WORKERS COMPENSATION COMMISSION

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

Matter No:	**M1- 6205/15**
Applicant:	**Tomislav Martinovic**
Respondent:	**Corporate Projects Pty Ltd**
Date of Decision:	**7 January 2020**
Citation:	**[2020] NSWWCCMA 7**

Appeal Panel:	
Arbitrator:	**Mr John Harris**
Approved Medical Specialist:	**Dr David Crocker**
Approved Medical Specialist:	**Dr Brian Noll**

BACKGROUND TO THE APPLICATION TO APPEAL

1. Mr Tomislav Martinovic (the appellant) suffered injury on 15 August 2013 in the course of his employment with Corporate Projects Pty Ltd (the respondent).

2. The respondent served a notice dated 8 December 2013[1] accepting liability and agreeing to pay weekly compensation and medical expenses.

3. The appellant served a letter of claim dated 10 April 2015 seeking permanent impairment compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act).[2] The claim was based on the opinion expressed by Dr Guirgis for 20% whole person impairment (WPI) comprising 15% WPI for the lumbar spine, 5% for the cervical spine and 1% for the scar.[3]

4. By letter dated 4 September 2015 the respondent offered to resolve the claim based on the opinion expressed by Dr Ryan in a report dated 24 June 2015.[4] Dr Ryan assessed the appellant at 11% WPI attributable to the lumbar spine, no assessable impairment of the cervical spine and no impairment in respect of the scar.

5. The applicant commenced proceedings claiming permanent impairment compensation pursuant to s 66 of the1987 Act for the lumbar and cervical spines and associated scarring.

6. The respondent filed an Application to admit late documents dated 23 November 2014, attaching a Reply (Reply). No liability issues were raised in the Reply.

7. The assessment of WPI was then referred by the Registrar to Dr Adler, an Approved Medical Specialist (AMS), who examined the applicant and provided the Medical Assessment Certificate dated 16 December 2015 (MAC). The relevant findings made by the AMS pertinent to the various grounds of appeal are set out later in these Reasons.

[1] Application, p 28
[2] Application, p 30
[3] Application, p 7
[4] Application, p 32

8. The AMS assessed the applicant as having a 10% WPI of the lumbar spine less a one-quarter deduction pursuant to s 323 of the Workplace Injury Management and Workers Compensation Act 1998 (1998 Act). The cervical spine and the skin (scar) were assessed at 0% WPI.

9. The assessment of WPI was undertaken in accordance with the *WorkCover Guides for the Evaluation of Permanent Impairment, 3rd edition* (third edition guidelines). The third edition guidelines applied to assessments conducted prior to 1 April 2016.

10. The assessment of WPI is now undertaken in accordance with the fourth edition of the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment* (fourth edition guidelines).[5] The fourth edition guidelines adopt the 5th edition of the *American Medical Association's Guides to the Evaluation of Permanent Impairment* (AMA 5). Where there is any difference between AMA 5 and the fourth edition guidelines, the fourth guidelines prevail.[6]

11. Accordingly, whether the AMS erred must be determined by reference to the third edition guidelines. In the event that error is shown, any re-assessment must be undertaken in accordance with the fourth edition guidelines.

THE APPEAL AND JUDICIAL REVIEW APPLICATION

12. On 11 January 2016, the appellant filed an Application to Appeal Against a Medical Assessment (the appeal) to the Registrar of the Workers Compensation Commission (the Commission).

13. On 29 January 2016, the respondent filed an Application to Appeal Against a Medical Assessment (the respondent's appeal) to the Registrar of the Commission.

14. The WorkCover Medical Assessment Guidelines (the Guidelines) set out the practice and procedure in relation to appeals to Medical Appeal Panels under s 327 of the 1998 Act.

15. The appellant claims that the medical assessment by the AMS should be reviewed on the ground that the MAC contains a demonstrable error and/or the assessment was made on the basis of incorrect criteria.

16. The Appeal was filed within 28 days of the date of the MAC. The submissions in support of the grounds of appeal are referred to later in these Reasons.

17. On 7 April 2016, a Medical Appeal Panel (the first AP) allowed the appeal insofar as it concerned the assessment of the lumbar spine and confirmed the assessments of the cervical spine and the skin. The MAC was revoked and the first AP issued an assessment of 12% WPI.

18. A certificate of determination consistent with the assessment of the first AP was issued on 12 May 2016 (the COD).

19. On 27 March 2018, the appellant filed an application (the reconsideration application) seeking to set aside the COD pursuant to s 350(3) of the 1998 Act and to have the matter referred back to the first AP pursuant to s 378.

20. On 30 May 2018, Arbitrator Egan dismissed the reconsideration application.[7]

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[5] The fourth edition guidelines are issued pursuant to s 376 of the s 376 of the *Workplace Injury Management and Workers Compensation Act 1998*

[6] Clause 1.1 of the fourth edition guidelines

[7] *Martinovic v Corporate Projects Pty Ltd* [2018] NSWWCC 148

21. The appellant then filed proceedings in the Supreme Court of New South Wales. On 8 November 2019, the Court made the following orders:[8]

> "(1) Quash the decision of the Arbitrator dated 30 May 2018.
>
> (2) Quash the decision of the Appeal Panel dated 7 April 2016.
>
> (3) Remit the matter to the second defendant for allocation to a review panel for determination according to law.
>
> (4) The fourth defendant is to pay the plaintiff's costs."

22. The Court stated:[9]

> "Thus, the Arbitrator was satisfied that three out of the four errors contended for by Mr Martinovic were apparent from the reasons of the Appeal Panel. Despite this, he went on to dismiss the review on the basis that, in effect, none of these matters would have made any difference to the WPI.
>
> I have examined these four alleged errors for myself. I am satisfied that the first three of them are apparent from the terms of the decision. All three errors concern matters that were not dealt with by the Appeal Panel: Mr Martinovic's application for a new medical examination was not addressed at all, the new evidence was not addressed at all and the question of whether there should be an additional 3% for radiculopathy was not addressed at all."

23. Her Honour then concluded that there was jurisdictional error in the decision of the first AP. The reasoning appears in the following paragraphs:[10]

> "I am satisfied that three jurisdictional errors have been established. Whether they be classified as a failure to engage with Mr Martinovic's arguments (*Dranichnikov v Minister for Immigration and Cultural Affairs 92003) 77 ALJR* 1088) or as a failure to provide reasons (*Campbelltown City Council v Vegan* (2006) 67 NSWLR 272), jurisdictional error is established. It follows that there are grounds to quash the decision of the Appeal Panel for jurisdictional error(s).
>
> **Conclusion**
>
> I am satisfied that the decision of the Appeal Panel is vitiated by jurisdictional error. On this basis the decision of the Arbitrator cannot stand and is liable to be quashed as well. This can only occur if an extension of time is granted to Mr Martinovic to seek judicial review of the decision of the Appeal Panel. Corporate Projects opposed an extension of time being granted. I will now turn to consider these arguments and the principles pertaining to them."

24. On 18 November 2019, the Commission rescinded the COD.

25. An appeal panel was initially constituted by the Registrar on 19 November 2019. The Appeal Panel (AP) was reconstituted in its present form on 25 November 2019.

