WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-636/19**
Appellant:	**William Wayne Fraser**
Respondent:	**Lingstar Pty Ltd**
Date of Decision:	**22 July 2019**
Citation:	**[2019] NSWWCCMA 97**

Appeal Panel:	
Arbitrator:	**Ms Deborah Moore**
Approved Medical Specialist:	**Dr Philippa Harvey-Sutton**
Approved Medical Specialist:	**Dr J Brian Stephenson**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 8 May 2019, William Wayne Fraser lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Tim Anderson, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 11 April 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,
    - 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 that preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination because no request was made, and we consider that we have sufficient evidence before us to enable us to determine the appeal.

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.

SUBMISSIONS

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

10. In summary, the appellant submits that the assessment of DRE II for the thoracic spine was an error and should have been DRE III because of the presence of vertebral body fractures, and that the AMS also erred in his assessment of the lumbar spine because of "relevant evidence" he had at the time of assessment.

11. In reply, the respondent submits that the assessments were correct because the thoracic fractures were of long-standing and the assessment with respect to the lumbar spine was consistent with the evidence.

FINDINGS AND REASONS

12. 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.

13. 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.

14. The appellant was referred to the AMS for assessment of whole person impairment (WPI) in respect of the lumbar spine and thoracic spine resulting from an injury on 29 November 2013.

15. The AMS obtained the following history:

> "Mr Fraser related that when this event occurred, he was normally in a managerial position. Nevertheless, if they were shorthanded, he would 'go on the tools'. This would involve driving a bulldozer. As he took on this task on 29/11/13, he experienced increasing pain in his back.
>
> He saw his Doctor. His only treatment since then has been massage, acupuncture and analgesic tablets. More recently, he has been using a vibration machine which gives him partial relief.
>
> He was unable to continue with his work after this occasion."

16. Mr Fraser's present symptoms were described as "Pain between his shoulder blades radiating down towards his lower back."

17. As for any past injuries or conditions, the AMS said:

> "Although it is quite difficult to find, in the extensive file there is evidence of pre-existing issues concerning his thoracic and lumbar spine. This features in the General Practitioner notes, some of which is hand written and very difficult to read. As long ago as 1993 and 2002, there are records of back pain. There is also the admission to Broken Hill Base Hospital in March 2013 which was some 8 months before this event. At that stage, the crush fractures in the thoracic spine were identified. These pre-existing features are also amply demonstrated radiologically. Specifically, a plain x-ray of the thoracic spine of July 2001 is reported as demonstrating, 'Minor longstanding wedge fracture of T7'".

18. As regards activities of daily living (ADL's), the AMS said:

> "In years gone by, he played golf. His only hobby now is using a golf buggy to drive up the road to visit a friend. He is able to drive his own car for short, local distances. For this assessment, he drove about 100 kms to this appointment. He had no particular difficulty in managing this.
>
> At home, a cleaner calls regularly. He is able to do his own shopping and cooking. Due to the climate, there is no grass that needs cutting."

19. Findings on physical examination were reported as follows:

> "As advised, Mr Fraser was very grossly overweight… He moved with a heavy and awkward gait and gave the impression of being in quite a lot of discomfort.
>
> **Back.** Pain was located in the midline from the upper shoulder blades all the way down into his lumbar spine. There was associated tenderness. This was most severe in the mid thoracic spine.
>
> All spinal movement was very grossly reduced. There was virtually no movement of extension or lateral flexion to each side. Lateral rotation to each side was reduced to one third of the range. Forward flexion was also very limited with 0cm of Macrae- Wright movement. This is particularly stiff.
>
> **Lower Limbs**. He walked with a wide based gait. Due to the apparent severity of his condition and also his excess weight, walking on his heels and toes and squatting was just not attempted.
>
> In March 2017, there had been a right sided knee joint replacement… Because of this procedure, circumferential measurements of the thighs and calves would not have been of diagnostic value. Due to his size and morphology, it was not possible to accurately measure the leg lengths although by inspection, there did not appear to be any significant leg length discrepancy.
>
> Examination of the lower limbs was very difficult since he had an intolerance of lying supine on the examination couch. Nevertheless, no significant features were identified with the hips or the ankles…

Sensation was difficult to demonstrate although there was no convincing evidence of radiculopathy in either leg. Similarly, reflexes were very difficult to demonstrate and could not be regarded as diagnostic. This is likely to be associated with his longstanding diabetic condition.

