# WORKERS COMPENSATION COMMISSION

## STATEMENT OF REASONS FOR DECISION OF THE APPEAL PANEL IN RELATION TO A MEDICAL DISPUTE

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| **Matter Number:** | **M1-2674/19** |
| **Appellant:** | **Australian Red Cross Blood Service** |
| **Respondent:** | **Lambe Durmisovski** |
| **Date of Decision:** | **25 June 2020** |
| **Citation:** | **[2020] NSWWCCMA 113** |

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| **Appeal Panel:** | |
| **Arbitrator:** | **Mr William Dalley** |
| **Approved Medical Specialist:** | **Associate Professor Michael Fearnside** |
| **Approved Medical Specialist:** | **Dr Robin Fitzsimons** |

### BACKGROUND TO THE APPLICATION TO APPEAL

1. On 9 September 2019, Australian Red Cross Blood Service (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Ross Mellick, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 12 August 2019.

2. The appellant relies on the ground of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act): availability of additional relevant information (being additional information that was not available to, and that could not reasonably have been obtained by, the appellant before the medical assessment appealed against).

3. The Registrar is satisfied that, on the face of the application, the ground of appeal has been made out. The Appeal Panel has conducted a review of the original medical assessment but limited to the ground of appeal on which the appeal is made.

4. The WorkCover Medical Assessment Guidelines set out the practice and procedure in relation to the medical appeal process under s 328 of the 1998 Act. An Appeal Panel determines its own procedures in accordance with the WorkCover Medical Assessment Guidelines.

5. The assessment of permanent impairment is conducted in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment, 4th* ed 1 April 2016 (the Guidelines) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th ed (AMA 5).

### RELEVANT FACTUAL BACKGROUND

6. The respondent to the appeal, Lambe Durmisovski, is a 51-year-old worker who was employed as a Logistics Manager by the appellant. He suffered a back injury when he became caught in lift doors at his workplace on 12 May 2016 (the subject injury). He experienced immediate pain in the back and was taken by ambulance to the Prince of Wales Hospital Emergency Department.

7. Radiological investigations disclosed pathology in the thoracic and lumbar spine. Mr Durmisovski was initially treated with analgesia but his symptoms worsened and he was referred to a neurosurgeon, Dr Ralph Mobbs who diagnosed “extreme canal stenosis at L1/2 and severe stenosis L2/3 due to a large disc prolapse”. Dr Mobbs noted early cauda equina compression and severe neurogenic claudication.

8. Dr Mobbs recommended surgery. Mr Durmisovski was initially unwilling to undergo surgery but ultimately agreed and Dr Mobbs performed a multilevel laminectomy at L1/2 and L2/3 with rhizolysis on 7 November 2016.

9. Mr Durmisovski continued to report suffering severe symptoms although he informed Dr Mobbs that he was able to mobilise with a single stick whereas prior to the operation he had been “wheelchair-bound”[1].

10. Dr Mobbs performed facet block injection at L5 S1 on 24 March 2017 as Mr Durmisovski was continuing to report significant symptoms.

11. In September 2017 Dr Mobbs noted that Mr Durmisovski “continues to struggle” and was using a walking frame to assist with mobilisation. Dr Mobbs did not feel that further surgery would be beneficial and Mr Durmisovski was referred to Dr Sachin Shetty for pain management.

12. Dr Shetty recommended use of a motorised wheelchair to assist with mobility over longer distances and referred Mr Durmisovski for urological and nerve conduction studies.

13. Mr Durmisovski was examined by a neurosurgeon, Dr Bentivoglio in August 2017 at the request of the insurer. Dr Bentivoglio reported that Mr Durmisovski had; “virtually no movement in his legs from hip flexion all the way down to his feet and his reflexes revealed bilaterally absent knee and ankle reflexes.” There was decreased back movement. Dr Bentivoglio, at that time, felt that Mr Durmisovski had not yet reached maximum medical improvement.

14. Upon review in October 2018 Dr Shetty noted that Mr Durmisovski was continuing to have problems with pain and restriction of movement as well as continuing bladder problems. Dr Shetty felt at that time that Mr Durmisovski had achieved maximum medical improvement and was using a forearm support frame for mobility with a need for a powered mobility device for longer distances and outdoor mobility.

