in the amount of $2,145.00, submitted on July 7, 2015 and denied on July 15, 2015;

(g) Treatments provided by Monarch Laser & Wellness Centre in the total amount of $11,770.95, submitted on July 7, 2015 and denied on July 15, 2015;

(h) Treatments provided by Immunotec Inc. in the total amount of $1,428.46, submitted on July 7, 2015 and denied on July 15, 2015;

(i) Chiropractic treatments provided by CDPC Canadian Decompression & Pain Centers in the amount of $350.00, submitted on July 7, 2015;

(j) Treatments provided by Naturopathic and Allergy Clinic for colon hydro therapy and Rectal Oz in the total amount of $881.40 submitted on July 7, 2015 and denied on July 15, 2015;

(k) Treatments provided by Vmax Fitness Whole Body Vibration in the amount of $90.40 submitted on July 7, 2015 and denied on July 15, 2015;

(l) Treatment provided by Winner's Edge for Biofeed consultation in the total amount of $519.97 submitted on July 7, 2015 and denied on July 15, 2015;

(m) Treatment provided by Anna Marie Lappani in the total amount of $335.00 submitted on July 7, 2015 and denied on July 15, 2015;

(n) Treatment provided by Dr. Maura McKeown in the total amount of $229.38 submitted on July 7, 2015 and denied on July 15, 2015;

(o) Treatment provided by O24 Zone for Pain Neutralizer/Respite care in the amount of $2,618.01 submitted on July 7, 2015 and denied on July 15, 2015;

(p) Chiropractic treatments provided by Markham Chiropractic Centre in the amount of $335.00 submitted on July 7, 2015 and denied on July 15, 2015;

(q) Cost of Heart to Heart for personal support services in the total amount of $1,555.00 submitted on July 7, 2015 and denied on July 15, 2015;

(r) Dental treatment provided by Dr. Amita Bajwa in the total amount of $122.00, submitted on January 7, 2016 and denied on January 20, 2016;

(s) Cost of a sauna in the amount of $5,983.35, submitted January 12, 2016;

(t) Cost of a sports massager from Legge Fitness Store in the amount of $5,305.35, submitted January 12, 2016;

(u) Cost of PSW services from Roseanne Desmaris in the amount of $36,790.57, submitted January 12 2016; and

(v) Travel expenses?

3. Is the Applicant entitled to interest for the overdue payment of benefits awarded?

4. Is either party required pay the other's expenses of this Hearing, pursuant to subsection 282(11) of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended?

RESULTS:

3

1. The Applicant sustained a catastrophic impairment as a result of the accident, as defined in clauses 2(1.2) (f) and (g) of the *Schedule*.

2. The Applicant is entitled to payment for a Mental Health Treatment and Assessment Plan (OCF-18), dated May 18, 2013, and submitted by Dr. Gaskovski, in the amount of $1,925.00, pursuant to the *Schedule*.

3. The Applicant is not entitled to payment for any other benefits claimed, pursuant to the *Schedule*.

4. The Applicant is entitled to interest for the overdue payment of the benefit awarded, pursuant to the *Schedule*.

5. If the parties are unable to resolve the issues of expenses, either party may make an appointment for me to determine the matter in accordance with Rules 75-79 of the *Dispute Resolution Practice Code*.

EVIDENCE AND ANALYSIS:

Factual Background

4 On June 29, 2009, the Applicant was injured in an automobile accident. She was the driver of a 1996 Honda Accord, traveling eastbound on the QEW Burlington Skyway in the second lane from the right and restrained in the traditional shoulder/lap-belted manner. A transport truck, which was in the third lane from the right, drove into her lane striking her vehicle along the driver's side. Her car was pushed into the guardrail along the right passenger side of her vehicle. It then bounced off the guardrail and spun around into an oncoming transport truck. Her car's front bumper was then ripped off, and her vehicle rear-ended the median guardrail, sustaining extensive damage. Her vehicle was later written-off.

5 The Applicant struck her knees against the door, and hit her head on the driver side window, the back of the headrest, and the roof of her car during the collision. Her left leg jammed upon impact into her pelvis. She was able to exit the vehicle independently and had immediate headache, dizziness, neck pain, mid-back pain and low back pain. She was not rendered unconscious, cut or bleeding. Immediately following the collision, she had muscle spasms in both calves, pain in her head and mouth, and whole body stiffness.

6 The police and ambulance personnel attended the collision scene. The Applicant was taken to the Hamilton General Hospital via ambulance. She was assessed in the emergency department and admitted overnight. X-rays were taken of her head, neck and low back, and a cervical collar was provided. X-rays showed no fractures. She was discharged from the hospital the next day and was told to return home and take it easy. She felt dizzy and had a constant headache.

7 The Applicant followed up with Dr. David Saul, pain specialist, one week after the collision. She was assessed and directed to treatment. She visited a chronic pain clinic because of extensive pain, and received osteopathic and spinal decompression treatments. She then pursued natural remedies to address the pain, and began taking orthomolecular medicine and followed the living foods diet plan. She then began attending rehabilitation.

8 The Applicant has been fearful of driving since the accident. She reported having a lot of anxiety, being irritable, short-tempered and becoming easily overwhelmed. She has emotional outbursts. She complained of having difficulty with concentration, being forgetful, missing appointments, and the like. She has been unable to focus and organize, and she has been slow to respond. Her sleep pattern has also been disturbed. She continues to experience ongoing cognitive, physical, and emotional sequelae since the accident, and she finds each day a struggle to function.

Prior Accident and Injury History

9 The Applicant has a significant prior automobile and injury history. She sustained a work-related lower back injury in 1991 after being struck in the back by a tow motor. This injury apparently resolved after approximately 2 months of physiotherapy.

10 The Applicant was involved in a motor vehicle accident in September 1993, in which her vehicle was rear-ended on Highway 26. She suffered from cervical injury/whiplash and headaches following this accident.

11 In 1995, the Applicant suffered a work-related repetitive strain injury, which resulted in an exacerbation of physical pain from the 1993 motor vehicle accident injury, particularly around the neck and arms/shoulders.

12 The Applicant was involved in a second motor vehicle accident on March 1, 2003, in which her vehicle was rear-ended while she was waiting at a stoplight in Toronto. When this accident occurred, the Applicant had been a passenger turned sideways, which may have worsened the nature of the impact. She reported experiencing some "brain fog" in the aftermath of this accident. She did not strike her head during this accident but her head "flew around".

13 Before the June 29, 2009, accident, the Applicant had improved and was doing better.

Application for Determination of Catastrophic Impairment (OCF-19)

14 By an Application for Determination of Catastrophic Impairment (OCF-19), signed by the Applicant on October 1, 2014, the Applicant applied to Wawanesa for determination of catastrophic impairment in respect of the June 29, 2009 motor vehicle accident.

15 The Applicant's family physician, Dr. Francesco Anello, completed the OCF-19, and confirmed that the Applicant suffered a catastrophic impairment as a result of the motor vehicle accident. Based on his assessment, Dr. Anello believed the following criteria were applicable to the Applicant:

> 7. an impairment or combination of impairments that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in 55 percent or more impairment of the whole person; or
>
> 8. an impairment that, in accordance with the American Medical Association's Guides to the Evaluations of Permanent Impairment, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.

16 Dr. Anello described the impairments sustained by the Applicant in the automobile accident as follows:

> 1. Somatic symptom disorder — severe, persistent, predominant pain;
>
> 2. Post-traumatic stress disorder;
>
> 3. Adjustment disorder; and
>
> 4. Post-traumatic anxiety, depression, anger.

Notice of Refusal of Application for Catastrophic Impairment ("CAT")

17 By letter dated May 4, 2015, Wawanesa advised the Applicant that it reviewed her Application for Determination of Catastrophic Impairment and determined that she had not sustained a catastrophic impairment as a result of the accident because her current impairment does not meet criterion 8 for catastrophic impairment as defined by the *Schedule*.

18 Wawanesa advised the Applicant to treat this letter as appropriate notice of refusal of her application for catastrophic impairment pursuant to section 54 of the *Schedule*.

POSITIONS OF THE PARTIES ON THE CAT CLAIM:

The Applicant's Position

19 The Applicant's position is that she sustained a catastrophic impairment as result of the accident, as defined in the *Schedule*.

Wawanesa's Position

20 Wawanesa takes the position that the Applicant has not met the onus placed on her to prove that she is catastrophically impaired as a result of the accident.

21 Causation is not the deciding factor in this case because the totality of the Applicant's injuries are still insufficient to meet the CAT threshold pursuant to either clause 2(1.2) (f) or 2(1.2) (g) of the *Schedule*.

22 This claim rests mostly on the Applicant's subjective complaints and her perceptions of her own pain and restrictions. The Applicant downplayed her pre-accident health history and life, and failed to present a consistent and logical picture of her health history before and after the accident. I must focus on, consider, and evaluate whether the Applicant's complaints, taken as a whole, are reliable. Lack of clarity is endemic and present in all aspects of the Applicant's evidence. Her recollection, beliefs and evidence are very much swayed and shifted by matters of convenience.

23 The Applicant has not produced clear, unequivocal medical evidence in support of her impairments. Key pieces of expert medical evidence on which the Applicant's claim rests do not meet the tests of being a legitimate, scientifically accepted foundation for the opinions offered by her experts. The opinions of Dr. Thornton, Dr. Baird, and, to a lesser degree, Dr. Ranney, are grounded on questionable medical science and should be approached with caution.

24 The WPI ratings provided by the Applicant's expert, Rod Hare, must be approached with extreme caution. Rod Hare was a belligerent witness who appeared to be a partial advocate on behalf of the Applicant, and who "cut corners" with his analysis and ratings, which calls into question his entire report. He also exceeded his expertise when he substituted his discretion and judgment for that of the underlying experts, Dr. Thornton and Dr. Ranney, who declined to provide any WPI ratings in accordance with the *AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition* (the "*Guides*").

25 Rod Hare misapplied the provisions of Chapter 14 in dealing with the Applicant's psychological impairments against the express wording of the *Guides* as well as the settled jurisprudence in this area.

26 He relied upon questionable interpretations of x-ray films as ordered and authored by Dr. Baird.

27 Rod Hare relied upon questionable science when he used findings of the digital motion x-ray to find that the Applicant had loss of motion segment integrity ("LMSI") to warrant a 25% WPI.

28 He relied upon questionable science when he used the SPECT scan results to find that the Applicant had a closed head injury to warrant a 14% WPI.

29 He double counted the complaints of sleep disorder to find an additional 9% WPI.

30 Rod Hare had no evidentiary basis to find 5% and 3% WPI ratings for the occipital nerves in the absence of nerve conduction studies.

31 He had no evidentiary basis to find a 2% WPI rating for patellofemoral crepitus in the absence of any knee complaints in the initial period of the Applicant's treatment.

32 Accordingly, Rod Hare's ratings should be rejected.

33 Wawanesa submits that the ratings of Rod Hare are wholly unreliable. It requests that the WPI rating of 27% be upheld.

34 In the alternative, Wawanesa submits that this Arbitrator should exercise his discretion to find another WPI rating that is below the 55% threshold, and then dismiss the Applicant's claims with costs.

The Witnesses

35 Eleven individuals testified at the Hearing. They are:

1. The Applicant, Leigh Czombos;
2. Dr. John F. Thornton, Psychiatrist;
3. David Hutchings;
4. Dr. Don A. Ranney, Orthopaedic Consultant;
5. Dr. John W. Baird, Chiropractor;
6. Rod Hare, Registered Kinesiologist;
7. Dr. J. Castiglione, Physician;
8. Tracey Shaw, Occupational Therapist;
9. Dr. L. Kiraly, Psychiatrist;
10. Philip Ottman; and
11. Dr. S. Soriano, Orthopaedic Surgeon.

Burden of Proof

36 The burden of proof rests with the Applicant. She must prove on the balance of probabilities that, as a result of the accident, she sustained a catastrophic impairment as defined in clauses 2(1.2)(f) and (g) of the *Schedule*. [2]

Role of the Arbitrator

37 Under the *Schedule*, the determination of catastrophic impairment is ultimately an adjudicative, not a medical determination.

38 The role of the assessor is to provide a clinical opinion as to the level of an individual's impairment. The *Guides* at pages v-vi state:

> Evaluating the magnitude of these impairments is in the purview of the physician while determining disability is usually not the physician's responsibility. This addition emphasizes that impairment percentages derived by using the Guides criteria represent estimates rather than precise determinations. Permanent impairments are evaluated in terms of how they affect the patient's daily activities.

39 Under clauses 2(1.2)(f) and (g) of the *Schedule*, the trier of fact has the responsibility to try to accurately express and estimate all of the impairments that an insured person has sustained as a result of the accident, and then to determine whether the insured person, on a balance of probabilities, has sustained a catastrophic impairment, as defined in the *Schedule*.

40 The adjudicator must weigh expert evidence and determine its probative value. Like all other evidence, expert testimony must be given only the weight it deserves — no more, no less. The adjudicator may accept the expert evidence, reject it, or accept part of it and reject other parts of it. [3]

41 In *Walker v. State Farm Mutual Automobile Insurance Co.*,[4] Senior Arbitrator Rotter aptly summarized the role of the adjudicator as follows:

> The evidence of a DAC assessor is and remains opinion evidence, which I must weigh carefully in coming to any conclusion. The weight to be accorded any such evidence must be in the discretion of the adjudicator, based on a careful evaluation of the thoroughness, relevance, neutrality and value of the opinion provided. Such factors as, for example, the familiarity with the details and history of a particular case, the length and thoroughness of the examination, and the particular area of expertise of the evaluator must all be carefully assessed. Ultimately, the arbitrator has the responsibility of considering *all* of the evidence — not just the evidence from the DAC — and making a final determination based on his or her best judgment. It is not sufficient to simply accept or adopt the judgment of the DAC assessor, who does not have the legal responsibility or opportunity to hear and weigh all the available evidence in a particular case.

42 It is the role of the adjudicator to scrutinize the evidence and give to it such weight as he or she thinks it deserves.

43 As I stated in *Taylor v. Pembridge Insurance Co. of Canada*,[5] "Adjudicators decide cases, experts do not".

DID MS. CZOMBOS SUSTAIN A CATASTROPHIC IMPAIRMENT AS A RESULT OF THE ACCIDENT AS DEFINED IN CLAUSES 2(1.2)(F) AND (G) OF THE SCHEDULE?