Power of the extensor hallucis longus (L5) was equivalent. He was also able to sit on the edge of the couch and could fully extend each knee without difficulty."

20. The AMS then documented the radiological material he had before him. These included the following:

    a. 31 July 2001: Plain x-ray: "Minor longstanding wedge fracture at T7."

    b. 22 June 2004: Plain x-ray: "No further changes."

    c. 6 March 2013: CT Scan: ""Compression fractures of the T5, T7 and T8 vertebral bodies are noted, maximal at T7 of the order 25% – 30%."

    d. 23 August 2013: CT Scan: "There is a loss of height of the anterior cortices of T7/8 and to a lesser degree T9 vertebral bodies. This is greatest at T7 level where there is approximately 25% loss of height of the anterior cortex".

    e. 2 December 2015: Plain x-ray: "Chronic condition. Degenerative changes throughout the thoracic spine."

21. In summarising the injuries and diagnoses, the AMS said:

    "Mr Fraser gives a history of hurting his back while driving a D9 bulldozer in late November 2013. Subsequent radiological investigation demonstrated a crush fracture at T7. Other less severe crush fractures have also been demonstrated radiologically.

    There is extensive evidence of a longstanding chronic condition in his thoracic spine where this phenomenon was originally identified as long ago as 2001. There has also been a hospital review of his back condition some 8 months before this particular event.

    The reasonable clinical conclusion therefore is that associated with driving the D9 bulldozer, Mr Fraser experienced an aggravation of a longstanding chronic condition predominantly in his thoracic spine. The effects of this aggravation are continuing…"

22. The AMS assessed 0% WPI for the lumbar spine and 7% WPI for the thoracic spine.

23. He explained his conclusions as follows:

    "The major clinical features in Mr Fraser's spinal column are focused to the thoracic spine. Although there was a notation in the General Practitioner notes of his lower lumbar spine in 1993, I have been unable to identify any radiological investigation of the lumbar spine which therefore suggests that this was not an issue of significant concern. On the other hand, there is extensive radiological investigation of the thoracic spine.

    At this assessment, there was no indication of continuing significant lumbar pathology and also no indication of radiculopathy.

> The radiological features clearly demonstrate thoracic spinal pathology with wedge fracturing predominantly at the T7 level although this all occurred long before the claimed event of 29/11/13. Therefore, his impairment revolves around the aggravational features to the thoracic spine which are continuing. This is addressed in AMA-5, Page 389, Table 15-4. In the absence of radiculopathy, Mr Fraser is classified in DRE Thoracic Category II. This provides a whole person impairment ranging between 5% and 8%, depending on his activities of daily living. For this, he would reasonably attract a further 2%, giving him 7%."

24. In commenting upon other medical evidence, the AMS said:

> "Specialist Orthopaedic Surgeon Dr Jonathan Negus in his reports of 28/03/18 and 11/12/18 concludes that the wedge fracture at T7 with the 25% compression is due to the event of 29/11/13 when Mr Fraser was driving the D9 bulldozer. I am at variance to this conclusion for two major reasons. Firstly, there is extensive evidence of this condition existing in a chronic state long before November 2013. Also, there would have to be a substantial event while driving the D9 bulldozer for such an injury to occur. This would need to include some kind of a fall or rapid forced flexion of the thoracic spine and neither of these was ever described. I note, however, that Dr Negus has deducted one tenth of the impairment evaluation for pre-existing degenerative conditions. I would agree with that.
>
> Dr John Bentivoglio in his report of 25/07/18 very clearly and convincingly argues the point that the wedge fracturing of the thoracic spine was chronic and long pre-existed the event of 29/11/13. I would completely agree with this analysis. Dr Bentivoglio then goes on to conclude a whole person impairment of 6% due to Mr Fraser being classified in DRE Lumbar Category II. I would suggest that although there is an obvious overlap in the clinical features of pathology with the thoracic and lumbar spine, it would be more appropriate for Mr Fraser to be in DRE II of the thoracic spine. Each, however, carries exactly the same whole person impairment. Dr Bentivoglio has attributed 1% for activities of daily living. In all fairness to Mr Fraser, I believe that 2% is more appropriate."

