WORKERS COMPENSATION COMMISSION

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

Matter No:	**M1-3022/19**
Appellant	**Bozo Mioc**
Respondent:	**Boldway Pty Ltd**
Date of Decision:	**15 January 2020**
Citation:	**[2020] NSWWCCMA 8**

Appeal Panel:	
Arbitrator:	**Mr John Harris**
Approved Medical Specialist:	**Dr Neil Berry**
Approved Medical Specialist:	**Dr Drew Dixon**

BACKGROUND TO THE APPLICATION TO APPEAL

1. Mr Bozo Mioc (the appellant) suffered injury deemed to have occurred on 1 May 2004 in the course of his employment with Boldway Pty Ltd (the respondent).

2. A previous claim for compensation pursuant to s 66 *Workers Compensation Act 1987* (the 1987 Act) was referred to Dr Bodel who assessed the left lower extremity at 7% whole person impairment (WPI) and 0% for the lumbar spine.

3. The appellant served a letter of claim dated 25 January 2019 seeking further permanent impairment compensation.[1] This claim was for 12% for the lumbar spine, 6% for the right upper extremity and 1% for the digestive system. The claim did not "include" the previous assessment of 7% for the left lower extremity.

4. By notice dated 15 May 2019 issued pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) the respondent disputed that the appellant suffered any injuries or consequential conditions to either the lumbar spine, digestive system or the right upper extremity.[2]

5. The appellant commenced proceedings claiming permanent impairment compensation pursuant to s 66 of the1987 Act for the lumbar spine, right upper extremity (wrist) and upper gastrointestinal tract.

6. The liability issues were determined by Arbitrator Homan who held that the appellant suffered consequential conditions to the upper gastrointestinal tract and the right wrist. During the hearing the respondent accepted that the appellant suffered from a consequential condition to the lumbar spine.[3]

[1] Application to Resolve a Dispute (Application), p 250
[2] Reply, p 1
[3] *Mioc v Boldway Pty Ltd* [2019] NSWWCC 309

7. The Arbitrator found that the appellant had used analgesics over a period of more than 15 years as a result of the left foot injury and accepted Dr Greenberg's opinion that the results shown on the gastroscopy report were caused by the injury.[4]

8. The assessment of WPI was then referred by the Registrar to Dr Michael Long, an Approved Medical Specialist (AMS), who examined the applicant and provided the Medical Assessment Certificate dated 4 November 2019 (MAC). The relevant findings made by the AMS pertinent to the various grounds of appeal are set out later in these Reasons.

9. The AMS assessed the appellant as having a 7% WPI of the lumbar spine and 0% for the right upper extremity (wrist) and 0% for the upper digestive tract.

10. The appellant has not requested a combined assessment incorporating the previous finding of 7% WPI for the left lower extremity. This matter is referred to later in these Reasons.

11. The assessment of WPI is now undertaken in accordance with the fourth edition of the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment* (fourth edition guidelines).[5] The fourth edition guidelines adopt the 5th edition of the *American Medical Association's Guides to the Evaluation of Permanent Impairment* (AMA 5). Where there is any difference between AMA 5 and the fourth edition guidelines, the fourth guidelines prevail.[6]

THE APPEAL

12. On 15 November 2019, the appellant filed an Application to Appeal Against a Medical Assessment (the appeal) to the Registrar of the Workers Compensation Commission (the Commission).

13. The WorkCover Medical Assessment Guidelines (the Guidelines) set out the practice and procedure in relation to appeals to Medical Appeal Panels under s 327 of the 1998 Act.

14. The appellant claims that the medical assessment in respect of the lumbar spine and upper digestive tract should be reviewed on the ground that the MAC contains a demonstrable error and/or the assessment was made on the basis of incorrect criteria. There are no grounds of appeal concerning the assessment of the right upper extremity.

15. The Appeal was filed within 28 days of the date of the MAC. The submissions in support of the grounds of appeal are referred to later in these Reasons.

PRELIMINARY REVIEW

16. The Appeal Panel (AP) conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Guidelines. As a result of that preliminary review, the AP determined, for the reasons provided subsequently, that a ground of appeal had been established.

17. The appellant requested a re-examination by an AMS who is a member of the AP. There were no relevant submissions as to why the appellant should be re-examined.