44 I find that Ms. Czombos did sustain a catastrophic impairment as a result of the accident, as defined in clauses 2(1.2) (f) and (g) of the *Schedule* because she does meet the 55% WPI and the Class 4 impairment (marked impairment) thresholds.

Credibility Assessment

45 Regarding the evidence of the Applicant, I have considered the generally accepted factors in assessing her credibility in this case including her demeanour, ability and opportunity to observe, power of recollection, interest, bias, prejudice, sincerity, inconsistency, and the reasonableness of her testimony when considered in the light of all of the evidence.[6]

46 John Sopinka, in his text, The Trial of an Action (1981, Toronto, Ontario: Butterworths), wrote of the role of the assessment of credibility through probabilities, at p. 77, as follows:

> Probability is the great touch-stone of all evidence. A witness whose testimony strays from the truth will often have built into it some inherent improbability.

47 As the British Columbia Court of Appeal stated in *Faryna v. Chorny*:[7]

> ...the real test of the truth of the story of a witness...must be its harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions.

48 In the present case, I have considered the testimony of the Applicant on a stand-alone basis, and I have evaluated her testimony based upon the consistency with the testimony of other witnesses and with the documentary evidence. I find that in general the substance of her testimony is inherently believable and is consistent with the "preponderance of probabilities which a practical and informed person would recognize as reasonable in that place and in those circumstances."[8]

49 I do not find Wawanesa's challenge to the credibility of Ms. Czombos, based on the contention that her evidence was muddled, inconsistent, illogical, or unclear, to be persuasive. I do not accept that lack of clarity is endemic and present in all aspects of her evidence, or that her recollections, beliefs and evidence are very much swayed and shifted by matters of convenience, as contended by Wawanesa. I acknowledge that her motives may be inclined to advocacy rather than to the provision of objective evidence. I agree that her evidence must be approached with care. I accept and rely on most of her testimony based upon her veracity and sincerity.

50 Some of her evidence, however, I find to be unreliable because of her inability to accurately describe, recall and recount certain relevant facts and circumstances. This is understandable, however, given her medical condition, currently and at the time of the material events, the traumatic experiences and its aftermath and the limitations and frailties of recollection generally.

51 Where there is inconsistency between the evidence of the Applicant, and the testimony of non-party, disinterested witnesses and the information contained in the medical records, I consider the information in the latter to be more reliable because that evidence and information was more contemporaneous to the events in issue and was provided by either non- or less interested individuals or professionals. They provide the most accurate reflection of what occurred, rather than memories that have faded over time, have been reconstituted, or have hardened through this arbitration proceeding.

52 That stated, I find the Applicant to be an honest reporter of her historical symptoms and feelings. I note that: (1) Dr. Michel P. Rathbone in his Medical Report, dated July 4, 1997, observes that Ms. Czombos "appears consistent and genuine in her beliefs"; (2) Dr. Eldon Tunks, in his Chronic Pain Management Unit, Admission Note, dated May 25, 1998, confirmed that the diagnosis of a "fibromyalgia" disorder has not changed, and that Ms. Czombos "appears well-motivated and hopeful"; (3) Dr. Tunks, in his Chronic Pain Management Unit, Discharge Summary, dated July 29, 1998, stated that Ms. Czombos "became much more positive, insightful, more aware of the effect that she had on others and able to respond positively in a group setting. Her motivation and openness to insight was a positive feature and the change in this area was dramatic"; (4) Dr. Noel A. Kerin, in his Insurer Examination, dated June 11, 2009, stated that "Ms. Czombos appears quite highly pain-focused and has many complaints spanning the six years since her MVA", which occurred on March 1, 2003; (5) Scott Blad, Kinesiologist, in his Functional Abilities Evaluation, dated October 26, 2012, noted that "Ms. Czombos presented as being genuine and putting forth effort but her reported symptoms overshadowed her ability to fully engage in the assessment"; (6) Dr. Gordon Ko and Dr. Gordon Lawson, in their Comprehensive Multidisciplinary Assessment, dated January 9, 2013, stated that they had no reason to suspect that Ms. Czombos' stated conclusions were incorrect and that "Ms. Czombos presented in a straightforward, honest manner as an historian"; (7) Dr. A. Mossanen, Neurologist, in his report dated August 4, 2011, stated that he "had difficulty quantifying the extent of pain attributable to the client's [Ms. Czombos] most recent accident [June 29, 2009] as opposed to what she was experiencing prior to that. There were many possible reasons for this which was partly due to the client's present psychological status as well as past experiences. Her interpretation of her symptoms was another factor. This author believes that he didn't have all of the relevant psychological information with regard to this client"; (8) Dr. Erin Warriner, Psychologist, in her Cognitive Rehabilitation Summary Report, dated October 1, 2013, stated that "we are proud of Ms. Czombos' effort and dedication to finish the training program over the past few months"; (9) In the Insurer's Examination Catastrophic Determination, dated April 24, 2015, Dr. S. Soriano stated that "Ms. Czombos related her history in detail. She did not appear uncomfortable while sitting as she related her medical history for the thirty minutes or so. Her history was somewhat complicated and convoluted. She had an extensive medical file (of several thousand pages)"; (10) Dr. Kiraly, Psychiatrist, stated that Ms. Czombos "was not a very good historian. She provided too many details and at times became tangential"; and Pearl Mark, Registered Kinesiologist, stated that Ms. Czombos "was talkative, cooperative and pleasant"; and (11) Dr. Don Ranney, in his Report, dated October 1, 2015, stated that "Leigh Czombos is a pleasant individual who gives her history well"; and (12) Dr. John Thornton, in his Report, dated January 13, 2016, stated that in his opinion, Ms. Czombos is an honest reporter but the information provided may be incomplete or non-sequential because of her memory and focusing difficulties".

53 I find that there is a sufficient evidentiary basis on which to find Ms. Czombos generally credible, when combined with the evidence from other witnesses and from the documentary evidence in this arbitration proceeding. I find that Ms. Czombos' evidence concerning her pre- and post-accident condition, life, needs, and level of impairment, withstood scrutiny. It was also supported and corroborated by the preponderance of the medical and non-medical evidence in this case.

THE LAW

The Relevant Thresholds

54 The *Schedule* defines "impairment" as a loss or abnormality of a psychological, physiological or anatomical structure or function. [9]

55 Under clause 2(1.2) (f) of the *Schedule*, a catastrophic impairment is an impairment or combination of impairments that, in accordance with the *Guides*, results in 55 percent or more impairment of the whole person.

56 Under clause 2(1.2) (g) of the *Schedule* a catastrophic impairment is an impairment that, in accordance with the *Guides*, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to a mental or behavioural disorder.

57 The *Schedule* requires that medical and legal professionals rate impairment under clause (g) using the criteria and methods set out in Chapter 14 of the *Guides*, entitled Mental and Behavioural Disorders.

58 Following evaluation of the patient, assessors must rate any resulting impairment according to how it impacts four broad and overlapping areas of function. They are:

1. Activities of Daily Living ("ADLs");

2. Social Functioning;

3. Concentration, Persistence and Pace; and

4. Adaptation — Deterioration or Decompensation in Work or Work-like Settings.

59 The Table, at page 301, provides a guide for rating mental impairment in each of the four areas of functional limitation on a five category scale that ranges from no impairment (Class 1) to extreme impairment (Class 5). The *Guides* recommends the following as anchors for the categories of the scale: "None" means no impairment is noted in the function; "Mild" implies that any discerned impairment is compatible with most useful functioning; "Moderate" means that the identified impairments are compatible with some but not all useful functioning; "Marked" is a level of impairment that significantly impedes useful functioning; and "Extreme" means that the impairment or limitation is not compatible with useful function.

60 The Ontario Court of Appeal in *Pastore* [10] confirmed that a finding of marked impairment in one of the four areas of function delineated in the *Guides* is sufficient to qualify as a catastrophic impairment under clause (g) of the *Schedule*.

61 In *Pastore*, the Court of Appeal delineated a three-stage process for determining the issue of catastrophic impairment due to mental or behavioural disorders under clause 2(1.2)(g) of the *Schedule*, as follows: [11]

> An assessment under s.2(1.1)(g) is carried out by reference to the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (the "*Guides*"). Chapter 14 of the *Guides* sets out a three-stage process for evaluating catastrophic impairment based on mental disorder using four categories of functional limitation and five levels of dysfunction. The first stage is diagnosis of any mental disorders, followed by the second stage where the impact on daily life is identified. The third stage is assessing the severity of limitations by assigning them into the four categories and determining their levels of impairment. The *Guides* direct the assessment in the following four categories of functional limitation.

62 Under the *Guides*, the WPI for physical impairment is arrived at by first rating each individual rateable physical impairment as a percentage. These percentages are then combined in accordance with the "Combined Values Chart" at pages 322-324 of the *Guides*, to arrive at a percentage impairment of the whole person.

63 In *Kusnierz*, [12] the Ontario Court of Appeal confirmed that mental impairments can also be combined with physical impairments to arrive at a WPI under clause (f) of the *Schedule*, using the same Combined Values Chart. However, mental and behavioural impairments rated under clause (g) of the *Schedule* must first be converted into a numerical scale so that they too can be rated at a percentage. The mental and behavioural impairments can then be combined in a like manner with physical impairments to arrive at a combined WPI, using the Combined Values Chart.

64 The *Guides* does not provide a specific methodology for converting descriptions of mental and behavioural impairments into percentage ratings of impairment. Neither does the Court in *Kusnierz* mandate a particular conversion methodology. Assessors, arbitrators and judges have used various methods in determining a percentage impairment rating for mental and behavioural impairments. In *Jaggernauth*, [13] Arbitrator Feldman analyzed six approaches or methods used by assessors and decision-makers to determine a percentage impairment rating for mental and behavioural impairments, including using Table 3 from Chapter 4 of the *Guides* (page 142), and using GAF scores and the "California Method".

65 Table 3 from Chapter 4 of the *Guides* provides a method for rating whole person impairment which results from emotional or behavioural impairments that are neurologically based but which may also have psychiatric features.

Table 3 - Emotional or Behavioural Impairments

Impairment Description	% Impairment of the Whole Person
Mild limitation of daily social and interpersonal functioning	0-14
Moderate limitation of some but not all social and interpersonal daily living functions	15-29
Severe limitation impeding useful actions in *almost* all social and interpersonal daily functions	30-49
Severe limitation of all daily functions requiring total dependence upon another person	50-70

66 The GAF (Global Assessment of Functioning) is a numeric scale (0-100) used to estimate a person's current state of mental and emotional wellness, and to subjectively rate the social, occupational and psychological functioning of adults, including how well or adaptively one is meeting various problems-in-living. The State of California introduced, through a regulation, a Table which permits GAF scores to be converted into Whole Person Impairment ratings. The GAF Scale is included in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) in the section on multi-axial assessments. [14]

67 In *G. (M.) v. Economical Mutual Insurance Co.*, [15] Arbitrator Sapin, citing *Jaggernauth*, noted that assessors have devised a number of approaches for converting qualitative mental or behavioural ratings to percentage values, including the GAF scores and the California Method, that have been considered with approval by triers of fact.

AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition

68 The *Guides* define an impairment as a deviation from normal in a body part or organ system and its functioning. The *Guides* add that impairments are conditions that interfere with an individual's activities of daily living, such as standing, walking, caring for the home, recreational activities, social activities and work activities. [16]

69 The premise of the *Guides* is that it is possible to improve estimates of the severity of human impairments based on generally accepted medical standards. An impairment percentage derived by means of the *Guides* is intended, among other purposes, to represent an "informed estimate" of the degree to which an individual's capacity to carry out daily activities has been diminished. [17]

70 For an evaluation to be considered to have been done "in accordance" with the *Guides*, it should be carried out in accordance with the directions in the *Guides* and should be based on the following three components:

1. Gather and review as much information as possible;

2. Follow the *Guides*' protocols for evaluating each body part or system;

3. Utilize the tables relating to the evaluation protocols. [18]

71 The *Guides* at page 3 state:

> The physician's judgment and his or her experience, training, skill, and thoroughness in examining the patient and applying the findings to Guides criteria will be factors in estimating the degree of the patient's impairment. These attributes compose part of the "art" of medicine....

72 The *Guides* are designed to estimate impairment of function. Therefore, it is important not to confuse the seriousness of a diagnosis with the level of impairment.

73 The *Guides* recognize that certain impairments can be evaluated by using a single numerical percentage; and that for some impairments there are valid reasons to use ranges of percentages for estimating impairment. However, where a range of percentages is provided, the *Guides* give little or no direction or guidance for how a specific number is to be selected within that range. [19]

74 The use of fixed percentages to measure impairment is seen primarily but not exclusively in Chapter 3 of the *Guides*, which deals with the Musculoskeletal System. Other chapters of the *Guides* use ranges of percentages to evaluate impairments. [20]

75 The objective to be achieved under the *Guides* and the *Schedule* is to use a method — either a fixed percentage or a range of percentages — that reflects an accurate estimate of the extent of the impairment. As the Ontario Court of Appeal has acknowledged in *Kusnierz*:

> An objective, standardized system of assessment is only useful to the extent that it can reflect a person's actual level of impairment. [21]

MS. CZOMBOS' WPI RATINGS ON ACCOUNT OF HER PHYSICAL IMPAIRMENTS

Rod Hare

76 In his Catastrophic Impairment Report, dated March 3, 2016, Rod Hare provided WPI impairment scores for impairments identified in his report as being associated with physical injuries sustained by Ms. Czombos in the accident. They are summarized as follows. Chapter, page, and table references are made to the *Guides*.

