WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-2203/19**
Appellant:	**Joanne Margaret Johnson**
Respondent:	**Country Classic Services Pty Ltd (in liquidation)**
Date of Decision:	**3 October 2019**
Citation:	**[2019] NSWWCCMA 142**

Appeal Panel:	
Arbitrator:	**Carolyn Rimmer**
Approved Medical Specialist:	**Dr Drew Dixon**
Approved Medical Specialist:	**Dr Greg McGroder**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 22 July 2019, Joanne Margaret Johnson (Ms Johnson) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Jonathan Negus, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 9 July 2019.

2. The appellant relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act):

    - the assessment was made on the basis of incorrect criteria, the MAC contains a demonstrable error.

3. The Registrar is satisfied that, on the face of the application, at least one ground of appeal has been made out. The Appeal Panel has conducted a review of the original medical assessment but limited to the ground(s) of appeal on which the appeal is made.

4. The Workers Compensation Medical Dispute Assessment Guidelines set out the practice and procedure in relation to the medical appeal process under s 328 of the 1998 Act. An Appeal Panel determines its own procedures in accordance with the Workers compensation medical dispute assessment guidelines.

5. The assessment of permanent impairment is conducted in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment,* 4th Ed 1 April 2016 (the Guidelines) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th Ed (AMA 5).

RELEVANT FACTUAL BACKGROUND

6. Ms Johnson sustained an injury in the course of her employment as a cleaner due to the nature and conditions of her employment between 2009 and 28 August 2011.

7. Proceedings were commenced in the Commission on 8 May 2019. Ms Johnson made a claim for lump sum compensation.

8. The matter was referred to the AMS, Dr Negus, in the Referral for Assessment of Permanent Impairment to Approved Medical Specialist dated 29 May 2019 for assessment of whole person impairment (WPI) of the lumbar spine as a result of the injury on 28 August 2011.

9. The AMS examined Ms Johnson on 12 June 2019. He assessed 16% of the lumbar spine and deducted 1/10th for pre-existing injury, condition or abnormality which resulted in a total assessment of 14% WPI as a result of the injury on 28 August 2011.

PRELIMINARY REVIEW

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

11. The appellant did not request that she be re-examined by an AMS, who is a member of the Appeal Panel.

12. As a result of that preliminary review, the Appeal Panel determined it was not necessary for Ms Johnston to undergo a further medical examination because there was sufficient evidence by way of medical reports and clinical investigations in relation to assessment of the lumbar spine on which to make a determination.

EVIDENCE

Documentary evidence

13. 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

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

SUBMISSIONS

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

16. The appellant's submissions include the following:

- The AMS applied a deduction of 1/10th pursuant to s 323 of the 1998 Act.
- The AMS recorded that he was in agreement with the assessment findings of Dr Bodel.
- On page 6 of the MAC the AMS noted the following:

> "Report of Dr James Bodel from 14/02/2017. He was of the opinion that while there is clearly pre-existing degenerative change within the lumbar spine. The [sic] injury in 2011 was a frank injury with additional structural damage caused by the nature of her work as a cleaner. He therefore assessed her as DRE Lumbar Category III (10% WPI) with 2% for ADLs and 3% for persisting signs of radiculopathy with a 1% addition for TEMSKI, giving her a 16% whole person impairment overall. He assigned a 1/10th deduction for a pre-existing condition. I am in agreement with Dr Bodel's assessment of the situation. Mrs Johnstone has a pre-existing condition but she suffered an injury in 2011 which required surgery."

- Dr Bodel did not apply a 1/10th deduction, as the AMS has recorded and explained in great detail why no deduction was appropriate in his two supplementary reports 22/05/2018 and 14/06/2018. The AMS made no reference to these supplementary reports, and incorrectly recorded Dr Bodel's clinical opinion on the matter.

- The AMS has also recorded reasoning that would appear to endorse Dr Bodel's finding that there be no deduction for pre-existing impairment, to the extent that the AMS has noted Dr Bodel was of the opinion that while there is clearly pre-existing degenerative change within the lumbar spine, the "injury in 2011 was a frank injury with additional structural damage caused by the nature of her work as a cleaner. He therefore assessed..." Dr Bodel's assessment that results from this reasoning (via the word 'therefore') was that there can be *no deduction* for pre-existing impairment.

- Whilst it is accepted that an AMS is not bound to explain why his reasoning differs from that of other experts given in a matter, where an AMS has explained his reasoning by reference to agreement with another expert, there is appealable error demonstrated where the clinical opinion of the expert averred to is incorrectly recorded. This is especially the case where the clinical reasoning of the expert averred to is endorsed by the AMS, but not the conclusion this reasoning leads to.

