WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-5953/19**
Appellant:	**Carmen Montebello**
Respondent:	**Mount Pritchard & District Community Club (Mounties)**
Date of Decision:	**16 April 2020**
Citation:	**[2020] NSWWCCMA 74**

Appeal Panel:	
Arbitrator:	**Carolyn Rimmer**
Approved Medical Specialist:	**Dr David Crocker**
Approved Medical Specialist:	**Dr Drew Dixon**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 11 February 2020, Carmen Montebello (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr David Gorman, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 3 February 2020.

2. The respondent to the Appeal is Mount Pritchard & District Community Club (Mounties) (the respondent). The respondent was insured by GIO General Limited at the relevant time.

3. The appellant relies on the following ground 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 Medical Assessment Certificate (MAC) contains a demonstrable error.

4. 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.

5. 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.

6. The assessment of permanent impairment is conducted in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment, 4th* Edition 1 April 2016 (the Guidelines) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th Edition (AMA 5).

RELEVANT FACTUAL BACKGROUND

7. In these proceedings, the appellant is claiming lump sum compensation in respect of an injury to the cervical spine and lumbar spine on 15 April 2012 that occurred in the course of her employment as a bar attendant with the respondent. The appellant was walking out of the back of the bar, when she stepped onto the grill, at the door to the bar, and slipped and fell, landing heavily on her back.

8. The matter was referred to the AMS, Dr Gorman, in the Referral for Assessment of Permanent Impairment to Approved Medical Specialist dated 19 December 2019 for assessment of whole person impairment (WPI) of the cervical spine and lumbar spine as a result of the injury on 15 April 2012.

9. The AMS examined the appellant on 30 January 2020. He assessed 7% WPI of the cervical spine and made a deduction of one tenth pursuant to s 323 of the 1998 Act which resulted in an assessment of 6% WPI. He assessed 0% WPI of the lumbar spine. Therefore, the total assessment was 6% WPI in respect of the injury on 15 April 2012.

PRELIMINARY REVIEW

10. 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 Assessment Guidelines.

11. The appellant requested that she be re-examined by an AMS, who is a member of the Appeal Panel.

12. 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 there was sufficient evidence by way of medical reports and clinical investigations in relation to assessment of the lumbar spine and Activities of Daily Living (ADL) on which to make a determination.

EVIDENCE

Documentary evidence

13. 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.

Medical Assessment Certificate

14. 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

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

16. The appellant's submissions include the following:

    - The AMS made his assessment of the lumbar spine on the basis of incorrect criteria and, in the alternative, has made a demonstrable error in making an assessment.

    - It is conceded that the AMS is not required to refer to every document lodged in the proceedings or to accept the opinion of any specific doctor.

- Paragraph 4.18 of the Guidelines provides that DRE II is a clinical diagnosis based upon the features of the history of the injury and clinical features. Clinical features which are consistent with DRE II and which are present at the time of the assessment include radicular symptoms in the absence of clinical signs (that is, non-verifiable radicular complaints), muscle guarding or spasm, or asymmetrical loss of range of movement. Localised (not generalised) tenderness may be present. In the lumbar spine, additional features include a reversal of lumbosacral rhythm went straightening from the flexed position and compensatory movement for an immobile spine, such as flexion from the hips. In assigning category DRE II, the assessor must provide detailed reasons why the category was chosen.

- The AMS has not engaged with the treating reports of the applicant worker and the material matters raised in their reports, in particular, Dr Ashish Diwan and Associate Professor Peter Papantoniou in relation to right leg pain and radiation of pain from the lumbar spine to the right buttock and posterior lateral thigh.

- The AMS was given a history that there was some radiation to the right leg in the past. Even in the event that the AMS did not note radiation of pain or neurological impairment on the day of the assessment, it is respectfully submitted that there is evidence of a history and consistent clinical findings of non-verifiable radicular pain and the MAC was therefore issued on the basis of incorrect criteria and, in the alternative, contains a demonstrable error.

