Oshidari, Alborz, Physiatrist

Sopher and Primmum https://www5.fsco.gov.on.ca/AD/5405

Decision Date: 2017-11-09, Adjudicator: David Snider, Regulation: 34/10, Decision: Arbitration, Final Decision, FSCO 5405

This hearing involved nine days of evidence from the applicant, two of his daughters and a number of expert witnesses for each side. The Applicant called 4 expert witnesses – Dr. Kevin Jones, Dr. Lisa Becker, Dr. Lara Davidson and Dr. Harold Becker. The Insurer called 3 expert witnesses – Dr. Kerry Lawson, Dr. Alborz Oshidari and Ms. Laura Youm, O.T. There were allegations by the Insurer that Mr. Sopher had engaged in symptom magnification from early on in his treatment when he was assessed by a neuropsychologist while at West Park until right up into his testimony during the hearing. There were significant problems identified with the testimony of a number of the expert witnesses as well. In the end, however, the Insurer conceded that Mr. Sopher is significantly and seriously impaired at this point in his life – but maintained its theory that a pre-existing back injury contributed greatly to the Applicant's level of impairment.

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I found it significant that the Insurer's expert, Dr. A. Oshidari, who compiled the executive summary in their catastrophic assessment, testified that he agreed (approximately) with the 77% rating described by the Applicant's author of their executive summary (Dr. H. Becker) concerning the degree to which Mr. Sopher is now disabled. However, Dr. Oshidari relied heavily on one physical finding relating to upper body hyper-reflexivity to opine that Mr. Sopher had a pre-existing condition which accounted for 38% of the total 77% WPI rating that Dr. H. Becker found and which therefore had to be deducted from the 77% rating. Thus, by Dr. Oshidari's calculations, which were somewhat modified during his testimony, even utilizing the numbers from Dr. H. Becker's Executive Summary in the Applicant's Catastrophic Assessment Report, Mr. Sopher had no more than a 39% WPI as a direct result of the accident in question.

The entire hearing came down to this one point, to my mind. Did Mr. Sopher have a pre-existing back injury which accounted for a 38% portion of his post-accident disability? The Insurer conceded, during Dr. Oshidari's testimony and in its final submissions, that Mr. Sopher is now seriously disabled. It remained strong in its position, though, that the accident did not result in a significant enough injury, in and of itself, to justify a finding of a greater than 55% WPI for Mr. Sopher for purposes of qualification for catastrophic level benefits pursuant to the *Schedule*.

I respectfully disagree. I find that, on balance of probabilities, Mr. Sopher suffered injuries in this motor vehicle accident which directly left him with impairments which exceed the 55% WPI level set out in the Guides. I have concluded that the catastrophic impairment assessment carried out at his behest by Omega Medical Associates was accurate in its determination that his overall WPI rating exceeded the 55% threshold by a considerable margin. I found there were real problems with the testimony and expert opinions of two of the Insurer's experts – Dr. A. Oshidari and Dr. K. Lawson – which far outweighed any concerns I may have had with the exact accuracy of the impairment percentages set out in the opinion(s) of the Applicant's experts. As a result, I prefer the evidence of the Applicant's catastrophic impairment team over those of the Insurer. Put simply, I cannot find as a fact that Dr. Oshidari's conclusion that there was a 39% pre-existing impairment is valid. His testimony on this point dissolved entirely under cross-examination. He could not explain why numerous medical opinions, treatments and advice given to Mr. Sopher concerning his pre-existing back pain did not at any time describe or diagnose him with having the DRE category VI level of injury to his spine (at any level) which Dr. Oshidari was relying on for his pre-existing injury diagnosis. The pre-accident medical evidence clearly proved that Mr. Sopher was given strong pain

killers and other medications as a consequence of his pre-existing back pain, which serves to demonstrate that Mr. Sopher has, perhaps, a low pain threshold, but the most apparent diagnosis available from those pre-accident medical records clearly sets out that he was suffering from sciatica. Sciatica is not mentioned as a cause of any percentage of Mr. Sopher's WPI in either of the catastrophic impairment assessments and therefore has not been diagnosed as a significant factor in, or component of, Mr. Sopher's present impairments.

As well, Dr. Oshidari could not explain why he failed to find Hoffman's signs during his examination of Mr. Sopher when two prior doctors had found them prior to his examination of the Applicant. He had already testified in response to a clarifying question that a Hoffman's sign cannot fail to be found in a subsequent exam after it has been identified in a medical examination on a prior date, because it is permanent and involuntary. When this was pointed out to him he had to concede that "he may have missed them". He became progressively more defensive under cross-examination and eventually his opinion on the pre-existing condition came to mean very little, in my view.

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Taken together, the expert witnesses provided by the Insurer failed entirely to invalidate the catastrophic impairment report provided by the Applicant's assessors. The only conclusion I can reach is that, given the vagaries of the *AMA Guidelines* and the wide ranges of interpretation and number manipulation that are available to the expert medical witnesses, the Applicant has demonstrated, on balance of probabilities, that the level of his impairment which can be directly attributed to this accident well exceeds the 55% WPI requirement set out in the *Schedule*.

Gavin and Coachman https://www5.fsco.gov.on.ca/AD/5398

Decision Date: 2017-10-31, Adjudicator: Louise Barrington, Regulation: 34/10, Decision: Arbitration, Final Decision, FSCO 5398

Dr. Oshidari, the physiatrist who examined the Applicant at the request of the Insurer, also prepared an executive summary assigning overall WPI ratings. He has done over 100 Catastrophic Impairment assessments, "99% on behalf of insurers." He assessed Mr. Gavin first on November 14, 2015 and again on January 16, 2016 He noted headaches, possibly stemming from neuralgia (nerve damage), atrial fibrillation, and a fracture of the right clavicle and of the right elbow, resulting in sensory abnormality and deceased range of motion in the upper body. He arrived at a physical impairment of 32%, which combined with the psychological impairment assessed by Dr. Prendergast produced a WPI of 42 to 46%.[23]

This assessment did not take into consideration the impairment reported by Dr. Mate, which was not contradicted, nor the spinal and skin disorders reported elsewhere. Counsel for the Insurer provided an extremely useful chart at page 10 of its Post Hearing Brief, comparing the two summaries and showing where the data differed according to the choices made by each physician's methodology.

