WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-4410/19**
Appellant:	**Merivale Investments Pty Ltd t/as the Trustees for Hemmes Administration Trust**
Respondent:	**Abhishek Manandhar**
Date of Decision:	**3 July 2020**
Citation:	**[2020] NSWWCCMA 120**

Appeal Panel:	
Arbitrator:	**Ms Deborah Moore**
Approved Medical Specialist:	**Dr Roger Pillemer**
Approved Medical Specialist:	**Dr Margaret Gibson**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 13 March 2020, Merivale Investments Pty Ltd t/as the Trustees for Hemmes Administration Trust lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Greggory Burrow, an Approved Medical Specialist (AMS), who issued an initial Medical Assessment Certificate (MAC) on 20 December 2019.

2. The assessment was conducted “on the papers” as the respondent resides in the Kingdom of Nepal.

3. The matter was subsequently referred back to the AMS to reconsider his MAC in light of a supplementary statement from the respondent dated 26 November 2019.

4. As a result of that statement the AMS issued a revised MAC on 18 February 2020.

5. It is from that MAC that the appellant appeals.

6. 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.

7. 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.

8. 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.

9. 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

10. 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.

11. 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 he does not reside in the jurisdiction.

EVIDENCE

Documentary evidence

12. 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

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

14. In summary, the appellant submits that the AMS erred by applying an uplift on his whole person impairment (WPI) assessment of the lumbar spine for activities of daily living (ADL).

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

FINDINGS AND REASONS

16. 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.

17. 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.

18. The respondent was referred to the AMS for assessment of WPI in respect of the lumbar spine and scarring (TEMSKI) resulting from an injury on or about 13 October 2010.

19. The AMS recorded the following history:

> "Brief history of the incident/onset of symptoms and of subsequent related events, including treatment: In the report by treating neurosurgeon Dr Kohan, [he] records that Mr Manandhar was referred by Dr Hassin for initial consultation 13/12/2010 and had reported that he had been cleaning and packing tables some 2 months prior when a trolley that he had been using lost its wheel and fell on him causing him to lose balance and then fall to the ground. Thereafter, Mr Manandhar had experienced low back pain and pain into the left leg.
>
> Dr Kohan organised an MR scan which showed a broad based disc bulge at L5.

He recommended non-operative treatment…Dr commented that the MR scan from May 2011 reported disc narrowing at L4/5 and recommended L4/5 discectomy with fusion. This surgery was performed, and there were no significant post-operative complications but there was increased pain around March 2012. In May 2012, Doctor diagnosed facet arthropathy at L3/4, recommeded continued non-operative management and referral to Dr Henry Lam for pain management.

In June 2012 Doctor noted L3/4 facet injections had improved the pain for a day, and the repeat MR scan showed 'excellent decompression of L5 nerve roots'.

On 20/3/2013, Doctor recoded that Mr Manandhar had made staedy progress, 'returning to normal activities, had returned to work 5 days a week and studying.' There are no further reports from Dr Kohan."

20. The AMS then noted: "Social activities/ADL: Unknown, but I note that treating surgeon Dr Saad, confirmed 'return to normal activities post-operatively.'"

21. The AMS then summarised the injury and diagnoses saying:

> "Mr Manandhar seems to have injured his lumbar spine as a result of a work incident around October 2010 whilst working as a waiter. He came under the care of Dr Kohan who confirmed a significant lumbar disc bulge and performed decompression and fusion surgery. He had ongoing symptoms afterwards and at one stage Dr Kohan organised more proximal facet joint injections which afforded very temporary relief. Mr Manandhar has since moved to Nepal and was not available for my review."

22. The AMS then noted that the facts on which he based his assessment of WPI were "The report of his treating surgeon at most recent review."

23. The AMS assessed 20% WPI in respect of the lumbar spine and 0% for scarring.

24. As regards "Impact of ADL" the AMS said:

> "According to his treating surgeon Dr Kohan, at post-operative review Mr Manandhar had returned to normal activities. I take this to mean that there were no significant disabilities with yard, garden, sport, recreation, home care or self -care resulting in impact of ADL's of 0% as per SIRA paragraphs 4.33, 4.34 and 4.35."

