WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-303/19**
Appellant:	**Yvette Maree Moroney**
Respondent:	**Spotlight Pty Ltd**
Date of Decision:	**8 January 2020**
Citation:	**[2020] NSWWCCMA 5**

Appeal Panel:	
Arbitrator:	**Catherine McDonald**
Approved Medical Specialist:	**Dr John Ashwell**
Approved Medical Specialist:	**Dr Margaret Gibson**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 12 August 2019 Yvette Maree Moroney lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Trevor Best, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 26 July 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 in s 327(3)(d). The Appeal Panel has conducted a review of the original medical assessment but limited to the grounds 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. Ms Moroney suffered an injury to her right elbow on 6 September 2012 for which she underwent surgery on 22 March 2012.

7. In a Certificate of Determination dated 5 June 2019, a Commission arbitrator found that Ms Moroney suffered a consequential condition in her right and left shoulders as a result of that injury.

8. The AMS assessed 14% whole person impairment (WPI) resulting from the injury to Ms Moroney's right elbow, consequential conditions in the right and left shoulders and scarring under the TEMSKI.

9. He assessed 12% upper extremity impairment (UEI) in respect of Ms Moroney's right shoulder and deducted one-tenth under s 323 of the 1998 Act because Ms Moroney had previously complained of shoulder pain as a result of a previous cervical fusion operation in 2001. He said that her right shoulder symptoms would have been aggravated by the development of rheumatoid arthritis.

10. The AMS said that Ms Moroney's left shoulder symptoms did not develop until 2018 when rheumatoid arthritis was diagnosed. For that reason and because of left shoulder pain following the cervical fusion in 2001, the AMS said that one-half of the left shoulder impairment of 4% WPI should be deducted under s 323.

11. The AMS assessed 8% right UEI impairment as a result of the right elbow injury and assessed scarring at 1% WPI.

12. The total assessment was 14% WPI

PRELIMINARY REVIEW

13. 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.

14. As a result of that preliminary review, the Appeal Panel determined that the worker should undergo a further medical examination because the AMS had failed to set out the clinical findings which supported his deduction in respect of rheumatoid arthritis and failed to provide adequate reasons to support a deduction of one-half of the assessed impairment of the left shoulder.

EVIDENCE

15. 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.

16. 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.

17. Dr Margaret Gibson of the Appeal Panel conducted an examination of the worker on 28 November 2019 and reported to the Appeal Panel. Her report is as follows.

> "Ms Moroney attended as arranged. She was accompanied by her mother who remained in the waiting room.
>
> Ms Moroney when asked about the history of her accident and consequent symptoms, she confirmed she had jarred her right elbow at work on 6 September 2012. This injury had occurred while she was pushing a pillow on to a shelf. She indicated the discomfort as being felt in the region of the right lateral epicondyle. She reported her injury to her employer. That evening her right elbow symptoms worsened. She remained off work. She visited her general practitioner Dr Ismay and was prescribed analgesic medication. Her right elbow symptoms were ongoing, so referral was made to orthopaedic surgeon, Dr Bateman, who she visited on 5 November 2012.

Dr Bateman had referred her to Dr Halpin for PRP injection which was performed 2 December 2012. Then given this intervention had provided no significant resolution of her symptoms, she returned to Dr Bateman and an MRI scan was organised of the right elbow. This had been reported as showing a tear at the extensor origin. Dr Bateman undertook repair of the extensor tendon of her right elbow on 22 March 2013 at Gosford Private Hospital. Ms Moroney said that post-operatively a cast was applied which extended from her right hand up to her right axilla. And following removal of the cast she noticed pain over the front of her right shoulder and this was soon spreading to the right trapezius region.

She had physiotherapy and then pain management intervention from Dr Prickett and use of a TENS machine, but nevertheless there was ongoing right elbow pain.

On 25 February 2016, Dr Bateman performed a pectoralis minor release operation in order to improve her new right shoulder symptoms. Ms Moroney felt that the right shoulder was '*not so tight*' following this procedure, but she was still feeling '*nerve shocks*' and felt that she had reduced power in the right arm.