- Dr Bodel's clinical opinion on the matter of deduction is "medical evidence accepted or preferred by the AMS in connection with the medical assessment of the matter" in accordance with s 323, and it is therefore consistent with legislation and logical to rely upon the conclusions drawn by that medical evidence.

- At page 6 of the MAC the AMS recorded:

  "a. In my opinion the worker suffers from the following relevant previous injuries, pre-existing conditions or abnormalities:

  (i) Nil.

  b. The previous injury, pre-existing condition or abnormality directly contributes to the following matters that were taken into account when assessing the whole person impairment that results from the injury, being the matters taken into account in 10a, and in the following ways:

  (i) Nil."

- The AMS failed to identify the pre-existing injuries, conditions or abnormalities and failed to explain how the pre-existing injuries, conditions or abnormalities directly contribute to matters taken into account when assessing the WPI.

- The AMS failed to describe matters taken into account when assessing the WPI.

- In failing to identify or explain matters taken into account when assessing WPI, the AMS failed to provide a clinical basis or due justification for the application of a 1/10th deduction. This is especially the case where reasoning provided elsewhere in the MAC for this found to demonstrate appealable error.

- In failing to provide an adequate clinical basis or reasoning for applying a deduction, the applicant is denied procedural fairness and due process.

- The application of a deduction amounts to appealable error, and the appellant requests a review of the application of a deduction pursuant to s 323 of the 1998 Act.

17. The respondent's submissions include the following:

    - The AMS has correctly applied a s 323 deduction. The opinion of the AMS differed from the appellant's medical assessor in that Dr Bodel did not believe that that deduction should be applicable but the AMS found that applying a s 323 deduction was appropriate.

    - At the time of the assessment by the AMS, the AMS applied his own expertise to the question of whether there was a pre-existing condition which necessitated a deduction. In this case, he considered a 1/10th deduction to be appropriate. The deduction applied was not at odds with the available evidence.

    - The AMS took a thorough history of the appellant's back complaints, and notes that the appellant had a prior lumbar spine injury in 2006, which was the subject of previous WCC proceedings in which she was assessed at 6% WPI.

    - Regardless of Dr Bodel's opinion, a deduction should be applied in this case in any event, as indicated by the AMS.

    - The AMS made specific reference to radiological investigations taken prior to the subject incident on 14 December 2004, 2 August 2006, 28 June 2007 and 13 November 2007.

    - The AMS reported, "I have taken into account her history of no back pain prior to the date of injury, noting the previous lumbar spine injury in 2006 to which she claims had become asymptomatic." It is false to say that the AMS failed to explain describe or identify matters taken into account when assessing whole person impairment is false.

    - The evidence clearly established that but for the pre-existing degenerative changes seen on radiological investigations, the appellant's permanent impairment would not have been as great (see *Ryder v Sundance Bakehouse* [2015] NSW SC 526).

    - Further, in his report of 14 February 2017, Dr Bodel opined that, "Additional structural damage has occurred in 2011 [to that of the injury in 2006] ... "

    - In his report of 22 May 2018, Dr Bodel opined:

        > "...at most one could make a case for a one-tenth deduction for pre-existing impairment because it is too difficult to determine whether that pre-existing degenerative change is a contributing factor or not but I am included to accept that this lady really was asymptomatic at the time of her injury at the new place of employment and that the factors that began at that time are the cause of the disc disruption or the disturbance of the previous degenerative condition in the lumbar spine, which led to the need for the decompression and there is in fact no basis for a deduction for pre-existing impairment."

- Despite Dr Bodel's assertion that no deduction pursuant to s 323 of the Act be applied in the instance, in *Vitaz v Westform (NSW) Pty Ltd* [2011] NSWCA 254; per Basten JA, McColl JA and Handley AJA agreeing:

  > " .. .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."

- The MAC of Dr Jonathan Negus be confirmed and the Appeal be dismissed.

FINDINGS AND REASONS

18. 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.

19. 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.

20. The role of the Medical Appeal Panel was considered by the Court of Appeal in the case of *Siddik v WorkCover Authority of NSW* [2008] NSWCA 116 (*Siddik*). The Court held that while prima facie the Appeal Panel is confined to the grounds the Registrar has let through the gateway, it can consider other grounds capable of coming within one or other of the section 327(3) heads, if it gives the parties an opportunity to be heard. An appeal by way of review may, depending upon the circumstances, involve either a hearing de novo or a rehearing. Such a flexible model assists the objectives of the legislation.

