WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-3914/20**
Appellant:	**Gregory John Nicholls**
Respondent:	**L.A.D. Investments Pty Ltd**
Date of Decision:	**20 January 2021**
Citation No:	**[2021] NSWWCCMA 13**

Appeal Panel:	
Arbitrator:	**Ms Deborah Moore**
Approved Medical Specialist:	**Dr Roger Pillemer**
Approved Medical Specialist:	**Dr Tommasino Mastroianni**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 20 October 2020, Gregory John Nicholls lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Tim Anderson, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 19 October 2020.

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).

PRELIMINARY REVIEW

6. 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.

7. As a result of that preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination because although one was requested, no specific reasons were given other than the appellant's statement that "given the deficiencies of the AMS's determination, the Appellant will need to be re-examined."

8. Although this is a complex matter, the respondent has conceded that that the MAC contains errors in the calculations undertaken by the AMS, and we consider that we have sufficient evidence before us to enable us to determine this appeal.

EVIDENCE

Documentary evidence

9. 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.

SUBMISSIONS

10. Both parties made written submissions. They have been carefully considered by the Appeal Panel.

11. Because of the complexity of the matter and the terms of the referral, it is appropriate to set out the appellant's submissions in full.

12. The appellant submits that the AMS erred in numerous respects as follows:

    "a. He has failed to include his assessment of 20% whole person impairment ("WPI") for the right knee in his final certificate for the right lower extremity.

    b. His deduction of 1/5 for the left upper extremity was factually and legally incorrect.

    c. He erroneously misinterpreted the previous 31 March 2015 award and the Consent Orders in the AMS referral as requiring him to apportion the left upper extremity impairment between the 15 November 2010 frank injury (which was an injury to the right upper extremity and not the left upper extremity) and the nature and conditions injury to the left upper extremity with a deemed date of 1 December 2011.

    d. He failed to properly consider and apply clauses 4.33 to 4.36 of the Guidelines.

    e. He failed to consider probative evidence as was contained in the appellant's final statement with respect to his reduced ability with personal care, in assessing the effects of his injuries on his activities of daily living.

    f. He failed to provide any or any adequate reasons for his assessment of the appellant's activities of daily living in relation to his assessment of the lumbar spine.

    g. He failed to consider or apply the requirements for assessing radiculopathy in clause 4.27 of the Guidelines.

    h. He failed to provide adequate reasons for determining there was no radiculopathy present in assessing the appellant's permanent impairment of the lumbar spine or cervical spine.

i. He failed to consider or correctly apply the Temski scale… in his assessment of the appellant's scarring from his various surgeries.

j. He failed to provide adequate reasons by reference to the Temski scale in rejecting the appellant's claim for scarring.

k. He applied a deduction for pre-existing conditions to the cervical spine, lumbar spine, left hip, right hip and both knees where there was no evidence of any such pre-existing condition prior to the commencement of the appellant's employment with the respondent in 1995, contrary to the principles in *Cullen v Woodbrae Holdings Pty Ltd* [2015] NSWSC 1416.

l. He failed to provide adequate reasons for the 1/10th s323 deduction in relation to the cervical spine, lumbar spine, both hips and right knee."

13. In reply, the respondent acknowledges that the MAC contains errors in the calculations undertaken by the AMS but submits that these errors are able to be corrected in accordance with section 329(1A) of the Act, and once done, the MAC should be confirmed.

FINDINGS AND REASONS

14. 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.

15. 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.

16. The respondent was referred to the AMS for assessment of whole person impairment (WPI) in respect of two different dates of injury.

17. The first was in respect of an injury on 15 November 2011 to the right upper extremity (shoulder) and scarring (Temski).

18. The second was in respect of the "combined effects" of injuries on, or rather between, 13 April 2011 to 1 December 2011 (deemed). The body parts referred were the cervical spine, the lumbar spine, the left upper extremity (shoulder), the right lower extremity (hip and knee), the left lower extremity (hip) and scarring.

19. The AMS obtained the following history:

> "**First Event**. Mr Nicholls hurt his right shoulder while lifting a calf in November 2010. While discussing this with Mr Nicholls, he also advised that around this time he had hurt his shoulder while tagging bulls. During these activities, Mr Nicholls injured his right shoulder. He came under the care of Dr Alex Jovanovic. Surgical treatment for the right shoulder did not occur until June 2015.
>
> Three years later in November 2018, a further surgical procedure was conducted at the right acromio-clavicular joint where the outer extremity of the clavicle was excised. These procedures tended to be helpful.

