WORKERS COMPENSATION COMMISSION

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

Matter No:	**M1-773/19**
Appellant:	**Fujitsu General Pty Ltd**
Respondent:	**Wilfred Jude Mendez**
Date of Decision:	**21 August 2019**
Date of Amendment:	**21 August 2019**
Citation:	**[2019] NSWWCCMA 119**

Appeal Panel:	
Arbitrator:	**Gerard Egan**
Approved Medical Specialist:	**Dr Roger Pillemer**
Approved Medical Specialist:	**Dr Gregory McGroder**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 13 June 2019, Fujitsu General Pty Ltd (the appellant, and/or the employer) made an application to appeal against a medical assessment (the appeal) to the Registrar of the Workers Compensation Commission (the Commission). The medical assessment was made by Dr Ross Mellick, an Approved Medical Specialist (the AMS) in a Medical Assessment Certificate dated 17 May 2019 (the MAC).

2. The respondent to the Appeal is Wilfred Jude Mendez (the worker).

3. 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.

4. 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.

5. The WorkCover Medical 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 WorkCover Medical Assessment Guidelines.

6. 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).

EVIDENCE

Documentary evidence

7. The Panel has before it all the documents that were sent to the AMS for the original assessment and has taken them into account in making this determination.

8. Neither party seeks to adduce further evidence.

RELEVANT FACTUAL BACKGROUND

9. The worker (now 63 years of age) claimed lump sum compensation from an injury to his lumbar spine while trying to lift and move an air conditioner on 19 February 2013.

10. However, prior to the date of injury relied upon by the worker, the Pacific Medical Centre clinical notes disclose numerous attendances for back pain. On 11 November 2010, the notes record a workcover related complaint: "lower back pain not radiated, mechanical happened due to work, advised nsaids rest heat and rev after 4/7 [sic]". A CT scan of the lumbar spine was arranged on 18 November 2010 and the worker returned to work on light duties with continuing physiotherapy and analgesics. A number of attendances record ongoing back pain and treatment until January 2011, when it appears the worker returned to normal duties.

11. On 14 July 2011, a further record describes: "mva, hit from the back, presented with lower back pain and left knee painful and lom , sent for x-ray and rev x-ray nad. advised rest pain killers and bandage unfit until18/7" [sic]. A further workcover certificate was prepared.

12. Over the following few months, the left knee seems to have been the focus, ultimately diagnosing medial meniscal tear, which was arthroscoped in October 2011. By 23 December 2011, the notes say the worker's back and knee felt better and he again returned to normal duties. He continued on painkillers and by March 2012, was again on light duties (for the left knee).

13. On 19 April 2012, the following notation is made: "still have back pain, and lom, shobers test positive, slr psoitive adviced [sic] rest pain killers and physio". (Schobers test is a test for lumbar flexion, and "slr" is straight leg raising).

14. Further ongoing symptoms recorded before the subject injury on 13 February 2013 include a "flare up" on 24 July 2012, when the worker still remained on light duties, probably primarily for ongoing left knee problems. He was still getting intermittent central low back pain on 22 August 2012 and his lumbar rocking exercises were reviewed.

15. On 19 September 2012 a clinical note records:

> "aggravated back today at work. Was asked to assist with more heavy MM6g duties because they were busy and understaffed"
>
> and
>
> "still have same pain and lorn, of lower back and knee, seeing drll:lale, on 23/10 adviced continue on the same restrictions, plus pain killers rev"

16. On 26 September 2012, the workers reported the pain had “settled since last aggravation”.

17. He next saw his treating doctor at the Pacific Medical Centre on the day of the subject injury, 19 February 2013, who recorded:

> “First attendance for during heavy lifting at work- feels heavy LBP,
> left wrist pain MAH
> become a chronic condition
> have had similar issues at the past
> pain at the wrist with movements but no swelling or restriction
> back- restricted movements no red flag
> analgesic/rest rev-”

18. A CT scan of the lumbar spine was arranged.

19. On 18 March 2016, Dr Kam, the worker’s treating neurosurgeon said:

> “There is no doubt there is ongoing pre-existing degeneration in Mr Mendez’s lumbar spine. You have to decide whether the triggering event that occurred at work a few years back is the substantial contributing factor to his ongoing pain. If he did not have any documented symptoms of back pain, leg pain or buttock pain prior to the work-related accident, I would put it to you that work has been a substantial contributing factor to Mr Mendez’s current condition.”
>
> “I am of the opinion that while Mr Mendez is 59 years of age and – there is a back ground of degeneration. I still believe that there is a work related component to his condition and hence, I feel that the proposed surgery should be considered under the provisions of Workers Compensation”.

20. He underwent a right L5/S1 decompression and transforaminal lumbar interbody fusion and pedicle screw fixation on 8 August 2016 by Dr Kam Neurosurgeon. The Operation Report noted the presences of “lumbar spondylosis with degenerative disc, hypertrophic ligamentum flavum and hypertrophic facet joints”. On 8 June 2017, Dr Kam noted persisting symptoms in the right leg.

