WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1- 4939/19**
Appellant:	**Paige Pritchard**
Respondent:	**Australian Personnel Global Pty Ltd**
Date of Decision:	**16 March 2020**
Citation:	**[2020] NSWWCCMA 54**

Appeal Panel:	
Arbitrator:	**Catherine McDonald**
Approved Medical Specialist:	**Dr Mark Burns**
Approved Medical Specialist:	**Dr Brian Noll**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 6 December 2019, Paige Pritchard lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Rob Kuru, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 20 November 2019.

2. Ms Pritchard 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 Pritchard was employed by Australian Personnel Global Pty Limited (APG), a labour hire company, to work at the Baiada poultry processing plant at Beresfield, NSW. She began working on 14 December 2016 and her main task was to pass four or five frozen or unfrozen chickens into a high sided chute. She performed a number of other repetitive and fast paced tasks.

7. Ms Pritchard said that she developed pain in her hands and wrists soon after she commenced employment. She consulted a medical centre on 24 December 2016 and her usual general practitioner on 28 December, who diagnosed carpal tunnel syndrome. She was referred for further treatment but was unable to afford it. She continued to work until about October 2017.

8. The AMS was asked to assess Ms Pritchard's right and left upper extremities (hand and wrist). He assessed 0% whole person impairment (WPI).

PRELIMINARY REVIEW

9. 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.

10. As a result of that preliminary review, the Appeal Panel determined that the worker should undergo a further medical examination because the AMS had not set out the results of tests which would ordinarily be performed to diagnose carpal tunnel syndrome.

11. Dr Mark Burns of the Appeal Panel conducted an examination of the worker on 20 February 2020 and reported to the Appeal Panel.

EVIDENCE

12. 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.

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.

14. Dr Burns' report is attached to these reasons.

SUBMISSIONS

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

16. In summary, Ms Pritchard submitted that she should be re-examined. She said that the AMS had failed to make a diagnosis – either of carpal tunnel syndrome or any alternative diagnosis. She said that the MAC is incomplete because it does not disclose the path of reasoning adopted by the AMS.

17. Ms Pritchard also submitted that the AMS limited his focus to determining whether or not she had carpal tunnel syndrome and that he had failed to apply the Guidelines by limiting his consideration to that condition. She relied on part of clause 1.23 of the Guidelines which provides:

> "AMA5 (P11) states: 'Given the range, evolution and discovery of new medical conditions, these guidelines cannot provide an impairment rating for all impairments ... In situations where impairment ratings are not provided, these guidelines suggest that medical practitioners use clinical judgment, comparing measurable impairment resulting from the unlisted conditions and measurable impairment resulting in similar conditions with similar impairment of function performing activities of daily living."

18. In reply, APG submitted that paragraph 1.6 does not require the AMS to make a diagnosis. The AMS found inconsistencies on Ms Pritchard's presentation and deficiencies in the clinical and radiological assessments so that it was open to him to refrain from providing a diagnosis.

19. APG noted that clause 2.2 of the Guidelines provides:

> "Evaluation of anatomical impairment forms the basis for upper extremity impairment (UEI) assessment. The rating reflects the degree of impairment and its impact on the ability of the person to perform ADL. There can be clinical conditions where evaluation of impairment may be difficult. Such conditions are evaluated by their effect on function of the upper extremity, or, if all else fails, by analogy with other impairments that have similar effects on upper limb function."

20. APG submitted that assessment by analogy is to be adopted as a last resort. The AMS noted his findings and found limited anatomical deficiencies so that the assessment he made was open to him.

FINDINGS AND REASONS

21. 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.

22. 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.

The MAC

23. The AMS set out the history of the onset of Ms Pritchard's symptoms. He noted that her treatment involves using hand splints at night, which stops the contraction in her fingers. She takes Lyrica four times a day. He set out her present symptoms:

> "Ms Pritchard indicates she has ongoing numbness in her hands and loss of sensation. She reports this loss of sensation as being in the ulnar three digits of her hands. This is associated with a global throbbing in her arms. She says the pain has been relatively constant over time but she feels as though the numbness in the ulnar digits has progressively become worse. The symptoms are worse in the left rather than the right hand."

24. The AMS conducted a physical examination. He said:

> "On examination, Ms Pritchard was a well looking young woman in no obvious distress. I noted no deformity or scars in the upper limbs. There was no wasting of the forearm musculature, thenar or hypothenar eminence. There was no wasting of the first dorsal interosseus.
>
> There was non-specific tenderness around the wrists."

