WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-873/20**
Appellant:	**Paul James Pallett**
Respondent:	**Secretary of Department of Communities and Justice**
Date of Decision:	**23 December 2020**
Citation No:	**[2020] NSWWCCMA 185**

Appeal Panel:	
Arbitrator:	**Carolyn Rimmer**
Approved Medical Specialist:	**Dr Robin Fitzsimons**
Approved Medical Specialist:	**Dr Ross Mellick**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 2 March 2020, Paul James Pallett (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Ian L Meakin, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 2 September 2020.

2. The respondent to the appeal is the Secretary of Department of Communities and Justice (the respondent).

3. 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 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* 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

7. In these proceedings, the appellant is claiming lump sum compensation in respect of the left lower extremity as a result of the injury on 26 July 2018 that occurred in the course of his employment as a truck driver with the respondent.

8. The matter was referred to the AMS, Dr Meakin, in a Referral for Assessment of Permanent Impairment to Approved Medical Specialist dated 29 July 2020 for assessment of whole person impairment (WPI) of the left lower extremity, scarring -TEMSKI and Complex Regional Pain Syndrome (CPRS) (left lower extremity) as a result of the injury on 26 July 2018.

9. The AMS examined the appellant on 26 August 2020. He assessed 10% WPI of the left lower extremity and 2% WPI under TEMSKI for scarring. This resulted in a total of 12 % WPI as a result of the injury on 26 July 2018.

Fresh evidence

10. Section 328(3) of the 1998 Act provides that evidence that is fresh evidence or evidence in additional to or in substitution for the evidence received in relation to a medical assessment appealed against may not be given on an appeal by a party unless the evidence was not available to the party before the medical assessment and could not reasonably have been obtained by the party before that medical assessment.

11. The admission of 'fresh evidence' into an appeal was considered by Deputy President Fleming in *Ross v Zurich Workers Compensation Insurance* [2002] NSWWCC PD7 (*Ross*). The principles set out in *Ross* are relevant and have been applied to the admission of fresh evidence by a panel (see discussion in *Australian Prestressing Services Pty Ltd v Vosota* WCC10798-04). In *Ross* the Deputy President stated:

> "A number of authorities have considered the tests at common law for the introduction of fresh evidence in appellate proceedings before the Courts. The relevant tests are, firstly, that the evidence which is sought to be admitted on appeal was not available to the Appellant at the time of the original proceedings or could not have been discovered at that time with reasonable diligence, and secondly that the evidence is of such probative value that it is reasonably clear that it would change the outcome of the case (*Wollongong Corporation v Cowan* (1955) 93 CLR 435; *McCann v Parsons* (1954) 93 CLR 418; *Orr v Holmes* (1948) 76 CLR 632). These tests are addressed to the underlying principle of the need for finality in litigation and the importance of the ability of the successful party to rely on the outcome of the litigation. They are also addressed to the fundamental demands of fairness and justice in the instant case."

12. The appellant seeks to admit the following evidence:

    (a) Report of Dr J Brian Stephenson dated 24 September 2020.

13. The appellant submitted that Dr Stephenson has commented on the difference between his method of assessment and that of the AMS in the report of 24 September 2020. The appellant argued that clearly this report came into existence after the appeal and could not have been obtained before the appeal. The appellant submitted that the report clearly contained material or an opinion that could not have been formed or made before the appeal came into existence.

14. The respondent submitted that the report of Dr Stephenson dated 24 September 2020 was inadmissible pursuant to s 328(3) of the 1998 Act and/or did not contain any additional relevant information in accordance with 327(3)(b) of the 1998 Act.

15. The respondent noted that the appellant had obtained a report from Dr Stephenson dated 5 August 2019 and relied upon this report in the Workers Compensation Commission (WCC) proceedings. Therefore, Dr Stephenson's opinion as expressed in the further report dated 24 September 2020 was clearly not something which was not available to the appellant and could not reasonably have been obtained by him prior to the medical assessment.

16. The respondent argued that Dr Stephenson's supplementary report dated 24 September 2020 contained no fresh evidence or evidence in addition to or in substitution of the evidence which was contained in his report dated 5 August 2019 and which was before the AMS. Rather, Dr Stephenson's report dated 24 September 2020 was merely a critique of the AMS's determination and did not offer any additional information relevant to the AMS in performing his assessment.