15. In December 2018, Mr Durmisovski was assessed by Dr Paul Teychenné for the purposes of a claim for lump-sum compensation pursuant to section 66 of the *Workers Compensation Act 1987* (the 1987 Act). Dr Teychenné assessed Mr Durmisovski as suffering 88% whole person impairment (WPI) as a result of the subject injury, noting that Mr Durmisovski was “now paralysed from T12 down”. The doctor commented that he was “unable to perform back muscle or lower limb examination due to pain.” He diagnosed “marked paraplegia and tetra paresis.”

16. Mr Durmisovski was again examined by Dr Bentivoglio on behalf of the insurer. Dr Bentivoglio noted “On examination, Mr Durmisovski was wheelchair-bound with no movement in his legs. He could not stand independently.” Dr Bentivoglio assessed Mr Durmisovski as having 73% WPI. Dr Bentivoglio was of the opinion that part of that impairment resulted from the pre-existing degenerative spinal condition and deducted one tenth which after rounding yielded 66% WPI.

[1] report of Dr Mobbs 20 December 2016 (page 52 of Application to Resolve a Dispute)

17. The dispute as to the extent of impairment was referred to the AMS to assess:

> "lumbar spine – corticospinal impairment due to injury sustained on 12 May 2016, including left upper extremity, right upper extremity, station and gait, bladder, neurologic anorectal impairment, neurologic sexual impairment."

18. The AMS examined Mr Durmisovski on 11 July 2019. He assessed lumbar impairment due to injury at 14% WPI. Station and gait were assessed at 54% WPI, bladder at 15% WPI and neurological sexual impairment at 18% WPI. Each of those figures included reduction of one tenth in respect of a pre-existing condition. The AMS assessed 0% WPI in respect of the upper extremities and neurological anorectal impairment. The total assessment, assessed in accordance with the Combined Values Chart, was 72%.

19. On 28 August 2019 and 1 September 2019, investigators observed and recorded the applicant mobilising with a single stick held in the right-hand. Based on those observations Dr Bentivoglio issued a further report expressing strong doubts as to his earlier assessment and suggesting that further assessment was required.

**PRELIMINARY REVIEW**

20. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the WorkCover Medical Assessment Guidelines.

21. The Notice of Appeal lodged by the appellant sought to introduce a DVD recording, a supplementary report of Dr Bentivoglio dated 5 September 2019 and certain other documents relating to claims made by Mr Durmisovski pursuant to section 60 of the 1987 Act.

22. Mr Durmisovski's representatives submitted that:

> "It is the respondent's submission that this evidence is in effect neither new and it was not reasonably available, if the appellant had conducted its enquiries in a timely fashion this evidence could have been available well before the matter was referred to an AMS."

23. Mr Durmisovski's representatives also submitted that the surveillance evidence was not evidence of a "medical nature" but was simply factual evidence.

24. The Panel did not accept those submissions. Mr Durmisovski had consistently presented to several medical practitioners with paraplegia, that is paralysis of the legs. However, in September 2017 Dr Mobbs noted that Mr Durmisovski "is using a walking frame to assist with mobilisation".

25. Dr Shetty in October 2017 noted:

> "Lambe mobilises with a forearm support frame bearing a significant weight through his shoulders. He has bilateral foot drop which he compensates with mild circumduction and dragging the foot along. He is unable to support his bodyweight without assistance, even for a short duration."

26. In October 2018, Dr Shetty noted that Mr Durmisovski was "continuing to mobilise with his mobility scooter". He commented:

> "He should continue to maintain reasonable independence in indoor mobility. He currently requires a forearm support frame. This potentially may be downgraded to a four wheel walker in the future. However, for longer distances and outdoor mobility, he would require a powered mobility device".

27. On examination in August 2017, Dr Bentivoglio noted:

> "When I tried to get him to move his legs there was virtually no movement in his legs from hip flexion all the way down to his feet and his reflexes revealed bilaterally absent knee and ankle reflexes. Decreased back movement."

28. In his report following examination in February 2019 Dr Bentivoglio noted: "on examination Mr Durmisovski was wheelchair-bound with no movement in his legs. He could not stand independently."

29. Dr Teychenné reported that Mr Durmisovski "was only able to take a few steps before he needed to stabilise his legs or sit down. He experienced difficulty clearing his right foot off the ground during the swing phase of gait due to the pain and frank weakness." Dr Teychenné assessed Mr Durmisovski as having "a flaccid paraplegia".

30. Mr Durmisovski's presentation to treating doctors and to the respective independent medical experts, Dr Teychenné and Dr Bentivoglio, provided no reasonable basis for the appellant to cause observations to be carried out prior to the MAC examination. There is no evidence to indicate that any such observations would have disclosed the level of mobility which is shown in the observation evidence recorded on 28 August 2019 and 1 September 2019.