21. On 9 June 2017, a CT scan of the lumbar spine noted “an ovoid density adjacent to L5/S1 outlet foramen of uncertain significance”. On the 12-month post-surgery review, Dr Kam said he was “delighted with the results”.

Dr Stephenson’s opinion

22. The applicant made his claim for lump sum compensation supported by a medico-legal assessment by Dr Brian Stephenson on 6 November 2018. The doctor noted the presence of various indicators of right-sided radiculopathy in accordance with the Guidelines. He said there were no pre-existing injuries or conditions.

23. Dr Stephenson assessed the worker in DRE Lumbar Category IV (20% WPI) and a modifier for persisting radiculopathy of 3% WPI. He did not describe any effects of the injury upon the applicant’s activities of daily living (ADLs) in the history recorded, but when assessing impairment said:

> “To that I would add 2% for ADLs, i.e., for assistance with and avoidance of sport, recreation, yard, garden and homecare”.

24. When asked: “Is the worker suffering from a pre-existing condition or abnormality?”, he answered “No”.

25. Dr Stephenson assessed 0% WPI for the surgical scarring. The total impairment assessed and claimed was 24% WPI.

A/Prof Miniter’s opinion

26. A/Prof Miniter though the worker displayed “many non-physical signs including a grossly restricted range” of lumbar movement. He concluded that there was no radiculopathy, saying:

> “Sitting over the side of the bed, there was clearly no evidence of radiculopathy. There was slight reduction in the right ankle jerk but the neurological examination was otherwise unremarkable. The femoral nerve stretch test was negative and there were well-healed surgical scars posteriorly consistent with the surgery performed by Dr Kam.”

27. The radiology reviewed was a pre-surgery MRI scan of the lumbar spine, which A/Prof Miniter said “suggested the presence of an L5/S1 disc abnormality”. The post-surgery CT scan on 9 June 2017 noted the internal fixation at the L5/S1, with an intervertebral body spacer. He thought there were “no obvious issues causing canal stenosis or outlet foraminal obstruction”.

28. A/Prof Miniter made no comment about the presence (or otherwise) of pre-existing degenerative changes or any other pathology when reviewing the imaging, other than a comment by the radiology reporting on the CT scan that "adjacent to the L5/S1 outlet foramen within the canal there is an irregular ovoid density".

29. A/Prof Miniter assessed the worker within DRE IV (20% WPI). He allowed a further 1% WPI “related to the loss of sport and recreation” but not homecare. He made no allowance for TEMSKI scarring, or ongoing radiculopathy as he believed there was none, and even expressed doubt that there ever was true radiculopathy.

30. A/Prof Miniter consider that there was pre-existing pathology and applied a deduction of one-quarter, resulting in 16% WPI.

The worker’s statement dated 15 February 2019

31. Relevant to the appeal regarding ADLs, the worker says he has difficulty sleeping because of back and leg pain; has difficulty doing domestic tasks around the home; cannot mow his lawn; and standing in comfort for about 5 to 10 minutes to cook a meal after which he has to move around to relieve the back pain. He gives an example of “simple tasks” that he has to rely on his wife to do, such as changing the sheets or making the bed. Driving for more than 20 to 25 minutes leads to pain in his back and legs intensifying.

32. Relevant to the appeal regarding a deduction for the any proportion of impairment due to pre-existing condition or abnormality, the worker says,

> “I suffered an injury to my back while working Fujitsu back on 10 November 2010. At most I would have taken a few days off work. I had some physiotherapy. I did light duties for a few weeks and then I resumed my normal work and I was not further troubled by any further back pain.”

THE MAC FINDINGS

33. In the MAC, the AMS noted the circumstances of the injuries and subsequent treatment.

34. He noted the worker said he had increased pain in his back and right leg after the operation, which has persisted and increased. He noted Dr Kam's record dated 9 August 2013 in which Dr Kam said the worker did not appear in "too much discomfort, walking without an antalgic gait". Dr Kam's examination of the lower extremities did not reveal weakness, reflex asymmetry or impairment of straight leg raising. He noted the only current treatment was analgesic medication and the use of a gel to be applied to his back and heat packs.

35. The AMS described presenting symptoms as mainly lower back pain "with extension into the right leg involving especially the lower outer aspect of the right lower leg". There were no left leg symptoms. There was some urgent incontinence of urine from time to time. He does feel his urine pass and has a normal urge to pass it. There is similarly a normal sensation when he needs to open his bowels. There has been no sexual function since the operation and he indicates there has been a considerable loss of libido.

36. The AMS did not record a history of pre-injury back pain, although he did note the motor vehicle accident in 2010 he understood that "was a minor event and there was no absence from work". While he reviewed the radiology including the CT scan of the lumbar spine performed on 9 June 2017, he did not make reference to the statements regarding pre-existing degeneration, and findings by Dr Kam during surgery set out at [19] and [20] above.