17. The respondent refers to the observations of Hoeben J in *Petrovic v BC Serv No 14 Pty Limited and Ors* [2007] NSWSC 1156 at [31]-[34] (*Petrovic*). The respondent noted that the decision in *Petrovic* was recently referred to by the Medical Appeal Panel in *Keane v State of New South Wales (NSW Police Force)* [2020] NSWWCCMA 136 (*Keane*), in which case the appellant sought to rely upon a statement written after the MAC was issued in support of the contention that the AMS had taken an incorrect history. The respondent asserted that the statement did no more than cavil with the assessment and expand upon the history taken by the AMS during the assessment.

18. In *Keane* the respondent cited the decision in *Lukacevic v Coates Hire Operations Pty Limited* [2011] NSWCA 112 per Handley AJA at [98]-[99] as follows:

> "The applicant's statement contains lengthy details of his activities and habits before and after his work injury. In so far as this adds to the history and his statement of 2 April 2008, or the histories in the medical reports before the AMS, it was available and could reasonably have been obtained before the assessment and was not admissible.
>
> In so far as the statement repeats information in the earlier statement or in the medical reports it was not evidence 'in addition to ... the evidence received in relation to the medical assessment' and was not admissible."

In *Keane*, the Appeal Panel found the statement to be inadmissible.

19. The respondent submitted that in this case, as in *Keane*, the additional evidence did no more than criticise the AMS's assessment and reiterated information which was before the AMS at the time of his assessment, contained in various medical reports including that of Dr Stephenson dated 5 August 2019. On that basis, Dr Stephenson's report was inadmissible according to s 328(3) of the 1998 Act.

20. The issue concerning "additional relevant information" which is a separate ground of appeal under s 327(3)(b) was addressed by Hoeben J in *Petrovic v BC Serv No 14 Pty Limited t/as Broadlex Cleaning Services* [2007] NSW SC1156 (*Petrovic)*. Hoeben J held that a statutory declaration addressing the way in which an AMS carried out his examination was not "additional relevant information" as it was not information of a medical kind or which directly related to the decision made by the AMS. At [31] – [34], Hoeben J said:

> "31. In my opinion, the words 'availability of additional relevant information' qualify the words in parentheses in s 327(3)(b) in a significant way. The information must be relevant to the task which was being performed by the AMS. That approach is supported by subs 327(2) which identifies the matters which are appealable. They are restricted to the matters referred to in s 326 as to which a MAC is conclusively taken to be correct. In other words, 'additional relevant information' for the purposes of s 327(3)(b) is information of a medical kind or which is directly related to the decision required to be made by the AMS. It does not include matters going to the process whereby the AMS makes his or her assessment. Such matters may be picked up, depending on the circumstances, by s 327(3)(c) and (d) but they do not come within subs 327(3)(b).

32. It follows that the statutory declarations which related to the way in which the AMS carried out his examination and the way in which questions and answers were interpreted during the examination were not 'additional relevant information' for the purposes of subs 327(3)(b) and should not have been treated as such by the Registrar.

…

34. There is another consideration which I have taken into account. If the function of the Registrar under s327 is to be in reality that of a gatekeeper, then statutory declarations such as were sworn in this case should not be regarded as 'additional relevant information' for the purposes of s327(3)(b). If they are, it would be open to every dissatisfied party to challenge the assessment process of an AMS in the same way thereby gaining automatic access to an appeal."

21. The Appeal Panel noted that those observations of Hoeben J were made in respect of s 327(3), which is substantially similar to ~~s~~ 328(3) in terms of defining what would constitute additional relevant information. However, Hoeben J did note that once the matter came before an Appeal Panel, the matter in the statutory declaration could be considered by the Appeal Panel.

22. As noted in *Pitsonis v Registrar of WCC & Anor* (2008) NSWCA 88 (*Pitsonis)* at [48] an appeal under ~~s~~ 327 is not an opportunity for an application on the basis of fresh evidence tendered without any constraint and/or on the basis of no more than an Appeal Panel being invited to decide an application afresh. Allowing the introduction of the fresh evidence is not consistent with the statutory process of resolving medical disputes. The purpose of referral to an AMS is to bring finality to medical disputes, other than where there are legitimate grounds of appeal. It is expected that the parties will place all relevant documents before an AMS in the referral documents.