31. The Panel was satisfied that the DVD recording and the report of Dr Bentivoglio represented new information when considered in the light of the findings by the AMS and the respective independent medical experts as to Mr Durmisovski's capacity with respect to station and gait.

32. That material would not have been available at the time of the MAC and could not reasonably have been obtained at the time of the MAC. The AMS noted that, at the time of the MAC, Mr Durmisovski was presenting as having an inability to move his legs[2].

33. The video evidence contained in the DVD and the further report of Dr Bentivoglio dated 5 September 2019 were admitted and considered by the Panel.

34. The balance of the material did not represent material which was not available at the time of the MAC and was not admitted.

35. The decision having been made to admit the new evidence the Panel issued directions:

    (a) The respondent, Lambe Durmisovski is to provide any medical report and/or other evidence upon which he wishes to rely in answer to the above 'fresh evidence' on or before 6 January 2020.

    (b) The respondent is to file and serve any further submissions upon which he seeks to rely in the light of the admission of the 'fresh evidence' on or before 6 January 2020.

    (c) Leave is granted to the respondent to seek an extension of that time frame if it cannot reasonably be met. Any application for extension of the timetable by the respondent is to be made by email on or before close of business on 20 December 2019.

    (d) The appellant is to file and serve any further submissions in reply by 13 January 2020, or within one week following receipt of the respondent's submissions, whichever is the later, with leave to the appellant to seek an extension of that time frame if it cannot reasonably be met.

[2] MAC para 4 p.3

(e) In their respective submissions, the appellant and the respondent are requested to address the meaning of the word "assistance" where used in AMA 5, Table 15-6 (c) (Page 396) within Class 2 and Class 3 and whether the word includes the use of artificial aids or is limited to assistance by another person.

36. The Panel considered the submission of the appellant that the Panel should re-examine Mr Durmisovski in the light of the activity shown on the video recording and the report of Dr Bentivoglio.

37. In his report dated 5 September 2019 Dr Bentivoglio noted that he had previously examined Mr Durmisovski and reported in February 2019. He said:

> "When I examined him at that time he was wheelchair-bound and had no movement in his legs. He could not stand independently. There was no wasting of his legs. He did have bilateral absent ankle and knee reflexes….
>
> Since that time I have seen an investigative tape on Mr Durmisovski where it shows that he is quite able to walk with the aid of a walking stick. He does not put a lot of weight on the walking stick. He is able to stand independently with the aid of the walking stick but as I said he does not put a lot of pressure on the walking stick so this is a totally different picture to the one he described to me when I saw him on 21 February 2019."

38. Dr Bentivoglio said that in order to assess Mr Durmisovski he would need to re-examine him, undertake nerve conduction studies and EMG's in the legs and consider urodynamic studies as well as anal manometry.

39. The Panel does not accept that re-examination would assist in the circumstances. Nerve conduction study results could be made available to the Panel as well as the results of other tests. The AMS had assessed 0% WPI in respect of anorectal impairment there was no basis to disturb that assessment.

40. The Panel was of the view that a more accurate assessment of station and gait could be made from the observation evidence than from an account provided by Mr Durmisovski.

41. For these reasons the Panel was of the opinion that re-examination would not assist in determining impairment resulting from the subject injury.

42. No further evidence was filed pursuant to the direction issued by the Panel although submissions were received from the parties which largely restated their earlier submissions and dealt with the meaning to be ascribed to the use of the word "assistance" in the relevant Guideline.

## EVIDENCE

### Documentary evidence

43. The Appeal Panel has before it all the documents that were sent to the AMS for the original medical assessment and has taken them into account in making this determination. In addition to that material, the Panel considered the video recording made on 28 August 2019 and 1 September 2019 and the report of Dr Bentivoglio dated 5 September 2019.

44. Having concluded that re-examination of Mr Durmisovski would not assist with further assessment the Panel issued a further direction calling for production of:

> "a) All EMG/nerve conduction/evoked potential studies relating to Mr Durmisovski including (but not limited to) those referred to in the report of the treating pain management specialist, Dr Sachin Shetty, dated 16 January 2018 (page 60 of the Reply).

b) All reports from Dr Thomas Jarvis relating to Mr Durmisovski including results of urodynamic studies and any other tests performed by Dr Jarvis as noted by Dr Shetty with reference to bladder function in his report dated 17 July 2018 (page 62 of the Reply).

c) Reports of neurological function referred to by Dr Shetty in his report dated 16 April 2019 (page 66 of the Reply).

d) Results of any rectal/anal manometry investigation(s)".