2. Loss of Motion Segment Integrity (LMSI) at C1, C2, C5 & C6 — 25% WPI (Chapter 3, page 104, 108, 110, Tables 70 & 73 — DRE — Spine Category 4);

3a. Closed brain injury (SPECT scan, perfusion deficits and dyssymmetries) — 14% WPI (Chapter 4, page 142);

3b. Sleep and Arousal Disorders — 9% WPI (Chapter 4, page 143, Table 6);

4. Nerves of Head and Neck Greater Occipital — 5% WPI (Chapter 4, page 152, Table 23);

5. Nerves of Head and Neck Lesser Occipital — 3% WPI (Chapter 4, page 152, Table 23); and

7. Post traumatic patellofemoral crepitus — 2% WPI (Chapter 3, page 83, Table 62)

77 When the above values are combined, Rod Hare concluded that Ms. Czombos' injuries and impairments sustained as result of the accident reached 48% WPI (25•14 = 36, 36•9 = 42, 42•5 = 45, 45•3 = 47, 47•2 = 48 WPI) under criterion 7 (physical impairments) in accordance with the *Guides*.

North York Rehabilitation Centre

78 In the Insurer's Examination Catastrophic Determination, Catastrophic Impairment Rating, dated April 24, 2015, Dr. J. Castiglione, of North York Rehabilitation Centre, provided whole person impairment scores under criterion 7 (physical impairment) for Ms. Czombos' injuries and impairments sustained as a result of the accident. They are summarized as follows:

1. Neck Pain

Dr. Soriano, Orthopaedic Surgeon, examined Ms. Czombos' neck injury and concluded that overall he "does not think this lady has any musculoskeletal issues that are directly attributable to the accident of 2009." From a musculoskeletal perspective, her cervical spine injury falls under Diagnostic Related Estimates (DRE) Category I cervicothoracic impairment, which equates to a 0% whole person impairment. (Chapter 3, Page 103 of the *Guides*).

2. Back Pain

Dr. Soriano, Orthopaedic Surgeon, examined Ms. Czombos' back injury and concluded that overall he "does not think this lady has musculoskeletal issues that are directly attributable to the accident of 2009". From the musculoskeletal perspective, her lumbar spine injury falls under DRE Category I, which equates to a 0% whole person impairment. (Chapter 3, Page 102 of the *Guides*).

3. Bilateral Shoulder Pain

Dr. Soriano, Orthopaedic Surgeon, examined Ms. Czombos' neck injury and concluded that overall he "does not think this lady has any musculoskeletal issue that are directly attributable to the accident of 2009". Shoulder ranges of motion were entirely normal and Dr. Soriano did not specifically apply a shoulder diagnosis in his report, which would extrapolate to a 0% whole person impairment for the shoulders. Chapter 3, Section 3.1j of the *Guides* (pages 41-45) addresses impairment ratings related to loss of shoulder motion; however, as there is no loss of motion as per Dr. Soriano's examination there are no findings on which a rating would apply.

FINDINGS — PHYSICAL IMPAIRMENT RATINGS

Loss of Motion Segment Integrity

79 I find that the correct rating for Ms. Czombos' loss of motion segment integrity is 25% WPI.

80 I accept Mr. Hare's opinion which was based on evaluations of Ms. Czombos by Drs. Ranney and Baird.

81 In his report, dated October 1, 2015, Dr. Ranney stated:

The following orthopaedic diagnoses are causally related to the motor vehicle accident of June 29, 2009:

2. Cervical ligament disruption with subluxation of the atlas.

4. Lumbar spine ligament disruption

...I was able to obtain a copy of Dr. Baird's June 9, 2015 Digital Motion X-ray study of Leigh Czombos. This study assesses the position of cervical vertebrae under load and with movement. It is abundantly clear to anyone who has a painful spine that some relief can be obtained by lying down and not moving. Yet we routinely perform MRIs recumbent and without movement. Dr. Baird's study of Ms. Czombos demonstrates a lateral shift of the atlas both to left and to right and also significant abnormal flexion/extension of C4 and C5.

Dr. Baird's Digital Motion X-ray study is the only radiographic assessment made in the upright position. Based on the severity of this accident it is highly probable that all the ligament disruptions she has now, other than those at C5/6 were caused by this accident.

82 In his Assessment of Spinal Impairment Utilizing the Diagnostic Related Estimates (Injury Model) of the *American Medical Association Guides to the Evaluation of Permanent Impairment, 4*th Edition, dated November 29, 2016, Dr. Baird, as corrected in his testimony, stated that:

• Atlas Orthogonal Radiographs were taken of the cervical spine on July 3, 2013.

• The vector demonstrates that Ms. Czombos has a misalignment of her skull on C1 with a 1° acute angle on the left.

• There is a 3° counter rotation of C2 to the left in relation to C1 and a lower cervical angle of 1° which is acute to the right. This resulting misalignment pattern is associated with long axis stress tension on the spinal cord as well as tubular compression of the vertebral arteries.

• A DMX assessment was also performed [on June 9, 2015].

• Flexion and extension views were captured demonstrating loss of motion segment integrity at C2 in translation (4.17mm) at C4 in translation (4.17mm) and angular (11.66°) and at C5 angular (14.44°).

• Anterior/Posterior open mouth lateral flexion views were captured at right and left end range. Left lateral shift of 2.51mm and right lateral shift of 3.72mm was demonstrated. This is indicative of alar ligament disruption. Lateral shift of Atlas on Axis greater than 1.7mm is considered subluxation and associated with poor prognosis for whiplash injury.

• Of the various measurements and calculations performed in the DX Analyzer software, the most significant finding in the case of Ms. Czombos is loss of motion segment integrity at C2 in translation (4.17mm) at C4 in translation (4.17mm) and angular (11.66° and at C5 angular) (14.44°) as well as left lateral shift of 2.51mm and right lateral shift of 3.72mm noted on DMX.

• Loss of Motion Segment Integrity is classified as Diagnostic Related Estimates Category IV in the American Medical Association Guides to the Evaluation of Permanent Impairment, 4th Edition. Ms. Czombos also demonstrates loss of the cervical lordosis (kyphosis) at C5/6. Kyphosis is a poor prognostic indicator for whiplash injury.

• **Atlas Orthogonal X-rays:**

Misalignment patterns as observed with Ms. Czombos are associated with spinal cord tension which pulls the cerebellum down into the foramen magnum (Cerebellar Tonsillar Ectopia) and causes tubular compression of the vertebral arteries resulting in abnormal brain profusion and abnormalities in Cerebellar Spinal Fluid (CSF) flow.

• **HPMAO Brain SPECT**

I have reviewed the January 13, 2016 report of Dr. John Thornton. I concur with Dr. Thornton that the June 29, 2009 accident is the most plausible cause of Ms. Czombos' current complaints. As described on page 2 of this Report the rotational forces of the 2009 accident constitute the most biologically plausible cause of the alar and accessory ligament disruption demonstrated by the atlas lateral shift displayed on the DMX and in turn this would result in the misalignment of C1/C2 noted on the Atlas Orthogonal X-rays. In fact, I made a correction of the misalignment of the C1/C2 misalignment pattern noted above and Ms. Czombos reported immediate improvement in her symptoms. This establishes that the misalignment pattern is acquired and responsive to corrective reduction. The fact that her symptoms improved immediately is consistent with obstruction of CSF due to a combination of injury to the cranial cervical junction and underlying degenerative changes to the first and second accident. The HPMAO Brain SPECT scan results noted by Dr. Thornton include hyporperfusion of the cerebellum which is consistent with C1/C2 misalignment and has been noted by the author.

• I also reviewed the October 1, 2015 report of Dr. Don Ranney and concur with both he and Dr. Thornton that an upright examination would be especially helpful in this case as it would include a CFS flow study in weight bearing which would likely further corroborate the HPMAO Brain SPECT scan results.

• I have reviewed the March 3, 2016 report of Mr. Rod Hare. I agree with Mr. Hare that the correct way to assess spinal impairment in the AMA Guides, 4th Edition, is using the injury model and measurement of flexion and extension x-rays.

• I concur with Mr. Hare's summary of rateable impairments given on page 10 of his report.

• I accept the diagnoses, assessments, opinions, findings and conclusions of Drs. Ranney and Baird.

Closed Brain Injury (SPECT Scan, Perfusion Deficits and Dyssymmetries)

83 I find that the correct rating for Ms. Czombos' closed brain injury (SPECT Scan, Perfusion Deficits and Dyssymmetries) is 14% WPI.

84 Dr. Castiglione did not rate Ms. Czombos' closed brain injury.

85 I accept Mr. Hare's rating of 14% which was based on Dr. Thornton's report, dated January 13, 2016.

86 In his report, Dr. Thornton stated:

Opinion

This woman reports she is experiencing difficulty and is disabled in the domains of: cognition, mobility, self-care, getting along, life activities: domestic and work in particular and participation in society.

SPECT scanning confirms decreased perfusion in the frontal, temporal, and parietal lobes and shows increase in perfusion to the thalamus which clinically correlates with patient symptomatology and self-reports.

Radiographic findings confirms cervical spine hypermobility and which is often associated with cerebellar ectopia which can cause interference with normal spinal fluid flow.

Symptomatically the patient gives a history which would support the likelihood of a diagnosis of cerebellar tonsil ectopia.

This complex combination of psychiatric, cognitive and physical conditions has resulted in impairments that prevent this woman from working and participating in multiple aspects of her activities of daily living.

Summary

This 47-year-old woman with a history of at least four motor vehicle accidents reports that she has been having significantly more problems functioning since her 2009 accident. Since that time she has continued to experience problems with pain, balance, cognition, and in memory and fatigue resulting in her being unable to work and participate in many of her activities of daily living. In addition, she has been experiencing emotional symptoms secondary to her inability to function in life. SPECT scanning has confirmed that there are areas of low blood flow and excessive blood flow which correlate with the cognitive, memory, emotional and other symptomatology with which she presents...

87 I agree with Mr. Hare that "this closed brain injury directly relates to disturbances of cerebral integrative functioning" and is a rateable impairment in accordance with the *Guides*, Chapter 4, The Nervous System (Page 142, Table 2).

88 I accept these opinions, findings and conclusions of Dr. Thornton.

Sleep and Arousal Disorders

89 I find that the correct rating for Ms. Czombos' Sleep and Arousal Disorders is 9% WPI.

90 Dr. Castiglione did not rate Ms. Czombos' Sleep and Arousal Disorders.

91 I accept Mr. Hare's rating of 9% WPI which is based on medical records that confirm Ms. Czombos has been suffering from sleep disorders, especially since the 2009 accident, that relate to the nervous system, with reduced daytime attention, concentration, and other cognitive abilities.

92 I accept this evidence and agree with Mr. Hare that this sleep disorder is rateable, in accordance with the *Guides*, Chapter 4 — The Nervous System (Page 143, Table 6).

Nerves of Head and Neck Greater and Lesser Occipital

93 I find that the correct ratings for Ms. Czombos' nerves of head and neck greater and lesser occipital are 5% WPI and 3% WPI, respectively.

94 Dr. Castiglione did not rate Ms. Czombos' nerves of head and neck greater and lesser occipital. I accept Mr. Hare's ratings of 5% and 3% WPI which are based on the reports of Drs. Ranney, Thornton, Rajwani, and Soriano, all of which indicate Ms. Czombos was suffering from neck pain, headaches and shoulder pain. In his report, Dr. Soriano, states that:

> • Current Status
>
> She continues to complain of most of her pain in her neck, shoulders, low back and right foot and she does not feel she is improving. As well, she has difficulty concentrating. Her neck pain is constant and radiates towards both shoulders and into her head but her neck pain does not radiate into her arms. Her neck pain is worse whenever she turns her neck in any one direction. She also complains of a burning sensation in both arms but no specific numbness or weakness. Coughing and sneezing do not aggravate her neck pain. Her neck pain is constantly present.
>
> • She also complains of frequent diffuse dull headaches which start in the occipital area and radiating to the frontal area of her head. They last for hours.
>
> • Since her various accidents she has difficulty concentrating and complains of fatigue and is emotionally volatile. These symptoms are becoming worse.

95 I accept these opinions, findings and conclusions of Drs. Ranney, Thornton, Rajwani, and Soriano, and I agree with Mr. Hare that Ms. Czombos' impairments of spinal nerves in her head and neck regions due to sensory deficit, pain, or discomfort are rateable in accordance with the *Guides*, Chapter 4 — The Nervous System (Page 152, Table 23).

Post-Traumatic Patellofemoral Crepitus

96 I find that the correct rating for Ms. Czombos' Post-Traumatic Patellofemoral Crepitus is 2% WPI.

97 Dr. Castiglione did not rate Ms. Czombos' Post-Traumatic Patellofemoral Crepitus.

98 I accept Mr. Hare's rating of 2% WPI which was based on Dr. Ranney's report.

99 In his report, Dr. Ranney diagnoses Ms. Czombos' bilateral patellofemoral pain syndrome, left greater than right, as being causally related to the 2009 accident. I accept Dr. Ranney's diagnosis and opinion, and I agree with Mr. Hare that this impairment is rateable in accordance with the *Guides*, Chapter 3 — The Musculoskeletal System (Page 83, Table 62).

Dr. Ranney and Dr. Soriano

100 In his report, dated October 1, 2015, Dr. Ranney stated:

> • Diagnosis:
>
> The following orthopaedic diagnoses are causally related to the motor vehicle accident of June 29, 2009:
>
> 1) Recurrence of fibromyalgia which at that point in time, by history, was in remission. [Dr. Ranney testified that the fibromyalgia may not have been in remission at that time].
>
> 2) Cervical ligament disruption with subluxation of the atlas
>
> 3) Cervical facet joint syndrome with cervicogenic headaches
>
> 4) Lumbar spine ligament disruption
>
> 5) Sacroiliac joint inflammation with a fixation on the left sacroiliac joint
>
> 6) Bilateral patellofemoral pain syndrome, left greater than right
>
> 7) Generalized myofascial pain affecting her trunk and upper limbs.

101 In his report, dated April 24, 2015, Dr. Soriano stated:

> Overall I do not think this lady has any musculoskeletal issues that are directly attributable to the accident of 2009. Her medical history is very complicated and convoluted with significant psychological overtones together with overlapping injuries over the past 20 years or so, some work related and some related to the three motor vehicle accidents she was involved in.
>
> The opinions expressed here are those of the evaluator. The evaluation has been conducted on the basis of a medical examination and documentation provided with the assumption that this information is true and correct. If more information becomes available, an additional report or service may be required. Such information may or may not alter the opinion of this evaluation.
>
> From a musculoskeletal perspective, her cervical and lumbar spine injuries both fall under Diagnostic Related Estimates (DRE) Category I.
>
> There is 0% impairment of the whole person. I suggest a psychologist determine the nature of her psychological impairment. However, the post-traumatic stress disorder diagnosis preceded the accident of 2009.

