WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-6200/19**
Appellant:	**Ismail Ismail**
Respondent:	**Permaculture Research Institute**
Date of Decision:	**8 July 2020**
Citation:	**[2020] NSWWCCMA 124**

Appeal Panel:	
Arbitrator:	**Ross Bell**
Approved Medical Specialist:	**Dr David Crocker**
Approved Medical Specialist:	**Dr Brian Noll**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 16 April 2020, Ismail Ismail, the appellant, 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 a Medical Assessment Certificate (MAC) on 6 April 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 (SIRA Guidelines) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th ed (AMA 5).

RELEVANT FACTUAL BACKGROUND

6. It is convenient to extract the history reported by the AMS at Part 4 of the MAC,

> "Brief history of the incident/onset of symptoms and of subsequent related events, including treatment:

In 2009, employed by Rous Hotel, working as a Chef, Mr Ismail developed right shoulder pain when working with vegetables. He tells me he had an x-ray but no physiotherapy and was off work for about a week.
In 2011, now working with The Permaculture Research Institute as a Chef, he injured his right shoulder manipulating a box of tomatoes, was off work for 6-8 months, had extensive physiotherapy and a shoulder injection but did not require surgery. He thereafter returned to normal duties.

16/01/2013, Dr Mark Pearce, Orthopaedic Surgeon, noted the history including 2 injuries to the right shoulder and 'significant pain' despite physiotherapy and 2 injections. Dr Pearce found no evidence of rotator cuff tear or an unstable shoulder. He recommended rehabilitation.

On 12/12/2013, the date of the incident of concern, Mr Ismail tells me that the boss' daughter was in the kitchen spraying Canola oil, some of which got on the floor and made it slippery and he fell slipping on the floor and re-injured his right shoulder and right arm as well as his neck. He was driven by a colleague to attend his GP, Dr Young at Lismore Clinic. He was off work initially for 2 weeks but had persisting symptoms and eventually had to stop work in 2014.

24/12/2013, x-ray right shoulder reported no bone or joint abnormality. Ultrasound reported thickening of the subacromial bursa with no rotator cuff tear.

12/02/2014, MR scan right shoulder reported swelling of the supraspinatus with an area of high signal measuring 2mm which was new compared to previous scanning, there was no full-thickness tear but there was 'mild progression of subacromial bursitis'.

19/02/2014, Dr Pearce reviewed the MR scan and confirmed a small partial thickness supraspinatus lesion and confirmed 'There is no indication that he requires surgery'.

02/06/2014, Ultrasound right shoulder reported mild thickening of the bursa and mild tendinopathy.

19/05/2015, Dr Graze, orthopaedic surgeon recorded the previous right shoulder incident in 2012 and the work incident of concern in December 2013. Dr Graze recommended MR scan of the neck with EMG and nerve conduction studies as well as chronic pain management.

15/06/2015, MR scan cervical spine recorded 'Minor degenerative change at C3/4 and C4/5. No canal or foraminal compromise at any level.'

18/06/2015, Professor Corbett, Neurologist, confirmed a diagnosis of right elbow cubital tunnel ulnar nerve compression but no evidence of carpal tunnel compression.

19/06/2015, Dr Graze confirmed a diagnosis of cubital tunnel syndrome and noted the diagnosis did not 'account for his shoulder symptoms' and recommended an AC joint injection for local tenderness as well as ulnar nerve anterior transposition.

28/07/2015, Dr Graze noted no improvement with the right shoulder AC joint injection, a further subacromial injection was performed and right shoulder MR scan was repeated which reported supraspinatus tendinopathy, a small area intra-substance tearing, no full thickness tear and no atrophy.

Mr Ismail tells me he became addicted to pain medications in 2015 and self-admitted to Damascus, a drug rehab facility in Brisbane, in May 2015 he attempted suicide because of ongoing pain issues.

Right shoulder and elbow surgery:

09/03/2016, Dr Graze went on to perform right shoulder arthroscopic acromioplasty and distal clavicle excision combined with open anterior transposition of the ulnar nerve (at the right elbow cubital tunnel).
At review on 22/03/2016, Dr Graze reported good pain control. Mr Ismail reports however that the surgery did not improve his arm symptoms.

In 2017, at home, Mr Ismail was getting up from a couch and felt his right shoulder 'pop'. Thereafter, he started to wear the post-operative sling intermittently. There is been no specific investigations or interventional treatment for the shoulder since.