The Applicant retained a chiropractor, Dr. Dos Santos, who reviewed the Insurer's assessments. Dr. Dos Santos examined Mr. Gavin in November 2016, when his weight had gone down to 325 pounds. He did not testify at the Hearing, but according to his report the Insurer's assessors were flawed, both in what was counted and how it was counted. Dr. Dos Santos concluded that the Insurer's assessors should have found a physical impairment rating of 45% WPI, not including Dr. Mate's respiratory rating, or the psychological impairment.[24]

At the Hearing, Dr. Oshidari criticised Dr. Rado's summary for double-counting, while Dr. Bacal's report criticised Dr. Oshidari's summary for failure to properly consider every disorder. One particular statement of Dr. Oshidari's was, although of relatively minor influence, rather remarkable, regarding Mr. Gavin's lower back pain. He testified that pursuant to the AMA Guides if there is a pre-existing spinal injury it stays for the duration of the patient's life. Mr. Gavin had sustained minor lower back pain in a previous accident, which did not cause him to take time off work and which had been completely resolved within a few weeks, that is, months prior to the subject accident. According to Dr. Oshidari, a 5% lower back impairment from the *resolved* previous condition had to be subtracted from the 5% impairment found subsequent to the subject accident. Under cross-examination, he admitted that this did not seem to make sense and he did not understand the reason for the subtraction, but "that's what the Guide says."

The AMA Guides reads as follows

[I]n apportioning a spine impairment, first the current spine impairment would be estimated, and then impairment from any pre-existing spine problem would be estimated. The estimate for the pre-existing impairment would be subtracted from that for the present impairment… Using this approach to apportionment would require accurate information and data on both impairments.[25]

At the Hearing Dr. Oshidari appeared to say that "pre-existing" included all impairments which *had existed* prior to the accident, including those which were resolved prior to the accident. Given that there is no objective data regarding the first impairment, described as minor, and which had completely resolved prior to the accident, I find that this subtraction interpretation of the AMA Guides is both illogical and impossible to calculate, and should not be used for the purpose of this assessment. This leaves Dr. Sekyi-Otu's 0-5% lower back impairment rating intact.

The Insurer suggests that Dr. Rado's longstanding doctor-patient relationship with the Applicant has affected his impartiality in applying the AMA Guides. On the other hand, his long-term relationship with the Applicant affords him the most comprehensive insights into the patient's history, signs and symptoms, development and prognosis.

In collating and evaluating all the measurements and using the AMA Guides, physicians do retain some discretion; perfect objectivity is impossible and professional judgment plays a part in arriving at a "final" score. The AMA Guides is for evaluating impairments, not a binding set of rules. There is no single "right" figure, but rather "ranges of impairment" which at most can be subdivided into low, medium or severe within those ranges. Thus, I make no general finding about which doctor's data was more "accurate" but observe that in most cases, their measurements are not seriously different, the variation in conclusions arising from the individual doctors' decisions about what to include and how to interpret those measurements.

Looking at the WPI scores from the three reports, the musculo-skeletal impairment evaluation of the lower body is where the major differences in conclusions appear. Dr. Oshidari's WPI score, using Gait alone and with no value given for skin disorders, is 48 to 51%; Dr. Rado's score, including other lower body impairments, is 48%to 57%; Dr. Sekyi-Otu's score, including other physical impairments (also without the psychological impairments), is 42% to 53%. The discrepancies, which the experts agree should not normally exceed 10% among trained assessors, arise largely from the method of counting the lower extremity impairment. I prefer the approach of Dr. Rado and that of Dr. Sekyi-Otu, both of whose physical impairment scores if combined with the psychological and respiratory scores would take the Applicant over the 55% bar. Dr. Oshidari's rigid adherence to a rule of the AMA Guides, which he admitted did not always make sense, seems contrary to the remedial interpretation to be accorded under the *Schedule*. I find the Applicant's level of WPI is 55% or higher, and is therefore catastrophic within the meaning of s. 3(2)(e) of the *Schedule*.

[22] In written submissions dated October 8, 2015, the worker's representative noted that the MMR date of July 6, 2010[3], as determined by the Board, coincided with the date of Dr. Oshidari's report[4]. Mr. Collie submitted that the physical examination findings in Dr. Oshidari's report did not provide sufficient, objective range of motion measurements which would have allowed the Board to calculate the NEL quantum. Mr. Collie further submitted that since the medical documentation on file after the MMR date did not provide sufficient detail to determine the degree of the worker's permanent impairment, the worker was entitled to an independent NEL assessment conducted by a roster physician of her choice. Moreover, he argued that it was not appropriate to rate a permanent impairment using medical evidence which pre-dates the MMR date, as medical documentation pre-MMR would not be reflective of a worker's true level of permanent impairment.

[23] The worker's representative also provided submissions regarding the 7% reduction in the quantum of the worker's NEL award from 13% to 6%, due to a pre-existing condition. He stated that while it was not disputed the worker had moderate underlying degenerative changes (and surgery in October 2003) that existed prior to the compensable accident, these had been asymptomatic and did not result in a period of disability, as defined in Board policy. Mr. Collie also noted Board Medical Consultant Dr. Kanalec's opinion that the worker's prior surgery did not constitute a relevant pre-existing condition and appeared to be a separate and distinct injury; furthermore, Dr. Oshidari had noted that the worker's surgery in 2003 had resolved all of her prior symptoms. Mr. Collie submitted that since the worker did not have a pre-existing impairment, she was entitled to the full NEL award without reduction for the pre-existing condition.

(vi) Analysis

[24] The appeal is allowed for the reasons set out below.

