WORKERS COMPENSATION COMMISSION

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

Matter No:	**M1-2113/19**
Appellant:	**Linde Materials Handling Pty Ltd**
Respondent:	**Tainui Senifili**
Date of Decision:	**18 September 2019**
Citation:	**[2019] NSWWCCMA 134**

Appeal Panel:	
Arbitrator:	**Mr John Harris**
Approved Medical Specialist:	**Dr Philippa Harvey-Sutton**
Approved Medical Specialist:	**Dr David Crocker**

BACKGROUND TO THE APPLICATION TO APPEAL

1. Mr Tainui Senifili (the respondent) suffered injury to the lumbar spine on 15 June 2017 in the course of his employment with Linde Materials Handling Pty Ltd (the appellant).

2. The respondent brought proceedings claiming permanent impairment compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act). The only body part claimed was the lumbar spine.

3. The appellant accepted liability for the injury. It disputed that the respondent's assessment of whole person impairment exceeds the threshold for entitlement to s 66 compensation.[1] As liability was not in issue, the claim was referred to an Approved Medical Specialist (AMS). Dr Mohammed Assem was appointed as the AMS.

4. The AMS examined the respondent and provided a Medical Assessment Certificate dated 19 June 2019 (MAC). The relevant findings by the AMS pertinent to the various grounds of appeal are set out later in these Reasons. The AMS assessed the lumbar spine at 11% whole person impairment.

5. The assessment of whole person impairment is undertaken in accordance with the fourth edition of the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment* (fourth edition guidelines).[2] The fourth edition guidelines adopt the 5th edition of the *American Medical Association's Guides to the Evaluation of Permanent Impairment* (AMA 5). Where there is any difference between AMA 5 and the fourth edition guidelines, the fourth edition guidelines prevail.[3]

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[1] Reply, pg 2
[2] The 4th edition guidelines are issued pursuant to s 376 of the *Workplace Injury Management and Workers Compensation Act 1998*
[3] Clause 1.1 of the fourth edition guidelines

THE APPEAL

6. On 17 July 2019, the appellant filed an Application to Appeal Against a Medical Assessment (the appeal) to the Registrar of the Workers Compensation Commission (the Commission).

7. The Workers compensation medical dispute assessment guidelines (the Guidelines) set out the practice and procedure in relation to the medical appeal process under s 328 of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act). An Appeal Panel determines its own procedures in accordance with the Guidelines.

8. The appellant claims, in summary, that the medical assessment by the AMS with respect to the assessment of the lumbar spine should be reviewed on the ground that the MAC contains a demonstrable error and/or the assessment was made on the basis of incorrect criteria.

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

PRELIMINARY REVIEW

10. The Appeal Panel (AP) conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Guidelines.

11. The appellant submitted no re-examination was required and that the matter could otherwise be determined on the submissions as filed. The respondent agreed with that submission.

EVIDENCE

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

Respondent's statement

13. The respondent provided a statement dated 10 April 2019. He noted the effects of the injury and his attempts to continue to work. He stated that he continues to work with difficulty and takes painkillers as he is worried about losing his employment.[4]

Clinical reports/scans

14. A CT Scan dated 27 June 2017 is reported by Dr Tony Lu as showing moderate spondylotic disc disease at L3/4 and L4/5 as well as a moderate disc protrusion at L5/S1. There is also a moderate to severe bilateral L5/S1 foraminal stenosis with potential impingement of the bilateral L5 nerve roots.[5]

15. An MRI scan dated 8 August 2017 records a clinical history of lower back pain right more than left leg with a L3 pars defect.[6] The scan is reported by Dr Lu as showing a bilateral pars defect at L3 with marked degenerative disease at L3/4. The scan also refers to a small left central disc protrusion minimally indenting the anterior epidural fat.

[4] Application, pg 3-4
[5] MAC, pg 4
[6] Application, pg 17-18

16. Dr Kam, Neurosurgeon, examined the CT scan and noted the evidence of pars defect at L3 and suggestion of minor spondylosis at the L5/S1 level[7]. In a subsequent report Dr Kam noted the MRI scan showing significant disc loss at the L3/4 and L4/5 levels.[8]

Qualified opinions

17. The respondent was examined by Dr Frank Machart on behalf of the appellant who provided a report dated 15 January 2019.[9] Dr Machart accepted that the injury aggravated pre-existing spondylosis. The doctor assessed the respondent at 6% whole person impairment after allowing 1% for the effects on the activities of daily living.

