WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-1416/19**
Appellant:	**Thomas Raymond Norton**
Respondent:	**Anambah Constructions Pty Ltd**
Date of Decision:	**22 August 2019**
Citation:	**[2019] NSWWCCMA 121**

Appeal Panel:	
Arbitrator:	**John Wynyard**
Approved Medical Specialist:	**Dr Drew Dixon**
Approved Medical Specialist:	**Dr Brian Noll**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 20 May 2019, Thomas Raymond Norton (the appellant) 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 7 May 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 WorkCover Medical 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 WorkCover Medical 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 Guides) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th ed (AMA 5). "WPI" is reference to whole person impairment.

RELEVANT FACTUAL BACKGROUND

6. On 15 April 2019, a delegate of the Registrar referred this matter to an AMS for an assessment of WPI caused to the lumbar spine and scarring (TEMSKI) caused on 12 September 2011.

7. Mr Norton was employed as a truck driver when he missed his step alighting from the cab of a trip truck on the passenger's side. He landed on his back and although he had some pain for a few days, the pain settled. However, some six weeks later, whilst at home after a cup of tea, following his changing a light bulb, he suffered acute pain in the right hand side of his back when he was standing up.

8. He was referred to Dr Ghabrial and in February 2012 came to a discectomy with him. This alleviated pain in his leg but by February 2013 Mr Norton's symptomatology was such that he came to further surgery in the form of revision discectomy/decompression and insertion of an interspinous spacer. This stopped him from having the falls that he had been experiencing but he continued with persistent weakness in his leg.

9. In November 2017 he came to a third surgical procedure being a revision decompression and removal of the interspinous spacer which again helped the pain in his leg.

10. The AMS certified an 18% WPI from which he deducted 1/10th pursuant to the provisions of s 323 of the 1998 Act giving a rounded total of 16% WPI. He found nil WPI in respect to the scarring

PRELIMINARY REVIEW

11. 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.

12. The appellant requested a re-examination by a Panel AMS. As a result of the preliminary review, demonstrable error was identified as explained below, and the Appeal Panel determined that the worker should undergo a further medical examination.

Further medical examination

13. Dr Brian Noll of the Appeal Panel conducted an examination of the worker on 22 July 2019 and reported to the Appeal Panel.

EVIDENCE

Documentary evidence

14. 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.

Further medical examination

15. Dr Brian Noll of the Appeal Panel conducted an examination of the worker on 22 July 2019 and reported to the Appeal Panel.

Medical Assessment Certificate

16. 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

17. Both parties made written submissions which have been considered by the Appeal Panel.

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. Mr Norton challenged the assessment by the AMS on four grounds. He submitted that the AMS fell into error in finding a nil impairment for the scarring referral. He submitted that the AMS also fell into error in making any deduction in relation to the s 323 of the 1998 Act. He submitted that the AMS has incorrectly applied the Guides in his assessment of the injury to the lumbar spine, including an alleged failure by the AMS to assess peripheral nerve disorders.

Scarring

21. The AMS in his examination did not refer to the scar. In giving his reasons for the assessment he said[1]:

> "According to the WorkCover Guidelines 14.6, I assess no impairment for the surgical scar".

Submissions

22. Mr Norton alleged that "in effect" the AMS by making a nil finding found that there was no scarring. He submitted that there had been a failure to apply the criteria required and that had it properly been applied an additional score would have been available. The compensatory lump sum was accordingly incorrectly and adversely low. The AMS, it was said, had failed to assess the scarring and he had "failed to perform his statutory function". This was said to be "legally unreasonable".

23. The respondent referred to paragraph 14.6 of the Guides noting that the AMS had observed the scar and indeed applied chapter 14.6 correctly.

Discussion

24. We found Mr Norton's submissions to be somewhat discursive and imprecise. Doing the best we can, it would seem that Mr Norton's complaint is that the AMS failed to give adequate reasons for applying Chapter 14.6 of the Guides.

25. Chapter 14.6 provides[2]:

> "A scar may be present and rated as 0% WPI.
>
> Note that uncomplicated scars for standard surgical procedures do not, of themselves, rate an impairment"

[1] Appeal papers 27
[2] Guides at 73

26. Mr Norton has undergone three surgical procedures and the scarring left by such procedures was not described by the AMS at all. Whilst it is possible to assume that the AMS was of the view by his reference to the guideline that he thought the scar was uncomplicated and standard, his reasons fail the test referred to at paragraph 19 above.[3] The Table at 14.1[4] contains numerous criteria by which an AMS is to assess a scar, and without some description of the scarring on examination it was impossible for the Panel to assess the submissions made by the parties or to form any view itself as to the accuracy of the assessment.