23. In *Lukacevic v Coates Hire Operation Pty Ltd* [2011] NSWCA 1122 (*Lukacevic)* at [78], Hodgson JA said:

> "A dispute by the workers as to the history set out in the certificate, or the observations made by the AMS, can be readily raised; and it could be raised honestly or dishonestly, on strong or flimsy grounds. Having regard to the matters I have set out, in my opinion it would be reasonable for an AP not to admit evidence raising such a dispute unless that evidence had substantial prima facie probative value, in terms of its particularity, plausibility and/or independent support. …"

24. In this case the Appeal Panel formed the view that Dr Stephenson's report of 24 September 2020, because of its nature and content, was not of such probative value that it was reasonably clear that it would change the outcome of the case. We agreed with the approach taken by the Medical Appeal Panel in *Lord v University of Technology* [2008] NSWWCC MA 132:

> "In the Panel's view, the appellant, who is legally represented in these proceedings, has been provided with an opportunity to present her symptoms to the AMS by way of the examination and also in the medical reports provided in support of her 'Application to Resolve a Dispute'. In the Panel's view the appellant was not denied an opportunity to obtain medical evidence prior to the assessment. The appellant's attempt to obtain and admit further 'commentary' in respect of the MAC may be achieved by way of submissions and this opportunity has been provided."

25. The Appeal Panel has therefore determined not to admit Dr Stephenson's report dated 24 September 2020 as evidence before the Appeal Panel. In coming to this decision we noted that part of Dr Stephenson's report was, in effect adopted in the submissions made by the appellant. These submissions were considered below.

PRELIMINARY REVIEW

26. 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.

27. The appellant did not request that he be re-examined by an AMS, who is a member of the Appeal Panel.

28. As a result of that preliminary review, the Appeal Panel determined that it was not necessary for the appellant to undergo a further medical examination because there was sufficient evidence by way of medical reports, clinical and hospital notes and clinical investigations on which to make a determination.

EVIDENCE

Documentary evidence

29. 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

30. 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

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

32. The appellant’s submissions lodged with the Application to Appeal Against the Decision of Approved Medical Specialist include the following:

    (a) The appellant submitted that there is a "demonstrable error" pursuant to s 327(3)d of the Act.

    (b) The AMS in his MAC failed to consider the whole of Mr Pallett's nerve damage that arose from his accident.

    (c) The AMS did not consider the appellant’s evidence or complaints in its entirety and how those symptoms should have led to an assessment of the sciatic nerve as well as the femoral nerve (the only one assessed by the AMS).

    (d) When the AMS examined the appellant he noted on page 4 of the MAC under the heading "Present Symptoms" that the applicant complained of hyperaesthesia over the anterior aspect of the shin and under "findings on Physical Examination" the AMS found on page 7 of the MAC "there are areas of palpable hyperaesthesia ... [and] there is distorted super tactile sensation with light touch in the area". These findings formed the basis for finding sensory loss for the CRPS that the AMS found and in the appellant's submission were an incomplete assessment of the nerves damaged in the accident.

    (e) When the AMS assessed the appellant he also noted under Present Symptoms "heat effect under the left heel”. This finding is in line with Dr Stephenson’s examination of "burning sensation under the foot". Dr Stephenson then included the sciatic nerve when assessing the sensory loss under the CRPS because of the "burning sensation under the foot". The AMS noted the "heat effect under the left heel" but failed to assess the sciatic nerve as well as the two branches of the femoral nerve.

(f) The AMS has on the above basis committed a demonstrable error. If the sciatic nerve was included in the sensory assessment under Table 17.37 and both nerves were combined then the LEI of the AMS goes from 9% to 16% with an increase in the WPI from 3.5% to 7.5%.

33. The respondent's submissions attached to the Notice of Opposition Against the Decision of Approved Medical Specialist include the following:

(a) The MAC did not contain any demonstrable error in accordance with s 327(3)(d) of the 1998 Act and should be confirmed.

(b) The appellant asserted that the AMS committed a demonstrable error pursuant to s 327(3) of the 1998 Act by not assessing the sciatic nerve as part of the sensory loss relatable to CRPS. The respondent emphasises that "[a] 'demonstrable error' is an error which is readily apparent from an examination of the medical assessment certificate and the document referring the matter to the AMS for assessment": per Hoeben J in *Merza v Registrar of the Workers Compensation Commission* [2006] NSWSC 939 at [39] and *Aircons Pty Limited v Registrar of the Workers Compensation Commission of NSW & Anor* [2006] NSWSC 322 per Malpass AJ.

