WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-3256/19**
Appellant:	**Robert Hart**
Respondent:	**Hays Specialist Recruitment (Australia) Pty Limited**
Date of Decision:	**24 January 2020**
Citation:	**[2020] NSWWCCMA 11**

Appeal Panel:	
Arbitrator:	**Jane Peacock**
Approved Medical Specialist:	**Dr Brian Stephenson**
Approved Medical Specialist:	**Dr Phillipa Harvey-Sutton**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 1 October 2019 Mr Robert Hart (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Gregory McGroder, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 4 September 2019.

2. The appellant relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act):

    - the assessment was made on the basis of incorrect criteria, and
    - the MAC contains a demonstrable error.

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

4. The Workers compensation medical dispute 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 Workers compensation medical dispute 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).

PRELIMINARY REVIEW

6. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Workers compensation medical dispute assessment guidelines.

7. As a result of the Appeal Panel's preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination.

EVIDENCE

Documentary evidence

8. 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.

Medical Assessment Certificate

9. 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

10. Both parties made written submissions. They are not repeated in full but have been considered by the Appeal Panel.

FINDINGS AND REASONS

11. 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.

12. In *Campbelltown City Council v Vegan* [2006] NSWCA 284 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.

13. The matter was referred by the Registrar to the AMS as follows:

> "The following matters have been referred for assessment (s 319 of the 1998 Act):
>
> - Date of injury: 21 May 2012
> - Body parts/systems referred: Left Lower Extremity (knee) and consequential condition to Right Lower Extremity (knee)
> - Method of assessment: Whole Person Impairment"

14. The AMS assessed as follows:

Body Part or system	**Date of Injury**	**Chapter, page and paragraph number in NSW workers compensation guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA5 Guides**	**% 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)
1. Left Lower Extremity	21/5/12	Chapter 3 Pages 16-15	Page 537 Table 17.10	4%	Nil	4%

2. Right Lower Extremity	21/5/12	Chapter 3 Pages 16-15	Page 537 Table 17.10	12%	½	6%
Total % WPI (the Combined Table values of all sub-totals)					10%	

15. There was no appeal from the assessment of the left lower extremity.

16. There was no appeal from the overall assessment of impairment of the right lower extremity at 12% whole person impairment (WPI). The appeal concerns the deduction made by the AMS under s 323 of one-half.

17. In summary, the appellant submitted that the AMS erred as follows:

- The AMS erred in making a one-half deduction under s 323 and the deduction should have been limited to one-tenth deduction;
- In making a one-half deduction the AMS engaged in an impermissible speculative exercise;
- The evidence available to the AMS about the impact that the prior injury (which occurred 20-30 years) had upon Mr Hart's right knee arises from Mr Hart's statements and those statements are that he had a good result from the prior surgery and was able to engage in active activities;
- The AMS has merely assumed that the prior injury has contributed to one-half of the total impairment without assessing the evidence.

18. In summary, the respondent worker submitted the AMS has appropriately exercised his clinical judgment having regard to the available evidence and that the MAC should be confirmed.

19. The role of the AMS is to conduct an independent assessment on the day of examination. The AMS is required to take a history, conduct a physical examination, review the special investigations, make a diagnosis and have due regard to other evidence and other medical opinion that is before the AMS. The AMS must bring his clinical expertise to bear and exercise his clinical judgement when making an assessment of impairment and make such assessment in accordance with the criteria in the Guides. When considering the assessment of a deductible proportion under s 323 the AMS can only make a deduction if he considers in the exercise of his clinical judgment that the pre-existing condition, abnormality or injury has contributed to the level of permanent impairment assessed. Where the extent of the deduction would be too difficult or too costly to determine, the deduction will be one-tenth.

20. Here the AMS took a detailed history as follows, including the history relating to the prior in injury to the right knee:

> **"Brief history of the incident/onset of symptoms and of subsequent related events, including treatment:** On 21 May 2012, during the course of his work, Mr Hart slipped on some oil on the ground. He said that his left leg came up against the excavator track and he hyper-extended and twisted his knee. He said that there was immediate pain and swelling and he thinks he dislocated his patella. He had difficulty bending the knee. He said that he was transferred to an ambulance by fellow workers and he said he felt a clunk and the patella seemed to relocate. He was taken to a local medical centre and then transferred to St George Hospital. X-rays were performed and no bony injury was demonstrated.

He then saw his GP and he was referred to Dr Vertzyas, Orthopaedic Surgeon, who he saw on 5 June 2012. X-rays of the knee demonstrated only minor degenerative changes and an ultrasound suggested a medial collateral ligament strain. Clinically, Dr Vertzyas diagnosed a torn medial collateral ligament and a medial meniscal tear. He had physiotherapy. He was then sent for a MRI. This demonstrated no significant abnormality but some bone bruising on the lateral femoral condyle.

