WORKERS COMPENSATION COMMISSION

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

Matter No:	**M1-6160/19**
Appellant	**MyHouse (Aust) Pty Ltd**
Respondent:	**Debra Boreland**
Date of Decision:	**14 April 2020**
Citation:	**[2020] NSWWCCMA 72**

Appeal Panel:	
Arbitrator:	**Mr John Harris**
Approved Medical Specialist:	**Dr Drew Dixon**
Approved Medical Specialist:	**Dr Gregory McGroder**

BACKGROUND TO THE APPLICATION TO APPEAL

1. Debra Boreland (the respondent) suffered injury on 3 March 2017 in the course of her employment with MyHouse (Aust) Pty Ltd (the appellant). The respondent suffered a fracture to her thoracic spine when she fell backwards off a step ladder, striking her head and landing on her back.

2. A claim for compensation pursuant to s 66 *Workers Compensation Act 1987* (the 1987 Act) was made for 22% whole person impairment (WPI) resulting from the injury to the thoracic spine. The appellant made a counter offer of 20% WPI.

3. The respondent then commenced proceedings claiming permanent impairment compensation. The assessment of WPI was then referred by the Registrar to Dr Tom Rosenthal, an Approved Medical Specialist (AMS), who examined the respondent and provided the Medical Assessment Certificate dated 3 February 2020 (MAC). The relevant findings made by the AMS pertinent to the various grounds of appeal are set out later in these Reasons.

4. The AMS assessed the respondent as having a 22 % WPI of the thoracic spine. The AMS made no deduction pursuant to s 323 of the *Workplace Injury Management and Workers Compensation Act 1998 Act* (the 1998 Act).

5. The assessment of WPI is undertaken in accordance with the fourth edition of the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment* (fourth edition guidelines).[1] The fourth edition guidelines adopt the 5th edition of the *American Medical Association's Guides to the Evaluation of Permanent Impairment* (AMA 5). Where there is any difference between AMA 5 and the fourth edition guidelines, the fourth guidelines prevail.[2]

[1] The 4th edition guidelines are issued pursuant to s 376 of the 1998 Act
[2] Clause 1.1 of the fourth edition guidelines

THE APPEAL

6. On 28 February 2020, the appellant filed an Application to Appeal Against a Medical Assessment (the appeal) to the Registrar of the Workers Compensation Commission (the Commission).

7. The WorkCover Medical Assessment Guidelines (the Guidelines) set out the practice and procedure in relation to appeals to Medical Appeal Panels under s 327 of the 1998 Act.

8. The appellant claims that the medical assessment in respect of the thoracic spine should be reviewed on the ground that the MAC contains a demonstrable error and/or the assessment was made on the basis of incorrect criteria. The sole basis for the appeal is an allegation of error with respect to the failure to make a deduction pursuant to s 323 of the 1998 Act.

9. The Appeal was filed within 28 days of the date of the MAC. The submissions in support of the grounds of appeal are referred to later in these Reasons.

PRELIMINARY REVIEW

10. The Appeal Panel (AP) conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Guidelines. As a result of that preliminary review, the AP determined, for the reasons provided subsequently, that a ground of appeal had been established.

11. The appellant did not seek a re-examination by an AMS who is a member of the AP.

12. The respondent did not directly address this submission although conceded that the matter can be decided solely on the basis of the written submissions.

13. The AP formed the view that a re-examination of the respondent was not required. Our reasons explain why the AMS erred and the correct s 323 deduction can be made without the need for a re-examination.

EVIDENCE

14. The AP has before it all the documents that were sent to the AMS for the original assessment and has referred to portions of the evidence and taken them into account in making this determination.

SUBMISSIONS

Appellant's submissions

15. The appellant submitted that the AMS conceded that the osteoporosis resulted in a disposition to sustaining a fracture but did not consider whether it compounded the "ultimate outcome of that condition".[3] It was observed that the AMS stated that as there was no pre-existing impairment then there could be no s 323 deduction.

[3] Appellant's submissions, paragraph 5.