18. The respondent was assessed by Dr Charles New on his behalf who provided a report dated 6 September 2018[10]. Dr New noted hypoaesthesia and dysaesthesia in the L5 and S1 distributions with a pars defect at L3. The doctor opined that the respondent met the criteria for radiculopathy and allowed a further 1% for the effects on the activities of daily living. Accordingly, the doctor assessed 11% whole person impairment.

REASONS PROVIDED BY THE AMS

19. The relevant portions of the MAC are set out in the respective grounds of appeal.

GROUND OF APPEAL 1 – FINDING OF RADICULOPATHY

Submissions

Appellant's submissions

20. The Appellant referred to the history recorded by the AMS under the heading "current status" that there "are no radicular symptoms" in the lower extremities and the summary of injuries and diagnoses where the AMS observed that there was atrophy of the right thigh but no weakness or sensory loss. It was observed that the AMS was satisfied that there was concordant evidence on radiological imaging of pathology involving the right L3 nerve root.

21. The Appellant referred to Table 15-3 of AMA5 and paragraphs 4.27 – 4.29 of the fourth edition guidelines.

22. Based on the AMS findings it was submitted that there was "a demonstrable error in finding radiculopathy when the AMS specifically stated that there are no radicular symptoms in his lower extremities".[11]

23. It was further submitted that the AMS failed to address the criteria set out in paragraph 4.27 of the fourth edition guidelines, in particular, that there was a major criterion to support the finding of radiculopathy.[12] The appellant also submitted that the AMS "relied solely" on "concordant radiological evidence" which was contrary to paragraph 4.28 of the fourth edition guidelines.

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[7] Application, pg 12
[8] Application, pg 14
[9] Reply, pg 17
[10] Application, pg 5
[11] Appellant's submissions, paragraph 16(i)
[12] Appellant's submissions, paragraph 16(ii)

24. The appellant observed that, in accordance with paragraphs 1.5 and 1.13 of the fourth edition guidelines, the AMS is required to exercise clinical judgment in determining a diagnosis and assessing permanent impairment. Reference was made to the recent Medical Appeal Panel decision of *Lefoe v Department of Education and Communities* (*Lefoe*)[13] where that Panel found that the AMS found no objective signs of radiculopathy present on the day of the physical examination. This was said to "constitute a demonstrable error".

Respondent's submissions

25. The respondent referred to the findings on physical examination made by the AMS at page 3 of the MAC where he found "knee jerk reflexes symmetrically reduced requiring reinforcement" and a "slight reduction in the left ankle jerk reflex." It was submitted that the findings made by the AMS on physical examination, particularly loss or asymmetry of reflexes and relevant atrophy, amounted to radiculopathy.

26. The assertion that the AMS could not find radiculopathy because the respondent reported no radicular symptoms is, at its highest "the AMS's precis of the workers self-reported symptoms"[14].

Reasons

27. The relevant portion of the AMS factual findings on radiculopathy were:[15]

> "He had a normal lumbar lordosis. There were no scars or deformities. There was slight tenderness reported on palpation but no muscle guarding or spasm.
>
> He had a good range of lumber [sic] flexion, reaching to the middle of his shin. Extension was restricted to half normal range with pain reported. Lateral flexion and rotation were restricted to half normal range with pain at the end of range.
>
> He did not have any difficulty climbing on or off the examination couch. Active straight leg raising in the supine position was 70^{o} bilaterally without any pain reported. Neural tension signs were negative.
>
> His knee jerk reflexes were symmetrically reduced, requiring reinforcement. His right ankle jerk reflex was normal but there was a slight reduction of his left ankle jerk reflex. Sensation was normal. There was 2cm atrophy of his right thigh compared to the left when measured 10cm above the superior pole of the patella and 1cm atrophy of his right calf compared to the left. There was no weakness. Neural tension signs were negative."

