WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-753/19**
Appellant:	**Ray Rasimoglou**
Respondent:	**Décor Painting Pty Ltd**
Date of Decision:	**19 July 2019**
Citation:	**[2019] NSWWCCMA 96**

Appeal Panel:	
Arbitrator:	**Catherine McDonald**
Approved Medical Specialist:	**Dr David Crocker**
Approved Medical Specialist:	**Dr Brian Noll**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 30 April 2019, Ray Rasimoglou lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Roger Pillemer, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 3 April 2019.

2. The appellant relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act):

    - the assessment was made on the basis of incorrect criteria,
    - the MAC contains a demonstrable error.

3. The Registrar is satisfied that, on the face of the application, at least one ground of appeal has been made out, being that the AMS contains a demonstrable error The Appeal Panel has conducted a review of the original medical assessment but limited to the ground of appeal on which the appeal is made.

4. The Workers compensation medical dispute assessment guidelines set out the practice and procedure in relation to the medical appeal process under s 328 of the 1998 Act. An Appeal Panel determines its own procedures in accordance with the Workers compensation medical dispute assessment guidelines.

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

RELEVANT FACTUAL BACKGROUND

6. Mr Rasimoglou suffered an injury to his lumbar spine on 30 September 2016 in the course of his employment with Décor Painting Pty Ltd (Décor) as a painter and decorator. He had only been employed for a few days. He fell from a ladder and suffered a brief loss of consciousness then pain in his back and left leg.

7. The AMS assessed 12% whole person impairment (WPI) and deducted one-third under s 323 of the 1998 Act.

PRELIMINARY REVIEW

8. 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.

9. As a result of that preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination because the decision made by the AMS was open to him and there is enough evidence in the file to deal with the appeal.

EVIDENCE

10. 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.

11. 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

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

13. In summary, Mr Rasimoglou, through his solicitor, submitted that the AMS did not provided reasoning why a deduction of more than one-tenth was warranted, noting that neither Dr J G Bodel, qualified on his behalf, nor Dr R Breit, qualified for Décor, had made a deduction. He also submitted that the AMS did not adequately consider the difference in symptoms and capacity before and after the injury.

14. Mr Rasimoglou conceded that he did suffer intermittent pain before the injury but submitted that the previous complaints are right sided and include his right hip for which surgery has been recommended. He submitted that the current complaints are left sided. He submitted that the last complaint to his general practitioner before the work injury had been in January 2016 and his last complaints to Dr McKechnie, his treating neurosurgeon, had been in February 2016 and were right sided.

15. In reply, Décor submitted that the assessment made by the AMS was not consistent with that of Dr Bodel – Dr Bodel considered that the L5 nerve root was involved where the AMS considered that it was the S1 nerve root. The AMS noted that Dr Bodel was not provided with the correct history set out in the reports of Mr Rasimoglou's general practitioner. Décor submitted that the AMS considered the previous injuries and the reports in the file in making his assessment and that it was open to him to make the assessment he did.

16. With respect to the submission that the AMS did not consider Mr Rasimoglou's condition before the injury, Décor submitted that the AMS had provided a comprehensive MAC and used his clinical skill and judgement to reach his decision.

FINDINGS AND REASONS

17. 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.

18. 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.

The MAC

19. The AMS noted that Mr Rasimoglou was immediately aware of low back pain radiating down his left leg to the lateral border of his left foot and lateral toes. He considered that he had evidence of S1 nerve root involvement, which was consistent with the MRI scan. He described the MRI scan:

> "I note that a multi-positional MRI scan of his lumbar spine carried out on 7 February 2017 suggested multilevel disc degenerative changes in keeping with age, as well as showing a left sided L4/5 foraminal herniation in contact with the left L4 nerve root, and a central L5/S1 herniation contacting the left S1 nerve root."

