WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-2143/19**
Appellant:	**John Madrigal Juarez**
Respondent:	**Optus Administration Pty Ltd**
Date of Decision:	**22 November 2019**
Citation:	**[2019] NSWWCCMA 171**

Appeal Panel:	
Senior Arbitrator:	**Josephine Bamber**
Approved Medical Specialist:	**Dr Roger Pillemer**
Approved Medical Specialist:	**Dr Ross Mellick**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 25 June 2019, the appellant lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Ian Meakin, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 17 June 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. The appellant was an Accounts Officer employed by the respondent when on 23 April 2003 while sitting at his desk holding his phone to his ear with his right hand when he reached down to pick up some heavy documents off the floor with his left hand. He says he developed acute neck pain at that time. He also sustained a lumbar injury. At the time, the appellant was aged 54 and he is now 70 years of age. He has not returned to work since the time of the injury.

7. Prior to the injury he had no history of pain or disorder in his cervical or lumbar spines.

PRELIMINARY REVIEW

8. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the *Workers compensation medical dispute assessment guidelines.*

9. As a result of that preliminary review, the Appeal Panel identified that there was error in the MAC and found that it was necessary for the worker to undergo a further medical examination. This was conducted by a member of the Panel who is an AMS Dr Pillemer on 9 September 2019.

10. The reasons for the finding of error are set out below.

EVIDENCE

Documentary evidence

11. 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. It also has the report of the Panel member, AMS Dr Pillemer.

Medical Assessment Certificate

12. The AMS was asked to assess permanent impairment of the cervical and lumbar spines as a result of injury on 23 April 2003. AMS Dr Meakin did this and placed the appellant in DRE Category II for both the cervical and lumbar regions, and the AMS added an additional 2% for Activities of Daily Living (ADL) in relation to the cervical spine. Therefore, the assessment of the cervical spine was 7% whole person impairment (WPI) and the assessment of the lumbar spine was 5% WPI, making a combined total of 12% WPI.

13. 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

14. Both parties made written submissions. The appeal is confined to the AMS's assessment of the cervical spine.

15. The appellant submitted that AMS Dr Meakin has erred in finding that there was not radiculopathy as defined. It was argued that:

> "Dr Meakin has referred to numbness in the middle and ring fingers. These fingers are serviced by the median nerve. The median nerve is affected by nerves coming from several levels of the cervical spine, including C5/6 & C6/7. The MRI scan of 26.06.2018 reported:
>
> > 'Multilevel degenerative change in the spine most marked at C5/6, particularly on the right and the left side of C6/7 and C3/4. There is severe foraminal stenosis and moderate to severe stenosis at the C5/6 level. There is left sided moderate stenosis at C6/7.'"

16. It was further submitted that in the circumstances, three of the criteria referred to in Table 4.29 were present, being:

    - loss or asymmetry of reflexes
    - reproducible impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution

- findings on an imaging study consistent with the clinical signs

17. Therefore, the appellant submitted that radiculopathy as defined was present, so Dr Meakin should have made a finding of DRE III in respect of the cervical spine.

18. In reply, the respondent submits that the appeal ought to be dismissed and the AMS's combined assessment for the cervical and lumbar spines of 12% WPI ought to be confirmed.

19. The respondent submits the appellant's submissions fail to identify valid and credible appealable grounds.

20. The respondent submits that the AMS provided his reasons for not finding any of the paragraph 4.27 criteria for radiculopathy:

    "Cervical Spine:

    At the time of today's assessment with reference to the cervical spine, there is an asymmetrical active loss of range of motion of the cervical spine with no palpable evidence of paravertebral muscle spasm or guarding and no clinical symptoms or signs in the right or left upper extremity that would satisfy the definition of radiculopathy as set out in Item 4.27 of the guides. There is no loss or asymmetry of reflexes or evidence of muscle weakness or wasting that can be localised to an appropriate spinal nerve root distribution or not explained by the applicant's right handedness.

    There is a sensory loss on the volar aspect of the left middle and ring finger suggestive of possible nerve root irritation at the C7/C8 nerve root. These symptoms however are not supported by either of the two imaging studies at the time of today's assessment and in my opinion the definition of radiculopathy as set out in Item 4.27 is not met." (respondent's emphasis)

21. The respondent submits having regard to the above passage, the appeal is without merit. It also submits that the appellant has identified no error nor application of incorrect criteria in the AMS's finding that there was no cervical radiculopathy on assessment.