Revision right elbow cubital tunnel surgery
With continuing right ulnar nerve symptoms, Mr Ismail was referred to Dr Thomas, who apparently confirmed ongoing nerve issues at the cubital tunnel and went on to perform revision right ulnar nerve surgery (which may have also included common flexor origin release), at John Flynn Private Hospital in 2017.

Bilateral carpal tunnel surgery
Mr Ismail noted bilateral pins and needles in the index and long finger of both hands, particularly worse at night, a diagnosis of bilateral carpal tunnel syndrome was made. Dr Thomas performed left carpal tunnel release surgery in March 2018 followed by right carpal tunnel release in July.

Mr Ismail tells me he attempted suicide again in May 2019 and was admitted to South Pacific Private Hospital for 3 weeks.

There has been no further interventional treatment, but Mr Ismail reports gradually increasing pain in the left wrist without specific trauma, no investigations and no treatment."

PRELIMINARY REVIEW

7. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the WorkCover Medical Assessment Guidelines.

8. 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 for the reasons given below.

EVIDENCE

Documentary evidence

9. 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.

Medical Assessment Certificate

10. The parts of the medical certificate given by the AMS are set out, where relevant, in the body of this decision.

SUBMISSIONS

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

Appellant

12. The AMS has erred in applying a deduction under s 323 of the 1998 Act of 4/5 in relation to the left wrist assessment. This deduction offends the authorities in that it involves an assumption that because there has been previous injury there must be a deduction.

13. The AMS has erred in applying 1/5 deduction under s 323 of the 1998 Act to the right shoulder assessment because there is insufficient evidence of pre-existing problems and the deduction is again based on assumption.

14. The AMS should not have used paragraph 2.16 of the SIRA Guidelines on finding inconsistency of presentation because this is only to be used if there is no loss of range of motion (ROM).

Respondent

15. The AMS was correct and not against authority in applying 4/5 deduction for the left wrist given extensive evidence of pre-existing injury and symptoms. The reasons were adequate.

16. The AMS was correct not to take into account in the assessment of impairment injuries not pleaded in regard to the right shoulder.

17. There is ample evidence of inconsistency of presentation. Paragraph 2.5 of the SIRA Guidelines states that ROM should not be used in the circumstances and paragraph 1.36 should be referred to. The AMS has followed the correct course in making the assessment of the right shoulder.

18. The MAC should be confirmed.

FINDINGS AND REASONS

19. 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.

20. 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.

Ground of appeal – assessment of 4/5 deduction applied to the left wrist assessment for pre-existing injury, condition, or abnormality pursuant to s 323 of the 1998 Act

21. The respondent relies on authority for the principles that for a deduction to be properly made under s 323 there must be evidence that there is a pre-existing injury, condition, or abnormality; and that this element contributes to the impairment[1]; and “assumption will not suffice”.[2]

[1] *Cole v Wenaline Pty Ltd* (2010) NSWSC 78 (*Cole*).
[2] *Fire & Rescue NSW v Clinen* [2013] NSWSC 629.

22. In *Ryder v Sundance Bakehouse* [2015] NSWSC 526, Campbell J explained the requirement (emphasis in original),

> "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 the *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 the 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."

23. The AMS notes the four occasions on which Mr Ismail fractured his left wrist at the ages of 14, 18, 21, and 24,

> "As a 24 year old, he again injured his left wrist and was placed in plaster. He says despite these multiple injuries, he had no significant strength problems, but acknowledges there was some pain with cold weather and some limited movement in the wrist prior to the incident of concern in 2013."

24. At Part 5 the AMS notes his findings on examination of the left wrist,

> "Left wrist movements were markedly reduced and included dorsiflexion 20°, volar flexion 30°, radial deviation 10° and ulnar deviation 10°. There was marked deformity about the ulnar head which was deformed and quite locally tender. There was translational stability of the ulnar head in the distal radioulnar joint consistent with instability."

25. At Part 10 the AMS gives his "reasons for assessment",

> "There is significant dysfunction of the left wrist, but also a history of at least 4 previous wrist-forearm fractures which Mr Ismail acknowledges resulted in some element of left wrist stiffness and weakness prior to the 2013 work incident. There has been no new traumatic event concerning the left wrist, but it has become increasingly symptomatic in the years since 2013, and WCC has determined it has been injured as a result of the 2013 work incident."

26. Contrary to the submissions for Mr Ismail, the deformity and instability around the ulnar head found by the AMS on examination was clearly considered by him to be the result of the history of previous injury. Overuse due to the right shoulder injury did not cause the deformity and instability, although the history is of some worsening of symptoms after the 2013 injury, as recognised by the AMS. In the Panel's view the conclusion of the AMS was open to him given the extensive history and findings on examination.