18. The respondent did not address this submission. It otherwise submitted that no error had been established.

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[4] Arbitrator's reasons at [85]

[5] The 4th edition guidelines are issued pursuant to s 376 of the s 376 of the *Workplace Injury Management and Workers Compensation Act 1998*

[6] Clause 1.1 of the fourth edition guidelines

19. The AP formed the view that a re-examination of the appellant was not required. In respect of the grounds of appeal concerning radiculopathy, the AP was not satisfied that error was established. In respect of the error established for the assessment of the upper digestive system, the AP has relied particularly on the objective evidence established by the gastroscopy and colonoscopy examinations undertaken in 2018 and the records of symptoms as recorded by the AMS. In these circumstances the AP did not consider that a re-examination was required. This is subsequently discussed later in these reasons.

EVIDENCE

20. The AP has before it all the documents that were sent to the AMS for the original assessment and has referred to portions of the evidence and taken them into account in making this determination.

GROUND OF APPEAL – RADICULOPATHY

Submissions

Appellant's submissions

21. The appellant referred to the requirements under paragraph 4.27 of the fourth edition guidelines and noted the findings by the AMS of wasting in the right calf, patchy diminished sensation in the left foot and the finding of disc protrusion at L5/S1 encroaching on the S1 nerve root.[7]

22. The appellant relevantly submitted:

> "5. It is submitted having regard to the MRI finding of moderate posterior disc protrusion at L5/S1 and the finding by the Assessor of diminished sensation to light touch on the dorsum of the foot, sensation of blunt pin pressure test left or right legs, the Assessor has made an error. That is on the Application of the Guidelines, the Assessor ought to have found that radiculopathy was present because he has findings on the imaging study consistent with the clinical signs, that is, at L5/S1 the Applicant has reproducible impairment and sensation that is anatomically localised to the nerve root, being L5/S1 and he has muscle wasting as there was 2cm wasting in the right calf which is muscle atrophy that is consistent with there being a problem in the S1.
>
> 6. The Applicant therefore respectfully submits that he fulfils the criteria for radiculopathy including an assessment of L5 radicular symptoms causing numbness and pain in the big toe and S1 symptoms causing pain down the back of the leg and into the calf."

Respondent's submissions

23. The respondent referred to paragraphs 4.27 to 4.29 of the fourth edition guidelines. It was noted that there were inconsistencies on examination.

24. The respondent submitted that the AMS was not satisfied that there was clinical evidence of radiculopathy as defined in the fourth edition guidelines. The findings on MRI examination do not of themselves constitute radiculopathy as the AMS did not find any major criteria within the meaning of paragraph 4.27.

25. The respondent otherwise submitted that the previous AMS made findings consistent with the AMS.

[7] Appellant's submissions paragraphs 1 - 4

Reasons

26. The detailed findings on examination provided by the AMS on this issue are set out in full. They were:[8]

> "Examination of made difficult by pronounced over-reaction. However, with advice that this would compromise his examination, it was noted that flexion was restricted to 70% of normal.
>
> Extension was 40% of normal.
>
> Right and left angulation was each 70% of normal.
>
> Paravertebral muscular guarding was noted at the extremes of movement.
>
> Right and left straight leg raising was each 40 degrees, limited by lumbar back pain but not by pain in his legs.
>
> Right and left femoral stretch test was negative.
>
> Right and left sacroiliac stress test was negative.
>
> Muscle Power: Compromised by over-reaction with weakness of flexion and extension in the left knee and no movement in the left ankle or left foot, even though he was able to walk without a limp.
>
> No difference in skin colouration in the right or left legs.
>
> No evidence of muscular atrophy and the circumference of the left calf measured 10 cm distal to the tibial tuberosity of the right and left lower legs. However, 2 cm of wasting in the right calf compared with the left calf (possibly secondary to symptoms and signs right knee).
>
> There was no oedema in the right leg.
>
> There was no tenderness of the right or left calf.
>
> There were no varicose veins.
>
> The following reflexes were recorded on repeated testing:

Reflexes	Right	Left
Adductors	+	+
Knee jerk	++	++
Ankle jerk	+	+

> **Sensation:** Patchy diminished sensation light touch dorsum of the left foot not considered dermatomal in distribution or extent. No difference sensation blunt pin pressure left or right legs.
>
> These findings are considered insufficient to diagnose radiculopathy as specified in Guidelines page 27, 4.27.
>
> Peripheral pulses were present."