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[8] *Martinovic v Workers Compensation Commission* [2019] NSWSC 1532
[9] At [116]-[117]
[10] At [125]-[126]

26. On 6 December 2019, Mr Petrovich advised, in response to a Commission email, that he acted for the appellant.

27. There has been no application by the appellant to adduce further evidence or otherwise make further submissions subsequent to the decision of the Supreme Court quashing the decision of the first AP.

PRELIMINARY REVIEW

28. The AP conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Guidelines. As a result of that preliminary review, the AP determined, for the reasons provided subsequently, that some of the grounds of appeal had been made out.

29. The appellant requested a re-examination by an AMS who is a member of the AP.

30. The respondent did not address this submission. It submitted that no error had been established "and the matter should not be referred to the Medical Appeals [sic] Panel for determination".[11] That submission appears to be directed to the gatekeeper's function under s 327(4) of the 1998 Act. Within the Opposition to the Appeal the respondent otherwise submitted that the Appeal Panel could deal with the matter solely on the papers.[12]

31. The AP formed the view that the appellant was required to be re-examined. The reasons for this decision are set out later in this decision.

32. The appellant was advised shortly after the preliminary review that he was required to attend an appointment with Dr Crocker on 16 December 2019. On 6 December 2019, Mr Petrovich advised, in response to a Commission email, that he was acting for the appellant.

33. Despite the fact that the parties were advised that the appellant was being re-examined, no application was made by either party to update the state of the evidence and/or their respective submissions. However, the preliminary review issued by the AP indicated that we would be looking at updated evidence. The preliminary review provided:

> "A report of the clinical examination restricted to the cervical, thoracic and lumbar spines, is to be provided to the Appeal Panel and is to address the following:
>
> - additional history since the original Medical Assessment Certificate was performed;
> - findings on clinical examination;
> - assessment of Whole Person Impairment of the skin, cervical and lumbar spines, and
> - Results of any additional investigations since the original Medical Assessment Certificate."

34. There was no response by either party to the preliminary review other than the appellant attending the examination appointment organised with Dr Crocker.

[11] Respondent's submissions, paragraph 40
[12] Opposition to Appeal, Part 2.3

APPLICATION TO ADMIT FRESH EVIDENCE

35. Section 328(3) of the 1998 Act provides that the Appeal Panel is not to receive evidence that is fresh evidence, or evidence in addition to, or in substitution for, the evidence received in relation to the medical assessment appealed against, unless the evidence was not available to the appellant before the medical assessment and could not reasonably have been obtained by the appellant before the medical assessment.

36. The appellant has sought to rely on a statement by the appellant dated 11 January 2016 and a statement by Renata Martinovic dated 11 January 2016, who was present when the appellant was examined by the AMS. As part of the reconsideration application the appellant relied on a further statement dated 19 March 2018.

37. The AP has accepted these documents but has given them generally little or no weight. The assertions within these statements are generally misconceived and/or lacking in probative value. Particular aspects of the statements are discussed later in these Reasons.

38. The AP has determined that the appellant be re-examined by a Panel member due to the findings of demonstrable error and application of incorrect criteria set out later in these Reasons. In these circumstances the complaints made of incorrect history could not impact on the ultimate determination. Further, it is unnecessary to consider the appellant's grounds questioning the nature of the original examination because the appellant was re-examined for the purposes of assessment pursuant to the fourth edition guidelines. However, the AP has addressed some of the criticisms made by the appellant of the original examination because we consider these assertions to be misconceived and lacking in probative value.

39. The AP observes that the AMS does not respond to these complaints.[13]

40. The appellant has complained about the history taken by the AMS. Some of those aspects were not relevant to assessment, such as the type of medication, although the appellant appeared aggrieved by the recorded history. In any event, Dr Crocker obtained an updated history from the appellant. It is clear from Dr Crocker's report that the appellant was provided with an opportunity to correct what the appellant perceived as inaccuracies in history taking in the MAC.

41. The AP does not accept that the allegation from Ms Martinovic that the AMS was "biased". That assertion raised a serious allegation which was unsupported by the material referred to in the statement.

42. Reference was otherwise made in the appellant's submissions to "reports assessing radiculopathy by Dr Teychenne" which were to be provided.[14] These reports were never filed by the appellant and have not been provided to the AP.

43. The AP observes that the matter has been unnecessarily complicated in this appeal because the appellant has filed submissions in the reconsideration application which added to the grounds of the appeal. No attempts were made by the appellant to provide any structure in the submissions to correlate these with the grounds for appeal.

44. The AP has examined the further submissions filed on the reconsideration application as the respondent was provided with an opportunity to and exercised a right of reply. Given the history of the matter we have considered the submissions. Aspects of the submissions, particularly with regard to radiculopathy, are wrong and inconsistent with AMA 5 and the fourth edition guidelines. This is discussed later in these Reasons.

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[13] See also the discussion by Hodgson JA in *Lukacevic v Coates Hire Operation Pty Ltd* [2011] NSWCA 112 at [78]

[14] Appellant's written submissions, paragraph 4

EVIDENCE

45. The AP has before it all the documents that were sent to the AMS for the original assessment and has referred to portions of the evidence and taken them into account in making this determination.

46. The AP has examined the substantial documentation filed by the parties in respect of the application for reconsideration considered by Arbitrator Egan and the Judicial Review proceedings in the Supreme Court.

47. The decision by the first AP was quashed by the Supreme Court. The AP therefore does not consider the reasons of the first AP in making this determination.

48. The document produced by the appellant in response to the preliminary review, that is an updated MRI scan, has been considered by the AP. The scan was considered by the AP to be unsupportive of the appellant's case that he had ongoing radiculopathy.

GROUND OF APPEAL – S 323 DEDUCTION

Submissions

Appellant's submissions

49. The appellant submitted that the AMS held that he had "pre-existing severe canal stenosis" and that he referred to Dr Bentivoglio's opinion that the severe canal stenosis was a "congenital basis". Reference was made to Dr Bentivoglio's opinion that the appellant had a "congenital small spinal canal" but that he concluded that he was unaware of any pre-existing condition which this injury had aggravated.

50. The appellant submitted that the AMS had made a demonstrable error and that there was "no medical evidence of any pre-existing injury".

Respondent's submissions

51. The respondent's submissions do not directly respond to the appellant's submissions.

52. The respondent submitted that the deduction under s 323 was "a matter for the clinical judgment and discretion of the AMS"[15] and any deduction could be based on a pre-existing condition or abnormality.

53. It was submitted that the AMS had "described a pre-existing condition or abnormality in the Appellant's spine and has accordingly made a deduction based on his clinical judgment".[16]

54. The respondent otherwise submitted that the AMS "has applied the correct criteria throughout the MAC".[17]

Reasons

55. Section 323 of the 1998 Act relevantly provides:

> "(1) In assessing the degree of permanent impairment resulting from an injury, there is to be a deduction for any proportion of the impairment that is due to any previous injury (whether or not it is an injury for which compensation has been

[15] Respondent's submissions, paragraph 32
[16] Respondent's submissions, paragraph 33
[17] Respondent's submissions, paragraph 29

paid or is payable under Division 4 of Part 3 of the 1987 Act) or that is due to any pre-existing condition or abnormality.