She had then started to notice left shoulder pain, again localised over the front of the left shoulder. When asked about this, she said that she was finding she was using her left arm more so to compensate for the loss of power and also the symptoms in her right dominant limb.

When asked about her consultations with Dr Toh, rheumatologist, commencing in August 2018, she said the main reason that she had been referred to Dr Toh was that she had aching and burning over both feet and also swelling over the joints of her feet. She did admit there was shoulder discomfort but the pain was in a different location, and the problems with her feet were the main reason she saw Dr Toh. She was prescribed methotrexate and she was then visiting Dr Toh every few months as she required frequent blood testing due to the medication. She said the methotrexate was ceased after about ten months. She said she was initially suffering gastric side effects from the oral methotrexate and so she was moved to an injection, but then this was also a problem, so the medication was ceased. She added that she was finding the methotrexate was not helping in any case. There was no other treatment for her rheumatoid arthritis. She understands she is to see Dr Toh again in a few months. When asked how the treatment for the rheumatoid had affected her shoulder symptoms, she said the shoulder pain was '*totally different pain*.'

Ms Moroney her current treatment for her work related injuries includes Panadol and Nurofen, two Panadol and one Nurofen several times a day, generally two Panadol to one Nurofen. She takes the Lexapro as an antidepressant and she has been using this for several years. There was no other medication. She performs exercises at home. She said that she applies pain management principles to manage the pain.

Ms Moroney currently described pain over the front of the right shoulder extending to the right trapezial region. She said the right shoulder is stiff and sore most of the time and on bad days it aches. The soreness and aching is felt deep within the shoulder joint. There is a separate pain over the front of the right shoulder and right trapezial region. She described this as being '*like an electric shock*' or 'buzzing' sensation. Her right elbow still aches, and this was described as a heavy dull ache. In relation to the left shoulder, the discomfort relates more to movement. She said once she tries to move her left arm from her side, there is a pulling sensation and discomfort and the discomfort is also felt over the front of the shoulder. She said her left arm feels weak and lazy. Her neck is stiff and movements are very restricted. The neck pain disturbs her sleep and can precipitate headaches.

Physical Examination

Ms Moroney was 157cm tall and weighed 60 kg.

On examination of the neck, movements were restricted with less than a third normal, negligible flexion or extension. Rotation to the right was half normal, rotation to the left third normal, lateral flexion third normal bilaterally. There was some guarding.

On examination of the upper limbs, circumferential measurements were consistent with right hand dominance, therefore there was no muscle wasting. There was normal power and reflexes. There were reported sensory changes over the right upper limb which were fairly diffuse and patchy and did not follow a nerve root or peripheral nerve distribution.

On examination of the right elbow, there was a pale 5-cm scar without suture marks. Elbow movements were bilaterally to 90 degrees of flexion and full extension but these movements were variable.

On examination of both shoulders there were some pain behaviours. There was drawing back at even light touch of the neck and shoulder region. There was tenderness over both shoulders globally and in particular over the AC joints bilaterally. There was no crepitus or swelling of either shoulder. There were no temperature changes. There was a pale scar over the anterior aspect of the right shoulder. This measured 4.5 cm. There was no suture marks.

Shoulder Movements	**Active ROM Measured RIGHT**	**Active ROM Measured LEFT**
Flexion	30° 40° 60°	50° 70° 70°
Extension	5° 20° 30°	5° 5° 20°
Internal Rotation	60° at side, 20° when arm elevated	50° at side, 30°
External Rotation	30°	20° at side
Abduction	50° 70° 70°	50° 80° 100°
Adduction	5° 10° 20°	10° 40° 50°

When asked about the variability in movements during the course of the examination, she stated that she had '*over-done it a bit*', meaning essentially after the first or second repetition of shoulder movements. She also said that she was having a particularly '*bad day*' with respect to her symptoms."

SUBMISSIONS

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

19. In summary, Ms Moroney noted that a Commission arbitrator found that Ms Moroney suffered the onset of left shoulder pain in 2015 as a result of favouring her right shoulder, not 2018 as recorded by the AMS. She submitted that the AMS erred in relying on complaints of pain when he was required to assess the range of motion of her shoulders. She submitted that there was no evidence that rheumatoid arthritis had caused any reduced range of motion in her upper extremities. Ms Moroney submitted that a finding of 1% under the TEMSKI as wrong when there were scars from two separate operations.