22. The Panel finds that the AMS has made a demonstrable error when assessing the impairment of the cervical spine, but as stated above, the Panel is of the view that a re-examination is required.

23. The parties' submissions are considered further below.

FINDINGS AND REASONS

24. 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.

25. 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.

26. The AMS in his MAC set out the history of the injury on 23 April 2003 and the treatment undertaken by the appellant thereafter. The AMS noted that a previous assessment of permanent impairment for this injury was performed by AMS Dr Stephenson on 13 August 2004, who found DRE II in relation to the cervical spine with 5% WPI and DRE I for the lumbar and thoracic spines. This was in matter 3602/04. The AMS also noted there was a Medical Appeal involving Dr Stephenson's assessment and the Reasons of that Appeal Panel were issued on 17 March 2005 confirming Dr Stephenson assessment.

27. The AMS also notes that by way of a complying agreement dated 17 January 2011 the parties agreed the appellant suffered 12% WPI, with credit given for the prior 5% WPI. This agreement states it was based on the assessment of Dr Bodel dated 7 June 2010. Dr Bodel's assessment comprised of 7% WPI for the cervical spine and 5%WPI for the lumbar spine.

28. At that time, Dr Bodel found in relation to the cervical spine asymmetry of movement and guarding but no clinical sign of radiculopathy.

29. The appellant, in his statement for the current proceedings in relation to his cervical spine, states that he suffers pain, tenderness and restriction of movement in his neck and that the pain in his neck radiates down the neck and over the top of his left shoulder. He also states that prolonged sitting, bending or lifting aggravates the pain in his neck as does head down posture.

30. The appellant was examined by Associate Professor Michael Ryan, who provided a medico-legal report for his solicitors dated 14 November 2018. On physical examination A/Prof Ryan found that Mr Juarez had reduced cervical spinal motion, with asymmetry of movement. He also found the appellant had numbness in his left hand, in the middle finger and to a limited extent in his left ring finger, and that his left triceps reflex was absent. A/Prof Ryan concluded that motor examination was unreliable because of Mr Juarez's inability to cooperate. Nonetheless, he concluded that the signs recorded above indicated Left C7 Nerve root compression.

31. A/Prof Ryan assessed the appellant as being in DRE Category III, with 15% WPI and 3% ADLs. The doctor described the appellant's ADLs as now being severely limited. He noted these assessments total 18% WPI. A/Prof Ryan explained that the injury in 2003 involved the appellant having to suddenly rotate his neck resulting in what was probably a disc protrusion and what is now clearly compression of the left C7 nerve root.

32. The appellant was examined by Dr Powell for the respondent and in his report dated 8 February 2019 he notes

> "Mr Juarez reports an intermittent sharp burning pain in the midline region of the neck which radiates across to the left side. Symptoms occur on a daily basis. Pain radiates down the left arm to the elbow. It is accompanied by pins and needles affecting the tips of the long and ring fingers of the left hand on an intermittent basis. He is aware of neck stiffness and restriction in range of motion and headaches."

33. Dr Powell stated his diagnosis was that the appellant had a musculoligamentous injury and aggravation of some underlying changes of cervical spondylosis and his examination by Dr Powell was characterised by diffuse tenderness, restriction in range of motion and non-verifiable radicular symptoms. He added:

> "I believe the ongoing symptoms involving the cervical spine and associated functional restrictions are reasonable and directly related to the injury sustained in the course of his employment in 2003 This incident resulted in aggravation of pre-existing degenerative pathology within the cervical spine which is permanent."

34. Dr Powell assessed the appellant as DRE II with 7% WPI and deducted one-tenth for the presence of pre-existing pathology.