He subsequently developed problems with his right knee. He felt that this was from limping. He saw Dr Vertzyas regarding this and he gave him a cortisone injection. He organised a MRI which was done on 9 May 2013. This demonstrated significant chondral wear, particularly in the medial compartment, along with a previous partial medial meniscectomy and a chronic anterior cruciate ligament rupture. Dr Vertzyas diagnosed aggravation of an arthritic knee.

He said that he has had problems with both knees on-going. He said that Dr Vertzyas has told him that he needs bilateral replacements but he said that he hasn't had these because of medical problems.

Present treatment: He takes analgesic and anti-inflammatory medication but otherwise no treatment.

Present symptoms: He said that he has severe pain in both his knees, even at rest. He said that he has significant restriction of range of movement of the knees and he cannot bend them and cannot straighten them. He said that any weight-bearing results in severe pain. He cannot squat or kneel. He said that his knees grate. He can only walk short distances.

Details of any previous or subsequent accidents, injuries or condition: Thirty years ago he was involved in a road traffic accident where he fractured his right patella. This underwent open reduction and internal fixation at Westmead Hospital. He said that he had a good result from this. He was able to play sport and work in an unrestricted manner. The subsequent investigations, however, demonstrated that he had also had a partial medial meniscectomy and a ruptured anterior cruciate ligament.

General health: He said that he is insulin controlled diabetic. He has hypertension. He has back pain and was told this is due to disc prolapses. He has liver secondaries with the primary unclear. He had a DVT towards the end of 2013.

Work history including previous work history if relevant: Mr Hart was a plant operator. At the time of his injuries he was working with Hays Specialist Recruitment and he had been with them for one year. He was injured at the Revesby Workers Club site. After the injury he attempted to drive a forklift as a form of light duties for a short period but this was only temporary and he hasn't really worked since that time.

Social activities/ADL: He is currently living alone and said that his activities of daily living are compromised by multiple medical factors but he finds that he also has a lot of difficulty performing a lot of tasks around the house and the yard because of his knee problems."

21. The Panel notes that the AMS has correctly recorded that Mr Hart suffered an injury to his left knee on when he slipped in oil. The condition in the right knee which has been referred for assessment is a consequential condition that resulted from the injury to the left knee.

22. The AMS conducted a physical examination and his findings are not the subject of complaint on appeal.

23. The AMS reviewed the special investigations as follows:

"26 June 2012 – MRI Left Knee
The anterior and posterior cruciate ligaments are intact. The medial and lateral collateral ligaments are normal in appearance. The menisci are intact. There is a small effusion within the knee joint. The articular cartilage is well preserved. The patellar and quadriceps tendons are intact. Minor bone bruising is present in the lateral femoral condyle and soft tissue oedema is noted surrounding the knee joint.

MRI Right Knee
Full thickness articular cartilage wear in the medial tibiofemoral compartment. Grade 2 to 3 articular cartilage wear in the central femoral trochlear. A prior partial medial meniscectomy and a chronic anterior cruciate ligament rupture."

24. The AMS summarised the injury and diagnosis as follows:

> "In an incident at work on 21 May 2012 Mr Hart injured his left knee in the form of a medial collateral ligament tear and a bone bruise involving the lateral femoral condyle.
>
> He had a previous injury to his right knee in the form of a fractured patella which underwent open reduction and internal fixation and he also had a partial medial meniscectomy. He had a torn anterior cruciate ligament. He had developed arthritis by the time the left knee was injured."

25. The AMS commented on Mr Hart's consistency of presentation as follows:

> "He was very difficult to examine because of some abnormal pain response."

26. The AMS explained his assessment of impairment as follows:

> "Range of movement has been used to assess impairment. On the left there is no flexion contracture and flexion to 90 degrees is 10% LEI which converts to 4% WPI. There is no deduction for a pre-existing condition.
>
> On the right, using Table 17.10 for range of movement, flexion to 90 degrees is 10% LEI and a flexion contracture of 5 degrees is 10% LEI. Varus deforminty is 10% LEI, in the mild range. This results in 30% LEI, which converts to 12% WPI. After a one-half deduction this is 6% WPI."