21. Section 327(2) was amended with the effect that while the appeal was to be by way of review, all appeals as at 1 February 2011 were limited to the ground(s) upon which the appeal was made. In *New South Wales Police Force v Registrar of the Workers Compensation Commission of New South Wales* [2013] SC 1792 Davies J considered that the form of the words used in s 328(2) of the 1998 Act being, 'the grounds of appeal on which the appeal is made' was intended to mean that the appeal is confined to those particular demonstrable errors identified by a party in its submissions.

22. In this matter, the Registrar has determined that he is satisfied that at least one of the grounds of appeal under s 327(3(c) and (d) is made out, in relation to the AMS's assessment of the left lower extremity and scarring (TEMSKI).

23. The Appeal Panel reviewed the history recorded by the AMS, his findings on examination, and the reasons for his conclusions as well as the evidence referred to above.

24. Under "History relating to Injury" the AMS noted:

> "She describes no specific injury related to the date of injury but a culmination of working conditions causing lower back injury and pain. She first noticed her low back pain after she started working with a vacuum cleaner that was strapped to her back. The support straps did not work properly and she reported this but nothing was done. Her lower back just got more painful over time as she continued to use the vacuum cleaner.

By 28/08/2011, the pain was too severe to work and she informed her Supervisor on 29/08/2011 and then saw her GP on 30/08/2011 who organised for CT and MRI scans. She was found to have L4/5 and L5/1 disc protrusions compressing the L5 and S1 nerve roots on the left…"

25. Under "Details of any previous or subsequent accidents, injuries or condition" the AMS wrote:

> "She had a back injury on 07/06/2006 when working as a nurse and was awarded 6% WPI.
>
> I note a CT guided steroid epidural injection on 25 September 2006 at L5/S1."

26. Under "Details and dates of special investigations" the AMS referred to the reports in the attached documentation and commented:

> "14 Dec 2004 -XR and CT lumbar spine - Disc spaces preserved. Small osteophytes on L4 and L5. Minimal disc bulging at L4/5. Neural foramina preserved. Small broad-based disc protrusion at L5/S1. No neural compression.
>
> 2 August 2006 -MRI lumbar spine - Small central disc protrusion with annular tear at L5/S1. Mild left foraminal narrowing at L3/4. No neural compromise identified.
>
> 28 June 2007 - MR lumbar spine - this to gentle (sic) changes at the lower 3 levels. Minor displacement of the left L3 and L4 nerve root.
>
> 13 November 2007- mild multilevel degenerative change. No significant canal or foraminal compromise identified."

27. Under "Summary" the AMS wrote:

> "Joanne Johnston is a 54-year-old lady who injured her back while working as a cleaner in 2011. She has demonstrated disc protrusions at L4/5 and L5/S1 compressing her L5 and S1 nerve roots which have led her to 2 decompression operations. She has been left with lumbar spine pain and radicular pain. She has a history of previous lumbar spine injury. All imaging prior to the date of injury of 28 August 2011 show a minor disc bulges at L4/5 and L5/S1 with minor displacement of the left L3 and L4 nerve roots with no involvement of L5 or S1."

28. Under 'Evaluation of Permanent Impairment" the AMS wrote:

> "e. Is any proportion of loss of efficient use or impairment or whole person impairment, due to a previous injury, pre-existing condition or abnormality? No.
>
> f. If so, please indicate which body part/system is affected by the previous injury, pre-existing condition or abnormality. Not applicable.
>
> g. Indicate whether there has been any further injury subsequent to the subject work injury. If this injury has caused any additional impairment this should not be included with the assessment of impairment due to the subject work injury. Not applicable."

29. Under “Reasons for Assessment” the AMS wrote:

> “a. My opinion and assessment of permanent impairment WPI 14%
>
> In making that assessment I have taken account of the following matters:-
>
> I have taken into account her history of no back pain prior to the date of injury, noting the previous lumbar spine injury in 2006 to which she claims had become asymptomatic. Her back pain starting after working with that particular vacuum cleaner. There is radiological evidence of protruding discs and nerve root compression at the L4/5 and L5/S1 levels. Surgery for radiological findings. Her current situation includes objective findings that correlate to the radiological findings.
>
> ……
>
> 10% (DRE) ADDED with 2% (ADLs) = 12%
> 12% COMBINED with 5% (3% (Radiculopathy) ADDED 2% (second operation)) = 16% 16% MODIFIED by 10% for pre-existing = 14%”

