WORKERS COMPENSATION COMMISSION

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

Matter No: **M1-014976/12**
Appellant: **Komatsu Australia Pty Ltd**
Respondent: **Warren Ewart**
Date of Decision: **16 August 2013**
Citation: **[2013] NSWWCCMA 57**

Appeal Panel:
Arbitrator: **Marshal Douglas**
Approved Medical Specialist: **Dr James Scougall**
Approved Medical Specialist: **Dr William Lyons**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 15 May 2013 Komatsu Australia Pty Ltd ('the appellant') made an application to appeal against a medical assessment ('the appeal') to the Registrar of the Workers Compensation Commission ('the Commission'). The medical assessment was made by Dr Michael Long, an Approved Medical Specialist ('the AMS').

2. The Respondent to the Appeal is Warren Ewart ('the respondent').

3. The matter involves a claim to entitlement under the workers compensation legislation (the *Workers Compensation Act* 1987 ('the 1987 Act') and the *Workplace Injury Management and Workers Compensation Act* 1998 ('the 1998 Act')). The WorkCover Medical Assessment Guidelines ('the Guidelines') set out the practice and procedure in relation to appeals to Medical Appeal Panels under section 327 of the 1998 Act.

4. The Appellant claims, in summary, that the medical assessment by the AMS should be reviewed on the following grounds (s 327(3) of the 1998 Act):
   - the assessment was made on the basis of incorrect criteria,
   - the medical assessment certificate contains a demonstrable error.

5. The Registrar **is satisfied that at least one of the grounds for appeal is made** out in accordance with section 327(4) of the 1998 Act and the Registrar has referred the Appeal to this Appeal Panel ('the Panel') for review of the original medical assessment.

6. The Appeal was made within 28 days of the date of the medical assessment.

PRELIMINARY REVIEW

7. The Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Guidelines.

Further examination

8. As a result of that preliminary review, the Panel determined that it was not necessary for the respondent to undergo a further medical examination. This is because, in the Panel's view, the AMS's examination of the respondent was thorough and the AMS's findings from that examination are reliable such that the Panel is able to determine the appeal based on those findings and the other material before the Panel. There is therefore no need to have the respondent examined again because the Panel considers that it would not obtain any additional useful information.

Further Submissions

9. The Panel notes that each party made written submissions, which they filed with their respective Application to Appeal and Notice of Opposition. The Panel identified during its preliminary review of this matter an issue that the Panel considered was relevant to its consideration of whether the MAC contained a demonstrable error, which the Panel considered neither party had addressed explicitly in their respective Application to Appeal and Notice of Opposition. The Panel shall set out below in Findings and Reasons what this further issue is, but mindful of what the Court of Appeal held in *Siddik v WorkCover Authority of NSW* [2008] NSWCA 116, being that the Appeal Panel is not limited to correcting errors identified in the grounds of appeal, the Panel determined during its preliminary review to invite the parties to make further submissions on this point.

10. The appellant made further submissions, which the Panel received on 7 August 2013. The respondent's solicitor wrote to the Commission by email on 1 August 2013 wherein he said with respect to the issue about which the Panel invited further submissions: "these have been raised in the Appeal by the Appellant and in Opposition by the Respondent". The respondent did not provide any further submissions.

11. To the extent necessary for the Panel to explain its decision, the parties' submissions are recounted below under Findings and Reasons.

EVIDENCE

Documentary Evidence

12. The Panel has before it all the documents that were sent to the AMS for the original assessment and has taken them into account in making this determination.

Medical Assessment Certificate

13. The parts of the medical certificate given by the AMS and issued on 17 April 2013 that are relevant to the Appeal are set out below in Findings and Reasons.