25. Both parties have prepared extensive and comprehensive submissions which we have carefully considered but do not intend to repeat here in any detail.

26. The overwhelming evidence, so far as the thoracic spine is concerned, is that the appellant had long standing problems in his thoracic spine, and the evidence as regards the compression fractures clearly pre-dates the date of injury.

27. Dr Negus obtained a history of two prior injuries to the lumbar spine, and in the incident on 29 November 2013, he noted that "he jarred his back and developed pain in the mid thoracic region."

28. It seems to us that in noting the radiological material, Dr Negus has perhaps not paid sufficient attention to the dates of the various investigations and simply assumed, on the basis of the history he obtained, that the changes in the thoracic spine occurred at the time of the nominated injury. He added: "He developed pain in the mid thoracic region for the first time [on 29 November 2013] and he has radiological evidence of crush fractures of T7 and slight loss of height of T8 and T9."

29. This statement is clearly inconsistent with the evidence.

30. We also note the records from Broken Hill Base Hospital where the appellant attended on 6 March 2013 with a history of "a week of R sub scapular RHS pain constant… CXR T spine x-ray showed anterior wedging of T6-T8 for which I have organised a non- urgent CT? acute # and radiculopathy… He has been driving loaders and this seems to exacerbate his pain although he has only just made the connection…"

31. The terms of the referral were clearly stated and the assessment was to be made on the basis of an injury on 29 November 2013 only.

32. The appellant also relies upon a report of Dr Crossman dated 31 May 2017. Dr Crossman said:

> "The above patient presented with mid thoracic pain and findings of a T7 crush fracture after working in Tilpa. This would be consistent with heavy earthmoving works in which he was employed."

33. That in itself is not supportive of a conclusion that the T7 fracture occurred on the date of injury. It is merely a statement of Dr Crossman's history on presentation, and is again inconsistent with all the evidence.

34. In summary, the original clinical data referred to above confirms the presence of significant pre-existing injuries to the thoracic spine.

35. In our view, the AMS conducted a thorough and comprehensive examination of the appellant, and his conclusions in respect of the thoracic spine were consistent with the evidence and AMA 5.

36. For these reasons, we see no error in his assessment.

37. As regards the lumbar spine, the appellant's submissions are not entirely clear but seem to focus principally on the range of movement (ROM) aspect of the assessment.

38. There are two methods of assessing impairment of the spine in AMA 5. Chapter 4 of the Guidelines states that "evaluation of impairment of the spine is only to be done using diagnosis-related estimates (DREs)."

39. The particular category of DRE is assessed according to clinical findings.

40. In this case, the AMS noted on examination that "Pain was located in the midline… all the way down into his lumbar spine."

41. He added:

> "Although there was a notation in the General Practitioner notes of his lower lumbar spine in 1993, I have been unable to identify any radiological investigation of the lumbar spine which therefore suggests that this was not an issue of significant concern…"

42. The Panel has noted a reference to imaging studies of the "lumbosacral spine and pelvis" apparently dated 20 April 1993, but the information is limited. We have been unable to locate any subsequent imaging studies of the lumbar spine.

43. Although Dr Bentivoglio obtained a history that Dr Crossman "arranged for him to have a CT scan taken of his lumbar spine" no such scan was available.

