Oshidari, Alborz - Physiatrist

Complaints to the College of Physicians and Surgeons (CPSO) followed up by hearings at the Health Professions Appeal and Review Board (HPARB):
Balkansky v Oshidari, 2022 CanLII 49675 (ON HPARB), <https://canlii.ca/t/jpq99
Feletig v Oshidari, 2021 CanLII 125681 (ON HPARB), <https://canlii.ca/t/jl55f
II v AO, 2013 CanLII 1054 (ON HPARB), <https://canlii.ca/t/fvpdr
W.H.H. v. A.O., 2011 CanLII 26433 (ON HPARB), <https://canlii.ca/t/flcz9

Note: a complete record of complaints at the CPSO is not publicly available

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Campuzano v Aviva Insurance Company, 2023 CanLII 103789 (ON LAT), <https://canlii.ca/t/k11ls

[52] On July 26, 2022, the applicant underwent an approximately thirty minute in-person physical medicine and rehabilitation assessment with Dr. Oshidari and advised him that her primary concern was lingering pain in her lumbar area. She did not recall if she discussed any concentration issues to Dr. Oshidari.

[53] Like Mr. Pritchett, Dr. Oshidari receives this independent assessment assignment from Viewpoint. Also like Mr. Pritchett, Dr. Oshidari acknowledged that he had no independent recollection of his assessment of the applicant and relied entirely on the findings in his report dated August 9, 2022. He also conducts a significant number of such assessments each year, almost exclusively for various insurance companies. He retains his notes until Viewpoint issues his report. After he reviews his report, he shreds his notes. He explained that while he keeps a copy of his dictations, he does not retain a copy of his assessment notes as he does not have a doctor-patient relationship with claimants such as the applicant. As a result, although he personally reviews all of his reports for errors, he no longer has access to his notes used to dictate the report shortly after the examination.

[54] The case conference order issued by the Tribunal on January 20, 2023 required the respondent to produce a complete copy of Viewpoint's file, including draft reports, referral letters, rough notes, questionnaires completed by the applicant, correspondence received from the respondent and a copy of all medical and/or clinical notes and records from each section 44 assessor's assistant, clerk, nurse or anyone present during a section 44 assessment. The summons issued by the Tribunal on September 27, 2023 ordered Dr. Oshidari to bring to the hearing a similar list of documents. However, Dr. Oshidari denied receiving the summons and explained that the respondent had advised him of the date and time of the hearing. He also denied having access to the documents on the Viewpoint ADMS portal that he would have reviewed prior to the assessment and only last checked this portal to confirm that his report was accurate and last accessed the site around May 2023. That Mr. Pritchett was able to access his own documents on the Viewpoint site in very short order at the hearing does not equate to evidence that his access is comparable to that of Dr. Oshidari. It is also entirely possible that Dr. Oshidari simply lacks Mr. Pritchett's familiarity and expertise in navigating the Viewpoint portal.

[55] Dr. Oshidari's lack of access to these documents is however relevant to the various instances when the applicant denied making specific statements contained in the report or alleged that Dr. Oshidari interpreted her statements in a misleading manner. For instance, the applicant's statements on the effectiveness of treatment have been at times contradictory. Although she testified at the hearing that they have been helpful in maintaining her functionality, on her own evidence, the improvement is not lasting. As she stated to Dr. Oshidari, the benefits from these sessions follow a fairly reliable pattern of expiry after a few weeks:

At the same time, she also attended physiotherapy initially twice per week and then once a week until about one or two months ago. The physiotherapist used shockwave therapy, stretching and a core exercise program. She also received 12 sessions of the acupuncture. When I confirmed with her that she received more than one and a half years of treatment, she reported yes. When I asked her how much the pain improved, she reported there is only temporary improvement regarding her pain.

[56] As Dr. Oshidari lacked a specific recollection of the assessment and purported to have no means of accessing the original documents that could served to refresh his memory, his evidence with respect to the details of the assessment must be accorded reduced probative weight since he could not point to anything in his notes to support his version of events regarding statements the applicant denied making. However, despite the unavailability of Dr. Oshidari's original notes, I find that his description of the applicant's evidence is nonetheless reliable as it conforms with similar evidence she offered to others. In the present case, the above statement is consistent with her evidence at the hearing that the pain relief only lasts until the next chiropractic or physiotherapy session four or five weeks later, much as she advised Dr. Charlton, who completed the OCF-18 for this treatment plan.

[57] Following the applicant's first visit to Dr. Drakshan after the accident, Dr. Drakshan examined the applicant's spine but only diagnosed midline tenderness. At Dr. Drakshan's recommendation, the applicant obtained a cervical x-ray on July 27, 2020. While there was no evidence of fracture, the x-ray showed mild degenerative changes and an apparent congenital fusion of C6 and C7 vertebrae. Similarly, a lumbar spine x-ray taken on the same date showed no evidence of a fracture and no acute injury but more degenerative change and anterior osteophyte formation. A subsequent lumbar spine MRI conducted on March 2, 2021 also revealed "minimal/early degenerative changes" and that the "definite cause for symptoms not identified."

[58] However, the reports by Dr. Charlton and, to some extent, Dr. Ochidari were able to offer more clarity with respect to the applicant's symptoms. Unlike Dr. Drakshan, neither noted any ambiguity with respect to the basis of the applicant's pain symptoms. As well, the respondent did not suggest that the applicant's injuries did not cause her symptoms or that they did not exacerbate her pre-existing conditions. Rather, the respondent argued that the services proposed are simply not reasonable and necessary.

[59] In the OCF-18, Dr. Charlton wrote that the applicant reported difficulty with prolonged sitting, dressing, sleeping (due to shooting pain in her lower back), prolonged standing, walking, bending and rising from a seated position. The stated goals of the treatment plan are pain reduction, increase in strength and increased range of motion. The functional goals listed are to return the applicant to activities of daily living, modified work activities and/or pre-accident work activities.

[60] Dr. Ohidari testified that although he found that the applicant exhibited a decreased range of motion as noted by Dr. Charlton, he emphasized that he believed that this decrease was subjective not objective. He distinguished between an active and a passive range of motion and stated in broad terms that patients may not move body parts out of fear of pain. Range of motion is the capability of a joint to go through its complete spectrum of movements. It can be passive or active. Passive range of motion can be defined as what is achieved when an outside force, such as a therapist, causes movement of a joint. It is usually the maximum range of motion. Active range of motion is what can be achieved when opposing muscles contract and relax, resulting in joint movement.

[61] That said, he acknowledged that he found the applicant to suffer from a decreased range of active motion

but did not test her passive range of motion. As a result, I find that Dr. Oshidari did not contradict the findings of Dr. Charlton and avoided conducting tests that may have supported Dr. Charlton's determinations in favour of an unsupported assumption that Dr. Charlton also referred to active and therefore subjective restrictions to the applicant's range of motion. He also acknowledged that the applicant complained of pain and that pain is by definition subjective. When asked about his understanding of the duties of the applicant's employment, he was initially evasive in his response but ultimately referred to his report to state that he understood her work involved computer work at a desk.

[62] Dr. Charlton stated in the OCF-18 that the plan was intended to strengthen the applicant's areas of weakness but the closure of gyms due to the pandemic interfered with this objective. Dr. Oshidari disagreed that the treatment plan would assist with this goal but solely on the basis that the applicant's symptoms only temporarily improved despite the passage of one and a half years since the accident. As a result, he did not believe that another eight sessions would improve the applicant's condition. He also disagreed that the only venue for strengthening her areas of weakness would be at Dr. Charlton's clinic since part of the goal of rehabilitation, as contrasted with palliative care, would be to encourage a transition after a three to six months to self-directed exercise. He did clarify precisely how directed exercise and treatment under the supervision of a qualified profession were inherently inferior to self-directed exercises, likely instructed at least in part by that same professional.

[63] Subsection 16(1) of the Schedule describes "rehabilitation" as measures "that are reasonable and necessary for the purpose of reducing or eliminating the effects of any disability resulting from the impairment or to facilitate the person's reintegration into his or her family, the rest of society and the labour market." However, Dr. Oshidari took the position that only physical or "objective" disabilities qualify as impairments. I find that this is an unduly restrictive definition as the Schedule defines an impairment more broadly as "a loss or abnormality of a psychological, physiological or anatomical structure or function." As the applicant rightly notes, if an impairment was limited to only a fracture, muscular or neurological issues as Dr. Oshidari insisted, there would be no market for chiropractors or massage therapists.

[64] There is no dispute that the chiropractic treatment has provided relief to the applicant from her pain symptoms. The respondent takes the position that because this relief is temporary, the plan is not reasonable and necessary. However, there no limitation in subsection 16(1) of the Schedule that limits the activities and measures employed to treat an impairment to those that achieve only permanent relief. As the applicant noted, given that the treatments provide four or five weeks of relief from pain, the eight sessions proposed in the OCF-18 could reasonably provide approximately thirty-two to forty weeks of relief.

[65] In the OCF-18, Dr. Charlton also stated that the applicant "did experience a flare up which will require more care." Dr. Oshidari testified that it would be important to understand the causality of the flare up to determine if appropriate instruction would permit treatment through exercise outside of the clinic setting. Again, he denied that more treatment would be necessary to address a flare up of symptoms primarily on the presumptions that the flare up is unlikely to have been caused by the accident and the impairment is subjective or emotional not objective. He stated that although there was no doubt that she has pain and a restricted range of motion, he opined that rather than any objective impairment, her perception of harm is a major contributing factor for these symptoms. Specifically, in report he stated,

There is no doubt she experienced discomfort and pain in the back, which radiated to the buttock area. There is no doubt there is a significant restriction in range of motion of the lumbar spine, but I find there is good potential that

her perception of causing harm or the expectation of experiencing pain is a major contributing factor to this restriction.