Second Event. This was predominantly the component of the MAC which I had produced on 19/12/17.

On 13/04/11 Mr Nicholls had a crash on a quad bike which partially capsized. In this event he had injured his right knee and his left shoulder. He was in a remote area at the time and with great difficulty managed to right the quad bike and got on it and made his way back to the farm buildings. His major treatment at that time was a partial medial meniscectomy under the care of Specialist Orthopaedic Surgeon, Dr Ray Randall. Since then, the right knee has deteriorated quite rapidly. It got to a stage where his only reasonable option was a total knee joint replacement despite his relatively young age… in February 2014 under the care of Dr Alex Jovanovic…Both of his shoulders continued to cause problems.

As already advised, an arthroscopic procedure was carried out on the right shoulder in June 2015. Three months later, a similar procedure was conducted on the left shoulder, again by Dr Alex Jovanovic.

Earlier, Mr Nicholls had tried to continue working as the farm manager but ultimately was terminated from this position in 2011. He still had his own farm and did his best to run this with a lot of assistance from his wife.

He had experienced pain in his lower back for many years and as time went on this deteriorated further. He came under the care of Specialist Neurosurgeon, Dr Neil Cleaver on the Gold Coast. The low back condition was ultimately managed by a fusion at L5/S1 in November 2016. This was conducted with initially an anterior and at the same occasion, a posterior approach. He achieved quite a reasonable result from this.

Running fairly rapidly after the back condition was dysfunction of both hips. These evolved to a stage where the only effective clinical management considered at that time were hip joint replacements. Again, these were conducted by Dr Alex Jovanovic with a hip joint replacement on the left in March 2017 and the right in July 2017. Unfortunately, the procedure on the right side was considerably less successful than on the left. There was a significant tendency for this prosthesis to either dislocate or feel as though it was going to dislocate, particularly if he was standing and flexing.

After further review, a further procedure was conducted in February 2018 by Dr Alex Jovanovic. An attempt was made at minimal invasion to try to stabilise the hip joint more effectively. Ultimately this necessitated a surgical approach and a modification to the acetabular component. This stabilised the hip joint much more effectively, although at the expense of increasing the leg length by about 7mm. Whilst this gave him improvement, the right hip never was as good as the left. There was also an alteration of patella tracking of the right knee which had not been identified before. This was addressed extensively, both by Dr Jovanovic and later by Specialist Hip and Knee Surgeon, Dr Craig Waller. Ultimately it was considered that the best plan was to concentrate on Mr Nicholls' self-managed exercising.

As already advised, as 2018 progressed towards November of that year, the condition of the right shoulder was again reviewed and the major issue at that stage was the right acromio-clavicular joint. This was managed in November 2018 by an arthroplasty with excision of the distal part of the clavicle.

Mr Nicholls' overall condition continued to deteriorate, and it was identified that there was significant dysfunction in the cervical spine. He came under the care of Dr Neil Cleaver again and in February 2019, a fusion with an anterior approach was carried out at C3/4. Again, this seemed to give him some improvement."

20. When asked to provide details of any previous or subsequent accidents, injuries or conditions, the AMS said:

> "In 1978 he fell off a horse and hurt his left hip. Nevertheless, the condition fully resolved, and he was able to get back to his horsemanship, all of the very arduous work around the property, and also played rugby.
>
> In 1981, he hurt his right knee. This resulted in an effusion. This was drained and again, he achieved a complete recovery, also being able to return to his very physically arduous working and sporting life.
>
> In 1986 while playing rugby, he hurt his right shoulder. This was managed conservatively. He achieved a very good result and was able to return to rugby for several further years.
>
> There does appear to have been an earlier anterior cruciate ligament repair since residual screws from this have been demonstrated on subsequent x-rays."

21. As regards the appellant's social activities and activities of daily living (ADL's) the AMS said:

> "Mr Nicholls is married. His wife apparently has her own constellation of clinical issues, although these appear to be under control, and she is managing surprisingly well. The couple live together on their farm of 121 acres, which they are now trying to sell. They do not have any further plans at this stage.
>
> They have a dog at home. Mr Nicholls, despite the extent of his clinical issues, still wants to ride horses but realises that this is most unlikely to occur. He is able to drive and can manage surprisingly well, up to 2 ½ hours.
>
> He is able to cut the grass, do some pruning and trim the hedges, although these activities are done with difficulty."

22. The AMS then set out in considerable detail his findings on physical examination and the radiological and other investigation he had before him.