45. Pursuant to those directions, further material was produced and made available to the parties for inspection. Much of the material produced duplicated material that was already in evidence. Additional material is referred to below where relevant.

**Medical Assessment Certificate**

46. The parts of the medical certificate given by the AMS that are relevant to the appeal are set out, where relevant, in the body of this decision.

**SUBMISSIONS**

47. Both parties made written submissions. They are not repeated in full, but have been considered by the Appeal Panel. The submissions with respect to the admission of new evidence have been referred to above.

48. With respect to the assessment of impairment resulting from the subject injury, the appellant submits that the new evidence warrants reassessment of the respondent in the light of that evidence.

49. In reply, the respondent submitted that:

> "The respondent has undergone a central canal decompression and is still using an aid to walk. With the applicant [*scil* appellant] offering no alternative whole person impairment rating flowing from the surveillance evidence appeal panel would not be assisted in its task and again the new evidence should not be admitted."

**FINDINGS AND REASONS**

50. The procedures on appeal are contained in s 328 of the 1998 Act. The appeal is to be by way of review of the original medical assessment but the review is limited to the grounds of appeal on which the appeal is made.

51. In *Campbelltown City Council v Vegan*[3]*,* the Court of Appeal held that the Appeal Panel is obliged to give reasons. Where there are disputes of fact it may be necessary to refer to evidence or other material on which findings are based, but the extent to which this is necessary will vary from case to case. Where more than one conclusion is open, it will be necessary to explain why one conclusion is preferred. On the other hand, the reasons need not be extensive or provide a detailed explanation of the criteria applied by the medical professionals in reaching a professional judgement.

52. The Panel concluded that the new evidence comprising the video recording of observations of Mr Durmisovski and the report of Dr Bentivoglio dated 5 September 2019 did constitute additional relevant information (being additional information that was not available to, and that could not reasonably have been obtained by, the appellant before the medical assessment appealed against) for the reasons set out above. The ground of appeal has accordingly been made out and it is necessary for the Panel to conduct an assessment on the basis of the currently available evidence.

[3] [2006] NSWCA 284

53. The impairments resulting from the subject injury are to be considered under a number of headings. It is convenient to deal with each of those areas of function separately but in the light of the whole of the evidence.

54. Upon examination the AMS reported:

> "Mr Durmisovski exhibited no abnormality of mood or cognition. He was able to propel himself in the wheelchair using his upper extremities. He was wearing pads because of urinary incontinence.
>
> There was a sensory level to temperature and pinprick at T 11. There was flaccid paraparesis with absent reflexes in the lower extremities and no response to the Babinski testing. There was absent sensation to light touch and pinprick in the lower extremities.
>
> I found no abnormalities of cervical contour, posture or movement. There was no wasting of the upper extremities and no abnormalities of contour, posture, tone, power production, coordination or sensation in the upper extremities. I found no asymmetry of shoulder, elbow, wrist or finger movement. The deep tendon reflexes were present and symmetrical in the upper extremities."

55. The finding of flaccid paraparesis is inconsistent with the video evidence but the absence of response to the Babinski testing is consistent with impairment and not dependent upon accurate reporting by the subject.

56. The Panel accepts the findings with respect to the upper extremities as being soundly based upon appropriate examination.

**Lumbar Spine**

57. The Panel accepts that there are the significant signs of radiculopathy including sensory loss and loss of relevant reflexes. These are consistent with the reports of the treating neurosurgeon, Dr Mobbs and with the report of the MRI scan performed on 12 May 2016 which noted "severe – extreme central canal stenosis at this level (L1/2) with complete effacement of the CSF around the cauda equina and distal conus."

58. Dr Mobbs reported a "good decompression" at the affected levels, L1/2 and L2/3. In his report dated 10 October 2017 Dr Mobbs noted a grade 1 spondylolisthesis at L5/S1 which he said was "causing a significant component" of the low back problems.

59. The EMG study dated 5 December 2017 which formed part of the additional material requested by the Panel and produced pursuant to direction for production was reported:

> "lower limb sensory responses are reduced, with preserved conduction velocities in motor responses, consistent with axonal sensory peripheral neuropathy. Motor amplitudes towards the lower limit of normal (but in the normal range)."