35. AMS Dr Meakin conducted his examination of the appellant on 11 June 2019. He found the following:

> "On examination of the cervical spine there is an asymmetrical loss of range of motion of the cervical spine due to discomfort with no palpable evidence of paravertebral muscle spasm or guarding. Forward flexion and extension is to normal expected range of motion but rotation and lateral flexion of the right and left is to two thirds of normal expected range. He has symmetrically equal right and left power grip. All deep tendon reflexes of the right and left upper extremities are symmetrically present but reduced and there were no abnormalities of tone. The most significant discomfort is low in the midline of the cervical spine.
>
> At the time of today's assessment, there was a partial decrease of sensory appreciation on the volar aspect of the tip/pulp of the left third and fourth fingers.
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> …
>
> There is also a full symmetrical range of motion referencing the right and left elbow wrist and all hand movement. There is no wasting of hand musculature."

36. The AMS set out the cervical scan findings as follows:

> **"MRI Scan Cervical Spine** – 12 July 2003 – Specialist Medical Imaging – Dr David Ho. The C5, C6 discs show early degenerative change with a small focal disc protrusion at each level.
>
> **MRI Scan Cervical Spine** – 26 June 2018 - Western Imaging Group – Dr Matthew Lee. Multilevel degenerative change in the spine most marked at C5/6, particularly on the right, and the left side of C6/7 and C3/4. There is severe foraminal stenosis and moderate to severe stenosis at the C5/6 level. There is left sided moderate stenosis at C6/7. There is a central disc herniation which just contacts the cord but with no signal change or contour deformity at the C4/5 level and a broad-based disc osteophyte causing moderate foraminal stenosis, more marked on the right of the C3/4 level."

37. The AMS found under the heading summary of injuries and diagnosis that the appellant had continuing neck pain and a symptom of intermittent paraesthesia involving the pulp of the left index and middle finger.

38. The AMS's assessment and findings about radiculopathy were expressed as follows:

> "At the time of today's assessment with reference to the cervical spine, there is an asymmetrical active loss of range of motion of the cervical spine with no palpable evidence of paravertebral muscle spasm or guarding and no clinical symptoms or signs in the right or left upper extremity that would satisfy the definition of radiculopathy as set out in Item 4.27 of the guides. There is no loss or asymmetry of reflexes or evidence of muscle weakness or wasting that can be localised to an appropriate spinal nerve root distribution or not explained by the applicant's right handedness.
>
> There is a sensory loss on the volar aspect of the left middle and ring finger suggestive of possible nerve root irritation at the C7/C8 nerve root. These symptoms however are not supported by either of the two imaging studies at the time of today's assessment and in my opinion the definition of radiculopathy as set out in Item 4.27 is not met.

Therefore, with reference to Table 15.5, AMA 5, at the time of today's assessment the applicant demonstrates a DRE Cervical Spine Category II Impairment – **5-8% Whole** Person Impairment.

With reference to Items 4.34 to 4.36 of the current workcover guidelines, I have added an extra **2% Whole Person Impairment** to the base impairment as Mr Juarez is unable to precede to work and cannot perform external gardening activities.

5 + 2 = **7% Whole Person Impairment"**

The Panel finds demonstrable error present in the MAC because the AMS found sensory loss, as noted above, but, in the Panel's view, the AMS does not adequately consider the changes on MRI. The AMS just states, without explanation, that the sensory loss symptoms that he found (on the volar aspect of the left middle and ring finger suggestive of possible nerve root irritation at the C7/C8 nerve root) are not supported by either of the two imaging studies. Yet, as submitted by the appellant, the MRI scan of 26 June 2018 did reveal severe changes, including to the C6/7 level. The Panel finds that such stenosis at C6/7 is in keeping with the clinical signs of sensory loss in the fingers, suggesting C7 nerve root involvement.

39. The Panel notes that the AMS recorded that A/Professor Ryan found that Mr Juarez's left triceps jerk was absent and that he found sensory changes, but the AMS does not specifically reject these findings, although this may be inferred.

40. Paragraph 4.27 of the *Guidelines* 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 (AMA5 Box 15-1, p 382)
- muscle wasting- atrophy (AMA5 Box 15-1, p 382)
- findings on an imaging study consistent with the clinical signs (AMA5, p 382)." (bold in the original)

41. The Panel considers the presence of demonstrable error on the part of the AMS means he has not correctly applied the *Guidelines* referred to above. Findings on imaging study consistent with clinical signs and reproducible impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution are sufficient for there to be a finding of radiculopathy and therefore placing the appellant in DRE III, not DRE II.