25. The AMS then commented upon other medical opinions as follows:

> "Dr James Bodel…05/10/2017 performed a file review and also concluded there was evidence of single level spinal fusion, confirming DRE Category IV for the lumbar spine. I agree.
>
> Despite Dr Kohan saying that Mr Manandhar had returned to normal activities, Dr Bodel assessed additional impairment for impact of ADL's at 1% or 2%. Certainly this does apply for some patients who have a clear history of sport, recreation, garden and home care difficulties but in this case there is certainly no documentary evidence of that, and the surgeon said himself that the patient returned to 'normal activities.' I would somewhat disagree then with Dr Bodel's presumption that there is impact of ADL's."

26. The AMS' comments as regards scarring are not relevant since his assessment is not the subject of appeal.

27. In the subsequent MAC dated 18 February 2020 the AMS was requested to review his MAC having regard to a statement from the respondent dated 26 November 2019.

28. The AMS then said:

> "Mr Manandhar, in his statement, confirms ongoing difficulties with activities of daily living including recreation, sport (basketball, cricket, soccer), including social activities and extensive difficulty performing 'tasks around the home and [that he requires) assistance from others to lift and carry heavy items when performing tasks such as grocery shopping' thereby having difficulty with home care.
>
> [He] does have some difficulties putting on shoes and socks but there is no documentary evidence that he has difficulty toileting or showering. That is, he is substantially independent of self-care."

29. In light of this evidence, the AMS assessed an additional 2% WPI for the impact on ADL's, giving a total WPI of 22%.

30. The appellant makes the following submissions:

    a. The assessment of the impact of an injury or condition on ADL should be verified by reference to objective assessment. Self-reporting is but one of the factors in assessing the restriction of ADL.

    b. The Guidelines explicitly state: "…an assessment of the effect of the injury on ADL is not solely dependent on self-reporting, but is an assessment based on all clinical findings and other reports."

    c. In *Ferguson v State of New South Wales* [2017] NSWSC 887 Campbell J said at [33]: "The pre-eminence of the clinical observations cannot be understated. The judgment as to the significance or otherwise of the matters raised in the consultation is very much a matter for assessment by the clinician with the responsibility of conducting his/her enquiries with the applicant face to face…"

    d. There is a significant discord between the medical reports within the Application and the respondent's self-reporting.

    e. In the event the respondent described ongoing radiculopathy in his statement, such allegation would undoubtedly need to be confirmed by clinical assessment. There is no reason why such verification should be any different with respect to the impact on ADL.

    f. Whilst it is unfortunate that the respondent was unable to be physically assessed, regard must be had to the totality of the medical evidence. Currently, the contemporaneous clinical notes are at odds with the self-reporting by the respondent.

    g. Without objective clinical evidence or updated treating medical evidence demonstrating the impact on ADL, the AMS should not have accepted the respondent's self-reporting. This is especially the case when the current medical evidence on file is inconsistent.

31. The respondent makes the following submissions:

    a. He had provided a statement dated 14 May 2019. In which he described restrictions in social and recreational activities as well as domestic and household activities. He described restrictions in lifting, pushing and pulling as well as restricted movement and pain in his back.

    b. The AMS relied upon the final report of Dr Kohan dated 20 March 2013. Dr Kohan said that the Worker had made steady progress "returning to normal activities, had returned to work 5 days a week and studying".

c. In the report of 20 March 2016 Dr Kohan had qualified his remarks by saying that the Worker had "essentially" returned to normal activities. The qualification is important as it still means that there has not been a full return to normal activities. Dr Kohan described a continuing problem of lumbar discomfort after long sitting and is woken on occasions.

d. Contrary to Dr Burrows comments, there was a subsequent report from Dr Kohan dated 31 October 2016. In that report Dr Kohan said he last saw the Worker on 20 March 2016 when he said he was very pleased that the Worker had made steady good progress with returning to normal activities. This report has the same qualification as the earlier report in that it comments on progress but not a complete resumption of all activities.

e. The original assessment appears to have been based upon an incomplete understanding of what Dr Kohan had actually said. It was also not consistent with the Worker's statement that was before the AMS.

f. Having been provided with the respondent's further statement dated 26 November 2019, the AMS assessed ADLS at 2%. That assessment is clearly consistent with the Worker's two statements and the expectations of Dr Bodel. They are not inconsistent with the reports of Dr Kohan once those reports are properly understood.

g. The appellant does not identify any incorrect criteria or suggest that the assessment does not accord with the Worker's statements. The appellant merely asserts that there is discord between the Worker's statement and the medical reports. Unfortunately, the appellant does not articulate what that discord is.

h. The assessment is consistent with the assessment of Dr Bodel (who was the only other doctor to make an assessment) and as has been explained is not inconsistent with Dr Kohan's reports particularly when it is noted that Dr Kohan makes no specific comment about sporting, recreational and domestic activities.

i. A mere assertion that the assessment is at odds with the medical reports does not make out a case. At the very least the appellant needs to identify what constitutes the claimed inconsistencies and present an argument that those inconsistencies show a demonstrable error or the use of incorrect criteria. The appellant has done none of these things.