(a) NEL medical assessment

[25] Based on the Board determined MMR date of July 6, 2010, there is no question that Dr. Oshidari's report of July 6, 2010 provides the most contemporaneous findings to the MMR date. However, as submitted by Mr. Collie, Dr. Oshidari does not provide specific range of motion findings, noting only that the worker is "restricted in flexion" and that rotation and lateral bending were "both about 80 percent of normal and produced mild pain." As well, subsequent medical documentation on file does not provide range of motion (ROM) measurements for the worker's spine. Notwithstanding the lack of specific ROM measurements on or after July 6, 2010, the NEL Clinical Specialist (NCS) rated the worker's lumbosacral flexion ROM at 45º, and her extension, left lateral flexion, and right lateral flexion at 18º each. No explanation was provided in the NEL evaluation as to how these ROM measurements were calculated. Furthermore, as Dr. Oshidari indicated the worker's range of motion was not restricted in extension, the basis for assigning a ROM measurement of 18 degrees for extension is unknown. I also note that Dr. Oshidari's findings with respect to the worker's lateral flexion appears to reflect a worsening in this movement as the REC report of May 2010, which predates the worker's MMR date, indicated that the worker's lateral flexion was normal.

[28] I find that in this case, the information available for the worker's ROM measurements was insufficient to perform a proper NEL assessment due to the lack of measurements provided in Dr. Oshidari's report. The report did not include specific measurements for flexion, and right and left lateral flexion. I find these measurements were required for the NCS to properly assign impairment percentages to them in the NEL evaluation. Moreover, as noted above, there is no indication in the NEL evaluation as to how or why the NCS chose the ROM measurements used in the assessment; in particular, the reduced ROM measurement for extension is inconsistent with Dr. Oshidari's finding that ROM in extension was not limited.

[29] In summary, I find that the medical information used for the NEL assessment was insufficient based on Board policy and the AMA Guides. Accordingly, the worker is entitled to an assessment by a NEL roster physician.

16-003010 v Aviva Insurance Canada, 2017 CanLII 46346 (ON LAT), <http://canlii.ca/t/h4xkk

[30] Dr. Oshidari performed an insurer examination to determine whether five treatment plans, including this one, were reasonable or necessary. Dr. Oshidari concludes that his assessment was limited due to the applicant's lack of participation, discomfort and pain, but then indicates there were numerous findings which cannot be explained by any specific neuromusculoskeletal abnormality. Dr.Oshidari found that the applicant suffered from non-complicated soft tissue injuries and that no further physical intervention is necessary. However, Dr. Oshidari strongly encouraged the applicant to continue with self-directed community aquatic therapy.

[31] I found Dr. Oshidari's conclusions with respect to the treatment plan for aquatic therapy contradictory. I find that Dr. Oshidari's conclusion supports the need for some type of aquatic therapy and based on the evidence, the applicant would need supervised sessions. Therefore I find that this treatment plan to be reasonable and necessary.

16-000874 v Certas Home and Auto Insurance Company, 2017 CanLII 69444 (ON LAT), <http://canlii.ca/t/h8rwc

25. In support of its position that the only physical factors interfering with the applicant's ability to work are pre-existing arthritis and pain and restricted mobility of his right hand unrelated to the accident, Certas relies on the report of Dr. A. Oshidari. Dr. Oshidari, a physiatrist, conducted an insurer's examination (IE) for Certas in November 2015, to determine if he met the post-104 week disability test. Dr. Oshidari noted the applicant's subjective complaints of aching pain and discomfort in his neck which radiated into the right shoulder and upper arm with numbness, tingling and weakness, and that the applicant was receiving four injections a week into his neck and shoulder for pain. However, Dr. Oshidari opined that any sprain or strain of the neck due to the accident should have healed "a long time ago," on the basis that "we expect the prognosis for this type of soft tissue injury to be for full recovery in less than three months." He stated that the applicant had reached "pre-injury status or maximum medical improvement." He reported that there was no correlation between the applicant's reported constant pain in the right wrist, aggravated by activity, and restricted range of motion of the small joints of the hand and the accident because the applicant first complained of this symptom over a year later. The pain was due to arthritis and, possibly, diabetes.

26. I reject Dr. Oshidari's opinion that diabetes might be a factor, a comment he did not explain or support. The applicant does suffer from Type 2 diabetes as well as high blood pressure. However, I note that Dr. T. Abouhassan, an endocrinologist, specifically addressed diabetes in an assessment at Certas' request and ruled it out as a cause of the applicant's neuropathic pain because his diabetes was well controlled and he was under the care of an endocrinologist.

27. Regarding the applicant's fitness for work, Dr. Oshidari felt that the applicant could return to his "pre-loss activity levels," including occupational duties, but that due to osteoarthritic changes in his right hand, he would have difficulty performing fine motor movements. He simultaneously concluded the applicant was capable of engaging in all of the occupations listed in the Transferrable Skills Analysis report obtained by Certas, but that the pre-existing arthritis in his hands presented a barrier to his return to work.

28. I place little weight on Dr. Oshidari's opinion. Having reviewed the clinical notes and records of Dr. R. Kwok, the applicant's family doctor, which date from April 2011 to February 2016, I disagree with Dr. Oshidari's opinion that there is no correlation between the accident and the applicant's hand pain. According to Dr. Kwok's notes, the applicant complained of tingling symptoms in his right hand as early as January 2014, a month after the accident, and complained consistently of right hand pain, tingling, numbness, weakness and inability to make a fist at every monthly visit thereafter.[4]

29. Furthermore, although Dr. Kwok's notes indicate the applicant complained of pain in his right middle finger in May 2011 and swollen PIP joints in his hand in December 2011, which he attributed to arthritic flare-ups, there was no mention of any hand pain or arthritic flare-up from that time until the month after the accident, over two years later, despite regular visits about other health issues.

30. Dr. L. Majl, a neurologist who saw the applicant on a referral from Dr. Kwok, connected the applicant's hand pain to the accident, reporting in August 2014 that the applicant suffered from constant ongoing neck pain since the accident that radiated to his right hand. The pain was not, however, neurological, EMG studies finding no nerve root impingement. In a report dated September 27, 2014, Dr. Kwok acknowledged that the applicant still had neck and back pain, but his right hand pain and weakness had become his main concern, and although it was not well defined, it seemed to be a chronic pain syndrome related to soft tissue injury.