[66] Dr. Oshidari suggested that the cause of the applicant's pain may be psychological but acknowledged that he is not a psychologist. He denied that the temporary relief the applicant derived from treatment constitutes an improvement because he could not find an objective impairment in the course of his examination. While he claimed to lack any recollection of the details of the assessment, he also claimed that the applicant stated that she only achieved a few days of temporary relief from treatment, a quantification not found anywhere in his report and in direct conflict with the applicant's own evidence at the hearing. I find that this estimate should be accorded virtually no weight as on the witness's own evidence, he relied entirely on his report which described the relief as merely "temporary" and with no estimate of duration.

Lei v Aviva General Insurance Company, 2023 CanLII 87438 (ON LAT), <https://canlii.ca/t/k0bt9

[26] S.L. submits that the support for the OCF-18 for a chronic pain assessment is found in the family physician records, where they note persistent pain, the referral of the family physician to a chronic pain program with Dr. D'Souza, and the OCF-18 which suggest that S.L. suffers from chronic pain.

[27] In response, Aviva relies on the March 7, 2022 s. 44 report from Dr. Oshidari, general physician, who diagnosed S.L. with sprain/strain injuries of the cervical and lumbar spine. Dr. Oshidari opined that there was no objective evidence to support a somatic pain disorder to suggest that a chronic pain assessment is reasonable. The report goes on to further note that S.L was able to function and continued to work.

[28] I agree with S.L.

[29] Notably, in his report, Dr. Oshidari confirmed that S.L. reported pain symptoms returning when he did not receive treatment, which Dr. Oshidari opined was indicative that he had reached maximum medical recovery. I agree with S.L. that Dr. Oshidari's report confirms that S.L. experiences temporary relief with treatment; suggests that S.L. requires time off work as a result of chronic pain; that he will not recover beyond his current status; and there is no structural abnormality to explain his symptoms.

[30] I find that Aviva's position that S.L. "was able to function at this stage and continued to work" is misplaced in this context. For the purposes of determining if an individual suffers from functional limitation as a result of chronic pain, Aviva would have made a valid argument. However, the chronic pain assessment is the step before the functional limitation analysis is considered. It has not yet been confirmed that S.L. suffers from chronic pain, as the recommended assessment is intended to determine; therefore, whether there is functional limitation as a result of chronic pain is a situation of putting the cart before the horse.

[31] The chronic pain assessment is reasonable and necessary to determine the severity of S.L.'s accident-related pain complaints. Given the evidence of more than two years of documented neck, back and shoulder pain, it is reasonable to conclude that S.L. suffers from a condition that the assessment is meant to determine.

Murray v Aviva General Insurance, 2023 CanLII 87413 (ON LAT), <https://canlii.ca/t/k0bt6

[15] On question (1), the applicant argues that OT Oatman erred in not attributing all of the functional impairments to the accident. In particular, he argues that the functional impairments in dispute were caused by an increase in his general pain after the accident. In this regard, the applicant argues that the s. 44 assessment of physiatrist Dr. Oshidari, which found that some of the applicant's impairments were related to other medical issues as opposed to the accident, should not have been considered by OT Oatman given that Dr. Oshidari allegedly failed to canvass how the applicant's pain had changed post-accident. This omission, the applicant argues, undermines the argument that these functional impairments are not accident related.

[16] On question (2), of whether the proposed costs for mobility support, skin care, and supplies are reasonable and necessary, the applicant argues that OT Oatman neglected to consider the applicant's mobility outdoors where there may be limited objects available to help stay supported. He argues that ACB assistance to supervise the applicant outside the home is reasonable and necessary to assist in mobility outdoors. No submissions were made regarding skin care or the need for supplies.

[17] On question (1), the respondent argued that OT Leung only recommended assistance with grooming, hygiene, and bathing as a result of assessing the applicant while he was in the hospital for an unrelated liver issue. It argues that the applicant's difficulties with these functional tasks are as a result of his liver issues and an unrelated fall, and not the subject motor vehicle accident. It also argues that there is no medical evidence to substantiate the applicant's difficulties with these functional tasks as a result of the subject accident. The respondent argues that Dr. Oshidari did make specific reference to the Applicant's reported worsening of pain after the accident, but that this does not negate the arguments around causation advanced above.

[18] On question (2), when considering the need for mobility, the respondent argues that the applicant was able to ambulate using his walker or wheelchair without the need for any cueing or supervision during his assessment with OT Oatman. The respondent points out that the applicant made no submissions regarding the necessity of skin care support. The respondent made no submissions regarding the need for supplies.

[19] The parties also made submissions regarding the applicant's automatic entitlement to payment for ACBs incurred during the month of March 2021. The applicant argued that pursuant to s. 42(6) of the Schedule, upon receipt of a Form 1 an insurer shall begin payment of ACBs pending the receipt of a report from a s. 44 examination indicating otherwise. The applicant indicated that he incurred ACB for one month during March 2021 in the amount of $3,669.82. The respondent argued that there was no evidence presented to the Tribunal to demonstrate that this expense was incurred. Given the lack of evidence that this was incurred, I reject this argument by the applicant.

[20] In considering submissions from both parties on the causation of certain functional impairments (question (1)), it is incredibly difficult to parse out the issue of causation given the applicant's substantial medical history, which includes (but is not limited to): spinal stenosis, diabetes, hepatitis-c, seizures, a liver abscess, and a fall that required hospitalization. Much of the discussion turns on the report of Dr. Oshidari, who opines that "in relation to the motor vehicle accident, there is no structural or physiological abnormality. […] from a physical point of view, there is no specific impairment due to the motor vehicle accident.".

[21] To establish causation, pursuant to Sabadash vs. State Farm et al., 2019 ONSC 1121, the applicant must establish that his impairments would not have occurred "but for" the accident. Apart from asserting that Dr. Oshidari did not consider the applicant's changing pain condition pre- and post-accident (which is incorrect, as Dr. Oshidari does this), the applicant does not advance a compelling case as to why these functional impairments in

grooming, hygiene, and bathing would not have been present but for the accident. As such, I do not accept these items as part of the ACB quantum.

Munar v Aviva Insurance Canada, 2023 CanLII 40086 (ON LAT), <https://canlii.ca/t/jx5c5

33] The respondent denied both of the OCF-18s on the basis of a prior physiatry IE report of Dr. Oshidari dated March 28, 2018. Although the report considered treatment plans not in dispute, the respondent relies on Dr. Oshidari's findings that the applicant had sustained only sprain/strain of the cervical, upper back and lumbar spine, contusion of the right shoulder and a tension headache as a result of the accident. Dr. Oshidari concluded that the applicant had achieved maximum medical improvement and that the applicant had received extensive treatment without any long-term benefit.

[34] Although the respondent denied the two OCF-18s on the basis that the applicant had reached maximum medical improvement from a physical perspective, the respondent failed to address the OCF-18s' stated goal of pain reduction. The applicant's chronic pain is well-documented in the medical record. The central goal of each of the OCF-18s was addressing the applicant's pain to aid in her return to ADLs. I note that Dr. Oshidari's own report noted that the applicant reported that she sometimes required her husband's assistance for ADLs if she was in too much pain. I further agree with applicant's submissions and caselaw that pain relief and maintenance of functionality are legitimate goals of treatment.

[35] Moreover, the applicant has provided a note from her family physician Dr. Leung specifically on the issue of the reasonableness and necessity of the treatment plans in dispute. Dr. Leung states that the applicant does require periodic rehabilitation treatment, such as chiropractic, massage and physiotherapy to address her chronic pain. The family physician also specifically references both the OCF-18 for therapeutic devices and the OCF-18 for physical treatment and states that they are reasonable and necessary. I place substantial weight on the opinion of the applicant's family physician. The clinical notes and records of Dr. Leung indicate that the applicant attended at his office numerous times for accident-related impairments and chronic pain. Dr. Leung was actively involved in the applicant's ongoing care, including attempting to manage her chronic pain by referrals to a pain rehabilitation specialist.

[36] I note that additional physiotherapy, chiropractic treatment and massage were also recommended in the s. 25 occupational therapy report of Ms. Amy Law, dated July 19, 2017. The respondent has not provided sufficient evidence to refute the recommendations of both Ms. Law, and Dr. Leung. Further, I find that the overall cost of the applicable OCF-18s is also reasonable.

[37] As such, I find that the applicant has established that both the OCF-18 dated March 9, 2019 and the OCF-18 dated April 28, 2018 are reasonable and necessary.

OCF-18 dated March 14, 2018 for a home/attendant care assessment is reasonable and necessary

[38] In determining whether an assessment is reasonable and necessary, it must also be noted that assessments, by their nature, are speculative. The purpose of an assessment is to determine if a condition exists. Notwithstanding their speculative nature, the applicant still bears the onus of establishing on a balance of probabilities that an assessment is reasonable and necessary.

[39] The applicant has provided sufficient evidence that she suffers from some impairments in her ability to carry out her ADLs due to her chronic pain. This has been noted by the applicant's family physician Dr. Leung, her chronic pain specialist Dr. Kachooie and in a s. 25 functional abilities assessment. The respondent's IE assessor Dr. Oshidari also noted the applicant's reports that her husband at times had to assist with ADLs if she was in too much pain. Given the evidence I am satisfied the applicant has provided objective grounds to warrant an assessment of the extent of the applicant's impairments in this area.