30. Under “My brief comments regarding the other medical opinions and findings submitted by the parties and, where applicable, the reasons why my opinion differs” the AMS wrote:

> “Report of Dr James Bodel from 14/02/2017. He was of the opinion that while there is clearly pre-existing degenerative change within the lumbar spine. The injury in 2011 was a frank injury with additional structural damage caused by the nature of her work as a cleaner. He therefore assessed her as DRE Lumbar Category III (10% WPI) with 2% for ADLs and 3% for persisting signs of radiculopathy with a 1% addition for TEMSKI, giving her a 16% whole person impairment overall. He assigned a 1/10th deduction for a pre-existing condition. I am in agreement with Dr Bodel's assessment of the situation. Mrs Johnstone has a pre-existing condition but she suffered an injury in 2011 which required surgery. I note that he does not add any WPI for a second procedure.
>
> Dr Chris Harrington's report of 18/08/2017 concludes that she suffered back pain as a result of a workplace injury in 2006 and details the injury through August 2011 and her discectomy by Dr Ghabrial in November 2013. However, he found a lot of inconsistencies on clinical examination including her 'useless ankle'. He believed there was no evidence of radiculopathy from L4/5 and that her presentation was contrived. Therefore, although she has had a discectomy which places her in DRE Category III at 10% whole person impairment, he does not believe there is criteria to meet persistent radiculopathy and with 2% for ADLs, this gives her a WPI of 12%. He deducted 50% for pre-existing condition in 2006, giving her a 6% whole person impairment. I am of the opinion that a 50% deduction is too large and difficult to justify in this situation.”

31. Under “Deduction (if any) for the proportion of the impairment that is due to previous injury or pre-existing condition or abnormality”, the AMS wrote:

> “a. In my opinion the worker suffers from the following relevant previous injuries, pre-existing conditions or abnormalities:
>
> (i) Nil.

b. The previous injury, pre-existing condition or abnormality directly contributes to the following matters that were taken into account when assessing the whole person impairment that results from the injury, being the matters taken into account in 10a, and in the following ways:

(i) Nil.

c. The extent of the deduction is difficult or costly to determine so in applying the provisions of s.323(2) I assess the deductible proportion as one tenth. (can only be used when not at odds with available evidence)"

Deduction pursuant to s 323

32. The appellant argued that the AMS erred in making a 10% deduction on his WPI assessment under s 323(2) of the 1998 Act. The appellant noted that Dr Bodel did not in fact apply a 1/10th deduction as recorded by the AMS. Further, the AMS did not refer to the two supplementary reports of Dr Bodel dated 22 May 2018 and 14 June 2018 in which Dr Bodel explained why no deduction should be made.

33. The Appeal Panel agreed that the AMS erred in recording the opinion of Dr Bodel in relation to the s 323 deduction Dr Bodel applied in this case. The Appeal Panel also agreed with the appellant that the AMS erred in Part 8 of the MAC in that he made a deduction pursuant to section 323 but expressed the opinion that the worker did not suffer from any relevant previous injuries, pre-existing conditions or abnormalities and there was no direct contribution from a previous injury, pre-existing condition or abnormality which was taken into account when assessing the whole person impairment that results from the injury. A similar error was made at Part 11 of the MAC.

34. Section 323 of the 1998 Act provides:

"(1) In assessing the degree of permanent impairment resulting from an injury, there is to be a deduction for any proportion of the impairment that is due to any previous injury (whether or not it is an injury for which compensation has been paid or is payable under Division 4 of Part 3 of the 1987 Act) or that is due to any pre-existing condition or abnormality.

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

Note. So, if the degree of permanent impairment is assessed as 30% and subsection (2) operates to require a 10% reduction in that impairment to be assumed, the degree of permanent impairment is reduced from 30% to 27% (a reduction of 10%).

(3) The reference in subsection (2) to medical evidence is a reference to medical evidence accepted or preferred by the approved medical specialist in connection with the medical assessment of the matter.

(4) The WorkCover Guidelines may make provision for or with respect to the determination of the deduction required by this section."