20. Importantly, Ms Moroney did not argue that the primary assessments made by the AMS were incorrect.

21. In reply, Spotlight submitted that the referral to the AMS was for an assessment of the degree of WPI as a result of the right elbow injury inclusive of scarring and the consequential conditions in Ms Moroney's right and left shoulders. Spotlight submitted that Ms Money's submissions merely reflected differences of opinion between the medical experts.

22. Spotlight argued that the AMS was required to make a deduction in respect of any pre-existing impairment and for any subsequent condition. It set out evidence in support of the contention that the pre-existing and subsequent conditions caused significant impairment. Spotlight submitted that the Panel should increase the deduction under s 323 in respect of the right shoulder. It submitted that, in circumstances where Ms Moroney suffered a debilitating rheumatoid arthritis condition, a deduction of 50% was warranted.

23. Spotlight noted that the Guidelines provide at paragraph 14.5 that the skin is regarded as a single organ and that all non-facial scarring is measured together. It also noted that the Guidelines provide that scars may be present and rated at 0% and that paragraph 14.6 provides that uncomplicated scars do not of themselves rate an impairment.

FINDINGS AND REASONS

24. 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.

25. 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.

26. In *Ingham's Enterprises Pty Ltd v Lakovska*[1] , Barrett AJA (Gleeson JA agreeing) said:

> "Under s 328(2), a medical Appeal Panel's function is to make a 'review of the original medical assessment', being, however, a review that is 'limited to the grounds of appeal on which the appeal is made' being grounds formulated and advanced by the party concerned within the limits allowed by s 327(1). Inghams notes that the part of s 328(2) confining a review to the grounds advanced by the appealing party was added by the *Workers Compensation Legislation Amendment Act 2010* (NSW) in apparent response to the decision of this Court in *Siddik v WorkCover Authority of New South Wales* [2008] NSWCA 116."

27. The Panel is limited to undertaking a review of the MAC that is limited to the grounds of appeal on which Ms Moroney relies. Ms Moroney did not make any complaint with respect to the assessment of her right elbow at 8%UEI (which converts to 5% WPI) or the primary figures with respect to her shoulders.

28. Even though the range of movement observed by Dr Gibson on her examination of Ms Moroney's right shoulder was more limited than that observed by the AMS, her findings will not be substituted for those of the AMS. For the same reason, in the absence of an appeal or cross appeal by Spotlight, its submission that the deduction under s 363 in respect of Ms Moroney's right shoulder should be increased will not be considered.

29. The AMS did not make any deduction under s 323 in respect of Ms Moroney's right elbow. That assessment was appropriate.

[1] [2014] NSWCA 194 at [40].

Right Shoulder

The MAC

30. The AMS recorded the following history of the onset of right shoulder pain following the injury to Ms Moroney's elbow:

> "It was about this time that Ms Moroney noted pain in the right shoulder region. The pain occurred over the front and dorsal aspect of the right shoulder as well as the right scapula and right trapezius region. Ms Moroney was given Lyrica. The pain continued in the right shoulder and the right elbow region. Subsequently on the 25 February 2016 Dr Bateman carried out a pectoralis minor release operation in order to alleviate her right shoulder symptoms. Ms Moroney reports partially [sic] improvement following this operation."

31. The AMS recorded the following history with respect to the development of left shoulder pain and the diagnosis of rheumatoid arthritis:

> "During the mid-part of 2018 Ms Moroney noted pain developing in the left shoulder. Again, the pain has been located over the front, dorsum and left scapula area of the left shoulder. This pain also spreads down the left arm and was associated with weakness and aching in the left arm. About this time Ms Moroney noted the development of an aching pain in the finger joints of both hands, feet, ankles and toes.
>
> Ms Moroney noted sense of weakness in both upper limbs associated with pins and needles in the hands. Ms Moroney also has noted development of lower back pain about this time.
>
> Ms Moroney was referred to Dr Toh who saw her initially in August 2018. Dr Toh noted that the rheumatoid factor measured thirty. (14 June 2018) Dr Toh suggested that the rheumatoid arthritis had developed on a background of hepatitis C. Treatment was in the form of Methotrexate 20mm weekly. He also noted pain in the hands, wrists, elbow, feet, ankles and back.
>
> Ms Moroney reports today that Dr Toh ceased the Methotrexate three weeks previously and will reassess her in a further three weeks. He will then decide on further treatment at that time."