27. The reasons given by the AMS were inadequate, and accordingly he has fallen into error. A re-examination was required as a result. Dr Noll's report is incorporated below into these reasons.

Pre-existing impairment

28. The AMS noted investigations in the form of plain x-rays of 12 February 2016, an MRI of 10 March 2016 and a neurophysiological study by Dr Andre Loiselle, Consultant Neurologist dated 23 June 2016. Under "Summary" [5], the AMS said:

> **"**Mr Norton has been diagnosed as having sustained a foraminal disc protrusion and has undergone multiple surgical procedures for this. His imaging also demonstrates him to have significant pre-existing degenerative disease and also L5 isthmic spondylolysis."

29. The MRI of 10 March 2016 we note was in the following terms[6]:

> "This again confirmed multilevel degenerative disease. There was evidence of previous surgery at L3/4 with some right sided epidural scarring consistent with his previous surgery. The interspinous space was noted. There was persistent foraminal stenosis on the right at this level. There was mild central stenosis at L2/3. There was no significant compressive pathology at L4/5. Bilateral spondylolysis were noted at L5/S1 without evidence of slip or significant neural compromise."

30. The AMS said[7]:

> "In my opinion the worker suffers from the following relevant previous injuries, pre-existing conditions or abnormalities:
>
> Osteoarthritis of the spine.
> L5/S1 spondylolysis.
>
> 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:
>
> The residual symptoms in the back are likely the result of the underlying degenerative disease/spondylolysis rather than originating from persistent nerve root compression.

[3] The test applies to an AMS also. See *Jones v The Registrar WCC* [2010] NSW SC 481 at [34 – 39] Per James J; *Vitaz v Westform (NSW) Pty Ltd* [2010] NSW SC 677 at [57]; see also *Vitaz v Westform (NSW) Pty Ltd* [2011] NSW C App 254 at [34]
[4] 575
[5] Appeal Papers 26
[6] Appeal Papers 25
[7] Appeal Papers 28

> 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.**"**

SUBMISSIONS

31. Mr Norton submitted that there was no evidence of any pre-existing injury, only of the pre-existing degenerative disease. He said that the finding that Mr Norton was suffering from osteoarthritis of the spine and spondylosis was "legally unreasonable", there being no evidence that would have allowed that conclusion to be made.

32. The respondent referred to the well-known authorities regarding the application of s 323 including *Vitaz v Westform NSW Pty Ltd*[8]*; Cole v Wenaline Pty Ltd*[9] and *Ryder v Sundance Bakehouse*[10]. The respondent submitted that the presence of an underlying degenerative disease which was asymptomatic did not determine the question of whether it contributed to the WPI caused by the subject incident.

DECISION

33. Section 323 provides:

> "323 Deduction for previous injury or pre-existing condition or abnormality
>
> (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."

34. It is trite law that deductions pursuant to this section cannot be made on the basis of assumption or hypothesis, but the assessor is required to take into account all of the relevant evidence, including the fact that it was asymptomatic[11].

35. *Vitaz* is authority for the proposition that such an asymptomatic pre-existing condition can be found to be a contributing factor, depending on the facts of the situation.

36. Mr Norton had been working for the respondent since 2011 in the occupation of a truck driver. There is no evidence that he had any prior symptoms, but the extent of the degeneration within Mr Norton's back as evidenced by the MRI to which we have referred, we find to be significant.

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[8] [2011] NSWCA 254 (*Vitaz*)
[9] [2010] NSWSC 78 (*Cole*)
[10] [2015] NSWSC 526 *(Ryder)*
[11] *Cole; El Cheikh v Diamond Formwork (NSW) Pty Ltd (in liquidation)* [2013] NSW SC 365 *(El Cheikh)*

37. In *Ryder* Campbell J said at [45]:

> "What s 323 requires is an inquiry into whether there are other causes, (previous injury, or pre-existing abnormality), of an impairment caused by a work injury. A proportion of the impairment would be due to the pre-existing abnormality (even if that proportion cannot be precisely identified without difficulty or expense) only if it can be said that the pre-existing abnormality made a difference to the outcome in terms of degree of impairment resulting from the work injury. If there is no difference in outcome, that is to say, if the degree of impairment is not greater than it would otherwise have been as a result of the injury, it is impossible to say that a proportion of it is due to pre-existing abnormality. To put it another way, the Panel must be satisfied that but for the pre-existing abnormality, the degree of impairment resulting from the work injury would not have been as great."