25. The AMS set out his observations of the active range of motion of Ms Pritchard's wrists and said that there was a normal range of active movement in her fingers. He said:

> "Light touch and pinprick testing was discernible in all dermatomal segments of both upper limbs, although Ms Pritchard reported subjectively left arm sensation was less intense than the right. Light touch was globally reduced in the hands but more notable in the ulnar versus median digits of both hands."

26. The AMS reviewed the nerve conduction study undertaken on 23 February 2017 which he said was

> "is consistent with severe median nerve entrapment of the carpal tunnel on both sides, more pronounced on the left than on the right."

27. When summarising the injuries and diagnoses, the AMS said:

> "Ms Pritchard has a standing diagnosis of bilateral carpal tunnel syndrome, although she presents with symptoms generally inconsistent with this. Her reported numbness is predominantly in the ulnar three digits of both hands, which is anatomically discordant with carpal tunnel syndrome. She reports pain in her wrists but does not appear to have had any other investigation of this."

28. The AMS assessed 0% WPI in respect of each of Ms Pritchard's upper extremities. He explained his findings:

> "Ms Pritchard presents with a history of pain in her wrists and numbness in her hands. Following initial assessment, she was sent for a nerve conduction study which demonstrated an underlying carpal tunnel syndrome. The difficulty is that the symptoms she reports now and those repeatedly documented in her notes are not consistent with a diagnosis of carpal tunnel syndrome.
>
> Dr Bodel, in his report dated 23 July 2018 notes that she is complaining of '*numbness and tingling in all five digits but principally in the thumb, index and middle finger*.' In his report dated 27 May 2019, however, he notes that Ms Pritchard presents with 'Pain, numbness and tingling in both hands which '*As I indicated, this mainly involves the middle, ring and little finger*.' He does note that 'It can also involve the thumb and index finger.'"

29. The AMS noted that Dr Alexander recorded on 28 December 2016 that she had altered sensation in her right middle and ring fingers and that a discharge summary from Maitland Hospital on 18 August 2018 referred to decreased sensation on her fourth and fifth fingers. The AMS said:

> "According to AMA 5 page 481, 16-5(b) impairment evaluation methods, paragraph 1 in impairment determination method states '*If sensory deficit or pain is present, localise the distribution and relate to the nerve structure involved*.' The distribution of symptoms reported by Ms Pritchard is not consistent with compression of the median nerve in carpal tunnel, then hence according to the Guidelines, is not assessable for impairment due to sensory impairment.
>
> This lady has not been properly assessed, clinically or radiologically. She has had a nerve conduction study which has returned a finding of compression of the median nerve in the carpal tunnel but is not presenting with symptoms characteristic of this."

30. The AMS explained why he disagreed with the assessments of sensory loss made by other examiners.

Re-examination

31. Dr Burns noted that the active range of movement in both Ms Pritchard's wrists was normal. He noted:

> "Active range of movement of both wrists was within the normal range.
>
> Neurological examination of the right hand revealed variable loss of sensation in in the forearm, wrist and hand. The most significant loss was in the distribution of the median nerve. Two-point discrimination was also variable in the right hand. There was reported

loss in all fingers and thumb of the right hand, but the exact distribution varied widely with repeated testing. Power testing revealed good grip strength in the right hand but the thenar eminence did appear slightly wasted. There was a negative Tinel's sign but a positive Phalen's test on the right side. The Phalen's test resulted in tingling in her middle and index fingers and to a lesser extent her thumb.

A negative Tinel's sign was also noted for the ulna nerve at the cubital tunnel and the posterior elbow.

Neurological examination of the left hand revealed variable sensation in the hand and the forearm. Repeated testing revealed marked inconsistency in distribution. Two-point discrimination was variable in all fingers and the thumb. It did not follow a peripheral nerve distribution. Power testing revealed good grip strength in the left hand but the thenar eminence did appear slightly wasted. There was a negative Tinel's sign and Phalen's test on the left side.

A negative Tinel's sign was also noted for the ulna nerve at the cubital tunnel and the posterior elbow."

Consideration

32. The referral to the AMS required him to assess Ms Pritchard's permanent impairment. It did not set out a diagnosis nor was that appropriate.