(2) If the extent of a deduction under this section (or a part of it) will be difficult or costly to determine (because, for example, of the absence of medical evidence), it is to be assumed (for the purpose of avoiding disputation) that the deduction (or the relevant part of it) is 10% of the impairment, unless this assumption is at odds with the available evidence.

(3) The reference in subsection (2) to medical evidence is a reference to medical evidence accepted or preferred by the approved medical specialist in connection with the medical assessment of the matter."

56. A deduction pursuant to s 323 of the 1998 Act is required if a proportion of the permanent impairment is due to previous injury or due to pre-existing condition or abnormality: *Vitaz v Westform (NSW) Pty Ltd (Vitaz)*[18]; Ryder *v Sundance Bakehouse* (*Ryder*)[19]*; Cole v Wenaline Pty Ltd* (*Cole*)[20].

57. A deduction can be made despite the fact that the worker is asymptomatic prior to injury. In *Vitaz* Basten JA stated:[21]

"42. The appeal to the Appeal Panel did not expressly identify an erroneous failure to give reasons. Rather, the submissions on the appeal, which appear to set out the grounds of challenge, complained that there can be no deduction under s 323, as a matter of law, in the absence of a pre-existing physical impairment. It was further submitted, by reference to the opinion of three medical commentators in a local publication:

> 'If a worker develops permanent pain and symptoms due to work consistent with spondylosis in the neck region, that condition might be assessed at DRE II. Although the spondylosis is likely to have been degenerative, if there were no symptoms in the period prior to the work-related complaint, then there was no rateable impairment at that time. So, nothing would be subtracted from the current impairment.'

43. That opinion contained a legal assumption which is inconsistent with the approach adopted by this Court in, for example, *D'Aleo v Ambulance Service of New South Wales* (NSWCA, 12 December 1996, unrep) (quoted by Giles JA, Mason P and Powell JA agreeing, in *Matthew Hall Pty Ltd v Smart* [2000] NSWCA 284; 21 NSWCCR 34 at [30]-[32] and, more recently, by Schmidt J in *Cole v Wenaline Pty Ltd* [2010] NSWSC 78 at [13]). The resulting principle is that if a pre-existing condition is a contributing factor causing permanent impairment, a deduction is required even though the pre-existing condition had been asymptomatic prior to the injury."

[18] [2011] NSWCA 254
[19] [2015] NSWSC 526 (*Ryder*) at [54]
[20] [2010] NSWSC 78 at [29] - [30]
[21] At [42]-[43], McColl JA and Handley AJA agreeing

58. In *Vannini v Worldwide Demolitions Pty Ltd*[22] (*Vannini*) Gleeson JA stated that an Appeal Panel, when considering the reasoning of an Approved Medical Specialist on the question of causation under s 323, was required to determine "whether any proportion of the impairment was due to any previous injury, or pre-existing condition or abnormality" and if so, "what was that proportion".[23]

59. In relation to the answer to the first question set out above, his Honour stated:[24]

> "The first question involved an assessment by the Panel, substantially of fact by reference to the evidence, although in part informed by the exercise of a clinical judgment. Such an assessment may be characterised as an evaluative judgment or conclusion based on findings of fact. Nonetheless, the legal criterion applied to reach that conclusion on causation demands a unique outcome, rather than tolerates a range of outcomes. Accordingly, the reasoning and finding of the medical specialist attracts the correctness standard of review by a Panel."

60. However, in respect of the extent of the deduction, Gleeson JA observed that a finding as to the degree of proportion of permanent impairment due to a previous condition or abnormality "involves matters of degree and impression". His Honour stated:[25]

> "The position may be different in relation to the second question. A finding as to *the* proportion of permanent impairment due to previous injury, pre-existing condition or abnormality involves matters of degree and impression. The applicable standard of the 'proportion' of contributory contribution under s 323 permits some latitude of opinion such as to admit of a range of legally permissible outcomes. That is not to say that such a conclusion is necessarily beyond review by an Appeal Panel on the ground of demonstrable error. However, the resolution of that question should be left to a case by case basis."

61. The relevant finding made by the AMS on the extent of the deduction was as follows:[26]

> "Mr Martinovic sustained an L4-5 disc protrusion in the context of an underlying severe canal stenosis. A canal stenosis of this severity is very likely to give rise to a lumbar disorder. As described by Dr Bentivoglio, this has a congenital basis."

62. Dr Peter Bentivoglio, Neurosurgeon, treated the appellant and noted that the MRI scan showed a severe L4-5 spinal canal stenosis secondary to a large central disc prolapse and a congenitally small spinal canal.[27] He noted that the injury occurred in the context of lifting a heavy door and twisting at the same time causing acute low back pain and radiating pain to both legs. The Doctor stated that the "large central L4-5 disc prolapse is narrowing his spinal canal and causing a significant nerve root and causa equina compression".

63. Dr Bentivoglio opined that he was unaware of any pre-existing condition.[28]

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[22] [2018] NSWCA 324 (*Vannini*) at [90]
[23] At [90]
[24] At [91]
[25] At [92]
[26] MAC, p 9
[27] Application, p 17
[28] Application, p 19

64. Surgery was undertaken by Dr Bentivoglio in January 2014 involving a decompression of the L4-5 spinal canal stenosis, posterior rhizolysis on both L5 nerve roots and a right sided rongeuring of the L4-5 disc.[29]

65. An MRI scan dated 24 July 2014 was reported as showing a reduction in the size of the central L4/5 disc protrusion with a remaining small right paracentral focus within the L4/5 disc which may represent granulation tissue.[30] Dr Kam noted that the findings on the MRI scan could be the explanation for the intermittent leg symptoms.[31]

66. Dr Guirgis opined that the lifting injury caused the L4-5-disc injury causing severe canal stenosis and a central posterior tear at L5-S1. The doctor did not assess any deduction referable to any pre-existing condition.[32]

67. Dr Michael Ryan, Orthopaedic Surgeon, examined the appellant on behalf of the respondent. He accepted the link between the surgery for claudicant sciatica including a right side L4/5 discectomy. He made no deduction pursuant to s 323 of the 1998 Act.[33]

68. The AP accepts the appellant's submission that the reliance by the AMS on the opinion of Dr Bentivoglio was inaccurate. Dr Bentivoglio's opinion, when properly analysed, attributed the large disc protrusion at L4/5 to the injury. The disc protrusion was the cause of severe canal stenosis against a background that the canal was otherwise small.

69. An AP may analyse the evidence when determining whether the certificate contains a demonstrable error: *Vannini*.[34]

70. It is also apparent from the medical evidence that the injury caused the need for surgery and the resultant impairment. In this respect there is an absence of medical evidence that any pre-existing condition was causative of impairment. We reject the respondent's submission that the answer to the proposition is that the deduction was a matter for the clinical judgment and discretion of the AMS[35]. Dr Bentivoglio opined that there was severe canal stenosis due to the large prolapsed disc, not the contrary as suggested by the AMS. The analysis by the AMS in relying on opinion that does not support the specific contention is a demonstrable error as discussed in *Vannini*.