32. The AMS reviewed an MRI scan of Ms Moroney's right shoulder dated 9 July 2014 and said:

> "MRI of the right shoulder (HIG) This investigation demonstrates moderate degeneration of the right acromioclavicular joint. Otherwise the rotator cuff is intact."

33. With respect to previous injuries, the AMS said:

> "Ms Moroney suffered a neck injury when lifting a carton of wine at Pepper Tree Wines in 2002 and developed pain in the neck spreading down both arms as far as the forearm at that time. There was a spread of neck pain into both shoulders at that time and this is confirmed by the report of Dr Claire Hollo in 2003 which is on file. Dr Spittaler carried out a C5-6 fusion in the cervical spine on the 28 May 2002.
>
> Ms Moroney reports that the recovery following this operation was slow and recovery slowly occurred over a two to three-year period. Sometime later Ms Moroney was able to return to sales at Lows initially. There continued to be stiffness in the neck with some pain spreading into both shoulders but on the whole Ms Moroney reports that her bilateral shoulder symptoms had improved by about 70%. Ms Moroney reports that she continued to have some flair [sic] ups from time to time with the spread of neck pain into both shoulders."

34. The AMS recorded his findings on examination, in particular with respect to the range of movement. He did not comment on whether there was any swelling in the shoulder joint. With respect to Ms Moroney's hands he noted:

> "On examination of the wrist and fingers I note that the proximal joints of all fingers have moderate swelling including the thumbs. Ms Moroney is generally tender in these areas and tends to fully flex and stretch these joints to alleviate her symptoms in this region. Ms Moroney has rings on the ring figures of both hands, left index and right thumb. Ms Moroney is unable to remove these rings due to swelling. There is generally a weak grip in both hands due to the pain in the associated joints."

35. The AMS assessed 12% UEI in respect of Ms Moroney's right shoulder and said:

> "Her right shoulder symptoms developed soon after the elbow splint was removed. Therefore, there is good contemporaneous evidence of association of the right shoulder with the right elbow condition. However, Ms Moroney did have previous right and left shoulder symptoms in association with her cervical neck fusion. These symptoms had partially but not completely recovered following the cervical fusion and today Ms Moroney reports that the cervical symptoms did flair up from time to time with pain spreading to both shoulders. These continuing symptoms have been confirmed by the reports on file of Dr Claire Hollo dated the 24 June 2003. Her right shoulder symptoms would also have been more recently aggravated with the development of rheumatoid arthritis. Therefore, in this situation I have elected to discount one tenth of her right shoulder impairment in relation to pre-existing conditions."

36. The impairment assessed by the AMS in respect of Ms Moroney's right shoulder was 11% UEI. His statement that the right shoulder symptoms "would have been … aggravated" is speculative and he did not provide the reasoning to support that statement.

37. It is necessary to consider the impact of three separate conditions when dealing with the appropriate deduction under s 323 with respect to Ms Moroney's right shoulder – the referred pain from her previous neck injury, osteoarthritis and rheumatoid arthritis.

Other medical reports

38. Dr D O'Sullivan, neurologist, saw Ms Moroney for Spotlight's insurer for the first time on 15 May 2014. He recorded that she complained of persistent pain in her right upper limb, spreading from the right side of the neck to the shoulder and scapula and radiating to her hand. She had suffered that pain before the elbow injury in 2012 but it increased after the removal of the cast from her right elbow. Dr O'Sullivan noted a history of the injury to Ms Moroney's neck in 2002 and subsequent surgery. He recommended that Ms Moroney undergo an MRI of her cervical spine and an ultrasound of her right shoulder. An MRI of the right shoulder was undertaken on the same day as that of Ms Moroney's cervical spine.