[8] MAC, pp 5-6

27. Later the AMS observed:[9]

> "On examination, he provided a protracted history through the interpreter and tended to overreact throughout the examination. The weakness of movement of flexion and extension in the left knee or any movement in the left ankle and left foot could not be explained on clinical grounds. It was noted that the left calf was not wasted and was 2 cm greater in diameter at the same point compared to the right calf.
>
> In the lumbar back, he had painful restriction of movement with paravertebral muscular guarding, but there was no clinical evidence of radiculopathy, as defined under WCC Guidelines, Page 29, 4.23.
>
> It was noted from the general practitioner notes that he had sustained a fracture about the right ankle requiring internal fixation in 2009 and in a motor vehicle accident in 2011 sustained an injury to his right knee. He has ongoing pain in the right knee with a fixed flexion deformity of 5 degrees and wasting of the right calf."

28. The AMS noted inconsistencies on examination mainly associated with overreaction. Following advice by the AMS, the appellant was recorded as providing consistent findings.[10]

29. The AMS concluded that on examination the appellant had dysmetria and paravertebral muscular guarding and non-verifiable radicular complaints affecting his left leg. He concluded there was "no clinical evidence of radiculopathy".[11]

30. The MRI scan of the lumbar spine dated 5 September 2014 is reported by Dr Gale as showing moderate posterior disc protrusion at L5/S1 more marked to the left of mid-line with encroachment on each S1 nerve root slightly more marked on the left.[12]

31. Radiculopathy is defined in paragraph 4.27 of the fourth edition guidelines which provides:

> **"Radiculopathy** is the impairment caused by malfunction of a spinal nerve root or nerve roots. In general, in order to conclude that radiculopathy is present, two or more of the following criteria should be found, one of which must be major (major criteria in bold):
>
> - **Loss or asymmetry of reflexes**
> - **Muscle weakness that is anatomically localised to an appropriate spinal nerve root distribution**
> - **Reproducible impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution**
> - Positive nerve root tension (Box 15-1, p 382, AMA5)
> - Muscle wasting – atrophy (Box 15-1, p 382, AMA5)
> - Findings on an imaging study consistent with the clinical signs (p 382, AMA 5)." (emphasis in original)

32. Paragraph 4.28 of the fourth edition guidelines provides:

> "Note that radicular complaints of pain or sensory features that follow anatomical pathways but cannot be verified by neurological findings (somatic pain, non-verifiable radicular pain), do not alone constitute radiculopathy."

[9] MAC, p 8
[10] MAC, p 9
[11] MAC, p 11
[12] Application, p 71

33. Paragraph 4.29 of the fourth edition guidelines provides:

> "Global weakness of a limb related to pain or inhibition or other factors does not constitute weakness due to spinal nerve malfunction."

34. The AMS did not conclude that muscle wasting of two centimetres in the right calf was caused by the lumbar spine pathology. The appellant's submission that this was "muscle atrophy that is consistent with there being a problem in the S1"[13] was made in the absence of evidence supporting this submission.

35. The AP notes that the AMS thought that it was "possible" that the right calf wasting was due to the right knee injury caused by a motor vehicle accident in 2011 and unrelated to the work injury. The AMS did not make a positive finding that the muscle atrophy was due to the signs shown on the imagining study.

36. The AP notes the wasting was on the right side. Such wasting is extremely unlikely to be related to left sided symptoms and is more likely due to the right knee symptoms.

37. Accordingly, there is no causative link between the wasting in the right calf and the signs shown in the MRI scan. The AMS did not find a relationship between the wasting and the lumbar spine and there is no error in that finding. Indeed, the AP agrees that the right calf wasting is unrelated to the pathology shown in the scan.

38. The appellant also submitted that the sensory findings of "numbness and pain into the big toe" were L5 radicular symptoms and there were also "S1 symptoms causing pain down the back of the leg and into the calf".

39. The actual findings by the AMS on sensation were of "patchy diminished sensation, light touch dorsum of the left foot not considered dermatomal in distribution or extent".[14]

40. The appellant's submissions at paragraph 38 herein inaccurately quote the examination findings made by the AMS. Under the heading "Present symptoms" the AMS noted that there were complaints of pain radiating down the left buttock and posterolateral aspect of the left leg onto the dorsum of the left foot.

41. The AMS did not make the sensory findings as the appellant submitted. The relevant sensory finding made by the AMS was of "patchy diminished sensation" which was not considered dermatomal.

