WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-244/19**
Appellant:	**Daniel Bronzon**
Respondent:	**All Concrete SLD Pty Limited**
Date of Decision:	**19 December 2019**
Citation:	**[2019] NSWWCCMA 197**

Appeal Panel:	
Arbitrator:	**R J Perrignon**
Approved Medical Specialist:	**Dr Michael Fearnside**
Approved Medical Specialist:	**Dr John Ashwell**

BACKGROUND TO THE APPEAL

1. The appellant worker, Mr Bronzon, appeals from the Medical Assessment Certificate of Approved Medical Specialist Dr Burrow dated 28 August 2019.

2. On 22 March 2017 Mr Bronzon injured his lumbar spine and hips, among other things, when he bashed his head against the tine of a forklift truck at work and fell three metres to the ground.

3. On 25 March 2019, Approved Medical Specialist Dr Burrow declined to assess whole person impairment (lumbar spine, right hip, left hip) on the basis that maximum medical improvement had not been reached.

4. By a Medical Assessment Certificate dated 28 August 2019, Dr Burrow assessed an 11% whole person impairment (6% lumbar spine, 3% right lower extremity – hip, 2% left lower extremity – hip) as a result of injury on 22 March 2017. In doing so, he:

    (a) assessed DRE category II impairment in respect of the lumbar spine, yielding a 7% whole person impairment (lumbar spine) from which he deducted 1/10th for a pre-existing condition to arrive at 6% whole person impairment (lumbar spine); and

    (b) assessed a 14% whole person impairment (right hip) and 12% whole person impairment (left hip), from each of which he deducted 4/5ths to account for the effects of pre-existing seronegative spondyloarthritis, yielding a 2% whole person impairment in respect of each hip.

5. The appellant worker appeals from the assessment, on the bases that:

    (a) the lumbar spine should have been assessed as DRE category III, in accordance with the assessment of Professor Patrick, and

    (b) the 4/5ths deduction for pre-existing seronegative spondyloarthritis in respect of the hips was not justified.

6. On 24 October 2019, the Registrar by his delegate was satisfied that the ground of demonstrable error was made out, and referred the matter to this Appeal Panel for determination.

7. On 25 November 2019, the Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the *Guidelines*. Though it identified error of the kind asserted by the appellant, it was unnecessary to refer the worker for examination by a member of the Panel, as the error was capable of correction without further examination.

Submissions

8. The Appeal Panel has had regard to the written submissions filed by both parties. It is unnecessary to set them out here in full, but appropriate to summarise them as follows.

9. The appellant worker submits that the Medical Assessment Certificate demonstrates error and the application of incorrect criteria, for the following reasons.

    (a) In respect of the lumbar spine, the Approved Medical Specialist erred in assessing a DRE category II impairment. He should have assessed a DRE category III impairment in accordance with the assessment of Dr Patrick, based on the wasting of the left thigh, reduced left ankle jerk, and bilateral radiculopathy into the buttocks complained of by the appellant. He failed to consider Dr Patrick's report, explain why his clinical findings and assessment differed from those of Dr Patrick, and to consider the applicant's complaint of bilateral pain in the buttocks.

    (b) In respect of the hips, the Approved Medical Specialist assumed that, because seronegative spondyloarthritis had been diagnosed in 2012, it must contribute to impairment. Such an assumption was impermissible: *Cole v Wenaline Pty Limited* [2010] NSWSC 78*; Pereira v Siemens Limited* [2015] NSWSC 1133. The Approved Medical Specialist was required to determine whether that condition was in fact contributing to impairment on the evidence before him. He failed to do so, or to give reasons for any such conclusion. The approved medical specialist also erred in applying a deduction of 4/5ths. A 1/10th deduction is appropriate.

10. The respondent submits in summary as follows.

    (a) The assessment contained in the Medical Assessment Certificate of 28 August 2019 must be read in the context of the clinical findings on examination recorded in the Medical Assessment Certificate of 25 May 2019.