16. The appellant referred to the Supreme Court decisions of *Cole v Wenaline*[4], *Fire & Rescue NSW v Clinen*[5] and *Ryder v Sundance Bakehouse*[6] and the Court of Appeal decision in *Vitaz v Westform (NSW) Pty Ltd*[7]. It acknowledged that a pre-existing condition does not [8]automatically result in a s 323 deduction and "the test is whether the previous condition or injury actually ***contributes*** to the current impairment" (emphasis in appellant's submissions). A previous asymptomatic "injury", if it contributes to impairment, must lead to a deduction.[9]

17. The appellant referred to the evidence establishing that the respondent underwent a Bone Mineral Densitometry on 3 December 2009 which demonstrated "osteopenia"[10] and asserted that "decreased bone density leads to bone fragility and an increased chance of breaking a bone".[11]

18. The appellant submitted that the underlying osteopenia/osteoporosis was not only a pre-existing pre-disposition (as described by the AMS) but that the vertebral loss of height was to some extent caused by the pre-existing condition.[12] In the circumstances, the underlying condition "could have caused a greater loss of disc (sic vertebral) height" and a one-tenth deduction pursuant to s 323(2) is required.

Respondent's submissions

19. The respondent described the appellant's submission of error as "their subjective view that the AMS incorrectly applied s 323" and based their appeal on the opinion of Dr Bentivoglio.[13]

20. The respondent noted that Dr Bentivoglio had provided an earlier report dated 30 May 2017 which was only provided "upon request". It described the reliance on one report and not all reports as "misleading and unethical".[14]

21. In the earlier report Dr Bentivoglio opined that there was no acceleration or exacerbation of a pre-existing condition and "no pre-existing conditions which are affecting [the worker's] current level of certification." This is contrasted with the later report where the doctor made a deduction for the pre-existing osteoporosis.

22. That opinion was contrasted with the supplementary opinion provided by Dr Pillemer which opined that the osteoporosis was a "predisposition or vulnerability" and was not an indication for making a deduction. Dr Pillemer further stated that the osteoporosis "would not have rated an impairment".

23. The respondent noted that the AMS did not have the benefit of seeing Dr Bentivoglio's earlier report.

24. The respondent noted that the AMS had the clinical notes from the general practitioner "and considered the potential impact of osteoporosis before making his decision on whole person impairment".

---

[4] [2010] NSWSC 78 (*Cole v Wenaline*).
[5] [2013] NSWSC 629.
[6] [2015] NSWSC 526.
[7] [2011] NSWCA 254 at [43] (*Vitaz*)
[8] Appellant's submissions, paragraph 15.
[9] Appellant's submissions, paragraph 11.
[10] See Application at p 223.
[11] Appellant's submissions, paragraph 12.
[12] Appellant's submissions, paragraph 13.
[13] Respondent's submissions, paragraph 2.
[14] Respondent's submissions, paragraph 4.

25. It was submitted that both the AMS and Dr Pillemer considered *Cole v Wenaline* "and both came to the view that there was no evidence that the worker's osteoporosis caused or contributed to the impairment which they both assessed as being 22% whole person impairment."[15]

26. The respondent otherwise submitted, referring to paragraph 16 of the appellant's submissions, that it was "basically" conceded that they cannot claim that osteoporosis made any difference to the level of WPI.

27. The respondent submitted that no error had been established and the appeal should be dismissed.

APPLICATION TO ADMIT FRESH EVIDENCE

28. Whilst not directly expressed, the application to rely on the report of Dr Bentivoglio dated 30 May 2017 is an application to admit fresh evidence.

29. Section 328(3) of the 1998 Act provides that the Appeal Panel is not to receive evidence that is fresh evidence, or evidence in addition to, or in substitution for, the evidence received in relation to the medical assessment appealed against, unless the evidence was not available by a party before the medical assessment and could not reasonably have been obtained by the party before the medical assessment.

30. Section 328(3) specifies that the right to tender fresh evidence is to a "party" and is not restricted to the appellant. The provision has been amended since the decision of the Court of Appeal in *Markovic v Rydges Hotels Ltd*.[16]

31. The AP has determined that the "fresh evidence" should be received in the Appeal because the report was not available to the respondent at the time of the provision of the MAC. The respondent's solicitor appears to state that the report was only recently furnished by the appellant following a request that it be provided.