31. I find Dr. Oshidari's opinion that the applicant's soft tissue injuries should have healed within three months of the accident has no factual basis. It is unfounded editorial opinion given that the applicant continued to complain of pain to the neck and shoulders and received weekly injections for this pain. It is well known that in a small percentage of cases, soft tissue injuries do not heal within the expected time. I find it was unreasonable for Dr. Oshidari to simply dismiss the applicant's pain complaints, and not address the issue of referred pain to the arm and hand as a possible explanation, or the possibility that the accident injuries might have aggravated the underlying arthritis or caused it to become symptomatic. As the pain was not due to any neurological cause, I find on a balance of probabilities that it was likely due to unresolved soft tissue injury from the accident.

50. Certas relied on a September 11, 2015 assessment conducted by Dr. Oshidari. Dr. Oshidari noted the applicant's complaints of neck pain that radiated through the shoulder and down the arm to the fingers, and that the pain was aggravated by motion of the neck. He cited soft tissue injuries from the accident as the cause, but felt these had resolved and maximal medical recovery had been achieved. He observed reasonably good range of motion of the neck, back, shoulders and hips, although noting complaints of discomfort on end range motion. Because the applicant had received extensive identical treatment in the past, he concluded the treatment described in the treatment plan was neither reasonable nor necessary, and the applicant should continue with a home-based exercise programme. Certas submits that the applicant had already had over $30,000 worth of this type of treatment, with no appreciable benefit other than temporary pain relief. Although temporary pain relief can be a legitimate goal of treatment, the applicant testified that he only felt "a little bit better" for a short period of time after treatment. I am not satisfied from the applicant's testimony that the pain relief was anything more than transitory. I agree with the opinion of Dr. Oshidari that more of the same kind of treatment as outlined in the July 2, 2015 plan was necessary or reasonable.

E.B. and Security National https://www5.fsco.gov.on.ca/AD/4380

Decision Date: **2015-01-16**, Adjudicator: **Stuart Mutch**, Regulation: **34/10**, Decision: **Arbitration, Final Decision, FSCO 4380**

In her testimony, the Applicant indicated that by December 2011 she was able to do light housekeeping. It was at that time that she was assessed by Dr. **Oshidari**, a physiatrist.[19] In his opinion, the Applicant had experienced soft tissue injury with contusion that had exacerbated her pre-existing medical condition. He found no active tendonitis or bursitis around the shoulders or pelvic girdle area. He found no cervical thoracolumbar radiculopathy or cervical thoraco myelopathy. In his opinion she did not suffer a substantial inability to perform caregiving or housekeeping and home maintenance activities. That is in fact a legal question and not within Dr. **Oshidari**'s purview. On cross-examination Dr. **Oshidari** discounted the opinions of other specialists, including those who later found the Applicant to be suffering from chronic pain.

J.M. and State Farm https://www5.fsco.gov.on.ca/AD/3935

Decision Date: **2013-01-24**, Adjudicator: **Judith Killoran**, Regulation: **403/96**, Decision: **Arbitration, Preliminary Issue, FSCO 3935**

Dr. Alborz Oshidari was qualified as an expert in physiatry and performing CAT assessments. He conducted an assessment of J.M. for State Farm on March 11, 2011. His findings did not correlate with the weaknesses displayed by J.M. and he was unable to provide a rating. If he were to provide a rating of impairment based on the *AMA Guides*, he stated that he would have to rate impairment based on weakness of the group of muscles in the lower extremity. However, he found "no specific neurological condition or orthopaedic condition, which can explain this amount of weakness. Therefore, based on the *AMA Guides*, he concluded that J.M.'s impairment is not ratable and he does not meet catastrophic impairment for this criteria."[9]

Dr. Oshidari found inconsistent findings on examination of J.M. Due to the pain experienced by J.M. during the testing, he could not make a thorough assessment. Although he observed significant weakness in the lower extremities consistent with nerve injury in the back there appeared to be no nerve injury in the back with no structural abnormality. Two MRIs of the knees revealed that the left knee has a tearing of the posterior medical meniscus with damage to the anterior cruciate ligament. Dr. Oshidari testified that the right knee has an emulsion at the fibular head with no organic cause for an instability of the knee. Also, he stated that the medial meniscus tear is not addressed by the brace which cannot unload the knee but only stabilizes it. Dr. Oshidari testified that J.M. used crutches from habit or fear of causing harm to himself. He thought that J.M.'s presentation was disproportionate to his injury. He also commented that J.M. had a neck complaint which he did not raise with Dr. Sangha.

Dr. Oshidari testified that for a diagnosis-based impairment, the rating would be higher because of neck pain. However, he stated that would require a true structural abnormality, which J.M. does not have. No surgical treatment was necessary and a brace only supports the front and back of his knees. In his opinion, the gait derangement table was not applicable as there was no structural abnormality in the right knee or right leg with no ligament rupture and no brace or crutches needed. The fracture to J.M.'s fibula bone he diagnosed as nothing major. He commented that the Gait Derangement Table is used rarely as it requires multiple fractures, dislocations, and ligament ruptures. He insisted there were no dislocations and only a fractured fibula head which did not meet the requirement for multiple bilateral lower limb injuries. Dr. Oshidari testified that the right medial meniscus tear would result in pain but not instability. He was of the opinion that there was no physical reason for J.M. to use braces and crutches.

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State Farm submitted that it agrees that J.M. is impaired but disagrees about the extent of his impairment. State Farm relied on its orthopedic examinations by Drs. Wolfson, Dipasquale, Esmail, French, Kwok and Oshidari. These

examinations found varying degrees of impairment involving the right and left knees with some instability but no atrophy in the legs which raised a question about J.M.'s need for crutches. State Farm insisted that the Gait Derangement Table should not be used to rate J.M.'s impairment when there is evidence of symptom magnification. I disagree.

I prefer the reasons articulated by Drs. Sangha and Becker for using the Gait Derangement Table in the case before me. J.M.'s primary physical impairment involves his lower extremities and bilateral instability. He suffers from a constellation of injuries which include a right fibula fracture, a left ACL tear, and a left and right medial meniscus tear coupled with major depression and pain disorder. Also, I do not accept that J.M. is unrateable for physical impairment. None of his medical assessors disagreed that he suffered from a physical impairment. While it may have been challenging to assess J.M., it is reasonable to consider all of the information, as Dr. Sangha did in order to rate the degree of his impairment.