35. The approach to be taken in assessing the s 323 deduction was considered by the Supreme Court in *Cole v Wenaline Pty Limited* [2010] NSWSC 78 (*Cole*). Schmidt J said:

> "29. The section is directed to a situation where there is a pre-existing injury, pre-existing condition or abnormality. For a deduction to be made from what has been assessed to have been the level of impairment which resulted from the later injury in question, a conclusion is required, on the evidence, that the pre-existing injury, pre-existing condition or abnormality caused or contributed to that impairment.
>
> 30. Section 323 does not permit that assessment to be made on the basis of an assumption or hypothesis, that once a particular injury has occurred, it will always, 'irrespective of outcome', contribute to the impairment flowing from any subsequent injury. The assessment must have regard to the evidence as to the actual consequences of the earlier injury, pre-existing condition or abnormality. The extent that the later impairment was due to the earlier injury, pre-existing condition or abnormality must be determined. The only exception is that provided for in s 323(2), where the required deduction 'will be difficult or costly to determine (because, for example, of the absence of medical evidence)'. In that case, an assumption is provided for, namely that the deduction 'is 10% of the impairment'. Even then, that assumption is displaced, if it is at odds with the available evidence.
>
> 31. That is a matter of fact to be assessed on the evidence led in each case".

36. The assessor must point to the actual consequences of the pre-existing condition or abnormality on the assessed impairment, and how it contributes to that assessment. In *Vitaz v Westform (NSW) Pty Limited and Ors* [2010] NSWSC 667, decided on 22 June 2010, Johnson J said at [48]: "...it is insufficient to assume that the existence of a pre-existing injury or condition will always contribute to the impairment flowing from any subsequent injury: Cole v Wenaline Pty Limited at [30]."

37. Basten JA in *Vitaz v Westform (NSW) Pty Ltd* [2011] NSWCA 254 referred to the approach adopted by the Court in, for example, *D'Aleo v Ambulance Service of New South Wales* (NSWCA, 12 December 1996, unrep) (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, more recently, by Schmidt J in *Cole*. His Honour said:

> "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."

38. In *Pereira v Siemens Ltd* [2015] NSWSC 1133, Garling J said:

> "81. The assessment required by s 323 is one which must be based on fact, not assumptions or hypotheses: *Elcheikh v Diamond Formwork (NSW) Pty Ltd (In Liq)* [2013] NSWSC 365 at [89]; *Matthew Hall Pty Ltd v Smart* [2000] NSWSC 284 at [33]*; Ryder v Sundance Bakehouse* [2015] NSWSC 526 at [40].

82. The process encompassed by s 323 requires the application of each of the following steps before reaching the ultimate conclusion of the existence of a pre-existing injury which has an impact on the assessment of the injury the subject of the worker's claim.

83. The first step requires a finding of fact that the worker has suffered an injury at work which has resulted in a degree of permanent impairment which has been assessed pursuant to s 322 of the 1998 Act: see *Elcheikh* at [125].

84. The second step which needs to be addressed is, assuming such an injury has been sustained and impairment has resulted, what is the extent of that impairment expressed as a percentage of the whole person: see *Cole v Wenaline Pty Ltd* [2010] NSWSC 78 at [38]; *Elcheikh* at [126].

85. The third matter to be addressed is whether the worker had any previous injury, or any pre-existing condition or abnormality. The previous injury does not have to be one in respect of which compensation is payable under the 1998 Act. If the phrase 'pre-existing condition or abnormality' is to be relied upon, then such condition or abnormality must be a diagnosable or established clinical entity: *Fire & Rescue NSW v Clinen* [2013] NSWSC 629.

86. A finding of the existence of a previous injury can be made without the presence of symptoms, but there must be evidence which demonstrates the existence of that pre-existing condition: *Mathew Hall* at [31]-[32].

87. The pre-existing injury or condition must, on the available evidence, have caused or contributed to the assessed whole person impairment: see *Matthew Hall* at [32]; *Cole* at [29]-[31]; *Elcheikh* at [88] and *Ryder* at [42].

88. It cannot be assumed that the mere existence of a pre-existing injury means that it has contributed to the current whole person impairment: *Clinen* at [32]*; Cole* at [30]; *Elcheikh* at [91]. What must occur is that there must be an enquiry into whether there are other causes of the whole person impairment which reflect a difference in the degree of impairment: *Ryder* at [45].

89. Next in dealing with the application of s 323, the extent of the contribution, if any, of the pre-existing condition to the current impairment must be assessed in order to fix the deductible proportion. If the extent of the deductible proportion will be difficult or costly to determine, an assumption is made that the deductible proportion will be fixed at 10%, unless that is at odds with the available evidence: s 323(2) of the 1998 Act.

90. Each of these steps, and considerations, is a necessary element of a determination that an assessed whole person impairment is to be reduced by a deductible proportion by virtue of the application of s 323 of the 1998 Act."