28. The AMS reported the respondent's complaint of symptoms under the heading "Current Status" when he stated:[16]

> "Mr Senifili is pain free at the present time. He experiences intermittent low back discomfort early in the morning and towards the end of his shift. He has difficulty sitting for more than one hour or standing and walking for long periods. There are no radicular symptoms in his lower extremities, but he feels that his thighs are weak."

[13] [2018] NSWWCCMA 78 at [25]-[27]
[14] Respondent's submissions, paragraph 2(d)
[15] MAC, pg 3-4
[16] MAC, pg 2-3

29. Under the heading "summary of injures and diagnoses" the AMS stated[17]:

> "Mr Senifili is a 44-year old left hand dominant man who was employed as a fork lift driver. He sustained an injury to his lower back on 15 June 2017 after repetitively lifting boxes weighing up to 20kg or 30kg. He continued to experience intermittent discomfort across his lower back with concordant evidence on radiological imaging of disc pathology at multiple levels. At the L3/4 level, there is a broadbased diffuse disc bulge with a disc osteophyte complex contacting the right exiting L3 nerve root. On examination, there was atrophy of his right thigh and calf but no weakness or sensory loss."

30. In his conclusions the AMS opined that the respondent satisfied the criteria for radiculopathy due to atrophy of his right leg and radiological imaging involving the right L3 nerve root.[18]

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

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

32. Paragraph 4.28 of the fourth edition guidelines provides:

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

33. The AP agrees with the respondent's submission that the history recorded by the AMS of no current "radicular symptoms" is a record of what the worker stated. They are not findings by the AMS on physical examination.

34. There is also a distinction between "radicular symptoms" and "radiculopathy". Table 15-3 of AMA5 distinguishes between "complaints of radicular pain" and "radiculopathy". The distinction between the concepts is also evident from paragraph 4.28 of the fourth edition guidelines which records that radicular complaints of pain or non-verifiable radicular pain that is not verified by neurological findings do not alone constitute radiculopathy.

35. The respondent did not complain of radicular pain. That does not mean that he did not have radiculopathy as defined by paragraph 4.27 of the fourth edition guidelines.

[17] MAC, pg 4
[18] MAC, pg 5

36. The definition of radiculopathy in paragraph 4.27 makes no reference to subjective complaints of symptomatology. Radiculopathy, as defined, is about motor or sensory loss or weakness rather than subjective complaints.

37. The appellant's submissions that there is an absence of radicular complaints is irrelevant to the issue of whether the medical expert is satisfied there is true radiculopathy as defined in the fourth edition guidelines. This aspect of the appeal is rejected.

38. The finding made by the AMS was of radiculopathy at the L3 level. This finding was based on the imaging and the atrophy at that level. The AMS did not state, as the respondent submitted, that the radiculopathy was based on the loss of an ankle jerk reflex because these are not related to the L3 level.

39. Whilst it is correct, as the Respondent submitted, that the AMS found a slight reduction of the left ankle jerk reflex, the AMS did not use that factual finding in determining that there was radiculopathy. That is clear from the conclusions expressed at paragraph 10 of the MAC where the AMS based the finding of radiculopathy on atrophy in the right leg and concordant evidence of radiological imaging involving the right L3 nerve root. For that reason, the AP rejects the respondent's submission that the major criterion was the loss of ankle reflex because the AMS did not state this in his conclusions. In any event, the loss of ankle reflex is not related to L3 nerve root and could not be a medical basis for supporting a finding of radiculopathy from that level of the lumbar spine.

40. Accordingly, the AP accepts that the finding of radiculopathy was made in the absence of a major criterion, as atrophy is only a minor criterion within the meaning of paragraph 4.27 of the fourth edition guidelines. This amounts to an error within the meaning of s 327(3)(c) of the 1998 Act: see *Marina Pitsonis v Registrar of the Workers Compensation Commission of New South Wales*[19] applying Basten JA in *Campbelltown City Council v Vegan*.[20]

41. The AP otherwise observes that the reference by the appellant to a finding of fact by another Panel in another case (*Lefoe*) is of no assistance to the determination of factual issues in this matter.