- The applicant should have been assessed as DRE II as there are findings of non-verifiable radicular pain notwithstanding the lack of complaints to the AMS of radiation of pain on the day of the assessment or findings of discomfort over the lower thoracic spin as opposed to the lumbar spine.

- In relation to the physical examination by the AMS of the applicant's cervical spine and lumbar spine, the AMS noted in respect of the cervical spine that there was no tenderness, guarding or muscle spasm present. However, for the examination for the lumbar spine, there is no indication on the face of the MAC whether the same matters were considered during the examination.

- Given the matters raised by paragraph 4.18 of the Guidelines and the importance of clinical findings (or lack thereof) has on the category of DRE, the applicant submits that a demonstrable error can be demonstrated as a result of the AMS remaining silent on these issues.

- The AMS erred in his assessment of ADL. The AMS assessed 2% WPI for the impact that the injury had on her ADL. The AMS opined that 3% WPI which Dr M Giblin has included in his assessment of WPI for the impact the injury has had on the applicant was excessive as the applicant has been able to work full-time.

- The ability to perform work and the ability to undertake personal care activities are two separate matters which should not influence the other. In her statement the applicant said that, as a result of her injuries, she has difficulties with putting on and taking off her trousers and other pants. This relates directly to the matter of self-care.

- The appropriate assessment of the impact that the applicant's injury has on her ADL should be assessed at 3% WPI.

17. The respondent's submissions include the following:

- The appellant submitted that the AMS did not have proper regard to complaints she had previously made of non-verifiable radicular symptoms to Dr Diwan in 2012 and 2013 and to Associate Professor Papantoniou in 2014. The appellant also submitted that the AMS failed to provide within the MAC comprehensive physical examination findings in order to appropriately assess the correct DRE Category. However, the appellant did not submit that the radiological evidence revealed pathology in her lumbar spine that would satisfy the criteria of DRE II.

- The various radiological investigations the appellant has undergone for her lumbar spine which revealed she had degenerative changes. However, the presence of degeneration in a worker's lumbar spine does not indicate that she has radiculopathy or experiences radicular pain or symptoms. For that conclusion to be drawn, the person must be exhibiting signs of radiculopathy or the symptoms of such.

- Paragraph 4.18 of the Guidelines makes clear that if a worker at the time of the assessment experiences radicular symptoms in the absence of clinical signs then the worker's impairment can be assessed as correlating with DRE II. Therefore, although the appellant may have complained of symptoms some five years prior to the examination, the AMS was entitled to rely upon the signs and symptoms complained of at the time of the assessment.

- The AMS recorded at page 2 of the MAC that the appellant continued to experience various ongoing symptoms. However, he did not record her making any complaint of symptoms of pain or sensory loss in a dermatomal distribution from her lumbar spine, that is, he did not obtain a history of the worker experiencing non-verifiable symptoms at the time of assessment. In fact, the AMS noted: "She can get low back pain without radiation to her legs now - in the past some radiation to the right leg was reported".

- On page 3 of the MAC, the AMS confirmed the following:

  > "In the lumbar spine, thoracolumbar flexion was 2/3 expected but the main limitation was discomfort over the lower thoracic spine (not lumbar spine). Lateral flexion was 2/3 expected in both directions as was extension limited to 2/3 expected. In the lower limbs, there was no radiation of pain indicated. There was no sensory abnormality. Power and reflexes were normal."

- The AMS had the advantage of assessing the appellant worker in person and explained his reasons for his decision. The appellant now seeks to cavil with matters of clinical judgment of the AMS and attempts to assert error on the part of the AMS by referring to historical complaints that were not exhibited at the time of assessment.

- The respondent submits that in the circumstances, where the appellant did not complain at the time of the assessment of any radicular symptoms and did not exhibit any sign of radiculopathy, the AMS was correct to assess the appellant's signs and symptoms as correlating with DRE I and therefore was correct to assess the appellant's permanent impairment of the lumbar spine as being 0% WPI.