32. In his statement dated 14 May 2019 which was before the AMS at the time of his initial assessment, the respondent said:

"As a result of the 13 October 2010 injury, I still suffer from the following disabilities:
(a) Constant pain in my back.
(b) Restriction of movement in my back.
(c) Sleep disturbance.
(d) Loss of concentration.
(e) Requirement to perform home exercises.
(f) Reduced capacity to lift and carry heavy objects.
(g) Reduced capacity to push and pull heavy objects.
(h) Reduced capacity to reach and get into awkward positions.
(i) Daily requirement to take medication.
(j) -Interference with employment activities.
(k) Interference with social and recreational activities.
(I) Interference with household and domestic activities.
(m) Worsening of pain in cold weather.
(n) Stress, depression and anxiety.
(o) Loss of social interaction."

33. In our view, there was clear evidence at that time that the respondent was indeed experiencing some restrictions as regards ADL's.

34. It seems to us that initially, the AMS did indeed base his assessment principally on the opinion of Dr Kohan in his report of 20 March 2013, and does not appear to have adequately taken into account the respondent's statement that was also provided to Dr Bodel.

35. We agree with the appellant's submissions as to the requirements set out in the Guidelines.

36. Having said that, the AMS was clearly restricted in being unable to conduct a full clinical assessment, and was reliant on the material before him. That was the inevitable nature of the referral.

37. We do not agree that there is "a significant discord between the medical reports within the Application and the respondent's self-reporting." As the respondent points out, Dr Kohan, whilst considering that the respondent had made an excellent recovery, nonetheless qualified his comments by adding that he had "essentially" returned to normal activities.

38. Critical to the issue in this case is the weight to be provided to the respondent's further statement of 26 November 2019.

39. In a Certificate of Determination dated 14 November 2019, the Arbitrator said:

> "Within 14 days, the parties are to file an agreed bundle of further documents to be referred to an Approved Medical Specialist (AMS).
> Absent agreement as to the documents in (1) above, the parties have liberty to apply to the Commission for a further teleconference to determine which further documents, if any, are to be referred to the AMS.
> The documents to be referred to the AMS to assist with their assessment are to include the following:
> a. This Certificate of Determination;
> b. Application to resolve a Dispute and attachments;
> c. Colour copies of photographs of alleged scarring;
> d. Any documents filed in accordance with Order (1) and/ or (2) above.
>
> The following is not a determination of the Commission; however, it is noted:
> a. The applicant resides in Nepal.
> b. The respondent wishes to place before the AMS certain medical reports.
> The applicant does not oppose treating doctors' reports being referred, however, there may be an issue as to whether previous IME reports (if any) should be referred.
> If that issue arises, parties have liberty to apply.
> Otherwise, an agreed bundle is to be filed within 14 days."

40. Unfortunately, we do not know the nature or extent of the "bundle" of documents to which the Arbitrator refers.

41. Nevertheless, it is clear that no objection was taken to the further statement of the respondent in which he described the impact of his injury on ADL's.

42. In those circumstances, we are of the view that the AMS was entitled to take into consideration the subsequent statement from Mr Manandhar with regard to his activities of daily living.

43. The AMS needs to be guided in his final assessment by the information provided to him, as he was unable to examine or question Mr Manandhar directly. Understandably then, in light of that statement, the AMS decided to increase the impairment for ADLs to 2% WPI giving a 22% WPI.

44. We see no error in this approach.

45. The additional WPI of 2% was consistent with the evidence before the AMS.

46. For these reasons, the Appeal Panel has determined that the MAC issued on 18 February 2020 should be confirmed.

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

G Bhasin

Gurmeet Bhasin
Dispute Services Officer
As delegate of the Registrar