71. This ground of appeal is successful. Having found error, the AP is required to reassess according to law: *Drosd v Nominal Insurer.*[36] We subsequently address the appropriate deduction later in these Reasons.

GROUND OF APPEAL – RADICULOPATHY

Submissions

Appellant's submissions

72. The appellant referred to paragraph 4.23 of the third edition guidelines which provides that "radiculopathy must be assessed in accordance within a strict set of guidelines and tests". It was asserted that Dr Adler had not provided "any medical basis nor details of the testing

[29] Application, p 21
[30] Application, p 25
[31] Application, p 27
[32] Application, p 7
[33] Reply, p 4
[34] At [78]
[35] Opposition submissions, paragraph 32
[36] [2016] NSWSC 1053

performed which allowed him to arrive at his conclusions with regards to there being no radiculopathy in the spine."[37]

73. The appellant referred to the statement by the AMS on neurological examination and submitted:[38]

> "The Appellant disputes that the sensory and reflex testing was tested adequately. It does not enable transparency showing how Dr Adler arrived at his conclusion."

74. The appellant, in submissions on the reconsideration application, suggested that dermatome maps were "inaccurate with a surprising lack of consensus about the size and location of the dermatomes" and that there is "an overlap between adjacent dermatomes".[39]

75. The appellant submitted that the AMS had failed to consider Table 4.2 of the fourth edition guidelines. It was submitted that, whilst the AMS had concluded that there was no radiculopathy, "his history taking with respect to symptoms is completely absent and he fails to undertake any assessment to specifically determine the following"[40] matters provided by paragraph 4.27 of the fourth edition guidelines.

76. It was further submitted that the AMS "did not provide any medical basis nor details of the testing performed which allowed him to arrive at his conclusion that there was no radiculopathy."[41]

Respondent's submissions

77. The respondent relevantly submitted:[42]

> "21. By inference the Appellant submits that the AMS applied incorrect criteria in his assessment as to whether or not the Appellant had radiculopathy affecting his lower limbs. It would seem that this submission is premised upon the failure of Dr Adler to address all possible ways in which radiculopathy can be verified pursuant to the WorkCover Guides.
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> 22. The Respondent submits that it is not necessary for an AMS to set out negative findings on examination in this way (that is setting out exhaustively what the AMS has not found) and the AMS's findings that there was 'normal neurological examination' is sufficient. We also comment that the Appellant has quoted selectively from the MAC as it is clear that, in considering radiculopathy, the AMS took a history of the manner in which the pain radiates into the Appellant's legs, assessed straight leg raising, and found the femoral nerve stretch test to be negative.
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> 23. The Respondent further observes in relation to radiculopathy that the AMS dealt with this in consideration of the Appellant's reports. The AMS specifically accepts that Dr Bentivoglio may have found radiculopathy when that doctor assessed the Appellant but notes that he could not confirm any such finding when the AMS examined the Appellant and, further, the Appellant did not identify symptoms consistent with verifiable radiculopathy.

[37] Appellant's submissions, paragraph 8
[38] Appellant's submissions, paragraph 9
[39] Appellant's reconsideration submissions, paragraph 18
[40] Appellant's reconsideration submissions, paragraphs 15-16
[41] Appellant's reconsideration submissions, paragraph 17
[42] Respondent's submissions, paragraphs 21-24

24. The Respondent submits that the AMS provided adequate and sound reasons why he considered radiculopathy had resolved. The failure to address every possible criterion does not represent the application of incorrect criteria."

78. In its response to the reconsideration application, the respondent suggested that the appellant's submissions "were the same submissions in the context of the original appeal from the Medical Assessment Certificate of Dr Adler".[43]

Reasons

79. The findings on examination provided by the AMS on this issue were:[44]

> **"Lumbar:** minor barely visible scar. Mildly tender L5-S1. Mild bilateral paralumbar muscle guarding. Mild flexion restriction. Normal extension. Straight leg raising 30° bilateral, but without any leg pain evoked. Sitting straight leg performed without restriction. Femoral nerve stretch test negative. Normal neurological examination on motor, sensory and reflex testing in the lower limbs. No leg length discrepancy."

80. Later in the MAC the AMS observed:[45]

> "There is persisting low back pain, with some radiation into the lower limbs. I could not demonstrate any neurological deficit. Straight leg raising was inconsistent."

81. When examining the opinions of other medical practitioners, the AMS observed that the basis for Dr Guirgis' opinion "is not clearly stated". The AMS also stated that he carefully evaluated the appellant of any residual sensory radiculopathy noting Dr Bentivoglio's previous finding of some S1 radiculopathy but "could not confirm any such finding".

82. The AP rejects a number of the appellant's submissions made in the reconsideration application before addressing the issue of adequate testing.

83. The appellant's submission that "dermatomes vary and there is an overlap between adjacent dermatomes" is wrong.[46] The appellant's submission that there is an unspecified variation for dermatomes in unspecified texts is irrelevant as AMA 5 provides a clear delineation of the dermatomes.

84. The principles of assessment for the spine are contained in paragraph 15.1 of AMA 5 and contain specific references to the various dermatomes in Table 15-2 and Figure 15-1 of AMA 5.

85. The suggestion in the appellant's submissions that there should be a "more robust and specific report with respect to the pinprick test" and that there be a "more robust and specific comment concerning the reflex test" is made without reference to any relevant provision of AMA 5 or the third and fourth edition guidelines.[47]

86. There is nothing in either AMA 5, the third and the fourth edition guidelines that support the appellant's submission. We do not accept that this is a proper basis alleging error as defined in s 327(3)(c) and/or (d) of the 1998 Act.

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[43] Respondent's reconsideration submissions, paragraph 18
[44] MAC, p 3
[45] MAC, p 4
[46] Appellant's reconsideration submissions, paragraph 18
[47] Application for Reconsideration, paragraph 35

87. Further, there is a presumption of regularity that the AMS has performed such tests as might be required: *Jones v the Registrar of the Workers Compensation Commission* (*Jones*)[48]. A similar presumption arises with respect to regularity which affects administrative action: *Bojko v ICM Property Services Pty Ltd* (*Bojko*)[49] and *Jones*[50].

88. An unusual feature in this matter is that the AMS assessed the appellant under the third edition guidelines. The fourth edition guidelines applied when the first AP reassessed the appellant.

89. We are determining error by the AMS as the decision of the first AP has been quashed. Accordingly, the appellant must show error under the third edition guidelines, in particular, by misapplying Table 4.2. An entitlement to a further 3% in the circumstances of this case requires the appellant to establish radiculopathy as defined in paragraph 4.23 of the third edition guidelines.

90. Pursuant to paragraph 4.23 of the third edition guidelines, the appellant is required to show at least one major criteria. In that respect the essential finding by the AMS was that there was a "normal neurological examination on motor, sensory and reflex testing in the lower limbs."

91. That statement represents an adequate description of evaluating major criteria for radiculopathy because the motor test relates to muscle weakness, the sensory testing to "reproducible impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution" and the reflex test to "loss or asymmetry of reflexes" as defined in paragraph 4.23 of the third edition guidelines.

92. Whilst the reasons may be brief, the AP accepts that the testing was undertaken and understands the path of reasoning consistent with the decision of the High Court in *Wingfoot Australia Partners Pty Ltd v Kocak*[51].