42. To the extent that it is suggested by the Appellant that the AMS did not exercise his clinical judgment, that submission was made in the absence of reference to the appropriate findings made by the AMS. The clinical findings made by the AMS are detailed. Indeed, apart from the general submission that there may be some error in his clinical findings, the appellant failed to articulate the basis of this allegation. The AP returns to the clinical findings made by the AMS later in these Reasons.

43. The only error that the AP accepts is that the AMS did not find a major criterion within the meaning of paragraph 4.27 of the fourth edition guidelines based on a finding of radiculopathy at the L3/4 level. This finding by the AP does not detract from our observation that the AMS clinical findings are consistent and precise.

44. The AP accepts the appellant's submission that the AMS has not found a major criterion in the L3 dermatome.

[19] [2008] NSWCA 88 (*Marina Pitsonis*) at [40]-[42], McColl and Bell JJA (as their Honours then were) agreeing
[20] [2006] NSWCA 284 at [94], McColl JA agreeing

GROUND OF APPEAL 2 – ACTIVITIES OF DAILY LIVING

Submissions

Appellant's submissions

45. The appellant submitted that the AMS erred in applying a 1% uplift for the restrictions in the activities of daily living which is either a demonstrable error and/or an assessment made on the basis of incorrect criteria.

46. It was submitted that the only relevant history taken by the AMS was that the respondent had difficulty mowing the lawn. No history was taken of the respondent's pre-injury status in order to compare the difference in activity level.

47. It was submitted that the respondent failed to address "his ADL status prior to the work injury" and the report of Dr New was "silent on the worker's historical ADL status".[21] It was noted that Dr Machart also assessed 1% for the effects on the activities of daily living but that doctor "failed to take a history of the workers ADL status prior to his injury and provides minimal justification for his allocation of 1% WPI."[22]

48. The appellant submitted that the AMS failed to take into account the clinical findings and "other reports relating to the effects of the injury of the worker's ADLs and relied solely on the worker's self-reporting comment that he had difficulty starting the lawn mower".[23] No ADLs should be applied in the matter.

Respondent's Submissions

49. The Respondent submitted that paragraph 4.34 of the fourth edition guidelines is "a guide only to the assessment of the ADLs" citing *Habbits v Chilana Pty Ltd* [2019] NSWWCCMA99. Despite this, it was submitted that the AMS complied with the paragraph.

50. The Respondent referred to paragraphs 1.24 and 1.25 of the fourth edition guidelines and Table 1-2 of AMA5.

51. The Respondent noted that the Appellant's submission ignores the history recorded by the AMS that there was no past history of back complaints and the present status which included intermittent low back discomfort and difficulty sitting for more than one hour or standing or walking for long periods. It was submitted that this is consistent with a difference in activity compared to the status prior to the injury.

52. The Respondent also submitted that the Appellant incorrectly submitted that Dr New was silent on the respondent's historical status on the effects of activities of daily living.

Reasons

53. The AMS allowed 1% for the effects on the activities of daily living. Within the history the AMS noted:[24]

> "He has recently separated from his wife and five children. He lives alone in a one bedroom property at Rooty Hill. He is independent in his personal and domestic activities of daily living. He is able to mow the lawn but has difficulty starting the lawn mower due to pain across his lower back."

[21] Appellant's submissions, paragraph 28
[22] Appellant's submissions, paragraph 30
[23] Appellant's submissions, paragraph 33
[24] MAC, pg 5

54. Later in his reasons the AMS cited paragraph 4.35 of the fourth edition guidelines and stated:[25]

> "In addition, he has 1% whole person impairment for a minor limitation in activities of daily living."

55. Paragraphs 4.33 – 4.36 of the *fourth edition guidelines* relate to the assessment of an appropriate percentage for the activities of daily living. Paragraph 4.33 provides that an "assessment of the effect of the injury on ADL is not solely dependent on self-reporting but it is an assessment based on all clinical findings and other reports".

56. Paragraph 4.34 provides that the diagram "should be used as a guide" in determining the appropriate percentage. There can be no doubt about the significance of the word "guide" as the *4th edition Guidelines* has used bold print to emphasise the word.