32. The appellant has otherwise not replied to the respondent's allegation that the report was withheld and not previously produced.

33. If the insurer has not previously produced the previous report then it is of concern given that Dr Bentivoglio had provided an inconsistent opinion and the insurer has only supplied and relied upon the later report.

34. Legal practitioners must produce all medical reports in their possession and cannot selectively rely on inconsistent medical opinion provided by a doctor.

35. The AP records that it did not request the appellant's solicitors to respond to this allegation and that these observations have been made in the absence of such notice. We however observe that nothing was filed in response to the respondent's criticisms.

36. The AP admits the report of Dr Bentivoglio dated 30 May 2017.

[15] Respondent's submissions, paragraph 16.
[16] [2009] NSWCA 181 at [13].

REASONS

37. The reasons provided by the AMS on the existence of a pre-existing condition were:[17]

> "There is no evidence of pre-existing injury or condition. I have noted Dr Bentivoglio's opinion indicating that there was evidence of osteoporosis which he considers a pre-existing condition. There was no pre-existing fracture. I will comment further under 10c."

38. Later in his reasons the AMS concluded:[18]

> "The report of Dr Pillemer 23/10/2018 is noted. Dr Pillemer also found greater than 50% collapse of T12 and did not believe that the osteoporosis that was discovered after the fracture warranted a deduction for pre-exiting condition quoting '*Cole vs Wenaline'*.
>
> Dr Peter Bentivoglio in his report 26/06/2019 disagrees. He believes that the osteoporosis is a pre-existing condition and warrants a one-tenth deduction. With all due respect I do not agree with Dr Bentivoglio. Whilst osteoporosis could increase her predisposition to sustaining a fracture, there was no impairment in the T12 vertebra at the time she had the accident. Thus, no deduction can be warranted under section 323(2). Assuming there was pre-existing osteoporosis, the actual osteoporosis itself was not aggravated and the injury that occurred was a frank injury to the T12. There may have been an increased predisposition to sustain a fracture but this does not warrant a deduction under the current guidelines."

39. Section 323 of the 1998 Act relevantly provides:

> "(1) In assessing the degree of permanent impairment resulting from an injury, there is to be a deduction for any proportion of the impairment that is due to any previous injury (whether or not it is an injury for which compensation has been paid or is payable under Division 4 of Part 3 of the 1987 Act) or that is due to any pre-existing condition or abnormality.
>
> (2) If the extent of a deduction under this section (or a part of it) will be difficult or costly to determine (because, for example, of the absence of medical evidence), it is to be assumed (for the purpose of avoiding disputation) that the deduction (or the relevant part of it) is 10% of the impairment, unless this assumption is at odds with the available evidence.
>
> (3) The reference in subsection (2) to medical evidence is a reference to medical evidence accepted or preferred by the approved medical specialist in connection with the medical assessment of the matter."

40. A deduction pursuant to s 323 of the 1998 Act is required if a proportion of the permanent impairment is due to previous injury or due to pre-existing condition or abnormality: *Vitaz*[19], *Ryder*[20] and *Cole*[21].

[17] MAC, paragraph 8(e).
[18] MAC, paragraph 10(c).
[19] [2011] NSWCA 254.
[20] [2015] NSWSC 526 (*Ryder*) at [54].
[21] [2010] NSWSC 78 at [29] - [30].