23. In summarising the injuries and diagnoses, the AMS said:

> "Mr Nicholls has experienced frequent and on occasions, quite severe trauma throughout his working life in farming. The vast amount of this was conducted at the LAD Investments Group where he was the farm manager for about 16 years. The work was extremely arduous and involved all components of cattle care and associated features such as drenching, branding, tagging, feeding, fencing, drainage, irrigation and property maintenance.
>
> Over the years Mr Nicholls has had surgery to the following components:
>
> a. Cervical spine
>
> b. Both shoulders
>
> c. Lumbar spine
>
> d. Both hips (twice on the right)
>
> e. Right knee joint replacement.
>
> He worked for about 16 years on this property and his position was terminated in 2011. There have been other less physically arduous jobs, although he continues to try to cautiously run at least some of the activities on his own modest farm of over 120 acres.

> On both occasions that I have seen Mr Nicholls, he has presented most consistently. He comes across as an honest and decent man. He still yearns to get back on a horse but realises that this is realistically an impossibility."

24. When asked the question: "Is any proportion of loss of efficient use or impairment or whole person impairment, due to a previous injury, pre-existing condition or abnormality?" the AMS replied: "Yes", adding:

> "There is extensive radiological evidence of significant pre-existing conditions with his cervical spine, lumbar spine, shoulders, hips (and) right knee."

25. The AMS assessed 3% WPI in respect of the injury on 15 November 2010 and 61% WPI in respect of the injury "13/04/11 and 01/12/11."

26. The AMS then summarised the other medical opinions as follows:

> "Specialist Orthopaedic Surgeons, Dr Alan Hopcroft and Dr Robert Breit have both carried out extensive calculations of whole person impairment. With great respect to Dr Alan Hopcroft, I am at variance with some of his technique. For example, I can find no indication as to the addition of 3% for 'non-verifiable radiculopathy'. I am also at variance for the fairly large component of 2% for scarring and also for 1% for further scarring. In general, I agree with his selection of DRE Category IV for both the cervical spine and the lumbar spine. I also agree with the deductions.
>
> Dr Robert Breit's assessment runs along similar lines. Nevertheless, as with Dr Hopcroft's assessment of the hips, I was unable to establish a 'good' result of the hip joint replacements. My assessment for each was 'fair'".

27. As we said at the outset, this is a very complicated matter and it is certainly understandable that there are actually numerous errors that we have identified. Some are, as the respondent points out, merely errors in calculations, but we have also identified other errors which we will address in due course.

28. For ease of reference, we will deal with each body part in turn.

The Right Upper Extremity (Shoulder) resulting from the injury on 15 November 2010.

(a) The AMS carried out his assessment of impairment firstly on the basis of the restricted range of movement of the right shoulder which he indicates gives 7% upper extremity impairment. He then combines this with a further 10% for excision of the distal clavicle according to AMA 5, page 506, table 16-27. He suggests that this gives a combined total of 16% upper extremity impairment which converts to 10% WPI.

(b) We note however that the Guidelines (4th edition- 1 April 2016) indicate that this figure of 10% upper extremity for excision of the distal clavicle has now been changed from 10% to 5% upper extremity impairment. The AMS then should have had a combined figure of 7 and 5, giving 12% upper extremity impairment which in turn equates with 7% WPI. (In his table he has suggested 4% WPI in the third column from the left, whereas he actually should have put 10% according to his figures).

(c) The next issue in relation to the right upper extremity is that the AMS has elected to make a deduction of three-quarters of this amount as the Commission apparently has determined that *'…only one-quarter of this is due to the event in 2010'*. The AMS would seem to have based this on the comments of Arbitrator Gerald Egan of 31 March 2015, where he has indicated that only one-quarter of the right shoulder impairment was due to the event of 2010, with three-quarters due to the event of 2011.

(d) However, the referral and the COD only note the right shoulder as being injured on 15 November 2010 and do not indicate any impairment for the second date of injury. It seems to be more likely than not therefore that the AMS should not have made this deduction as indicated by Arbitrator Egan in 2015.

(e) The impairment then should be 7% WPI with no deduction.

The Cervical Spine

(a) Firstly, the AMS has correctly placed Mr Nicholls in DRE Category IV of his cervical spine, suggesting a range of impairment from 25% to 28% WPI. The AMS goes on to note that 25% is selected as appropriate as activities of daily living are attributed to the lumbar spine. In his final table however, he has entered 28% whereas the intention was clearly to have awarded 25%. This we see as a simple error on his part when completing the Table.