[40] Moreover, I do not find the respondent's additional arguments denying the assessment to be persuasive. In addition to citing a lack of compelling evidence, the respondent submits that this assessment was duplicative, as it had previously received an OCF-18 for an attendant care assessment from another facility. While I would find this argument to be persuasive if the prior attendant care assessment had been approved, the respondent had denied the previous treatment plan. Therefore, I do not find that the proposed OCF-18 would be a duplication of services. The respondent also cites the fact that the proposed OCF-18 was dated March 14, 2018, but it had been submitted over a year later on April 24, 2019. However, I do not find the date of the submission to be a determinative argument with respect to the reasonableness and necessity of the assessment. The applicant's chronic pain, functional impairment and difficulties in performing her ADLs has been documented in the medical file throughout 2018 and 2019 – both when the OCF-18 was dated and when it was submitted.

[41] Given the evidence cited above related to the applicant ongoing difficulties with fulfilling her ADLs, I find this assessment is reasonable and necessary pursuant to the Schedule.

Pakulski v Aviva General Insurance, 2023 CanLII 34457 (ON LAT), <https://canlii.ca/t/jwwqf

[13] The respondent relies on the s. 44 report of Dr. Alborz Oshidari, physiatrist, dated September 14, 2021. Dr. Oshidari noted during his physical examination that the applicant had reduced range of motion of the cervical spine and pain in his neck and upper back. He had reduced range of motion in his lumbar spine with discomfort and pain. Dr. Oshidari states: "based by [sic] assessment today considering it did not reveal any physical or structural abnormality and in response to treatment received in the past, I found the treatment plan submitted by Dr. Marciniak is not reasonable or necessary." He does not indicate what might be causing the applicant's pain or limited range of motion, nor does he suggest any treatment alternatives. He does not concur or disagree with the previous diagnoses of chronic pain, or the recommendation for chronic pain treatment made by Dr. Yufe. It is not clear what treatment response Dr. Oshidari is referring to as he does not delve into this area in his report. He only states that the applicant has received some treatment but does not speak to its effectiveness. Given the omissions and lack of thoroughness in Dr. Oshidari's report, I accordingly assign it less weight.

Villano v Aviva Insurance Company of Canada, 2023 CanLII 30774 (ON LAT), <https://canlii.ca/t/jwq3r

[19] I assign limited weight to the respondent's medical evidence, a series of insurer examination ("IE") assessments and paper reviews conducted by Dr. Alborz Oshidari, physiatrist, that resulted in reports dated May 14, 2019, July 30, 2019, and January 26, 2021. Although the respondent cited Dr. Oshidari's May 14, 2019 report as the main reason to deny both of the treatment plans in dispute, in correspondence dated August 20, 2019 and September 19, 2019, Dr. Oshidari does not actually comment on the two plans. This examination and report are focused on the withdrawn NEB claim, so the majority of his comments relate to the physician's views on the applicant's ability to carry on a normal life, the standard test in determining NEB eligibility. As a result, I do not find

Dr. Oshidari's report entirely relevant to the issues before me.

[20] Furthermore, I agree with the applicant that Dr. Oshidari's conclusions in the May 14, 2019 report somewhat support the treatment plans in dispute. Dr. Oshidari notes range of motion at 40-70 per cent of normal in the lumbosacral and cervical spine, along with 30 per cent normal extension and lateral bending. Shoulders are also noted to be at 90 per cent normal range of motion. Granted, Dr. Oshidari qualifies these observations with a later comment in his report that the applicant is pain-focused and self-limiting in her range of motion testing. He also states his belief that the applicant's symptoms seem "somewhat disproportionate to the nature of the accident." But he does not challenge the applicant's symptoms of pain, or that she is experiencing difficulties as a direct result of the accident, writing that, "There is no doubt, she continues to experience some discomfort and pain in the spine." Dr. Oshidari's acceptance of the applicant's ongoing pain makes it difficult to give his report much weight with regard to the treatment plans, as each features pain relief as a primary goal.

[21] For the same reasons, I assign limited weight to the IE occupational therapy assessment report of Ron Findlay, occupational therapist, whose report is also dated May 14, 2019. As with Dr. Oshidari, the primary focus of Mr. Findlay's assessment is the withdrawn NEB matter. The majority of Mr. Findlay's observations deal with standard in-home observations, strength tests, and range of motion tests geared to assess if the applicant is able to carry on a normal life. He finds that the applicant displays mostly normal range of motion, and also that she is displaying pain-focused and self-limiting behaviour, similar to what was opined by Dr. Oshidari. Still, Mr. Findlay does not assess the treatment plans before me, which leaves his report of minimal value.

[22] I reject the respondent's submission that its medical evidence should be given "vastly" more weight than the applicant's evidence, as her medical evidence was provided by Ms. Sharma and Dr. Louvish, each of whom had a pecuniary interest in "providing overblown injury information as to gain further payments for treatments at their facilities." No evidence is provided to support such allegations.

Dai v Aviva Insurance Company of Canada, 2023 CanLII 30784 (ON LAT), <https://canlii.ca/t/jwq3p

[20] Aviva partially denied the November 10, 2020 OCF-18 by removing the transportation costs, reducing the cost of the progress report, and removing 16 sessions of massage therapy. The insurer also submits that there is no basis to approve the denied treatment now, as there is no evidence that the applicant will incur it. Aviva denied the entirety of the OCF-18 dated December 8, 2020 largely on the basis of an IE report by Dr. Alborz Oshidari dated January 29, 2021 that found this treatment plan unnecessary as he concluded the applicant had reached maximum medical improvement.

[21] The applicant's medical evidence is well-founded, extensive, and ultimately persuasive with regard to the reasonable and necessary nature of these two OCF-18s. As noted above, the applicant visited his two family doctors at least 17 times between the date of the accident on October 4, 2017 and February 2021, always complaining of the same injuries and sequelae mirrored in the OCF-18s in dispute here. Both doctors also recommended continued physiotherapy on numerous occasions. In addition, the applicant reported symptom improvement and pain relief to his family doctors due to physiotherapy that he attended at Perfect Physio & Rehab Centre and Total Recovery Rehab Centre in 2017 and 2018. It is also noteworthy that the applicant reported more pain in his neck and shoulder when he stopped attending physiotherapy toward the end of 2018. It seems clear, to me at any rate, that the physiotherapy was well supported medically and that it was relieving the

applicant's pain.

[22] I also prefer the applicant's additional medical evidence in the reports of Dr. Lance Majl, neurologist, Dr. Simon Harris, orthopedic surgeon, and Dr. Thomas Steeves, neurologist. Dr. Majl documented paracervical tenderness and 20 per cent reduced range of motion in the applicant's neck, and made referrals to Dr. Harris and Dr. Steeves for follow-up examinations and testing. Dr. Harris, in his report dated September 11, 2020, diagnoses cervical strain and chronic neck pain and recommends that these conditions be managed with an active physiotherapy program. Dr. Steeves, in his interpretation of an electromyography ("EMG") nerve conduction assessment conducted on December 18, 2020, diagnoses abnormalities showing evidence for mild and chronic left C6 and C7 radiculopathies. He recommends physiotherapy. Granted, none of these reports specifically refer to the OCF-18s in dispute. However, when assessed together and alongside the CNRs of the family doctors, the medical evidence overall supports the reasonable and necessary nature of these physiotherapy plans.

[23] I am not persuaded by the argument of the respondent with regard to the November 10, 2020 OCF-18. The partial denial seems somewhat arbitrary. More importantly, this decision is not properly explained by Aviva on the Explanation of Benefits ("EOB") letter sent to the applicant on November 13, 2020, which simply lists the portions of the plan that it agrees to approve with no accompanying rationale. This is in contravention of s. 38(8) of the Schedule, which holds that "Within 10 business days after it received the treatment and assessment plan, the insurer shall give the insured person a notice that identifies the goods, services, assessments and examinations described in the treatment and assessment plan that the insurer agrees to pay for, any the insurer does not agree to pay for and the medical reasons and all the other reasons why the insurer considers any good, services, assessments and examinations, or the proposed costs of them, not to be reasonable and necessary." This invokes s. 38(11)2., which holds that the insurer failing to give notice pursuant to s. 38(8) "shall pay for all goods, services, assessments and examinations described in the treatment and assessment plan."

[24] I am similarly unpersuaded by Dr. Oshidari's report focusing on the December 8, 2020 OCF-18, largely because of inconsistencies. While Dr. Oshidari did not find evidence of significant abnormalities, or radiculopathy or myelopathy, he does note that the applicant demonstrated restricted range of motion and extension in his cervical spine, and that the applicant complained of pain throughout testing. Dr. Oshidari also remarks on significant disc degeneration, which is noted in an MRI of the applicant's cervical spine dated October 9, 2019, and even that the "sprain/strain" that the applicant experienced in the accident "exacerbated pre-existent degenerative change in the cervical spine." Despite the above, Dr. Oshidari opines in his report that the applicant has reached maximum medical improvement and that the treatment in the OCF-18 is not reasonable and necessary. Dr. Oshidari seems to base this opinion almost entirely on the self-reporting of the applicant, who allegedly told him that physiotherapy had not resulted in any functional improvements or a lessening of his pain. This is not, in my view, entirely credible, as the applicant reported the opposite to other medical practitioners and received physiotherapy referrals from his family doctors.

[25] Additionally, Dr. Oshidari somewhat contradicts himself by concluding that no "physical intervention" would be of rehabilitation benefit. I find it difficult to understand how the physician could accept the applicant's complaints of pain and even acknowledge the possible exacerbation of degenerative disc disease as a result of injuries suffered in the accident and still conclude that any sort of physical therapy would be pointless, regardless of whatever the applicant may have said to him. In the end, I find the Dr. Oshidari report to be an outlier in comparison with the medical evidence produced by the applicant.