The flaw in Dr. Oshidari's methodology is that no consideration is given for J.M.'s knee problems as surgery is not required. However, the sole reason surgery is not required is because it would not correct J.M.'s impairment issues. In these circumstances, the Gait Derangement more accurately captures and rates J.M.'s disability. J.M.'s injuries are consistent with his experiences with instability and falling which were corroborated by his family members. As a result, he routinely relies on the use of crutches to ambulate. I prefer Dr. Sangha's approach to rating J.M.'s impairments to that of Dr. Oshidari. Even if Dr. Oshidari had inconsistent test results, I do not find it reasonable that he concluded that it was impossible to rate J.M.'s physical impairments when it was evident from all of the assessment reports that J.M. has a physical impairment.

T.S. and Allstate – 3 https://www5.fsco.gov.on.ca/AD/3369

Decision Date: **2011-11-15**, Adjudicator: **Wilson, John**, Regulation: **403/96**, Decision: **Arbitration, Final Decision, appeal rendered, FSCO 3369**.

The consensus report, however, found that:

With respect to the (f) criterion, "any impairment or combination of impairments that, in accordance with the American Medical Association Guides to the Evaluation of Permanent Impairment, 4th Edition, 1993, results in a 55% or more impairment of the whole person":

Dr. Oshidari, physiatrist, opined that due to numerous inconsistencies and non-organic findings during [T.S.]'s examination, her impairment is not ratable.

Dr. Oshidari's comment that T.S.'s impairments are not "ratable" is given some context by further comments in his report. He cites two situations which gave rise to his opinion of non-ratability:

There is a diagnosis of Fibromyalgia. [T.S.] believes that all of her symptoms are caused by Fibromyalgia and that any time she has a flare-up of Fibromyalgia her function deteriorates. Unfortunately, based on the American Medical Association's Guidelines I am not able to provide any impairment based on Fibromyalgia. There is no proven structural abnormality in those suffering from Fibromyalgia, therefore, the AMA Guidelines provide zero impairment for Fibromyalgia.

Dr. Oshidari also concluded that: "(A)gain, based on the AMA Guidelines due to numerous inconsistencies and non-organic findings her impairment is not ratable."

It should be recalled, however, that section 2(3) of the *Schedule* also provides:

For the purpose of clauses (1.1) (f) and (g) and (1.2) (f) and (g) of the definition of "catastrophic impairment" in subsection (1), an impairment that is sustained by an insured person but is not listed in the American Medical Association's *Guides to the Evaluation of Permanent Impairment,* 4th edition, 1993 shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.

Given the clear legislative direction granted to the DAC as identified above [See note 6 below], it is regrettable that Dr. Oshidari felt unable to provide an assessment rating for the fibromyalgia related disorders. I note that although he was listed as a witness by Allstate, he was not produced, and consequently had no opportunity to elaborate on any reasons he had for according no weight to a condition that comprised a significant portion of T.S.'s complaint. [See note 7 below]

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Note 6: See *Liu v. 1226071 Ontario Inc.* [2009] I.L.R. I-4867 MacFarland J.A for the primacy of legislation in a CAT determination."In my view the trial judge fell into error in equating the statutory test to a medical one. It is not. Any notion of catastrophic injury, other than the specific meaning ascribed to that term by the legislation must be discarded when considering whether a claimant meets the statutory test**.**"

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Note 7: Although in the past there has been some controversy about fibromyalgia, the courts, human rights tribunals and worker's compensation schemes have long since recognized the condition as forming a physical basis of disability. See *Dickson v. Canada Life Casualty Insurance Co., 1996 CanLII 8045*

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Although the DAC rendered a decision on the question of full body impairment (f criterion), the process leading up to its conclusion is less than transparent. The DAC report has inserted amongst its pages (at the end of Dr. Oshidari's report) a hand-written addendum noting as follows:

Whole person impairment fibromyalgia	 = 0
Tailbone Dislocation	= 5% - 10%
Psychological	= not given a score.

Whatever Dr. Oshidari's personal opinion as to the attribution of ratings to psychological impairments and to conditions such as fibromyalgia which do not involve "structural abnormality", he should have been aware by May 5 2006 [See note 8 below], the date when the CAT assessments began, of an emerging consensus to include such ratings in an evaluation of a whole person impairment.

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While there has been and remains some controversy amongst some CAT DAC assessors as to the method of calculation of the whole person impairment rating, it is not unheard of for an assessment team to calculate alternative ratings based on both the inclusion of psychological impairments and their exclusion. In this case, it would have been more useful had the assessors not taken a dogmatic position on combined

> ratings. Clearly this was not done, leaving us only to guess as to what an open-minded assessment team would have found for a combined score.

The DAC assessment's shortcomings were not, however, limited to its blinkered view of the assessment approach to be taken. Among the legislative directives and administrative guidelines referred to by Simmons J.A. is the *Catastrophic Impairment Designated Assessment Centre Assessment Guidelines* issued by the Financial Services Commission, and revised April, 2002.

Kusnierz v. The Economical Mutual Insurance Company, 2010 ONSC 5749 (CanLII), <http://canlii.ca/t/2d0kp

[123] Dr. Lacerte criticizes Dr. Ameis' assessment strongly because Dr. Ameis did not follow the generally accepted methodology for assessing a person as outlined in Guides. For example, in assessing the amputation, the length of the residual limb is critical. If it is less than three inches, the WPI rating is 32 per cent, but if it is three inches or more, the WPI rating is 28 per cent. In his initial assessment of Mr. Kusnierz, however, Dr. Ameis reported: "The stump is about three inches in length". Dr. Lacerte testified that the methodology requires a definitive measurement: "Don't put 'about' because it brings a [page146] degree of vagueness that is really not helpful when you're reviewing." Based on the measurements performed by Dr. Alborz Oshidari and Dr. Edward English, Mr. Kusnierz's residual limb is more than three inches in length. The Guides make the distinction, Dr. Lacerte explains, "because essentially the shorter your stump, the harder it is, essentially, to fit the prosthesis because you don't have as much leverage".