(b) Secondly, the appellant submits that the AMS applied a deduction for a pre-existing condition in the cervical spine where there was no evidence of any such pre-existing condition prior to the commencement of employment with the respondent.

(c) The AMS observed that the MRI in November 2017 showed "extensive foraminal narrowing bilaterally, worse on the right, at C3/4". On this basis, he elected to make a one-tenth deduction. This is consistent with the opinion of Dr Breit in his report of 23 December 2019. We note however that Dr Hopcroft did not make any deduction for pre-existing condition.

(d) In his statement, Mr Nicholls confirmed that when he started working for the respondent in 1995, he had no problems with his cervical spine. Accepting that statement and bearing in mind the observation by the AMS that the appellant "comes across as an honest and decent man" we cannot see any basis for making any deduction pursuant to s323.

(e) The final assessment then in respect of the cervical spine should be 25% WPI.

29. It is perhaps timely at this point, given the appeal issues raised with regard to s323, to note some important principles in respect of the proper application of s323.

30. The assessment required by s323 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].

31. In *Cole v Wenaline Pty Ltd* [2010] NSWSC 78 *(Cole*), Schmidt J said that: "The assessment must have regard to the evidence as to the actual consequences of the earlier injury, pre-existing condition or abnormality…"

32. Bearing these principles in mind, in our view, there is no compelling evidence that any deduction in respect of the cervical spine is warranted.

The Lumbar Spine

(a) The AMS in our view has correctly placed Mr Nicholls in DRE Category IV with 20% WPI and to this he had added an additional 2% for interference with activities of daily living, giving a total of 22% WPI. Once again, he has made a one-tenth deduction.

(b) We repeat our comments as regards the application of s323 in relation to the cervical spine.

(c) For the same reasons, we cannot see that any deduction in respect of the lumbar spine is warranted.

(d) This then would leave Mr Nicholls with 22% WPI in relation to his lumbar spine.

The Left Upper Extremity (Shoulder)

(a) The Consent Orders and the AMS referral provided that the AMS was to assess WPI in respect of the left upper extremity (shoulder) arising from the combined effects of the 13 April 2011 injury and the deemed 1 December 2011 nature and conditions injury.

(b) The AMS found a 7% WPI due to the restricted range of movement which equates with 4% WPI.

(c) He once again refers to the comments of Arbitrator Egan of 31 March 2015 indicating that four-fifths of the left shoulder is due to the event in 2011, and one-fifth due to 2010, and he therefore makes a one-fifth deduction, but leaves out the sub-total, which should have been 4%.

(d) Arbitrator Egan in fact found that:

> "The applicant suffered injury to his left shoulder on 13 April 2011 and as a result of the nature of his work duties by way of the cause or aggravation of a disease process on 1 December 2011. …… Liability for medical treatment in respect of the left shoulder is apportioned as to 20% to the injury on 13 April 2011 and 80% to the injury on 1 December 2011. "

(e) The appellant submits that the AMS' deduction of 1/5 for the left upper extremity was factually and legally incorrect, because he erroneously misinterpreted the previous 31 March 2015 award and the Consent Orders in the AMS referral as requiring him to apportion the left upper extremity impairment between the 15 November 2010 frank injury (which was an injury to the right upper extremity and not the left upper extremity) and the nature and conditions injury to the left upper extremity with a deemed date of 1 December 2011.

(f) We agree. In these circumstances, there is no basis for any deduction, such that the final total for the left upper extremity (shoulder) should be 4% WPI.

The Right Lower Extremity (Hip and Knee)

(a) The appellant submits that the AMS failed to include his assessment of 20% WPI for the right knee in his final certificate for the right lower extremity.

(b) This is correct. It is simply an error which we will correct.

(c) The AMS has indicated a fair result for each of the hip and knee replacements, both of which give 50% lower extremity impairment (20% WPI).

(d) Combining the 50% for each of the hip and knee replacements in terms of lower extremity impairment, we calculate one 75% lower extremity impairment, which in turn equates with 30% WPI.

(e) The appellant repeats his submissions as regards the impact of s323.

(f) In his statement, the appellant said that indicates he injured his right knee at home in June 2003, but was able to continue working, and then had an injury to his left knee while working for the Respondent, but he did not make a workers compensation claim. He saw an orthopaedic surgeon who carried out an anterior cruciate ligament reconstruction on his right knee in February 2004 but indicated that no operation for the left knee was indicated.