DECISION MADE AFTER PRELIMINARY REVIEW WITHOUT HOLDING AN ASSESSMENT HEARING

14. Neither party sought the opportunity to make oral submissions to the Panel. The Panel does not consider it would benefit by hearing oral submissions from the parties. The Panel shall therefore determine the appeal without an Assessment Hearing. The parties agreed to the determination of the matter without an Assessment Hearing

FINDINGS AND REASONS

15. The role of the Medical Appeal Panel was considered by the Court of Appeal in the case of *Siddik v WorkCover Authority of NSW* [2008] NSWCA 116. The Court held that while prima facie the Appeal Panel is confined to the grounds the Registrar has let through the gateway, it can consider other grounds capable of coming within one or other of the section 327(3) heads, if it gives the parties an opportunity to be heard. Their Honours noted that" it would

be curious if the Appeal Panel could not cure an error in a conclusive certificate merely because the parties had not identified it with the result that a court could be required to determine the parties' rights on the basis of what, in the Appeal Panel's view, was an erroneous MAC". An appeal by way of review may, depending upon the circumstances, involve either a hearing de novo or a rehearing. Such a flexible model assists the objectives of the legislation.

16. 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 detailed explanation of the criteria applied by the medical professionals in reaching a professional judgement.

17. Though the power of review is far ranging it is nonetheless confined to the matters which can be the subject of appeal. Section 327(2) of the 1998 Act restricts those matters to the matters about which the AMS certificate is binding.

18. In this matter the Registrar has determined that she is satisfied that at least one of the grounds of appeal under section 327(3) is made out. The Panel has accordingly conducted a review of the material before it and reached its own conclusion concerning the correct assessment of the impairments suffered by the Respondent.

19. The respondent suffered an injury to his back and left leg on 20 June 2008 when a large heavy hydraulic pipe rolled onto him striking him on his left leg. A medical dispute arose between the parties relating to the degree of permanent impairment of the respondent resulting from this injury, and the Registrar referred this to the AMS to assess.

20. The AMS made the following findings from his clinical examination of the respondent:

> **Spine:**
>
> **Cervical/Thoracic Spine:** Freely mobile without tenderness, guarding or spasm.
>
> **Lumbar Spine:** Vertical, pale, 10 cm well-healed midline lumbar operation scar.
>
> Movement of his lumbar back was limited and he was only able to flex and reach with his hands to the mid-thigh and slowly regain an erect posture. There was pronounced paravertebral muscular guarding and spasm.
>
> There was no clinical evidence of radiculopathy.
>
> Straight leg raising and femoral stretch test were negative.
>
> Muscular: Slight reduction in strength plantar flexion right foot.
>
> **Reflexes:**

Reflex	RIGHT	LEFT
Adductors	+	+
Knee	+	+
Ankle	+	+

Sensation: Diminished light touch under surface right foot and toes.

Lower Limbs:

Hips: Normal movement.

Knees: There was no differential muscular wasting.

Movement	RIGHT	LEFT
Flexion	130^0	130^0
Extension	0^0	0^0

Gross crepitus left knee. Fine patellofemoral crepitus right knee but no significant tenderness of the patella.

No effusions right or left knee.

No ligamentous or other instability right or left knees.

21. The AMS certified that he had assessed the respondent's permanent impairment from his injury to be 29 percent whole person impairment, comprising 11 percent whole person impairment of the lumbar spine and 20 percent whole person impairment of the left lower extremity. The AMS advised that his assessment was based on his clinical findings; the history he obtained; the reports on several radiological investigations on the respondent's lumbar spine and knees; and plain x-rays of the respondent's knees done on 12 September 2012 which the respondent provided to the AMS at the time of the examination. The AMS's explanation for his calculation of the respondent's permanent impairment is set out at parts 10a and b and 11a and c of the MAC, and is as follows:

10a. *my* opinion and assessment of whole person impairment

My opinion and assessment of Whole Person Impairment is 29%.

In making this assessment, I have taken account of the following matters:

Lumbar spine: Restriction of movement with marked paravertebral muscular guarding and spasm, but with an absence of radiculopathy, as defined in WorkCover Guides 4.23 page 29. He has impairment of activities of daily living, including home care, as defined WorkCover Guides 4.30, page 30 – 2% WPI.