(c) An error is clearly not demonstrable if it can only be established by reference to a medical report obtained subsequent to the assessment for the purposes of critiquing the AMS' s determination. On that basis, while the respondent disputed the existence of any error, it is also asserted that if an error is found it was not 'demonstrable' in the relevant sense.

(d) In respect of the WPI assessment of the left lower extremity, the appellant submitted that the AMS erred because he failed to consider the whole of the appellant 's nerve damage that arose from the injury and did not consider the appellant's evidence or complaints in their entirety.

(e) The appellant further asserted that there was a demonstrable error in that the AMS took note of the symptom of 'heat effect under the left heel' but did not go on to assess the sciatic nerve. The appellant's assertion appeared to be that this must have been an error because Dr Stephenson had identified a similar symptom, i.e. burning sensation under the foot, and had on that basis included the sciatic nerve when assessing sensory loss under CRPS. However,

> "The assessment of the worker by the AMS is a matter for his expertise. His conclusions, his diagnoses, the accuracy of measurements taken, and the interpretation of findings on examination, are all matters within the domain of the AMS": *Painter v Bi-Lo Pty Ltd* [2009] NSW WCC MA351 ('Painter').

(f) The appellant took issue with the AMS's assessment because it was not the same as that of Dr Stephenson. In that regard, it is submitted that the AMS reached his own conclusions in his assessment of the appellant, as he was entitled to do so: *Stramit Corporation Pty Ltd t/as Stramit Building Products v Holl* [2009] NSW WCC MA32.

(g) The Application to Appeal Against Decision of Approved Medical Specialist has no merit and should be dismissed on the grounds set out above.

FINDINGS AND REASONS

34. 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.

35. 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.

36. 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.

37. 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.

38. In this matter, the Registrar has determined that he is satisfied that a ground of appeal under s 327(3 (d) is made out in relation to the assessment of the sciatic nerve.

39. 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 left lower extremity

40. The AMS under "Reasons for Assessment" wrote:

> "LEFT LOWER EXTREMITY:
> Loss of Range of Motion: Mr Pallett demonstrates a loss of range of motion relating to his left ankle, subtalar joint and great toe. Reference is made to the Guidelines and Tables 17.11,17.12, 17.13 and 17.14. There is no malalignment of the heel. There are no clinical symptoms today or impairment relating to the left knee or hip. There is a minimal loss of circumference of the left thigh consistent with the historical injury to the left lower extremity. The very minimal loss of left knee flexion does not rate impairment under Table 17.10 AMA 5.

Ankle	**Left**	**Lower Extremity Impairment**
Flexion	20º	7%
Extension	0º	7%
Subtalar Joint		
Inversion	10º	2%
Eversion	0º	2%
TOTAL		**18%**

> The great toe on the left side demonstrates metatarsophalangeal joint extension to 30º - 2% lower extremity impairment, Table 17.14. There is no impairment relating to the lesser toes or to interphalangeal joint flexion of the great toe.

The above range of motion impairments may be combined using combinations of AMA 5 18% for the ankle and subtalar joint and 2% for the great toe = 20% lower extremity impairment - range of motion loss.

Complex Regional Pain Syndrome: Reference is made to Chapter 7 of the Guidelines and AMA 5, particularly referencing Table 17.1. The diagnosis in my opinion is confirmed by criteria Table 17.1 with the diagnosis being present for at least one year and has been verified by more than one examining physician. With reference to Table 17.1 the following is noted:

- There is continuing pain with evidence of clinical sensory hyperaesthesia on examination.
- There are reports of septia (sic) asymmetry.
- There is noted intermittent oedema which was present today on examination.
- There is also reported above decreased range of motion.
- There is clinical evidence of hyperalgesia to sensory examination at the time of today's assessment with temperature asymmetry being particularly noted at night.
- Active range of motion loss.
- It is also noted that there is no other diagnosis which better explains the above symptoms. In my opinion the diagnostic criteria for Complex Regional Pain Syndrome Type 1, as set out in Table 17.1 is satisfied.