41. A deduction can be made despite the fact that the worker is asymptomatic prior to injury. In *Vitaz* Basten JA stated:[22]

> "42. The appeal to the Appeal Panel did not expressly identify an erroneous failure to give reasons. Rather, the submissions on the appeal, which appear to set out the grounds of challenge, complained that there can be no deduction under s 323, as a matter of law, in the absence of a pre-existing physical impairment. It was further submitted, by reference to the opinion of three medical commentators in a local publication:
>
> > 'If a worker develops permanent pain and symptoms due to work consistent with spondylosis in the neck region, that condition might be assessed at DRE II. Although the spondylosis is likely to have been degenerative, if there were no symptoms in the period prior to the work-related complaint, then there was no rateable impairment at that time. So, nothing would be subtracted from the current impairment.'
>
> 43. That opinion contained a legal assumption which is inconsistent with the approach adopted by this Court in, for example, *D'Aleo v Ambulance Service of New South Wales* (NSWCA, 12 December 1996, unrep) (quoted by Giles JA, Mason P and Powell JA agreeing, in *Matthew Hall Pty Ltd v Smart* [2000] NSWCA 284; 21 NSWCCR 34 at [30]-[32] and, more recently, by Schmidt J in *Cole v Wenaline Pty Ltd* [2010] NSWSC 78 at [13]). The resulting principle is that if a pre-existing condition is a contributing factor causing permanent impairment, a deduction is required even though the pre-existing condition had been asymptomatic prior to the injury."

42. Basten JA referred to the reasoning of other Court of Appeal decisions including the decision in *Matthew Hall Pty Ltd v Smart*[23] (*Smart*). In *Smart* Giles JA stated:

> "The same, in my view, must be said as to the current s 68A(1). It does not matter that the pre-existing condition was asymptomatic, and if the loss is to some extent due to the pre-existing condition there must be deduction of the deductible proportion for that loss. But it is necessary that the pre-existing condition was a contributing factor causing the loss. And, of course, it is necessary that there was a pre-existing condition."

43. The use of the word "asymptomatic" was used in the context of the condition then considered, that is, loss of vision. A worker may be asymptomatic and still suffer "impairment". However, the Court has clearly held that a deduction could apply even if a pre-existing condition was asymptomatic and caused no loss prior to injury (generally the terms used for assessing s 66 compensation for injuries prior to 1 January 2002) or had no rateable impairment under s 66 for injuries occurring on or after 1 January 2002.

44. In *Vannini v Worldwide Demolitions Pty Ltd*[24] Gleeson JA stated that an Appeal Panel, when considering the reasoning of an Approved Medical Specialist on the question of causation under s 323, was required to determine "whether any proportion of the impairment was due to any previous injury, or pre-existing condition or abnormality" and if so, "what was that proportion".[25] In relation to the answer to this question, his Honour stated:[26]

---

[22] At [42]-[43], McColl JA and Handley AJA agreeing.
[23] [2000] NSWCA 284 at [32], Mason P and Powell JA agreeing.
[24] [2018] NSWCA 324 (*Vannini*) at [90].
[25] At [90].
[26] At [91].

> "The first question involved an assessment by the Panel, substantially of fact by reference to the evidence, although in part informed by the exercise of a clinical judgment. Such an assessment may be characterised as an evaluative judgment or conclusion based on findings of fact. Nonetheless, the legal criterion applied to reach that conclusion on causation demands a unique outcome, rather than tolerates a range of outcomes. Accordingly, the reasoning and finding of the medical specialist attracts the correctness standard of review by a Panel."

45. Gleeson JA observed that a finding as to the degree of proportion of permanent impairment due to a previous condition or abnormality "involves matters of degree and impression". The present case involves the former, that is whether there should have been any deduction, as opposed to the issue as to the extent of the deduction.[27]

46. The AMS stated that because there was "no impairment in the T12 vertebrae at the time" of the injury there could be no deduction warranted under s 323(2). The AMS referred to Dr Pillemer who also found no s 323 deduction and the latter's reliance on *Cole v Wenaline.*

47. In his second report dated 13 August 2019 Dr Pillemer stated:

> "According to *Cole v Wenaline*, in order to make a deduction for a pre-existing condition one needs to be able to establish that the pre-existing condition was causing an impairment prior to the actual injury."

48. The AMS made similar observations when he said that "there was no impairment in the T12 vertebrae at the time [the worker] had the accident" and "thus no deduction can be warranted under section 323(2)".