His lumbar spine is further assessed by taking account of effect of surgery, 4.33, page 31, WorkCover Guides. *"operations where radiculopathy has resolved are considered under DRE Category III (AMA 5, Table 15-3)…*

Left Knee: His impairment is determined on the basis of the degenerative arthritis revealed on MRI and the weight-bearing plain x-rays of 12 September 2012. Note was also made of the surgeon's report of the arthroscopy undertaken on 6 September 2011.

- **6 September 2011, Dr A. Woo, Orthopaedic Surgeon, Operation Report left knee arthroscopy:** :

"There was grade III/IV chondral wear of all compartments most severe in the lateral compartment with extensive denuded subchondral bone… there was a degenerative of the free edge of the lateral meniscus. Meniscectomy was performed…"
Arthritis: WorkCover Guides 3.20, page 19 indicates: *"The presence of osteoarthritis is defined as cartilage loss. Cartilage loss can be assessed by plain radiography, computed tomography (CT), magnetic resonance imaging (MRI) or by direct vision (arthroscopy)"*.

Table 17-2, page 526 indicates that arthritis can be combined with Diagnosed-Based Estimates (total lateral meniscectomy = 3% WPI, Diagnosis-Based Estimates, Table 17-33, page 546. Patellofemoral arthritis could not be accurately determined and has been excluded in the determination of his impairment. It is now assumed on the basis of previous "menisectomy" in prior arthroscopies of the left knee (following his injury), that an effective total lateral menisectomy has been achieved.

b. an explanation of my calculations (if applicable)

worksheet /actual calculations attached? *Yes.*

Reference is made to WorkCover Guides 3rd Edition:

Chapter 3 – Lower Extremity: pages 16-25;
Chapter 4 – The Spine: pages 26-33

Lumbar spine – DRE Lumbar Category III, page 384, Table 15-3; 10-13% Impairment of the Whole Person, as directed by WorkCover Guides.

Impairment of activities of daily living = 2% WPI

Total impairment of lumbar spine = 12% WPI.

Left knee – Extensive degenerative arthritis as demonstrated by plain x-ray, MRI and direct observation at arthroscopy 0 mm cartilage interval **20% WPI**, see Table 17-31, page 544. There was insufficient evidence to provide a further patellofemoral impairment because of the degenerative changes at this level, in his left knee.

11a In my opinion the worker suffers from the following relevant previous injuries, pre-existing conditions or abnormalities:-

(i) **Degenerative asymptomatic osteoarthritis lumbar spine.**
(ii) **Degenerative osteoarthritis asymptomatic left knee.**

c. The extent of the deduction is difficult or costly to determine so in applying the provisions of s.323(2) I assess the deductible proportion as one-tenth.

22. The appellant's submissions attached to its Application to Appeal are, in summary:
    a. that it was prejudiced by the AMS having regard to the plain x-rays of the respondent's knee done on 12 September 2012, which the respondent provided to the AMS at examination. This is because it could not have its qualified specialists review these x-rays and had to rely on the AMS's interpretation of them;
    b. that the AMS has misapplied the relevant criteria in assessing the respondent's impairment of the left lower extremity because the AMS found the plain x-rays revealed less than 2mm joint interval but then assessed the respondent's impairment based on the criteria for 0mm cartilage interval;
    c. that the AMS assessed the respondent's impairment of the left lower extremity, excluding any deduction for pre-existing degeneration, to be 20 percent whole person impairment yet certified it as 22 percent;
    d. given that the radiological investigations of the respondent's lumbar spine revealed long standing and generalised degenerative change, the AMS was wrong only to make a deduction under s323(1) of 10 percent on account of pre-existing abnormality or condition.

23. In reply, the respondent submitted the appellant was not prejudiced by the AMS having regard to the plain x-rays of his knees and this is because one of the doctors by whom he had been examined at the request of the appellant had seen the x-rays and assumedly commented on them in his report to the appellant. The respondent also submitted that the AMS applied the correct criteria when assessing the impairment of his left knee because when the MAC is read as whole it is apparent the AMS was of the view that there is 0mm cartilage interval in his left knee. The respondent conceded that the AMS made an error with respect to the discrepancy the appellant had highlighted in its submissions between the AMS's assessment of impairment of the left lower extremity and the AMS's certification with respect to this assessment. The respondent also submitted that the AMS did not err by deducting only 10 percent for pre-existing degeneration when assessing the permanent impairment of his spine.