37. Under a heading in the MAC, "Social activities/ADL", there is no history recorded.

38. The AMS noted the worker use a walking stick and exhibited an antalgic gait without placing weight on the walking stick. In the seated with hips flexed and knees extended he appeared in some discomfort. There was no definite wasting in either lower extremity. There was limitation of straight leg raising on the right side to 30° and limitation on the left side to 70°.

39. The AMS noted weakness of ankle dorsiflexion on the right with some wasting of extensor digitorum brevis; impaired power of ankle dorsiflexion and eversion on the right side associated with back pain; and objective loss of superficial sensation to light touch and temperature in the L5/S1 distribution on the right side and reflexes were normal.

40. The conclusion in the MAC is:

> "He is troubled by back pain and leg pain which he reports has been worse since the fusion procedure. These symptoms are now associated with clear objective radicular signs involving limitation of spinal flexion and lateral flexion, associated with paravertebral muscle spasm, impairment of straight leg raising on the right side, objective sensory loss involving the L5/S1 distribution and muscle weakness, and wasting which involves the extensor digitorum brevis".

41. The AMS thought the worker's presentation correlated with the history of injury, the symptoms dating from the injury, the radiological data, the nature of the operation performed and the current clinical picture.

42. The AMS assessed DRE IV (20%), 3% for ADL's and 3% because of persistence of radiculopathy. Combined, this resulted in 25% WPI.

43. The AMS said he differed from Dr Stephenson regarding allowance for ADLs and explained his allowance of 3% for ADL's was justified "as (the worker) does require, on occasions assistance with dressing".

44. When asked whether any proportion of the impairment, is due to a previous injury, pre-existing condition or abnormality, the AMS responded "N/A". He noted the assessments by Dr Stephenson and A/Prof Miniter. He said there was good correspondence between A/Prof Minter's report and his own, but did not specifically consider the one-quarter deduction by A/Prof Minter for pre-existing pathology.

45. He explained this as follows:

> "Pre-existing, degenerative diseases which was asymptomatic and predated the injury in question [sic]. However, its unremarkable magnitude and the absence of any relevant history indicates no deduction is indicated on the basis of the degenerative disease. This is in agreement with Dr Stephenson's assessment."

46. Accordingly, the AMS made no deduction of impairment under s 323 of the 1998 Act.

GROUNDS OF APPEAL: SUBMISSIONS

47. Both parties made written submissions, attached to the Application to appeal and the Opposition respectively.

48. The grounds of appeal, subject to falling within one of the categories in s 327(3) of the 1998 Act are the grounds restricted to those specified in the submissions accompanying the appeal: *New South Wales Police Force v Registrar of the Worker Compensation Commission* [2013] NSWSC 1792 (*Police Force v Registrar)* Davies J at [49]). This was confirmed by His Honour in *The UGL Rail Services Pty Ltd (formerly United Group Rail Services Pty Ltd) v Attard* [2016] NSWSC 911; see also *Wilkinson v C & M Leussink Pty Ltd* [2015] NSWSC 69.

49. The submissions will be dealt with below, but the grounds of appeal by the employer are the AMS's:

    (a) allowance of 3% for impairment of ADLS;

    (b) failure to make any deduction for a proportion of permanent impairment due to previous injury or pre-existing condition or abnormality (Section 319(d)).

PRELIMINARY REVIEW

50. 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.

Further medical examination by a Panel Member

51. Although neither party requested examination again by a medical member of the panel, the Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Guidelines. The Panel concluded that the AMS considered the question of whether a deduction for pre-existing condition or injury was appropriate under s 323 of the 1998 Act based on an incorrect history or prior back symptoms, treatment and investigation.

52. The only prior history of back problems recorded by the AMS was "a motor vehicle accident in 2010 when his vehicle was struck from behind. It was a minor event and there was no absence from work". The AMS said he based his assessment upon, inter alia, that the "pre-existing, degenerative diseases which was asymptomatic and predated the injury in question" [sic], and the degeneration's "unremarkable magnitude and the absence of any relevant history".

53. As a result of a preliminary review, the Panel determined that the evidence regarding numerous and significant pre-injury complaints of back pain in 2010, 2011 and 2012, including arrangements for CT scan of the lumbar spine on 18 November 2010 and X-ray on 14 July 2011 establish the existence of pre-injury symptoms, and pre-injury condition.

54. Further the worker's treating neurosurgeon, Dr Kam commented on 18 March 2016 that there was "no doubt there is ongoing pre-existing degeneration in Mr Mendez's lumbar spine". The AMS did not note or consider this.

55. The Panel, having been convinced that an error in the MAC existed, required the worker to present for further examination by Dr Pillemer, an AMS Panel member.

56. Having determined error, the Panel must re-assess all impairment resulting from the subject injury to the lumbar spine on 19 February 2013: *Drosd v Workers Compensation Nominal Insurer* [2016] NSWSC 1053.