44. It seems clear to us that the appellant was perhaps confused about his history and symptoms at the time he saw Dr Bentivoglio in July 2015.

45. We are reinforced in this view because of further comments in Dr Bentivoglio's report dated 29 July 2015 as follows:

> "Mr Fraser advised me sometime in mid to late 2013… he was driving a bulldozer…when he sustained a jarring injury to his back. He immediately experienced low back pain. He advised me he had not had a problem with his back previously…he has low back pain most of the time…I was unable to get results of any investigations done on Mr Fraser. He did not know what his investigations showed.
>
> In the absence of any investigations on Mr Fraser I would have to assume that he has sustained some degree of discal damage as a result of the specific incident he described…
>
> On today's physical examination there is no evidence of any nerve root irritation or compression…I suspect Mr Fraser has aggravated pre-existing degenerative changes present in his back as a result of the specific incident he described at work…"

46. In a subsequent report dated 13 August 2015, Dr Bentivoglio added:

> "Mr Fraser advised me he had six injured vertebra that had collapsed. I assume that this means that he had degenerative disc disease at multiple levels…The Verifact Report indicated there was another injury to Mr Fraser's back at some time in the past that was not work related that I was unaware of….I have also not viewed any investigations of Mr Fraser and have not seen any results of any investigations of Mr Fraser…"

47. In his final report dated 26 July 2018, the history on this occasion was noted as "a jarring Injury to his back… he immediately experienced back pain." No specific area of back pain was described.

48. On this occasion, Dr Bentivoglio noted that "He has recently had a CT scan taken of his lumbar spine region" which apparently showed some changes, but he added "These abnormalities are minimal in nature and would not be producing his symptoms."

49. The report of this investigation was not available.

50. Dr Bentivoglio noted the various reports and investigations in respect of the thoracic spine. He concluded that it was "likely" that the incident in November 2013 contributed to some aggravation of his lumbar spine condition but again, this was based on the history he was given. He also observed that "I would have been happier if there had been a CT scan taken of his lumbar spine in the first three or four months following the specific incident" to corroborate his opinion.

51. It is clear from the questions posed by the insurer to Dr Bentivoglio that he was only requested to provide an opinion with respect to the condition of the appellant's lumbar spine. He assessed 5% WPI to which he added 1% for ADL's.

52. The appellant submits that the AMS' assessment of 0% WPI in respect of the lumbar spine was an error because of "relevant evidence" he had at the time of his assessment. Although not entirely clear from the submissions, we assume the appellant is referring to the opinion of Dr Bentivoglio.

53. The submissions tend to overlap with respect to the lumbar and thoracic spine. For example, the appellant submits that the DRE category found by the AMS was incorrect since it did not "include the correct vertebral body fracture assessment, loss of asymmetric ROM and lumbar spine impairment referred to in the clinical findings."

54. This is consistent with the observation by the AMS that “although there is an obvious overlap in the clinical features of pathology with the thoracic and lumbar spine, it would be more appropriate for Mr Fraser to be in DRE II of the thoracic spine. Each, however, carries exactly the same whole person impairment…”

55. Ultimately, the AMS is not required to adopt any opinion of an IME. His or her task is to make an assessment on the day of examination. It is clear as we said that the AMS conducted a thorough examination and clearly and concisely recorded his findings.

56. He examined the spine from thoracic to lumbar, and although he observed a significantly reduced range of movement, he nonetheless concluded that “there was no indication of continuing significant lumbar pathology and also no indication of radiculopathy,” a conclusion that was open to him on the whole of the evidence.

57. In summary, we cannot see any error in the DRE category adopted by the AMS, and his conclusion, specifically as regards the lumbar spine, was open to him on the evidence which indeed suggested some overlap of symptoms and signs.

58. For these reasons, the Appeal Panel has determined that the MAC issued on 11 April 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*.

G De Paz

Glicerio De Paz
Dispute Services Officer
As delegate of the Registrar