- In respect of ADL, the AMS applied an uplift of 2% WPI to the overall assessment of the cervical spine for the impact on ADL. It was noted that she was working on a full-time basis and was limited in household tasks, but not personal care. The AMS concluded that the appellant was consistent in her presentation. The AMS reported various matters that the appellant was either unable or had difficulty undertaking.

- The appellant referred to difficulties with "putting on and taking off her trousers and other pants", which is related to selfcare and appears to argue that the AMS failed to consider and refer to the statement in the MAC.

- Paragraph 4.34 of the Guidelines states: "the following diagram should be used as a guide to determine whether 0%, 1%, 2% or 3% WPI should be added to the bottom of the appropriate impairment range". The words "as a guide" are emphasised. Additionally, self-report is but one of the indicia in assessing the restriction of ADL.

- Paragraph 4.33 of the Guidelines explicitly states:

  > "... an assessment of the effect of the injury on ADL is not solely dependent on self-reporting, but is an assessment based on all clinical findings and other reports".

- However, in the event the appellant's submissions are accepted and the description of the difficulties experienced in some aspects of self-care, there is no evidence that she requires assistance with toileting, washing or shaving. With respect, such activities are of considerable significance: paragraph 4.35 of the Guidelines.

- Dr Giblin, in his report dated 18 December 2017, confirmed the appellant was "able to manage her personal care such as washing and dressing, provided she is careful" but applied the maximum 3% WPI for the impact on ADL.

- Dr Machart, in his report dated 16 September 2019, commented that Dr Giblin's "application of maximum 3% for self-care is in contrast to her being able to work as a bar attendant full time. She is doing her own housework. She pays someone to cut the lawn".

- The AMS was entitled to form the view that, consistent with her clinical signs, the appellant met the criteria for a 2% uplift for the impact on ADL. The AMS had the advantage of consulting with the appellant and discussing her situation.

- The appellant has failed to establish the application of incorrect criteria or a demonstrable error and the MAC should be confirmed.

FINDINGS AND REASONS

18. 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.

19. 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.

20. 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 (*Siddik*). 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. 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.

21. Section 327(2) was amended with the effect that while the appeal was to be by way of review, all appeals as at 1 February 2011 were limited to the ground(s) upon which the appeal was made. In *New South Wales Police Force v Registrar of the Workers Compensation Commission of New South Wales* [2013] SC 1792 Davies J considered that the form of the words used in s 328(2) of the 1998 Act being, 'the grounds of appeal on which the appeal is made' was intended to mean that the appeal is confined to those particular demonstrable errors identified by a party in its submissions.

22. In this matter, the Registrar has determined that he is satisfied that a ground of appeal under s 327(3(c) and (d) is made out, as the AMS's failed to apply the correct criteria and failed to provide reasons when assessing DRE I for the appellant's injury to the lumbar spine.

23. The Appeal Panel reviewed the history recorded by the AMS, his findings on examination, and the reasons for his conclusions as well as the evidence referred to above. The Panel accepted the findings on examination that the AMS made in the MAC.

Assessment of the lumbar spine

24. The appellant submitted that the AMS did not have proper regard to complaints she had previously made of non-verifiable radicular symptoms to Dr Diwan in 2012 and 2013 and Associate Professor Papantoniou in 2014. Further, the appellant submitted that the AMS failed to provide within the MAC comprehensive physical examination findings in order to appropriately assess the correct DRE Category.

25. The AMS, under "Present symptoms", on page 2 of the MAC noted:

> "She can get low back pain without radiation to her legs now - in the past some radiation to the right leg was reported."

26. The AMS, under "Findings on physical examination", on page 3 of the MAC wrote:

> "In the lumbar spine, thoracolumbar flexion was 2/3 expected but the main limitation was discomfort over the lower thoracic spine (not lumbar spine). Lateral flexion was 2/3 expected in both directions as was extension limited to 2/3 expected. In the lower limbs, there was no radiation of pain indicated. There was no sensory abnormality. Power and reflexes were normal."