102 In the Insurer's Examination Catastrophic Determination Multidisciplinary Addendum, dated December 5, 2016, Dr. Soriano stated that, "she has no specific musculoskeletal issues that are solely attributable to the accident of June 29, 2009."

103 I prefer the opinion of Dr. Ranney over that of Dr. Soriano. I accept Dr. Ranney's opinion and give it significant weight. I give less weight to Dr. Soriano's opinion. My reasons for these conclusions follow.

104 I find the evidence of Dr. Ranney persuasive. His report was thorough and contains detailed supporting reasons for his opinions. He analyzed Ms. Czombos' history of motor vehicle accidents, reviewing 69 documents, including radiographic reports/studies (including Dr. Baird's digital motion x-ray study of Ms. Czombos), he reviewed the treatment received by Ms. Czombos since the motor vehicle accident of June 29, 2009, significant radiographic assessments, Ms. Czombos' personal history, education, employment, history of past health and functional inquiry, current medications, current symptoms, and disability, reviewed pain diagram and neck and back pain questionnaires completed by Ms. Czombos, examined Ms. Czombos, provided orthopaedic diagnoses that are causally related to the motor vehicle accident of June 29, 2009, and orthopaedic diagnoses unrelated to this accident, answered specific questions, and considered the opinions contained in the

Insurer's Examination of Catastrophic Determination by Rajwani, Castiglione, Soriano, Kiraly, Shaw, and Mark of North York Rehabilitation Centre, that states on page 13 "Ms. Czombos is not considered catastrophic and rates her neck pain and back pain 0% WPI", which Dr. Ranney strongly rejects regarding her spine because they did not have access to radiographic assessment loaded by gravity and with movement.

105 I find Dr. Ranney's evidence to be compelling. The facts on which his opinions are based are clearly delineated, are accurate and are complete. The preponderance of the medical and non-medical evidence supports his opinions. Overall, his testimony withstood a forceful and thorough cross-examination conducted by counsel for Wawanesa.

106 By contrast, I find Dr. Soriano's opinion less persuasive and therefore give it less weight than the opinion of Dr. Ranney. Dr. Soriano's reasoning with respect with to causation and Ms. Czombos' level of impairment of the whole person is not compelling. There is a lack of detailed supporting reasons and analysis to provide a solid foundation for his opinion. His opinion is not supported by the weight of the medical and non-medical evidence. His diagnosis is based on inadequate evidence and assessments. Ms. Czombos' impairments are simplistically described and the analysis is not carried sufficiently further. During his examination of Ms. Czombos, Dr. Soriano did not attempt downward pressure on her neck (Spurlings test) which, according to Dr. Ranney, he should have. Dr. Soriano did not have access to the voluminous documents, including a radiographic assessment loaded by gravity and with movement, namely, Dr. Baird's June 9, 2015 Digital Motion X-ray study of Ms. Czombos, which were reviewed by Dr. Ranney. Dr. Soriano focuses on whether Ms. Czombos has any musculoskeletal issues that are directly or solely attributable to the accident of June 29, 2009, instead of conducting the requisite analysis in respect of apportionment or aggravation of a pre-existing medical condition or infirmity as required under the *Guides*. [22]

107 Dr. Soriano's reports are unhelpful and warrant little weight.

WAWANESA'S CRITICISMS OF ROD HARE

108 Wawanesa submits that the WPI ratings of Rod Hare are wholly unreliable and should be rejected by this Arbitrator. I reject this argument for several reasons, not least because it is not supported by the evidence, the applicable law, or the *Guides*.

Rod Hare did not demonstrate a complete lack of impartiality.

109 Generally, the issue of whether an expert lacks independence or impartiality is addressed as a matter of weight rather than admissibility. A court retains a residual discretion to exclude the proposed evidence if it is so tainted by bias or partiality as to render it of minimal or no assistance. [23]

110 I am not persuaded that Mr. Hare's evidence is so tainted by bias or partiality as to render it of minimal or no assistance.

111 Neither am I convinced that Mr. Hare ceased to be impartial and moved beyond the bounds of legitimacy into improperly advocating for a party in his testimony, his report, dated March 3, 2016, or in his Reply to the Insurer's CAT IE Rebuttal Response, dated December 19, 2016.

112 I find that Mr. Hare did not clearly demonstrate a complete lack of impartiality. In so doing, I have considered the following fourteen factors listed by the Supreme Court of British Columbia in *United City Properties Ltd. v. Tong*, [24] which may warrant consideration when ascertaining bias and impartiality:

1. The nature of the stated expertise or special knowledge;

2. Statements publicly or in publications regarding the prosecution itself or evidencing philosophical hostility toward particular subjects;

3. A history of retainer exclusively or nearly so by the prosecution or defence;

4. Long association with one lawyer or party;

5. Personal involvement or association with a party;

6. Whether a significant percentage of the expert's income is derived from court appearances;

7. The size of the fee for work performed or a fee contingent on the result in the case;

8. Lack of a report, a grossly incomplete report, modification or withdrawal of a report without reasonable explanation, a report replete with advocacy and arguments;

9. Performance in other cases indicating lack of objectivity and impartiality;

10. A history of successful attacks on the witness's evidence;

11. Unexplained differing opinions on near identical subject manner in various court appearances or reports;

12. Departure from, as opposed to adherence to any governing ethical guidelines, codes or protocols respecting the expert witness's field of expertise;

13. Inaccessibility prior to trial to the opposing party, follow through on instructions designed to achieve a desired result, shoddy experimental work, persistent failure to recognize other explanations or a range of opinion, lack of disclosure respecting the basis for the opinion or procedures undertaken, operating beyond the field of stated expertise, unstated assumptions, work or searches not performed reasonably related to the issue at hand, unsubstantiated opinions, improperly unqualified statements, unclear or no demarcation between fact and opinion, unauthorized breach of the spirit of a witness exclusion order; and

14. Expressed conclusions or opinions which do not remotely relate to the available factual foundation or prevailing special knowledge.

Mr. Hare did not exceed his expertise by substituting his discretion and judgment for that of Drs. Thornton and Ranney.

113 The purpose of Mr. Hare's reports was to address Ms. Czombos' catastrophic impairment status in accordance with the *Guides*, and to serve as an updated accompaniment to the OCF-19, Application for Determination of Catastrophic Impairment, prepared by Dr. Francesco Anello, dated September 24, 2014.

114 Mr. Hare's areas of expertise include providing professional kinesiology, primarily with rehabilitation, health and ergonomic consultation, whole person impairment rating estimates using the *Guides*, including critical evaluations, rebuttals and professional critiques of others' impairment ratings, and kinesiological, physical medicine types of evaluations.

115 As a kinesiologist, Mr. Hare's scope of practice "is the assessment of human movement and performance and its rehabilitation and management to maintain, rehabilitate or enhance movement and performance": *Kinesiology Act*, 2007, S.O. 2007, c.10, Sch. O, section 3.

116 I disagree with Dr. Soriano that it is beyond Mr. Hare's scope of practice as a registered kinesiologist to comment on diagnosis and causation of impairment.

117 I agree with Dr. Ranney that kinesiologists are not precluded from commenting on diagnosis or impairment, and that knowledge of diagnosis and impairment is essential to properly assess human movement and rehabilitation. Mr. Hare's report does make explicit references to the *Guides* and the relevant sections for determining specific impairments. He has not only been trained to use these *Guides* but he has also lectured nationally on the completion of Whole Person Impairment Ratings utilizing the *Guides*.

118 I am unable to find that Mr. Hare exceeded his expertise by substituting his discretion and judgment for that of the underlying experts, Drs. Thornton and Ranney who declined to provide WPI ratings in accordance with the *Guides*.

119 In my view, any tendency on the part of Mr. Hare to stray outside this realm of his expertise did not, by itself, disqualify him from testifying about his true, core areas of expert knowledge.

120 To the extent that Mr. Hare strayed outside the realm of his expertise, I place less reliance and weight on those parts of his evidence.

Mr. Hare did not rely on questionable interpretations of x-ray films or questionable science when he used findings of the digital motion x-ray.

121 I am unable to find that Mr. Hare relied upon questionable interpretations of x-ray films as ordered and authored by Dr. Baird or that he relied upon questionable science when he used findings of the digital motion x-ray to find that the Applicant had Loss of Motion Segment Integrity (LMSI) to warrant a 25% WPI, as contended by Wawanesa.

122 The evidence does not support these arguments.

123 To the contrary, the evidence establishes that the Digital Motion X-ray system used by Dr. Baird was inspected by Mr. Joseph Dooley, X-ray Safety Inspector, X-ray Inspection Service, Ministry of Health and Long-Term Care, when it was put into service in 2005. Moreover, Dr. Baird had regularly scheduled *HARP* (*Healing Arts Radiation Protection Act*, 1990) Inspections of the equipment, confirming fully compliant performance, and Health Canada Dosimetry results have been reported to be within limits the entire time, as confirmed by his account (C) 04227.

124 The evidence further demonstrates that Dr. Baird met the Standard of Practice S-006, of the College of Chiropractors of Ontario, in respect of the Ordering, Taking and Interpreting Radiographs.

125 Neither am I persuaded that Dr. Baird relied on questionable science when he used findings of the Digital Motion X-ray to find that the Applicant had Loss of Motion Segment Integrity (LMSI) to warrant a 25% WPI.

126 I recognize that there is "a continuum of reliability in matters of science from near certainty in physical sciences to the far end of the spectrum inhabited by junk science and opinion akin to sorcery or magic". [25]

127 It is therefore important to avoid the dangers of unreliable science.

128 Based on the evidence presented, I find that Dr. Baird's Digital Motion X-ray study of Ms. Czombos is reliable.

129 I accept Dr. Ranney's evidence that,

> Digital Motion X-ray is available in Ontario and British Columbia. This is a dynamic study that like fMRI [Functional Magnetic Resonance Imaging] utilizes a series of images captured in sequence while the client is in the upright posture and hence the spine, loaded as in a real-life situation is visualized in motion. The x-ray machine works with a video camera taking 30 individual x-ray frames per second to create a motion x-ray that lasts approximately 90 seconds. The result is about 3,000 individual x-ray images that can be viewed on a computer monitor, freeze-framed, zoomed in or out, or viewed in slow motion. Even though it does not show the cervical ligaments, the technician can see the results of ligamentous injuries by abnormal movements of the vertebral bodies. These are easily observed by anyone trained in musculoskeletal radiography. Computerized analysis of the movement of selected points generates measurements of translation in millimeters and angular movement in degrees with a measurement precision that is superior to hand measurement.

130 I also accept the documentary evidence that states:

> 1) "For more than 20 years, i.e., since its introduction around the eighties, videofluoroscopy has been considered the gold standard in the diagnosis, choice of treatment and follow-up of swallowing disorders in general, but of dysphagia of neurological origin in particular"; [26]

2) "In conclusion, at present the role of VFS [videofluoroscopy] continues to be essential in the diagnosis and the planning of rehabilitation treatment for dysphagia, particularly in that of neurological origin, even if performance of this examination should always be preceded by a careful and overall clinical evaluation of the patient on the part of the specialist, who will then decide upon the need to perform the examination on the basis of the findings obtained." [27]

Mr. Hare did not rely on questionable science when he used the SPECT scan results.

131 I am not persuaded that Mr. Hare relied upon questionable science when he used the SPECT scan results to find that the Applicant had a closed head injury to warrant a 14% WPI, as contended by Wawanesa.

132 I am satisfied, based on the weight of the evidence before me, and find, that the SPECT scan results are sufficiently reliable to support Dr. Thornton's opinion and Mr. Hare's rating of 14% WPI.

133 The use made by Dr. Thornton of the SPECT scan results in reaching his conclusions has been subjected to peer review and publication. These are relevant, though not dispositive, considerations in assessing the reliability and scientific validity of SPECT scans on which his opinion and that of Mr. Hare are premised, in part. Scrutiny of the scientific community is part of good science, and it increases the probability that substantive flaws in methodology will be identified.

134 Expert evidence that is supported by literature and the professionalism of an expert witness will likely be given more weight by a judge or an arbitrator.

135 I find that Dr. Thornton was professional and rigorous in his report and in his testimony given in this arbitration proceeding.

136 Dr. Thornton acknowledged that:

1) Using SPECT for psychiatric diagnosis is controversial; [28]

2) There are publications, literature, and people in the scientific and non-scientific communities that maintain, "While some physicians insist that they are able to use brain imaging now for psychiatric diagnosis, there is currently no reliable evidence supporting this view. On the contrary, there are many reasons to doubt that imaging will play a role in the psychiatric diagnosis in the near future. As argued here, much psychiatric imaging research remains to be done to achieve sensitivity, specificity, and standardization of imaging protocols"; [29] and

3) That there are those who maintain, "Few top researchers and scientists say that SPECT is anything but a research tool of limited clinical use in identifying strokes, brain injuries and the like. It is helpful in *group* studies to say *broad* things about *groups* of patients but not *specific* things about *individual* patients. And, researchers say, SPECT has largely since been surpassed by technologies such as PET and Functional MRIs, which give images of far greater clarity. It's no longer viewed as cutting edge". [30]

137 In response, Dr. Thornton's evidence is that:

1) He is not using SPECT for psychiatric diagnosis. Rather, SPECT is used as an aid in diagnoses and differential diagnoses, and to evaluate regional cerebral perfusion;

2) Many critics of SPECT are uninformed, biased, self-designated experts who are not medical doctors and are not themselves doing the SPECT scanning. Furthermore, their conclusions are based on outdated and unreliable data, and the literature relied on by them is often not peer-reviewed; and

3) SPECT is useful for groups and individual patients.