57. Paragraph 4.35 provides that the base impairment is increased 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 if the worker can manage personal care and household tasks but is unable to get back to previous sporting or recreational activities.

58. There was no contest in the medical evidence that the respondent was assessed at 1% for the effects on the activities of daily living. In this respect, the AP notes the observations by Basten JA in *Vitaz v Westform (NSW) Pty Ltd*[26] of the absence of any medical evidence establishing a contest on s 323 of the 1998 Act. His Honour stated:[27]

> "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."

59. The AP applies these observations with respect to a lack of contest in the medical evidence on this particular issue.

60. Dr New provided a report dated 6 September 2018.[28] The doctor obtained a history of no prior back pain or sciatica. Past social history included playing volleyball and golf.

61. Under the heading "Activities of Daily Living", Dr New noted that the respondent looked after himself "if he is slow and careful". The pain affected lifting weights, restricted walking sitting and standing for lengthy periods. Sleeping pattern and sexual relations were affected as well as social life and travel by motor vehicle.[29]

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[25] MAC, pg 7
[26] [2011] NSWCA 254
[27] at [43], with whom McColl JA and Handley AJA agreed
[28] Application, pg 5
[29] Application, pg 7

62. Dr New allowed 1% for the impact on the activities of daily living.

63. The appellant's submission that Dr New "is silent on the worker's historical ADL status" is incorrect.

64. Dr Machart was qualified by the appellant and provided a report dated 15 January 2019.[30] The doctor obtained a history that the respondent "participates in housework", is "unable to lift anything heavy" and "plays volleyball and golf less often, now only once a month"[31].

65. Dr Machart allowed 1% for the impact on the activities of daily living[32]. The suggestion by the appellant that Dr Machart's opinion on this issue provided "minimal justification" is correct although the AP observed that Dr Machart was qualified by the appellant and tendered in its case. The failure by Dr Machart to explain himself in providing an opinion supportive of the respondent could not detract, in these circumstances, from the respondent's entitlement to be assessed at 1% in respect of this issue.

66. The AMS was clearly entitled to form the view that, consistent with the clear clinical signs, the respondent was assessed at 1% for the effects on the activities of daily living. The respondent has clear clinical signs of ongoing back pain. The history, particularly that recorded by Dr New, establish how the effects of the lumbar spine condition and impairment have impacted on the respondent.

67. The history recorded by Dr New must be read with the respondent's condition and the activities he was performing prior to injury. In these circumstances it was entirely open for the AMS to conclude that there should be an allowance of 1% for the effects on the activities of daily living. No error, let alone demonstrable error, has been established by the appellant.

68. The AP, for the same reasons, rejects the ground of appeal that the assessment was made on the basis of incorrect criteria.

69. This ground of appeal is rejected.

REASSESSMENT

70. Having found error, the AP is required to reassess according to law: *Drosd v Nominal Insurer.*[33]

71. The parties did not seek a re-examination in the event that error was shown. The AP does not speculate on why the appellant did not seek a re-examination. The fact that error has been shown does not mean that the outcome is different, it means that the AP is required to reassess according to law. In any event, the AP is satisfied that we can properly perform the statutory function to reassess in the absence of a re-examination.

72. The AP accepts the clinical findings on examination made by the AMS which are repeated as part our reassessment:[34]

> "He had a normal lumbar lordosis. There were no scars or deformities. There was slight tenderness reported on palpation but no muscle guarding or spasm.

[30] Reply, pg 17
[31] Reply, p 18
[32] Reply, pg 21
[33] [2016] NSWSC 1053
[34] MAC, pg 3-4

> He had a good range of lumber [sic] flexion, reaching to the middle of his shin. Extension was restricted to half normal range with pain reported. Lateral flexion and rotation were restricted to half normal range with pain at the end of range.
>
> He did not have any difficulty climbing on or off the examination couch. Active straight leg raising in the supine position was 70° bilaterally without any pain reported. Neural tension signs were negative.
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> His knee jerk reflexes were symmetrically reduced, requiring reinforcement. His right ankle jerk reflex was normal but there was a slight reduction of his left ankle jerk reflex. Sensation was normal. There was 2cm atrophy of his right thigh compared to the left when measured 10cm above the superior pole of the patella and 1cm atrophy of his right calf compared to the left. There was no weakness. Neural tension signs were negative."