Hearing on the papers

57. The appellant does not seek an oral hearing before the Appeal Panel. The employer agrees that it is not necessary.

58. In the Preliminary Review the Panel determined that there is sufficient evidence in the materials before the Panel, written submissions identifying the alleged errors, and grounds of appeal. Further, the re-examination report provides the Panel with sufficient detail to allow the Panel to deal with the appeal and re-assessment without such a hearing in accordance with the Registrar's Guideline: Appeal Against Medical Assessment.

FINDINGS AND REASONS

59. The Appeal Panel is obliged to give reasons, the extent of which will vary from case to case: *Campbelltown City Council v Vegan* [2006] NSWCA 284.

60. The power of review is far ranging but nonetheless confined to the matters set out in s 327(2) of the 1998 Act which can be the subject of appeal. The procedure on appeal is one of limited review, as set out in s 328.

61. In this matter the Registrar has determined that a ground of appeal under s 327(3) is made out.

DEALING WITH THE APPEAL

62. Clause 1.6 of the Guidelines provides that assessing permanent impairment involves clinical assessment on the day of assessment.

63. Clause 1.8 makes it clear that: "The degree of permanent impairment that results from the injury must be determined using the tables, graphs and methodology given in the Guidelines and AMA5, where appropriate". Section 1.5 of Chapter 1 of AMA 5 (p 10) applies to the conduct of assessments and expands on this concept.

Report following further examination by MAS Panel Member, Dr Pillemer on 14 August 2019

64. Dr Pillemer reported as follows:

> **"1. The workers medical history, where it differs from previous records**
>
> I read Mr Mendez the history that he gave to Dr Ross Mellick at the time of his consultation on 30 April 2019 and he feels that this was all correct.
>
> Mr Mendez was questioned very specifically about his activities of daily living, and he felt that he could only walk for 5 to 10 minutes rather slowly, and he could only drive for a maximum of say 15 kilometres. He says he had to negotiate stairs one at a time and use a rail, and he also uses a stick at all times.
>
> He lives at home with his wife and the most he could do in the way of home duties would be some dusting, and he certainly could not vacuum or hang washing. He would go shopping with his wife but the most he would carry would be a litre of milk or *'cornflakes'*.
>
> On specific questioning with regard to self-care he felt that his wife had to help him with his shoes and socks and often with his underwear.
>
> Mr Mendez was also questioned very specifically about his previous history in relation to his lumbar spine and he confirmed that he had been involved in a motor vehicle accident in 2010 when his vehicle was struck from behind. He says he felt some slight pain in his back at the time and saw his general practitioner, and these symptoms lasted for about a month and then settled down.
>
> On specific questioning he felt he had no further problems with his low back until his injury in February 2013.
>
> When I pointed out to Mr Mendez that there was a significant history of ongoing problems with his low back ever since the motor vehicle accident in 2010 and noting visits to his general practitioner on a number of occasions in 2010, 2011 and 2012, and that he had had a CT scan of his lumbar spine carried out on 22 January 2013, some 4 weeks prior to his injury on 19 February 2013, his response was that *'I can't remember'*.
>
> **2. Additional history since the original Medical Assessment Certificate was performed**
>
> Mr Mendez does not feel that there has been any change in his condition since his examination by Dr Mellick on 30 April 2019.

3. Findings on clinical examination

Mr Mendez was noted to walk with a stick in his right hand but was also noted not to place any weight on the stick. As noted he informed me that he had to negotiate stairs one at a time and use a rail, but this was not confirmed and he was noted to descend seven stairs in a normal fashion without holding onto a rail and without using his stick.

Mr Mendez was able to undress and dress again by sitting on a small stool in the rooms, and was able to remove his socks but did not replace these afterwards. When removing his socks and putting on his trousers, a range of flexion of his right knee of at least 120° was noted to be present. (He has ongoing problems with his right knee and wears a knee guard).

Mr Mendez was unable to walk on his heels and toes today and shows very significant restriction of back movement, only getting his fingertips as far as the tops of his knees in flexion and other movements were equally restricted.

Straight leg raising was limited to 10° on the right and 30° on the left with inability to exert any force against resisted movements of his right foot and ankle, and fairly diffuse hypoaesthesia to pinprick of his right lower limb. There was no wasting to circumferential measurement.

He does have a full range of left knee movement but on the right side would only flex to 50° today because of discomfort in his right knee. As noted above, flexion to 120° was noted while dressing.

4. Results of any additional investigations since the original Medical Assessment Certificate

Mr Mendez has not had any further investigations carried out.

General Comments:

Please note that today's re-examination was carried out with two specific purposes in mind:

- Determination of ADLs.
- Determination of s323 deduction.

<u>ADLs</u>

It was the opinion of Dr Pillemer at the time of the consultation that there was a very significant exaggeration of physical signs and maximization of claimed disability, noting that Mr Mendez for example felt that the most he could carry while shopping would be a litre of milk and a packet of cornflakes and that his wife had to help him with undressing and dressing, particularly in regard to his shoes and socks, and putting on underwear.