138 Dr. Thornton's evidence is supported by:

• Exhibit 30, an article in Le Patient, Special Edition 2017: Nuclear Medicine, titled "SPECT in Neuroimaging", which states:

> Brain Perfusion Single-Photo Emission Computed Tomography (SPECT) is a nuclear imaging technique performed to evaluate regional cerebral perfusion.
>
> -**Advantages** — Provides a snapshot in time of cerebral blood flow from the precise injection time of the radioactive tracer. This allows professionals to understand brain activity during complex neurological conditions such as seizures. It also allows for analysis of biological activity in highly-specific regions of the brain. The SPECT scan remains lower cost than PET scans and is capable of using tracers with long half-lives.
>
> **Indications**
>
> Brain perfusion SPECT imaging can aid in the diagnosis and ongoing evaluation of many different medical conditions as follows:
>
> • Detection and evaluation of cerebrovascular disease
>
> • Aid in the diagnosis and differential diagnoses of suspected dementia
>
> • Detection of seizure focus
>
> • Assessment of brain death
>
> • Evaluating suspected brain trauma
>
> • Neuropsychiatric disorders: mood disorders
>
> • Substance abuse
>
> • Infection/inflammation

• Exhibit 12, "Clinical Utility of SPECT Neuroimaging in the Diagnosis and Treatment of Traumatic Brain Injury: A Systematic Review",[31] an article co-authored by Dr. Thornton, which states:

> A SPECT can assist in the diagnosis, prognosis, and treatment of patients who have sustained brain trauma.
>
> . . .
>
> In conclusion, the current state of literature demonstrates both associative and predictive value of SPECT in the setting of TBI. This same literature also demonstrates certain advantages of SPECT compared to structural MRI and CT in multiple studies, particularly in mild TBI. SPECT can therefore be used to provide actionable information in the identification and management of TBI.

• Exhibit 13, "Improved Outcomes Using Brain SPECT — Guided Treatment Versus Treatment — as — Usual in Community Psychiatric Outpatients: A Retrospective Case — Control Study", a peer-reviewed article co-authored by Dr. Thornton, which states:

> Brain Single — Photon Emission Computed Tomography (SPECT) scans indirectly show functional activity via measurement of regional cerebral blood flow.

> SPECT is well-established nuclear medical imaging technology. 3D SPECT combines the scanning data via thresholding functions to synthesize a 3D model of the brain. This retrospective study showed that 3D brain SPECT scanning improved community psychiatric patient outcome.

139 I accept Dr. Thornton's evidence and his and Mr. Hare's use of the SPECT scan study of Ms. Czombos in the present case.

Rod Hare did not double count the complaints of sleep disorder.

140 I am not persuaded that Rod Hare double counted the complaints of sleep disorder to find an additional 9% WPI, as alleged by Wawanesa.

141 Chapter 4 of the *Guides* provides criteria for evaluating impairments resulting from dysfunction of the brain. [32] Table 6 describes the impairment criteria for Sleep and Arousal Disorders on which Mr. Hare relies to qualify Ms. Czombos for 9% WPI for her sleep disorders.

142 Section 4.1e — Episodic Neurologic Disorders — of the *Guides* provides, in relevant part, at pages 143 and 144, as follows:

> The categories of impairment that may arise from sleep disorders (Table 6, below) relate to (1) the nervous system, with reduced daytime attention, concentration, and other cognitive abilities; (2) mental and behavioural factors, including depression, irritability, interpersonal difficulties, and social problems...sleep disorders relating to these systems should be evaluated according to the *Guides* chapters that deal with the respective systems.

143 Wawanesa submits that this section asks the assessors to turn back to the Chapter in which the sleep problem originates, which would be in this case Chapter 14 of the *Guides*.

144 I disagree.

145 Because Ms. Czombos' sleep disorders related to the nervous system, Mr. Hare was required to evaluate those disorders according to Chapter 4 of the *Guides* that deals with that system, and not Chapter 14 of the *Guides* which deals with another system: Mental and Behavioural Disorders.

146 Mr. Hare complied with the *Guides* in this regard.

147 Even if Ms. Czombos' impairments that may arise from sleep disorders relate to mental and behavioural factors which should be evaluated according to Chapter 14 of the *Guides*, [33] this would not inevitably lead to double counting. It would be up to the Arbitrator to determine which impairments that arise from Ms. Czombos' sleep disorders relate to the nervous system and which relate to mental and behavioural factors. In case of any overlap, the Arbitrator could then adjust the percentages of whole person impairment, as Arbitrator Lee did in *Moser v. Guarantee Co. of North America*. [34]

Did the accident cause Ms. Czombos to suffer a mental or behavioural disorder?

148 Subsection 2(1) of the *Schedule* defines "accident" to mean "an accident in which the use or operation of an automobile directly causes an impairment or directly causes damage to any prescription eyewear, denture, hearing aid, prosthesis or other medical or dental device".

149 The *Guides*, at page 316, defines "causation" as follows:

> *Causation* means that a physical, chemical, or biologic factor contributed to the occurrence of a medical condition. To decide that a factor alleged to have caused or contributed to the occurrence or worsening of a medical condition has, in fact, done so, it is necessary to verify both of the following.

a. The alleged factor *could* have caused or contributed to worsening of the impairment, which is a medical determination.

b. The alleged factor *did* cause or contribute to worsening of the impairment, which is a nonmedical determination.

150 In this case, the burden of proof rests with Ms. Czombos. She must prove on the balance of probabilities that the accident materially or significantly contributed to her mental or behavioural disorders. She is not required to prove that the accident was the only cause of her mental or behavioural disorders; [35] rather, Ms. Czombos is required to show only that the accident was a cause of the mental or behavioural disorders and not the sole cause in order to satisfy the "but for" test.

151 Moreover, if pain due to purely physical injuries cannot be factored out, Ms. Czombos is not required to prove that her impairment is due solely to mental or behavioural disorders. In *Pastore*, the Court of Appeal approved the Director's Delegate's finding that, in determining whether impairment was "due to" mental or behavioural disorders, "there was no statutory requirement to dissect the mental disorder into constituent parts." [36]

FINDINGS — CAUSATION

152 I find that the accident caused Ms. Czombos a mental or behavioural disorder.

153 I find that both accident and non-accident related factors, including Ms. Czombos' pre-accident medical condition and post-accident stressors, contributed to Ms. Czombos' mental or behavioural disorders. However, the accident was of causative significance, which means more than a minimal or insignificant aspect of Ms. Czombos' mental or behavioural disorders. I find that the accident was a material or significant aspect thereof.

154 Having considered the evidence, I find that there was a physiological association and a temporal relationship of sufficient degree and duration between the accident and Ms. Czombos' mental or behavioural disorders, such that the accident materially or significantly contributed to Ms. Czombos' mental or behavioural disorders.

155 There was compelling medical and non-medical evidence including the testimony of Ms. Czombos, which I accept in pertinent part, that supports a finding that the accident materially or significantly contributed to Ms. Czombos' mental or behavioural disorders.

156 In the Insurer Examination, dated January 7, 2010, Dr. Platnick said:

> Based upon review of file documentation, interview and assessment, I would conclude that Ms. Czombos had pre-existing and significant chronic neck and back pain prior to the June 29, 2009 motor vehicle accident. I would conclude that the June 29, 2009 motor vehicle accident temporarily exacerbated these symptoms.

157 In the Confidential Psychology Report, dated February 5, 2011, Ms. Tavella and Dr. Dar said:

> Ms. Czombos is a forty-two year-old female who was referred for psychosocial assessment following her motor vehicle accident on June 29, 2009.
>
> Based on our assessment, Ms. Czombos suffered both physical and psychological impairments including pain in her lower, middle back, and neck, her face and in back of her head, as well as general anxiety and post-traumatic stress disorder when she is driving.

158 In his Psychiatric Report, dated July 7, 2011, Dr. Patmanidis diagnosed Ms. Czombos as follows:

> **DIAGNOSIS:**
>
> Axis 1 Chronic Post-traumatic Stress Disorder with anxiety/phobic features.

Axis 2 Post-traumatic personality change with a poor stress tolerance.

Axis 3 Chronic neck, middle and lower back pain, as well as right shoulder pain. Also, post-traumatic headaches most likely cervicogenic.

Axis 4 Major stressor had been the last motor vehicle accident of June 2009.

Axis 5 Moderate impairment of functioning over the last two years with a GAF score of 55.

159 In his neurological and pain evaluation of Ms. Czombos, dated August 4, 2011, Dr. Mossanen, said:

As a result of the above accident, this client has sustained the following:

. . .

2. Migraine headaches. It is unclear whether had similar headaches prior to the last accident or not.

3. Referred low back pain. The sacroiliac joints are supplied by L4-S2 dermatomes and, therefore, extension of pain to the lower extremities can be explained on this basis. Similarly, facet joint involvement can cause extension of pain to the lower extremities.

4. Post-traumatic anxiety, depression and anger.

5. Some cognitive difficulty secondary to anxiety and not due to traumatic brain injury.

6. Hyperventilation syndrome.

160 In a Comprehensive Multidisciplinary Assessment, dated January 9, 2013, Dr. Gordon Ko and Dr. Gordon Lawson said:

XVI — Clinical Diagnoses and Medical Opinion Related to the Collision:

In accordance with FSCO Guidelines on Whiplash Associated Disorders the level of injury is a Grade 2.

1) Lumbar strain and sprain

2) Probable lumbar facet syndrome

3) Left sacroiliac joint hyper mobility, 2+

4) Cervicogenic/post-traumatic headache

5) Aggravation of previous cervical strain and sprain. This included hypertonicty and tenderness of the semispinalis capitis muscle. Probable cervical facet syndrome.

6) Thoracic strain and sprain and left upper quadrant abdominal pain, with possible muscle tear.

7) Possible thoracic outlet syndrome

8) Aggravation of previous diffuse chronic neuropathic pain syndrome with 18 out of 18 fibromyalgia tender points (according to the American College of Rheumatology)...

9) Possible traumatic/acquired brain injury.

10) Abnormal motion/dysfunction pattern of the cervical and lumbar spine.

11) Alterations in menstrual cycle.

12) Biomechanical joint dysfunction. Due to the spinal trauma there is abnormal movement and alignment of the vertebral joints.

13) Pes planus, left side, not collision-related

14) Temporomandibular joint dysfunction.

14) Core muscle stabilizer weakness.

Relationship of Symptoms to the Collision

Given the reported mechanism of injury, Ms. Czombos has sustained injuries as described in her presenting complaints, examination and diagnoses outlined above that are related to the motor vehicle collision. The impairments outlined in the report were directly sustained as a result of the use or operation of an automobile. The collision is a significant cause and a material contributing factor to the complaints outlined above. On the balance of probabilities, the complaints are materially contributed by the above-noted collision and but for the collision she would not likely have developed the symptom complex that she currently is suffering with. Ms. Czombos indicated that prior to the collision she did not suffer with a number of musculoskeletal complaints as related to her previous motor vehicle collisions. She stated that she had recovered to approximately 75% of her pre-collision function and symptoms. We have no reason to suspect that this conclusion be incorrect. [sic]

Research has found the consequences of a neck injury in a motor vehicle collision can have long lasting effects and predispose individuals to experience recurrent episodes of neck pain. This is probable in the situation of Ms. Czombos. It can be considered a component of the "thin skull scenario".

161 In his Psychological Assessment, dated October 14, 2014, Dr. Gaskovski said:

Causality

Based on Ms. Czombos' extensive available documentation there is clear evidence that she did report psychological (including cognitive) difficulties prior to the subject accident of 2009, typically in association with physical pain and pain-related factors. However, there are three lines of evidence and inference that suggest that Ms. Czombos' overall psychological difficulties worsened following the subject accident. First, Ms. Czombos herself emphasized that her level of psychological function had markedly improved prior to the subject accident of 2009, and only worsened again immediately after this accident. Second, in so far as physical pain appears to significantly underlie many of Ms. Czombos' current psychological difficulties the reported worsening of her physical pain following the subject accident (e.g., see the reports of Dr. Papa, dated August 13, 2009 and Drs. Ko and Lawson, dated January 9, 2013) would (not surprisingly) exacerbate her psychological difficulties, and/or render them more entrenched. Third, some of Ms. Czombos' psychological difficulties following the 2009 accident, such as episodes of rage/anger and driving/passenger anxiety, were not prominent or apparent prior to the 2009 accident based on her available documentation; the development of these new symptoms following the subject accident is thus consistent with an added psychological impact of this accident.

Given these observations, it is my opinion that Ms. Czombos' ongoing psychological difficulties have been more probably than not materially contributed to by the subject accident of June 29, 2009, and would not have arisen in their present form and severity had it not been for this accident.

162 In the Application for Determination of Catastrophic Impairment (OCF-19), dated October 1, 2014, Dr. Francesco Anello confirmed that Ms. Czombos suffered catastrophic impairment, namely, an impairment that in accordance with the *Guides* results in 55 percent or more impairment of the whole person; or an impairment that in accordance with the *Guides*, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder, as

a result of the accident. Ms. Czombos' impairments sustained in the accident were described as "(1) Somatic Symptom Disorder — severe, persistent, predominant pain; (2) Post-traumatic Stress Disorder; (3) Adjustment Disorder; and (4) Post-traumatic Anxiety and Depression Anger".

163 In the Insurer's Examination Catastrophic Determination, Psychiatric Assessment, dated April 24, 2015, Dr. Kiraly said:

> The pre-existing pain symptoms made her vulnerable. The index accident was the major precipitating factor resulting in exacerbation of pain, as well as new pain symptoms.

164 In his report dated, October 1, 2015, Dr. Ranney said:

> **10. What is the Causation of her Injuries?**
>
> She was involved in three motor vehicle accidents (MVAs). Technically speaking the tow motor accident in 1991 was also a motor vehicle accident in that a motorized vehicle struck her. Therefore she, in fact, was involved in four MVAs. However she returned to work after this first one and did not suffer any significant limitations therefrom. The 1993 and 2003 accidents were considered relatively minor collisions which nevertheless did result in her having injury to the disc at the cervical 4/5 level. She was not completely disabled from these accidents but she was after the subsequent 2009 accident. Note that her fibromyalgia, began many years ago prior to the 2009 accident, but was in remission just prior to this last accident. It is quite severe now in so far as she has 18 of 18 tender points tender, has good days and bad days and some days cannot get out of bed at all. Her pre-existing fibromyalgia is certainly a contributing factor to her present fibromyalgia, but the severe trauma of the 2009 accident made a material contribution to her current situation with regard to her fibromyalgia. The same is true of her cervical instability. Having some ligamentous instability at the C5/6 level from a prior accident no doubt contributed to her current condition by axis movement and rotation are the key factors required to disrupt alar ligaments. This relative laxity at C5/6 would not have been materially contributed to the development of the problems higher up and it is the cranial axial ligament instability that is her primary problem now.
>
> I must state that it is highly probable her current general dysfunction is the result of the 2009 accident and she has a permanent disability as a consequence of this motor vehicle accident. She has sustained a permanent, serious impairment of important physical function as a direct consequence of the 2009 accident. This impairment substantially interferes with her ability to perform any kind of useful employment or to be trained in a career and substantially interferes with the activities of daily living, considering her age, and this impairment is permanent.