[26] I do not agree with the respondent's argument that there would be no point awarding the applicant with

these treatment plans, as there is no evidence that he would return to Canada from China to avail himself of them. The applicant's residency status has no bearing on the dispute before me.

Fang v Aviva Insurance Company of Canada, 2023 CanLII 19847 (ON LAT), <https://canlii.ca/t/jw6b7

[16] Aviva relies on the report of its s. 44 insurer examination (IE) assessor, orthopaedic surgeon, Dr. Oshidari, who opined that objective testing failed to reveal any structural or physiological abnormality to account for the limitation of function. Dr. Oshidari noted that CPF's presentation at the assessment was disproportionate to the nature of the accident. Dr. Oshidari noted that, based on CPF's own statement there is no impairment, concluding that as there is no impairment, he was not able to put any physical or medical restriction upon CPF.

[17] Aviva also relies on the June 5, 2019 neurology report of Dr. Yufe, who opined that there was no neurological basis for CPF's complaints. I place less weight on Dr. Yufe's report, because he indicates that CPF suffers from chronic neck pain and low back but does not find that the March 2019 OCF-18 is reasonable and necessary.

[18] I find Dr. Oshidari and Dr. Yufe's reports to be conflicting. While Dr. Oshidari finds that CPF does not suffer any impairments, Dr. Yufe determines that CPF has chronic pain. Despite the chronic pain diagnosis, Dr. Yufe concludes the March 2019 OCF-18 is not reasonable and necessary. Lastly, Aviva denied the September 2019 treatment plan, although there is no objective opinion from its assessors that considered the September 2019 OCF-18. Given the consumer protection nature of the Schedule, where the IE reports conflict, or where there is no basis given for a denial by way of an opinion from an IE assessor, I find that my determination should be made in favour of CPF.

Ferlisi v Allstate Insurance Company of Canada, 2022 CanLII 81521 (ON LAT), <https://canlii.ca/t/jrtcx

[13] The respondent relied on the testimony and report of Dr. Oshidari. He testified that the appropriate methodology for assessing the applicant's gait was with the SCS turned on. Chapter 3.2b of the AMA Guides states that the ratings in Table 36 are for full-time derangements of persons who are dependent on assistive devices. He was asked about the recommendation in chapter 2 of the AMA Guides that the evaluation should be done without the prosthesis if it can be removed easily. He testified that it cannot be removed because it is surgically implanted. He drew an analogy between a hip replacement and a pacemaker where neither can be removed because they are surgically implanted like the applicant's SCS. When asked about turning off the SCS, Dr. Oshidari testified that the AMA Guides say nothing about the prosthesis being stopped, only removed. He testified that because the SCS is implanted it cannot be easily removed and the AMA Guides do not say the prostheses should be turned off.

[14] According to Dr. Oshidari, turning off the SCS is not the same as eliminating the use of the SCS. Dr. Oshidari explained that this is because the SCS is a neuroprosthesis. He testified that the AMA Guides were issued prior to neuroprosthesis being used.

[15] The respondent submitted that Dr. Oshidari's interpretation is more in keeping with the AMA Guides because they recommend assessment of a permanent impairment or an impairment that is stable. Similarly, the respondent further submitted that the applicant should be assessed in the state she is in most of the time (e.g.

with the SCS on) because the AMA Guides requires assessors to conduct the assessment when the patient's impairments are permanent and stable.

[16] For the reasons that follow, I am not persuaded by the respondent's position.

[17] Dr. Oshidari's opinion ignores that the AMA Guides were adopted into the Schedule in 2010 and again in the 2016 revision, well after neuroprosthesis were being used. I find that the wording of the AMA Guides is broad enough to include new technology. Otherwise, it would explicitly reject prostheses invented after a certain period of time.

[18] Dr. Oshidari's interpretation of the "elimination of use" in the AMA Guides is too narrow. Short of surgical removal, the first thought for eliminating the use of a device is to turn it off. I find Dr. Oshidari's understanding of how an assessment is to be conducted when there is a neurological prosthesis like the applicant's ignores the AMA Guides' wording. I find the plain and ordinary meaning of the wording in the AMA Guides, "removed or its use eliminated relatively easily," includes the stoppage of the use of the device. Eliminating the use of a device can be done by turning it off.

[19] The applicant can turn her SCS on or off with a remote control. In fact, it has been turned off without her knowledge by other electronic devices such as a cell phone or security sensors in stores. It has also stopped working when her battery has run out. The fact that the SCS may stop working at times is even more reason to assess the applicant without the SCS.

[20] A further reason for rejecting Dr. Oshidari's opinion is that, unlike a pacemaker, the applicant does not risk death when the SCS is turned off. What occurs is that her extreme pain levels return when the SCS is turned off. By including the language of easy elimination of the use of the prosthesis, I conclude that the authors of the AMA Guides contemplated those situations exactly like this one, where the prosthesis cannot be removed, but its effects can be stopped without risking the overall health of the person being examined.

[21] I disagree with the respondent's argument about assessing an impairment that is permanent or stable in this context. The Schedule does not require an impairment to be stable if two years have passed. I fail to see how the timing of the assessment based on stability informs whether it is easy or difficult to remove the prosthesis or whether it is easy or difficult to turn it off or on. What is relevant for the applicant's situation is whether the use or effect of the SCS can easily be eliminated or stopped. The applicant is able to easily eliminate the effect of the SCS by turning it off with her remote control.

[22] In conclusion, I find that the meaning of the direction in the AMA Guides to assess a person without the prosthesis when its use can be easily eliminated is plain and clear. The use of the SCS is easily eliminated when it is turned off. According to the AMA Guides, this means the applicant should have been assessed with the SCS turned off.

B. Whether the Applicant Requires One Cane or More

[23] Under Table 36 of chapter 3 of the AMA Guides, a 20% WPI requires routine use of a cane, crutch, or a long leg brace (knee ankle-foot orthosis). A 30% WPI requires routine use of a cane or crutch and a short leg brace. A 40% WPI requires routine use of two canes.

[24] The applicant relied on the report of Dr. Sharma, who testified that she asked the applicant to turn off her SCS. Once she did so, the applicant could not put her left foot on the ground. Dr. Sharma testified that it would be impossible for the applicant to walk any distance with just the use of one cane.

[25] The respondent submitted that I should give less weight to Dr. Sharma's evidence and more weight to Dr. Oshidari's evidence for the following reasons. Dr. Sharma is not as experienced as Dr. Oshidari. Dr. Sharma's specialty as listed on the College of Physicians and Surgeons of Ontario ("CPSO") website is as an emergency physician. She is not a specialist in rehabilitation medicine like Dr. Oshidari. Dr. Sharma testified that she was initially recognised as a specialist in emergency medicine, but that she has since complied with the requirements for a specialist in pain management. However, this does not show up on the CPSO website because she was originally listed as an emergency physician. I have no reason to disbelieve her and accepted that she is an expert in pain management.

[26] The respondent submitted that Dr. Sharma's evidence left something to be desired, but it did not submit what that was. Dr. Sharma works at the DeGroot Pain Clinic at McMaster University Hospital. She has referred a number of her patients for SCS implants and treats a number of patients with reflex sympathetic dystrophy (RSD). The respondent submitted that I should give more weight to Dr. Oshidari as he has been accepted by the Tribunal as an expert before. However, so has Dr. Sharma. The respondent also submitted that Dr. Sharma believed the applicant had four surgeries with her SCS when she only had three. However, I find that the applicant has had four surgeries: the first was her initial trial of the SCS; the second was just over a month later on October 16, 2017 when the battery was implanted;[5] the third on April 19, 2017 when it was repositioned; and the fourth was another repositioning of her battery. Accordingly, Dr. Sharma was correct.

[27] Dr. Oshidari did not assess the applicant with her SCS turned off as he thought it would be unethical to ask her to turn it off because it would cause her a great deal of pain. He relied on the applicant's report to him that she requires the use of a cane when her SCS is turned off. He therefore assigned her a 20% WPI for her gait derangement. Accordingly, I find that Dr. Oshidari did not assess the applicant's gait derangement with her SCS off but assigned a gait derangement for the applicant as if her SCS was off and utilized that rating for the combined WPI%.

[28] The respondent submitted that I should prefer Dr. Oshidari's 20% WPI for a gait derangement over Dr. Sharma's 40% WPI because of surveillance evidence and the medical records show that the applicant advised various assessors and treatment providers that, prior to having the SCS inserted, she was able to walk with one cane. At a functional capacity assessment conducted in December 2015, the applicant was able to walk 600 ft with her cane.[6] However, the applicant testified that she was in extreme pain doing so, that she had to walk on tiptoe on her left foot while using the cane and that she could not walk without the cane. She also testified that her CRPS has become worse since December 2016 as it went untreated for too long.

Barrett v Aviva Gen. Ins, 2022 CanLII 8670 (ON LAT), <https://canlii.ca/t/jmd8g

[10] I agree with the applicant that pain relief has been accepted as a legitimate goal for treatment and that additional facility-based treatment like that proposed in the OCF-18 was recommended by both Dr. Kwong and Dr. Chivers and again by Dr. Pivtoran, even after a denial based on Dr. Oshidari's report. It is clear on the evidence that the applicant continued to experience pain as a result of the fracture and shoulder impairment that he suffered in

2014, as the clinical notes reveal ongoing complaints into 2020, or over six years post-accident. On this evidence, and on a balance of probabilities, it is difficult to find (even if it was not provided to Aviva at the time) that the treatment plan in the relatively modest amount of $2,212 was not a reasonable expense to potentially alleviate years of ongoing pain, even if the applicant was able to continue working as a welder during this period. While I also accept that the applicant's pain may be exacerbated by his work as a welder, I do not find that this renders the goals of the OCF-18 (decreasing pain, increasing range of motion, increasing function, etc.) unreasonable or unachievable.