39. Dr O'Sullivan prepared several further reports, answering questions asked of him. He reviewed the MRI scans and said that the osteoarthritis of the AC joint of Ms Moroney's right shoulder was degenerative.

40. Ms Moroney's solicitors qualified Dr YAE Ghabrial who reported on 13 December 2017 and 27 June 2018. His reports are brief. He did not make any deduction under s 323, nor did he consider the diagnosis of rheumatoid arthritis but his examination took place before that diagnosis. With respect to the onset of right shoulder pain, he said:

> "She saw her local doctor who recommended an MRI scan for her right shoulder as well as an MRI scan to the cervical spine. The MRI scans performed on the 9th July 2014 showed moderate acromioclavicular joint osteoarthritis in the right shoulder and the neck showed evidence of spondylosis at the C3/4 segment with osteophyte formation and foraminal narrowing. There was evidence of an anterior cervical fusion at the C5/6 segment (Dr Peter Spittaler performed surgery to her neck in 2002)."

41. Rheumatoid arthritis was diagnosed by Dr Mark Toh who saw Ms Moroney for the first time on 22 May 2018. His notes for that day record:

> "Date: Tuesday, 22/05/2018 11:09 AM
> Presenting Problem:
> Provider: Dr Marc Toh
> History: pain in mtps 4 years
> last 12 months lower back pain and right groin and back of knee
> ana 160 rheumatoid factor 37
> - last 1-2 mo ache all over- feet tight when getting out of bed, ankles early morning stiffness 10 mins
> - hands wrists shoulders - hands feel tight
> - feet burning fingers swelling last few months
> - feels like old lady when gets up
> - hep c recent dx - on last month of treatment - hnehs- epclusa
> - right elbow surgery- 'tendon ripped' - plate
> · no rashes or palpura purpura
> - fingers can turn white ? red - paraesthesia
> - prescribed but not taken mobic
> **Examination**: tender ankles and mtps ++
> v mild mcps, wrists, elbows, gh joints, knees
> no rash or vasculitis signs
> **Diagnosis**: ? inflammatory arthritis rheumatoid arthritis
> ?? sec cts/tts - numb feet/hands
> ? cryoglobulins /hep c
> **Treatment/Plan**: Laverty Symbion Pathology: FBC/Diff/ESR, E/LFT- Electrolytes/Liver Function Tests, CReactive Protein, Rheumatoid Factor, Anti-CCP antibody, ENA, ds DNA, HLA B27, cryoglobulins, Calcium,
> Urate, Vitamin D
> ?? try mobic
> Creatinine: 59"

42. Dr Toh wrote to Ms Moroney's general practitioner on the same day and said:

> "Yvette presents with a 4 year history of pain in the MTP joints, a 12 month history of pain in her lower back, right groin and back of knee, and a 1-2 month history of generalised pain including hands, wrists, shoulders and ankles associated with early morning stiffness lasting for 10 minutes. She describes her hands feeling tight and has had some burning and swelling in the fingers over the last 6 months.
> …
>
> On examination she had moderate tenderness in her ankles and MTP joints of the feet. She had very mild tenderness in the MCP joints of the hands, both wrists and elbows, glenohumeral joints and knees. She had no signs of vasculitis including rashes. She had no nodules, nail changes or Raynaud's today.
>
> There are signs of an inflammatory arthritis."

43. On 14 June 2018, Dr Toh noted that Ms Moroney had "some signs of an inflammatory arthritis with pain and tenderness in the ankle and MTP joints of her feet and some of the upper limb joints to a lesser degree."

44. Dr O'Sullivan saw Ms Moroney for the second time on 30 October 2018. He obtained the history that left shoulder pain commenced 12 months before. He considered that Ms Moroney's complaints of pain in her neck, both shoulders, elbows, wrists and fingers and lower limb joints was consistent with the diagnosis of rheumatoid arthritis. He attributed all symptoms to that diagnosis and in a subsequent report dated 17 December 2018 declined to make an assessment of permanent impairment.