165 In his report, dated January 13, 2016, Dr. Thornton said:

> This 47-year-old with a history of at least four motor vehicle accidents reports that she has been having significantly more problems functioning since her 2009 accident. Since that time she has continued to experience problems with pain, balance, cognition, and in memory and fatigue resulting in her being unable to work and participate in many of her activities of daily living. In addition she has been experiencing emotional symptoms secondary to her inability to function in life. SPECT scanning has confirmed that there are areas of low blood flow and excessive blood flow which correlate with the cognitive, memory, emotional and other symptomatology with which she presents. There is a radiological evidence suggesting that she has Atlas/axis instability which has the potential to trigger many of the physical and psychological symptoms she has reported above. Because of bad reactions to medication in the past she is unwilling to try more medication for fear it will aggravate her condition as it has done in the past. She remains unable to work and her symptomatology has not responded to any treatment she can tolerate. Without resolution of her physical symptoms it is unlikely her psychiatric symptoms will resolve. At this time she is significantly disabled and her prognosis to recover any further is very poor.

166 I accept this evidence and give it significant weight.

167 Based on the preponderance of medical evidence, I find that the accident materially or significantly contributed to the development, continuation, worsening and aggravation of Ms. Czombos' mental or behavioural disorders. These disorders include depression, anger, profound mood, anxiety and psychotic symptoms, post-traumatic stress disorder, hyperventilation

syndrome, multiple significant cognitive impairments, emotional behavioural or cognitive functioning impairments, emotional distress, cognitive difficulties, level of pain severity and associated symptomology.

If the accident caused Ms. Czombos to suffer a mental or behavioural disorder, what is the impact of the mental or behavioural disorder on her daily life?

168 I find that the mental or behavioural disorders significantly impacted on Ms. Czombos' daily life. The overall weight of the evidence before me supports this finding.

169 I agree with Dr. Gaskovski, and find, that "in light of all of her post-accident psychological difficulties, and in particular given the impact of the accident of June 2009...that Ms. Czombos' personality and emotional functioning has likely become overall less stable, more vulnerable to stress and more prone to dysfunction"; and that "given her overall psychological vulnerability, she remains at increased risk for a worsening of her psychological condition over the longer term, in particular in the face of life stresses and personal losses. She would likely benefit from psychological therapy in order to ensure her best levels of functioning, and to help prevent any decline".

170 I accept Dr. Kiraly's opinion, and find, that "the previous pain symptoms were exacerbated and she also had new pain symptoms. The pre-existing pain symptoms made her vulnerable. The index accident was the major precipitating factor resulting in exacerbation of pain, as well as new pain symptoms".

171 I accept the opinion of Drs. Ko and Lawson, and find, that Ms. Czombos' pre-accident circumstances left her vulnerable, in a "thin skull" sense, to future physical, mental or behavioural disorders. Ms. Czombos was an emotional "thin skull".

172 Parenthetically, in tort law, there is an established principle that a tortfeaser must take his or her victim as found. This principle is known as the "thin skull rule". The rule renders a tortfeaser liable for damages in respect of a plaintiff's injuries, even if they are unexpectedly severe due to a pre-existing condition, including not only a pre-existing physical condition but also a pre-existing condition of mental health frailty. [37]

173 These findings are supported by the non-medical evidence which comprised the testimony of Ms. Czombos, David Hutchings and Philip Ottman. I accept and rely on the testimony of Mr. Hutchings and Mr. Ottman, both of whom I find to be credible. Both, in my view, did their best to provide truthful and complete evidence concerning Ms. Czombos and her pre and/or post-accident condition, expectations, needs, daily life functioning, and physical, mental or behavioural impairments. Their evidence is consistent with the weight of the medical evidence and with Ms. Czombos' testimony in that regard.

IN VIEW OF THE IMPACT, WHAT IS MS. CZOMBOS' LEVEL OF IMPAIRMENT?

Summary of Catastrophic Impairment (CAT) Assessments

174 In the Application for Determination of Catastrophic Impairment (OCF-19), dated October 1, 2014, Dr. Anello confirmed that Ms. Czombos suffered a catastrophic impairment that, in accordance with the *Guides*, results in a Class 4 impairment (marked impairment) or Class 5 impairment (extreme impairment) due to mental or behavioural disorder.

175 In the Insurer's Examination Catastrophic Determination, dated April 24, 2015, Dr. Kiraly said:

> Based on the American Medical Association Guides to the Evaluation of Permanent Impairment, 4 th Edition, the whole person impairment from an emotional and behavioural point of view according to Table 3, Chapter 4, Ms. Czombos falls into moderate limitations of some but not all, social and interpersonal daily living functions. Her GAF of 52 to 54 translates into a 24% to 27% whole person impairment based on the Schedule for Ratings of Permanent Disabilities under the provisions of the Labour Code of California.

176 In the Insurer's Examination Catastrophic Determination, dated April 24, 2015, Dr. Castiglione said:

> **FINAL IMPAIRMENT RATING**

> Based on the findings and opinions of the Catastrophic Assessment Team, Ms. Czombos' does not meet the threshold for Catastrophic Impairment under either criteria E, or under criteria F individually.
>
> Under criteria E, Ms. Czombos is calculated to have a 27% whole person impairment for her combined neuromusculoskeletal and mental/behavioural impairments. Under criteria F, Ms. Czombos is rated as having a moderate impairment (Class 3) for her mental and behavioural status.

177 In his report, dated March 3, 2016, Rod Hare rated Ms. Czombos' mental and behavioural impairments at 40% WPI. He said:

> Psychological difficulties, based on medical and claimant reports, easily qualify for a (Class 3 Moderate Impairment). Reports include dizziness, memory difficulties, focus and concentration difficulties mood disorders, adjustment challenges, depression, difficulty with ADL's, inability to perform steady or continuous work, decrease in social functioning, concentration and adaptation challenges.

178 In his Reply to Insurer's CAT IE Rebuttal Response, dated December 19, 2016, Mr. Hare explained that he arrived at a 40% WPI score for Ms. Czombos' mental and behavioural impairments by using the moderate impairment (25-50%) percentage range in the *Guides*, 2 nd edition (1984). He said:

> In Chapter 14, on the right side of page 301, there is a discussion under the heading "Comments on the Lack of Percentages in this Edition". The *Guides* go on to explain how a percentage was first introduced and used in the AMA Guides 2 nd edition. It goes on to provide the ranges as follows: Normal (0 — 5%), Mild Impairment (10 — 20%), Moderate Impairment (25 — 50%), Moderately Severe Impairment (55 — 75%), and Severe Impairment (>75%). It is important to note that percentage ranges for mental and behavioural disorders are the only percentage ranges ever established and provided by any addition of AMA Guides.
>
> On Page 301, in the same paragraph describing percentage scores, the *Guides* further state:
>
> > From estimates of the individuals functioning, a whole person impairment estimate could be made.
>
> The Chapter 14 paragraphs on Page 301 also discuss both the advantages and disadvantages of using percentage ranges when classifying and then combining percentage range scores. The Chapter 14 discussion and excerpts alone confirm that the *Guides* had intended that individuals could utilize this methodology of percentage range scoring described. In doing so, the *Guides* have also addressed human rights legislation regarding discrimination on the grounds of disability. The *Guides* continue this discussion commenting that the process for utilizing percentage ranges is not absolute, lacking in specificity and objectivity, and confirming that the process is imperfect. Nevertheless, in spite of this uncertainty, the *Guides* also state on Page 301 that the medical profession (physicians not psychologists) must "*continue to make clinical judgments*" directly referring to assigning a classification number score from a percentage range of scores.
>
> Page 301 of Chapter 14 of the *Guides* provides for a scoring range of between 25 — 50% for Class 3 Moderate Impairments. All of the qualified practitioners on Ms. Czombos' file agreed that she has least Class 3 impairments in all four domains. The mean score for a Moderate Impairment 37%. According to the medical information on file, including that of both Dr. Kiraly and Dr. Thornton, Ms. Czombos is suffering from impairments that are beyond the halfway point of Class 3 Impairment. Therefore, I added three more points (being extremely conservative) to best illustrate Ms. Czombos' circumstances, in accordance with the multiple practitioners who have evaluated her in this same regard.

THE FINDINGS — MS. CZOMBOS' LEVEL OF IMPAIRMENT

179 I find that the correct rating for Ms. Czombos' mental and behavioural impairments is 33% WPI.

180 This rating is six percentage points higher than the value of 27% WPI assigned by Dr. Castiglione, based on Dr. Kiraly rating Ms. Czombos as having an overall Class 3 rating for Moderate Impairment, and it is seven percentage points lower than the value of 40% WPI assigned by Mr. Hare.

181 For the reasons stated below, I find that Dr. Castiglione underrated Ms. Czombos' mental and behavioural impairments, and Mr. Hare overrated them.

182 I find that Ms. Czombos has an overall Class 4 (Marked) Impairment on account of her mental or behavioural disorders.

183 I find that Ms. Czombos' level of impairment in her Activities of Daily Living is Class 3 (Moderate).

184 I find that Ms. Czombos' level of impairment in Social Functioning is Class 4 (Marked).

185 I find that Ms. Czombos' level of impairment in Concentration, Persistence and Pace is Class 4 (Marked).

186 I find that Ms. Czombos' level of impairment in Adaptation is Class 4 (Marked).

187 In making these findings, I share the observation of Arbitrator Sapin made in *G. (M.) v. Economical Mutual Insurance Co.*, [38] that the descriptions of "moderate" "marked" and "extreme" impairment levels are part of a continuum, and in between category 3 ("impairment levels are compatible with some, but not all, useful functioning") and category 5 ("impairment levels preclude useful functioning"), there is category 4: "impairment levels significantly impede useful functioning".

188 Based on the overall weight of the evidence, I find that in each of the spheres of function: Social Functioning, Concentration, Persistence, Pace, and Adaptation, Ms. Czombos' impairment levels significantly impede useful functioning.

189 I accept Ms. Czombos' evidence concerning: (1) her activities of daily living before and after the accident, and her capacity to carry out daily activity; (2) her impairment within the domain of social functioning; (3) her difficulties with concentration and persistence at a task; and (4) her ability to work in stressful circumstances.

190 Under the *Guides*, in Chapter 14, on page 294:

> Activities of daily living include "such activities as self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, and social and recreational activities. In the context of the individual's overall situation, the quality of these activities is judged by their independence, appropriateness, effectiveness, and sustainability. It is necessary to define the extent to which the individual is capable of initiating and participating in these activities independent on supervision or direction. What is assessed is not simply the number of activities that are restricted, but the overall degree of restriction or combination of restrictions...."
>
> Social Functioning refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. Social Functioning includes the ability to get along with others, such as family members, friends, neighbours, grocery clerks, landlords, or bus drivers. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, or similar events or characteristics....strength in social functioning may be documented by an individual's ability to initiate social contact with others, communicate clearly with others, and interact and actively participate in group activities. Cooperative behaviour, consideration for others, awareness of others' sensitivities, and social maturity also need to be considered. Social Functioning in work situations may involve interactions with the public, responding to persons in authority such as supervisors, or being part of a team.
>
> Concentration, Persistence and Pace refer to the ability to sustain focused attention long enough to permit the timely completion of tasks commonly found in work settings. In activities of daily living, concentration may be reflected in terms of ability to complete everyday household tasks. Deficiencies in concentration, persistence and pace are best noted

> from previous work attempts or from observations in worklike settings, such as day-treatment centers and incentive work programs...
>
> Deterioration or Decompensation in Work or Work-like Settings refers to repeated failure to adapt to stressful circumstances. In the face of such circumstances, the individual may withdraw from the situation or experience exacerbation of signs and symptoms of a mental disorder; that is, decompensate and have difficulty maintaining activities of daily living, continuing social relationships and completing tasks. Stresses common to the work environment include attendance, making decisions, scheduling, completing tasks, and interacting with supervisors and peers...

191 I find that the preponderance of medical and non-medical evidence shows Ms. Czombos' repeated failure to adapt to stressful circumstances and her deterioration or decompensation and difficulties maintaining activities of daily living, continuing social relationships, and completing tasks in the face of such circumstances.

192 Further evidence supporting my findings above include:

1. The Comprehensive Multi-Disciplinary Assessment, dated January 9, 2013, of Dr. Gordon Ko and Dr. Gordon Lawson in which they said:

> Based upon all the relevant material, it is our impression that there is significant physical impairment present that is collision-related.

2. The Cognitive Rehabilitation Summary Report, dated October 1, 2013, in which Dr. Erin Warriner said:

> Ms. Czombos informed me that she has not received consistent care and requested therapeutic interventions following the most recent accident have mainly been denied. This is unfortunate as she continues to experience a myriad of issues at over four years post-accident. She continues to be overwhelmed with her life circumstances and struggles to adjust/cope with ongoing stressors and the changes in her level of functioning and lifestyle since the accident.
>
> While this targeted cognitive intervention seems to have benefited Ms. Czombos in some respects, she continues to struggle on a daily basis in terms of adjusting to life since the motor vehicle accident. She describes chronic pain, sleep disturbance, limited stress tolerance, emotional dysregulation and ongoing attentional and executive issues that pose significant barriers for her resumption of many activities of daily life.

3. The Addendum — Cognitive Rehabilitation Summary Report, dated April 27, 2014, in which Dr. Warriner said:

> Unfortunately, Ms. Czombos continues to experience ongoing cognitive physical and emotional sequelae since the most recent MVA and she finds each day a struggle to function. She will need ongoing interdisciplinary support/interventions.