[11] I note that the applicant received treatment to date from the same provider, a fact echoed in Dr. Oshidari's report, and it does not appear that the treatment proposed in the OCF-18 was incurred, nor has the applicant undergone any treatment since, as Aviva submits that the balance at the clinic is zero. In this vein, I appreciate Dr. Oshidari's opinion that further treatment of a similar nature from the same provider would not be reasonable. However, where the applicant continued to have pain over six years post-accident, in my view, it undermines Dr. Oshidari's belief that his accident-related impairments had resolved. In turn, I assign Dr. Oshidari's report less weight than the contemporaneous recommendations of Dr. Kwong and Dr. Chivers and find that the OCF-18 in dispute is reasonable and necessary up to the amount proposed and on receipt of evidence of incurred treatment. Interest applies on any overdue amounts incurred under s. 51.

Thiruchelvam v. RBC General Insurance Company, 2022 ONSC 554 (CanLII), <https://canlii.ca/t/jm1vb

[14] The Arbitrator turned her attention to the evidence presented by RBC General Insurance Company. It was essentially one report, albeit a multidisciplinary report prepared under the guidance of Dr Alborz Oshidari, a physiatrist (who specializes in physical medicine and rehabilitation) with Dr. Karen Wiseman, a psychologist and Laura Youm, an occupational therapist. It is dated July 7, 2016. This report expressed the opinion that Stalin Thiruchelvam did not sustain catastrophic impairment as a result of the motor vehicle accident of September 4, 2013. Based on the physical injuries suffered by Stalin Thiruchelvam in relation to the accident of September 4, 2013, Dr Oshidari concluded that he sustained 0% impairment of the whole person (whole person impairment (WPI) of 0%)[28]. The Arbitrator was puzzled by the approach taken by Dr. Oshidari:

Dr. Oshidari, after noting a number of physical weaknesses, stated that "there were numerous findings which cannot be explained by specific neuromusculoskeletal abnormality. Therefore, in relation to the 2013 motor vehicle accident there is no impairment." This statement is puzzling, as Dr. Oshidari seems to suggest that *only* neuromusculoskeletal abnormalities can cause impairment. Dr. Oshidari had previously said "there is no diagnosis of pain disorder associated with both psychological factors and the general medical condition… Any abnormality or limitation of function is due to long-standing pre-existing condition." This comment is contradicted by the Omega report, which was delivered some weeks after his report and did find psychological impairment.[29]

[28] The reference in this 2007 report to "low marked range" was referred to by the Director's Delegate when he determined that at the time of the accident of September 4, 2013 Stalin Thiruchelvam was already catastrophically impaired:

As the Arbitrator noted, in the domain of Adaption, at most his impairment *had moved from a low marked range to a higher marked range*, simply getting him closer to Extreme. But it cannot be said that this made him more catastrophically impaired, which is in effect what the Arbitrator found.[49]

[Emphasis added]

[29] This conclusion takes no note of what happened in the intervening years. It takes no account of the multidisciplinary report prepared by Dr. Oshidari, Dr. Wiseman and Laura Youm which found that Stalin Thiruchelvam has never been catastrophically impaired. It makes no reference to the improvement referred to by Stalin Thiruchelvam in his testimony and the notes of Dr. Maselle Virey. It ignores the finding of various experts that the catastrophic impairment of Stalin Thiruchelvam was the result of all three of the accidents: March 16, 2002, March 23, 2002, and September 4, 2013. I point out that among those who came to this conclusion are the two authors of the 2007 Psychological Legal Report (Drs. Levitt and Kaplan). For the application for the recognition of Stalin Thiruchelvam as catastrophically impaired made in 2014 (OCF-19) they updated their report and included that finding.[50] There was evidence that just prior to the accident of September 4, 2013 his condition had improved.

[30] There has never been a finding identifying that Stalin Thiruchelvam was catastrophically impaired at any time prior to the accident of September 4, 2013. Nor does the evidence suggest that he necessarily would have qualified to be so identified. The limitation of the appeal to issues of law means that it was not proper for the Director's Delegate to conclude that he was. The Arbitrator did not make that finding. Her decision recognized that the process had not been engaged and no determination that Stalin Thiruchelvam was catastrophically impaired had been made. She approached the matter differently. She was concerned with any change caused by the accident of September 4, 2013. The operative issue is whether in approaching the matter in this way she used the right test. The difficulty is that, not content to examine the test she used, the Director's Delegate went further and applied the test he believed to be the correct one. The finding that Stalin Thiruchelvam was already catastrophically impaired is critical to his application of that test. If, just prior to the accident of September 4, 2013 he was already catastrophically impaired the application of the "but for test" (but for the accident he would not have been catastrophically impaired) would have demonstrated that the September 4, 2013 accident was not the cause of his catastrophic impairment. But if he was not catastrophically impaired or if it is not possible to determine if he qualified to be so found, the use of the "but for" test cannot lead to a definitive answer. It would be possible to determine that he was catastrophically impaired but not to decide when Stalin Thiruchelvam crossed that threshold, particularly whether he had crossed it prior to September 4, 2013 and given the improvement he showed in the weeks leading up to that date whether he remained on the side of the threshold that qualified him to be so found.

Feletig v Oshidari, 2021 CanLII 125681 (ON HPARB), <https://canlii.ca/t/jl55f

The Applicant's Submissions

17. The Applicant submitted to the Board that she never consented to the release of her medical information, and submitted that she did not have the capacity to sign the consent due to her concussion. The Applicant also submitted that, having read the Respondent's report, personal health information of her son was also released without his consent. The Applicant explained that there were a number of references to her son's health within the report, and submitted that this was very concerning and she did not understand how the Respondent obtained information about her son. The Applicant noted that the College had recently updated its regulations for physicians on consent, and stated that she was happy to see those changes. The Applicant submitted however that she felt her human rights have been breached as a result of the release of her personal health information.

18. A focus of the Applicant's submissions was that there were multiple inaccuracies in the Respondent's written report. The Applicant stated that the report contained errors and she provided the Board with details of her concerns, including the following summarized examples:

- the Respondent mentioned a previous head injury but she had never had a previous head injury;
- the Respondent did not consider her sleep patterns, which were all a result of her concussion, and did not say enough about her chronic-post concussion headaches;
- the Respondent wrote about a pre-existing hearing loss, but not about her hearing issues due to the accident;
- the Respondent stated her medical file indicated that she was able to drive home following the accident and did not vomit but that was not true, she was shocked and confused, and it was the police that told her to get back in her car; and
- the Respondent never wrote anything about her physiotherapy, or mention that she had an MRI, but he did write about things that occurred 20 years before the accident.

19. The Applicant also submitted that she had no idea there would be a paper report, and that she never received a copy of the paper report. The Applicant stated that she was not surprised a copy was never sent to her, because when she finally read the report, she saw it was full of inaccuracies and false statements.

The Committee's Decision

32. The Committee addressed the two areas of concern in the Applicant's complaint, that the Respondent conducted a paper review, and that he wrote a report without the Applicant's consent.

33. The Committee stated that it was up to the insurance company to obtain signed permission from the insured [the Applicant] to review the files and provide an assessment. The Committee noted that in this case, the medical record demonstrated that the Applicant did sign a consent giving the insurance company permission to obtain any documentation or report required to assess the Applicant's claim.

34. The Committee also addressed the concern that the Respondent failed to notify the Applicant prior to conducting a paper review. The Committee stated that it is up to the insurance company to notify the insured [the Applicant] of any assessments required, and the signed Application for Accident Benefits Form (OFC-1) allowed the insurer to release personal information to healthcare professionals.

35. The Committee determined that it was satisfied that it was appropriate for the Respondent to review the documentation and make recommendations regarding further assessments.

The Board's Analysis

36. As noted above, the Applicant made submissions related to consent for the paper report and that she had not received a copy of the Respondent's report. Counsel for the Respondent submitted that the decision was reasonable.

37. The Board has considered the submissions and the information in the Record, and finds that the Committee's decision to take no further action on the concerns raised in the Applicant's complaint is reasonable.

38. The Board finds that the Committee's conclusions were supported by the information in the Record.

39. The Board notes that the Committee made specific reference to information in the Record in reaching its decision. This included considering the Respondent's explanation of the insurance company's process of obtaining consent from the insured and of notifying the insured about any assessments. The Committee also relied on the signed OCF -1 form contained in the Record, which included the Applicant's acknowledgment that her health information could be shared. The Board concludes that it was reasonable for the Committee to rely on this information and determine that it was up to the insurance company to obtain consent and notify the Applicant regarding assessments.

Decision No. 180/21, 2021 ONWSIAT 1844 (CanLII), <https://canlii.ca/t/jlvds

[40] Fourth, we acknowledge that the employer representative submitted in written submissions dated July 26, 2021, that "Dr. Oshidari's opinion on the connection between the osteoarthritis and other pathology demonstrated on the MRI should be given, little, if any, weight" because the opinion was "vague and not supported by objective medical evidence or any explanation" and was based on "an incorrect understanding of the patient's medical history".

[41] The Panel, however, places significant weight on the opinion of Dr. Oshidari for the following reasons. We note that Dr. Oshidari considered the diagnostic reporting before him, ie. the MRI of the left knee, dated November 6, 2013, which Dr. Oshidari noted showed "moderate to severe three compartment osteoarthrosis. […]" and "incomplete radial tear of the posterior root insertion medial meniscus with associated peripheral meniscal extrusion". We also see that Dr. Oshidari physically examined the worker. On the basis of Dr. Oshidari's review of the MRI reporting and physical examination of the worker, the Panel concludes that Dr. Oshidari's report was based on objective medical evidence.