27. Under "Summary of Injuries and diagnoses" on page 4 of the MAC, the AMS wrote:

> "Ms Montebello is a 69 year old lady who suffered soft tissue injuries to the cervical spine, lumbar spine and left shoulder in a work related fall more than 7 years ago. She has continued to work as a bar attendant. The majority of her symptoms are in the cervical and lumbar spine now with the left shoulder symptoms having improved."

28. Under "Reasons for assessment", the AMS wrote:

> "In the lumbar spine, there is restriction in movement but it is symmetrical. The symptoms are present but not as severe as the cervical spine. There is no radiation to the buttocks or legs. I believe that she is best characterised as DRE I giving her 0% WPI based on Table 15-3 on page 384."

29. In commenting on the other medical opinions on page 5 of the MAC, the AMS wrote:

> "Dr Frank Machart (Orthopaedic Surgeon) dated 16 September 2019. He also noted that the left shoulder injury had resolved. He noted, as I did, that part of her pain is now over the thoracic spine. He felt that the soft tissue injuries which had occurred at the time of the accident had now healed.
> ….
> I noted the IME by Dr Matthew Giblin dated 18 December 2017. He assessed the cervical spine as DRE II and the lumbar spine as DRE II. I disagree as the lumbar spine now did not meet the criteria for DRE II."

30. The appellant referred to various reports from the treating specialists, Dr Ashish Diwan and Associate Professor Peter Papantoniou. In particular, the appellant referred to:

    (a) Report of Dr Diwan dated 11 October 2012 in which he rated her low back pain at "8/10, right leg pain 10/10 ....." The Appeal Panel noted that Dr Diwan made a diagnosis of herniation of nucleus pulposus at L4-5 with right radiculopathy. Dr Diwan recommended a spinal injection program.

    (b) Report of Dr Diwan dated 2 May 2013 in which it was noted:

        > "Her lumbar spine pain is radiating to her proximal thigh and is as a consequence of the contained herniation at L4/5 and there are also some endplate changes seen in the sagittal cuts of T2 weighted Image. Again, in the axial cut, the far lateral bulge is seen predominantly on the right side whereas symptoms appear to bother her."

        Dr Diwan considered that it was reasonably necessary to offer the appellant the option of surgery, namely, a spinal fusion at L4/5.

    (c) Report of Associate Professor Peter Papantoniou dated 4 December 2014 in which he noted:

        > "She gets right-sided L5-S1 facet level lower back pain with radiation to her right buttock and the posterolateral thigh. She has a right L5 radiculopathy which is worse with walking or activities…On examination today, Ms Montebello was tender in the right L5-S1 paraspinal muscle level. This radiated to her right buttock.
        > ….
        >
        > She could forward flex with the fingertips to the mid-leg level with associated right L5/S l level lower back pain. Lateral tilts both reproduced the same pain…. Mrs Montebello presents with MRI of her lumbar spine, which demonstrates a large L4/5 posterior disc prolapse with an annular tear. The L4/5 disc is right sided more than central…. I feel Mrs Montebello has suffered an acute L4/5 disc prolapse and annular tear as a result of the fall at work. This is in keeping with the clinical findings of more right sided pain and right radiculopathy. The imaging docs match the clinical picture and the history given and there is no indication of any prior injury."

31. The Appeal Panel accepts that there was a history of radiation of pain to the right leg in the past and a diagnosis of right radiculopathy having been made by treating specialists.