Assessment of Impairment with reference to Table 16.10 AMA 5, I have elected to utilise Grade 3 lower extremity impairment due to sensory deficit - 26 - 60%. The Guides state that the maximum amount is not automatically applied and I have elected to accept a 50% sensory impairment.

The two nerves involved in the sensory impairment are those of the distal branches of the femoral nerve (saphenous nerve) with a 7% dysaesthesia impairment related to Table 17.37.

The superficial peroneal nerve, with reference to Table 17.37 equates to a 5% lower extremity impairment for dysaesthesia. Each of these impairments is multiplied by 50% - 50% impairment (Table 16.10). 50% x 7% = 3.5% rounded up to 4% lower extremity impairment femoral nerve. 5% lower extremity impairment x 50% = 2.5% rounded up to 3% lower extremity impairment superficial peroneal nerve.

Lower extremity impairment relating to loss of range of motion (20% lower extremity impairment) is combined with the sensory deficit (4 + 3) = 7% lower extremity impairment 26% lower extremity impairment.

Reference is made to Table 17.3 AMA 5 and the Guidelines, 26% lower extremity impairment equates with 10% whole person impairment."

41. The appellant submitted that there was a demonstrable error in the MAC because the AMS failed to consider the whole of appellant's nerve damage that arose from his accident.

42. The Appeal Panel noted that the appellant proceeded to argue that the appellant's symptoms should have led to an assessment of the sciatic nerve as well as the femoral nerve.

43. The Appeal Panel reviewed the evidence in this matter.

44. The Appeal Panel noted that both the AMS and Dr J B Stephenson made a diagnosis of CPRS 1. The Appeal Panel agreed with that diagnosis and was satisfied that the appellant had reported at least one symptom in the four categories that is, sensory, vasomotor, sudomotor/oedema and motor/trophic. The Appeal Panel agreed with the AMS that the appellant had displayed at least one sign the time of evaluation by the AMS in all of the four categories, that is, sensory, vasomotor, sudomotor/oedema and motor/trophic.

45. The AMS made an assessment that was based on sensory deficit and considered that the two nerves involved in the sensory impairment were the distal branches of the femoral nerve (saphenous nerve) and the superficial peroneal nerve. His assessment of 7% for sensory deficit was combined with the assessment for loss of range of motion (20% lower extremity impairment).

46. The Appeal Panel noted that Part 17.5 of the Guidelines under "Complex Regional Pain Syndrome Type 1" provides:

> "For Complex Regional Pain Syndrome Type 1 (CRPS1) to be present for the purposes of assessment:
>
> - the diagnosis is to be confirmed by criteria in Table 17.1
> - the diagnosis has been present for at least one year (to ensure accuracy of the diagnosis and to permit adequate time to achieve maximum medical improvement)
> - the diagnosis has been verified by more than one examining physician
> - other possible diagnoses have been excluded.
> - CRPS1 is to be assessed as follows:
>   - Apply the diagnostic criteria for complex regional pain syndrome type 1 (Table 17.1)."

47. Table 17.1 "Diagnostic Criteria for Complex Regional Pain Syndrome types 1 and 2" provides:

> "1. Continuing pain, which is disproportionate to any causal event.
>
> 2. Must report at least one symptom in each of the four following categories:
>
> - Sensory: Reports of hyperaesthesiae and/or allodynia.
> - Vasomotor: Reports of temperature asymmetry and/or skin colour changes and/or skin colour asymmetry.
> - Sudomotor/oedema: Reports of oedema and/or sweating increase or decrease and/or sweating asymmetry.
> - Motor/trophic: Reports of decreased range of joint motion and/or motor dysfunction (tremor, dystonia) and/or trophic changes (hair, nail, skin).
>
> 3. Must display at least one sign* at time of evaluation in all of the following four categories:
>
> - Sensory: Evidence of hyperalgesia (to pin prick) and/or allodynia (to light touch and/or deep somatic pressure and/or joint movement).
> - Vasomotor: Evidence of temperature asymmetry and/or asymmetric skin colour changes.
> - Sudomotor/oedema: Evidence of oedema and/or sweating asymmetry.
> - Motor/trophic: Evidence of decreased active joint range of motion and/or motor dysfunction (tremor, dystonia) and/or trophic changes (hair, nail, skin).

4. There is no other diagnosis that better explains the signs and symptoms.

*A sign is included only if it is observed and documented at time of the impairment evaluation.