42. The AP in its medical expertise otherwise agrees with the AMS that patchy changes on the dorsum of the foot do not satisfy sensory losses in either the L5 or S1 dermatomes.

43. The AP rejects the appellant's submissions that the findings by the AMS established a major criterion for radiculopathy. The AP adds that the findings by the AMS are clear and otherwise contradict the appellant's submission that the findings of wasting and sensory loss were consistent with the imaging shown in the MRI scan.

44. This ground of appeal is rejected.

[13] Appellant's submissions, paragraph 5
[14] MAC, p 5

GROUND OF APPEAL – UPPER DIGESTIVE TRACT

Submissions

Appellant's submissions

45. The appellant referred to the history taken by the AMS and submitted that the findings were inconsistent "as on the one hand he indicates the [Appellant] ceases taking non-steroidal anti-inflammatory drugs some six years and on the other hand that he is taking some Panadeine Forte on occasion."[15]

46. The appellant referred to the acceptance by the AMS of Dr Greenberg's opinion that panadeine forte is known to cause gastrointestinal motility and delay gastric emptying.

47. It was submitted that the AMS, having accepted Dr Greenberg's opinion, should have accepted that ongoing use of panadeine forte could result in the gastric motility and cause reflux.

Respondent's submissions

48. The respondent submitted that the findings by the AMS inconsistent with those expressed by Dr Greenberg "is not a basis for an appeal".[16]

49. The respondent submitted that there was no basis to support the appellant's submission that the intermittent use of panadeine forte could result in gastric motility and cause reflux.[17] In contradiction, the respondent then referred to the AMS findings that panadeine forte can decrease gastric motility and cause reflux.[18]

50. It was submitted that the appellant denied having "ongoing indigestion or symptoms of reflux and any symptoms which do occur infrequently" were treated with bicarbonate. In these circumstances a finding of 0% WPI was "appropriate in all [the] circumstances."

51. The respondent otherwise referred to the opinion of Dr Garvey that assessed 0% WPI for the upper gastrointestinal tract. The respondent referred to Dr Garvey's opinion that there must be "objective evidence of upper digestive tract disease" and there "must be histological proof of chemical gastropathy, reactive gastropathy or non-steroidal anti-inflammatories gastropathy in the biopsy reports".[19] It was submitted that these were not present.

Reasons

52. The AMS recorded a history that the appellant ceased taking any NSAIDs "in about 2013" and currently "very rarely" takes "Panadeine Forte".[20] A further gastroscopy of 22 February 2018 indicated gastritis and duodenitis.[21]

53. The AMS concluded:[22]

> **"Upper GI tract: Page 121; Table 6-3 Class I:** He is no longer taking non-steroidal anti-inflammatory drugs, which were discontinued approximately six years ago. He is taking minimal medication and is no longer taking H2 antagonists as previously prescribed. He indicated that his symptoms of indigestion are now minimal and he self-

[15] Appellant's submissions, paragraph 7
[16] Respondent's submissions, paragraph 19
[17] Respondent's submissions, paragraph 20
[18] Respondent's submissions, paragraph 22
[19] Respondent's submissions, paragraph 26
[20] MAC, pp 2-3
[21] MAC, p 4
[22] MAC, p 11

> medicates using sodium bicarbonate. He relies on Panadol Osteo, up to four tablets a day, for pain relief and only very rarely takes Panadeine Forte. These drugs do not cause gastritis. Panadeine Forte can decrease gastric motility and cause reflux, but this does not appear to be affecting this case."

54. The AMS agreed with the opinion of Dr Anthony Greenberg that taking occasional panadeine forte "could result in reflux". The AMS however observed that the appellant denied "having significant ongoing indigestion or symptoms of reflux and any symptoms which do occur infrequently" are "treated with self-medication with bicarbonate."[23] That finding appears to accept ongoing symptomatology, albeit those that are not significant.

55. The AMS indicated that he was in agreement with Dr Greenberg's assessment "although providing an impairment of 1% WPI". This appears to be a statement that he agreed with Dr Greenberg's analysis although not with the impairment assessment. This is because the AMS then states that he was in agreement with the assessment provided by Dr Garvey of 0% WPI for the upper digestive system.

56. There is a degree of confusion in the submission of both parties and an apparent disregard of the liability findings made by the Arbitrator.