20. The AMS assessed Mr Rasimoglou in DRE Lumbar Category III because there were significant signs of radiculopathy.

21. The AMS noted other relevant reports and said:

> "I note the report of Dr J G Bodel orthopaedic surgeon of 20 August 2018, suggesting evidence of radiculopathy on the left side on the basis of an L5 nerve root, (in my opinion it was the S1 nerve root that is involved), with FYa 12% WPI which is the same as the figure I have suggested. Dr Bodel has not made any deduction and I note from his report that he did not obtain any history of any pre-existing condition in relation to Mr Rasimoglou's lumbar spine.
>
> I note from a report of Dr R Breit, orthopaedic surgeon of 13 November 2018, he notes that Mr Rasimoglou's past history was in marked contrast to his general practitioner's notes and he suggested that there were a number of inconsistencies and he elected to place Mr Rasimoglou in DRE Category II with 7% WPI, but despite the general practitioner's previous history, did not make any deduction.
>
> Importantly then with regard to past history, I note from the general practitioner's notes (Dr B Yagoub) of 19 January 2016, that Mr Rasimoglou presented with low back pain radiating to his right leg and that he had low back tenderness at the time. There are ongoing symptoms with regard to the low back and on 21 January, the back pain is suggested as being worse, and on 2 August 2016, noting that he has prescribed Panadeine Forte and Lyrica tablets, but does not say what this is for. He had been prescribing these tablets all along.
>
> There are reports of Dr S McKechnie, neurosurgeon of 19 February 2016, some seven months prior to Mr Rasimoglou's injury, noting that he has had recent onset of pain in his low back and refers Mr Rasimoglou for an MRI, but there are no further reports from Dr McKechnie.
>
> There are reports of Dr R Adler and Dr F Machart referring to Mr Rasimoglou's right hip."

22. The AMS explained the deduction he made:

> "As noted, there is clear evidence that Mr Rasimoglou was having significant problems with his low back prior to his injury in September 2016, with the first entry from his general practitioner noting low back pain on 19 January 2016, which is ongoing, and a further report of neurosurgeon, Dr S McKechnie in February 2016 noting ongoing back pain and referring Mr Rasimoglou for an MRI. Under the circumstances it is difficult to suggest an accurate figure with regard to deduction for pre-existing condition, but this would certainly be more than the one tenth which is the suggested deduction when it is difficult to determine the degree of pre-existing condition. In my opinion in this instance for the reasons given, a deduction of more than one tenth is indicated and in my opinion, it would be reasonable to make a one-third deduction in the present situation noting the extent of his pre-existing symptoms. This then leaves Mr Rasimoglou with 8% WPI as a result of his injury on 30 September 2016."

23. Mr Rasimoglou's statement provides only limited detail with respect to his pre-existing condition. He said:

> "I did experience intermittent pain in my back prior to the subject work accident withsome pain in my right leg; however, at the time of the accident, I did not have anysymptoms and was able to carry out normal painting work. I also note that I only ever started to experience symptoms in my left lower extremity following the subjectaccident."

Medico-legal reports

24. Dr Bodel only obtained a history of a right hip replacement[1] and previous neck and right shoulder pain in his report dated 20 August 2018. He reviewed the CT scan dated 12 January 2016 and said:

> "The report of the CT scan of the lumbar spine dated 21 January 2016, which is eight months prior to the fall at work, confirms the significant disc pathology at the L4/5 level. There is some mention of impingement of the right LS root but the clinical signs are on the left.'

25. In his report dated 24 May 2018 Dr Bodel commented further on the CT scan of the lumbosacral spine dated 12 January 2016 in response to an email from Mr Rasimoglou's solicitor and said:

> "I acknowledge that you are quite correct that there has indeed been a CT scan of the lumbosacral spine done on 21 January 2016 which is about eight or nine months prior to the injury in September 2016. There was evidence of a central and left-sided disc prolapse in that scan.
>
> I did not obtain an accurate history as to why that scan was done at that time although I am aware that this gentleman has had intermittent problems previously dating back to about 2008 or 2009.
> …
>
> The clinical signs at the time of the examination did identify left sided pathology with radiculopathy justifying the DRE lumbosacral category III rating. I have no medical evidence to indicate this gentleman was still symptomatic in that area at the time of the fall and he was clearly at work doing normal painting work.

[1] Other medical reports suggest this surgery may have been recommended but did not place.

> In this circumstance therefore, it would be appropriate to make a deduction for pre-existing impairment because of the medical evidence contained in that CT scan. It is, however, in my view too difficult to determine the exact level of the contribution of that pre-existing abnormality or condition to the overall level of Whole Person Impairment in this circumstance and therefore, a one-tenth deduction in accordance with Section 323 would be appropriate."

26. Dr Bodel amended his assessment to 11% WPI. Mr Rasimoglou's submissions did not refer to that report.

27. The CT scan report does not appear in the Application to Resolve a Dispute and the only report from Mr Rasimoglou's general practitioner does not refer to this history.