    (b) In respect of the hips, notwithstanding Dr Powell's opinion that no deduction was appropriate in respect of the hips, the Approved Medical Specialist was entitled to find that loss of motion in the hips was most likely due to pre-existing disease, having regard to the evidence that seronegative arthritis had been diagnosed in 2012 by Prof Pile, and left sacroiliitis was demonstrated on bone scan dated 12 February 2012.

    (c) The amount of the deduction was a matter for the clinical judgment of the Approved Medical Specialist, and was supported by the evidence and his reasoning. It ought not be disturbed.

    (d) In respect of the lumbar spine, the findings on examination were consistent with DRE category II. The Approved Medical Specialist was not obliged to accept the contrary view of Dr Patrick. The assessment of the Approved Medical Specialist ought not be disturbed.

Reasoning of the Approved Medical Specialist

11. The Approved Medical Specialist examined the worker on 8 March 2019. In his Medical Assessment Certificate of 25 March 2019, he:

    (a) recorded a history of injury on 22 March 2017, and of subsequent scans and treatment,

    (b) diagnosed "debilitating hip pain, bilateral buttock (SI joint) pain and discomfort into the hips",

    (c) noted the diagnoses of seronegative spondyloarthritis by treating rheumatologist Professor Pile in 2012, and of bilateral sacroiliac disease on serial bone scans in 2012 and 2016, and

    (d) declined to assess whole person impairment because the worker was about to discuss lumbar spine surgery with neurosurgeon Dr Pik.

12. In a further Medical Assessment Certificate dated 28 August 2019, the Approved Medical Specialist noted that Dr Pik had advised the worker to continue with non-surgical treatment because:

    (a) he was able to control his symptoms with medication and physiotherapy, and

    (b) Dr Pik had advised HLA-B27 studies to exclude the possibility that pain was coming from the hip joints, notwithstanding his view that the likely pain generator was a desiccated L5/S1 disc.

13. On this basis, the Approved Medical Specialist considered that maximum medical improvement had been reached and proceeded to assessment, without further examination of the worker.

14. He relied on the symptoms elicited on previous examination. They were as follows (par 4):

> "Mr Bronzon complains of lower back, bilateral buttock pain that is worse first thing in the morning and is associated with stiffness where he describes his back 'locking up' until he takes his medications.
>
> There is referred pain into both groins. The pain is measured at 8/10 and after a particularly bad day can be worse at night. It is aggravated by running but he is able to walk on the flat 2km, but finds it difficult negotiating uneven ground despite being able to work on a construction site.
>
> ….
>
> The pain is not referred into the legs below the groins and certainly not to the soles of the feet."

15. He described his findings on physical examination, relevantly (at par 5 – emphasis added):

> "Examination of the lumbar spine showed no deformity but there was paraspinal guarding but no spasm. Spinal movements were reduced by one half and he was very ginger.
>
> There was no evidence of neural tension today with straight leg raise to 80° bilaterally. **He did complain of buttock, SI and low back pain.**
>
> Examination of the lower extremities showed **no radicular pattern weakness, dermatomal pattern sensation or abnormality**. I thought the left ankle jerk was reduced however just slightly. **There was no wasting of the thigh** or calf musculature.

Examination of his hips showed both hips were quite irritable. **Trendelenburg was uncomfortable but posteriorly it seemed to be related to the SI joint rather than the hip joint**. Hip Active range of motion was reduced ….:

He mostly complained of buttock or SI joint pain on hip movement."

16. He expressed the following opinions in his Medical Assessment Certificate dated 28 August 2019 (at par 6a – emphasis added):

> "It is my opinion Mr Bronzon suffered an aggravation to a desiccated disc at L5/S1 of the lumbar spine as a result of the work incident in 2017, as confirmed by his Treating Neurosurgeon, Dr Pik.
>
> SI Joint: It is difficult to determine if his current symptoms and complaints are only due to the L5/S1 disc, or may also involve pathology about the SI joints and/or the hips. It is particularly important as **there is likely to be background disease in all 3 areas, that is the lumbar spine, SI joint and the hips from the known seronegative arthropathy** which was diagnosed and pre-existent from 2012."

