WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-1947/19**
Appellant:	**Mary Green**
Respondent:	**Northern Beaches Health Services (Manly Hospital)**
Date of Decision:	**15 November 2019**

Appeal Panel:	
Arbitrator:	**Catherine McDonald**
Approved Medical Specialist:	**Dr James Bodel**
Approved Medical Specialist:	**Dr Gregory McGroder**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 23 August 2019 Mary Green lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Greggory Burrow, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 5 August 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, that the grounds of appeal have been made out. The Appeal Panel has conducted a review of the original medical assessment but limited to the grounds 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).

RELEVANT FACTUAL BACKGROUND

6. Ms Green was employed by Northern Beaches Health Service at Manly Hospital as an administration clerk.

7. Ms Green suffered an injury to her right shoulder and brachial plexus on 8 September 2016 when she extended her arm to attempt to stop a mental health patient following her into the nurses' station. The patient pushed on her arm, forcing it backward and she felt pain in her shoulder. Ms Green underwent surgery on 25 November 2016.

8. The AMS assessed 9% whole person impairment (WPI) because he assessed 15% upper extremity impairment. His assessment combined 7% upper extremity impairment as a result of loss of the active range of motion of the right shoulder and 6% upper extremity as a result of peripheral vascular system impairment. He considered that she suffered a lesion at the C6 nerve root or part of the upper cord.

PRELIMINARY REVIEW

9. 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.

10. 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 the assessment made by the AMS is appropriate.

EVIDENCE

11. 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.

12. 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

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

14. In summary, Ms Green, through her solicitor Mr Dufour, submitted that the finding by the AMS that Ms Green suffered a lesion involving the C6 nerve root or upper cord was in direct contrast to the injury determined by the Arbitrator, being an injury to the shoulder or brachial plexus. Ms Green assumed that the reference to “peripheral vascular system” impairment was meant to read “peripheral nerve disorder”. Ms Green said that she did not appeal in respect of the range of motion assessment.

15. Ms Green said that the AMS applied Table 16-13 of AMA 5 rather than the method described in section 16.5b of AMA 5. Ms Green did not cavil with the AMS’s application of Table 16-10 at 75%. She said that the AMS failed to apply Table 16-14. Ms Green said that she must be re-examined to obtain the correct assessment.

16. In reply, the Health Service submitted that Ms Green had not provided any submissions on whether the AMS had made a demonstrable error and did not address any of the criteria applied. The Health Service submitted that the AMS conducted his assessment in accordance with the referral by the Commission, noting that the AMS did not agree with Dr R Pillemer that Ms Green had suffered a radiculopathy but agreed with Dr R Mellick that Ms Green suffered a traction injury involving the upper cervical nerve roots and said that it was based around C6. The AMS explained why he used Table 16-13.

17. The Health Service submitted that the AMS was required to examine the right shoulder and brachial plexus but was not required to accept that the injury referred resulted in any permanent impairment.

18. The Health Service said that Ms Green had not “provided any submissions as to any failure, error or transgression of the AMS during his examination”. There is no basis to re-examine Ms Green, it said, and any re-examination would provide her with “a *de novo* determination of impairment” to which she was not entitled unless the Panel finds that there is a demonstrable error requiring re-examination or that there was insufficient clinical basis for the determination of impairment.

FINDINGS AND REASONS

19. 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.

20. 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.

21. Ms Green's statement and the medical reports note that she first noticed pain in her right shoulder and trapezius in May 2016 when she pushed on a large air locked door which jolted. She had some treatment but continued working. She did not rely on that injury in her Application to Resolve a Dispute. Dr Mellick said in his report dated 24 June 2019 that the "history indicates that the first injury involved soft tissue trauma without any indication of a brachial plexus problem."

22. A Commission Arbitrator issued a Certificate of Determination on 5 July 2019 as a result of an agreement between the parties. The parties agreed that Ms Green suffered an injury to her right shoulder and brachial plexus on 8 September 2019 and the matter was referred for assessment of the right shoulder and brachial plexus.