38. The circumstances of the onset of Mr Norton's symptoms are indicative of the presence of a significant degenerative condition.

39. The injury on 12 September 2011 occurred when Mr Norton's foot slipped as he was climbing out of a Mitsubishi Tipper truck. He had hold of the right hand rail but could not support himself and fell to the ground, suffering pain particularly in the area of the right buttock, which was severely bruised. After three or four days his symptoms resolved, and he continued to work. Some six weeks later, when he was standing up from drinking a cup of tea at home, he experienced the onset of the degree of symptomatology which has led to the invasive surgical treatment above described. The simple action of standing up is consistent with a further aggravation to the pre-existing degenerative changes.

40. The manner in which the incident occurred is consistent with the aggravation of the spondylolysis and, to apply the reasoning of Campbell J in *Ryder,* but for the presence of the advanced osteoarthritis, the degree of impairment would not have been as great.

41. We accordingly confirm the deduction by the AMS of 1/10th.

Peripheral nerve disorders

Submissions

42. Mr Norton submitted that there was material before the AMS containing "clear evidence" that he had radicular signs at the L4/5 dermatomes, foot drop and calf atrophy. These findings were in fact taken from the report of Dr Ghabrial in his report of 4 June 2018 which spoke of "partial right drop foot and right thigh calf atrophy" [sic].[12]

43. Mr Norton also referred to a finding by Dr Richard Powell that there was numbness along the anterior border of the right tibia. Reference was also made to findings by Dr Loiselle as to significant nerve neuropathy. Error had been made by the AMS, it was asserted, because he had not awarded additional WPI pursuant to Chapter 17 of AMA 5, particularly "17.6 and/or 17.37."

44. We would note that Chapter 17 of AMA 5 is entitled "The Lower Extremities." Tables 17.6 and 17.37 (to which we assume Mr Norton was referring) refer to impairment due to leg muscle atrophy and nerve deficits in lower extremity impairment respectively.

45. The respondent answered that the lower extremity had not been referred for assessment, and therefore the reference to muscle atrophy and peripheral nerve disorder was misconceived. Moreover, it argued, such an assessment was not supported by Professor Ghabrial.

[12] Appeal papers 112

Discussion

46. Doing the best we can with these submissions, it may be that the gravamen of Mr Norton's complaint was that he was suffering from the effects of radiculopathy following the last bout of surgery. The reference to foot drop and muscle atrophy would indicate that was the real purpose of the submission, in which case the relevant Guideline is to be found at Chapter 4.27 of the Guides. Pursuant to Table 4.2[13] of the Guides, a further 3% WPI can be added if residual symptoms and radiculopathy, as defined, continue following spinal surgery. This amount was credited to Mr Norton by the AMS,[14] but, following Dr Noll's re-examination, would have been disallowed by the Panel, had the Panel been empowered to do so, as no signs of radiculopathy were found. This aspect is discussed below.

WPI calculation

47. The AMS explained his calculations at Appeal papers 27:

> "According to New South Wales Workers' Compensation Guidelines for the Evaluation of Permanent Impairment, 4th Edition, 01/04/2016 and the AMA Guidelines for the Assessment of Permanent Impairment (5th Edition):
>
> Paragraph 4.37 indicates surgical intervention for a decompression of spinal stenosis be assessed at DRE Category III. Hence, according to Table 15-3 of the AMA Guides, I assess a 10% WPI.
>
> Under paragraph 4.34 of the WorkCover Guides, I assess 2% WPI consequent to restriction of activity of daily living."

Submissions

48. Mr Norton's legal advisors also submitted that the AMS should have applied a WPI of 13% as his starting point (as we understood the submissions) as provided by Table 15-3 of AMA 5 at 384.

Discussion

49. It does not appear that Mr Norton's legal advisors were cavilling with the assessment of a lumbar category III, but they have misconceived the bases on which entitlements under the Table are calculated. The entitlement section Table 15-3 provides:

> "DRE lumbar category III 10-13% Impairment of the Whole Person"

50. The method of the application of 15-3 is governed by the Guides at Chapter 4.34 which provide:

> "The following diagram should be used as a **guide** to determine whether 0%, 1%, 2% or 3% WPI should be added to **the bottom of the appropriate impairment range** This is only to be added if there is a difference in activity level as recorded as compared to the worker's status prior to the injury" (bold added).

51. As can be seen, the AMS has correctly applied the guidelines. He used the bottom of the appropriate impairment range, 10% WPI, and added thereto the further 2% in relation to the restrictions of daily living.