39. The Appeal Panel accepts that s 323 of the 1998 Act requires that a deduction be made "for any proportion of the impairment that is due to any previous injury or that is due to any pre-existing condition or abnormality." The assessor must point to the actual consequences of the pre-existing condition or abnormality on the assessed impairment, and how it contributes to that assessment.

40. The Appeal Panel reviewed the evidence in this matter.

41. The AMS reported that Ms Johnston had a back injury on 7 June 2006 when working as a nurse. He commented on various investigations predating this injury including an x-ray and CT of the lumbar spine dated 14 December 2004, a MRI of the lumbar spine dated 2 August 2006, a MRI of the lumbar spine dated 28 June 2007 and a report dated 13 November 2007.

42. In his summary, the AMS noted that all imaging prior to the date of injury of 28 August 2011 showed a minor disc bulges at L4/5 and L5/S1 with minor displacement of the left L3 and L4 nerve roots with no involvement of L5 or S1. He applied a deduction of one tenth to his assessment of 16% WPI.

43. Dr Bodel, in a report dated 14 February 2017, noted that Ms Johnston had a previous injury to the back in the year 2006. He noted that he had not viewed any CT scans done at that time, prior to the injury in 2011. Dr Bodel commented it was likely that there was some pre-existing degenerative change or possibly a disc injury caused by the original injury but further structural damage has occurred in the incident in 2011 which has led to the need for the surgery. In the second report dated 14 February 2017 containing an assessment of WPI, Dr Bodel was of the opinion that although Ms Johnston had the previous injury in 2006, it appeared that she "had resolved from that from a clinical point of view" and had then returned to work. He considered that additional structural damage has occurred in 2011 and there was therefore no basis for a deduction for pre-existing impairment.

44. In a supplementary report dated 22 May 2018, Dr Bodel noted he had reviewed further material including the report of a CT scan of the lumbosacral spine, dated 14 December 2014, which shows that there is a "small central disc protrusion at the L5/S1 level". This was done at the time that she was working as an assistant in nursing and there was an injury in that workplace. (It appears that Dr Bodel was referring to the CT scan dated 14 December 2004). He noted that with conservative treatment including rest, analgesic medication, physiotherapy and some assistance from a psychologist she made a reasonable recovery and then began work with Country Services Pty Limited and was relatively asymptomatic at that time until the injury which began as a gradual process in the year 2009.

45. Dr Bodel noted that the MRI scans of the lumbar spine in 2006 and again in 2007 showed a reported small disc protrusion at the LS/S1 level with an annular tear and then in the later film mild multilevel degenerative changes but "no significant canal or foraminal compromise identified". Dr Bodel considered that both the CT scan and the two MRI scans show evidence of some multilevel degenerative disc disease. He expressed the view that Ms Johnston had further internal disruption of the degenerate discs particularly at the lumbosacral junction and that additional structural injury led to the need for the surgery as a treatment option.

46. Dr Bodel was asked: "If Ms Johnson had never received her injury in 2006, do you believe it is likely she would still be experiencing the same level of impairment as you found in your original report?" and noted that this was a difficult question. He expressed the view that If the previous injury had never occurred she probably would have had radiological evidence and MRI scan evidence of some pre-existing degenerative change. He considered that the injury in 2006 may have caused additional structural damage in an already existing degenerative disc or it may have caused a disruption of a normal disc. Dr Bodel assumed therefore that Ms Johnston had some degenerative change but it was asymptomatic in 2006 but she was still vulnerable to injury of the type that occurred at the second workplace, and that led to the additional structural damage in the lumbar spine which led to the need for surgery. He wrote: "It is probable therefore that she would have been at a similar level of disability associated with the injury at this time."

47. Dr Bodel considered that the pre-existing degenerative change was an interesting observation but clinically was not the specific cause of the "impairment associated with injury" and it did not necessarily specifically contribute to the fact that Ms Johnston had a disc rupture for which she had the decompressive surgery. He wrote:

> "It may be a contributing factor.
>
> In this circumstance therefore, at the very most one could make a case for a one-tenth deduction for pre-existing impairment because it is too difficult to determine whether that pre-existing degenerative change is a contributing factor or not but I am inclined to accept that this lady really was asymptomatic at the time of her injury at the new place of employment and that the factors that began at that time are the cause of the disc disruption or the disturbance of the previous degenerative condition in the lumbar spine, which led to the need for the decompression and there is in fact no basis for a deduction for pre-existing impairment."