57. The liability issue was referred to the Arbitrator who made the finding that the gastritis and duodenitis shown in the gastroscopy report were caused by the injury. Such a conclusion was clearly within the power of an Arbitrator:

58. In *Jaffarie v Quality Castings Pty Ltd (Jaffarie No 2)* White J stated:[24]

> "What was said by Emmett JA at [109], quoted above at [70], must be understood in the context of the issues before the court in *Bindah*. I do not understand his Honour to mean that anything which falls within the definition of 'medical dispute' in s 319 will necessarily be outside the jurisdiction of an arbitrator.
>
> Under s 105(1) of the WIM Act the Commission has exclusive jurisdiction to examine, hear and determine all matters arising under the WIM Act and the *Workers Compensation Act*. This is subject to specific exclusions contained in both the WIM Act and the *Workers Compensation Act*. The specific exclusion in s 65(3) of the *Workers Compensation Act* does not extend to any medical dispute within the meaning of s 319 of the WIM Act, but only to a subset of such disputes, being a dispute about the degree of permanent impairment of an injured worker. Even a medical dispute concerning permanent impairment of an injured worker cannot be referred for assessment under Pt 7 of Ch 7, except by the Registrar and then where liability is not in issue, or, if in issue, liability has been determined by the Commission (ss 293(3)(a) and 321(4)(a)). The medical assessment is conclusive only in respect of the matters referred to in s 326 which are not as extensive as the matters falling within the definition of medical dispute in s 319."

59. His Honour endorsed the proposition that the jurisdiction of the Commission, as opposed to that of the AMS, is to determine "the nature of the injury sustained"[25] and noted that this was consistent with the orders of the earlier decision of the Court of Appeal in *Jaffarie v Quality Castings*[26] remitting the matter for re-determination in accordance with the reasons of the Deputy President in the earlier decision.

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[23] MAC, p 11
[24] [2018] NSWCA 88 at [75]-[76], Macfarlan and Leeming JJA agreeing on this point
[25] at [80]
[26] [2015] NSWCA 335

60. This reasoning is otherwise consistent with the approach taken by the Court of Appeal in *State of New South Wales v Bishop* (*Bishop*)[27] where it was held that the determination of a consequential condition was a matter for a Commission Arbitrator.

61. The appellant underwent a gastroscopy in early 2018 complaining of abdominal pain. The gastroscopy report dated 22 February 2018 reported by Dr Alexander Simring showed moderate gastritis and duodenitis. The doctor recommended that all NSAIDS cease.[28] The colonoscopy examination was reported as being normal although two small colon polyps were removed.

62. Dr Garvey was qualified by the respondent and provided a report dated 15 March 2019.[29] The doctor reported that the appellant complained of occasional problems with acid reflux. Dr Garvey concluded that the upper digestive tract injury suffered by the appellant was not related by way of cause, aggravation or acceleration of the accident at work.

63. That opinion is inconsistent with the liability finding made by the Arbitrator.

64. Dr Greenberg was qualified by the appellant and provided a report dated 3 April 2018.[30] The recorded history was consumption of NSAIDs until 2013 with ongoing use of panadol, losec and panadeine forte when the pain was severe.

65. Dr Greenberg opined that the panadeine forte is associated with nausea and vomiting and known to disturb gastrointestinal mobility and delay gastric emptying. The doctor concluded that this would "almost certainly aggravate any existing gastroesophageal reflux and aggravate the symptoms". The upper gastrointestinal tract was assessed by Dr Greenberg at 1% WPI.

66. The appellant's submissions on medication are slightly incorrect. Panadeine forte is not a NSAID.

67. The appellant consumed NSAIDs until approximately 2013. The liability finding, with which we agree, is that these medications caused the objective signs shown in the 2018 gastroscopy examination. That appears to have been accepted by the AMS in the MAC when he expressed agreement with Dr Greenberg's analysis (rather than his assessment).

68. We accept that panadeine forte, as the AMS held, does not cause gastritis and duodenitis. However, that appellant already had gastritis and duodenitis, as shown in the 2018 gastroscopy which was caused by the prior consumption of NSAIDs.

69. As Dr Greenberg opined and the AMS appears to have accepted, the ongoing intermittent use of panadeine forte resulted in decreased gastric motility and caused reflux on the appellant who was suffering from gastritis and duodenitis. The AP, in its medical expertise, agrees with that medical opinion.