93. To the extent that the appellant has raised an argument based on adequacy of reasons, we are satisfied that the AMS tested for and did not find a major criterion for radiculopathy.

94. The AP indicated earlier in its reasons the lack of probative value in respect of the further statements relied upon by the appellant. Portions of these statements were relevant to the issue of radiculopathy.

95. The appellant took issue with the comments by the AMS on inconsistency with respect to straight leg raising. The inconsistency identified by the AMS was the difference between straight leg raising at 30 degrees bilaterally and those performed without restriction whilst sitting.[52] The further statements relied upon by the appellant does not explain that inconsistency. We would otherwise not accept the evidence, preferring the observations of the independent AMS.

96. A further issue is that the appellant has not identified a major criterion within the meaning of paragraph 4.23 of the third edition guidelines. The issue of straight leg raising would only be relevant to the issue of "positive nerve root tension", a minor criterion in paragraph 4.23.

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[48] [2010] NSWSC 481 at [50].
[49] At [36] per Handley JA, with whom Allsop and Giles JJA agreed
[50] At [36]
[51] [2013] HCA 43 at [55]
[52] MAC, p 3

97. The appellant and his wife provided evidence on the reflex testing undertaken by the AMS. The AP gives that evidence no weight as it is a lay opinion on an expert test. We reject the evidence as being inconsistent with the observations recorded by the AMS that there was no neurological deficit with respect to reflexes. The same observations pertain to the appellant's evidence concerning sensory testing.

98. We note that an opinion provided by Dr Ryan shortly prior to the AMS examination was also consistent with the AMS's conclusion that there was no radiculopathy.

99. Applying these principles, the AP does not accept that this ground is established

100. We otherwise observe that it is necessary to re-examine the appellant for other reasons as error has been established on other issues. Those other issues, that is the assessment of the activities of daily living (ADL) and s 323, impact indirectly on the issue of radiculopathy. For that reason, whilst we do not accept that error is shown, Dr Crocker has provided further reasons on this issue in his re-examination.

GROUND OF APPEAL – ACTIVITIES OF DAILY LIVING

Submissions

Appellant's submissions

101. The appellant referred to the history taken by the AMS concerning the effects of the injury on the appellant's ability to jog and pushbike ride, complete housework and mow the lawn.

102. It was submitted that the third edition guidelines would provide an assessment of 2% for the effects on ADL. No assessment was made by the AMS within the MAC.

Respondent's submissions

103. The respondent submitted:[53]

> "26. The Respondent submits that an AMS is not bound by the history provided to him to make such an assessment; this would subvert the application of the clinical judgment of an AMS. We comment that the AMS observed some inconsistencies in the Appellant's presentation to him and speculate that it is possibly on this basis that no allowance was made for the activities of daily living.
>
> 27. The Respondent submits that this does not reflect the application of incorrect criteria. In any event, however, if this issue needed to be addressed, it should be addressed by the AMS having the opportunity to reconsider that point."

Reasons

104. In the Reasons for Assessment the AMS did not consider ADL when assessing WPI. As the appellant correctly noted, there was a history taken that the injury impacted on social activities such as jogging and pushbike riding, was independent in self-care but played a smaller role in house work.[54]

[53] Respondent's submissions, paragraphs 26-27
[54] MAC, p 3

105. The AMS did not apply correct criteria because he did not assess ADL in accordance with paragraphs 4.29 to 4.32 of the third edition guidelines. It is not to the point, as the respondent submitted that because there were inconsistencies found on presentation that it was possible that the AMS made no allowance.

106. It is clear that that there were no reasons provided by the AMS for ADL.

107. The AP finds that the absence of any finding for the effects on the activities of daily living is an application of incorrect criteria within the meaning of s 327(3)(c) of the 1998 Act: see *Marina Pitsonis v Registrar of the Workers Compensation Commission of New South Wales*[55] applying Basten JA in *Campbelltown City Council v Vegan*[56].

108. This is also a demonstrable error because there is an absence of reasons. The path of reasoning does not refer to the relevant criteria for assessing ADL.

109. The parties did not refer to any relevant authority in respect of the obligation by the AMS to provide reasons.

110. The AMS has a statutory obligation to provide reasons pursuant to s 325 of the 1998 Act. These principles were discussed in *El Masri v Woolworths Ltd*[57] (*El Masri*) a decision involving judicial review of a decision of an Appeal Panel, when Campbell J stated:[58]

> "As I have said, and at the risk of repeating myself unduly, the process is one of expert evaluation. Often when judgment of any type is called for, there will be a gap between expression of reasons and articulation of decision which cannot itself be fully articulated. That gap constitutes what might be called judgment. Although, as Ms Allars reminded me, *Wingfoot* does not necessarily apply to this case because it was a case where there was a statutory obligation to give reasons, and in this case the obligation to give reasons is implied by the general law as explained in *Campbelltown City Council v Vegan* [2006] NSWCA 284; (2006) 67 NSWLR 372, what their Honours said at [55] of *Wingfoot* must be applicable. Basically, the statement of reasons must explain that actual path of reasoning in sufficient detail to enable a court to see whether the opinion does or does not involve any error of law. Applying that standard, it is clear what was decided and why, as is the reasoning process that led to the decision, especially if one has regard to what was said by the Panel at paragraph 18 which I will not further set out."

111. Further the requirement to provide reasons with respect to discussing the effects on the activities of daily living was discussed by Patten AJ in *Vekic v Registrar of the Workers Compensation Commission* when his Honour stated:[59]

> "34. Dr Beer, despite having the Plaintiff's claims of impaired ADLs before him, does not appear, as in my view, section 325 required him, to have taken a history from the Plaintiff as to how her ADLs were affected and as to why it was that her daughter was called upon to perform so many household tasks. I would have thought that his interest might have been excited by the history he did take from a comparatively young woman, without comment that the only thing she can do when she arrives home from work is to lie down."

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[55] [2008] NSWCA 88 (*Marina Pitsonis*) at [40]-[42], McColl and Bell JJA (as their Honours then were) agreeing
[56] [2006] NSWCA 284 at [94], McColl JA agreeing
[57] [2014] NSWSC 1344
[58] *El Masri* at [50]
[59] [2009] NSWSC 552 at [34]-[35]

112. The AMS did not consider the issue and accordingly did not provide any reasons. Error within the meaning of both s 327(3)(c) and (d) of the 1998 Act is established. This portion of the claim requires reassessment.

GROUND OF APPEAL – CERVICAL SPINE

Submissions

Appellant's submissions

113. The appellant submitted that the AMS did not provide "the range of movement of the Appellant's cervical spine" which made it "impossible to ascertain whether or not there is asymmetric range of movement."[60]

114. It was also submitted that the lack of detailed information meant that there "is no transparency showing how Dr Adler arrived at his conclusion".[61]

115. In the reconsideration application the appellant further submitted that the objective findings recorded by the AMS were "normal flexion, extension and rotation" and that the "AMS did not undertake a full assessment of the cervical spine which incorporated lateral bending".