32. Paragraph 4.18 of the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment*, 4th edition, provides:

> "DRE II is a clinical diagnosis based upon the features of the history of the injury and clinical features. Clinical features which are consistent with DRE II and which are present at the time of the assessment include radicular symptoms in the absence of clinical signs (that is non verifiable radicular complaints), muscle guarding or spasm, or asymmetrical loss of range of movement. Localised (not generalised) tenderness may be present. In the lumbar spine, additional features include a reversal of lumbosacral rhythm went straightening from the flexed position and compensatory movement for an immobile spine, such as flexion from the hips. In assigning category DRE II, the assessor must provide detailed reasons why the category was chosen."

33. Paragraph 4.20 of the Guidelines provides:

> "While imaging and other studies may assist medical assessors in making a diagnosis, the presence of a morphological variation from 'normal' in an imaging study does not confirm the diagnosis. To be of diagnostic value, imaging studies must be concordant with clinical symptoms and signs. In other words, an imaging test is useful to confirm a diagnosis, but an imaging study alone is insufficient to qualify for a DRE category (excepting spinal fractures)."

34. The criteria for lumbar spine category DRE II are set out in Table 15.3 on page 384 of AMA 5. In order to meet the criteria for lumbar category II there must be a clinical history and examination findings compatible with a specific injury. Findings "**may"** (emphasis added) include significant muscle guarding or spasm, asymmetric loss of range of motion or non-verifiable radicular complaints defined as complaints of radicular pain without objective findings; no alteration of the structural integrity and no significant radiculopathy. Alternatively, DRE II applies if the

> "individual had a clinically significant radiculopathy and has an imaging study that demonstrates a herniated disc at the level and on the side that would be expected based on the previous radiculopathy, but no longer has the radiculopathy following conservative treatment."

35. The Appeal Panel agreed with the appellant that the AMS had failed to make findings in his examination as to whether or not there was any muscle spasm or guarding and that the assessment was made on the basis of incorrect criteria. In a case such at this, where there was a significant injury and a worker landed heavily on her buttocks and was diagnosed with a disc herniation at L4/5 and a right radiculopathy, it is important to make findings on the matters identified as relevant clinical features in the Guidelines and AMA 5. The AMS also failed to consider the alternative findings set out in Table 15-3 in AMA 5.

36. The Appeal Panel reviewed the evidence in this matter. The findings of the AMS, the reports of Dr Diwan and the report of Associate Professor Papantoniou were referred to above.

37. The appellant in her statement dated 30 October 2019 said:

> "18. I have constant pain in my lower back. The pain becomes quite bad at night.
>
> 19. I have noticed that the pain in my back gets worse during the course of the day. I have noticed a pain that goes down my right leg along my thigh. This pain keeps me up at night."

38. Dr Mark Waterland in the MRI report dated 1/12/14 noted:

> "The L4/5 disc is desiccated and narrowed. There is a small right paracentral disc protrusion associated with an annular tear best seen on the sagittal series. This is slightly flattening the right anterior aspect of the thecal sac causing mild canal stenosis. The disc protrusion extends into the right intervertebral foramen causing mild narrowing of the right intervertebral foramen. The left intervertebral foramen is of reasonable size."

39. Dr Giblin, in his report dated 18 December 2017 noted on examination of the lumbar spine:

> "she could only forward flex to the mid thigh and had pain on arising, straight leg raising was 80 degrees on the right and 90 degrees on the left. There were no significant peripheral neurological signs."

40. Dr Giblin assessed the appellant as falling into DRE II using Table 15.3 of AMA 5.

41. Dr Giblin referred to the MRI lumbar spine scan of 1 December 2014 noting:

> "Disc desiccation at L2/3. L3/4, L4/5 with a rudimentary disc at LS/SI. There is a small right paracentral disc protrusion at L4/5 with an annular tear and mild canal stenosis. The disc protrusion extends into the intervertebral foramen."

42. In his report dated 16 September 2019, Dr Machart made no examination findings in relation to the lumbar spine. He concluded that the lumbar spine symptoms had resolved.

43. The Appeal Panel considered that the mechanism of injury was significant in this case, that being a fall with a heavy landing on her buttocks.