28. Dr Breit's report dated 13 November 2018 is internally inconsistent. He saw the general practitioner's notes and the CT scan undertaken in 2016. He did not make a deduction under s 323 and he did not explain why.

Previous history

29. There are no reports in the Application to Resolve a Dispute which predate the injury in September 2016 but there are relevant reports in the Reply.

30. The notes from Dr Yagoub's practice date back to 28 December 2008 and there are references to right hip pain in the early consultations. Mr Rasimoglou suffered a right shoulder injury in 2011. He was prescribed medication for those conditions.

31. The first reference to back pain was on 3 July 2014. The pain radiated to Mr Rasimoglou's right leg and his prescriptions for Celebrex and Panadeine forte were renewed. The same complaint was made on 19 January 2016 and two days later, Dr Yagoub noted that it was getting worse. At that point, Dr Yagoub requested the CT scan and referred Mr Rasimoglou to Dr McKechnie.

32. The clinical history recorded as the reason for the CT scan was "low back pain radiating to the right leg."

33. Mr Rasimoglou saw Dr S McKechnie, neurosurgeon, on 19 February 2016. He noted the history of pain in Mr Rasimoglou's right hip and said:

> "He has had a recent injury to the lower back. There has been some pain radiating though the proximal right leg to the level of the knee although he does not report any symptoms below this level…The CT scan of the lumbar spine demonstrates a moderate L4/45-disc protrusion with a likely fragment of disc extending superiorly…It looks like a longstanding protrusion to me."

34. Mr Rasimoglou again complained of ongoing back pain and right sciatica to Dr Vuong on 27 January 2016. On 27 January Mr Rasimoglou also saw Dr Yagoub who referred him to Dr Vertzyas, whom he had previously seen for his right hip. There is no diagnosis in Dr Yagoub's notes but the reference to discussion of results suggests that it was in respect of the CT scan. Lyrica was prescribed.

35. Mr Rasimoglou saw Dr Yagoub on 28 January 2016, 29 February 2016, 29 March 2016, 17 May 2016 and 2 August 2016. On each of those occasions either Lyrica or Panadeine Forte was prescribed and there is no record in the notes of the condition for which Mr Rasimoglou sought treatment. The first reference to the relevant injury was on 30 September 2016, when Dr Yagoub noted tenderness from thoracic to lumbar spine.

Consideration

36. Mr Rasimoglou was investigated and treated for a symptomatic condition in his lower back shortly before the injury. The CT scan undertaken in January 2016 showed evidence of a central and left sided disc prolapse at L4/5, contacting the L4 nerve root.

37. The MRI scan undertaken on 6 February 2017 confirms the existence of the herniation at L4/5 and shows a further herniation at L5/S1.

38. The submission that Mr Rasimoglou did not report pain in his lumbar spine to his general practitioner after January 2016 cannot be accepted. He saw Dr McKechnie in February 2016 who suggested further investigation by MRI scan.

39. Mr Rasimoglou remained under active treatment from his general practitioner in the months before the injury. Though the diagnosis is not set out on each occasion, he was prescribed Lyrica which is used for neuropathic pain and was unlikely to have been prescribed for the osteoarthritis in his right hip. Those notes are at odds with Mr Rasimoglou's statement that the pain was intermittent.

40. While the MRI scan taken in February 2017 showed pathology at an additional level, the evidence shows that Mr Rasimoglou had an existing disc lesion in his lumbar spine. Although he had previously experienced pain in his right leg rather than his left, the report of Dr Bodel indicates that the CT scan in January 2016 revealed evidence of a central and left-sided disc prolapse.

41. The history and the radiological findings are significant enough to warrant a deduction of more than one-tenth. The deduction of one-third made by the AMS was an appropriate exercise of his clinical judgement.

42. The AMS has adequately explained his assessment by reference to Dr Yagoub's notes.

43. The AMS omitted to refer to Dr Bodel's report dated 28 August 2018. However, the submission that Dr Bodel did not make a deduction under s 323 is simply wrong.

44. For these reasons, the Appeal Panel has determined that the MAC issued on 3 April 2019 should be confirmed.

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

G Bhasin

Gurmeet Bhasin
Dispute Services Officer
As delegate of the Registrar