60. The Panel notes that paragraph 4.21 of the Guidelines proscribes the use of electrodiagnostic tests such as EMG or nerve conduction studies in order to determine DRE classification. Such studies may, however, provide useful evidence in relation to other possible causes of weakness or peripheral neurological findings. In any case the studies as reported were limited, with a study of only one muscle, namely the left tibialis anterior (L4/5) and as such are any case of limited diagnostic value.

61. Examination by the AMS disclosed the absence of reflexes and the negative Babinski test.

62. In the light of the surgery, Mr Durmisovski is appropriately classified and as within DRE Lumbar Category III, warranting an assessment of 10% WPI.

63. The objective evidence of spinal pathology resulting from the subject injury corroborates the history provided by Mr Durmisovski of an ability to perform activities of daily living other than self-care attracting a further 2% WPI. A further 1% WPI is added in respect of the second level operated upon by Dr Mobbs.

64. The AMS added a further 3% "because of the surgical procedure on the lumbar spine". That assessment is made in accordance with Table 4.2 which provides for an additional 3% WPI in respect of "Spinal surgery with residual symptoms and radiculopathy". However, the effects of surgery and radiculopathy in the present case are accounted for in the assessment of "station and gait" and the Panel has accordingly assessed impairment following surgery with residual symptoms of radiculopathy under that heading below. Accordingly, the lumbar spine is assessed at 13% WPI.

65. The reports of investigation to the lumbar spine show pre-existing degenerative changes which contributed to the level of pathology in the lumbar spine which in turn led to the requirement for surgery carried out by Dr Mobbs. The level of impairment is assessed in the light of that surgery and its outcome. The pre-existing degenerative condition in the lumbar spine would have contributed in part to the requirement for treatment and the ultimate impairment.

66. Consideration of the extent of degenerative changes revealed by the imaging and described by Dr Mobbs indicates that a deduction of one tenth would be at odds with the evidence of the imaging. The extent of impairment is still substantially less than the contribution of the subject injury and a more appropriate deduction would be one fifth.

**Right Upper Extremity and Left Upper Extremity**

67. The Panel accepts the findings of the AMS on examination of the left and right upper extremities. Those findings appropriately warrant an assessment of 0% WPI in the case of both the right and left upper extremities.

68. There is no complaint of symptoms, radiological reports or other evidence of impairment in either shoulder other than the report of Dr Teychenné dated 8 November 2018. In the opinion of the panel the findings of the AMS on examination are to be preferred over the assessment of Dr Teychenné who based his assessment upon an inference that there was an "incomplete cervical cord lesion". No injury to the cervical cord was referred to the AMS.

69. The appropriate assessment in respect of both the right and left upper extremities is 0% WPI.

**Station and Gait**

70. The AMS assessed Mr Durmisovski's incapacity relating to "station and gait" on the basis of the documents attached to the Application to Resolve a Dispute and the Reply, his examination of the respondent and the history given to him at that time.

71. The AMS recorded:

> "At the time of his visit to my rooms, Mr Durmisovski made reference to persisting pain in the lower lumbar region with extension upwards to the region between the shoulder blades and extension into both feet, together with progressive impairment of his ability to walk. He described initially needing a walking stick, then a walker and ultimately a wheelchair."

72. The AMS noted the report of Dr Mobbs and the history provided to that doctor; "He has horrible pain in the buttocks and down the legs. When he tries to ambulate he can't feel his legs, more so on the right then on the left. He has horrible nerve pain shooting down both legs as far as the ankles and feet" and "he has absent reflexes in the lower extremities and… can barely walk." The AMS noted that Dr Mobbs considered that, at that time, Mr Durmisovski was "near wheelchair bound".

73. In his statement attached to the Application to Resolve a Dispute, Mr Durmisovski reported:

> "I rely on a wheelchair. Since the workplace accident, I have continued to suffer from severe weakness and a jellylike sensation in my leg [sic] which prevents me from being able to use a walker".

74. Dr Teychenné reported[4]:

> "He stated his legs remained severely weak such that he could not stand for about four days. However, his paralysis never improved. His legs are still sloppy and weak. He basically has had bilateral paraparesis from T8 down. He stated the leg still feel like floppy jelly. He has tried to use a walker but finds he cannot stand in his legs. They collapse after a few seconds of standing on his legs. He has to use a wheelchair virtually all the time. He states that if he stands, his legs go immediately like jelly and he has to sit down. He is legs go actually and give way."

And

> "He is paraplegic and his only form of occupation could be office work but not for prolonged periods of time. He is unable to stand for even a transient period. He states that if he attempts to stand, his legs immediately go like jelly, give way and he collapses."