Dr Bodel, in a report dated 14 June 2018, noted that Ms Johnston had gained work at Country Services Pty Ltd and was doing cleaning work in offices and factories. He wrote: "She had done this for two years without any particular difficulty until the injury that occurred at work in August 2011." Dr Bodel, in those circumstances, saw no indication of pre-existing abnormality or condition based on the history given that she was well and had recovered from the first injury at the time of her work injury in 2011.

48. Dr Chris Harrington, in a report dated 18 August 2017, noted that after the injury in 2006, Ms Johnston developed back pain but did not have any leg pain. He reported that she had investigations and conservative treatment including physiotherapy and analgesics. He noted that Ms Johnston had a year or two off work and tried to get back to work as an AIN but the compensation claim and back pain made this difficult. Dr Harrington noted that Ms Johnston ended up getting a job with a contract cleaning company. Dr Harrington made a deduction of one half for a pre-existing condition in 2006 which had required investigations, treatment and resulted in a settlement for WPI.

49. In a MAC dated 18 December 2007, A/Professor Higgs, AMS, noted that Ms Johnston sustained an injury on 7 June 2006. He refererd to an number of investigations, namely, MRI of the lumbo-sacral spine dated 13 November 2007, MRI of the lumbo-sacral spine dated dated 28 June 2007, CT scan lumbo-sacral spine dated dated 14 December 2004 and a CT lumbo-sacral injection procedure report dated 25 September 2006. He noted that Ms Johnston had undergone two epidural spinal injection proceedures, one on 25 September 2006 and one on 14 December 2006. A/Professor Higgs noted that Ms Johnston continued to suffer from low back pain.

50. A/Professor Higgs also refererd to Ms Johnston having previously suffered from low back pain and from left-sided sciatic distribution pain in 2004. He noted that the symptoms persisted for approximately two months. He noted that the CT scan dated 14 December 2004 demonstrated the presence of a lumbo-sacral (L5/S1) intervertebral disc protrusion.

51. A/Professor Higgs formed the view that Ms Johnston suffered from multilevel age. Caused degenerative intervertebral disc pathology and from age caused degenerative lumbar spondylosis and facet joint osteoarthritis. He noted that the intervertebral disc pathology had been associated with intervertebral disc bulging at many levels and with a posterior protrusion of the lumbo-sacral intervertebral disc. A/Professor Higgs concluded that the lumbo-sacral intervertebral disc pathology had suffered from permanent aggravation in the injury incident on 6 July 2006. He expressed the view that there was evidence of pre-existing, and co-existing, age caused degenerative lumbo-sacral spinal pathology that was partly contributory to the present condition. A/Professor Higgs made a deduction of one-fifth on the basis that could be associated, in a causal sense, with the suffering of pre-existing, and co-existing, age caused degenerative lower lumbar and lumbo-sacral spinal pathology.

52. Dr G Fitzgerald, in a report of a CT scan of the lumbo-sacral spine and x-ray of the lumbar spine dated 14 December 2004, noted that the CT scan revealed a small central disc protrusion at the L5/S1 level. The x-ray reported a minimal scoliosis to the right, and small osteophytes present on the bodies of L4 and L5.

53. Dr S Khoury, in a report of a MRI examination of the lumbar spine dated 2 August 2006, concluded that there was a small central disc protrusion with annular tear at L5-S1. At L3-L4 there was evidence of broad-based central and left paracentral disc bulge resulting in mild left foraminal narrowing, but without evidence of compression of the exiting left L3 nerve root. At L4-L5 there was evidence of mild posterior disc bulge and facet hypertrophy but no neural compromise.

54. Dr M Lannan, in a report of a MRI of the lumbar spine dated 28 June 2007, confirmed the presence of the lumbo-sacral intervertebral disc protrusion and also the presence of L4/5 intervertebral disc bulging that was associated with very minor displacement of the L4 nerve root. He commented that there was disc degenerative changes at the lower three levels.

55. Dr S Khoury, in a report of a MRI examination of the lumbar spine dated 13 November 2007, concluded that Ms Johnston had mild multilevel degenerative change but no significant canal or foraminal compromise was identified. He noted that at L3-L4, there was mild posterior disc bulge and facet hypertrophy but no neural compromise. At L4-L5, he reported broad based posterior disc bulge and facet osteoarthritis but no neural compromise. At L5-S1, he reported a minor right paracentral disc protrusion and no neural compromise.

56. Dr Hunt, in a report of a MRI of the lumbar spine dated 19 October 2011, concluded that there was a broad posterior disc bulge with disc osteophyte in the left lateral recess and neural exit foramen compromising the left LS and S1 nerve roots. She noted that there was mild hypertrophy of zygapophyseal joints at L3/4 and L4/5 levels and partial disc desiccation at L3/4, L4/5 and L5/S1 with reduction in disc height at L5/S1.