17. In respect of the lumbar spine, he assessed a DRE category II impairment, reasoning at par 6b:

> "AMA-5, Table 15-3, **DRE Lumbar Category II**: 5% whole person impairment as the clinical history and examination findings are compatible with a specific injury and **findings may include muscle spasm but without radiculopathy** (as per SIRA paragraph 4.27)."

18. He assessed 0% whole person impairment in respect of the sacroiliac joints, on the basis that there was "no evidence of joint dislocation nor fracture dislocation" (par 6b)."

19. In respect of the right hip, he reasoned (par 6b – emphasis added):

> "SIRA Table 3.5 Lower Extremity Worksheet: **There is no potential impairment from** limb length discrepancy, gait derangement, **muscle atrophy**, muscle weakness, ankylosis, arthritis, amputation, DBE, skin loss, peripheral nerve deficit, CRPS or vascular disorder.
>
> **There is potential impairment due to loss of range of motion** as per AMA-5, Table 17-9 Hip Motion Impairment: Flexion <100°: mild: 5% lower extremity impairment. Extension: No impairment as there is no flexion contracture. Internal rotation: Moderate: 10% lower extremity impairment. External rotation: Moderate: 10% lower extremity impairment. Abduction: Mild: 5% lower extremity impairment. Adduction: Mild: 5% lower extremity impairment.
>
> There is no abduction contracture."

20. On respect of the left hip, he reasoned (par 6b – emphasis added):

> "SIRA Table 3.5 Lower Extremity Worksheet: **There is no potential impairment from** limb length discrepancy, gait derangement, **muscle atrophy**, muscle weakness, ankylosis, arthritis, amputation, DBE, skin loss, peripheral nerve deficit, CRPS or vascular disorder.
>
> **There is potential impairment due to loss of range of motion** as per AMA-5, Table 17-9 Hip Motion Impairment: Flexion <100°: mild: 5% lower extremity impairment. Extension: No impairment as there is no flexion contracture. Internal rotation: Mild: 5% lower extremity impairment. External rotation: Moderate: 10% lower extremity impairment. Abduction: Mild: 5% lower extremity impairment. Adduction: Mild: 5% lower extremity impairment.

> Add range of motion impairment: Left lower extremity 30% lower extremity impairment. This equals 12% whole person impairment."

21. In respect of the deduction made for pre-existing seronegative spondyloarthritis in the hips, he explained (par 6c - emphasis added):

> "Deductible Proportion: It is clear from the history that Mr Bronzon was diagnosed with seronegative spondyloarthritis in 2012. **It is known this affects the lumbar spine, SI joints and other major joints including hips. It is my opinion that his current presentation then has been significantly affected by that pre-existing disease**. It is my opinion that **the available medical evidence indicates that the marked impairment seen in relation to loss of range of motion of the hips is most likely due to that background process and not due to the work incident**. Specifically, Dr Pik believes the 'major pain generator' is the desiccated disc at L5/S1.
>
> In relation to the lumbar spine then, in my opinion it is reasonable to confirm that the deductible proportion is 1/10th for that region.
>
> There is no specific impairment related to the SI joints although they appear to be subjectively painful.
>
> **In relation to the hips, however, the deductible proportion is significantly greater. I would estimate it at 4/5."**

Consideration and findings

1. Assessment of lumbar spine

22. The appellant asserts that the Approved Medical Specialist failed to consider Dr Patrick's report and to explain why his assessment differed.

23. The Approved Medical Specialist did not specifically refer to Dr Patrick's report in his reasons. However, the report had been provided to him, and there is no evidence to support the assertion that he failed to have regard to it.

24. He did not give reasons why his own assessment differed from that of Dr Patrick. It would have been preferable to do so, but his reasons for making assessing DRE category II in respect of the lumbar spine, based on range of movement, were patent, and required no further explanation.