44. Table 15.3 on page 384 of AMA 5 provides three sets of criteria for a DRE II rating including:

> "individual had a clinically significant radiculopathy and has an imaging study that demonstrates a herniated disc at the level and on the side that would be expected based on the previous radiculopathy, but no longer has the radiculopathy following conservative treatment."

45. The Appeal Panel accepted that the appellant had a longstanding degenerative condition affecting her lumbar spine, concurrent radiology that demonstrated a disc herniation at L4/5 and transient radicular complaints with thigh pain which, although not found in the AMS' examination, were clearly documented. The appellant had a L4/5 peri cortisone injection on right which did not relieve symptoms. Dr Diwan recommended surgical intervention and it can be inferred that he must have considered that there was a serious and significant disc injury. The radiological finding that the disc protrusion at L4/5 extended into the right intervertebral foramen causing mild narrowing of the right intervertebral foramen is very significant as this extension can cause intermittent pain which worsens with activity. The findings of a lateral disc protrusion with likely compression of the dorsal root ganglion and of an annular tear were significant. The nature of the fall is important in this case as the appellant fell heavily onto her buttocks sustaining a lateral rupture.

46. Table 15.3 on page 384 of AMA 5 provides criteria for a DRE II rating is that the:

> "individual had a clinically significant radiculopathy and has an imaging study that demonstrates a herniated disc at the level and on the side that would be expected based on the previous radiculopathy, but no longer has the radiculopathy following conservative treatment."

47. The Appeal Panel was satisfied that the treating specialists had made a diagnosis of radiculopathy and has a concurrent imaging study that demonstrates a herniated disc at the level and on the side that would be expected based on the previous radiculopathy, but no longer has the radiculopathy following conservative treatment. The Appeal Panel concluded that on balance the appellant fell into DRE II rather than DRE I.

48. The Appeal Panel therefore assessed 5% WPI in respect of the lumbar spine. A deduction of one tenth pursuant to s 323 for a pre-existing condition is appropriate in this matter for the reasons given by the AMS in his assessment of the cervical spine.

Assessment of ADL

49. Under “Social activities/ADL” the AMS noted: “She is divorced. She has 3 adult children. She lives alone.”

50. The AMS under “present symptoms” in the MAC, noted that the applicant had difficulty cutting her toenails. However, he wrote: “She is working but is limited in household tasks but not personal care”.

51. At Part 10 of the MAC, the AMS commented on Dr Giblin’s report dated 18 December 2017 and wrote:

> “He assigned 3% for effect on ADLs. I believe that this is excessive particularly noting that she is able to work full-time.”

52. The appellant submitted that the ability to perform work and the ability to undertake personal care are two separate matters which should not influence the other. The Appeal Panel accepts that the ability to work and the ability to undertake personal care are two separate and distinct matters. The ability to work is not a matter to be taken into account in the assessment of the ability to undertake personal care.

53. The appellant in her statement dated 30 October 2019 said:

> “32. I have struggle to put on and take off my clothes. With my trousers, I feel a lot of pain bending over to try and take them off. What I do now to take my trousers off whilst managing my back pain is to undo my belt and buttons and wiggle out of my trousers.
>
> 33. When I am putting on my trousers, I have to do my best to get one foot in one of the legs and then try and put the other one in without bending my back. But even so, this is very difficult and I will still have to bend down slightly to put them on. I can feel an increase in my back pain when I do this.
>
> 34. I have tried to sit on a chair or my bed to put on my trousers, but I have noticed that I still need to bend as well in order to put them on which causes more pain in my back.”

54. The AMS failed to address the problems that the appellant stated she had with dressing and undressing.

55. The Guidelines at 4.33 provide: "... an assessment of the effect of the injury on ADL is not solely dependent on self-reporting, but is an assessment based on all clinical findings and other reports".