49. Despite the observations of the AMS and Dr Pillemer, the opposite was stated by Schmidt J in *Cole v Wenaline* when her Honour stated:[28]

> "Equally it is an error to merely assert that there was an assessable impairment existing before the injury on 25 October 2005. It is clear from *D'Aleao* that it is not the mere existence or non-existence of a prior impairment that determines whether there should be a deduction. The question is whether the prior condition contributes to the assessment currently being assessed."

50. Her Honour stated that it is "not the mere existence or non-existence of a prior impairment" that is determinative of whether there should be a deduction. Whilst it is correct in the present matter that there was no pre-existing "impairment", that it is an incorrect test for the purposes of determining whether there should be any deduction pursuant to s 323. The discussion by Basten JA in *Vitaz*, relying on a line of Court of Appeal authorities, is clear that an asymptomatic condition can give rise to a s 323 deduction.

51. That incorrect legal assumption identified by Basten JA is similar to the error in the present matter where the AMS stated that, as there was no pre-existing impairment, there could be no s 323 deduction.

52. The language of s 323 dictates that there is to be deduction where a previous injury or pre-existing condition or abnormality, as opposed to a pre-existing impairment, contributes to impairment.

---

[27] See at [91]-[92].
[28] *Cole* at [49].

53. Section 327(3)(d) provides that the error must be "demonstrable". In *Vannini v Worldwide Demolitions Pty Ltd,*[29] Gleeson JA observed that, consistent with the observations of Basten JA in *Mahenthirarasa v State Rail Authority of New South Wales*[30], a "demonstrable error must be apparent in findings of fact or reasoning contained in the medical assessment certificate, although the error may be established in part by reference to materials that were before the approved medical specialist".[31]

54. The error is demonstrable as it is readily apparent in the findings made by the AMS when applying an incorrect legal test.

55. The AMS also stated that there was "no evidence of a pre-existing condition"[32]. He then stated that there was "no pre-existing fracture". It is unclear whether the AMS restricted his reasons to the notion that the pre-existing condition must be the same pathology as the injury, in the present case, the fracture at T12. We have set out later in these reasons[33] that the evidence clearly establishes that the respondent suffered from the pre-existing conditions of osteopenia and osteoporosis. There was also error by the AMS in failing to make this finding.

56. The wording in s 323 does not require that the pre-existing "condition or abnormality" be the same as the injury sustained by the worker. It is sufficient to warrant a deduction under s 323 if the pre-existing condition or abnormality contributed to the impairment.

57. The AP is also of the view that there has also been an application of incorrect criteria within the meaning of s 327(3)(c) of the 1998 Act: see *Marina Pitsonis v Registrar of the Workers Compensation Commission of New South Wales*[34] applying Basten JA in *Campbelltown City Council v Vegan*[35]. The application of incorrect criteria is the failure to properly apply paragraph 1.28 of the fourth edition guidelines, which is generally in accordance with s 323 of the 1998 Act.

58. The AP finds that there is error within the meaning of both s 327(3)(c) and (d) of the 1998 Act in the finding by the AMS that there was no pre-existing condition and, in the finding, that there can be no deduction in the absence of pre-existing impairment.

59. In these circumstances it is necessary for the AP to re-assess the WPI: *Drosd v Nominal Insurer.*[36]

Reassessment

60. There is an unanimity of opinion expressed by Dr Pillemer, Dr Bentivoglio and the AMS that the respondent is properly assessed at 22% WPI. There were no appeal submissions contesting that assessment. Accordingly, we accept that, prior to any s 323 deduction, the respondent has a 22% WPI that results from the injury. Given the duration of the symptoms and the pathology, specifically the extent of loss of vertebral height, we are satisfied that the impairment is permanent.

61. The only issue in dispute is the extent, if any, of the s 323 deduction.

---

[29] [2018] NSWCA 324 (*Vannini*) at [90].
[30] [2008] NSWCA 101
[31] *Vannini* at [86].
[32] MAC, paragraph 8(e).
[33] See paragraphs [74]-[92] herein.
[34] [2008] NSWCA 88 (*Marina Pitsonis*) at [40]-[42], McColl and Bell JJA (as their Honours then were) agreeing.
[35] [2006] NSWCA 284 at [94], McColl JA agreeing.
[36] [2016] NSWSC 1053.

