Tribunals Ontario
Licence Appeal Tribunal

Tribunaux décisionnels Ontario
Tribunal d'appel en matière de permis

2022 CanLII 81521 (ON LAT)

Citation: Ferlisi v. Allstate Insurance Company of Canada, 2022 ONLAT 21-000013/AABS

Licence Appeal Tribunal File Number: 21-000013/AABS

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

Between:

Erica Ferlisi

Applicant

and

Allstate Insurance Company of Canada

Respondent

DECISION

ADJUDICATOR: **Deborah Neilson**

APPEARANCES:

For the Applicant: Erica Ferlisi, Applicant
Carmine Tiano, Counsel
Frank Mercurio, Paralegal

For the Respondent: Rhonda Morrisey, Claims Representative
Ryan Kirshenblatt, Counsel

Court Reporters: Alyssa Scott, Michelle Gordon and Giles Tingey of Professional Court Reporters

Heard by Videoconference: **April 20 to 22, 2022**

REASONS FOR DECISION

BACKGROUND

[1] The applicant was involved in an automobile accident on July 4, 2015, and sought benefits pursuant to the *Statutory Accident Benefits Schedule – Effective September 1, 2010* (the "*Schedule*"). The applicant was denied certain benefits by the respondent and submitted an application to the Licence Appeal Tribunal - Automobile Accident Benefits Service ("Tribunal").

[2] The applicant sustained soft tissue injuries to her left side and developed chronic regional pain syndrome ("CRPS") in her left foot as result of the accident. She had a spinal cord stimulator ("SCS") surgically inserted into her spine to address the pain she experiences from the CRPS. She has had a total of three surgeries to address the SCS when it was initially just a trial and to address it when it shifted. She applied to the respondent for catastrophic impairment determination. The respondent denied that the applicant sustained a catastrophic impairment as a result of the accident. The parties disagree on the whole person impairment percentage to be applied in addressing the CRPS and whether she should be assessed with the SCS turned on or off.

ISSUES

[3] The issue I must determine is as follows:

1. Has the applicant sustained a catastrophic impairment as defined by the *Schedule*?[1]

[4] Specifically, the issue is whether the applicant sustained an impairment or combination of impairments that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993 ("*AMA Guides*"") results in a 55 percent or more impairment of the whole person ("WPI").[2]

ANALYSIS

[5] For the applicant to be catastrophically impaired, she must prove on a balance of probabilities that she sustained a 55%WPI of her combined physical and psychological impairments.

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[1] The applicant withdrew the issue of a Regulation 664 award.
[2] Section 3(2)(e) of the *Schedule* in force at the time

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[6] The applicant relied on the testimony and evidence of Dr. Sangita Sharma, a pain physician. Dr. Sharma diagnosed the applicant with a WAD-II, left shoulder rotator cuff strain, low back strain with left L5 motor and sensory radiculopathy, left knee strain, CRPS in the left ankle and foot, and chronic pain syndrome. Her opinion was that the applicant has a 51%WPI for her physical injuries.[3] Dr. Cherisse McKay, neuropsychologist, determined she had a 25% WPI for her psychological impairment. Dr. Sharma determined the applicant's combined impairments resulted in a 65% WPI.

[7] The respondent relied on the testimony and evidence of Dr. Alborz Oshidari, a physiatrist. Dr. Oshidari determined that the applicant has a 30% WPI for physical impairments. Dr. Kurt West, neuropsychologist, determined that the applicant has a 15% WPI for her psychological impairment. Her combined impairment based on these ratings is a 41% WPI.[4]

[8] The following is a chart of Dr. Sharma's and Dr. Oshidari's WPI percentage ratings:

	Dr. Sharma	**Dr. Oshidari**
Lower extremity	40% WPI gait	20% WPI gait
lumber spine	10% WPI	5%WPI
cervical spine	5% WPI	5% WPI
medication	3% WPI	
treatment		3% WPI
psychological	25% WPI	15% WPI
Total	65% WPI	41% WPI

[3] Ex.4: report of Dr. Sharma dated February 5, 2020
[4] Ex.5: Catastrophic IE report of Dr. Oshidari and Dr. Kurt West dated August 21, 2020

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[9] Both Dr. Sharma and Dr. Oshidari reached similar findings on the range of motion method of calculating the applicant's physical WPI%. The main disagreement between the parties is the WPI% for the applicant's gait derangement under chapter 3, Table 36 of the *AMA Guides*. They disagreed on whether the applicant should be assessed with her SCS turned off or on. If I accept Dr. Sharma's rating, the applicant's combined WPI% rating will be more than 55%, even if I use Dr. West's psychological 15%WPI. In order to determine whether the applicant sustained a catastrophic impairment, I must address the following:

a. Whether the applicant is to be assessed when the SCS is on or off?

b. Whether she requires one cane or more?

c. What rating should the applicant have for her gait derangement?