The MAC

23. The AMS described the surgery undergone by Ms Green and subsequent investigations:

> "She had non-operative treatment but came under the care of Dr Matthew Sherlock. An MR scan of the right shoulder was reported by Dr Noakes on 18/11/2016 as showing 'A partial tear of the supraspinatus with moderate subacromial bursitis.
>
> With continuing symptoms, she went on to have right shoulder arthroscopic decompression, biceps tenodesis and a cuff repair on 25/11/2016. There were no post-operative complications. There was routine post-operative rehabilitation, but she had increasing problems with arm pain, in particular numbness into the index finger, so much so that Dr Sherlock organised an MR scan of the cervical spine on 07/07/2017 which was reported by Dr Gunn as showing no abnormality. Brachial plexus MR scan was subsequent performed in April 2018 and reported by Dr Linklater as showing no abnormality."

24. The AMS described the opinion of Dr Pillemer and the investigations which followed:

> "She was reviewed by Dr Roger Pillemer, Orthopaedic Surgeon, for a medicolegal report initially in September 2017 and in addition to the rotator cuff injury, Dr Pillemer suggested there was an injury to the supraclavicular nerve or C6 (brachial plexus) and recommended neurological investigation. She was subsequently reviewed by Dr Raymond Schwartz, Consultant Neurologist, on 05/11/2018 who confirmed that vibration and pin prick 'was normal' but suggested there was a 'mild brachial plexopathy'. At one stage, she was recommended centrally acting medication, but Mrs Green was reluctant to continue with this medication."

25. Ms Green told the AMS that she suffers shoulder ache and that it is slightly weak. She experiences "constant pins and needles and altered sensation into the index finger, and occasionally, with too much shoulder movement or repetitive use, also into the thumb and long finger."

26. The AMS's findings with respect to Ms Green's shoulder are not the subject of appeal. He said:

> "The neurovascular examination showed generous range of motion at the neck without acute tension. The biceps jerks were symmetrical today. There was no peripheral nerve or radicular pattern weakness. She had altered sensation to light touch over the index finger which extended to the mid palm but normal sensation of the thumb and long fingers. Repeat carpal tunnel testing was negative."

27. The AMS summarised the injury and his diagnosis:

> "Mrs Green injured her right shoulder as a result of the work incident on 08/09/2016. She had some shoulder or neck discomfort as a result of the air lock incident in May 2016, but this was insignificant and non-contributory. She underwent right shoulder rotator cuff repair surgery. That has gone very well but she has persisting altered sensation into the index finger of her right hand.
>
> Her Treating Surgeon had this investigated by way of cervical spine and brachial plexus MR scans which were both reported as normal with numerous neurological consultations including normal EMG and nerve conduction studies. Dr Schwartz made a diagnosis of mild brachial plexopathy but did not specify a nerve root or specific part of the plexus or peripheral nerve. Dr Ross Mellick in his medicolegal report of June 2019 confirmed 'Neurological features which …. indicate the probability of a mild traction lesion involving the upper cervical nerve roots or the upper cords of the brachial plexus'. Based on today's history and examination of there being no alteration to biceps jerk or motor weakness and simply index finger reduced sensation, it is my opinion that the lesion probably involved the C6 nerve root or part of the upper cord."

28. The AMS assessed 9% WPI in respect of the Right Upper Extremity (shoulder and brachial plexus and said that he had considered:

> "There is persisting loss of active range of motion of the right shoulder and evidence of sensory deficit regarding the C6 distribution. There is no motor deficit and no evidence of cervical spine condition."

29. He set out his assessment:

> "Right shoulder loss of active range of motion:
> AMA 5: Figures 16-40, 16-43 and 16-46: 7% upper extremity impairment.
>
> Peripheral vascular system impairment: It is my opinion that the lesion involves the C6 nerve root or portion of the upper cord as per AMA Table 16-13. There is a sensory deficit of pain, no motor deficit and no combined deficit. Total maximum deficit then is 8% upper extremity impairment.
>
> AMA Table 16-10: Grade 2 severity with decreased superficial cutaneous pain and tactile sensibility with abnormal sensation or moderate pain: Sensory deficit 75% x 8% upper extremity impairment equals 6% upper extremity impairment.
>
> Combining 7% upper extremity impairment with 8% upper extremity impairment equals 15% upper extremity impairment which equals 9% whole person impairment."