Mr Mendez was able to manage these activities this morning without assistance. In addition as noted, the need to walk with a stick was discounted.

Please note that the Workers Compensation Guidelines (4th Edition) notes that *'The assessment of the impact of the injury or condition on ADL should be verified, wherever possible, via reference to objective assessments'*[(1)].

It was the opinion of Dr Pillemer that 2% WPI for ADLs is the correct assessment.

s323 Deduction

Please note that Mr Mendez was questioned very specifically today with regard to the previous history in his low back, and he simply confirmed that following his motor vehicle accident in 2010 he had had some slight pain in his back which had lasted a month and then settled down. He suggested that he had had no further problems with his back until his injury in February 2013, as noted above. When it was pointed out the significant history of problems with his lumbar spine from 2010 until his more recent injury, he simply noted that he was unable to remember any of these incidents or seeing his general practitioner.

Noting the extent of this history, it was felt that a deduction of one-tenth would be at odds with the available evidence, and that a deduction of one-fifth would be more appropriate.

Mr Mendez therefore falls into DRE Category IV of his lumbar spine[(2)], with an additional 2% for ADLs, giving a total of 22% WPI.

In addition Mr Mendez would be entitled to an additional 3% for his residual radiculopathy according to Table 4.2[(3)], and combining this with the DRE total of 22% above, gives a final total of 24% WPI.

With a deduction of one-fifth leaves Mr Mendez with 19.2% WPI which rounds to 19% WPI.

Body Part or system	**Date of Injury**	**Chapter, page and paragraph number in WorkCover Guides**	**Chapter, page, paragraph, figure and table numbers in AMA5 Guides**	**% WPI**	**% WPI deductions pursuant to S323 for pre-existing injury, condition or abnormality**	**Sub-total/s % WPI (after any deductions in column 6)**
Lumbar spine	30/04/19	Chapter 4 Page 24-29	Chapter 15 Page 384 Table 15-3	24%	1/5	(19.2) 19%
Total % WPI (the Combined Table values of all sub-totals)					**19%**	

Dated, Signed

Workers Compensation Guidelines, 4th Edition:
(1) Page 5, Item 1.25.

AMA Guides to the Evaluation of Permanent Impairment, 5th Edition:
(2) Page 384, table 15-3. Loss of motion segment integrity – spinal fusion.

NSW Workers Compensation Guidelines, 4th Edition:
(3) Page 29, table 4.2."

Ground 1: The Lumbar Spine (ADLs): the appellant's submissions

65. The appellant asserts that there is a demonstrable error in that the AMS did not record any history of restriction of ADL's of personal care activities; and he relied upon a restriction which is not reported by the appellant or evidence. The appellant raises cl 4.33 of the Guidelines which provides that the assessment for ADL is to be based upon an assessment of all clinical findings and other reports.

66. The employer notes cl 4.35 of the Guidelines which provides for the relevant allowance for ADLs. It is submitted that for an allowance of 3% there must be interference with the worker's capacity to undertake personal care activities such as dressing, washing, toileting and shaving, but there is no evidence of this in any of the documentation filed, nor does the AMS take a history of such interference. Yet, it is submitted, the AMS said that he took account of the history, findings on examination and the documentary evidence in making his assessment and went on to explain "a justified addition of 3% for ADL's as he does require, on occasions, assistance with dressing".

67. The appellant also asserts that there has been an application of incorrect criteria in the AMS' interpretation of cl 4.35 of the Guidelines because the AMS's explanation refers to assistance being required only on occasions.

68. The employer does note the workers statement refers to difficulties undertaking domestic tasks around the home, mowing his lawn, standing for lengthy periods to cook meals, changing the sheets on his bed or driving for longer than 25 minutes. Presumably, this is intended to point out that he did not complain about interference with personal care, and more properly reflects the Guideline examples in cl 4.35 for a 2% addition.

69. It is also noted by the appellant that the worker relied upon Dr Stephenson's opinion, and he only allowed 2% for ADL's "for assistance with and avoidance of sport, recreation, yard, garden and homecare". Similarly, A/Prof Miniter's disagreement is noted saying he would only allow "1% related to the loss of sport and recreation. There were no issues with regard to homecare".

70. A/Prof Miniter's comment as to "non-physical signs" during examination is noted, and the appellant points to cl 4.33 of the Guidelines requires the examiner to base an assessment upon of all clinical findings and other reports. The AMS, however, said there was a "good correspondence" between his report and A/Prof Miniter's.

Ground 1: The Lumbar Spine (ADLs): the respondent's submissions

71. The respondent points to the AMS's conclusion based on his examination that the worker's "symptoms are associated with clear objective radicular signs involving limitation of spinal flexion and lateral flexion, associated with paravertebral muscle spasm, impairment of straight leg raising on the right side, objective sensory loss involving the L5/S1 distribution and muscle weakness, and wasting which involves the extensor digitorum brevis"; and his acceptance of the worker's presentation as "consistent".