25. The appellant also asserts that a DRE category impairment III was warranted, because of the wasting of the left thigh, reduced left ankle jerk, and bilateral radiculopathy into the buttocks complained of by the appellant.

26. The criteria for selecting DRE categories are set out in Table 15-3 (AMA5). The relevant criteria for category II are:

> "findings compatible with a specify injury; findings may include significant muscle guarding or spasm observed at the time of examination, asymmetric loss of range of motion, or nonverifiable radicular complaints, defined as complaints of radicular pain without objective finding; no alteration of the structural integrity and no significant radiculopathy".

27. The Approved Medical Specialist found that symptoms were compatible with a specific injury. He noted muscle guarding and complaints of buttock pain. As these were not in a radicular pattern, he was unable to verify the radicular complaints. He could find no radiculopathy of significance. There was no alteration of structural integrity of the lumbar spine.

28. These findings were consistent with DRE category II. In our view, the selection of category II was open to the Approved Medical Specialist on the evidence before him.

29. The criteria for DRE category III include, 'significant signs of radiculopathy, such as dermatomal pain and/or in a dermatomal distribution, sensory loss, loss of relevant reflexes, loss of muscle strength or measured unilateral atrophy above or below the knee compared to measurements on the contralateral side at the same location'.

30. As no significant signs of radiculopathy were observed, category III was not available for selection by the Approved Medical Specialist. Reduced left ankle jerk alone was not sufficient to satisfy the criteria, with or without muscle wasting. In any event, the approved medical specialist did not find there was muscle wasting on measurement of the thighs. The mere fact that Dr Patrick had found muscle wasting did not compel a similar finding by the Approved Medical Specialist. His task was to assess the worker as he presented at examination. This is what he did.

31. We can identify no error in respect of his assessment of the lumbar spine.

2. Hips – deduction for effects of seronegative spondyloarthritis

32. In assessing whole person impairment, an Approved Medical Specialist must deduct from the assessment "any proportion of the impairment that is due to any previous injury … or that is due to any pre-existing condition or abnormality": Section 323 of the *Workplace Injury Management and Workers Compensation Act 1998*.

33. An assessor may not simply assume that, because there was a pre-existing condition, it necessarily contributes to current impairment. He or she must first find, on the evidence, that the pre-existing condition actually contributes to impairment: *Cole v Wenaline* [2010] NSWSC 78.

34. It is possible for a pre-existing condition to contribute to impairment, even if it was asymptomatic prior to injury. A deduction for such a pre-existing condition must be made, if it contributes to impairment: *Vitaz v Westform (NSW) Pty Limited* [2011] NSWCA 25.

35. The three steps for assessing whether a deduction ought to be made were expressed as follows in *Cole* (at 38):

> "What s 323 required, however, was that the evidence be considered, so that it could be determined, firstly, what the level of impairment after the second injury was. Secondly, whether a proportion of that impairment was due to the first injury. Thirdly, what that proportion was."

36. In this case, the Approved Medical Specialist accepted the diagnosis of pre-existing spondyloarthritis made by Prof Pik, noted that the disease was probably present in the lumbar spine, hips and sacroiliac joints (par 6a, extracted above), noted also that 'this [disease] affects the lumbar spine, SI joints and other major joints including hips', and concluded that 'the marked impairment seen in relation to loss of range of motion of the hips is most likely due to that background process, particularly the sacro-iliac joints, and not due to the work incident'.