30. Ms Green is correct to point out the typographical error where the AMS said vascular rather than nervous. It is clear that the AMS meant the peripheral nervous system. He used the appropriate tables and the typographical error does not impact on his assessment.

31. The AMS considered the opinions of Drs Pillemer and Mellick. He noted that Dr Pillemer found persisting altered sensation in Ms Green's index finger and found reduced biceps jerk. He said:

> "The various Neurologists involved in her management have found no evidence of reduced biceps reflex or radiculopathy and on examination today the biceps jerk was present and symmetrical to the left. In particular, additionally there was no evidence of radicular, cord nor peripheral nerve motor weakness.
>
> In a subsequent report of December 2018, Dr Pillemer acknowledged that Neurologist Dr Schwartz had found evidence of a 'mild brachial plexopathy' and gave the opinion that the most appropriate method of dealing with any associated impairment was to use an analogous condition affecting the cervical spine at DRE Category III, meaning radiculopathy.
>
> It is my opinion that this overstates the impairment and the condition. The condition is only related to altered sensation or pain, appears to be in a C6 distribution although it does not go above the palm today (acknowledging there was no evidence of Carpal Tunnel Syndrome as an alternative diagnosis) and it is my opinion that the lesion should be treated for assessment of permanent impairment based on it being centred around C6 as a more peripheral lesion affecting the upper plexus of C6 and therefore it is most appropriate to use AMA Table 16-13. It is my opinion that treating the lesion as a mild plexopathy of C6 is the most appropriate way forward. It is my opinion that the presentation is not one of cervical spine radiculopathy as suggested by Dr Pillemer.
>
> Dr Ross Mellick, Consultant Neurologist, in his report of June 2019 confirms a diagnosis of probable mild traction injury involving the upper cervical nerve roots. I agree and believe that it is based about C6. Dr Mellick does not assess permanent impairment."

Other medical reports

32. The only assessment of permanent impairment made by Dr Pillemer is in his report dated 4 December 2018. He assessed Ms Green on the basis that an analogous condition was radiculopathy following a disc lesion which would place her in DRE Cervical Category III, resulting in 15% WPI to which he added 2% for the impact on her activities of daily living. Dr Pillemer did not make any assessment in respect of Ms Green's right shoulder and his analogy in respect of the cervical spine is inapt.

33. The AMS summarised Dr Mellick's report and it is useful to set out his reasoning in full. He said:

> "One part of the clinical presentation is associated with a significant restriction of right upper extremity function, which arose because of the protracted period in a sling and the marked impairment of shoulder movement, which was initially present when the sling was removed. The neurological features which are present indicate the probability of a mild traction lesion involving the upper cervical nerve roots or the upper cords of the brachial plexus, occurring as a direct consequence of the second injury.
>
> The normality of the MRI scan of the brachial plexus and the electrophysiological findings do not contradict the diagnosis.
>
> The details of the second injury are in keeping with the probability of a traction lesion to the brachial plexus. The sensory symptoms which are described in the right upper extremity in temporal proximity to that injury indicate the occurrence of a neurological disorder to a mild degree. The persisting clinical features which I describe above on

examination are also internally consistent and diagnostic of the neurological disorder I refer to above."

Discussion

34. The nomenclature used by the AMS may have led to some confusion in interpreting his opinion and it may have been better if he had said "it is my opinion that the lesion probably involved the C6 nerve root or part of the upper trunk" rather than "the upper cord." However, his assessment and use of AMA 5 was correct and the AMS has assessed Ms Green's injury in the form agreed by the parties and set out in the Certificate of Determination.

35. To understand why, it is necessary to read the relevant parts of AMA 5 in context.

36. Section 16.5b of AMA 5 headed "Impairment Evaluation Methods" deals with assessment of upper extremity impairment generally:

> "The upper extremity impairment is calculated by multiplying the grade of severity of the sensory deficit (Table 16-10a) and/or of the motor deficit (Table 16-11a) by the respective maximum upper extremity impairment value resulting from sensory and/or motor deficits of each nerve structure involved as listed in Section 16.5c, Regional Impairment Determination: spinal nerves, Table 16-13; brachial plexus, Table 16-14; and major peripheral nerves, Table16-15."