72. It is argued that the AMS did take a history that the worker "does on occasions require assistance with dressing", and this justifies the 3% allowance because clearly that is a personal activity. He considered the opinions of Dr Stephenson and A/Prof Miniter, and disagreed with them for reasons stated.

73. Further he assessed consistently with the Guidelines in that cl 4.33 requires the assessment to be based not just on self-reporting, but on all clinical findings and other reports. This reliance on clinical judgement is also noted in cl 1.6 of the Guidelines.

Ground 1: The Lumbar Spine (ADLs): the Panel's conclusions

74. Clauses 4.33 to 4.35 of the Guidelines provide the framework for allowance for interference with ADLs by spinal injuries. Clause 4.34 is a pie chart. Clauses 4.33 and 4.35 provide:

> "4.33 Impact of ADL. Tables 15-3, 15-4 and 15-5 of AMA5 give an impairment range for DREs II to V. Within the range, 0%, 1%, 2% or 3% WPI may be assessed using paragraphs 4.34 and 4.35 below. 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."
>
> and
>
> "4.35 The diagram is to be interpreted as follows: Increase base impairment by:
>
> - 3% WPI if the worker's capacity to undertake personal care activities such as dressing, washing, toileting and shaving has been affected
> - 2% WPI if the worker can manage personal care, but is restricted with usual household tasks, such as cooking, vacuuming and making beds, or tasks of equal magnitude, such as shopping, climbing stairs or walking reasonable distances
> - 1% WPI for those able to cope with the above, but unable to get back to previous sporting or recreational activities, such as gardening, running and active hobbies etc."

75. Apart from a difference of opinion with Dr Stephenson and A/Prof Miniter by the AMS, the appeal first revolves around the lack of a history recorded by the AMS in the usual section of the MAC, before explaining his allowance cased on the occasional requirement for assistance in dressing. The Panel considers that to be an objection as to form rather than substance. It is clear enough on the face of the MAC that the AMS was told of such difficulties, and an error has not been established on that basis alone.

76. Secondly, the appellant argues that interference with dressing is not a complaint appearing elsewhere in the lay, clinical or medico-legal material. In February of this year, three months prior to the AMS's examination, the appellant prepared his statement, presumably with the assistance of his solicitors, and judging by the language used, with the provisions of cll 4.33 to 4.35 in mind. He mentions only sleeping, domestic tasks mowing his lawn, cooking, changing the sheets or making the bed, and driving. These are matters pointing to a 2% allowance.

77. On further examination, the worker was observed to undress and dress, remove his socks although he did not replace them. Flexion of his right knee of at least 120° was noted when removing his socks and putting on his trousers, while on formal examination the worker would only flex it to 50°. Unrelated problems with his right knee were noted,

> "Mr Mendez was unable to walk on his heels and toes today and shows very significant restriction of back movement, only getting his fingertips as far as the tops of his knees in flexion and other movements were equally restricted.
>
> Straight leg raising was limited to 10° on the right and 30° on the left with inability to exert any force against resisted movements of his right foot and ankle, and fairly diffuse hypoaesthesia to pinprick of his right lower limb. There was no wasting to circumferential measurement.

He does have a full range of left knee movement but on the as noted above, flexion to 120° was noted while dressing."

78. The Panel accepts the observations by Dr Pillemer, and determines that the allowance for ADLs is 2%. Importantly, this observation does not rely solely on self report in the examination itself. This assessment is consistent with the applicant's independent self report in his statement, and the observed ability to dress, undress, and remove his socks. It also allows for the unrelated knee condition causing the worker to restrict the right knee flexion on formal examination.

Ground 2: The deductible proportion (s 323): the appellant's submissions

79. In short, the appellant submits that the worker failed to disclose the significant pre-injury history, and the AMS erred in accepting the worker at face value, given the clear complaints in the notes and the observation of Dr Kam.

Ground 2: The deductible proportion (s 323): the respondent's submissions

80. The respondent submits that the appellant's submission that there was a pre-existing condition causing permanent impairment and ongoing symptomatology is incorrect and fails to deal with the correct approach to s 323. Essentially, it is asserted that the contemporaneous notes suggest improvement in back pain or recovery.

81. The relevant test is submitted to be whether the pre-existing condition contributed to whole person impairment (*Vitaz v Westform (NSW) Pty Ltd* (2011) NSWCA 254 (*Vitaz*); *Cole v. Wenaline Pty Ltd* (2010) NSWSC 78 (*Cole*)), and the appellant has not advanced any submission other than to merely state that pre-existing pathology must mean a deduction under section 323. The Particular passages in *Cole* and *Vitaz* will be considered below.

82. The various observation of pathology and symptoms before and after the subject injury, particularly the neurological aspects of it, are noted. It is also noted that the eventual pathology is what led to the L5/S1 lumbar fusion procedure, and "it is the lumbar fusion procedure that results in the degree of person impairment".

83. It is submitted that any suggestion that the degree of whole person impairment would not have been as great, or that surgery would have been required, but for the degenerative condition of the spine, is speculation.