62. The AP observes that the onus of proof in establishing a s 323 deduction lies on the employer.

63. In *Asbestos Remover & Demolition Contractors Pty Ltd v Kruse* [2017] NSWWCCMA 51, a Medical Panel concluded that the onus of proof was on the employer to establish a non-compensable cause in industrial deafness cases.[37] Reference was made by that Panel to the observations of Barwick CJ in *Sadler v Commissioner for Railways* (1969) 123 CLR 216 and Garling J in *Pereira v Siemens Ltd* [2015] NSWSC 1133.

64. In *Smart*, Giles JA accepted the employer's concession that it bore the onus in establishing a deduction under s 68A (the statutory predecessor to s 323).[38]

65. Accordingly, our findings are made on the basis that the appellant bears the onus of proof in establishing any s 323 deduction.

66. The AMS stated that there was "no evidence of pre-existing injury or condition" when noting Dr Bentivoglio's opinion "indicating that there was evidence of osteoporosis which he considers a pre-existing condition".[39]
67. The AMS returned to this issue later in the MAC. He accepted that osteoporosis could increase the respondent's predisposition to sustaining a fracture but that no deduction was warranted because there was "no impairment in the T12 vertebrae". The AMS then states that "assuming there was pre-existing osteoporosis", that condition was "was not aggravated".

68. It is not entirely clear whether there was a finding that there was, or was not, a pre-existing condition.

69. Having found error, we are required to reassess according to law. We are not bound by any finding made by the AMS.

70. The parties referred to the distinction between a genetic pre-disposition to a condition and a condition. This distinction was articulated by Giles JA in *Smart* when his Honour discussed the difference between a genetic predisposition to keratoconus and the condition of keratoconus.

71. The difference between a genetic disposition to a disease and the existence of "disease" for the purposes of s 4(b) of the 1987 Act was recently discussed by the Court of Appeal in *Booth v Fourmeninapub Pty Ltd*[40]. Leeming JA stated:[41]

> "The question ultimately is one of statutory construction. The definition is part of a single sentence in the statute, which distinguishes between cases of a disease being 'contracted' by a worker in the first limb, and cases of the 'aggravation, acceleration, exacerbation or deterioration' of a disease in the second limb. It must follow that in order for the disease to satisfy the second limb, it existed prior to the event in the workplace of which complaint is made. In any event, that has been confirmed by, *inter alia*, a unanimous High Court in *Asioty v Canberra Abattoir Pty Ltd.* A genetic predisposition exists from before birth, but it is not a disease in the sense of the second limb because there was nothing manifested which could be aggravated, accelerated, exacerbated or the subject of deterioration. A diagnosis of, say, breast cancer, in a person who is (and has since birth been) genetically predisposed to breast cancer, is not the aggravation, acceleration,

[37] at [52]-[54].
[38] At [37].
[39] MAC, paragraph 10(c).
[40] [2020] NSWCA 57 (*Booth*).
[41] at [58], Bell P and White JA agreeing.

exacerbation or deterioration of an existing disease. The person's genes do not change after the cancer has been detected. While it is true that the person's genes indicate an increased likelihood of developing the disease, the occurrence of breast cancer does not aggravate, accelerate, exacerbate or deteriorate an existing disease. That is because there was no disease, as opposed to a mere predisposition to the disease."

72. Accepting there are clear differences in the wording of s 4 of the 1987 Act and s 323 of the 1998 Act, we otherwise accept the respondent's submission that there is a distinction between a genetic disposition to a condition and a condition. That observation is consistent with the decision of the Court of Appeal in *Smart* and the observations in *Booth*.

73. The first factual issue for determination is whether the respondent suffered from a pre-existing condition.

74. The appellant referred to the bone mineral densitometry dated 3 December 2009 which it submitted demonstrated "osteopenia" and submitted that they "believed" that this was a serious risk factor for the development of osteoporosis. The appellant asserted that "decreased bone density leads to bone fragility and an increase chance for breaking a bone" and that there is "evidence of chronic degenerative disease" present for many years prior to the injury. We observe that the appellant's beliefs are not evidence.