75. The AMS noted that Dr Bentivoglio had been provided with a history of severe back pain, loss of feeling in both legs and inability to weight bear and walk.

76. The AMS concluded that Mr Durmisovski "is now unable to move his legs and has a loss of sensation in both lower extremities. Back pain is a continuing problem despite the surgery performed by Dr Mobbs."

77. The members of the Panel have viewed the video recording of Mr Durmisovski made on 28 August 2019 (approximately 40 seconds duration) in which Mr Durmisovski is seen from behind standing beside a suburban garage with a walking stick held in the right-hand. He appears to make a brief flicking motion with a walking stick then leans over from the waist with his hand reaching towards the ground and then straightening.

78. Video recorded on 1 September 2019 shows Mr Durmisovski entering a motor vehicle in the driveway of a home. He uses a walking stick in the right-hand, opening the front passenger door with his left. He is next seen arriving at the Sylvania Bowling Club using a walking stick in the right-hand and walking a short distance to the entrance. Inside the club he is seen seated at a table and moving between his table and the food service area and bar over a period of about nine minutes.

79. After viewing the video Dr Bentivoglio referred to his earlier report and said:

> "When I examined him at that time, he was wheelchair bound and had no movement in his legs. He could not stand independently. There was no wasting of his legs. He did have bilateral absent ankle and knee reflexes. I thought at that time he had a significant cauda equina syndrome secondary to the L1/2 and L2/3 canal stenosis from degenerative disc disease and an acute disc prolapse the L1/2 level.

[4] Report dated 8 November 2018 – Application to Resolve a Dispute, p. 32

> Since that time I have seen an investigative tape on Mr Durmisovski which shows that he is quite able to walk with the aid of a walking stick. He does not put a lot of weight on the walking stick. He is able to stand independently with the aid of the walking stick but as I said he does not put a lot of pressure on the walking stick so this is a totally different picture to the one he described to me when I saw him on 21 February 2019."

80. The Panel accepts Dr Bentivoglio's summary of the observations recorded on the DVD as accurate. The actions of Mr Durmisovski depicted present a markedly different level of function to that recorded by the AMS upon examination.

81. Assessment of "station and gait" is performed pursuant to Table 13-15 of AMA5[5]. The criteria for Class 2 impairment (10%-19% WPI) are: "Rises to standing position, walks some distance with difficulty and without assistance, but is limited to level surfaces." The Panel accepts that Mr Durmisovski does require assistance (walking stick) when walking even relatively short distances and, on the evidence of the surveillance video, Mr Durmisovski exceeds the criteria for Class 2.

82. The criteria for Class 3 (20%-39% WPI) are: "Rises and maintain standing position with difficulty, cannot walk without assistance." The Panel accepts that the use of a walking stick satisfies the requirement for the need for "assistance" to be shown.

83. The AMS assessed Mr Durmisovski as falling within Class 4 (40% – 60% WPI). The criteria for that class are "Cannot stand without help, mechanical support, and/or an assistant device." The surveillance material, although brief, clearly establishes that Mr Durmisovski does not fall within Class 4.

84. Where the surveillance evidence is at odds with the statement of Mr Durmisovski and the opinions of the AMS, Dr Teychenné and Dr Bentivoglio, the Panel prefers the evidence of the surveillance material.

85. The radiological and operative findings are consistent with pathology affecting the cauda equina, in the manner described, and in the assessed impairment. For the reasons noted above, the EMG findings are not to be relied upon in determining DRE classification or diagnosis. However, the panel does note electrophysiological findings that the electromyographer (Dr Granot, 5 December 2017) made a final comment that the findings taken together suggest that there could be better underlying power if pain is controlled. Although the Panel notes that this is consistent with the surveillance data, the Panel does not rely on this comment when determining its conclusions in relation to DRE classification.

86. The Panel accepts that the surveillance material, although limited to movement over relatively short distances, does show use of a single walking stick. It does not show Mr Durmisovski placing any substantial weight on the stick. He is able to stand while passing the stick to his left hand whilst paying at the counter.

87. The actions shown in the surveillance material place Mr Durmisovski at the lower end of the Class 3 range (Table 15-6 (c)), warranting an assessment of 20% WPI in respect of station and gait.

88. There is no evidence of impairment of station and gait prior to the subject injury and the impairment assessed flows from the subject injury and not from any pre-existing condition or abnormality nor any prior injury and accordingly no deduction is warranted pursuant to section 323 the 1998 Act.

