WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-310/20**
Appellant:	**Jewish Care NSW**
Respondent:	**Irina Polura**
Date of Decision:	**29 June 2020**
Citation:	**[2020] NSWWCCMA 115**

Appeal Panel:	
Arbitrator:	**Ms Deborah Moore**
Approved Medical Specialist:	**Dr Mark Burns**
Approved Medical Specialist:	**Dr Brian Noll**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 2 April 2020 Jewish Care NSW lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Drew Dixon, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 5 March 2020.

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. The Appeal Panel has conducted a review of the original medical assessment but limited to the ground(s) of appeal on which the appeal is made.

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).

PRELIMINARY REVIEW

6. 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.

7. As a result of that preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination because, although a re-examination was requested, no reasons were provided as to why it would be necessary. In any event, we consider that we have sufficient evidence before us to enable us to determine this appeal.

EVIDENCE

Documentary evidence

8. 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.

SUBMISSIONS

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

10. In summary, the appellant submits that the deduction of one-tenth pursuant to section 323 of the 1998 Act was at odds with the available evidence, and that a greater deduction was warranted given the extent of the pre-existing condition.

11. In reply, the respondent submits that no errors were made.

FINDINGS AND REASONS

12. 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

13. 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.

14. The respondent was referred to the AMS for assessment of whole person impairment (WPI) in respect of the left lower extremity and scarring (TEMSKI) resulting from an injury on 11 April 2016.

15. The AMS obtained the following history:

> "This claimant had a fall at Maroubra Junction when she had been driving between clients and walked across the road on Anzac Parade and fell on April 16, 2016 sustaining a direct injury to her left knee…[she] was referred to X-Ray and MRI. The scan showed a patella fracture and she saw an Orthopaedic specialist, Dr Broe…following review of the imaging studies she was booked in for operative intervention of her knee…she subsequently had a total knee replacement on March 29 at a Prince of Wales Hospital…"

16. The AMS then noted: "When she was a younger person living in Russia she had an arthrotomy of her left knee for a torn medial meniscus."

17. After documenting her activities of daily living and his findings on physical examination, the AMS then summarised the radiological material he had as follows:

> "X-Ray of the left knee on November 10, 2016 showed osteoarthritic change with medial and lateral compartment narrowing and medial and lateral joint line osteophytes and patello-femoral osteophytes with a trace of fluid in the supra-patellar bursa and degenerative chondrocalcinosis.

X-Ray of the left knee with ultrasound on September 15, 2017 showed a cemented left total knee replacement with patellar re-surfacing. Position of the components and alignment was satisfactory. There was no complication apparent in relation to the orthopaedic hardware. There was ossification adjacent to the medial femoral epicondyle, consistent with previous trauma. Comparison view of the right knee showed slight narrowing of the medial compartment but no other abnormality…

X-Ray of the left knee on January 23, 2018 showed left total knee replacement patella surfacing surgery in good position.

X-Ray on May 29, 2018 showed no change. There was no peri-prosthetic fracture nor lucency.

Whole body bone scan on June 4, 2018 including SPECT/CT showed diffuse increased uptake around the left total knee replacement which is non-specific. SPECT/CT labelled white cell scan of the knees showed no convincing evidence of septic arthritis or osteomyelitis involving the left knee.

X-Ray of the left knee on May 29, 2019 showed the left total knee replacement remained in good position and X-Ray of the other knee showed minor degenerative changes on the right…"

18. The AMS diagnosed: "Aggravation of pre-existing osteoarthritic change in her left knee with a healed fracture of the left patella ultimately treated with a left total replacement…""

19. When asked: "Is any proportion of loss of efficient use or impairment or whole person impairment, due to a previous injury, pre-existing condition or abnormality?" the AMS replied: "Yes" as a result of "Osteoarthritis left knee."

20. The AMS continued:

"She has a fair result from her left total knee replacement which is from Table 17-35, a 20% whole person impairment, from which is deducted one tenth for pre-existing OA of the left knee."

21. The AMS then summarised the other medical opinions as follows:

"This [his assessment] is consistent with the findings of Dr Jim Bodel in his IME report of September 16, 2019.