116. The appellant submitted:[62]

> "However, a point that does not appear to have been considered is that the AMS did not undertake a full assessment of the cervical spine which incorporated lateral bending. The cervical spine must be tested on all planes of motion including flexion, extension, rotation and lateral bending. Whilst the AMS' observations during informal examination are consistent with his findings on rotation they are not consistent with flexion and extension because the Applicant was not observed to flex or extend during informal examination and more particularly lateral flexion because it was never tested nor was it observed on informal examination."

Respondent's submissions

117. The respondent submitted that the appellant's submission does not equate to a demonstrable error. Further, the AMS indicated that flexion, extension and rotation of the cervical spine was "normal" and that the AMS commented that informal examination was consistent with the objective findings.

118. The respondent submitted that the AMS had provided a thorough and adequate assessment in arriving at the assessment of 0% WPI.

119. As previously noted, the respondent submitted in response to the reconsideration application that the "arguments … are substantively the exact same arguments that were made in the context of the appeal of Dr Adler's MAC."[63]

[60] Appellant's submissions, paragraph 14
[61] Appellant's submissions, paragraph 15
[62] Appellant's reconsideration submissions, paragraph 21
[63] Respondent's reconsideration submissions, paragraph 8

Reasons

120. The reasons provided by the AMS were:[64]

> "**Cervical:** This demonstrated normal flexion, extension and rotation. No focal tenderness with no guarding response. Shoulder girdle muscles normal on palpation. Neurological examination of the arms is normal on motor, reflex and sensory testing. Spurling's test normal for nerve root compression. I also observed during informal examination that he was able to freely turned his neck full range in rotation bilaterally, consistent with the objective findings."

121. The appellant failed to refer to relevant criteria when he made the submission recorded at paragraph 116 herein. The appellant's submissions are otherwise not entirely accurate.

122. The cervical spine must be assessed in three planes that is flexion/extension; lateral flexion to each side and rotation to each side. The appropriate descriptor raised in the appellant's submissions should be "lateral flexion", or more contemporaneously, coronal rotation.

123. AMA 5 Box 15-1 refers to the "three planes" of motion of the spine. Reference is also made to paragraph 4.17 of the third edition guidelines and paragraph 4.19 of the fourth edition guidelines. These planes of motion are sagittal, coronal and horizontal/transverse respectively as represented in figure 15-7, p 402 of AMA 5.

124. The AMS stated that he measured "normal flexion, extension and rotation". This is only two measurements as flexion and extension is one measurement.

125. It is correct, as the appellant submitted, that the AMS does not refer to assessing "lateral flexion". The appellant, however, incorrectly submitted that there are four as opposed to three separate planes of motion.

126. The AMS indicates that he assessed flexion/extension and rotation and that indirect observations confirmed his opinion on rotation. Accordingly, it is correct as the appellant submitted that there is no reference to assessing lateral flexion. The presumptions discussed in *Bojko* and *Jones*, referred to previously[65], do not assist as the direct evidence is that the AMS only tested for flexion/extension and rotation.

127. This is an application of incorrect criteria. This ground of appeal is upheld and requires reassessment.

GROUND OF APPEAL – SCARRING

Submissions

Appellant's submissions

128. The appellant referred to the findings of Dr Adler that the appellant has a "minor barely visible scar". It was submitted that the AMS has not used the proper assessment and that he was "deeply self-conscious about this scar, and is [sic] feels very uncomfortable, both physically and emotionally, even when he must swim for rehabilitation purposes."[66]

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[64] MAC, p 5
[65] See paragraph 87 herein
[66] Appellant's submissions, paragraph 15

Respondent's submissions

129. The respondent submitted that the AMS observed that the scarring is minor and barely visible and would, in the normal course, be covered by clothing.

Reasons

130. The AMS stated:[67]

> "Scar: this is barely visible. It is over the back, and is not significant in terms of cosmesis. This is based on Temski, 0% WPI."

131. The appellant submitted that he was "deeply self-conscious about the scar" and that he feels very uncomfortable, both physically and emotionally.[68]

132. The appellant's submissions failed to refer to the relevant criteria set out in the third edition guidelines.[69] The relevant provision provides that a number of criteria are considered including colour, trophic changes, staple marks, anatomic location, contour defect, the effects on the activities of daily living, necessity for treatment and adherence.
133. It was self-evident that the anatomic location of the scar is not clearly visible with usual clothing. The description given to the scar by the AMS suggests that the only possible criterion is that the appellant was conscious of the scar.

134. The AP is not satisfied that the appellant has shown error or the misapplication of correct criteria by merely asserting that he was "deeply self-conscious" of the scar. That assertion does not outweigh the objective features such as the position and colour contrast of the scar.

135. The AP observes that the appellant's stated evidence[70] on this issue is particularly unpersuasive given the minor nature of the surgical scar. The suggestion of pain from such a minor scar is medically implausible. It otherwise does not detract from the clear objective features of the scar that warrant a 0% WPI.

136. However, as the AP is required to assess because of other errors, that the assessment must now be undertaken in accordance with the fourth edition guidelines and that the assessment is occurring some four years later, we believe that an updated examination is appropriate.

GROUND OF APPEAL – HISTORY TAKING

Appellant's submissions

137. The appellant submitted that the AMS made a number of errors recording information supplied by the appellant including the time or length the appellant is capable of walking and the medication taken by the appellant.

138. The appellant also submitted that the AMS found inconsistency on straight leg raising, did not elaborate on this finding and otherwise did not accurately record his findings on examination.

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[67] MAC, pg 6
[68] Application to Appeal, paragraph 16.
[69] Third edition guidelines at p 84
[70] See statement dated 11 January 2016 at paragraph 7

Respondent's submissions

139. The respondent relevantly submitted:[71]

> "It is not apparent what the Appellant suggests by pointing out what the Appellant submits are deficiencies in the AMS's history taking. The Respondent submits that these matters are irrelevant and, in relation to inconsistency in straight leg raising, wrong."

Reasons

140. The AP agrees with the respondent's submissions. This ground for appeal does not raise an argument within the meaning of s 327(3)(c) and/or (d) of the 1987 Act.

141. We otherwise observe that Dr Crocker re-examined the appellant and was entitled to take a corrected history.

REASSESSMENT

Further medical examination

142. In view of the finding of error on various grounds of appeal, the AP was of the view there was a clear need for re-examination. The reasons for re-examination included the substantial delay since the original examination, undertaken four years previously and the fact that during the intervening period, the fourth edition guidelines replaced the third edition guidelines.

143. The AP is required to use the version as at the date of assessment. Even though the AP was not convinced in respect of all the grounds, the difficulty is that the MAC applied the guidelines then in force, that is the third edition guidelines. In the view of the AP it would be inappropriate to reassess the appellant in part applying the fourth edition guidelines but to apply the findings on body parts not the subject of a successful appeal, to guidelines no longer in force.

144. The appellant was examined by Dr Crocker, a member of the AP on 16 December 2019. Dr Crocker's findings are set out in full.

> "At the consultation, Mr Milan Prepelic, Croatian-English Interpreter (NAATI No CPN8LY6OU), was present to facilitate the consultation. Very little use was required of Mr Prepelic in view of Mr Martinovic's reasonably satisfactory English language skills.
>
> Mr Martinovic's wife had accompanied him. She remained present in the adjacent waiting area.
>
> **1. The worker's medical history, where it differs from previous records**
>
> I took the opportunity to obtain a comprehensive medical history to facilitate the consultation.
>
> In regard to history, points raised by Mr Martinovic's solicitor were taken into account at the time of the consultation.