(g) Having regard to all of the evidence, we are of the view that at least a one-tenth deduction for the injury that occurred at home would be indicated for the knee replacement, which gives 45% lower extremity impairment, and combining this with the 50% for the hip, gives 73% lower extremity impairment which in turn equates with 29% WPI.

(h) It should be noted that this deduction cannot be reflected in our amended Table because it is only a deduction for the knee and not the hip, and we have indicated this with an asterisk in our Table, and the asterisk at the bottom indicates that this is a combination of the impairment for the hip and knee replacements with a one-tenth deduction for the total knee replacement having already been made.

The Left Lower Extremity (Hip)

(a) The AMS has suggested a fair result from the surgery and assessed 20% WPI. He again made a one-tenth deduction.

(b) The appellant again challenges this deduction.

(c) We note that the appellant was employed by the respondent since 1995, and for the reasons stated earlier, we cannot see any basis for making any s323 deduction.

Scarring

(a) The AMS assessed 0% WPI in respect of scarring. In relation to the shoulder scars, he noted that these have all healed in an uncomplicated manner. He also noted the *"*sabre*"* scar of the right shoulder consistent with the acromioplasty and excision of the distal end of the clavicle.

(b) The appellant submits that this assessment is an error, and that the AMS "failed to consider or correctly apply the Temski scale… in his assessment of the appellant's scarring from his various surgeries."

(c) With regard to the lower limbs, the AMS noted that the scarring in relation to the scars in the hip and knees all remain well-healed with no further complications. The AMS does not make any comment with regard to scarring in the cervical spine and lower abdomen.

(d) We note that Dr Breit reported that the scar over the right AC joint is "somewhat hypertrophic and the loss of contour relates to the underlying bone which has been removed…" He notes that in relation to the right knee there are scars "which are somewhat thickened from his previous cruciate reconstruction as well as a 20cm scar from the knee replacement which is also normal for that area."

(e) Dr Breit also noted that there is a vertical scar below the umbilicus from the anterior surgery to his lumbar spine "which has spread and with some loss of contour and discolouration". In relation to the hip replacement scars he noted that while these are hidden in his underwear, "the one on the right is somewhat spread and discoloured having been opened a second time". He added that the scar from the cervical surgery is well-healed.

(f) Dr Breit however did not suggest any figures for scarring, but it certainly seems to us that there should be additional impairment for the scarring.

(g) Dr Hopcroft in his report of 4 March 2020 has suggested 2% WPI for scarring according to the TEMSKI scale.

(h) Having regard to Dr Breit's descriptions, this seems to us to be an appropriate figure for scarring.

(i) In our view the AMS has simply not taken the time to examine all the scars with sufficient care, nor given sufficient thought to the extent of impairment given.

(j) Generally speaking, if scarring was the only issue raised on appeal, we consider that the appellant would need to be re-examined by one of the members of the Appeal Panel.

(k) In the present case however, as there are so many errors identified in the MAC, we are of the view that the assessment by Dr Hopcroft seems consistent with the observations of Dr Breit, and in those circumstances, we consider that an additional 2% WPI for scarring is appropriate for the reasons given.

33. Combining all these impairments for the second date of injury would then give a final total of 69% WPI.

Activities of Daily Living (ADL's)

34. We have dealt with the principle issues on appeal with respect to the various body parts the subject of assessment.

35. The appellant also submits that the AMS "failed to consider probative evidence as was contained in the appellant's final statement with respect to his reduced ability with personal care, in assessing the effects of his injuries on his activities of daily living [and] failed to provide any or any adequate reasons for his assessment of the appellant's activities of daily living in relation to his assessment of the lumbar spine."

36. The appellant adds that the AMS "did not specifically ask or take any history on the effects of the appellant's injuries on his personal care." In addition, "he makes no specific reference at all to the appellant's final statement of evidence dated 7 July 2020 which sets out in detail the effects…" on the appellant's ADL's.

37. In that statement the appellant set out in detail the restrictions he experiences as regards his day to day activities including difficulty sleeping due to pain, and difficulty with many household tasks including maintenance, and driving.

38. He also said:

> "I also struggle with personal care tasks such as:
>
> (a) Putting on socks and shoes, shirts, jumpers and coats.
>
> (b) Showering is more difficult with washing and drying my feet.
>
> (c) I have difficulty cutting my toenails on my feet."

39. The appellant said: "Had that evidence been considered the correct allowance for ADL's was 3%, as the appellant's self-care had also been affected by his injuries."

40. We note that the AMS reported that although the appellant was not able to get back to riding horses, he could drive for up to 2½ hours and was able to cut grass and do some pruning with difficulty.