Dr Robert Drummond in his IME report of July 26, 2016 three months following the injury but before the total knee replacement confirmed an undisplaced fracture of the inferior half of the left patella extending to the retro-patellar articular surface and noted there was degenerative change in the knee joint with marginal osteophytes particularly in the medial compartment and patello-femoral compartment laterally and that the claimant had had an open medial meniscectomy for the left knee. He noted an MRI of the left knee on April 14 2016 showed an undisplaced fracture involving the inferior third of the patella with a partial thickness tear of the patella attachment and patella tendon and a previous partial meniscectomy of the medial and lateral menisci with associated chondrosis and marginal osteophyte formation in the medial and lateral compartment and a moderate to large joint effusion and intra-articular loose bodies and he reports that the fall did not aggravate or accelerate the osteoarthritis of her knee. I respectively disagree with this opinion, as before that the claimant was reasonably mobile and did her homecare work without restriction, three days a week, driving in between clients but since her fall has required analgesia constantly and a total knee replacement.

Dr Richard Powell Orthopaedic Surgeon, in his IME report to the Insurer…reported the claimant had had an open meniscectomy following a sporting injury over 30 years ago and had an arthroscopy several years ago but no details were available and that she had had spinal surgery as noted above. He noted the left total knee replacement remained a source of ongoing symptoms, requiring referral to a pain specialist. He felt that the claimant had reached maximum medical improvement and her knee rating according to Table 17-35 was 55 points, which is considered a fair result, consistent with what was found today. Although he makes a considerable deduction for pre-existing condition, I disagree with this, and feel the claimant had reasonable pain free function of the left knee which enabled her to work without difficulty and look after patients providing support care involving driving, walking and attending to their needs as part of a homecare program, working three days a week without difficulty, and but for her fall in which she sustained undisplaced fracture of the patella would not have had the acceleration and aggravation of the previously mainly asymptomatic arthritic change in her knee which led to a total knee replacement.

Her surgeon, Dr David Broe, noted on June 7, 2016 that there were arthritic changes in her left knee which following her accident acutely flared up the underlying degenerative change and that despite optimised medical therapy, the knee continued to worsen with associated night pain and the only procedure to give her long lasting pain relief and restoration of function was left knee replacement surgery. I concur with these remarks that the let total knee replacement was indicated. She has a fair result following this surgery based on her review today."

22. When asked about any deduction for the proportion of the impairment due to any pre-existing condition, the AMS said:

> "In my opinion the worker suffers from the following relevant previous injuries, pre-existing conditions or abnormalities: Osteoarthritis left knee.
>
> The extent of the deduction is difficult or costly to determine so in applying the provisions of s.323(2) I assess the deductible proportion as one tenth (can only be used when not at odds with available evidence)."

23. The appellant emphasises that the deduction made by the AMS was at odds with all the available evidence. The Guidelines state that: "For the injury being assessed, the deduction is 1/10th of the assessed impairment, unless that is at odds with the available evidence."

24. Section 323(2) of the 1998 Act provides that:

> "If the extent of a deduction under this section (or a part of it) will be difficult or costly to determine (because, for example, of the absence of medical evidence), it is to be assumed (for the purpose of avoiding disputation) that the deduction (or the relevant part of it) is 10% of the impairment, unless this assumption is at odds with the available evidence."

25. Reference is made to the decision of *Ryder v Sundance Bakehouse* [2015] NSWSC 526 where Campbell J held at paragraph 45:

> "What s 323 requires is an inquiry into whether there are other causes, (previous injury, or pre-existing abnormality), of an impairment caused by a work injury. A proportion of the impairment would be due to the pre-existing abnormality (even if that proportion cannot be precisely identified without difficulty or expense) only if it can be said that the pre-existing abnormality made a difference to the outcome in terms of degree of impairment resulting from the work injury. If there is no difference in outcome, that is to say, if the degree of impairment is not greater than it would otherwise have been as a result of the injury, it is impossible to say that a proportion of it is due to pre-existing abnormality. To put it another way, *the Panel must be satisfied that but for the pre-existing abnormality, the degree of impairment resulting from the work injury would not have been as great*." (our emphasis)

26. Equally, if a pre-existing condition is a contributing factor causing permanent impairment, a deduction is required even though the pre-existing condition had been asymptomatic prior to the injury. (*Vitaz v Westform (NSW) Pty Ltd* [2011] NSWCA 254).

27. We agree with the appellant that the deduction of one-tenth was at odds with the available evidence for reasons that follow.