[5] page 336

**Bladder**

89. The urodynamic report dated 5 June 2018, which formed part of the material requested by the Panel, recorded a history:

> "This gentleman's urinary symptoms have been present for two years and follow an L1 A/S C spinal cord injury. He primarily complains of intermittent urgency with urge incontinence. He usually voids two – three hourly by day and gets up twice per night. He complains of terminal dribbling. He did not have improvement with solifenacin (Vesicare 5 mg daily)."

90. The report concluded:

> "From this examination there is evidence of stable detrusor function. Sphincter function was normal. The patient has impaired bladder sensation with large capacity. No stress incontinence was demonstrated. The recommended intervention for this gentleman is a trial of mirabegron (Betmiga 50 mg daily) and frequent voiding to keep volumes around 500 ml."

91. Dr Shetty in his report dated 17 July 2018 noted: "Lambe has had a review with Dr Jarvis, [who] also did a urodynamics on him which shows significantly reduced urinary sensation with a filling going up to 799 mL and an erratic bladder emptying afterwards."

92. The reports of the general practitioner confirm the use of incontinence pads.

93. The treating urologist, Dr Thomas Jarvis, reported[6]:

> "His urinary symptoms have been bothersome since his injury. He describes urgency with associated incontinence for which he requires pads both day and night. He denies any stress incontinence. He voids every 3 to 5 hours during the day and arises once overnight. He is less likely to be incontinent overnight. He says there is some hesitancy at the initial part of his urine flow."

94. In his report dated 4 September 2018, Dr Jarvis noted some improvement recording:

> "He is now leaking less urine during the day, despite his frequent voiding every two hours. If he does have a leak, it is usually in the morning when his bladder is full or overnight when he only arises once."

95. Dr Shetty, reported to the general practitioner[7]: "*Bladder* – The urinary leaks which have been troubling Lambe to continue [sic], with his bladder behaving in an automatic capacity." In a subsequent report[8] Dr Shetty noted: "*Bladder* – overall Lambe has better control with his timed toileting routine, not having any leaks or urinary infections in the last few months."

96. The AMS assessed Mr Durmisovski as falling at about the middle of the Class 2 range described in Table 15-6 (d): "individual has good bladder reflex activity, limited capacity, and intermittent emptying without voluntary control." The AMS recorded the history "He reported increasing impairment of bladder function" and noted that Dr Bentivoglio had recorded "semi--control of his bladder" and the absence of sensation when passing urine.

97. Dr Teychenné obtained a history: "Mr Durmisovski indicated that around the time of the injury and subsequently he was incontinent of urine and had to wear a pad." He assessed Mr Durmisovski as falling within Class 1 noting "some degree of voluntary control but impaired urgency of intermittent incontinence" and assessed 7% WPI in respect of bladder impairment.

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[6] report dated 27 April 2018 – late documents produced pursuant to direction of the Panel p. 7.
[7] report dated 16 October 2018 – late documents produced pursuant to direction of the Panel p. 27.
[8] report dated 16 April 2019 – late documents produced pursuant to direction of the Panel p. 58.

98. The AMS noted that Dr Bentivoglio had assessed Mr Durmisovski as having a lower level of bladder impairment. Dr Bentivoglio reported: “From the point of view of his bladder impairment, he does have reflex emptying with some incontinence, so I would classify him as Class 1, 9% whole person impairment”.[9]

99. The Panel is of the opinion that the urodynamic study reported by Dr Jarvis and the reports of Dr Shetty support the opinions of Dr Teychenné and Dr Bentivoglio that Mr Durmisovski’s appropriately assessed as being within Class 1, although at the upper end of that range. He is appropriately assessed as having 9% WPI in respect of bladder impairment.

There is no evidence of any pre-existing condition or abnormality and no previous injury requiring a deduction pursuant to section 323 of the 1998 Act.

**Anorectal system**

In his statement attached to the Application to Resolve a Dispute Mr Durmisovski noted “constipation” but did not provide evidence of any other relevant symptoms.

100. Dr Teychenné placed Mr Durmisovski within Class I of Table 15-6(e)[10]. The criteria for inclusion in that class are “Individual has reflex regulation but only limited voluntary control.”

101. The AMS noted the history reported by Dr Bentivoglio: “constipation was present; however no faecal soiling was reported, bowel opening twice a day and no faecal incontinence.” The AMS recorded: “he reported increasing impairment of bladder function without impairment of bowel function.”

102. Dr Jarvis noted[11] “He says his bowels are satisfactory and that he opens them every day.” Dr Shetty reported[12] : “His bowels have been reasonably stable with no accidents.”