75. The appellant then submitted that the underlying osteopenia/osteoporosis was not "only a genetic pre-disposition" but "the vertebral loss suffered by the worker was to some extent due to such a pre-existing condition".[42]

76. That latter submission confuses the issues of whether there was a pre-existing condition and whether that condition contributed to impairment.

77. The respondent relied, in part, on the view expressed by Dr Pillemer and the original view expressed by Dr Bentivoglio that there was no evidence of a pre-existing condition and/or no pre-existing impairment.

78. In his report dated 30 May 2017, Dr Bentivoglio opined that there were "no pre-existing conditions which are affecting her current level of certification". Earlier in the report when addressing the issue of injury pursuant to s 4 of the 1987 Act, the doctor opined that this was not an acceleration or exacerbation of a pre-existing condition.

79. In his later report dated 26 June 2019, Dr Bentivoglio noted that a "diagnosis of osteoporosis was made shortly after review" in May 2017. The doctor subsequently concluded that there was "pre-existing osteoporosis". Dr Bentivoglio otherwise concluded that the pre-existing osteoporosis "enhanced the crush fracture" at T12.

80. Dr Bentivoglio's further opinion was provided to Dr Pillemer who provided a second report dated 13 August 2019. In response to Dr Bentivoglio's opinion on the s 323 deduction, Dr Pillemer stated:[43]

> "You then ask me to clarify why I have a different view from Dr Bentivoglio.
>
> - Importantly, Ms Boreland was asymptomatic prior to her injury in March 2017 and if not for the injury there is no reason why she should have developed symptoms in her thoracolumbar spine.

[42] Appellant's submissions, paragraph 14.
[43] Application, p 5

- The fact that she does have osteoporosis does not warrant- a deduction, as it is my understanding that predispositions or vulnerability are not an indication for making a deduction.

- According to Cole v Wenaline, in order to make a deduction for a pre-existing condition one needs to be able to establish that the pre-existing condition was causing an impairment prior to the actual injury. Ms Boreland's osteoporosis would not have rated an impairment.

I note that Dr Bentivoglio in his report clearly notes that there was no history of any pre-existing disease, and concludes that Ms Boreland's osteoporosis *' ... has probably exacerbated and made more severe the crush fracture that she has sustained at TI2* '. As noted, I do not agree with this, and I would suggest that a significant number of adult females in· their mid-50s would show investigative evidence of a degree of osteoporosis."

81. The AP has previously addressed the error with respect to the analysis of *Cole v Wenaline*.

82. Dr Pillemer otherwise appears to accept that the respondent had pre-existing osteoporosis which he stated did not warrant a deduction as "predispositions or vulnerability are not an indication for making a deduction".

83. We accept the observation that "predisposition or vulnerability are not an indication for making a deduction". The observation however does not answer the question whether osteoporosis is a condition and whether that condition contributed to impairment. The suggestion later in the quoted passage appears to contradict this when the doctor observes that "a significant number" of females in their mid-50's would show evidence of a degree of osteoporosis.

84. The respondent underwent a Bone Mineral Densitometry on 3 December 2009. The Bone Density Score was assessed at -1.7 in both the lumbar spine and the femoral neck. Dr Wadhwa stated that this meant that osteopenia was demonstrated.[44]

85. We agree with this conclusion.

86. The CT Scan taken shortly after injury demonstrated that "the bones are osteopenic".[45]

87. A Bone Mineral Density scan dated 8 June 2017 was reported by Dr Clingan as indicating osteoporosis.[46]

88. Based on this evidence there is no doubt that the respondent had a well-established condition of osteopenia seven years prior to injury. This is not a genetic predisposition to a condition but an actual condition.

89. In his latter report Dr Bentivoglio stated:[47]

> "A diagnosis of osteoporosis was made shortly after her review by myself on 30 May 2017 and she is currently being treated for this with injections of Prolia every six months, Caltrate and Vitamin D."

[44] Application, p 223.
[45] Application, p 56.
[46] Application, p 319.
[47] Reply, p 3.

