WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-363/20**
Appellant:	**Kathy Therese Mulholland**
Respondent:	**Uniting (NSW & ACT)**
Date of Decision:	**23 December 2020**
Citation No:	**[2020] NSWWCCMA 184**

Appeal Panel:	
Arbitrator:	**R J Perrignon**
Approved Medical Specialist:	**Dr John Ashwell**
Approved Medical Specialist:	**Dr Margaret Gibson**

BACKGROUND TO THE APPEAL

1. The appellant worker, Ms Mulholland, appeals from the Medical Assessment Certificate of Approved Medical Specialist Dr Kuru dated 19 March 2020.

2. On 1 September 2016, Ms Mulholland injured her lumbar spine when she slipped and fell at work. In February 2017, she came to decompression surgery at L4/5 and L5/S1 at the hands of her neurosurgeon, Dr Edger.

3. By a solicitor's letter dated 12 August 2019, she claimed permanent impairment compensation from the respondent in respect of an 18% whole person impairment (17% lumbar spine; 1% scarring) in accordance with the assessment of Dr Ghabrial dated 12 June 2019. Dr Ghabrial had not assessed the right lower extremity, and the appellant made no claim on the respondent for permanent impairment of that limb.

4. In her Application to Resolve a Dispute, under the heading 'Injury details', Ms Mulholland by her solicitor alleged injury to her back and right leg. Under the heading, 'Permanent impairment/pain and suffering', she claimed permanent impairment compensation in respect of both body parts. However, she relied on Dr Ghabrial's assessment of the lumbar spine and scarring only. Accordingly, the Registrar referred only the lumbar spine and scarring for assessment by approved medical specialist Dr Kuru. There is no evidence before us that the worker took any objection to that course.

5. By a Medical Assessment Certificate dated 19 March 2020, Dr Kuru assessed a 12% whole person impairment (12% lumbar spine, 0% scarring) as a result of injury on 1 September 2016. Ms Mulholland appeals from the assessment of the lumbar spine only, essentially on the basis that the approved medical specialist failed to diagnose and make allowance for radiculopathy into the right lower extremity.

6. On 18 May 2020, the Registrar by his delegate was satisfied that the ground of demonstrable error was made out in respect of the assessment of radiculopathy, and referred the matter to this Appeal Panel for determination.

7. On 26 May 2020, the Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the *NSW workers compensation guidelines for the evaluation of permanent impairment* (*Guidelines*). Having identified error in respect of the approved medical specialist's findings on radiculopathy, the Panel referred the appellant for further assessment by Dr Ashwell, whose report appears below.

Submissions

8. The Appeal Panel has had regard to the written submissions filed by both parties. It is unnecessary to set them out in full, but they may be summarised as follows.

9. The appellant worker seeks re-examination by the Panel, submitting that the Medical Assessment Certificate demonstrates error and the application of incorrect criteria, for the following reasons:

    (a) The approved medical specialist erred in failing to diagnose radiculopathy in the right lower extremity, and to make an appropriate allowance for radiculopathy in his assessment. He should have done so, because the appellant complained of pain radiating into the right lower extremity, that pain was consistent with spinal pathology evidenced on the scans particularly at L5/S1, and both Dr Ghabrial and Dr Kleinman diagnosed radiculopathy and made allowances for it in their assessments.

    (b) The approved medical specialist denied the appellant procedural fairness by failing properly to examine her for radiculopathy and to note her complaints of pain in the right lower extremity.

10. In reply, the respondent submits in summary as follows:

    (a) The approved medical specialist took into account the appellant's complaints of right buttock pain radiating to the mid-thigh, but those complaints did not compel a finding of radiculopathy. The criteria for such a finding are set out in paragraph 4.27 and 4.28 of the Guidelines. The appellant did not meet those criteria at examination, despite her symptoms.

    (b) The appellant was not denied procedural fairness. The approved medical specialist took a history of pain radiating into the right leg post-surgery, and noted the appellant's current complaints.

Reasoning of the Approved Medical Specialist

11. Dr Kuru examined the worker on 3 March 2020. He took a history of injury on 1 September 2016. He noted at paragraph [4] (emphasis added):

> "She was subsequently referred to Neurosurgeon, Dr Michael Edger. He diagnosed the pain in her right buttock to be from spinal stenosis from a degenerative spondylolisthesis and recommended a decompressive procedure at L4/5, L5/S1. The surgery was undertaken in February of 2017.
>
> Ms Mulholland says the surgery helped her back pain but **she has had worsening pain in her right leg subsequent to the surgery. The pain is in her buttock and radiates into the mid-thigh. She has no symptoms radiating below her knee**."