[71] Respondent's written submissions, paragraph 36

It was raised that the Approved Medical Specialist, Dr Adler, had recorded that the Appellant is capable of walking for up 1.5 hours. It is outlined that the Appellant disputes that this is what he said and, rather, he had stated that he could walk for up to 1.5km on a good day.

In respect to the above, Mr Martinovic stated that what has been outlined by his solicitor had been the case but he finds that he now needs to sit for a period of time after endeavouring to walk for approximately 300m.

With respect to questions relating to what Dr Adler had outlined in relation to medication, Mr Martinovic indicated that his present medication regime is as follows: Cymbalta, Seroquel XR, Comfarol forte (Panadeine forte equivalent) (approximately 20 per month) and Nurofen 200mg tablets (approximately 3-4 per week).

In relation to aspects relating to the Appellant's documentation pertaining to history, it was raised that Dr Adler had referred to some inconsistency relating to straight leg raising. Aspects of this type, however, will be further alluded to below with respect to physical examination and clinical findings.

2. Additional history since the original Medical Assessment Certificate was performed

The medical history was expanded to confirm that Mr Martinovic had been working as a Gyprocker with the company. He had reportedly worked with them for approximately six weeks prior to the subject incident with full hours. He stated that he had also earlier worked with the company.

Earlier work in Australia had been of a similar nature and pertaining to formwork.

Mr Martinovic had immigrated to Australia from Croatia in 2001 having worked in construction and as a Taxi Driver in that country.
Mr Martinovic confirmed aspects relating to the mechanism of injury, as previously documented.
Aspects relating to his current clinical status were reviewed.

He reports that he is experiencing constant variable pain to the posterior aspect of the neck with extension to the suprascapular regions from a mild to "strong" degree. There is limitation with range of motion as a consequence of pain, in particular, if having to turn his head to the left side. He gave the example of this being particularly evident when driving a motor vehicle.

He did not report pain extending to the upper limbs.

Mr Martinovic is continuing to experience pain to the central low back on a constant variable basis from a moderate to 'strong' degree. This extends to the buttocks and lower limbs to a diffuse distribution, also on a constant basis.

He reports limitation with truncal range of motion as a consequence of pain.

He also reports 'pins and needles' and burning pain diffusely affecting the lower limbs. He also reports an occasional feeling of numbness of the lower limbs if maintaining a more static posture, for example, with sitting for a longer period of time.

There is nil reported bowel or bladder disturbance. He reports negative impacts upon his sexual function.

He considers that his psychological status is ‘not good’ but has been assisted by use of medication.

He reports that his surgical scars worry him. He indicates that he is more conscious of these if wearing lighter clothes around the home in warmer months or if attending a swimming pool.

In relation to treatment, see details outlined above.

He is continuing to attend his General Practitioner approximately on 1-2 occasions per month. There has been nil recent specialist review.

He is not presently undergoing physiotherapy treatment or counselling.

He occasionally utilises hot or cold packs.

With respect to activities of daily living, he reports that his sleeping has been assisted by medication.

He finds that he experiences increased discomfort if seated for periods of greater than approximately 15 minutes.

Aspects relating to walking have already been alluded to above.

He reports that there are nil significant stairs at his home but he would have difficulty if having to negotiating these.

His wife attends to household chores. His son is having to mow the lawn.

Mr Martinovic may assist to a limited degree in relation to shopping.

It has been indicated that he has difficulty with driving, in particular, with neck movement.

He reports that he is substantially independent in relation to personal care but occasionally has sought assistance with laced shoes.

He did not report any other medical conditions arising since the time of his earlier examinations.

3. Findings on clinical examination

Mr Martinovic was a cooperative man in nil apparent physical distress while at rest. His English language skills were satisfactory. As alluded to above, there was only limited assistance required from the interpreter.

Mr Martinovic was informed that I would require his full cooperation but that I would cease or modify any manoeuvres that were potentially distressing for him.

His weight was 91kg, lightly clothed, with a height of 180cm in bare feet. According to Nutrition Australia, the healthy weight range for an Australian of this height is 60-81kg.

Examination of the cervical spine demonstrated active range of motion to be approximately as follows: Left axial rotation one-third that of normal; right axial rotation two-thirds that of normal; left coronal rotation half that of normal; right coronal rotation two-thirds that of normal; posterior sagittal rotation half that of normal; anterior sagittal rotation two-thirds that of normal.

Diffuse tenderness was reported with palpation overlying the posterior aspect of the neck and extending to the suprascapular regions.

Nil muscular spasm or guarding was evident.

There was satisfactory symmetric active range of motion in relation to the shoulders, elbows, wrists and within both hands.

Girth measurements within the upper limbs were approximately as follows: 34cm (right mid upper arm); 34cm (left mid upper arm); 30cm (maximal right forearm girth); 30cm (maximal left forearm girth).

Motor and sensory systems examination within the upper limbs was non-contributory.

General inspection of the trunk demonstrated flattening of the thoracolumbar curve. A mild thoracic scoliosis configuration was evident.

A healed longitudinal surgical scar was noted to overlie the lower lumbar spine. This was pale in colour and there was nil loss of contour.

Active truncal range of motion was approximately as follows: Left axial rotation one-third that of normal; right axial rotation one-third that of normal; left coronal rotation two-thirds that of normal; right coronal rotation unrestricted; posterior sagittal rotation one-third that of normal; anterior sagittal rotation (forward flexion) such that Mr Martinovic could reach to knee level with his fingertips while standing.

Diffuse tenderness was reported with palpation overlying the lumbar spine, paralumbar musculature, sacroiliac joints and buttocks. Mild guarding was evident with palpation overlying the left paralumbar region.

Mr Martinovic exhibited a symmetric gait when observed walking within the confines of my office.

Active straight leg raising was to approximately 40° bilaterally with low back and lower limb discomfort reported with the examination, in particular, to the central low back.

Girth measurements within the lower limbs were as follows: 48.5cm (right thigh); 48cm (left thigh); 38.5cm (right calf); 38.5cm (left calf).

Motor system examination within the lower limbs was non-contributory. All reflex responses were present and symmetrical inclusive of the hamstring responses. Sensory system examination demonstrated nil abnormality.

The Babinski responses were normal with both toes downgoing.

4. Results of any additional investigations

Multiple radiological films were inspected with accompanying reports. These included a more recent MRI examination of the lumbar spine dated 5.12.17. In relation to this study, the reporting Radiologist has documented the following by way of conclusions:

1. Mild disc bulges at L4/5 and L5/S1 associated with posterior annular tears. However, there is no evidence of nerve root impingement.

2. Mild bilateral facet joint degenerative change at L3/4, L4/5 and L5/S1.

Reference has not been made in relation to radiological findings pertaining to the earlier laminectomy/discectomy that had been performed at the L4/5 level.