37. The commentary explains the grading of the elements of the Tables – Sensory Deficit or Pain, Motor Deficit and Combined Motor/Sensory Deficits.

38. AMA 5 describes the brachial plexus at page 489:

> "The brachial plexus innervates the shoulder girdle and upper extremity and is formed by the anterior primary divisions of the fifth through eighth cervical roots and first thoracic root. These roots anastomose to form three primary trunks: upper trunk (C5 and C6), middle trunk (C7) and lower trunk (C8 and T1) (Figure 16-50). Specific findings result from the involvement of these structures."

39. The following paragraphs describe the features of total brachial plexus paralysis, upper trunk paralysis ("C5, C6, Erb-Duchenne") and lower trunk paralysis. The use of Table 16-14 is explained:

> "Table 16-14 provides maximum upper extremity impairment values resulting from unilateral sensory or motor deficits of the brachial plexus, or to combined deficits. A brachial plexus related impairment is determined according to the method described in Section 16.5b."

40. The trunks divide into branches and the structure of the brachial plexus is shown in Figure 16-50. There are three tables in AMA 5 relevant to the assessment of impairment of the brachial plexus depending on whether the injury is to the roots (Table 16-13), trunks (Table 16-14) or branches (Table 16-15).

41. The heading of Table 16-14 "Maximum Upper Extremity Impairments Due to Unilateral Sensory or Motor Deficits of Brachial Plexus or to *Combined* 100% Deficits" has led to some confusion in Ms Green's submissions. As the text set out above shows, the table applies where is an injury to either the whole brachial plexus or the whole of any of the trunks. The injuries to which it applies are serious and upper trunk paralysis is defined:

> "In upper trunk paralysis (C5, C6, Erb-Duchenne) the arm hangs in adduction and internal rotation with the elbow in extension and the forearm in pronation; the biceps deltoid, brachialis, supraspinatus, infraspinatus, ad rhomboid muscles are paralyzed; the triceps, pectoralis major, and extensor carpi radialis brevis and longus muscles are

weak; most finger movements are intact; biceps reflex is absent; and a sensory deficit in the C5 and C6 dermatomes is present (Figure 16-49)"

42. The impairment assessment in respect of the Upper Trunk does not apply to Ms Green's case because she has not suffered an injury to both the C5 and C6 nerves.

43. The AMS described his neurovascular examination. In doing so he established that Ms Green did not have the signs of a cervical disc injury because biceps jerks were symmetrical and there was no peripheral nerve or radicular pattern weakness. He also eliminated carpal tunnel syndrome as a cause of her condition.

44. The AMS said that Dr Pillemer's assessment overstates Ms Green's impairment and condition. He noted that the neurologists who have examined Ms Green found no evidence of reduced biceps reflex or radiculopathy.

45. The brachial plexus injury suffered by Ms Green is a relatively mild injury to part only of the upper trunk which the AMS identified as C6 because the altered sensation or pain appeared to be in a C6 distribution, even though it did not go above the palm at the time of the examination. The relevant sign observed when the AMS examined Ms Green was index finger reduced sensation.

46. In setting out his calculations, the AMS considered the criteria in Tables16-13, 16-14 and 16-15; he said that there was sensory deficit but no motor deficit or combined deficit. He then applied Table 16-10 to assess the sensory deficit within the range provided for Grade 2 deficit or pain. The Guidelines provide in paragraph 2.10:

> "When applying AMA5 tables 16-10(p 482) … the examiner must use clinical judgement to estimate the appropriate percentage within the range of values shown for each severity grade. The maximum value is not applied automatically."

47. The AMS was correct to apply Table 16-13 to the assessment of Ms Green's injury. His assessment of the impairment to Ms Green's upper extremity under Table 16-10 at 75% was an appropriate exercise of his clinical judgement.

48. For these reasons, the Appeal Panel has determined that the MAC issued on 5 August 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*.

~~Insert Staff Name~~
~~Insert Staff Position~~

G De Paz

Glicerio De Paz
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

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