12. Dr Kuru noted the following findings on physical examination of the lumbar spine at [5]:

> "Neurological examination of the lower limbs demonstrates symmetrical knee and ankle reflexes with a downgoing Babinski. Peripheral power is intact. Straight leg raise is to 80° bilaterally without tension signs. Hip range of motion and FABER test are non-irritable. Peripheral pulses are present."

13. Among other scans, Dr Kuru noted at [6] post-operative MRI scans of the lumbar spine performed on 8 March 2017 and 16 August 2018, which showed "right L5 hemilaminectomy with L4/5 degenerative spondylolisthesis and subsequent central lateral recess and foraminal stenosis".

14. He summarised the appellant's injury and diagnosis at [7] – emphasis added:

> "Ms Mulholland had an injury at work, which aggravated pre-existing L4/5 degenerative spondylolisthesis. **She has subsequently undergone a decompressive procedure but has persistent symptoms into her legs due to ongoing nerve root compression."**

15. In describing the method by which he arrived at his assessment of 12% (lumbar spine), he explained at [10b] – emphasis added:

> "Whilst Ms Mulholland has residual symptoms, **she does not have radiculopathy** and hence, I have not assessed a further 3% here."

16. At [10c] he indicated his agreement with Dr Kleinman and Dr Ghabrial that the worker qualified for assessment as DRE category III in respect of her lumbar spine, but disagreed with their findings that an allowance should be made for radiculopathy. There were other differences not here relevant.

17. From his assessment of 13% (lumbar spine) Dr Kuru deducted 1/10th for pre-existing degenerative spondylolisthesis at L4/5, yielding a 12% whole person impairment (lumbar spine). No error is alleged in respect of that deduction.

Ground 1: finding that there was no radiculopathy

18. Paragraphs 4.27 and 4.28 of the *Guidelines* provide as follows:

> "4.27 Radiculopathy is the impairment caused by malfunction of a spinal nerve root or nerve roots. In general, in order to conclude that radiculopathy is present, two or more of the following criteria should be found, one of which must be major (major criteria in bold):
>
> **•• loss or asymmetry of reflexes**
>
> **•• muscle weakness that is anatomically localised to an appropriate spinal nerve root distribution**
>
> **•• reproducible impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution**
>
> •• positive nerve root tension (AMA5 Box 15-1, p 382)
>
> •• muscle wasting – atrophy (AMA5 Box 15-1, p 382)
>
> •• findings on an imaging study consistent with the clinical signs (AMA5, p 382).
>
> 4.28 Radicular complaints of pain or sensory features that follow anatomical pathways but cannot be verified by neurological findings (somatic pain, non-verifiable radicular pain) do not alone constitute radiculopathy."

19. The task of the approved medical specialist was, first, to establish whether one or more of the three major criteria were satisfied. With regard to the first, Dr Kuru found that reflexes were present and symmetrical. With regard to the second, he found that power was intact. However, his reasons do not disclose any consideration of the third major criterion, that is, whether there was 'reproducible impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution'. His finding at [7] that there were 'persistent

symptoms into her legs due to ongoing nerve root compression' does not amount to a finding of impairment (or loss) of sensation. The failure to consider the third major criterion amounted to demonstrable error, and the certificate must be set aside.

Ground 2: procedural fairness

20. Contrary to the appellant's submissions, the approved medical specialist did give the appellant an opportunity to describe her symptoms in the right lower extremity, and he took them into account. There is no evidence that he failed properly to examine her. We are satisfied that he conducted a proper examination.

21. Even if such a failure could amount to a denial of procedural fairness, no such failure occurred. This ground fails.

Report of Dr Ashwell

22. As indicated, the appellant was referred for assessment by approved medical specialist Dr Ashwell. His report follows:

> "The consultation was performed according to WCC guidelines for Covid 19 with initial discussion by phone and examination face to face but with appropriate personal clinical protection.
>
> **The worker's medical history, where it differs from previous records:**
>
> She elaborated further about the injury that occurred on 1/9/16. She was working in the community and was showering a client with the help of another work colleague. While the client was on the toilet, Ms Kathy Mulholland reached with her up right hand to the shower hose. She then accidently slipped on the bath mat and her right hand went into the bath as she fell forward onto the bath tub edge. She twisted as she fell over the side of the bath and felt low back pain. This was the last client for her that day so she was able to finish up and go back to the office for a staff meeting. She then noticed increased low back pain, so went home and then attended her local doctor later that afternoon. She was put on light duties at work but later left the employment as there was no further work available. She subsequently retired in November 2018.
>
> She underwent surgery on her lumbar spine at two levels by Dr M Edger on 22/2/17. As she had persisting symptoms, she was referred to Dr Russo for pain management and had a number of injections but with only short-term benefit.
>
> **Additional history since the original Medical Assessment Certificate was performed**
>
> She has not had any further injuries, treatment or investigations since the MAC was performed on 19/3/20. There has been no further follow-up with Dr Edger or Dr Russo. She has remained under the care of her general practitioner, Dr Zhao. Her symptoms have remained much the same with persisting right sided low back pain radiating to her right buttock and down the back of her thigh to the knee. She has occasional numbness down the back of her right thigh occurring with prolonged sitting. She has not had symptoms below the knee. Due the Covid pandemic, she stopped attending the gym or aquarobics. She takes Panadol osteo 2 tablets, three times a day.
>
> At home, she can manage her self-care but has help from her husband for the housework (vacuuming and hanging out clothes) and any yard work. She can only vacuum one room a day. She looks after her raised vegetable garden bed. She can walk slowly for about 500 metres and tries to walk her dog. She has difficulty lifting her grand-daughter or bending down. She has not returned to dancing. Today, they drove three and a half hours to Sydney with a stop after one and a half hours.
>
> She denied any past history of back symptoms or condition.