Consideration

45. Ms Moroney had complained of referred pain from her cervical spine to her right shoulder following surgery to her cervical spine after the 2002 injury. The history with respect to her right shoulder is best set out in the report of Dr C Hollo, occupational physician dated 24 June 2003. Dr Hollo recorded that after the surgery at C5/6 in 2002, Ms Moroney continued to complain of pain at the base of her neck and along the trapezius region bilaterally. Her general practitioner, Dr Ismay, recorded complaints of shoulder pain as late as 2009. Ms Moroney does not claim compensation in respect of her cervical spine in these proceedings but Dr Gibson's examination reveals that neck pain is still a significant problem.

46. Given the history he obtained from Ms Moroney with respect to flare ups of this condition, it is clear that it contributed to her current condition and it was open to the AMS to take that condition into account in making a deduction under s 323.

47. Osteoarthritis diagnosed in 2014 on the MRI scan dated 9 July 2014 warranted consideration of a deduction under s 323. The AMS said that the "investigation demonstrates moderate degeneration of the right acromioclavicular joint." The existence of moderate changes less than two years after the injury indicates that they pre-dated the work injury. It was appropriate to consider the impact of this condition because changes of this severity contributed to the extent of the impairment.

48. Rheumatoid arthritis is not considered under s 323 because the diagnosis was made after the injury. Its contribution to permanent impairment must, however, be considered. In taking this condition into account, the Panel is assessing the impairment which results from the injury as required by paragraph (c) of the definition of medical dispute in s 319.

49. Dr Gibson's examination did not reveal any synovitis or swelling in Ms Moroney's shoulder joints so that rheumatoid arthritis had minimal effect on her range of movement. Nonetheless, Ms Moroney's range of shoulder movement was limited by pain and shoulder pain was an element of the history provided to Dr Toh. Dr Toh said at the time of his first examination that signs in her "gh joints" (gleno-humeral joints) were mild. Rheumatoid arthritis was diagnosed on blood testing and treated with methotrexate and prednisone in 2019.

50. Ms Moroney's history that the pain was "different" can be put to one side. The assessment is undertaken on the basis of the range of movement observed.

51. Taking the significant history of complaints of right shoulder pain and osteoarthritis into account together with the complaints of shoulder pain associated with rheumatoid arthritis, the appropriate deduction was two-fifths of the assessed impairment resulting from the right shoulder. That assessment reflects the s 323 deduction in respect of referred pain and osteoarthritis and a deduction in respect of the subsequent condition of rheumatoid arthritis .

52. Because no deduction is to be applied in respect of the right elbow, the two assessments in respect of the right upper extremity should be converted to WPI separately. The assessment of 12% UEI converts to 7% WPI. A deduction of two-fifths results in an assessment of 4.2% WPI in respect of the right shoulder, rounded down to 4%

Left Shoulder

53. The AMS assessed 6% UEI in respect of Ms Moroney's left shoulder and deducted one-half for the effects of rheumatoid arthritis. The AMS said:

> "However, Ms Moroney reports that her left shoulder symptoms did not develop until mid 2018, the time that the rheumatoid arthritis condition was diagnosed. Taking this into consideration as well as the pre-existing shoulder symptoms following the cervical fusion I suggest that ½ (one half) of her present left shoulder impairment is consequential from the right elbow injury and the other half pre-existing related to both

the rheumatoid arthritis and the pre-existing cervical injury. Otherwise I refer to the list of calculations that has been included in this report."

54. A Commission arbitrator in her Certificate of Determination dated 5 June 2019 found that Ms Moroney suffered a consequential condition in her left arm and that she had begun to complain to her general practitioner of left shoulder pain as early as 2015.

55. Ms Moroney's statement dated 21 July 2015 formed the basis for that finding. Ms Moroney said that she had used her left arm to compensate for her right arm, that it was starting to become painful and that she had complained to her general practitioner. The general practitioner's notes do not record those complaints but the notes generally are exceptionally brief and there are no notes at all for some consultations. The statement made in 2015 confirms the date of onset.

56. An AMS may reach conclusions about causation which are different to those reached by an arbitrator.[2] However, the history from Ms Moroney on which the AMS made his deduction was inconsistent with the evidence in the file as well as the determination of the arbitrator. Ms Moroney suffered left shoulder pain before the diagnosis of rheumatoid arthritis.