[124] Dr. Lacerte was also somewhat critical of Dr. Oshidari's approach, who assessed the range of motion in Mr. Kusnierz's cervical spine in terms of "per cent of normal". That is not the way in which the Guides require it to be done. The fourth edition requires the use of an "inclinometer", which provides precise range of motion measurements in terms of degrees. Dr. Oshidari also failed to assess the range of motion in Mr. Kusnierz's leg with his prosthetic on:

> So, basically, the thing is that he had zero, zero as it relates to objective, reliable, valid measurement using, you know, measuring instrument. So, basically, Oshidari can tell you that it is decreased -- you just have to believe him. He doesn't give you data, okay, and that's the whole point of the AMA Guide is that you need to give data because [otherwise] it cannot be reproducible.

[125] In his testimony, Dr. Lacerte deplored assessments aimed at generating impairment numbers for the purposes of WPI calculation. As Dr. Lacerte put it: "Overall I found that, you know, in general, how people are doing impairment rating is really out of control and, you know, is really generally poorly done."

[136] Since Mr. Kusnierz suffered a below-knee amputation, it seems natural for an assessor under the Guides to consider Table 63 in Chapter 3, entitled "Impairment Estimates for Amputations". This is what Dr. Alborz Oshidari, a physiatrist for Work Able Centres Inc., did in his report dated April 6, 2004, following an assessment of Mr. Kusnierz on February 15, 2004, a little more than 26 months after the accident.

[137] In his testimony, Dr. Ameis criticized Dr. Oshidari's approach. He argued that Table 63, which sets out "Impairment Estimates for Amputations" in the lower extremities, is not appropriate because it implicitly assumes a normal outcome for the amputee being evaluated. When he first saw Mr. Kusnierz on October 21, 2002, this is what he expected. By 2003, however, he considered Mr. Kusnierz to be a "failed prosthetic rehab case". If the outcome is abnormal, then Dr. Ameis testified that the assessor is free to look for other approaches within the Guides. [page149] Subsection 2(3) of the SABS provides that where an impairment is not listed in the Guides, an assessor can utilize the impairment that is listed in the Guides "that is most analogous to the impairment sustained by the insured person". Within the Guides, Dr. Ameis referred to s. 3.2i, entitled "Diagnosis-based Estimates". It provides:

> Some impairment estimates are assigned more appropriately on the basis of a diagnosis than on the basis of findings on physical examination. A good example is that of a patient impaired because of the replacement of a hip, which was successful. This patient may be able to function well but may require prophylactic restrictions, a further impairment. For most diagnosis-based estimates, the ranges of impairment are broad and the estimate will depend on the clinical manifestations.
>
> The evaluating physician must determine whether diagnostic or examination criteria best describe the impairment of a specific patient. He also relied on s. 3.2c, entitled "Muscle Atrophy (Unilateral)": "The evaluating physician should determine which method and approach best applies to the patient's impairment and use the most objective method that applies."

[152] Dr. Lacerte also points out that "Dr. Oshidari's examination of Mr. Kusnierz's left lower extremity and gait was basically normal". He added, "It is my strong opinion that this [attributed hip disarticulation] is contrary to Dr. Oshidari's own objective findings that 'Today he walked without a walking assistive device. There was no obvious limping in the lower extremity'" on his February 5, 2004 visit to Dr. Oshidari (emphasis in original). Dr. Lacerte concludes:
"Finally, Dr. Ameis has not used Table 36 properly, which he relies upon heavily. In any case, when appropriate methodology is fully employed, Dr. Oshidari's description of Mr. Kusnierz's gait would preclude the use of this table."

[153] Based on the evidence of Dr. Ameis and Dr. Oshidari, I find that gait derangement is one possible approach to the assessment of Mr. Kusnierz's impairments, at no more, however, than 40 per cent WPI.

Decision No. 976/08R, 2010 ONWSIAT 1586 (CanLII), <http://canlii.ca/t/2fhpc

[11] The decision reviewed the medical reporting and concluded that it did "not persuasively establish a causal link between the worker's ongoing organic condition and his workplace accident". It noted in particular that despite the plethora of medical reporting, only the reporting from Dr. Oshidari and Dr. Skupsky addressed the question of the role of the workplace injury. In particular, Dr. Oshidari postulated that "as a result of the injury, he might be experiencing lumbosacral radiculopathy" and Dr. Skupsky stated that the worker was suffering from a "chronic disability directly as a result of his WSIB traumatic event". Given the extensive medical reporting and diagnoses which included disc problems, stenosis and marked facet joint arthropathy, the opinion of Dr. Skupsky was not found to be persuasive as there was no explanation of how the accident played such a role in light of the worker's history of degenerative change in his back. The remark by Dr. was noted to be an expression of a possibility only and given the fact that it did not consider the worker's past history, it was not understood as evidence of what was likely. Further, the decision noted that "the radicular symptoms appear to be intermittent in the medical reporting, and the bulk of medical opinion attributes the worker's ongoing pain to his other organic problems."

Pastore and Aviva Canada https://www5.fsco.gov.on.ca/AD/2570

Decision Date: **2009-02-11**, Adjudicator: **Nastasi, Elizabeth**, Regulation: **403/96**, Decision: **Arbitration, Final Decision, appeal rendered, FSCO 2570**

Note 16: Dr. Oshidari is a specialist in physical medicine and rehabilitation. He was a CAT DAC assessor for more than 6 years where he estimated that he conducted 50-60 CAT DAC assessments per year.
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Counsel for Aviva retained Dr. Brigham [See note 17 below] to review the CAT DAC assessment. Dr. Brigham came to a different assessment for Ms. Pastore's left ankle. He concluded that she suffered a 2% WPI for the left ankle. Dr. Brigham agreed with the WPI rating of 20% with respect to Ms. Pastore's knee and, unlike

Dr. Oshidari, initially found that the accident was the cause of her right knee impairment. However, in his testimony at the hearing his evidence was that he had changed his opinion and concluded that the motor vehicle accident did not cause Ms. Pastore's right knee impairment.

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Note 17: Dr. Brigham is an American physician, Board-Certified in Occupational Medicine and a Certified Independent Medical Examiner. He is a prominent American advisor on disability issues.