A. Assessment With or Without Prosthesis

[10] The rules for evaluation of a person with a prosthesis are set out in s.2.2 of chapter 2 of the *AMA Guides.* The *AMA Guides* state that if an individual's prosthesis or assistive device can be removed or its use eliminated relatively easily, the organ system should be tested and evaluated without the device. The applicant submitted this means that she should be assessed with her spinal cord stimulator ("SCS") turned off.

[11] The applicant's SCS is surgically implanted. It provides an electrical impulse that disrupts the signal of pain from the applicant's foot to her brain. The applicant testified that it reduces her pain from her RSD from a 10/10 with 10 being the worst pain imaginable to a 3/10. The battery for the SCS is surgically implanted under her skin. The battery is supposed to be charged for 20 minutes per day and is done so by placing another battery up against the applicant's skin. The SCS can be turned off and on by a remote control that the applicant carries with her. Given the SCS is used to disrupt the pain signals and is surgically implanted, I find that it is an artificial body part or a prosthesis as contemplated by s.2.2 of chapter 2 of the *AMA Guides*.

[12] The applicant submitted that I should take judicial notice of the fact that SCS have been in use since the 1960's. In fact, they were approved by the US Food and Drug Administration in 1989.

[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

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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.

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[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.

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[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

[5] Ex.14: clinical notes and records of UHN Toronto Western Hospital and Dr Bhatia, operative report of Dr. Bhatia dated October 16, 2017, page 232

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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.

[29] The applicant was a fairly straightforward witness. However, she would not answer questions put to her directly on cross-examination but repeated a great deal of the evidence she gave in chief before finally answering the question put to her.

[30] The applicant testified that she always carries a cane with her whenever she goes to a store or a gym as she has had incidents where the SCS has quit working on her. If that happens, she is unable to walk at all without the use of her cane. She testified that she cannot walk with just a cane, but requires a person to assist her or something to lean on such as furniture or a wall. She cannot use two canes at a time because her left arm is weak.

[31] The respondent relied on surveillance evidence that shows the applicant going to the gym, the bank, a store and a physiotherapy clinic without a cane. When she was shown the video, the applicant explained that the cane was in the trunk of her mother's car that she was driving. There was no video of her putting the cane into the trunk. The applicant explained that this is because she always carries it in the trunk and does not take the cane out of the trunk. The only time it is removed is if her mother removes it when her mother uses her car. In that case, her mother leaves the cane in the applicant's car.

[32] I accept the applicant's explanation and find that Dr. Sharma's testimony as to her observations of the applicant with her SCS turned off carries the most weight. Dr. Sharma is a physician and capable of determining whether the applicant is capable of using one cane routinely with the SCS turned off. I find that use of a cane to be able to walk a short distance to get away from a public place when the applicant's SCS stops functioning is not routine, but is "use" for a very short time and distance. Based on Dr. Sharma's evidence, I find that the applicant would require the use of more than one cane to routinely walk. Accordingly, despite what the applicant was capable of before the SCS was inserted and what she told Dr. Oshidari, I find that when she was assessed by Dr. Sharma, the applicant was not capable of standing with the use of one

[6] Ex.1: IE report of Breanna O'Grady, occupational therapist, dated February 1, 2016

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cane. This means she could not routinely use one cane if her SCS is off. For these reasons, I find prefer Dr. Sharma's opinion that the applicant has a 40% WPI for her gait derangement over Dr. Oshidari's 20% WPI for gait derangement.

[33] I find that the applicant has proven on a balance of probabilities that she sustained a 40% WPI for her gait derangement. Using Dr. Sharma's 40% WPI with the rest of Dr. Oshidari's ratings of 5% WPI lumbar spine, 5% WPI cervical spine, 3% WPI treatment and 15% psychological, I find the applicant sustained a 56%WPI. As this is greater than the 55% WPI required for catastrophic determination under s.3(2)(e) of the *Schedule* applicable to this accident, I find that the applicant is catastrophically impaired as a result of the accident.

CONCLUSION

[34] I find that the applicant suffered a catastrophic impairment caused by the accident because she suffered a combination of impairments that, in accordance with the *AMA Guides*, resulted in more than a 55%WPI.

Released: September 6, 2022

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Deborah Neilson
Adjudicator

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