27. Unlike the situation in *Cole* there is evidence that the previous injuries to the left wrist contribute to the impairment, and the AMS has made no assumption. The AMS has then used his clinical judgement to assess the proportion of the contribution to the impairment. It is a situation in which, as the AMS says, s 323(2) cannot be applied as this would be at odds with the evidence of the pre-existing deformity, instability, and stiffness relative to minor subsequent aggravation due to overuse.

28. The appellant submits that the AMS has not provided reasoning as to why he applied 4/5 deduction, but the AMS says at Part 11.c.,

> "Left wrist
> Left Upper Extremity Left Wrist: Mr Ismail has an extensive history of pre 2013 traumatic fractures from a teenager to his mid-20s, with at least 4 fractures and acknowledged that these had resulted in some ongoing wrist stiffness and weakness prior to 2013. The clinical evidence therefore is at odds with a deduction of 1/10, for these reasons it is my opinion the deductible proportion is 4/5."

29. This, taken together with the report of the findings on examination at Part 5, including the deformity of the ulnar head, is ample explanation as to the conclusion of the AMS that 4/5 of the impairment found is due to the deformity, instability and pre-existing stiffness. The evidence was obvious on presentation for the AMS to apply his clinical judgement.

30. The findings on examination provided the AMS with accurate medical information as to the proportion of the impairment represented by the pre-existing elements beyond Mr Ismail's subjective history. There is no error discerned by the Panel on the face of the Certificate regarding the s 323 deduction applied for the left wrist and it was open to the AMS.

Ground of appeal – assessment of 1/5 deduction applied to the right shoulder assessment for pre-existing injury, condition, or abnormality pursuant to s 323 of the 1998 Act

31. The history of injury to the right shoulder is noted by the AMS as extracted above. There was a right shoulder injury in 2009, and in 2011 further injury manipulating a box of tomatoes, and Mr Ismail "was off work for 6-8 months", had extensive physiotherapy and a shoulder injection but did not require surgery. He thereafter returned to normal duties. The AMS goes on,

> "16/01/2013, Dr Mark Pearce, Orthopaedic Surgeon, noted the history including 2 injuries to the right shoulder and 'significant pain' despite physiotherapy and 2 injections. Dr Pearce found no evidence of rotator cuff tear or an unstable shoulder. He recommended rehabilitation."

32. At Part 10.a. the AMS refers to the previous issues and the fact that there was only a small partial tear present after the 2013 injury at arthroscopic decompression surgery,

> "The right shoulder had significant injuries predating the 2013 incident of concern including requirement for physiotherapy and injections and 6-8 months off work. He underwent right shoulder arthroscopic decompression (but there was no full-thickness cuff tear nor cuff surgery) in addition to excision of the distal clavicle for pre-existing arthritis."

33. At Part 11.b., the AMS explains the evidentiary basis for his opinion that a proportion of the impairment is due to pre-existing shoulder disease,

> "The history of pre-existing right shoulder trauma, time off work, treatment and MR reports of cuff tendinosis as well as the Operating Surgeon's diagnosis of AC joint arthritis contribute to the evidence of pre-existing disease."

34. At Part 11.c. the AMS provides the reasoning for his opinion that the proportion of impairment due to the pre-existing injuries is 1/5,

> "Right shoulder: In my opinion the deductible proportion is two tenths for the following reasons:

(i) He had extensive pre 2013 clinical right shoulder disease which required at least 6-8 months off work and multiple treatments including physiotherapy and injection."

35. The AMS also says that 1/10 deduction (s 323(2)) would be at odds with the evidence, and it was open to him to arrive at that conclusion given the extensive evidence of previous damage. The Panel discerns no error on the face of the Certificate regarding the s 323 deduction for the right shoulder.

Ground of appeal – s 322(2) of the 1998 Act and previous injury

36. The appellant submits that the AMS was required to include assessment of the previous injuries with the respondent on the authority of *Department of Juvenile Justice v Edmed* [2008] NSWWCCPD 6. However, the referral to the AMS was for assessment of the injury on 12 December 2013. This reflects the injury pleaded in the Application to Resolve a Dispute and the Certificate of Determination – Consent Orders issued on 20 February 2020.

37. The AMS made his assessment of the injuries suffered in the fall on 12 December 2013 in terms of the referral. There is no demonstrable error on the face of the Certificate in this regard.