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I find that a 2% WPI for Ms. Pastore's left ankle with the 20% WPI for her right knee are an accurate reflection of her physical impairments for the reasons that follow.

(i) The Left Ankle

I agree with Dr. Brigham's analysis and the WPI rating of 2% with respect to Ms. Pastore's left ankle for the reasons set out below.

Chapter 3.2 of the *Guides* is the relevant section for a lower extremity problem. There are 13 different ways to look at a patient and the assessor has options in choosing which method is most appropriate in calculating an impairment rating.

Dr. Oshidari approached the assessment of the left ankle using several different methods. It was difficult to get a clear sense of Dr. Oshidari's assessment and WPI rating as he gave contradictory positions within the CAT DAC report and his testimony. The CAT DAC assessment of the left ankle notes that Ms. Pastore was "not rateable" (which would result in a 0% WPI), however it also provides a "worst case scenario" (or "severe") impairment rating due to arthritis of 12%. [See note 18 below] Dr. Oshidari does not provide any explanation for assigning a "severe" as opposed to the "moderate" or "mild" impairment rating.

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Note 18: Exhibit #1, Tab 3, page 18.

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Dr. Oshidari's evidence at the hearing did not clear up any confusion on this point. During cross- examination he admitted that his report should have said that Ms. Pastore's physical impairment was not rateable and therefore assigned it 0%. When asked why he did not just stop his assessment at this point, he stated that he looked at other scenarios, however this was "idle speculation" and "academic" and of "no relevance to this case or the SABS." His evidence was slightly different again on re-direct, he said that to calculate an impairment for the ankle based on the structural abnormality assessment he conducted was an acceptable form of assessment in the CAT DAC process.

Dr. Brigham reviewed Dr. Oshidari's report and provided his own assessment of impairment. Contrary to Dr. Oshidari's assessment, Dr. Brigham found that the left ankle was in fact rateable according to the AMA *Guides* and assigned it 2% WPI. He found that Dr. Oshidari's WPI ratings of the left ankle and knee were not helpful in providing a reliable rating because he provided ratings that were speculative and based on worst case scenarios. In Dr. Brigham's opinion, Dr. Oshidari's ratings were consistent with a total obliteration of the joint space and that Dr.Oshidari provided no basis for adopting this worst case scenario approach.

Dr. Brigham provided detailed evidence of the steps that he took in rating Ms. Pastore's ankle and clear reasoning for adopting the approach chosen. Dr. Brigham provided a detailed description of each of the possible methods that could have been used to evaluate Ms. Pastore and gave reasons for the ultimate choice made. [See note 19 below] In Dr. Brigham's opinion, the medical records do not support Dr. **Oshidari**'s choice of assigning the most severe rating of impairment for arthritis. This is based on Dr. Brigham's examination of a January 27, 2006 x-ray report. [See note 20 below] The x-rays note "mild degenerative

changes" but otherwise "unremarkable." Dr. Brigham notes that although the x-rays did not provide specific measurements, which are required by the *Guides*, Dr. Brigham felt that it was appropriate to assign Ms. Pastore the "benefit of the doubt" and assign her the "mild arthritic ankle impairment" which results in a 2% WPI.

I find Dr. Brigham's approach was a reasonable and informed exercise of clinical discretion as permitted by the *Guides*. I accept his evidence and rating of 2%. I find this rating appropriately captures and is representative of Ms. Pastore's left ankle impairment.

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Note 19: Exhibit #1, Tab 13.

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Note 20: Exhibit #3, Tab 3, page 20.

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(ii) The Right Ankle

In the CAT DAC report, Dr. Oshidari also notes that there was no active range of motion testing done on Ms. Pastore's right ankle either but passive range of motion testing was done. He provided a worst case scenario rating for the right ankle of 3%, which is "mild." However, he then notes that there is no documentation of right ankle pain and thus the 3% is not included in the overall WPI rating.

Dr. Brigham agreed with Dr. Oshidari that there are no rateable factors to consider for assigning a rating to the right ankle and that the only physical injuries that could be potentially rateable were the left ankle and right knee.

I find that based on the evidence presented, Ms. Pastore's right ankle is not rateable and as such assign a 0% WPI rating.

(iii) The Right Knee

Dr. Oshidari and Dr. Brigham arrived at the same impairment rating for Ms. Pastore's knee of 20% WPI. Where their opinions diverge, at times, is with respect to the issue of causation.

In the CAT DAC report, Dr. Oshidari notes that the right knee was not rateable according to the AMA *Guides* because he found that the right knee was not caused by the accident. Dr. Oshidari's conclusion is based on the fact that "…there was no initial documentation of discomfort and pain in the right knee. Therefore there is no correlation between the car accident and the right knee. Initial x-rays also revealed some degenerative changes in the knee joint." [See note 21 below] Dr. Oshidari does, however, acknowledge that there is a "… possibility that the way [Ms. Pastore] walked due to discomfort and pain in the left ankle caused pressure on the right knee, which exacerbated her pre-existing degenerative changes." [See note 22 below]

B and RBC General https://www5.fsco.gov.on.ca/AD/274

Decision Date: **2009-01-16**, Adjudicator: **Murray, Maggy**, Regulation: **403/96**, Decision: **Arbitration, Final Decision, appeal rendered, FSCO 274**

In Dr. Oshidari's report, he stated that the Applicant "walked with a normal gait pattern" and he was not able to detect any limping. Furthermore, she did not use an assistive device to walk. [See note 34 below] Dr. Oshidari concluded that the Applicant's gait derangement is zero. [See note 35 below] However, at p. 9 of Dr. Oshidari's report, he stated: "She had an elastic bandage on around the right knee, with a small patella brace." I place little weight on Dr. Oshidari's conclusion that the Applicant did not use an assistive device to walk because, as he noted, the Applicant used a knee brace, which is an assistive device.