Then consider the following in assessing CRPS 1:

- If the criteria in each of the sections 1, 2, 3 and 4 in Table 17.1, above, are satisfied, the diagnosis of CRPS 1 may be made.
- Rate the extremity impairment resulting from loss of motion of each individual joint involved.
- Rate the extremity impairment resulting from sensory deficits and pain, according to the grade that best fits the degree or amount of interference with ADL, as described in AMA 5 Table 16.10a (p 482). Use clinical judgement to select the appropriate severity grade and the appropriate percentage from within the range shown in each grade. The maximum value is not automatically applied. The value selected represents the extremity impairment**. A nerve value multiplier is not used (emphasis added).**
- Combine the extremity impairment for loss of joint motion with the impairment for pain or sensory deficit using the Combined Values Chart (AMA 5, p 604) to obtain the final extremity impairment.
- Convert the final extremity impairment to WPI using AMA 5 Table 16.3, (p 439) for the upper extremity and AMA 5 Table 17.3 (p 527) for the lower extremity.

Complex Regional Pain Syndrome Type 2, causalgia

For Complex Regional Pain Syndrome Type 2, c (CRPS2), the mechanism is an injury to a specific nerve. The methodology in AMA 5 (pp 496–97) is to be followed:

- If the criteria in each of sections 1, 2, 3 and 4 in Table 17.1, above, are satisfied and there is objective evidence of an injury to a specific nerve, the diagnosis of CRPS 2 may be made.
- Rate the extremity impairment due to loss of motion of each individual joint involved.
- Rate the extremity impairment resulting from sensory deficits and pain of the injured nerves according to the determination methods described in AMA 5 Chapter 16, Section 16.5b and Table 16-10a. Use clinical judgement to select the appropriate severity grade and the appropriate percentage from within each range shown in the grade.
- Rate the extremity impairment resulting from motor deficits and the loss of power of the injured nerve according to the determination method in AMA 5 Chapter 16, Section 16.5b and Table 16-11a.
- Combine the extremity impairment percentages for loss of range of motion of the joints involved, pain or sensory deficits, and motor deficits, if present, to determine the final extremity impairment, using the Combined Values Chart in AMA 5 (p 604).

- Convert the final extremity impairment to WPI using AMA 5 Table 16.3 (p 439) for the upper extremity and AMA 5 Table 17.3 (p 527) for the lower extremity."

48. The Appeal Panel noted that CRPS 2 (causalgia) is diagnosed when the mechanism is by way of injury to a specific nerve. It requires there to be "objective evidence of injury to a specific nerve". CRPS 1 constitute the remainder of CRPS cases, that is, where an injury to a specific nerve has not been identified.

49. As noted above, there was no dispute in the present case that the diagnosis is CRPS 1. Dr Stephenson and the AMS made a diagnosis of CPRS 1 and the Appeal Panel agreed with this diagnosis. The hospital notes did not suggest that there has been injury to a specific nerve. There was an elliptiform soft tissue injury on the shin. There was no evidence of an injury to a specific nerve (such as the sciatic or femoral).

50. The Appeal Panel considered whether there was a sensory deficit involving the sciatic nerve.

51. Dr Stephenson, in his report dated 5 August 2019, wrote:

> "For the sensory loss of the sciatic nerve, there is a 17% lower extremity rating. Reference Table 17-37, Page 81, AMA-5. The predominant nerves involved in the sensory loss maximum are the sciatic nerve sensory branch and the femoral nerve sensory branch. The impairments due to nerve deficits, sensory maximal are set out at Table 17-37, Page 552, AMA-5 but first Chapter 16, Page 482, Table 16-10 is consulted, as to the grading of sensory loss."

52. Dr Stephenson noted that there was distorted superficial tactile sensibility, diminished light touch and two-point discrimination with some abnormal sensations with slight pain that interfered with some activities.

53. The AMS under "Present symptoms" did note that the appellant stated that at night "he gets a heat effect in his left heel". However, heat under the heel is not symptom that occurs in a defined nerve distribution. The Appeal Panel considered that the AMS did examine the sensory and motor system related nerves. He described sensory findings which crossed between the distal end of the saphenous nerve and the proximal area of the superficial peroneal nerve. He noted that the saphenous nerve is the terminal branch of the femoral nerve. It is important to note that this description is *not* that of sensory changes within the distribution of any one specific nerve, and are not in a distribution which would normally point to a defined lesion or injury of a specific nerve. Rather the sensory changes which cross neural boundaries in an irregular and incomplete way are likely manifestations of a more general physiological response through neural pathways in response to injury in the affected area.