57. For the reasons set out above, the Panel considers that a deduction is warranted as a result of the pre-existing complaints of bilateral shoulder pain and in respect of the effects of rheumatoid arthritis.

58. The complaints recorded by Dr Hollo before the right elbow injury were of bilateral shoulder pain. There is no evidence of significant osteoarthritis such as observed in the right shoulder. In those circumstances, the appropriate deduction in respect of the pre-existing condition in the left shoulder is one-fifth. The assessment is therefore 6% UEI or 4% WPI less one-fifth, resulting in an assessment of 3.2% WPI, rounded down to 3%.

Scarring

59. The AMS said:

> "I note there is a vertical 5cm post-operative scar over the front of the right shoulder following the pectoralis minor release operation. This scar is well healed with a good colour match with surrounding skin. There is no contour defect or cross hatching. The scar is not tender and has no effect on the activities of daily living.
>
> There is a post-operative scar over the outer aspect of the right elbow which is 4cm in length. This scar has excellent healing and a good colour match with surrounding skin. Again, there is no tenderness or cross hatching and minimal visibility. Again, there is no effect on activities of daily living.
>
> The above scars have healed very well with excellent cosmesis. However, in view of the fact that Ms Moroney is conscious of the scars I suggest they do qualify for total of 1% whole person impairment according to Table of TEMSKI. I was unable to detect descriptors that would qualify for higher impairment rating according to that Table."

60. Ms Moroney submitted that the AMS should have assessed 2% under the TEMSKI because she has scars in two areas. That submission is consistent with Dr Ghabrial's report but contrary to the Guidelines.

[2] *Jaffarie v Quality Castings Pty Ltd* [2014] NSWWCCPD 79

61. The AMS applied the Guidelines appropriately. As Spotlight noted, paragraphs 14.5 and 14.6 provide:

> "The skin is regarded as a single organ and all non-facial scarring is measured together as one overall impairment, rather than assessing individual scars separately and combining the results.
>
> A scar may be present and rated as 0% WPI.
>
> Note that uncomplicated scars for standard surgical procedures do not, of themselves, rate an impairment."

62. The observations recorded by the AMS might have permitted him to assess 0% impairment as a result of the scars. He assessed 1% because Ms Moroney is conscious of them. The TEMSKI "uses the principle of best fit."

63. The assessment made by the AMS was an appropriate exercise of his clinical judgement.

Conclusion

64. The assessment in respect of the right upper extremity (elbow) is 8% UEI or 5% WPI.

65. The assessment in respect of the right upper extremity (shoulder) is 12% UEI or 7% WPI, less two-fifths which equals 4.2% WPI, rounded down to 4%.

66. In respect of the left upper extremity, the assessment of 6% UEI converts to 4% WPI. A deduction of one-fifth results in 3.2%, rounded down to 3%.

67. Those figures are combined with 1% WPI with respect to scarring, resulting in a total assessment of 13% WPI.

68. For these reasons, the Appeal Panel has determined that the MAC issued on 26 July 2019 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*.

L Funnell

Leo Funnell
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **303/19**
Applicant: **Yvette Maree Moroney**
Respondent: **Spotlight 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 T Best 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. Right upper extremity (elbow)	6 September 2012	Chapter 2	Figures 16-40, 16-43, 16-45	5%	nil	5%
2. Right upper extremity (shoulder)	6 September 2012	Chapter 2	Figures 16-40, 16-43, 16-45	7%	Two-fifths	4%
2. Left upper extremity	6 September 2012	Chapter 2	Figures 16-40, 16-43, 16-45	4%	One-fifth	3%
3.Scarring	6 September 2012	Chapter 14, TEMSKI		1%	nil	1%
Total % WPI (the Combined Table values of all sub-totals)					**13%**	

Catherine McDonald
Arbitrator

Dr John Ashwell
Approved Medical Specialist

Dr Margaret Gibson
Approved Medical Specialist

8 January 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*.

L Funnell

Leo Funnell
Dispute Services Officer
As delegate of the Registrar