4. The Psychological Assessment, dated October 14, 2013, in which Dr. Gaskovski said:

> Ms. Czombos reported some very mild but noteworthy improvement in some of her symptoms over the past year, in particular with respect to her cognitive functioning, depressive symptoms and frequency of rage/anger episodes. Nevertheless, these concerns and her other psychological concerns remain significant and functionally disruptive.
>
> Ms. Czombos' ongoing psychological difficulties may be regarded as serious impairments and will continue to have a significant negative impact on her functioning in many areas of life. She will remain unable to obtain and maintain gainful employment, and would have great difficulty in the pursuit of any further formal education or training, with a very high risk of failure. She will remain prone to tension and conflict in her relationships, resulting in an increased likelihood of isolation. Her interest in sexual activity will remain reduced. She will continue to have difficulty participating in leisure and social activities that involve high cognitive demands (such

> as prolonged reading, speaking in multi-person conversations, completing income taxes, etc.). Her generally reduced interest and motivation will continue to blunt the overall quality and range of her daily experiences. She will continue to have difficulty traveling comfortably in a motor vehicle as a result of her driving/passenger anxiety.

5. The report, dated June 12, 2014, of Dr. Gaskovski, in which he said:

> Ms. Czombos also reported significant cognitive difficulties affecting concentration, memory and other cognitive functions (long-term planning, following-through, punctuality, time awareness).

6. The report, dated October 1, 2015, of Dr. Ranney, in which he said:

> 5. What is the impact on the Client's Functional Abilities?
>
> If this treatment is continued it will provide temporary relief of pain, but as this is a permanent condition the prognosis is that it will never heal.
>
> 9. Does she need Housekeeping Assistance?
>
> Leigh Czombos tells me and her physical examination confirms this, that she is unable to do any significant portion of her housekeeping, but relies on others for this. This severe limitation of function came on with the 2009 accident and in spite of the previous accidents she was able to keep up with her housework prior to this third accident of 2009. Based on the instability of her cervical spine it is appropriate that she avoid all housekeeping activities. In addition she has some significant problems with her back, which would prevent squatting and crouching. This is apparent in the physical assessment I did today.

7. The report dated January 13, 2016, of Dr. Thornton, in which he said:

> The combination of pain and cognitive dysfunction has caused this woman to be unable to engage in the normal activities of daily life, including self-care, exercise, work and social activities, etc. This has placed a severe financial strain on her life and she is constantly worried if she will ever regain her health. Caring for her ailing mother also places additional burden on her compromised physical and energy functioning.
>
> This complex combination of psychiatric, cognitive and physical conditions has resulted in impairments that prevent this woman from working and participating in multiple aspects of her activities of daily living.

193 I accept this evidence and give it significant weight.

ROD HARE AND DR. KIRALY

194 I place minimal weight on the opinions of Mr. Hare and Dr. Kiraly about Ms. Czombos' level of impairment on account of mental or behavioural disorders for several reasons.

Rod Hare

1. I am not convinced that Mr. Hare's methodology — using ranges of percentages for estimating impairments due to mental and behavioural disorders in the second edition of the *Guides* — provides the most accurate assessment of Ms. Czombos' mental or behavioural impairments. As the fourth edition of the *Guides* states on pages 301 and 302 of Chapter 14:

The procedure for the second edition was highly subjective. The third edition (1988) did not list percentages but instead provided the same classes of impairment as the fourth edition. There are some valid reasons to use ranges of percentages for mental impairments...A more persuasive argument is that, unlike the situation with some organ systems, there are no precise measures of impairment in mental disorders. The use of percentages implies a certainty that does not exist, and the percentages are likely to be used inflexibly by adjudicators, who then are less likely to take into account the many factors

that influence mental and behavioural impairment. Also, because no data exists that show the reliability of the impairment percentages, it would be difficult for *Guides* users to defend their use in administrative hearings. After considering this difficult matter, the Committee on Disability and Rehabilitation of the American Psychiatric Association advised *Guides*' contributors against the use of percentages in the chapter on mental and behavioural disorders of the fourth edition.

2. Mr. Hare's opinion did not sufficiently address Ms. Czombos' level of function across the requisite four areas of function, and did not provide individual ratings in the relevant spheres of function to support the impairment rating he assigned to Ms. Czombos, in accordance with the *Guides*.

3. The facts on which his opinion are founded are not clearly delineated nor are they complete.

4. Although his testimony went some way to remedy these defects, the absence of clear explanations of how and why conclusions were reached added to the difficulty of assigning weight to his opinion.

Dr. Kiraly

1. Dr. Kiraly's opinion is incomplete and unreliable because he did not have access to the pertinent documents reviewed by Dr. Ranney, especially the report of Dr. Gordon Ko and Dr. Gordon Lawson, dated January 9, 2013, the Cognitive Rehabilitation Summary Report, dated October 1, 2013, of Dr. Warriner, the Addendum — Cognitive Rehabilitation Summary Report, dated April 27, 2014, of Dr. Warriner, the Psychological Assessment, dated October 14, 2013, of Dr. Peter Gaskovski, the report, dated June 12, 2014, of Dr. Gaskovski, the report, dated October 1, 2015, of Dr. Ranney, Dr. John Baird's June 9, 2015, Digital Motion X-ray study of Ms. Czombos, and the report, dated January 13, 2016, of Dr. Thornton.

2. Dr. Kiraly failed to provide sufficient detailed reasons and analysis to support his conclusion, in the Insurer's Examination Catastrophic Determination Multidisciplinary Addendum, dated December 5, 2016, in which he stated, "After reviewing the new documentation, my opinion about Ms. Czombos' impairment status does not change."

3. Dr. Kiraly found Ms. Czombos to have a 27% WPI based on overall moderate level of impairment or Class 3 and her GAF score of 52 to 54 which translates into a 24% to 27% WPI based on the Schedule for Rating of Permanent Disabilities under the provisions of the Labor Code of California.[39] I find, however, that Dr. Kiraly's GAF score is unreliable and is not an accurate reflection of Ms. Czombos' impairments because: (1) A GAF score is only a "snapshot" of the how the person is doing at that moment and may be a poor measure of permanent or long-term mental or behavioural impairment; and (2) No evidence was presented to establish that sufficient GAF scores were taken over a considerable period of time by different qualified assessors with relatively consistent results indicating Ms. Czombos' permanent or long-term mental or behavioural impairment levels.

4. Dr. Kiraly's opinion is based on a sub-stratum of incomplete factual assumptions which do not correlate with, and are unsupported by, the facts proved.

Ms. Czombos' WPI on Account of Her Physical Impairments

195 For the reasons stated, I find Ms. Czombos' combined WPI for physical impairments is 48%, as follows:

Loss of Motion Segment Integrity		25% WPI
Closed brain injury (SPECT scan, perfusion deficits and dyssymmetries)		14% WPI
Sleep and arousal disorders		9% WPI
Nerves of Head and Neck Greater Occipital		5% WPI
Nerves of Head and Neck Lesser Occipital		3% WPI
Post traumatic patellofemoral crepitus		2% WPI
	TOTAL	**48% WPI**

Combined WPI Ratings

196 According to the Combined Values Chart in the *Guides*, the combined value of the physical impairment ratings is 48% WPI. This does not meet the threshold of 55% WPI specified in clause 2(1.2)(f) of the *Schedule*, which is required to satisfy the definition of "Catastrophic Impairment".

197 Ms. Czombos' impairment rating based on mental or behavioural disorders is, in my view, 33% WPI, based on an overall Class 4 (Marked Impairment) using Table 3 in Chapter 4 of the *Guides*.

198 When the Physical Impairment Rating of 48% is combined with the Mental and Behavioural Rating of 33%, this results in a WPI of 65%, which is sufficient to meet the criteria in clause 2(1.2)(f) of the *Schedule*.

199 Based on the above, I conclude that Ms. Czombos did sustain a Catastrophic Impairment as a result of the accident, as defined in clause 2(1.2)(f) of the *Schedule*.

Conclusion with Respect to Clause 2(1.2)(g) of the Schedule

200 I find that Ms. Czombos has a Marked level of impairment (Class 4) in three of four areas of function, namely, in Social Functioning, Concentration, Persistence and Pace and Adaption — Deterioration or Decompensation in Work or Worklike Settings, and a Moderate level of impairment (Class 3) in the fourth area, Activities of Daily Living.

201 Therefore, I find that Ms. Czombos has proven on a balance of probabilities that she sustained a Catastrophic Impairment as a result of the accident, as defined in clause 2(1.2)(g) of the *Schedule*.

BENEFITS

Is Ms. Czombos entitled to payment for the benefits claimed?

202 Ms. Czombos claims to be entitled to payment for benefits totaling $83,417.90, and described as follows: [40]

1. Mental Health Assessment Treatment Plan, submitted by Dr. Gaskovski, in the amount of $1,925.00, dated May 28, 2013;

2. Chiropractic treatment plan for spinal decompression, submitted by Mississauga Pain & Decompression Centre, in the amount of $2,438.06, dated January 16, 2012;

3. Chiropractic treatment plan for spinal decompression, submitted by Mississauga Pain & Decompression Centre in the amount of $2,000.00, dated October 11, 2013;

4. Chiropractic treatments provided by Norfolk Chiropractic Wellness Centre in the amount of $4,720.00, submitted on February 27, 2014 and denied on February 27, 2014;

5. Therapeutic Injections provided by Dr. Mordy Levy in the amount of $1,875.00, submitted on April 3, 2012 and denied on April 3, 2012;

6. Chiropractic treatments provided by Norfolk Chiropractic Wellness Centre in the amount of $2,145.00, submitted on July 7, 2015 and denied on July 15, 2015;

7. Treatments provided by Monarch Laser & Wellness Centre in the total amount of $11,770.95, submitted on July 7, 2015 and denied on July 15, 2015;

8. Treatments provided by Immunotec Inc. in the total amount of $1,428.46, submitted on July 7, 2015 and denied on July 15, 2015;

9. Chiropractic treatments provided by CDPC Canadian Decompression & Pain Centers in the amount of $350.00, submitted on July 7, 2015;

10. Treatments provided by Naturopathic and Allergy Clinic for colon hydro therapy and Rectal Oz in the total amount of $881.40 submitted on July 7, 2015 and denied on July 15, 2015;

11. Treatments provided by Vmax Fitness Whole Body Vibration in the amount of $90.40 submitted on July 7, 2015 and denied on July 15, 2015;

12. Treatment provided by Winner's Edge for Biofeed consultation in the total amount of $519.97 submitted on July 7, 2015 and denied on July 15, 2015;

13. Treatment provided by Anna Marie Lappani in the total amount of $335.00 submitted on July 7, 2015 and denied on July 15, 2015;

14. Treatment provided by Dr. Maura McKeown in the total amount of $229.38 submitted on July 7, 2015 and denied on July 15, 2015;

15. Treatment provided by O24 Zone for Pain Neutralizer/Respite care in the amount of $2,618.01 submitted on July 7, 2015 and denied on July 15, 2015;

16. Chiropractic treatments provided by Markham Chiropractic Centre in the amount of $335.00 submitted on July 7, 2015 and denied on July 15, 2015;

17. Cost of Heart to Heart for personal support services in the total amount of $1,555.00 submitted on July 7, 2015 and denied on July 15, 2015;

18. Dental treatment provided by Dr. Amita Bajwa in the total amount of $122.00, submitted on January 7, 2016 and denied on January 20, 2016;

19. Cost of a sauna in the amount of $5,983.35, submitted January 12, 2016;

20. Cost of a sports massager from Legge Fitness Store in the amount of $5,305.35, submitted January 12, 2016;

21. Cost of PSW services from Roseanne Desmaris in the amount of $36,790.57, submitted January 12 2016; and

22. Travel expenses (unspecified).

203 To be entitled to payment for the benefits claimed, an applicant must prove on a balance of probabilities that the benefits claimed are reasonable, necessary, and incurred, pursuant to the *Schedule*.

204 The Applicant and Wawanesa jointly filed a Chart, marked as Exhibit 47, summarizing the status of the expenses in dispute and the corresponding documentary proof or absence of proof that such expenses were or were not properly submitted to the Insurer.

205 Based on my analysis of the evidence before me, I find that the Mental Health Treatment and Assessment Plan (OCF-18), dated May 28, 2013, in the amount of $1,925.00, which was prepared by Dr. Peter Gaskovski, and was properly submitted to Wawanesa, is reasonable, necessary, and incurred, pursuant to the *Schedule*. [41]

206 Accordingly, I find that Ms. Czombos is entitled to payment for this benefit and to interest thereon.

207 I am persuaded by the submissions of counsel for Wawanesa and, based on the evidence before me, find that the Applicant is not entitled to payment for the other benefits claimed for two reasons.

208 First, there is no or insufficient evidence before me that these benefits claimed are reasonable, necessary, and incurred. In my view, the Applicant has failed to establish on a balance of probabilities that these benefits claimed are reasonable, necessary, and incurred, under the *Schedule*.

209 Second, the Applicant failed to comply with the procedure for claiming benefits under the *Schedule*.

210 I find that the Applicant did not submit her claims for benefits through the Health Claims for Auto Insurance ("HCAI") system, as required. Instead, she submitted her expenses to Wawanesa by: (1) an OCF-19 form (Treatment and Assessment Plan) and not through HCAI; (2) an OCF-6 (Expenses Claims Form) and not through an HCAI approved invoice (OCF-21); (3) invoices only and not with an OCF-18, OCF-21, or an OCF-6 form; or (4) not submitting expenses to Wawanesa at all by way of any OCF-18, OCF-6, OCF-21 form or an invoice.

211 Pursuant to subsection 64(7) of the *Schedule*, treatment plans and invoices must be submitted via HCAI.

212 The *Health Claims for Auto Insurance September 2010 Guideline, September 2010, Superintendent's Guideline No. 7/10, pg. 4*, a Guideline issued for the purposes of section 64 of the *Schedule*, provides that OCF-18, OCF-23, and OCF-21 forms are documents specified for the purposes of subsection 64(7) of the *Schedule*; that each of these documents must be delivered to the CPA [HCAI] (and not directly to the Insurer) unless otherwise specified in this Guideline when delivered by a Participating Facility to a Participating Insurer; and that subsection 64(7) of the *Schedule* provides that a document to which this Guideline applies is deemed not to have been delivered to an insurer unless it is delivered to the CPA as required by this Guideline. If such a document is delivered directly to an insurer instead of the CPA, despite the requirements of this Guideline, the insurer is under no obligation to respond to it, as the document will be deemed not to have been received by the insurer.