28. The available evidence indicating the extent of the pre-existing disorder includes the following:

    a. A history a previous arthrotomy of her left knee for a torn medial meniscus and a subsequent arthroscopic procedure.

    b. When seen by her treating orthopaedic surgeon Dr David Broe on 26 April 2016 (some 2 weeks after the work-related injury) the respondent was noted to have sustained an undisplaced fracture of the patella. Dr Broe noted however that he anticipated she would require a knee replacement "in time". This opinion related to the pre-existing degenerative changes of the knee joint rather than the undisplaced fracture of the patella which would normally have required nonsurgical treatment.

    c. When seen by Dr Broe again on 7 June 2016 (some 7 weeks after the subject injury) note was made that her up-to-date x-ray showed *'severe osteoarthritic change particularly of the medial compartment'.* He concluded that the only thing that would give her long term pain relief would be a knee replacement procedure.

    d. An x-ray of the left knee on 10 November 2016, some 7 months after the work-related injury, was reported to show osteoarthritic change with medial and lateral compartment narrowing and medial and lateral joint line osteophytes and patellofemoral osteophytes. Note was made that there had been no changes since the previous x-ray of June 2016 (which would have been some 2 months after the subject accident). These changes would have predated the work-related injury.

29. We do accept however, that although there was evidence of significant pre-existing degenerative change for which a knee replacement arthroplasty would have been required at some time, it would appear that the work-related injury probably accelerated the need for the procedure.

30. Having said that, in our view the underlying pre-existing disorder would have been a significant factor leading to the need for treatment by means of a knee replacement arthroplasty. For this reason a one-tenth deduction for the pre-existing disorder would be at odds with the available evidence.

31. Further information about the pre-existing status of the knee was provided by Dr Robert Drummond in his report dated 28 July 2016. This information is consistent with, but enlarges on, the information provided by Dr Broe. Dr Drummond noted: "Viewing the x-ray films it is evident that the osteoarthritis is advanced in all compartments of the knee joint including the patellofemoral… Crystal depositions disease or chondrocalcinosis is present with calcification on the menisci".

32. He commented further by indicating that *"…*the medial joint space is narrowed with close to bone on bone articulation". He indicated that the fracture of the patella sustained at the time of the work-related injury was "… distal and undisplaced and involves the distal margin of the articular surface without displacement or step". He concluded that the pre-existing disorder of the knee joint had reached the stage where a knee replacement arthroplasty would have been required and that the work-related injury had not further aggravated this pre-existing disorder.

33. Dr Powell commented that imaging studies were not made available to him. Nevertheless, he noted the information provided by Dr Broe regarding the pre-existing status of the knee joint including the reference to the preoperative MRI scan with “extensive chondromalacia throughout the knee particularly on the medial compartment”. He concluded that there was clear evidence of significant pre-existing degenerative pathology of the knee joint that would have led to the need for a total knee replacement irrespective of the effects of the injury sustained in the course of Ms Polura’s employment.

34. The report of Dr Bodel dated 16 September 2019 does refer to x-ray evidence of pre-existing osteoarthritis, but inexplicably, no deduction was made from the assessed impairment for this pre-existing disorder.

35. The AMS disagreed with the extent of the deduction applied by Dr Powell, stating that: “the claimant had reasonable pain free function of the left knee which enabled her to work without difficulty…”

36. Although this is a factor to consider, the task of an AMS is to consider all of the available evidence when considering the amount of any deduction to be applied, and to provide adequate reasons for the decision.

37. The AMS simply said: ““She has a fair result from her left total knee replacement which is… a 20% whole person impairment, from which is deducted one tenth for pre-existing OA of the left knee.”

38. Having carefully considered all the available evidence, we are of the view that a fifty percent deduction is appropriate in this case.

39. For these reasons, the Appeal Panel has determined that the MAC issued on 5 March 2020 should be revoked, and a new MAC should be issued. The new certificate is attached to this statement of reasons.

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

A MacLeod

Ann MacLeod
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **310-20**
Applicant: **Irina Polura**
Respondent: **Jewish Care NSW**

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 [insert name of Doctor] 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. **Left Lower Extremity**	**11/4/2016**	**Para 3.2 Page 22**	**Table 17-35 Page 549 and Table 17-33 Page 546**	**20%**	**1/2**	**10%**
2. **Scarring**	**11/4/2016**	**TEMSKI Table 14.1 Page 74**	**Table 8.2 Page 178**	**2%**	**0**	**2%**
3.						
4.						
5.						
6.						
Total % WPI (the Combined Table values of all sub-totals)						**12%**

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received before 1 January 2002

Ms Deborah Moore
Arbitrator

Dr Mark Burns
Approved Medical Specialist

Dr Brian Noll29
Approved Medical Specialist 29 June 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*.

A MacLeod

Ann MacLeod
Dispute Services Officer
As delegate of the Registrar