[42] The employer's representative submitted that Dr. Oshidari's report was based on an "incorrect understanding of the worker's medical history" which did not consider that the worker "did not have any discomfort or pain in the left knee prior to the accident" whereas the March 2010 chart entry indicated that the worker "complained of knee and back pain secondary to increased weight" and the consultation report of January 4, 2012 which noted that there was a long discussion about the role that the worker's "significant obesity may be playing in her joint pain". The Panel, however, was led to a different conclusion for the following reasons. Although we are aware that Dr. Oshidari reported that the worker told Dr. Oshidari that the worker "did not have any discomfort and pain in the left knee prior to the accident" and

Dr. Oshidari referred to the arthritis changes in the left knee being longstanding, we do not find that this reporting is inconsistent with the worker testifying at the hearing to having the usual aches and pains. We find it significant that prior to the workplace accident the worker was able to perform her work duties with these usual aches and pains but after the April, 2013 workplace accident was not able to.

[43] We are further aware that the employer representative submitted that Dr. Oshidari adopted a "somehow theory" and submitted that "I suspect the only reason he [Dr. Oshidari] is advocating for his patient is because she told him she had no symptoms before April 2013". However, in this regard we were led to a different conclusion. We find that the evidence before us, including the worker's testimony, demonstrated that the worker had not previously had pain in her left knee which limited her ability to walk and required her to self-modify

modified duties by taking breaks and sitting down.

[44] In addition, we are aware that the employer representative submitted, in written submissions dated July 26, 2021, that there was "no other medical evidence or opinion that supports the April 3, 2013 incident in any way aggravated or enhanced the underlying pathology". Significantly, however, the Panel, notes that there was a second medical opinion, referred to above from Dr. Gordon, dated February 18, 2014, that the April, 2013 incident "aggravated a pre-existing condition". We see in Dr. Gordon's opinion that he noted that at the time of his examination of the worker "said that she was in excruciating pain and had difficulty walking and doing stairs".

[45] Finally, we note that there was no significant other medical evidence before us regarding the compatibility of the diagnosis of the worker's osteoarthritis being attributable to any other cause than by the April, 2013 workplace accident.

[46] In sum, for the foregoing reasons, we find that the worker has entitlement for her left knee injury from the April, 2013 workplace accident.

P.P. v Wawanesa Mutual Insurance Company, 2021 CanLII 60480 (ON LAT), <https://canlii.ca/t/jgwgk

[21] The Applicant relies on *Bains* and related cases for the proposition that future surgery should be considered in assigning a WPI. With respect, the Applicant has completely misconstrued the reasoning in *Bains*. *Bains* deals with an applicant who met the test for catastrophic impairment. The insurance company argued that future surgery was likely to remediate Ms. Bains condition so that she would no longer meet the test. The Director's Delegate was critical of the insurer's expert witness, Dr. Oshidari, who testified that, only once all future surgery was completed and a period of rehabilitation had passed, could an assessment of catastrophic impairment be completed. The Director's Delegate rejected that approach, as do I.

S.W. v. Aviva Insurance Company, 2021 CanLII 18930 (ON LAT), <https://canlii.ca/t/jdpx8

[10] In the Original Decision, I concluded at paragraph 18 that:

the applicant continued with physiotherapy until May 2018, at which point these services were no longer approved by the respondent. This longstanding reliance on physical therapy not only speaks to its efficacy at dealing with her condition, but—as detailed in the assessment with [the respondent's psychological assessor, Dr. Monique Costa El-Hage—the applicant's pain worsened after she stopped receiving this treatment. Therefore, while Dr. Oshidari may have concluded that physical therapy would no longer be of assistance, this timeline of recovery and subsequent deterioration suggests otherwise.

[11] The respondent took issue with this finding for two reasons. First, by pointing to references in assessments with the applicant from 2019, it argued that she did, in fact, continue with physical therapy after May 2018. According to the respondent, if this error had not been made, the Tribunal would have had no reason to then disregard the opinion of Dr. Oshidari. The respondent also submitted that I erred in concluding the applicant ceased this physical therapy due to its denial of this funding. The respondent argued that I ignored how the applicant discontinued this therapy "voluntarily" and, had I not made this error, I would have reached a different conclusion.

Dr. Oshidari's Expert Reports

[23] The respondent also claims that I did not "consider" the paper review of Dr. Oshidari (dated August 8, 2019) in the Original Decision, a failure that amounts to "a violation of procedural fairness." The respondent then claims that "[t]he Tribunal had criticized Dr. Oshidari's report, on the basis that it ran contrary to the Applicant's timeline of recovery and subsequent deterioration." I believe this second argument relates to Dr. Oshidari's initial report (dated May 8, 2019).

[24] First, I do not find merit in the argument that I breached the respondent's right to procedural fairness, as this paper review was referenced in the Original Decision (albeit when summarizing the parties' positions on the evidence):

Then, in regard to the chronic pain treatment, the applicant submitted that not only would it assist with this longstanding issue, but the paper review conducted for the respondent by Dr. Oshidari is flawed (dated August 8, 2019). That is, Dr. Oshidari allegedly failed to consider the clinical notes of the applicant's physician, as well as the "ultra sound findings of Dr. Gofeld" (namely, the findings of supraspinatus and labral tears).[7]

While the Original Decision did not specifically reference the conclusions made in this paper review, it cannot be said that it was not considered in my deliberations.

[25] Then, concerning the claim that I incorrectly analyzed Dr. Oshidari's initial expert report, the respondent may disagree with my findings on this point, but a reconsideration will not be granted on the sole basis of a disagreement with a factual finding that is based on a weighing of the evidence.

Walcott v Aviva General Insurance, 2021 CanLII 13208 (ON LAT), <https://canlii.ca/t/jddh3

[28] The respondent also relies on a physiatry paper review report prepared by Dr. Oshidari, dated September 18, 2019.[9] He reviewed the February 2017 physiatry and psychiatry insurer assessments, multiple treatment plans submitted by Dr. Mahendranathan, and a disability certificate dated February 3, 2016.
Dr. Oshidari concluded that it was unlikely that the applicant would reach catastrophic impairment from a physical perspective, and although there were reports of psychological difficulty, she was able to resume her vocational activities in 2017.

[29] The applicant submits that Dr. Oshidari's report should be excluded on the basis that it was not fair, objective, and non-partisan, and outside of his area of expertise. While I decline to exclude the report, I do not find Dr. Oshidari's report persuasive, given the limited and outdated information he reviewed in preparing his opinion. The respondent did not obtain an assessment from a psychological perspective.

K.K. v Aviva General Insurance, 2020 CanLII 87927 (ON LAT), <https://canlii.ca/t/jblpg

[46] The applicant was denied ongoing IRBs after September 27, 2017 on the basis of a Multi-Disciplinary Report dated September 14, 2017[33]. This report consisted of a physiatry assessment of Dr. Alborz Oshidari, a psychology and a neuro-psychology assessment of Dr. Christopher Hope and a functional capacity evaluation by occupational therapist Brenda O'Grady.

[47] I also give little weight to this report. In his physiatry assessment, Dr. Oshidari was unable to detect any organic cause for the applicant's physical limitations. His opinion that the applicant did not suffer from a substantial inability to perform his pre-accident employment of a taxi driver does not account for any psychological impairment the applicant sustained in the accident. Dr. Oshidari found that the applicant appeared to be in a moderate degree of psychological distress as the encounter was dominated by pain-focused and self-limiting behaviour.

S. K. v Aviva General Insurance, 2020 CanLII 126933 (ON LAT), <https://canlii.ca/t/j97mm

[14] The applicant argued that the denial of these benefits was based on faulty assessments from Drs. Steve Barker and Alborz Oshidari (reports dated August 30, 2016 and August 1, 2018, respectively). Specifically, she alleged that these assessors did not consider recommendations from her family physician, nor did Dr. Oshidari turn his mind to an addendum report from her chiropractor, Dr. Paul Bruni (addendum dated July 30, 2018). Finally, the applicant cited progress reports from her treating clinic, East Sheppard Rehabilitation Clinic, to demonstrate that her physical condition has improved with this care.

[32] I also note that I do not accept the warning Dr. Oshidari provided in his addendum report (dated September 14, 2018). Specifically, in recommending that the respondent not fund this plan, Dr. Oshidari cautioned that the assessment could "reinforce maladaptive behaviour." I do not share this concern, as I fail to see how further investigation into the causes of—and potential treatment options for—addressing this pain would stymie any progress made to date. Instead, the applicant's inability to overcome this pain after years of therapy needs to be better understood, and I am satisfied that this assessment will help.

A1802133 (Re), 2020 CanLII 47639 (BC WCAT), <https://canlii.ca/t/j8p27

[34] In support of its appeal, the employer submits an October 10, 2018 report from Dr. Oshidari, a physiatrist licensed in another province. Dr. Oshidari did not examine the worker, but reviewed certain documents. He had never seen CRPS that affected three limbs. It was very difficult to diagnose CRPS in this case. The worker's bone scan did not confirm the condition and there were no major dystrophic changes to suggest she had CRPS type 2. There was good potential of some psychological component playing a major role in the worker's physical condition and functional limitations. Dr. Oshidari suggested further investigations, and deferred his opinion.