Ground of appeal – use of paragraph 2.16 to assess the right shoulder rather than range of motion (ROM)

38. The appellant submits that the AMS should not have made his assessment of the right shoulder based on paragraph 2.16 of the SIRA Guidelines because it is only to be used where there is no loss of ROM.

> "Diagnosis of impingement is made on the basis of positive findings on appropriate provocative testing and is only to apply where there is no loss of range of motion. Symptoms must have been present for at least 12 months. An impairment rating of 3% UEI or 2% WPI shall apply."

39. However, paragraph 1.36 of the SIRA Guidelines provides,

> "AMA5 (p 19) states: 'Consistency tests are designed to ensure reproducibility and greater accuracy. These measurements, such as one that checks the individual's range of motion are good but imperfect indicators of people's efforts. The assessor must use their entire range of clinical skill and judgment when assessing whether or not the measurements or test results are plausible and consistent with the impairment being evaluated. If, in spite of an observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the assessor may modify the impairment rating accordingly and then describe and explain the reason for the modification in writing.' This paragraph applies to inconsistent presentation only."

40. The AMS says at Part 10.b. that the ROM method was not useable in the circumstances,

> "Right Shoulder
> Acknowledging that the diagnosis is right shoulder impingement, tendinosis and status post distal clavicle resection, the right shoulder examination is inconsistent with the known pathology and surgeries performed with marked reduction of active range of motion, markedly atypical for a diagnosis of impingement-tendinosis even in the post-operative setting, given there is no clinical evidence of post-traumatic adhesive capsulitis nor arthritis.

Active range of motion in neutral included external rotation to 60° excluding significant arthritis or post-operative capsulitis. In fact, those diagnoses have never been mentioned by the various clinicians involved in assessing Mr Ismail.

Further, during my examination, Mr Ismail physically and voluntarily resisted passive range of motion in abduction and observed active movement when dressing and dressing was considerably greater than that recorded during the formal examination.

SIRA paragraph 1.36 with AMA-5, section 2.5(c) instructs Assessors that when there is evidence of inconsistency, the 'assessor must use their entire range of clinical skill and judgment when assessing whether or not the measurements of test results are plausible or consistent with the impairment being evaluated.'

In this particular case, the test results are not consistent with the impairment being assessed. This is echoed by Professor Cumming's concerns.

Acknowledging the diagnosis of impingement, SIRA provides impairment for impingement as 3% upper extremity impairment, as per paragraph 2.16, but acknowledges this is usually used when there is 'no loss of range of motion'. It is my opinion that assessing impairment for this diagnosis is the appropriate assessment tool to assess impingement in the face of such significant abnormal illness behaviour and inconsistency of examination.

There is additional impairment following the distal clavicle resection as per SIRA paragraph 2.14 which provides for 5% upper extremity impairment for resection arthroplasty of the distal clavicle.

Right upper extremity (shoulder) impairment 8% UEI."

41. The appellant appears to submit that the AMS was bound to use ROM regardless of the inconsistency of presentation. The Panel does not accept that submission. Paragraph 2.5 of the SIRA Guidelines states that ROM should not be used in such circumstances,

    "• If there is inconsistency in ROM, then it should not be used as a valid parameter of impairment evaluation. Refer to paragraph 1.36 in the Guidelines.

    • If ROM measurements at examination cannot be used as a valid parameter of impairment evaluation, the assessor should then use discretion in considering what weight to give other available evidence to determine if an impairment is present."

42. The extract above from Part 10.b. of the MAC comprises a detailed explanation as to why the AMS turned to paragraph 2.16 of the SIRA Guidelines. In the circumstances of this matter paragraph 1.36 allowed the AMS to use his clinical judgement to achieve an assessment of the shoulder by the most appropriate method available. This he has done, and the approach taken was available to him.

43. The appellant also submits that Professor Cummings did not find inconsistency of presentation, but the AMS has clearly read Professor Cummings' reports and refers to his expressed concerns at examination. In any event, the AMS himself found inconsistency of presentation on examination of the right shoulder and proceeded accordingly. There is no error on the face of the Certificate in this regard, and the AMS has not used incorrect criteria in assessing the right shoulder.

Findings

44. The grounds of appeal are not made out. The Panel discerns no demonstrable error on the face of the Certificate. The assessment was not based on incorrect criteria.

45. For these reasons, the Appeal Panel has determined that the MAC issued on 6 April 2020 is 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*.

T Ng

Tina Ng
Dispute Services Officer
As delegate of the Registrar