90. The respondent provided a statement dated 20 November 2019. In respect of the diagnosis of osteoporosis, the respondent stated:[48]

> "After the work accident in March 2017 I was diagnosed with osteoporosis after having a bone density test in around June 2017. I am now on medication for this as stated above."

91. The respondent stated that she now takes six monthly injections for osteoporosis.[49]

92. The respondent was diagnosed with osteopenia in 2009 and with osteoporosis in June 2017. The treatment regime for osteoporosis commenced around June 2017. It is the AP's view, particularly based on its medical expertise, that the respondent's osteopenic condition gradually deteriorated following the diagnosis in 2009 based on age factors and the absence of any medical treatment directed to the osteopenia. The respondent had osteoporosis by the time of the injury. The diagnosis in June 2017 means that it is highly likely that the condition existed prior to the injury. In that respect we agree with Dr Bentivoglio's opinion set out in his latter report that the respondent suffered from the pre-existing condition of osteoporosis.

93. The next issue is whether the pre-existing condition contributed to the impairment.

94. The evidence establishes that the respondent suffered a significant T12 compression fracture with over 50% loss of vertebral height. The x-rays and scans taken after injury record the significance of this fracture.

95. The loss of bone mineral density means that there is an increased risk of fracture and, if fracture occurs, the extent of the fracture is more severe. This is because during the progress of the untreated osteopenic condition, osteoporosis developed with loss of bone matrix and bone mass is significantly less with loss of bone density as confirmed by the bone density studies in 2017. In these circumstances the severity of the fracture (loss of vertebral height) will undoubtedly be greater as when the fracture occurred, the affected bone is more likely to collapse.

96. The respondent was diagnosed with osteopenia in 2009. As there was no treatment, the respondent's bone density would have reduced over the following eight years.

97. The respondent was assessed as DRE Category IV based on a compression fracture of over 50%.[50] The AP is satisfied, on the balance of probabilities, that the pre-existing osteoporosis contributed to and increased the extent of the loss of the vertebral height from the T12 fracture.

98. In this respect we agree with Dr Bentivoglio's revised opinion that the pre-existing osteoporosis "enhanced the crush fracture".

99. We observe that the respondent expressed criticism of Dr Bentivoglio's revised opinion and the inconsistency between his two reports. Whilst an unexplained change may warrant rejection of an opinion, the doctor has explained the reason why he altered his opinion. Dr Bentivoglio explained in his latter report that he became aware of a contributory condition causing impairment following the provision of his first report.

---

[48] Application, p 424, paragraph 22.
[49] Application, p 423, paragraph 22.
[50] AMA 5 at p 389.

100. The AP applies the one-tenth deduction pursuant to s 323(2) because the extent of the deduction is extremely difficult to determine. This deduction is consistent with the medical evidence. We have previously expressed our reasons why we do not accept the opinions of the AMS and Dr Pillemer as to why there should be no s 323 deduction. We accept that the revised opinion of Dr Bentivoglio accords with our independent view that a deduction of one-tenth is appropriate.

DECISION

101. For these reasons, the MAC is revoked and a new Medical Assessment Certificate is 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*.

A Jackson

Ann Jackson
Dispute Services Officer
As delegate of the Registrar

APPEAL PANEL

MEDICAL ASSESSMENT CERTIFICATE

Matter No: **6160/19**
Applicant: **Debra Boreland**
Respondent: **MyHouse (Aust) 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 Rosenthal and issues this new Medical Assessment Certificate as to the matters set out in the Table below:

Body Part or system	**Date of Injury**	**Chapter, page and paragraph number in fourth edition guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA5**	**% 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)**
Thoracic Spine	03/03/2017	Chapter 4,	Chapter 15.4, Table 15-4	22%	1/10th	20%
Total % WPI (the Combined Table values of all sub-totals)					20%	

John Harris
Arbitrator

Dr Drew Dixon
Approved Medical Specialist

Dr Gregory McGroder
Approved Medical Specialist

14 April 2020

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*.

A Jackson

Ann Jackson
Dispute Services Officer
As delegate of the Registrar