70. This opinion is confirmed by the absence of helicobacter pylori elements which were not shown in the September 2018 histopathology report.[31] The presence of helicobacter pylori indicates an infective cause for gastritis. As helicobacter pylori is not present, the gastritis and duodenitis must be related to intake of NSAIDs.

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[27] [2014] NSWCA 354 (Basten JA at [20]), (Emmett JA at [84]-[85], Gleeson JA agreeing at [93])
[28] Application, p 69
[29] Reply, p 142
[30] Application, p 41
[31] These findings are included in the report of Dr Garvey, Reply, p 145

71. To the extent that Dr Garvey has expressed a different opinion, this is contrary to the liability finding made by the Commission Arbitrator. The opinion by Dr Garvey, set out at paragraph 51 herein, is otherwise inconsistent with Chapter 16 of the fourth edition guidelines as the Doctor's opinion requires a standard far in excess of what is required. Objective signs of upper digestive tract disease can be established through a gastropathy.

72. The appellant must have both "symptoms and signs of digestive tract disease" as provided by paragraph 16.9 of the fourth edition guidelines. That paragraph notes that NSAIDs taken for prolonged periods can cause symptoms but "in the absence of clinical signs or other objective evidence" a 0% WPI is to be assessed.

73. The objective evidence is the findings on gastropathy of both gastritis and duodenitis. Further, the appellant reported ongoing, albeit intermittent symptoms. Those symptoms were otherwise corroborated by Dr Simring and referred to by the AMS.

74. The appellant has both objective signs (gastritis and duodenitis) caused by the use of NSAIDs and ongoing intermittent symptoms of decreased gastric motility and reflux aggravated by the use of panadeine forte.

75. Section 327(3)(d) provides that the error must be "demonstrable". In *Vannini v Worldwide Demolitions Pty Ltd* (*Vannini*),[32] Gleeson JA observed that, consistent with the observations of Basten JA in *Mahenthirarasa v State Rail Authority of New South Wales,* a "demonstrable error must be apparent in findings of fact or reasoning contained in the medical assessment certificate, although the error may be established in part by reference to materials that were before the approved medical specialist".[33]

76. This analysis establishes that ongoing use of panadeine forte causes gastric motility and reflux. This conclusion is consistent with the Arbitrator's findings, the history recorded by the AMS and the acceptance by the AMS of Dr Greenberg's opinion. The appellant otherwise has objective signs caused by injury.

77. The AP is also of the view that there has also been an application of incorrect criteria within the meaning of s 327(3)(c) of the 1998 Act: see *Marina Pitsonis v Registrar of the Workers Compensation Commission of New South Wales*[34] applying Basten JA in *Campbelltown City Council v Vegan*[35]. This is because the facts as found by the AMS establish symptoms and signs of digestive tract disease within the meaning of paragraph 16.9 of the fourth edition guidelines. In these circumstances it was necessary for the AMS to determine both the appropriate Class and percentage in Table 6-3 of AMA 5.

78. In these circumstances it is necessary for the AP to re-assess the impairment of the upper digestive tract: *Drosd v Nominal Insurer.*[36]

REASSESSMENT

79. The AP previously noted that the appellant requested a re-examination. No relevant submissions were made in support of this request.

80. For the reasons previously provided, the AP is not satisfied that there is error with respect to the assessment of radiculopathy from the lumbar spine. The assessment of the right upper extremity was otherwise not the subject of any ground of appeal.

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[32] [2018] NSWCA 324 (*Vannini*) at [90]
[33] *Vannini* at [86]
[34] [2008] NSWCA 88 (*Marina Pitsonis*) at [40]-[42], McColl and Bell JJA (as their Honours then were) agreeing
[35] [2006] NSWCA 284 at [94], McColl JA agreeing
[36] [2016] NSWSC 1053

81. We are of the view that we can properly re-assess in the absence of re-examination. In that regard we note the objective findings from the gastropathy and the detailed findings concerning ongoing complaints recorded by the AMS. In these circumstances an assessment of the upper digestive tract can be undertaken without a re-examination applying Table 6-3 of AMA 5 and the fourth edition guidelines.
82. The AP adopts the assessment provided by the AMS for the right upper extremity. No contrary submissions were made by either party. For the reasons provided, the ground of appeal in respect of the lumbar spine is rejected and the assessment made by the AMS is adopted.