73. We have set out a summary of the radiological evidence earlier in these reasons[35]. The reduction in the left ankle reflex represents loss in the S1 dermatome. That finding is consistent with the observations of Dr New in his report dated 6 September 2018 of "hypoaesthesia and dysaesthesia in the left greater than right L5 and S1 nerve root distribution" and "bilaterally decreased ankle jerks"[36].

74. The AP observes that Dr Machart's findings in respect of the loss of reflexes were slightly different to those recorded by both the AMS and Dr New. Dr Machart noted that "reflexes bilaterally depressed, hamstrings, knees, ankles"[37]. They are not precise findings although they do indicate bilaterally depressed reflexes of the lower extremity.

75. The AP has indicated, accepting the parties' common submission, that it will reassess in the absence of an examination. In our view we accept the recent and detailed findings of the AMS, particularly those pertaining to loss of reflexes. These clinical findings are consistent with the MRI scan dated 8 August 2018 which shows indentation at the L5/S1 level. They are clearly consistent with the CT scan dated 27 June 2017 which shows pathology at the L5/S1 level consistent with the appellant's acceptance of injury to the lumbar spine.

76. In conducting our reassessment, we have considered the Respondent's submission identifying a major criterion. Whilst the appellant sought the MAC to be revoked based on its submission of error, there were no relevant submissions on reassessment save that it submitted that there should be no allowance for the effects on the activities of daily living[38]. To the extent that the appellant submitted that there was "no objective evidence of radiculopathy"[39], this is addressed in our Reasons set out herein.

77. The finding by the AMS of a slight reduction in the left ankle jerk is a major criterion within the meaning of paragraph 4.27 of the fourth edition guidelines as it constitutes "asymmetry of reflexes". The findings in the CT and MRI scans are concordant with the clinical findings by the AMS of decreased left ankle jerk in the S1 distribution, that is arising from the L5/S1 disc.

78. This finding is independent of the other clinical finding of atrophy made by the AMS which otherwise supports the finding of radiculopathy. The AP observes that the finding of atrophy is clearly consistent with the physical finding on examination of motor loss.

79. The clinical findings made by the AMS are otherwise consistent with the conclusion reached by Dr New.

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[35] See [15]-[16] herein
[36] Application, pg 7
[37] Reply, pg 19
[38] Appellant's submissions, paragraph 33
[39] Appellant's submissions, paragraph 22

80. For these Reasons, the AP is satisfied that there is both a major and minor criterion from the L5/S1 disc within the meaning of paragraph 4.27 of the fourth edition guidelines. Accordingly, the AP is satisfied that the respondent is assessed as DRE Lumbar Category III which equates to 10% whole person impairment.

81. The AP repeats the Reasons provided earlier in respect of the activities of daily living. In respect of this assessment, we refer to paragraphs 4.33 to 4.36 of the fourth edition guidelines noting that the delineation is a guide. Based on the clinical signs recorded by the AMS and the history recorded by Dr New, we are satisfied that 1% be allowed for the effects on the activities of daily living. We also take into account the opinions expressed by Dr New, Dr Machart and the AMS on this issue.

82. The AP is not satisfied that there should be any deduction pursuant to s 323 of the 1998 Act. The basis of our conclusion is the unanimity of opinion expressed by the AMS, Dr New and Dr Machart on this matter. We also note that the Appellant did not contest in the appeal that this aspect of the decision made by the AMS involved any error.

83. Given the duration of symptoms, the AP is satisfied that the impairment is permanent.

84. Accordingly, the AP is satisfied that the respondent is assessed as DRE Lumbar Category III and a further 1% is allowed for the effects on the activities of daily living. The summated whole person impairment is 11%. The AP is satisfied, based on the clinical history and the nature of treatment following the injury, that the impairment results from injury.

85. Our conclusion on reassessment means that the whole person impairment is the same as that reached by the AMS.

DECISION

86. For these reasons, the Medical Assessment Certificate given in this matter is confirmed.

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*.

A Shaw

Andrew Shaw
Dispute Services Officer
As delegate of the Registrar