[64] The worker's lower limb symptoms were first documented on October 11, 2018, by the treating physiotherapist, and not long afterwards Dr. Montgomery queried whether the worker was developing a central sensitisation. There is a question in this case as to whether the worker was simply predisposed to developing CRPS at that time, independent of her workplace injuries from months earlier. Such a conclusion may well be consistent with Dr. Oshidari's experience over 23 years of not having once encountered a case of CRPS that affected three limbs.

[65] However, Dr. Oshidari's experience differs from the experiences of other physicians, whose findings have been documented in the medical literature cited by Dr. Chapman. More importantly, it differs from the experience of Dr. Van Oostrom, who in his January 2018 report, wrote, "We sometimes do see CRPS spreading to all 4 limbs." This anecdotal evidence is consistent with the medical literature reports, and undermines the weight I can give to Dr. Oshidari's opinion.

S.W. v Aviva General Insurance, 2020 CanLII 34434 (ON LAT), <https://canlii.ca/t/j7t1d

[18] Moving on to the question of whether the proposed treatment will assist with this impairment, I find that [S.W.] continued with physiotherapy until May 2018, at which point these services were no longer approved by the respondent. This longstanding reliance on physical therapy not only speaks to its efficacy at dealing with her condition, but—as detailed in the assessment with Dr. El-Hage—[S.W.]'s pain worsened after she stopped receiving this treatment. Therefore, while Dr. Oshidari may have concluded that physical therapy would no longer be of assistance, this timeline of recovery and subsequent deterioration suggests otherwise.

[19] Taken together, I am satisfied that both treatment plans are reasonable and necessary to assist [S.W.] with accident-related pain.

[34] [S.W.] submitted that the chronic pain assessment should have been approved, as she continues to experience intense pain. Then, in regard to the chronic pain treatment, [S.W.] submitted that not only would it assist with this longstanding issue, but the paper review conducted for the respondent by Dr. Oshidari is flawed (dated August 8, 2019). That is, Dr. Oshidari allegedly failed to consider the clinical notes of [S.W.]'s physician, as well as the "ultra sound findings of Dr. Gofeld" (namely, the findings of supraspinatus and labral tears).

17-008840 v. Aviva General Insurance, 2019 CanLII 58150 (ON LAT), <https://canlii.ca/t/j163s

[11] I prefer Dr. Karmy's report over the reports of the insurer's examiners. Dr. Karmy examined the applicant, noted her complaints of pain, and provided a treatment plan that addresses her complaints. While he only reviewed the disability certificate (and a treatment plan for passive therapies), his findings are supported by the medical records from the Prime Health Care clinic where she was receiving treatment, and the early notes from the family physician. In contrast, despite having the records from the Prime Health Care clinic noting regular visits for treatment, in the absence of any specific neuromuscular abnormality, Dr. Oshidari attributed her restricted range of motion to a perception of causing harm or expectation of experiencing pain, but not actual pain. Further, despite having reviewed Dr. Karmy's report, Dr. Oshidari does not refer to it or comment on it in his conclusions.

18-000456 v Aviva Insurance Canada, 2018 CanLII 130867 (ON LAT), <https://canlii.ca/t/hxfcr

[23] Dr. Oshidari conducted the other IE and drafted a multidisciplinary report dated March 6, 2018. He found the applicant had reached maximal medical recovery from a physical standpoint in relation to the 2016 Accident related injuries. Dr. Oshidari found that the applicant's recent weight gain was the cause of the back issues and nerve issues. He recommended an exercise program to address the applicant's weight. In addition, Dr. Oshidari found that the applicant no longer had any impairment related to the 2016 Accident.

[24] I give little weight to Dr. Oshidari's report as it relates to the applicant's entitlement to a chronic pain Treatment Plan. Dr. Oshidari's report was mostly a copy and paste of an earlier report on June 20, 2017. It was light on details and not well developed. For example, he notes that applicant has gained weight and puts in brackets "(not related to Accident)". Dr. Oshidari does not explain why he believes the weight gain is not related to the applicant's symptoms nor what information he relied on to reach that conclusion. Dr. Oshidari also suggested the applicant simply needs a gym membership to address his weight which would presumably address his ongoing

pain symptoms. However, the applicant had already stated to Dr. Brown that he was unable to go to the gym as a result of his chronic pain caused by the 2016 Accident.

[25] I prefer the report of Dr. Brown which is more detailed, thorough and provides explanation for the findings made over the report of Dr. Oshidari.

R.D. v Aviva Insurance Canada, 2018 CanLII 140988 (ON LAT), <https://canlii.ca/t/j067n

[62] I also give little weight to the opinion of Dr. Oshidari[40] that the assessment was not reasonable because the applicant's limitation was due to a pre-accident medical condition for the reason that I am satisfied that the accident exacerbated the applicant's pre-existing condition and in February 2015 it was reasonable that he be assessed.

[79] Aviva denied the plan and required an IE. As previously stated the applicant initially refused to attend an IE with a physiatrist and only attended
after the Aviva brought a motion to bar him from proceeding with his application for this benefit. The applicant attended an IE with physiatrist Dr. Oshidari 18 months after the treatment plan was submitted who provided the opinion that a kinesiology assessment was not reasonable or necessary.

[80] Aviva also argues that this benefit is not reasonable and necessary because there is no link between the assessment and a benefit claimed for the reason that the applicant made no claim for Income Replacement Benefits or Attendant Care benefits.

[81] The applicant argues that the written report of Dr. Oshidari lacks credibility because of a critical newspaper article[55] about investigations by the Ontario College of Physicians and Surgeons into his behaviour.

[82] I am not satisfied that the applicant has met his burden of proof with respect to this treatment plan for the following reasons:

i. In the treatment plan (dated over two years after the accident) Dr. Goldhawk does not recognize that prior to the accident the applicant had an existing condition that could affect his response to treatment.

ii. Dr. Goldhawk indicates that the applicant's employer was not able to provide suitable modified employment for the applicant. This is contrary to the evidence of the applicant that he has modified his work
tasks to accommodate his physical issues.

iii. Dr. Goldhawk testified that had she known that the applicant had returned to full-time work at the time of her assessment she would not have proposed this plan.

[83] In reaching this conclusion I do not rely on the IE of Dr. Oshidari which the applicant vehemently objects to arguing his report is not credible. I will add, however, that Dr. Oshidari was not called by either party as a witness and he has not been made aware that his credibility was going to be impugned and provided the opportunity to respond.

17-004679 v RBC Insurance Company, 2018 CanLII 110939 (ON LAT), <https://canlii.ca/t/hw6vz

[22] The respondent's denial of the benefits requested are based upon two insurance examinations conducted by Dr. Oshidari. The first one Mr. Trowsdale attended and the report was issued on July 4th, 2015, and the second a paper review, the report was issued on December 28th, 2016.

July 4th, 2015 report

[23] Dr. Oshidari found that the applicant has no physical impairment as it related to the accident, but concludes that the applicant could benefit from a self-directed community Aquatic Therapy program.

[24] In addition, the applicant in response to Dr. Oshidari's questioning stated he continued to suffer from neck pain and back pain. However, Dr. Oshidari states that today when I asked him if there is any further discomfort and pain he reported no". These statements are in the Present Complaints and Symptoms section of this report.

[25] Within the report's Functional Status section the above the narrative of pain disclosed by the applicant, Dr. Oshidari states pain is not referenced. Dr. Oshidari then concludes "he (Mr. Trowsdale, the applicant) is able to perform his house chore duty, but he is not as good as before".

[26] Dr. Oshidari concluded that in his opinion the OCF 18 dated May 6th, 2015 proposed for non-complicated soft tissue injury approximately 8 years post-accident is not reasonable or necessary.

[27] Dr. Oshidari also indicates no pre-existing injury from a Physiatry perspective. Based on this conclusion, he opines that no additional treatment is needed for the applicant.

December 28th 2016 Report (paper review)

[28] Dr. Oshidari in this report states that the CT scan of the cervical spine dated December 11, 2007 shows extensive spinal disease but no evidence of spinal fracture or trauma. He also notes in relation to the lumbar spine the L3 spinous process is displaced to the left of midline.

[29] He concludes that "Based on review of documentation, there was some traumatic brain event due to the motor vehicle accident following some behaviour and drug seeking approach in the past". However, Dr. Oshidari then concludes that the treatment plan in dispute for multidisciplinary assessment is not reasonable and necessary.

[30] The respondent has relied upon both Dr. Oshidari's reports to deny the treatment plans and chronic pain assessment.

CONCLUSION

[31] Based upon the evidence above the tribunal concludes that the applicant was in a motor vehicle accident which resulted in the applicant suffering the impairments of neck and lower back pain which the applicant continues to suffer 7-9 years after the accident.

[32] The ambulance report and hospital records provided by the applicant showed impairments which resulted in neck and lower back pain arising from the accident. The CT scan immediately after the accident as acknowledged by Dr. Oshidari indicated extensive spinal disc disease in the neck area, which pre-exists the accident. The CT scan also shows a displacement of the lumbar spine at the L3 spinous process left of the midline.

[33] The extensive spinal disc disease is therefore pre-existing and the displacement is directly linked to the accident. It is therefore reasonable that the neck and lower back pain are impairments arising from the accident

and still being suffered by the Applicant which over 9 years after the accident have become chronic in nature. This finding contradicts the respondent's assertion that these impairments are as a result of the drug overdose and assault suffered by the Applicant within days of the accident.

[34] Dr. Oshidari appears to acknowledge but then ignore the pre-existing extensive spinal disease and then either ignores the applicant's complaints or place a high regard to the applicant's failure in his estimation to convey facts about the overdoses and assault he suffered post-accident, in discounting the validity of the applicant's complaints.