27. The AMS made comment on the other evidence before him, including explaining why he has made a deduction of one-half under s 323 as compared to the one-tenth deduction made by Dr Briet as follows:

> "Dr N Vertzyas, Orthopaedic Surgeon, supplied treating doctor reports, dated from 5 June 2012. Dr Vertzyas concluded that Mr Hart developed a left medial collateral ligament strain and a bone bruise and he recommended conservative management. He diagnosed a post traumatic arthritis of the right knee because of his road traffic accident 30 years ago and that there was an exacerbation of this since his left knee injury. He did not assess impairment.
>
> The only assessment of impairment was performed by Dr R Breit, Orthopaedic Surgeon, dated 21 September 2017. Dr Breit noted the same problems with examination as I did but he also used range of movement to assess on the left 4% WPI, which is the same finding as my own with no deduction. On the right, Dr Breit estimated 7% WPI after a one-tenth deduction. I have found some extra impairment for the varus deformity and estimated a higher figure than Dr Breit but I made a one-half deduction which I felt is more appropriate considering the severity of Mr Hart's prior knee injury and the fact that there was no actual history of an injury to the right knee at the time of the referred date of injury."

28. The AMS addresses the question of the deduction for the pre-existing condition, abnormality or injury as follows:

> **"**DEDUCTION (IF ANY) FOR THE PROPORTION OF THE IMPAIRMENT THAT IS DUE TO PREVIOUS INJURY OR PRE-EXISTING CONDITION OR ABNORMALITY
>
> a. In my opinion the worker suffers from the following relevant previous injuries, pre-existing conditions or abnormalities:
>
> (i) Well established arthritis of the right knee at the time of the injury to the left knee.
>
> b. The previous injury, pre-existing condition or abnormality directly contributes to the following matters that were taken into account when assessing the whole person impairment that results from the injury, being the matters taken into account in 10a, and in the following ways:
>
> (i) I expect that were impairment to be assessed at the time of the injury to the left knee there would have been a significant degree of impairment assessed, despite Mr Hart suggesting that he had normal function.
>
> c. Whilst the extent of the deduction is difficult or costly to determine the available evidence is that the deductible proportion is large and a deduction of one tenth is at odds with the available evidence. In my opinion the deductible proportion is one-half for the following reasons:
>
> (i) There is evidence of significant damage to the right knee as a result of the road traffic accident that would have resulted in impairment which would have been present well before the referred date of injury, being 21 May 2012."

29. Mr Hart submitted that the AMS has engaged in a speculative exercise to arrive at a deduction of one-half and a deduction of one-tenth should have been made instead.

30. The AMS was required to assess the degree of permanent impairment, if any, in respect of the right lower extremity that has resulted from the injury to the left lower extremity on 21 May 2012.

31. The condition in the right knee that had to be assessed for impairment as a result of the injury on 21 May 2012 was a consequential condition. When assessing the level of permanent impairment as a result of this injury, the AMS was required to make a deduction under s 323 to take account of the pre-existing condition, injury or abnormality in the right knee if he found that the pre-existing condition, abnormality or injury contributed to the overall level of permanent impairment assessed for the right knee.

    The AMS reviewed the history, and the special investigations, the other medical evidence inducing other medical opinion. He was correct on the history to identify that a significant degree of arthritis change in the right knee pre-existed the injury to the left knee. This clinical assessment is consistent with the history of a significant injury to the right knee and subsequent surgery. It is consistent with the radiological investigation (MRIs of each knee after injury) which show that the arthritic changes in Mr Hart's knee are not bilateral.

32. The Panel notes that the MRI investigations for the right knee show the extent of the arthritic changes are such that it presents as 'bone on bone'.

33. The panel notes that the findings of the advanced arthritis are not bilateral. There is extensive cartilage wear in the right knee consistent with post traumatic arthritis, noting the prior significant injury and subsequent surgery to the right knee. These changes are not present in the left knee which presents normally with minimal changes.

34. The MRI of the right knee dated 9 May 2013 was undertaken at the request of the treating orthopaedic surgeon Dr Vertzyas who reviewed Mr Hart on 21 May 2013 and wrote to the GP Dr Tran reporting as follows:

> "The MRI showed full thickness articular wear in the medial tibiofemoral compartment. There was grade 2-3 articular cartilage wear in the central femoral trochlear. There was a tear of the anterior horn remnant of the medial meniscus following a prior partial medial meniscectomy. There was a chronic anterior cruciate ligament rupture.
>
> Mr Hart has advanced post-traumatic arthritis affecting his right knee with his symptoms being exacerbated since his left knee injury."

35. The AMS had to take account of the contribution of the advanced pre-existing arthritic changes in the right knee to the level of permanent impairment assessed. He has exercised his clinical judgment in doing so, based upon the available evidence, and the Panel can discern no error.

36. In this case, the panel can discern no error in the assessment of the AMS in making a one-half deduction under s 323 to take account of the contribution of the pre-existing condition of the right lower extremity to the level of permanent impairment assessed as a result of the injury on 21 May 2012. He has clearly explained his approach and the Panel can discern no error.

37. For these reasons, the Appeal Panel has determined that the MAC issued on 5 September 2019 should be confirmed.

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*.

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Ann MacLeod
Dispute Services Officer
As delegate of the Registrar