83. The appellant clearly falls within Class 1 of Table 6-3 of AMA 5 as continuous treatment is not required, there is no suggestion that the appellant's weight has been affected and there is no sequalae from surgery.

84. Table 6-3 of AMA 5 provides a range of 0-9% WPI for Class 1 impairment of the upper digestive tract. We accept that the assessment is at the lower end of the range given the intermittent nature of the symptoms. We do not believe that the assessment is 0% WPI given that the appellant has both duodenitis and gastritis. Applying clinical judgment based on these findings to the range within Class 1, we find that the assessment is 2% WPI given that there are only intermittent symptoms.

85. The AP is satisfied that a deduction pursuant to s 323 is required. The AMS recorded a history of a perforated gastric ulcer in 1986 when the appellant resided in Berlin. Open laparotomy surgery of the upper digestive tract was undertaken at that time.[37] The appellant had further ulcer bleeding in the upper gastrointestinal tract in 2005[38] which would have been associated with the problems evident in 1986 rather than any medication consumed after the 2004 injury.

86. The further ulcer bleeding in 2005 is confirmation of a serious pre-existing condition in the upper digestive tract prior to the 2004 injury. This is because the short time span between injury and the onset of bleeding is indicative of a serious pre-existing condition rather than the effects of medication over such a short period.

87. The AP is satisfied that the perforated gastric ulcer requiring laparotomy is a serious pre-existing condition in the upper digestive tract. In the AP's expert medical view that significant pre-existing condition also contributed, along with medication intake, to the appellant's gastritis and duodenitis shown on the gastropathy many years later.

88. A deduction pursuant to s 323 of the 1998 Act is required if a proportion of the permanent impairment is due to previous injury or due to pre-existing condition or abnormality: *Vitaz v Westform (NSW) Pty Ltd*[39]; *Ryder v Sundance Bakehouse*[40]*; Cole v Wenaline Pty Ltd*[41].

89. The AP views the pre-existing condition as extremely relevant to the ultimate whole person impairment of the upper digestive tract and finds that a deduction in the order of one-half is appropriate pursuant to s 323.

90. The AP is satisfied, given the duration of symptoms, that the impairment is permanent.

[37] Application, p 43 (Dr Greenberg); MAC, p 8
[38] Mac, p 8
[39] [2011] NSWCA 254
[40] [2015] NSWSC 526 (*Ryder*) at [54]
[41] [2010] NSWSC 78 at [29] - [30]

DECISION

91. For these reasons, the MAC is revoked and a new Medical Assessment Certificate is issued. The AP notes that it was not requested to provide a combined certificate incorporating the prior MAC of Dr Bodel who assessed 7% WPI for the left lower extremity. That body part was not referred for assessment pursuant to s 325 of the 1998 Act and no request was made by the appellant to have that assessment included as part of this Medical Assessment Certificate.

92. The new Medical Assessment Certificate for the body parts referred to the AMS, and on appeal to this AP, is attached to this statement of reasons.

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE REASONS FOR DECISION OF THE MEDICAL 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

APPEAL PANEL

MEDICAL ASSESSMENT CERTIFICATE

Matter No: **3022/19**
Applicant: **Bozo Mioc**
Respondent: **Boldway Pty Ltd**

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

The Appeal Panel revokes the Medical Assessment Certificate of Dr T Michael Long 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 fourth edition guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA5**	**% WPI**	**WPI deductions pursuant to S323 for pre-existing injury, condition or abnormality (expressed as a fraction)**	**Sub-total/s % WPI (after any deductions in column 6)**
Lumbar Spine	01.05.2004 (deemed)	Chapter 4, para 4.27 – 4.37	Chapter 15.4, Table 15-3	7%	nil	7%
Right upper extremity (wrist)	01.05.2004 (deemed)	Chapter 2, pp 10-12	Chapter 16, figure 16-28 and 16-31	0%	N/A	0%
Upper Digestive System	01.05.2004 (deemed)	Chapter 16, para 16.9	Chapter 6, Table 16-3, p 121	2%	1/2	1%
Total % WPI (the Combined Table values of all sub-totals)					8%	

John Harris
Arbitrator

Dr Neil Berry
Approved Medical Specialist

Dr Drew Dixon
Approved Medical Specialist

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE MEDICAL ASSESSMENT CERTIFICATE OF THE MEDICAL 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