37. His conclusion was a not a mere assumption. Though he did not specifically refer to the all the following evidence before him, his conclusion was amply supported by it. Previous hip and buttock pain had been recorded in the general practitioner notes by Dr H Nguyen. At consultation on 5 February 2012 he noted, 'pain L SIJ region for 5 months'. On 5 April 2012 he recorded, 'R sacro-iliitis', and on 11 July 2016, 'bilateral hip pain, left side worst affected'. The worker was taking anti-inflammatory tablets for these symptoms from February 2012 through to June 2015, and from November 2016 to March 2017. In his report dated 11 October 2018, Dr Powell noted a referral to rheumatologist Professor Kevin Pile in 2012 for the investigation of deep left buttock pain. A bone scan at the time indicated increased

uptake in the left sacro-iliac joint with subsequent diagnosis of seronegative spondylopathy. Treatment was with physiotherapy and corticosteroid injection. A bone scan was performed on 13 July 2016. The report of 14 July 2016 noted a history of bilateral hip pain, and indicated stress reaction in the SI joints bilaterally (left more than right) and mild pubic symphysis enthesitis. There was increased uptake in the left hemipelvis, more obvious than 2012. A bone scan on 3 August 2017 showed increased uptake in both sacro-iliac joints consistent with sacroiliitis/dysfunction.

38. This evidence, in our view, supports a finding that seronegative spondyloarthritis in the hips pre-dated injury by some years, and was contributing to hip symptoms as at the date of examination by the Approved Medical Specialist. It was well open to the Approved Medical Specialist to conclude, as he did, that the restrictions of movement observed by on examination were in part due to this pre-existing condition. We can identify no error in this finding.

39. However, the Approved Medical Specialist did not explain why he assessed a deduction of 4/5ths, rather than some other fraction. The failure to give reasons for this, in our view, constituted error on the face of the certificate, and the certificate must be set aside.

40. It remains for the Panel to assess an appropriate deduction, having regard to the medical evidence before us, and the findings on examination by the Approved Medical Specialist. In his assessment of 30 July 2018, Dr Patrick made a 1/10th deduction for all body parts. Considering all the available evidence of hip and buttock symptoms requiring investigation and treatment since 2012, we are of the view that the deduction is not difficult or costly to determine. In his assessment of 11 October 2018, Dr Powell declined to make any deduction for previous pathology, as he considered the hip condition had fully resolved. This is not supported by the medical evidence, which indicates that the hip symptoms were ongoing and required anti-inflammatory medication. A blood test reported on 7 March 2012 was positive for HLA B27 and indicated an ongoing inflammatory condition, which was doubtless seronegative spondyloarthritis, and controlled by taking anti-inflammatory medication. In our view, the medical evidence does not support the 4/5th deduction made by the Approved Medical Specialist, but it certainly supports a deduction of one-fifth. Having regard to the clinical history and to all the medical evidence, including that summarised above and the findings on examination, we are satisfied that a 1/5th deduction is appropriate.

Conclusion

41. For those reasons, the appeal is allowed and the Medical Assessment Certificate of Dr Burrow dated 28 August 2019 is set aside and replaced with the attached Medical Assessment Certificate.

A Shaw

Andrew Shaw
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **244/19**
Applicant: **Daniel BRONZON**
Respondent: **All Concrete SLD Pty Limited**

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 Burrow 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 NSW workers compensation guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA5 Guides**	**% WPI**	**% WPI deductions pursuant to S323 for pre-existing injury, condition or abnormality**	**Sub-total/s % WPI** (after any deductions in column 6)
Lumbar spine	22/03/17	Chapter 1, para 1.15, 1.16, 27, 1.28, chapter for para 4.27, 33, 34, 35, table 4.3	Chapter 15: Table 15–3	7%	1/10th	6% (rounded)
Right lower extremity (hip)	22/3/17	Chapter 3, table 3.5	Chapter 17, table 17–3, 7–2, 7–9	14	1/5	11% (rounded)
Left lower extremity (hip)	22/3/17	Chapter 3 table 3.5	Chapter 17, table 17–3, 7–2, 7–9	12	1/5	10% (rounded)
Total % WPI (the Combined Table values of all sub-totals)						**25%**

R J Perrignon
Arbitrator

Dr Michael Fearnside
Approved Medical Specialist

Dr John Ashwell
Approved Medical Specialist

19 December 2019

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*.

A Shaw

Andrew Shaw
Dispute Services Officer
As delegate of the Registrar