24. The issue on which the Panel invited the parties to make further submissions was this:

> Is the deduction the AMS made under s323(1) with respect to the assessment of the left lower extremity correct, and if not, what if any deduction should be made in the assessment of the respondent's permanent impairment for previous injury or pre-existing condition or abnormality. Is the deduction the AMS made under s323(1) with respect to the assessment of the left lower extremity correct, and if not, what if any deduction should be made in the assessment of the respondent's permanent impairment for previous injury or pre-existing condition or abnormality.

25. In response to this, the appellant submitted, in substance, that the deduction should have been greater than 10 percent. The respondent provided no further submissions. It seems however, implicit from the submissions attached to his Notice of Opposition that his position is that the deduction should remain as 10 percent.

26. The Panel notes that there is no evidence before it to support the respondent's contention that a doctor who had examined him at the request of the appellant had viewed the plain x-rays of his knees done on 12 September 2012. However, whatever be the case, the Panel considers the matter irrelevant. In the Panel's view, the AMS was right to view the x-rays of the respondent's knees done on 12 September 2012. The fact that neither party put these into evidence in the proceedings before the Commission does not matter. An AMS is not limited to considering only the evidence lodged by the parties with their application or reply or the brief of material the Registrar remits to the AMS at the time of referral. An AMS has the power under s324(1)(b) of the 1998 Act to obtain further material including x-rays. The legislation does limit in any way the persons on whom the AMS can call to provide further material. In other words, the AMS can require a worker to produce such material. An AMS's ability to call for such material is not conditional on a party requesting the AMS do so, nor does the exercise by an AMS of this power entail that the AMS must invite comment from the parties or their lawyers on any further material the AMS is able to obtain relying on this power. It is a matter for the AMS's clinical judgement whether he or she obtains any further clinical data that may be available and it also is a matter for the AMS's clinical judgement as to what make of that data if obtained.

27. Given that the x-rays the respondent provided to the AMS are the most recent clinical investigation carried out on the respondent's knees, it is the Panel's view that had not the AMS obtained these x-rays directly from the respondent, it would have been incumbent on the AMS to call upon the respondent or the radiologist to provide the x-rays, relying on the power conferred on the AMS under s324. It would be a curious situation if the AMS was prevented from considering these x-rays merely because the respondent provided them to him before he had a chance to seek them from the respondent, and the Panel considers the legislative provision is not to be interpreted so as to support such an outcome. In the Panel's view, the receipt of this material by the AMS accords with s324(1)(b).

28. The Panel notes that [3.20]- [3.22] of the WorkCover Guides for the Evaluation of Permanent Impairment read, as far as relevant, as follows:.

> 3.20 The presence of osteoarthritis is defined as cartilage loss. Cartilage loss can be assessed by plain radiography, computed tomography (CT), magnetic resonance imaging (MRI) or by direct vision (arthroscopy).
>
> 3.21 Detecting the subtle changes of cartilage loss on plain radiography requires comparison with the normal side. All joints should be imaged directly through the joint space, with no overlapping of bones. If comparison views are not available, AMA5 Table 17–31 (p 544) is used as a guide to assess joint space narrowing.
>
> 3.22 One should be cautious in making a diagnosis of cartilage loss on plain radiography if secondary features of osteoarthritis, such as osteophytes, subarticular cysts or subchondral sclerosis are lacking, unless the other side is available for comparison. The presence of an intra-articular fracture with a step in the articular margin in the weight bearing area implies cartilage loss.