84. It is also submitted that a deduction under section 323 "could only properly be made, if there was evidence that the pre-existing condition made the worker more prone to the injury he suffered", and there is no evidence of this.

85. It is submitted that the appellant has not identified error in the MAC.

Ground 2: The deductible proportion (s 323): The Panel's conclusions

86. Section 323(1) of the 1998 Act requires a deduction for any proportion of the impairment that is due to any previous injury or that is due to any pre-existing condition or abnormality. If the extent of a deduction 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: s 323(2).

87. The approach in making a deduction under s 323 of the 1988 Act is set out in *Cole*. The assessment of the extent to which a prior injury or pre-existing condition contributes to impairment must be based on evidence relevant to the likely effects of that condition or injury to the worker's present impairment. Any deduction under s 323(1) for the proportion of impairment due to prior factors must be based on evidence and not hypothesis or assumption. Schmidt J said in *Cole*:

> "…what section 323 requires is an inquiry into whether there are other causes, (previous injury, or pre-existing abnormality), of an impairment caused by work injury. The 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 have not been as great"

88. In *Vitaz*, Basten JA (McColl JA and Handley AJA agreeing), said, following the approach adopted in *D'Aleo v Ambulance Service of New South Wales* (NSWCA, 12 December 1996, unrep) (also quoted by Giles JA, Mason P and Powell JA agreeing, in *Matthew Hall Pty Ltd v Smart* [2000] NSWCA 284; 21 NSWCCR 34 at [30]-[32] and by Schmidt J in *Cole*):

> *"*The resulting principle is that 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. In the absence of any medical evidence establishing a contest as to whether the pre-existing condition did contribute to the level of impairment, the complaint about a failure to give reasons must fail. An approved medical specialist is entitled to reach conclusions, no doubt partly on an intuitive basis, and no reasons are required in circumstances where the alternative conclusion is not presented by the evidence and is not shown to be necessarily available." at [43].

89. The first task for the AMS, as Campbell J notes in *Greater Western Area Health Service v Austin* [2014] NSWSC 604 is to assess the body parts referred,

> "An Approved Medical Specialist's task is to assess the whole person impairment with which the injured worker presents. Whether it be caused by the injury or whether its cause is from an unrelated source, nonetheless the impairment should be recorded. If it is the opinion of the AMS that the losses, or part of them, had been caused for other reasons then an AMS has the power to make an appropriate deduction under s.323 of the 1998 Act, or to vary his assessment as provided at [8(g)] of the MAC."

90. In *Fire & Rescue NSW v Clinen* [2013] NSWSC 629 (*Clinen*) Campbell J said:

> "As Schmidt J pointed out in *Cole and Elcheikh*, it is necessary to find a pre-existing abnormality or condition, here the latter, actually contributing to the impairment before s. 323 WIM is engaged. This conclusion has to be supported by evidence to that effect. Assumption will not suffice."

91. Campbell J also noted that it is "... necessary for the evidence acceptable to the appeal panel to actually support the connection between a previous injury (here, pre-existing abnormality or condition) and the overall degree of impairment in the instant case."

92. In *Ryder v Sundance Bakehouse* [2015] NSWSC 526*,* Campbell J said at [54]:

> "Section 323 as I have already said, requires there to be a deduction for any proportion of the impairment that is *due to* any pre-existing condition. This is an essential element of the section; indeed, it is the pith of it. It is not enough to simply identify that there is a pre-existing condition and that there has been a subsequent impairment and therefore make a deduction under this section because of the existence of the pre-existing condition. Such reasoning fails to consider a necessary condition of the operation of the section; that a proportion of the permanent impairment is *due to* the pre-existing condition."

93. In *Cullen v Woodbrae Holdings Pty Ltd* [2015] NSWSC 1416 (*Cullen*), Beech-Jones J reiterated the need for evidence of an actual pre-existing condition rather than a predisposition or susceptibility, saying:

> "Thus, to establish a pre-existing condition for the purposes of s 323(1) there must, at the relevant date, be an actual condition although it may be asymptomatic. A mere predisposition or even a susceptibility is not sufficient to constitute a condition." (at 46).

94. While Dr Kam's statement in his report of 18 March 2016 (reproduced at [19] above), does not reflect the correct legal approach to whether the worker' employment was a substantial contributing factor to his injury, or whether the surgery was reasonably necessary as a result of the injury, it is instructive as to: that there was pre-existing degeneration; and that the existence of prior symptoms, had he known of them, would have affected his response to the matters he was considering.

95. The Panel does not accept the worker's assertion that that the degree of whole person impairment would not have been as great but for the degenerative condition of the spine is speculation. Nor does it accept that is determinative of the matter to suggest that it is speculation to infer that in the absence of the injury the applicant would have ultimately ended up having a lumbar fusion

96. The AMS's reasons that the worker was asymptomatic prior to injury is in error: *Cole*; *Vitaz.* The issue is whether any proportion of the assessed impairment is "due to" whatever was pre-existing: *Ryder*. Any pre-injury lack of symptoms, is not inconsistent with a conclusion pre-existing changes contribute to assessed impairment.