Madonik and Pilot Insurance – Appeal https://www5.fsco.gov.on.ca/AD/1996

Decision Date: **2008-09-18**, Adjudicator: **Evans, David**, Regulation: **403/96**, Decision: **Appeal, , FSCO 1996**

As set out in the pre-hearing letter, Dr. Madonik was injured in an automobile accident on December 24, 1997, and sought various benefits. The pre-hearing was held on July 24, 2008 in relation to Dr. Madonik's claim for medical benefits pursuant to s. 14 of the *SABS–1996*. [See note 1 below]

A dispute arose during the pre-hearing regarding productions. While Pilot agreed to a number of productions, Dr. Madonik agreed only to provide materials or authorizations to obtain them relating to his complaint about Dr. **Oshidari** to the Financial Services Commission. He objected to producing the documents requested by counsel for Pilot, Ms. Korte, in her letter to him of April 22, 2008, on the basis that Pilot had previously settled some claims for treatment expenses without obtaining a release from him.

[]

In any event, the arbitrator did recognize the issues he raised, in that she noted that Dr. Madonik undertook to provide materials relating to his complaints about Dr. **Oshidari**, as already noted above, and in production 11, she ordered "[a] complete copy of the College of Physicians and Surgeons' file regarding the complaint made to it by Dr. Madonik about Dr. **Oshidari**, including all correspondence between Dr. Madonik and the College and any documents regarding Dr. Madonik's appeal." She therefore issued an interim order in consideration of Dr. Madonik's concerns.

Sharma and Allstate https://www5.fsco.gov.on.ca/AD/3111

Decision Date: **2008-06-18**, Adjudicator: **Wilson, John**, Regulation: **403/96**, Decision: **Arbitration, Preliminary Issue, appeal pending, FSCO 3111**

Dr. Brigham's report, which I have examined in the context of whether it should be admitted as evidence in this arbitration, essentially reviewed the conclusion of Dr. **Oshidari**, the CAT DAC examiner, but significantly, commented: "It is our hope that this will result in a better understanding of the appropriate application of the AMA *Guides* and the assessment of mental and behavioral disorder impairment." Clearly the report is intended to be more than just a paper review of Ms. Sharma's medical reports in the context of her catastrophic impairment claim.

Decision No. 29/01, 2003 ONWSIAT 1144 (CanLII), <http://canlii.ca/t/1xrlm

[109] Dr. Oshidari reviewed a number of medical reports, questioned the worker about her accident, past and present complaints, and examined her. She described constant discomfort and pain in the back, radiating to both lower extremities and into the toes, with movements (such as standing sitting, walking) lasting more than ½ hour increasing that discomfort. She also described bowel irritation syndrome, problems with sleep, low energy, and concentration/memory problems. On examination, Dr.

Oshidari found only 8 positive tender points out of 18, and he noted that they were positive only from the waist down.

[110] Dr. Oshidari concluded that "her diagnosis is that of chronic pain syndrome or somatoform pain disorder".

[111] In suggesting those diagnoses, Dr. Oshidari was indicating that the worker's pain complaints were inconsistent with the organic findings, and that her low back pain arose predominantly from a psychological (or undetected organic) source.[1] Although these diagnoses suggest a psychological source of pain/disability, Dr. Oshidari did not address the question of whether the psychological factors were related to the worker's work injury. And there are no reports on file from psychiatrists or psychologists who addressed the question of the cause of any psychological factors that played a role in the worker's disability, although there are references to the worker taking anti-depressant medication before her injury, and to depression after the injury.

[112] Dr. Oshidari concluded that the worker's CT scan findings were coincidental (that the noted bulging disc finding occurs in approximately 40% of the population) and that the MRI had not confirmed this bulging. He wrote:

> ...There is no diagnosis of ongoing musculoskeletal impairment that I can identify today…
>
> Her level of functioning is self-limited due to pain and not due to any neuro-musculoskeletal abnormality…

[113] With respect to the diagnosis of fibromyalgia, Dr. Oshidari wrote:

> …With respect to the fibromyalgia, both fibromyalgia and chronic fatigue syndrome are highly controversial labels whose validity as medical diseases remains to be proven. Neither of these alleged conditions has been shown to have any recognizable and producible tissue pathology, etiology or treatment. Today's presentation does not fit with the criteria for fibromyalgia. Her discomfort and pain remain from the waist down. Therefore, her complaints coincide more with chronic pain syndrome than any other disease…

[114] Although Dr. Oshidari diagnosed chronic pain syndrome or somatoform pain disorder rather than fibromyalgia, and he saw no reason for any specific physical restrictions to be placed on the worker, he also felt that her prognosis was poor. He wrote that her "limiting factor is self-limitation due to a combination of fatigue and chronic low back pain". He concluded that returning to any work activity could not cause her any damage or harm although she may initially experience more discomfort.

[123] Dr. Leung concluded that the worker's physical and emotional state did not allow her to return to regular employment of any type. She also requested an MRI of the worker's neck. After receiving the MRI, and reviewing the reports of Dr. Oshidari and the FAE, Dr. Leung wrote the insurance company from which the worker was claiming long-term disability benefits. Dr. Leung indicated that she had reviewed the neck MRI that was done in October 2000. She interpreted that MRI as follows:

> …It showed large posterior discophyte at C4-5 and C5-6 indenting the thecal sac with narrowing of the cervical canal. There was narrowing of the intervertebral foramina at the C3-4 level, more on the right.
>
> Physical examination consistently showed hyperreflexia and bilateral positive Hoffman's signs. The neck and back remain tender and somewhat restricted with diffusely active trigger points…

[124] Dr. Leung concluded that the worker has chronic degenerative disc disease of the neck and back with fibromyalgia as the major disabling condition. She feels that the findings on the MRI of the neck account "for the clinical findings of muscular hyperirritability causing symptoms of marked pain, stiffness and severe fatigue". She expressed her opinion that the "disc abnormalities in [the worker's] neck and back result in significant mechanical impairment, with pain on prolonged loading of the spine, accounting for her limited tolerance of activity, load and flexion". She felt that the worker's chronic pain resulted in marked sleep disturbance, and the resulting need for regular rest seriously interferes with the worker's ability to "undertake regular commitments" or work. She also expressed disagreement with the conclusion of the FAE and Dr. Oshidari's report noting that a patient may "self-limit" activity because of pain he/she is genuinely experiencing. Dr. Leung concluded that the worker is "a subject who is in distress and performed inadequately for the pursuit of employment, even at a sedentary level".