29. The Panel's view is that the AMS has correctly applied the criteria set out in the paragraph immediately above to assess the respondent's impairment of the left lower extremity. The report of Dr Woo of 6 September 2011 on the arthroscopy the respondent had that day reveals "bone on bone" in the joint, that is no cartilage. This finding, as the AMS noted, is confirmed by the MRI that was previously done on the left knee, and the AMS noted that the most recent x-rays also confirmed it. Even without these x-rays, the arthroscopy report and MRI would have been sufficient to validate the AMS's assessment that the respondent's impairment of his left lower extremity due to arthritis is 20 percent whole person impairment.

30. The Panel notes that impairment assessed by reference to the criteria for Diagnosis-based estimates can be combined with impairment assessed by reference to arthritis. In this case, the Panel observes the respondent had a partial lateral meniscectomy on 20 April 2010. Possibly, the AMS added 2 percent whole person impairment for the left lower extremity because he considered this procedure involved a total meniscectomy. However, this is not explained in the MAC and it is certainly not clear why the AMS added 2 percent. In the Panel's view, based on what is before it, in the assessment of the respondent's permanent impairment of the left lower extremity 1 percent whole person impairment, based on the criteria for DRE, can be added to the 20 percent whole person impairment assessed by reference to the criteria for arthritis. That means the total permanent impairment of the respondent's left lower extremity is 21 percent whole person impairment, and not 22 percent as certified by the AMS.

31. The Panel also considers the deduction the AMS made for the pre-existing osteoarthritis is at odds with the evidence, and is therefore wrong. The radiological investigations reveal that the osteoarthritis in the respondent's left knee was substantial. Necessarily, the disease must have been long standing and existing before the respondent's injury. Whilst this disease may not have exhibited in the respondent suffering symptoms before his injury, it contributes very significantly now to his impairment of his knee. In the Panel's view, having regard to the radiological evidence, the contribution would not be of the order of 50 percent.

32. The Panel therefore finds that the MAC contains a demonstrable error as a consequence of the AMS incorrectly assessing the respondent's permanent impairment of the left lower extremity resulting from the injury.

33. The remaining issue is whether when assessing the respondent's permanent impairment of the lumbar spine resulting from the injury, the deduction the AMS made for pre-existing degeneration is incorrect. The Panel cannot discern any error in the MAC in regard to this. Whilst the radiological evidence clearly reveals the respondent had fairly widespread degeneration of his lumbar spine prior to his injury, and which was then asymptomatic, it is not such that the AMS can be considered to have erred in concluding the extent to which the degeneration now contributes to the respondent's impairment is one tenth. At any rate, it would not be possible to measure precisely what the contribution is, and to assume a one tenth deduction is not inconsistent with the evidence.

34. For these reasons, the Panel has therefore determined that the Medical Assessment Certificate dated 17 April 2013 given in this matter should be revoked, and a new Medical Assessment Certificate should be issued. The new Medical Assessment Certificate is attached to this statement of reasons.

DECISION

35. For the reasons set out in this statement of reasons, the decision in this matter is that:
the Medical Assessment Certificate given in this matter should be revoked, and a new Medical Assessment Certificate should be 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.

FOR REGISTRAR

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE
Injuries received after 1 January 2002

Matter No: **WCC M1-014976/12**
Applicant: **Warren Ewart**
Respondent: **Komatsu Australia 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 Michael Long and issues this new Medical Assessment Certificate as to the matters set out in the Table below:

Table - Whole Person Impairment (WPI)

Body Part or system	Date of Injury	Chapter, page and paragraph number in WorkCover Guides	Chapter, page, paragraph, figure and table numbers in AMA5 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	20/6/2008	Chapt 4	Chapt 15	12%	1/10	11%
Left lower extremity	20/6/2008	Chapt 3	Chapt 17	21%	1/2	11% (rounded)
Total % WPI (the Combined Table values of all sub-totals)						**21%**

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

A statement of reasons for the medical assessment is attached.

Marshal Douglas
Arbitrator

Dr James Scougall
Approved Medical Specialist

Dr William Lyons
Approved Medical Specialist

16 August 2013

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.

FOR REGISTRAR