41. In addition, it should be noted that any assessment of ADL's relates to the spine. In this case, due to his multiple injuries, the appellant's ADL's are also affected by the shoulders and lower limb injuries.

42. In these circumstances, the 2% WPI allocated by the AMS is not unreasonable. We cannot see any error in the AMS' assessment. In his clinical judgement 2% WPI was allocated for the spinal injury which seems to us an appropriate assessment of his restrictions.

43. The history given to the AMS does not in our view entitle Mr Nicholls to 3% WPI for ADLs.

44. It is perhaps timely at this point to set out the task of an Appeal panel as stated in *Ferguson v State of New South Wales* [2017] NSWSC 887 where Campbell J said:

> "[23] By reference to *NSW Police Force v Daniel Wark* [2012] NSWWCCMA 36: 'the pre-eminence of the clinical observations cannot be underrated. The judgment as to the significance or otherwise of the matters raised in the consultation is very much a matter for assessment by the clinician with the responsibility of conducting his/her enquiries with the applicant face to face'.
>
> [24] The Appeal Panel accepted that intervention was only justified: if the categorisation was glaringly improbable; if it could be demonstrated that the AMS was unaware of significant factual matters; if a clear misunderstanding could be demonstrated; or if an unsupportable reasoning process could be made out. I understood that all of these matters were regarded by the Appeal Panel as interpretations of the statutory grounds of applying incorrect criteria or demonstrable error. One takes from this that the Appeal Panel understood that *more than a mere difference of opinion on a subject about which reasonable minds may differ is required to establish error in the statutory sense*. (our emphasis)."

Radiculopathy

(a) The Appellant submits that the AMS has not considered the requirements for assessing radiculopathy.

(b) We note that the AMS said that he was "…not persuaded that these (signs) represent significant radiculopathy'".

(c) He differs very specifically from Dr Hopcroft who has in fact applied an incorrect use of the Guidelines to suggest that there was an additional 3% WPI "…for non-verifiable radiculopathy'".

(d) Non-verifiable radiculopathy is a concept that does not exist, and it is actually "non-verifiable radicular complaints'" which is a symptom and not a sign and does not fall under the heading of radiculopathy.

(e) In these circumstances we accept the AMS's opinion that there was no radiculopathy.

45. For these reasons, the Appeal Panel has determined that the MAC issued on 19 October 2020 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*.

R Gray
Robert Gray
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **3914/20**
Applicant: **Gregory John Nicholls**
Respondent: **L.A.D. Investments 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 Tim Anderson 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)**
Right upper extremity (shoulder)	15/11/10	Chapter 2 Pages 10-12	Chapter 16 Pages 433 to 521	7%	N/A	7%
Scarring	15/11/10	Chapter 14 Pages 73-74		0%	n/a	0%
Total % WPI (the Combined Table values of all sub-totals)						7%
Cervical spine	13/04/2011 and 1/12/2011 (deemed)	Chapter 4 Page 24-29	Chapter 15 Page 392 Table 15-5	25%	n/a	25%
Lumbar spine	13/04/2011 and 1/12/2011 (deemed)	Chapter 4 Page 24-29	Chapter 15 Page 384 Table 15-3	22%	n/a	22%
Left upper extremity (shoulder)	13/04/2011 and 1/12/2011 (deemed)	Chapter 2, pages 10-12	Chapter 16 Pages 433 to 521	4%	n/a	4%

Left lower extremity (hip)	13/04/2011 and 1/12/2011 (deemed)	Chapter 3 Pages 13-23	Chapter 17 Pages 523 to 564	20%	nil	20%
Right lower extremity (hip and knee)	13/04/2011 and 1/12/2011 (deemed)	Chapter 3 Pages 13-23	Chapter 17 Pages 523 to 564	29%	*	29%
Scarring TEMSKI	13/04/2011 and 1/12/2011 (deemed)	Chapter 14 Pages 73-74		2%	n/a	2%
Total % WPI (the Combined Table values of all sub-totals)						**69%**

* Please note that impairments for the hip and knee have been combined in terms of lower extremity impairment with a one-tenth deduction for the total knee replacement, giving a final total of 73% lower extremity impairment which equates with 29% WPI.

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

Deborah Moore
Arbitrator

Dr Roger Pillemer
Approved Medical Specialist

Dr Tommasino Mastroianni
Approved Medical Specialist

20 January 2021

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*.

R Gray

Robert Gray
Dispute Services Officer
As delegate of the Registrar