56. The Guidelines at 4.35 provide:

> "The diagram is to be interpreted as follows:
>
> Increase base impairment by:
>
> - 3% WPI if the worker's capacity to undertake personal care activities such as dressing, washing, toileting and shaving has been affected
>
> - 2% WPI if the worker can manage personal care, but is restricted with usual household tasks, such as cooking, vacuuming and making beds, or tasks of equal magnitude, such as shopping, climbing stairs or walking reasonable distances.
>
> - 1% WPI for those able to cope with the above, but unable to get back to previous sporting or recreational activities, such as gardening, running and active hobbies etc."

57. The Appeal Panel reviewed the evidence in this matter. The Appeal Panel noted the clinical findings made by the AMS, Dr Diwan, Associate Professor Papantoniou and Dr Giblin.

58. While the respondent noted there was no evidence that the applicant requires assistance with toileting, washing or shaving, the Appeal Panel accepted that she did have difficulty cutting her toe nails and had problems dressing especially with putting on and taking off clothes. These activities, that is, cutting her toe nails and dressing are personal care activities. The Appeal Panel accepted, therefore, that the appellant's capacity to undertake personal care activities had been affected. There is no provision in the Guidelines that required particular activities of personal care to be affected and the activities listed in the Guidelines at Part 4.35 are examples only and not necessarily, in our view, more significant than other unlisted activities, for example, the ability to feed oneself or dress oneself.

59. The Appeal Panel concluded that an assessment of 3% WPI in respect of ADL was appropriate in this case. It follows that an assessment of 8% WPI is made in respect of the lumbar spine with a one tenth deduction (0.8%WPI) for a pre-existing condition resulting in 7.2% which is rounded down to 7% WPI. The AMS made an assessment of 7% WPI in respect of the cervical spine with a deduction of one tenth pursuant to s 323 for a pre-existing condition deduction, that is, 0.7% WPI, resulting in 6.3% WPI which was rounded down to 6% WPI. It is the Appeal Panel's view, however, that the ADL rating is more appropriately ascribed to the impairment of the lumbar spine and as such, determines that there has been a 5% WPI of the cervical spine and after a deduction of one tenth pursuant to s 323 for a pre-existing condition, that is 0.5% WPI, resulting in 4.5% WPI which rounds up to 5%. Therefore, the combined total assessment was 12% WPI.

60. In summary, the assessment of total WPI by the Appeal Panel was 12% WPI in respect of the injury on 15 April 2012.

61. For these reasons, the Appeal Panel has determined that the MAC issued on 3 February 2020 should be revoked, and a new MAC should be issued. The new 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 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

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **5953/19**
Applicant: **Carmen Maria Montebello**
Respondent: **Mount Pritchard & District Community Club Pty Ltd**

This Certificate is issued pursuant to s 328(5) of the *Workplace Injury Management and Workers Compensation Act* 1998.

The Appeal Panel revokes the Medical Assessment Certificate of Dr David Gorman and issues this new Medical Assessment Certificate as to the matters set out in the Table below:

Table - Whole Person Impairment (WPI)

Body Part or system	**Date of Injury**	**Chapter, page and paragraph number in the Guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA 5 Guides**	**% WPI**	**Proportion of permanent impairment due to pre-existing injury, abnormality or condition**	**Sub-total/s % WPI (after any deductions in column 6)**
1.Cervical spine	15 April 2020	Chapter4; paragraph 4.24 on page 26; paragraphs 4.33 on page 27 and paragraph 4.34 on page 28	Table 15-5 on page 392	5%	One tenth	5% (rounded up from 4.5%)
2.Lumbar spine	15 April 2020	Chapter 4; paragraph 4.24 on page 26	Table 15-3 on page 384	8%	One tenth	7% (rounded down from 7.2%)
Total % WPI (the Combined Table values of all sub-totals)						**12%**

Carolyn Rimmer
Arbitrator

Dr David Crocker
Approved Medical Specialist

Dr Drew Dixon

Approved Medical Specialist

16 April 2020

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