33. As Ms Pritchard's submissions point out, the Guideline provide in paragraph 1.6(b) that "[a]ssessors are required to exercise their clinical judgement in determining a diagnosis when assessing permanent impairment…"

34. A diagnosis is essential before an assessment. Paragraph 1.23 of the Guidelines does not give an AMS license to assess by reference to an analogous condition in the absence of a diagnosis, merely on the basis of complaint of pain or restriction of movement.

35. Ms Pritchard's submissions did not set out the whole paragraph and the remainder of it reads:

> "The assessor must stay within the body part/region when using analogy.
>
> 'The assessor's judgment, based upon experience, training, skill, thoroughness in clinical evaluation, and ability to apply the Guidelines criteria as intended, will enable an appropriate and reproducible assessment to be made of clinical impairment.'"

36. The diagnosis relied on in the medical reports prepared on behalf of Ms Pritchard is carpal tunnel syndrome. Diagnosis by analogy was not relevant.

37. Carpal tunnel syndrome is the compression of the median nerve in the carpal tunnel of the wrist. The median nerve controls sensation and movement in the thumb and first three fingers.

38. The error in the MAC was the failure to carry out – or report that he had carried out – the usual provocative tests for carpal tunnel syndrome.

39. Dr Burns' findings are consistent with a diagnosis of carpal tunnel syndrome in Ms Pritchard's right arm but not the left. In her right arm she had marked sensory decrease in the thumb, index and middle finger and a positive Phalen's test.

40. Ms Pritchard's nerve conduction studies undertaken on 23 February 2017 were "consistent with severe median nerve entrapment in the carpal tunnel on both sides, more pronounced on the left." That is indicative of carpal tunnel syndrome.

41. However, both the AMS and Dr Burns were required to make a "clinical assessment of the claimant as they present on the day of assessment" taking all relevant medical information into account.

42. The findings at Dr Burns' examination in respect of Ms Pritchard's left arm are not consistent with any particular diagnosis. While the nerve conduction study supports carpal tunnel syndrome in her left hand, the clinical signs do not.

43. AMA 5 deals with "The Impairment Rating of Entrapment/Compression Neuropathies" on page 493. It states:

> "Only individuals with an objectively verifiable diagnosis should qualify for a permanent impairment rating. The diagnosis is not made only on believable symptoms but, more important, on the presence of positive clinical findings and loss of function".

44. The paragraph goes on to state that there is no correlation between the severity of conduction delay on nerve conduction velocity testing and the severity of either symptoms, or more important, impairment rating.

45. The variable and inconsistent findings on examination of Ms Pritchard's left hand and wrist therefore do not permit a diagnosis of carpal tunnel syndrome, despite the nerve conduction studies. The examination findings were not consistent with any other diagnosis.

46. The carpal tunnel syndrome in Ms Pritchard's right hand is sensory, rather than motor, based on the nerve conduction studies. Using Table 16-10 of AMA 5, her sensation would be rated as Grade 4, resulting in 25% of the maximum loss. The unreliable two-point discrimination findings preclude a higher rating. From Table 16-15 of AMA 5, total loss of median nerve sensation below the mid-forearm is rated at 39%, 25% of 39% is 9.75% upper extremity impairment (UEI) rounded to 10% UEI. That converts to 6% WPI.

47. For these reasons, the Appeal Panel has determined that the MAC issued on 20 November 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*.

J Burdekin

Jenni Burdekin
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **4939/19**
Applicant: **Paige Pritchard**
Respondent: **Australian Personnel Global 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 Rob Kuru 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 the Guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA 5 Guides**	**% WPI**	**Proportion of permanent impairment due to pre-existing injury, abnormality or condition**	**Sub-total/s % WPI (after any deductions in column 6)**
1.Right upper extremity (hand & wrist)	28.12.16		Page 481, paragraph 16.5(b), Table 16-10, Table 16-15	6	0	6
2. Left upper extremity (hand & wrist)	28.12.16		Page 481, paragraph 16.5(b), Table 16-10, Table 16-15	0	0	0
Total % WPI (the Combined Table values of all sub-totals)					**6%**	

Catherine McDonald
Arbitrator

Dr Mark Burns
Approved Medical Specialist

Dr Brian Noll
Approved Medical Specialist

16 March 2020

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*.

J Burdekin

Jenni Burdekin
Dispute Services Officer
As delegate of the Registrar