97. The worker's submission that the need for surgery was a consequence of the frank incident is relevant but not conclusive. The question of whether a proportion of the impairment is due to a pre-exiting condition is different to whether the surgery was "a result of" the injury. For the latter, the injury need only have materially contributed to the need for the surgery for it to be necessary "as a result of" the injury: s 60 of the 987 Act; *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49 Roche DP at [58]. That is, common law principles of causation are brought into play (subject to application of the statutory language in s 60 of the 1987 Act). These principles allow a finding that a consequence was caused by one of several competing contributing factors.

98. In *March v E & MH Stramare Pty Ltd* [1991] HCA 12; (1991) 171 CLR 506 (*March*), Mason CJ (at 509):

> "It has often been said that the legal concept of causation differs from philosophical and scientific notions of causation. That is because 'questions of cause and consequence are not the same for law as for philosophy and science', as Windeyer J. pointed out in *National Insurance Co. of New Zealand Ltd. v. Espagne* [(1961) [1961] HCA 15; 105 CLR 569, at p 591]. In philosophy and science, the concept of causation has been developed in the context of explaining phenomena by reference to the relationship between conditions and occurrences. In law, on the other hand, problems of causation arise in the context of ascertaining or apportioning legal responsibility for a given occurrence. The law does not accept John Stuart Mill's definition of cause as the sum of the conditions which are jointly sufficient to produce it. Thus, at law, a person may be responsible for damage when his or her wrongful conduct is one of a number of conditions sufficient to produce that damage: see *McLean v. Bell* [(1932) 147 LT 262 at p 264], per Lord Wright; *Sherman* v. Nymboida Collieries Pty. Ltd. [(1963) [1963] HCA 63; 109 CLR 580 at pp 590–591], per Windeyer J."

99. Under s 323, however, an apportionment is required in those very circumstances of multiple causes, provided it can be concluded that a proportion of the impairment is due to a pre-existing injury or condition. This conclusion for the purpose of s 323 does not undermine the relevant causal relationship between the injury and the surgery.

100. While, as the worker submits in this case, impairments are assessed by reference to the outcome following the surgery, there must still be a deduction for the impairment due to a pre-existing condition if the evidence requires it.

101. Based on, in particular, the clear and persistent complaint of symptoms prior to the injury, and the views of treating surgeon Dr Kam, the Panel is satisfied that there was an identifiable pre-existing condition, and that that condition contributes to the impairment assessed: *Ryder*. That is, but for the pre-existing abnormality the degree of impairment resulting from the work injury would not have been as great: *Ryder*. Nevertheless, the trauma of the frank injury has undoubtedly been the major contributor to the applicant's impairment in lumbar spine.

102. When it comes down to actually assessing the proportion to be deducted (provided it is based on the correct history and the evidence), however, the Panel acknowledges that there is a broad area for personal judgement in the application of s 323. Scientific precision is not achievable and inevitably, judgement is required.

103. In this case the Panel concludes that the duration and extent of pre-injury complaint of back pain, and the extent of degeneration acknowledged by Dr Kam to be pre-existing, does add to the impairment. The surgery performed was lumbar fusion (for back pain), not merely neural decompression (for leg pain).

104. Further the Panel agrees with the views expressed by Dr Pillemer, that a deduction of one-tenth would be at odds with the evidence. Subsection 323(2) may therefore not be applied, and despite the inherent difficulty in assessing pursuant to s 323(1), such an assessment must be made.

105. Doing the best on the evidence, an in the application of combined judgement of the medical members of the Panel, one fifth is considered the appropriate proportion to be deducted.

106. Accordingly, the findings and assessments of Dr Pillemer in the report included above are adopted.

DECISION

107. For the reasons set out in this statement of reasons, the decision in this matter is that the Medical Assessment Certificate given in this matter should be revoked and a new Certificate issued. This is attached.

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.*

T Ng

Tina Ng
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter No: **773/19**
Applicant: **Wilfred Jude Mendez Fujitsu General Pty Ltd**
Respondent: **Fujitsu General Pty Ltd**
Date of Decision: **21 August 2019**

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 Ross Mellick 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 WorkCover Guides	Chapter, page, paragraph, figure and table numbers in AMA5 Guides	% WPI	% WPI deductions pursuant to S323 for pre-existing injury, condition or abnormality	Sub-total/s % WPI (after any deductions in column 6)
Lumbar spine	30/04/19	Chapter 4 Page 24-29	Chapter 15 Page 384 Table 15-3	24%	1/5	(19.2) 19%
Total % WPI (the Combined Table values of all sub-totals)					**19%**	

Mr Gerard Egan
Arbitrator

Dr Roger Pillemer
Approved Medical Specialist

Dr Gregory McGroder
Approved Medical Specialist

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*.

T Ng

Tina Ng
Dispute Services Officer
As delegate of the Registrar