Findings on clinical examination:

Examination was performed with removal of her slacks and footwear and wearing a gown. She was asked to advise me of any increased pain whereupon movement would be discontinued. All movements were tested actively and measured with a goniometer.

She was right hand dominant. Her height was 158 cm and weight 120 kg. She walked without a limp and was able to walk on her heels and toes for balance. She could one leg stand but was unable to squat.

The scar measured 5.5 cm longitudinally with minimal colouring but was well healed with no contour defects, trophic changes or adherence. I noticed slight hallux valgus of the great toes with mild flat feet. The heels were mid-line. She had normal knee alignment.

On examining the spine, there was no scoliosis but there was loss of the normal lumbar lordosis. There was tenderness to palpation over the low lumbar spine, right buttock and greater trochanter area. There was asymmetrical loss of lumbar spine movement with muscle guarding. Forward flexion was to 50 degrees, extension 20 degrees, right lateral flexion 10 degrees and left lateral flexion 20 degrees. Thoracic spine rotation was restricted to the right to 40 degrees but to the left 50 degrees.

Straight leg raising was 70 degrees on either leg with no nerve root tension. She was able to sit on the examination table with her legs extended. There was equal leg length. There was no muscle wasting in the lower limbs with equal calf and thigh circumference. There was no neurological deficit with no sensory loss, reflex changes/asymmetry or power loss in her lower limbs. Both hips had full and equal range of movement but right hip flexion caused buttock pain. Lower limb peripheral pulses were palpable and equal.

At the end of the consultation she was asked if she had anything further to add or if anything was omitted. She replied ‘no, it had all been covered’.

Results of any additional investigations since the original Medical Assessment Certificate

None further have been performed.

Opinion and assessment

There was no clinical evidence of radiculopathy in her lower limbs with insufficient criteria to satisfy section 4.27 of the SIRA Guidelines (Fourth Edition). In terms of the major criteria for radiculopathy, I could identify no loss or asymmetry of reflexes, muscle weakness anatomically localised to an appropriate spinal nerve root distribution, or reproducible impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution.

On assessing the lumbar spine, using SIRA Guidelines section 4.37, it is DRE 3. This equates to 10% WPI (AMA 5 P384, T 15.3). There is an addition of 2% for restriction of ADLs. This gives 12% WPI.”

23. Using SIRA Guidelines, section 4.37 Table 4.2, there is a further 1% combined for surgery at a second level. The figure for the lumbar spine is 13% whole person impairment. I agree with Dr Kuru that the injury aggravated a pre-existing L4/5 degenerative spondylolisthesis, which is contributing to impairment, warranting a 1/10th deduction as the precise level of contribution is difficult to quantity. After deducting 1/10th, the final whole person impairment is 12%. The Panel adopts the report and assessment of Dr Ashwell.

Conclusion

24. For the reasons given, the appeal is allowed. The Medical Assessment Certificate dated is set aside and replaced with the attached Medical Assessment Certificate.

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*.

H Mistry

Heena Mistry
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: 363/20
Applicant: Kathy Therese Mulholland
Respondent: Uniting (NSW & ACT)

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 Kuru 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 the Guidelines**	**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)**
Lumbar spine	01/09/2016	Page 28 Paragraph 4.34 Page 29 Paragraph 4.37 Table 4.2	Page 384 Table 15-03	13%	1/10th	12%
Skin scarring (TEMSKI)	01/09/2016	Page 74 Table 4.1		0%	0	0%
Total % WPI (the Combined Table values of all sub-totals)						**12%**

R J Perrignon
Arbitrator

Dr John Ashwell
Approved Medical Specialist

Dr Margaret Gibson
Approved Medical Specialist

23 December 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*.

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Dispute Services Officer
As delegate of the Registrar