57. In her statement dated 6 December 2017, Ms Johnston said that she had a prior back injury on 7 June 2006 when she was working as a nurse. She wrote: “This injury later resolved and I was able to return to work”. She said that she started work with the respondent in 2009. It appears that she did not return to her work as a nurse or to any other employment before she started work with the respondent in 2009 or whether her employment with the respondent was her first employment following the injury in 2006.

58. Ms Johnston wrote:

> “Soon after commencing employment with insured, I began to experience a gradual onset of pain in my lower back. The discomfort I was feeling seemed to be triggered by the activities and movements I performed at work as I had been completely fine before I started working at Country Classic Services.”

59. The Appeal Panel was satisfied that the radiological investigations taken prior to Ms Johnston commencing work with the respondent are evidence of pre-existing degenerative changes. The radiological investigations showed that there was a small central disc protrusion with annular tear at L5-S1, broad-based central and left paracentral disc bulge resulting in mild left foraminal narrowing at L3-L4 and at L4-L5 a mild posterior disc bulge and facet hypertrophy. Ms Johnston was off work for at least one to two years after her injury in 2006. In the MAC dated 18 December 2007, A/Professor Higgs, AMS, noted that Ms Johnston continued to suffer from low back pain.

60. The Appeal Panel was satisfied that Ms Johnston had a previous injury in 2006 and a pre-existing condition, namely, degenerative disc disease. The radiological investigations in 2004, 2006 and 2007 were evidence which demonstrated the existence of that pre-existing condition. The radiological investigations in 2006 and 2007 demonstrated that the injury in 2006 caused additional structural damage in an already existing degenerative disc or a disruption of a normal disc.

61. The Appeal Panel is satisfied on the available evidence that the 2006 injury and pre-exiting condition caused or contributed to the assessed WPI. Ms Johnston had radiological investigations after the injury in 2011 that demonstrated disc protrusions at L4/5 and L5/S1 compressed the L5 and S1 nerve roots which led to two decompression operations. However, all of the imaging prior to the injury on 28 August 2011 showed minor disc bulges at L4/5 and L5/S1 with minor displacement of the left L3 and L4 nerve roots with no involvement of L5 or S1.

62. Ms Johnston was off work for at least one to two years after her injury in 2006. She was treated with physiotherapy, analgesics and two injections. She commenced work with the respondent in 2009 and has said that soon after commencing employment she began to experience a gradual onset of pain in her lower back. Dr Bodel, in his report dated 22 May 2018, noted that Ms Johnston made a reasonable recovery from the 2006 injury and then began work with the respondent and "was relatively asymptomatic at that time until the injury which began as a gradual process in the year 2009". The Appeal Panel noted that this history was inconsistent with the history recorded in Dr Bodel's report dated 14 June 2018 in which he noted that Ms Johnston had done her work with the respondent for two years without any particular difficulty until the injury that occurred at work in August 2011.

63. The Appeal Panel noted the AMS reported that Ms Johnston described no specific injury related to the date of injury but a culmination of working conditions causing lower back injury and pain. She first noticed her low back pain after she started working with a vacuum cleaner that was strapped to her back. The Appeal Panel was satisfied that Ms Johnston began to experience a gradual onset of pain in her lower back soon after she commenced employment with the respondent and did not accept that Ms Johnston had performed her work with the respondent for two years without any particular difficulty.

64. The Appeal Panel was satisfied that the injury in 2006 and pre-existing degenerative disc disease were causes of some of the WPI assessed and reflected a difference in the degree of impairment. The Appeal Panel agreed with the respondent that the appellant's permanent impairment would not have been as great without the pre-existing degenerative changes seen on radiological investigations. The Panel agreed with the AMS that the extent of the deductible proportion would be difficult to determine and made an assumption that the deductible proportion be fixed at one tenth. The Panel did not, on balance, consider that a one tenth deduction was at odds with the evidence.

65. In conclusion, the Appeal Panel considered that the AMS made a demonstrable error but the assessment of impairment by the Panel was the same as that made by the AMS.

66. In those circumstances the Appeal Panel will confirm the MAC as the review has not led to a different result and should not be interfered with (*Robinson v Riley* (1971) 1 NSWLR 403).

67. For these reasons, the Appeal Panel has determined that the MAC issued on 9 July 2019 should be confirmed.

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

J Burdekin

Jenni Burdekin
Dispute Services Officer
As delegate of the Registrar