103. In his report dated 17 July 2018 Dr Shetty noted *“Bowels* - Lambe has also had an erratic and irregular routine with his bowels, having occasional near accidents” and in October 2018 “The bowel regime has slightly improved since my last review, settling down to a routine of daily bowel opening.”

104. On the basis of that evidence, and in particular the history which Mr Durmisovski gave to the AMS, the Panel is satisfied that Mr Durmisovski does not meet the criteria for assessment within Class 1 of Table 15-6 (e) and is appropriately assessed at 0% WPI.

**Sexual impairment**

105. Mr Durmisovski in his statement notes “loss of erections” as a consequence of the subject injury. He has consistently informed doctors who have examined him that he has been unable to sustain an erection since the subject injury.

106. The AMS assessed Mr Durmisovski as having complete loss of sexual function warranting 20% WPI in accordance with Table 15-6 (f). Complete loss of sexual function is plausible given the nature of the injury, the pathology in the lumbar spine and the cauda equina injury. Mr Durmisovski is accordingly assessed at 20% WPI in respect of sexual impairment.

107. There is no evidence of any previous injury or pre-existing condition or abnormality which would warrant a deduction pursuant to section 323 of the 1998 Act in respect of loss of sexual function.

[9] report dated 26 February 2019 – Reply p. 40.
[10] AMA 5 page 396
[11] report dated 27 April 2018 – late documents produced pursuant to request of the Panel – p.7.
[12] report dated 10 October 2017 Reply p.58.

108. For these reasons, the Appeal Panel has determined that the MAC issued on 12 August 2019 should be revoked, and a new MAC should be issued. The new certificate is attached to this statement of reasons.

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE REASONS FOR DECISION OF THE APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

G Bhasin

**Gurmeet Bhasin**
**Dispute Services Officer**
As delegate of the Registrar

# WORKERS COMPENSATION COMMISSION

## APPEAL PANEL
## MEDICAL ASSESSMENT CERTIFICATE

**Injuries received after 1 January 2002**

**Matter Number:** **2674/19**
**Applicant:** **Lambe Durmisovski**
**Respondent:** **Australian Red Cross Blood Service**

This Certificate is issued pursuant to s 328(5) of the *Workplace Injury Management and Workers Compensation Act 1998*.

The Appeal Panel revokes the Medical Assessment Certificate of Dr Ross Mellick and issues this new Medical Assessment Certificate as to the matters set out in the Table below:

**Table - Whole Person Impairment (WPI)**

| Body Part or system | Date of Injury | Chapter, page and paragraph number in WorkCover Guides | Chapter, page, paragraph, figure and table numbers in AMA 5 Guides | % WPI | Proportion of permanent impairment due to pre-existing injury, abnormality or condition | Sub-total/s % WPI (after any deductions in column 6) |
|---|---|---|---|---|---|---|
| 1.<br>Lumbar spine | 12/05/16 | Chapter 4<br>Para 4.30<br>Table 4.2 | Chapter 15<br>Para 15-7<br>Table 15-3<br>Page 384 | 13% | 1/5 | 10%<br>(after rounding) |
| 2.<br>Right upper extremity<br><br>Left upper extremity | 12/05/16 | Chapter 2<br>Pages 10 - 12 | Chapter 16<br>Pages 443 – 518 | 0%<br><br>0% | | 0%<br><br>0% |
| 3.<br>Station and Gait | 12/05/16 | | Chapter 15<br>Table 15-6(c)<br>p.396 | 20% | 0% | 20% |
| 4.<br>Bladder | 12/05/16 | | Chapter 15.7<br>Table 15-6(d) | 9% | 0% | 9% |
| 5.<br>Anorectal impairment | 12/05/16 | | Chapter 15.7<br>Table 15-6 (e) | 0% | | 0% |
| 6.<br>Sexual function | 12/05/16 | | Chapter 15.7<br>Table 15-6 (f) | 20% | 0% | 20% |

| | |
|---|---|
| **Total % WPI (the Combined Table values of all sub-totals)** | **47%** |

The above assessment is made in accordance with the Guidelines for the Evaluation of Permanent Impairment for injuries received after 1 January 2002

**Mr William Dalley**
Arbitrator

**Associate Professor Fearnside**
Approved Medical Specialist

**Dr Robin Fitzsimons**
Approved Medical Specialist

25 June 2020

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE MEDICAL ASSESSMENT CERTIFICATE OF THE APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

G Bhasin

Gurmeet Bhasin
Dispute Services Officer
**As delegate of the Registrar**