[35] The tribunal finds based upon the applicant's medical evidence before it, which confirms that over 8 years after the accident the applicant continues to suffer neck and lower back pain which are respectively linked to the pre-existing extensive spinal disc disease and the displacement in the lower spine which are identified immediately after the accident and therefore these impairments are causally linked to the accident.

17-003450 v Aviva Insurance Canada, 2018 CanLII 95564 (ON LAT), <https://canlii.ca/t/hvj9b

[18] Turning to the respondent's evidence, I begin by noting that it did not dissuade me from my findings. The respondent's evidence focuses on the paper review of Dr. Oshidari, a physiatrist. As a whole, I find Dr. Oshidari's report does note the various physical issues and complaints similarly to the applicant's submissions and evidence. When taken in its entirety, I find the report further outlines the physical injuries the applicant suffered or that were exacerbated from the previous motor vehicle accident. However, where Dr. Oshidari differs is in his views of the most reasonable path forward. He does not believe a physical assessment for the chronic nature of these issues and complaints is reasonable and necessary, but rather that further psychological treatment alone can resolve said issues.

[19] I give less weight to the report of Dr. Oshidari because he clearly states that without a direct assessment he is unable to answer some key questions which I feel go directly to the dispute. For instance, Dr. Oshidari was unable to answer whether or not the applicant sustained impairment as a direct result of the subject motor vehicle accident. I find that being able to address this amongst other questions would have added weight to the opinions and conclusions of Dr. Oshidari. The report, when compared to the previously noted evidence of the applicant, does not persuade me on a balance of probabilities that a chronic pain assessment is not a reasonable and necessary course of action to ascertain the nature of the applicant's lingering pains and complaints.

[20] When arriving at his conclusion, Dr. Oshidari focuses on evidence that portrays the applicant as someone who can return to his previous level of activity and employment. Namely, he highlights a functional assessment evaluation completed in 2016 which notes that the applicant does not suffer a complete inability to return to previous activities including employment. I find Dr. Oshidari's honing in on the need to find a complete inability to return to previous activities illogical and misplaced. The dispute before me is in regards to ascertaining whether or not a chronic pain assessment is a reasonable and necessary exploration of potential treatment protocols to deal with the chronicity of the ailments and complaints of the applicant, not whether the applicant has a complete, or substantial, inability to return to previous activities including employment. I also note that Dr. Oshidari did not physically assess the applicant. For these reasons, I give his conclusion little weight.

E.E v Aviva Insurance Company, 2018 CanLII 76415 (ON LAT), <https://canlii.ca/t/htjh3

[8] The adjudicator, for reasons fully explained in her decision, preferred the evidence of Dr. Becker over that of Dr. Oshidari. She wrote the following:

I agree with Dr. Becker that Dr. Oshidari's approach underestimates [the applicant's] impairments. I accept Dr. Becker's rating of [the applicant's] WPI at 64% as the appropriate rating for physical impairment. When combined with a 15 to 18% rating for mental behavioural impairment, the resulting overall WPI Is 69 to 70%.

[19] The adjudicator dealt with causation at paragraphs 12 to 19 of the decision. She explained why she rejected the evidence of the respondent and in particular that of Dr. Oshidari. She referred to the opinions of Dr. Cushing and Dr. Fern an orthopaedic surgeon. She did not specifically refer to the evidence of Dr. Becker in this portion of the decision. However, elsewhere in the decision when the adjudicator dealt with the catastrophic impairment issue she wrote that she preferred the opinion of Dr. Becker "in all respects."

[20] In Dr. Becker's report of May 2, 2017, provided as a critique to the report of Dr. Oshidari, she wrote, "It remains my opinion that the January 2012 motor vehicle accident materially contributed to [the applicant's] current condition. At pages 22-23 of the transcript of her examination in chief, Dr. Becker testified that she agreed with the opinion of Dr. Fern when he wrote "I would consider his accident of January 28, 2012 to have more likely than not contributed to the progression of his problems that ultimately required cervical surgery."

16-004281/AABS v Aviva Insurance Company, 2018 CanLII 81909 (ON LAT), <https://canlii.ca/t/htrrb

[26] Dr. Oshidari disagrees that E.E. has two separate injuries. However, even if there are, he says they should both be rated under Chapter 3. Dr. Becker uses both Chapter 3 and Chapter 4 to rate as she says that E.E. has both a "bony issue" (a muskuloskelatal injury) and a neurological injury.

[27] I note that Chapter 4.3a deals specifically with "Station and Gait". Dr. Becker rated E.E. at 9% which is in the lowest of four categories. The description of the impairment is consistent with the evidence regarding E.E.'s difficulties.

[28] Aviva submits that Dr. Becker is double-counting impairments. In turn, E.E. submits that Dr. Oshidari is lumping impairments together resulting in an under-assessment of his actual impairments.

[29] I prefer Dr. Becker's opinion in all respects. Dr. Oshidari did not take into account important contemporaneous medical documents (as noted above). When presented with these documents at the hearing, he refused to alter his opinion. In contrast, Dr. Becker modified her opinion, adjusting her WPI rating after considering new information.[19] Dr. Oshidari also put forward interpretations of the *Guides* that are simply incorrect. For example, he stated that when combining impairment ratings, it is acceptable to move from the lowest to the highest rating. This is completely contrary to the instructions in the *Guides*.[20] As well, Dr. Oshidari relied on extraneous material[21] to interpret the *Guides.* Dr. Oshidari's unorthodox approach to interpretation of the *Guides* calls into question the reliability of his assessment and resulting opinion.

[30] I agree with Dr. Becker that Dr. Oshidari's approach underestimates E.E.'s impairments. I accept Dr. Becker's rating of E.E.'s WPI at 64% as the appropriate rating for physical impairment. When combined with a 15 to 18% rating for mental behavioural impairment, the resulting overall WPI is 69 to 70%.

S.P. v. RBC General Insurance Company, 2018 ONFSCDRS 1 (CanLII), <https://canlii.ca/t/jq9v5

During his exam, he found the Applicant to be highly uncooperative. She completed the interview, but she gave a half-hearted attempt in his professional opinion. When he was completing his report, he testified that he had Dr. Delaney's and Dr. Luczak's reports.

As part of the intake process, the Applicant told Dr. Oshidari about her pain complaints. He testified that he found the Applicant to be a difficult patient. He found she showed signs of pain magnification on a number of occasions. From what he could determine, the Applicant had no physical impairments that would cause her to be found catastrophic. At most, he could only give the Applicant a Whole Person Impairment ("WPI") rating of 15% based on his assessment.

In his report, he found the Applicant to be marked in the 3rd sphere of criteria 8 in the AMA Guides. However, he testified that being marked in this section was only a provisional conclusion due to difficulties in rating the Applicant due to her unruly behaviour. Dr. Oshidari ultimately gave evidence that at the time of his report, the Applicant met the definition of catastrophic impairment under Criteria 8, however, it was a "provisional" catastrophic impairment.

When asked to comment on the GAF score that he used in the CAT report, Dr. Oshidari stated that when conducting an assessment, it is just a snapshot in time. Things may change, daily, weekly, or monthly depending on circumstances. He was also questioned as to why a marked score was used, when if it was "provisional" as he claimed, he could have put an incomplete for that same category. He said this is how he writes his reports. In the end, Dr. Oshidari stood by the findings in his report.

[]

Dr. Valentin in her report found the Applicant to be marked in the third sphere (concentration, persistence and pace). However, Dr. Oshidari testified that the Applicant was only being "provisionally" marked in this section due to difficulties in rating the Applicant as a result of her unruly behaviour and lack of a completed PAI. Even though Dr. Oshidari said the marked category was a provisional conclusion, nowhere in the report written by Dr. Valentin were the words "provisional" ever documented next to the word "marked". If either Dr. Valentin or ultimately Dr. Oshidari felt that the results of the assessment were inconclusive, they could have put an "unable to rate" next to any of the four spheres.

[]
Ultimately, I prefer the findings of the Applicant's assessors over the evidence tendered by the Insurer even though the Insurer found the Applicant to be catastrophically impaired in another sphere and later attempted to modify this conclusion at the Hearing.

The Insurer is putting forward the position that the Applicant is functioning at a higher level than she is letting people believe. It also attempted to put forward the position that if the Applicant has psychological issues, it is because of a bi-polar disorder, not because of the accident.

Gary Sopher v. Primmum Insurance Co., 2017 ONFSCDRS 295 (CanLII), <https://canlii.ca/t/jq9nm

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.

[]

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.

[]

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*.

Brian Gavin v. Coachman Insurance Company, 2017 ONFSCDRS 285 (CanLII), <https://canlii.ca/t/jq9qx

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*.

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[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. v. Security National Insurance Co., 2015 ONFSCDRS 7 (CanLII), <https://canlii.ca/t/jq91r

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. v. State Farm Mutual Automobile Insurance Company, 2013 ONFSCDRS 14 (CanLII), <https://canlii.ca/t/jq8fj

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.

[]

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. v. Allstate Insurance Company of Canada, 2011 ONFSCDRS 103 (CanLII), <https://canlii.ca/t/jq823

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.

[]

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.”

Anna Pastore v. Aviva Canada Inc., 2009 ONFSCDRS 19 (CanLII), <https://canlii.ca/t/jq7vl

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 v. RBC General Insurance Company, 2009 ONFSCDRS 5 (CanLII), <https://canlii.ca/t/jq7rc

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.

Michael Lawrence Madonik v. Pilot Insurance Company, 2008 ONFSCDRS 152 (CanLII), <https://canlii.ca/t/jq7j6

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.

Tajendar Sharma v. Allstate Insurance Company of Canada, 2008 ONFSCDRS 96 (CanLII), <https://canlii.ca/t/jq7p3

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".