54. The defining difference between CRPS 2 and CRPS 1 is that in CRPS 2 "the mechanism is an injury to a specific nerve". In CRPS 1 there is no such injury to a specific nerve. There is no evidence that Mr Pallett has sustained an injury to a specific nerve. Therefore his CRPS is classified as CRPS 1.The incorrect use of the Guidelines resulted in a nerve value multiplier (i.e. an impairment value ascribed to an individual nerve in accordance with AMA5 definitions) being used in an assessment of CRPS 1 when the Guidelines specifically exclude the use of a nerve value multiplier being used in an assessment of CPRS 1. A nerve value modifier is only used in an assessment of CRPS 2. There can therefore be said to have been an inappropriate consideration of "nerve damage" in relation to the accident.

55. In CRPS 1 cases the impairment specific to an individual nerve is not relevant as it is in a CRPS 2 assessment. This is for the obvious and logical reason that CRPS1 is defined by the absence of an injury to a specific nerve. Section 16.5b and 16.11a of AMA 5 do not apply to evaluation of WPI in CRPS 1, as they do in CRPS 2 where there is injury to a specific nerve or nerves.

56. The application of the nerve value modifier (i.e. a value ascribed to an individual nerve) was not in accordance with the criteria for assessment of CRPS1. Assessment of WPI for CRPS 2 follows a different methodology pathway. The Appeal Panel considered that the incorrect use of the Guidelines was a demonstrable error.

57. The Appeal Panel proceeded to make an assessment of impairment using the assessment methodology for CRPS 1. This resulted in the following calculation:

- *Rate the impairments for each individual joint involved (restricted).* The Panel accepted the AMS's calculation of 20% based on restrictions of movement of the ankle and great toe.

- *Rate the extremity impairment resulting from sensory deficits and pain, according to the grade that best fits the degree or amount of interference with ADL, as described in AMA 5 Table 16.10a (p 482). Use clinical judgement to select the appropriate severity grade and the appropriate percentage from within the range shown in each grade. The maximum value is not automatically applied. The value selected represents the extremity impairment. A nerve value multiplier is not used.* The Panel accepted the gradation of sensory severity based on interference with ADLs etc and clinical judgement as assessed by the AMS as 50% (within the Grade 3 bracket of severity, Table 16.10a) for the reasons given. This "value represents the extremity impairment" for sensory deficit and pain).

- *Combine the extremity impairment for loss of joint motion with the impairment for pain or sensory deficit using the Combined Values Chart (AMA 5, p 604) to obtain the final extremity impairment.* Combining 50% and 20% results in a 60% Lower extremity impairment (LEI) for CRPS. This equates to 24% WPI (Table 17-3, AMA 5).

58. The Appeal Panel, therefore, made an assessment of 24% for the left lower extremity - CPRS 1 and 2% WPI for scarring (TEMSKI). This resulted in a combined assessment of 26% WPI.

59. In conclusion, the Appeal Panel considered that there was a demonstrable error in the AMS's assessment. The Appeal Panel reviewed that matter and has made an assessment of 26% WPI as a result of the injury on 20 December 2008.

60. For these reasons, the Appeal Panel has determined that the MAC issued on 2 September 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*.

H Mistry

Heena Mistry
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **873/20**
Applicant: **Paul James Pallett**
Respondent: **Secretary of Department of Communities and Justice**

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 Ian Meakin 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)**
Left lower extremity	26/07/18	Chapter 7	Table 16.10a Table 17.14. 17.10, 17.11, 17.12, 17.13, 17.14 and 17.3	24%	N/A	24%
Scarring	26/07/18	TEMSKI	P384 Table 15-03	2%	N/A	2%
Total % WPI (the Combined Table values of all sub-totals)					**26%**	

Carolyn Rimmer
Arbitrator

Dr Robin Fitzsimons
Approved Medical Specialist

Dr Ross Mellick
Approved Medical Specialist

23 December 2020

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE MEDICAL ASSESSMENT CERTIFICATE OF THE APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

H Mistry

Heena Mistry
Dispute Services Officer
As delegate of the Registrar