213 Under subsection 38(2) of the *Schedule*, "An insurer is not liable to pay an expense in respect of a medical or rehabilitation benefit or an assessment or examination that was incurred before the insured person submits a treatment and assessment plan that satisfies the requirement of subsection (3) unless..."

214 I agree with counsel for Wawanesa that a purpose of sections 38 and 64 of the *Schedule* is to ensure that expenses are presented in a fair process from the perspective of both the insurer and the insured.

215 Relying on *Doyon v. Allstate Insurance Co. of Canada*, [42] the Applicant submits that once a claimant has been declared catastrophically impaired, she is automatically entitled to her incurred expenses pursuant to subsection 45(6) of the *Schedule* which, as consumer protection legislation, must be given a remedial interpretation.

216 Subsection 45(6) of the *Schedule* provides as follows:

> (6) If an insured person is determined to have sustained a catastrophic impairment as a result of an accident, the insured person is entitled to payment of all expenses incurred before the date of the determination and to which the insured person would otherwise be entitled to payment under this Regulation by virtue of having sustained a catastrophic impairment. [43]

217 I reject this argument.

218 In my view, *Doyon and Allstate Insurance Co. of Canada, Re* [44] does not stand as authority for the proposition that the Applicant proffered. In that case, Arbitrator Mongeon was to decide how to implement the insured's marijuana licence under the *Schedule* which permitted her to grow marijuana or purchase it, but not both. In *Doyon*, the insurer agreed to pay for the costs associated with growing the marijuana *or* the cost of purchasing it as long as it was provided with particulars from licensed marijuana vendors. The case dealt with how to quantify in monetary terms the insured's usage of the drug retroactively for the purposes of an incurred expense. Arbitrator Mongeon did not hold that once an insured is determined to be catastrophically impaired that all pre-CAT determination expenses become payable by the insurer despite the absence of proof that the insured properly submitted those expenses to the insurer, and that those expenses were reasonable, necessary, and incurred, under the *Schedule*.

219 I agree with counsel for the Applicant that subsection 45(6) of the *Schedule* should be interpreted as being remedial. Pursuant to subsection 64(1) of the *Legislation Act*, S.O. 2006, c.21, an "Act shall be interpreted as being remedial and shall be given such fair, large and liberal interpretation as best ensures the attainment of its objects".

220 In *Arts (Litigation Guardian of) v. State Farm Insurance Co.*,[45] MacKinnon J. stated:

> The SABS is remedial and constitutes consumer protection legislation. As such it is to be read in its entire context and their ordinary sense harmoniously with the scheme of the Act, the object of the Act and the intention of the legislature. The goal of the legislation is to reduce the economic dislocation and hardship of motor vehicle accidents and, as such, assumes an importance which is both pressing and substantial.

221 However, in my view, properly construed and "read in their entire context and in their grammatical and ordinary sense",[46] the words in subsection 45(6) of the *Schedule* mean that an insured person, who has been determined to have sustained a catastrophic impairment as a result of an accident, is entitled to payment under the *Schedule* of all expenses incurred before the date of the determination, when the insured person is otherwise entitled to payments under the *Schedule* — including sections 38 and 64 thereof.

222 I find that the Applicant is not entitled to payment for the benefits claimed, under the *Schedule*.

223 Accordingly, for the reasons stated, the Applicant's claim in respect of these benefits is dismissed.

EXPENSES

224 Should the parties not agree on entitlement to or the amount of expenses, either party may make an appointment for me to determine the matter in accordance with Rules 75-79 of the *Dispute Resolution Practice Code*.

***Marvin J. Huberman Member*:**

225 Under section 282 of the *Insurance Act*, R.S.O. 1990, c. I.8, as amended, it is ordered that:

1. The Applicant sustained a catastrophic impairment as a result of the accident, as defined in clauses 2(1.2) (f) and (g) of the *Schedule*.

2. The Applicant is entitled to payment for a Mental Health Treatment and Assessment Plan (OCF-18), dated May 18, 2013, and submitted by Dr. Gaskovski, in the amount of $1,925.00, pursuant to the *Schedule*.

3. The Applicant is not entitled to payment for any other benefits claimed, pursuant to the *Schedule*.

4. The Applicant is entitled to interest for the overdue payment of the benefit awarded, pursuant to the *Schedule*.

5. If the parties are unable to resolve the issues of expenses, either party may make an appointment for me to determine the matter in accordance with Rules 75-79 of the *Dispute Resolution Practice Code*.

Footnotes

1 Effective September 1, 2010, the *Statutory Accident Benefits Schedule — Effective September 1, 2010* (the "2010 *Schedule*") came into force. The transition rules in the 2010 *Schedule* provide that, subject to certain exceptions, benefits that would have been available pursuant to the *Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996* (the "1996 *Schedule*") shall be paid under the 2010 *Schedule*, but in amounts determined under the *1996 Schedule*. As a result, both the 1996 *Schedule* and the 2010 *Schedule* are applicable to accidents that occurred on or after November 1, 1996 and before September 1, 2010 and both should be considered (collectively, the "*Schedule*").

2 *Scarlett v. Belair Insurance Co.*, [2013] O.F.S.C.D. No. 42 (F.S.C.O. Arb.), at para. 33; *Haddad v. Economical Mutual Insurance Co.* [2012 CarswellOnt 10322 (F.S.C.O. Arb.)], FSCO A10-003390, 2012, at p. 3; *D. (M.) v. Aviva Canada Inc.* [2013 CarswellOnt 18489 (F.S.C.O. Arb.)], FSCO A10-001381, December 19, 2013, at. p. 8.

3 *B. v. RBC General Insurance Co.*, [2009] O.F.S.C.D. No. 5 (F.S.C.O. Arb.), at para. 24.

4 *Walker v. State Farm Mutual Automobile Insurance Co.* [1996 CarswellOnt 1075 (Ont. Insurance Comm.)], FSCO A00-9905, February 23, 1996.

5 *Taylor v. Pembridge Insurance Co. of Canada* [2014 CarswellOnt 9339 (F.S.C.O. Arb.)], FSCO A12-004886, June 11, 2014, at p. 20.

6 *Faryna v. Chorny*, [1952] 2 D.L.R. 354 (B.C. C.A.), at pp. 356-8, per O'Halloran, J.A.

7 See footnote 6.

8 *Overseas Investments (1986) Ltd. v. Cornwall Developments Ltd.* (1993), 12 Alta. L.R. (3d) 298 (Alta. Q.B.), at para. 13.

9 Subsection 2(1).

10 *Pastore v. Aviva Canada Inc.*, [2012] O.J. No. 4508 (Ont. C.A.).

11 *Pastore v. Aviva Canada Inc.*, 2012 ONCA 642 (Ont. C.A.), at p. 4 (the number of the subsection is changed because of the date of accident, but the definition is the same).

12 *Kusnierz v. Economical Mutual Insurance Co.*, [2011] O.J. No. 5908 (Ont. C.A.).

13 *Jaggernauth v. Economical Mutual Insurance Co.* [2010 CarswellOnt 10194 (F.S.C.O. Arb.)], FSCO A08-001413, December 20, 2010.

14 The Global Assessment of Functioning (GAF) Scale was entered into evidence as Exhibit 48.

15 *G. (M.) v. Economical Mutual Insurance Co.* [2012 CarswellOnt 15739 (F.S.C.O. App.)], FSCO A09-002443, November 23, 2012, at p. 21.

16 *Guides*, ch. 1, p. 1 and the Glossary, at p. 315.

17 *Guides*, ch. 1, pp. 1-2.

18 *Jaggernauth*, *supra*, at pp. 9-10.

19 See the *Guides*' examples at pp. 32, 148, 174-5, 205, 222, 230, 236, 252, 271 and 281; see also the *Guides* at pp. 1, 2, 3, 5, 8 and 12 where reference is made to a singular percentage, and not a range of percentages.

20 See, for example, the chapters dealing with the Nervous System (ch. 4), the Respiratory System (ch. 5), the Cardiovascular System (ch. 6), the Hematopoietic System (ch. 7), the Visual System (ch. 8), the Digestive System (ch. 10), the Urinary and Reproductive Systems (ch. 11), the Endocrine System (ch. 12) and the Skin System (ch. 13).

21 *Kusnierz*, *supra*, at para. 27

22 *Guides*, Glossary, pp. 316-317.

23 *Carmen Alfano Family Trust v. Piersanti*, 2012 ONCA 297 (Ont. C.A.) (CanLII), 2012 ONCA; *R. v. Abbey*, 2009 ONCA 624 (Ont. A.) (CanLII).

24 *United City Properties Ltd. v. Tong*, 2010 BCSC 111 (B.C. S.C.) (CanLII).

25 *R. v. T. (J.E.)*, [1994] O.J. No. 3067 (Ont. Gen. Div.) (Q.L.).

26 Exhibit 31, "Role of videofluoroscopy in evaluation of neurologic dysphagia", *http://www.ncbi.nlm.nih.gov./tmc/articles/pmc2640050/*.

27 *Ibid.*; see also Exhibits 32, 35, 36, 37, 38 and 39.

28 Exhibit 16, "Diagnostic Brain Imaging In Psychiatry: Current Uses and Future Prospects", *http://journalofethics.ama-assn.org/2012/06/stas1-1206.html*.

29 *Ibid.*; see also Exhibit 15, "Post by Former NIMH Director Thomas Insel: Brain Scans — Not Quite Ready for Prime Time", *http://www.nimh.nih.gov/about/directors/thomas-insel/vlog/2010/brainscans-not-quite-ready-for-prime-time.shtml*.

30 Exhibit 14, "Daniel Amen is the most popular psychiatrist in America. To most researchers and scientists, that is a very bad thing", *http://www.washingtonpost.com/lifestyles/magazine/daniel-amen-is-the-most-popular-psychiatrist...*

31 "Clinical Utility of SPECT Neuroimaging in the Diagnosis and Treatment of Traumatic Brain Injury: A Systematic Review", (2014) PLos ONE 9(3): e.91088.

32 *Guides*, chapter 4, pp. 139-143.

33 See *Allen v. Security National Insurance Co. / Monnex Insurance Mgmt. Inc.* [2016 CarswellOnt 12537 (F.S.C.O. App.)], (FSCO P15-00018, July 6, 2016, Director's Delegate Blackman).

34 *Moser v. Guarantee Co. of North America* [2014 CarswellOnt 16342 (F.S.C.O. Arb.)], (FSCO A13-000812, September 26, 2014).

35 See *State Farm Mutual Automobile Insurance Co. and Sabadash, Re* [2017 CarswellOnt 15111 (F.S.C.O. App.)], FSCO Appeal P16-00029, September 18, 2017; *T. (M.) v. RBC General Insurance Co.* [2014 CarswellOnt 3005 (F.S.C.O. Arb.)], FSCO A11-001877, February 28, 2014; *Kump v. Economical Mutual Insurance Co.* [2012 CarswellOnt 8236 (F.S.C.O. Arb.)], FSCO A09-002712, May 14, 2012; *Mujku v. State Farm Mutual Automobile Insurance Co.* [2013 CarswellOnt 601 (F.S.C.O. Arb.)], FSCO A10-002979, January 14, 2013; *Arunasalam v. State Farm Mutual Automobile Insurance Co.* [2011 CarswellOnt 1945 (F.S.C.O. App.)], FSCO P09-00025, March 2, 2011; *Monks v. ING Insurance Co. of Canada*, 2008 ONCA 269 (Ont. C.A.), at para. 91; *Correia v. TTC Insurance Co.* [2000 CarswellOnt 4142 (F.S.C.O. Arb.)], FSCO A00-000045, October 27, 2000; *Worku v. Co-operators General Insurance Co.* [1998 CarswellOnt 6274 (Ont. Insurance Comm.)], FSCO A-002172; *Oleiro v. Commercial Union Assurance Co. of Canada* [1996 CarswellOnt 3882 (Ont. Insurance Comm.)], FSCO A-009132; *Elkaim v. State Farm Mutual Automobile Insurance Co.* [1997 CarswellOnt 5183 (Ont. Insurance Comm.)], FSCO A96-000329; *Moschonissios v. York Fire & Casualty Insurance Co.* [2001 CarswellOnt 5387 (F.S.C.O. App.)], FSCO Appeal No. P00-00008, March 12, 2001; *Videnov v. Royal Insurance Co. of Canada* [2002 CarswellOnt 5280 (F.S.C.O. Arb.)], FSCO A98-000021, August 20, 2002.

36 *Pastore*, *supra*, at p. 27.

37 *Athey v. Leonati*, 1996 CanLII 183, [1996] 3 S.C.R. 458 (S.C.C.), at p. 473.

38 *G. (M.) v. Economical Mutual Insurance Co.*, FSCO A09-002443, November 23, 2012.

39 Exhibit 48, Global Assessment of Functioning (GFA) Scale and Conversion Table.

40 Exhibit 1.

41 Exhibit 2, Tab 52.

42 *Doyon v. Allstate Insurance Co. of Canada* [2016 CarswellOnt 14472 (F.S.C.O. Arb.)], FSCO A15-002442, August 31, 2016.

43 *Statutory Accident Benefits Schedule — Effective September 1, 2010*, O.Reg. 34/10, section 45(6).

44 *Doyon and Allstate Insurance Co. of Canada, Re* [2017 CarswellOnt 15461 (F.S.C.O. App.)], Office of the Director of Arbitrations, Appeal P16-00070, September 25, 2017, Delegate Jeffrey Rogers.

45 *Arts (Litigation Guardian of) v. State Farm Insurance Co.*, 2008 CanLII 25055 (2008), 91 O.R. (3d) 394 (Ont. S.C.J.), at para. 16

46 *Rizzo & Rizzo Shoes Ltd., Re*, [1998] 1 S.C.R. 27 (S.C.C.), per Iacobucci J., para. 21, at p. 87, endorsing Driedger's "modern principle of statutory interpretation".

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