42. The Panel considered in the preliminary review, that in light of a finding of demonstrable error, a re-examination by an AMS who is a member of the Panel was appropriate. That examination was conducted by AMS Dr Pillemer.

43. The contents of the report of AMS Dr Pillemer is set out below:

"1. The workers medical history, where it differs from previous records

I read Mr Juarez the history that he gave to Dr I L Meakin on 11 June 2019, and he felt that this history is quite correct. As far as treatment is concerned, he did say that he also used Norspan patches.

He was continuing to complain of pain in the cervical spine, particularly on the left side, radiating down his left arm and into the tips of the middle and ring fingers of his left hand. He described these symptoms as being intermittent but when they occurred could be quite severe, going as high as 8-9/10. He says he has become *'used to it'*.

The rest of the history remained unchanged.

2. Additional history since the original Medical Assessment Certificate was performed

There was no additional history since the previous examination by the AMS.

3. Findings on clinical examination

Mr Juarez is an adult male in no obvious discomfort who undresses and dresses without any particular difficulty.

He does show moderate restriction of cervical spine movements, particularly in extension and lateral rotation to the left being more reduced than to the right with asymmetrical loss of range of motion.

As noted by the AMS, reflexes were all present and equal, and Mr Juarez was noted to have hypoaesthesia to pinprick of the tips of the middle and ring fingers of his left hand as well as down the anterior aspect of the left forearm and palm of his hand.

This sensory loss was in a typical C7 distribution. As noted, the AMS did find sensory loss in relation to the third and fourth fingers.

Motor power was satisfactory in all groups tested and reflexes were all present and equal.

Mr Juarez complained of discomfort to palpation in the mid/lower cervical region.

There was a full range of shoulder movements present. There was no evidence of guarding or spasm.

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

Mr Juarez has not had any further investigations carried out but it is worth noting that once again that the MRI of his cervical spine carried out on 26 June 2018 showed moderate stenosis on the left side at the C6/7 level."

44. The Panel agrees with the finding of Dr Pillemer that the sensory loss, described by him and referred to above, was in a typical C7 distribution. The Panel also notes that the radiologist when commenting on the MRI Scan Cervical Spine dated 26 June 2018 found left sided moderate stenosis at C6/7.

45. Therefore, the Panel finds in accordance with Chapter 4.27 of the *Guidelines* there are two criteria present, one being major and one being minor, and a diagnosis of radiculopathy should be made. These are:

    - The major criterion was *'reproducible impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution'* (that is C7); and
    - one minor criterion being findings on an imaging study consistent with the clinical signs (that is, the moderate left-sided stenosis at C6/7).

46. The Panel finds that the AMS's table is incorrect in that the appellant should be placed in DRE Category III of his cervical spine, with 15% WPI, as provided in the AMA Guides in Table 15-5 page 392 for significant radiculopathy. As noted, the AMS has suggested an additional 2% for ADLs which would give a total of 17% WPI in relation to the cervical spine.

47. The findings in regard to the lumbar spine of 5% for DRE Category II remain unchanged. The combined total WPI would therefore be 21%.

48. For these reasons given regarding the assessment of the cervical spine, the Appeal Panel has determined that the MAC issued on 17 June 2019 should be revoked, and a new MAC should be issued. The new certificate is attached to this statement of reasons.

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*.

H Mistry

Heena Mistry
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **2143/19**
Applicant: **John Madrigal Juarez**
Respondent: **Optus Administration Pty Ltd**

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 Meakin 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)**
Cervical spine	23/04/03	Chapter 4 Page 24-29	Chapter 15 Page 392 Table 15-5	17%	nil	17%
Lumbar spine	23/04/03	Chapter 4 Page 24-29	Chapter 15 Page 384 Table 15-3	5%	nil	5%
Total % WPI (the Combined Table values of all sub-totals)					**21%**	

The above assessment is made in accordance with the Guidelines for the Evaluation of Permanent Impairment for injuries received after 1 January 2002.

Josephine Bamber
Senior Arbitrator

Dr Roger Pillemer
Approved Medical Specialist

Dr Ross Mellick
Approved Medical Specialist

19 November 2019

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*.

H Mistry

Heena Mistry
Dispute Services Officer
As delegate of the Registrar