5. Determination of permanent impairment

It is evident that Mr Martinovic has ongoing features referable to the region of the cervical spine. It is likely that this is on the basis of earlier aggravation of some degree of multilevel degenerative changes as demonstrated on radiological investigations that had been performed previously.

In relation to the region of the lumbar spine, Mr Martinovic remains symptomatic with functional limitation. It is evident that he had required earlier decompressive surgery for a disc lesion at the L4/5 level.

More minor post-surgical scarring is evident overlying the lumbar spine.

Is it my opinion that Mr Martinovic exhibited caution in relation to the various aspects of the physical examination, however, nil overt inconsistences were apparent.

With respect to determination of Whole Person Impairment for the cervical spine, based upon the presence of asymmetry of movement in the absence of radiculopathy/neurological dysfunction, a DRE Category II rating is determined. This equates with a 5% WPI.

In relation to the region of the lumbar spine, a DRE Category III rating applies given that decompressive surgery has been required, ie 10-13%. Taking into account negative impacts upon activities of daily living, a 12% WPI has been determined. Based upon the current assessment, it is considered that nil modifiers for surgery are applicable. In particular, nil major criteria were evident with respect to radiculopathy were noted to be present in accordance with the NSW Workers' Compensation Guidelines (Chapter 4, 4.27, pg 27). In relation to minor criteria, it is considered that a positive nerve root tension sign was not clearly evident. There was nil evidence of muscular wasting/atrophy.
In relation to the radiological investigations, in particular the most recent MRI examination of 5.12.17, the reporting doctor has indicated that there were nil radiological features consistent with nerve root impingement.

With respect to scarring, it is considered that the surgical scar that is present is consistent with usual healing following a procedure of this type. In this regard, Chapter 14, paragraph 14.6, pg 73 of the NSW Workers' Compensation Guidelines for the Evaluation of Permanent Impairment (4th edition) needs to be taken into account. This states: 'A scar may be present and rated as 0% WPI. Note that uncomplicated scars for standard surgical procedures do not, of themselves, rate an impairment.'

As such, it is my opinion that a 0% WPI is applicable in this case.

In relation to potential deductions, there does not appear to have been pre-existing injuries or conditions pertaining to the spinous regions. Mr Martinovic had been able to undertake usual employment. He does not report pre-existing complaints referable to these areas. As such, I do not consider that any deductions are applicable by way of contributory impairment.

Taking into account the above, a final combined Whole Person Impairment of 16% is determined."

Further reasons on assessment

145. The AP adopts the precise findings of Dr Crocker as set out above. They represent an up to date and thorough account of the appellant's present symptoms. They are particularly relevant and persuasive given that neither party purported to rely on recent medical evidence pertaining to the appellant's symptoms.

146. The AP adds some further reasons in its assessment of the appellant's WPI.

147. In respect of the appropriate classification of the scar, the AP is required to apply Table 14.1 of the fourth edition guidelines. The appellant's submission that he is "deeply self-conscious" of the scar is contrary to the objective features that it is minor. The medical opinion provided by Dr Guirgis on the scar is outdated and irrelevant to an assessment some five years later.

148. We otherwise repeat our reasons for rejecting the ground of appeal concerning the scar in arriving at an assessment of 0% WPI.

149. Paragraphs 4.33 – 4.36 of the fourth edition guidelines relate to the assessment of an appropriate percentage for the activities of daily living. Paragraph 4.33 provides that an "assessment of the effect of the injury on ADL is not solely dependent on self-reporting but it is an assessment based on all clinical findings and other reports".

150. Paragraph 4.34 provides that the diagram "should be used as a guide" in determining the appropriate percentage. There can be no doubt about the significance of the word "guide" as the fourth edition guidelines has used bold print to emphasise the word.

151. Paragraph 4.35 provides that the base impairment is increased by:

- 3% WPI if the worker's capacity to undertake personal care activities such as dressing, washing, toileting and shaving has been affected;
- 2% WPI if the worker can manage personal care but is restricted with usual household tasks, such as cooking, vacuuming and making beds, or tasks of equal magnitude, such as shopping, climbing stairs or walking reasonable distances, and
- 1% WPI if the worker can manage personal care and household tasks but is unable to get back to previous sporting or recreational activities.

152. The AP refers to the history taken by Dr Crocker pertaining to the effects on home care and the history taken by the AMS with respect to loss of social and recreational activities. The outdated statement from the appellant is consistent with these histories.[72]

[72] Application, pp 36-37

153. The assessment of the effects on ADL is not solely based on self-reporting. We accept that the nature of the injury, particularly to the lumbar spine with the ongoing pain restrictions satisfies an increase of the impairment by 2% consistent with paragraph 4.35 of the fourth edition guidelines.

154. The lumbar spine is otherwise assessed at 10% WPI due to the surgery. That particular assessment was the subject of common opinion by all medical practitioners. The additional amount for ADL means that the lumbar spine is assessed at 12% WPI.

155. The AP does not assess any deduction pursuant to s 323 of the 1998 Act in respect of the assessment for the lumbar spine. In that regard we give particular weight to the opinion expressed by Dr Bentivoglio which is otherwise consistent with the opinion expressed by Dr Crocker.

156. The cervical spine was assessed by Dr Crocker as DRE Category II due to asymmetric loss of range of motion. The AP clarifies that the wording used by Dr Crocker for the three planes of measurement correlate with the Reasons provided at paragraph 123 herein, that is sagittal rotation for flexion/extension; coronal rotation for lateral flexion and axial rotation for rotation.

157. There is no basis to make any s 323 deduction for the assessment of the cervical spine.

158. The AMS observes that injury was admitted. The evidence establishes that the appellant had no relevant pre-existing symptoms, has a continuity of complaints and no relevant post-injuries. In these circumstances, the AP is satisfied that the impairments are as a result of the accepted work injury.

159. We are also satisfied, given the duration of symptoms, that the impairments are permanent.

DECISION

160. For these reasons, the Medical Assessment Certificate given in this matter for WPI is revoked and a new Medical Assessment Certificate is issued. The new Medical Assessment 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 MEDICAL APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

L Funnell

Leo Funnell
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL

MEDICAL ASSESSMENT CERTIFICATE

Matter No: **6205/15**
Applicant: **Tomislav Martinovic**
Respondent: **Corporate Projects Pty Ltd**

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

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

Body Part or system	**Date of Injury**	**Chapter, page and paragraph number in fourth edition guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA5**	**% WPI**	**WPI deductions pursuant to S323 for pre-existing injury, condition or abnormality (expressed as a fraction)**	**Sub-total/s % WPI (after any deductions in column 6)**
Lumbar Spine	15.8.13	Chap 4, para 4.27 – 4.37	Chap 15.4, Table 15-3	12%	nil	12%
Cervical Spine	15.8.13	Chap 4, para 4.17 – 4.25	Chap 15.6, Table 15-5, Figure 15-7	5%	nil	5%
Skin	15.8.13	Table 4.1 p 74		0%	N/A	0%
Total % WPI (the Combined Table values of all sub-totals)					16%	

John Harris
Arbitrator

Dr David Crocker
Approved Medical Specialist

Dr Brian Noll
Approved Medical Specialist

7 January 2020

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

L Funnell

Leo Funnell
Dispute Services Officer
As delegate of the Registrar