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[13] Guides 29
[14] MAC 27

Re-examination

52. Dr Noll examined Mr Norton on 22 July 2019. His report follows:

> "Mr Norton attended for the assessment with his partner, Ms Margaret Sheppard.
>
> 1. The workers medical history, where it differs from previous records
>
> Mr Norton confirmed the history provided by the AMS in the Medical Assessment Certificate regarding the nature of the accident on 12 September 2011 and his subsequent treatment.
>
> 2. Additional history since the original Medical Assessment Certificate was performed
>
> He elaborated on the previous history by indicating that he experiences intermittent lower back pain predominantly on the right side of his lumbosacral region. He said that the pain occurs particularly when he bends down. He said that he also experiences intermittent pain in relation to his right lower extremity predominantly over the anterior thigh. The pain occurs when he fully extends his leg when lying supine in bed at night. In order to avoid experiencing the pain he lies with his right leg externally rotated. He is aware of altered sensation when he touches the anterior aspect of his right shin. He has a feeling of weakness of his right lower extremity and his knee tends to give way at times when he is walking. When walking down stairs he always holds onto the rail.
>
> On direct questioning Mr Norton indicated that he is unaware of the surgical scar in relation to his lower back. It does not trouble him in any way. The scar has not required any specific treatment at any time.
>
> He lives in a three bedroom, one level house with his partner. He said that his partner undertakes most of the household chores but he does help at times. He said that he would be able to vacuum a room, but after about 15 minutes would experience aggravation of his lower back pain.
>
> He said that he is able to maintain the outdoor area and mow the lawn, but experiences pain with any bending or heavy lifting activity such as disconnecting and lifting the grass catcher. He is no longer able to undertake some of the outdoor maintenance activities such as trimming the hedges and pruning. He said that the insurer provides help in this regard approximately once a year.
>
> He is able to manage his own self-care activities. He has had to purchase an implement to help him put on his socks but otherwise dresses independently. He volunteered that he is able to do up his own shoelaces.
>
> He confirmed that he is not receiving any specific treatment currently and does not take any analgesic medication.
>
> He has not undertaken any paid employment since the work-related injury sustained in September 2011.

3. Findings on clinical examination

Mr Norton presented in a straightforward and cooperative manner.

He walked with a normal gait. He appeared to sit comfortably throughout the history taking. He sat down and got up from sitting and got on and off the examination couch without any obvious difficulty or discomfort.

On forward flexion he could reach to lower shin level. He had moderate restriction of backward extension, lateral flexion to each side and rotation to each side. Back movements were symmetrical and there was no evidence of muscle guarding or spasm.

He was noted to have a single longitudinal surgical scar in relation to the lower lumbar region in the midline measuring 6 cm in length. The scar was relatively fine. It was slightly pigmented compared to the surrounding skin. There were no obvious stitch or staple marks. There was some tethering to the underlying tissues. There was no significant contour defect.

He was able to walk on his toes and heels but did so somewhat unsteadily.

He was noted to have a longitudinal scar over the anterior aspect of his left knee and informed me that he had had a knee replacement arthroplasty in 2007 which had been very successful.

Straight leg raising was to 70° on both sides. He did not report any pain at the extreme of range. The femoral nerve stretch test was negative bilaterally.

Knee, ankle and medial hamstring reflexes were present and equal.

Muscle strength was normal on clinical testing.

There was no evidence of any lower extremity muscle wasting and circumferential measurement of the thighs and calves did not reveal any significant discrepancy between the two sides. (Thighs: right 47cm, left 46cm. Calves: right 39.5cm, left 38.5cm). The discrepancy noted was consistent with right side dominance.

He reported diminished sensation with point testing over the anterior aspect of the right lower leg between the knee and ankle region with sensation more significantly diminished over the region of the shin – the anteromedial aspect of his lower leg. Sensation was otherwise reported as normal.

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

No additional investigations have been undertaken since the original Medical Assessment Certificate.

The initial imaging studies undertaken following the work-related injury were not available for review.

Imaging studies which included MRI scans dated 22/10/13, and 10/03/16, and x-rays of the lumbosacral region dated 14/03/12, 10/03/16, and 12/12/16 revealed features as described in the relevant imaging study reports included with the documentation provided."

53. The Panel adopts the report of Dr Noll. With regard to the scarring, the following observations were made on examination:

- Mr Norton did not attach any significance to the surgical scar.
- The scar is relatively fine and not visible with usual clothing.
- The scar is relatively unobtrusive.
- There are no obvious staple or suture marks.
- There is no significant contour defect.
- No treatment for the scar is required.

54. As indicated above, the criteria for the assessment of scarring is set out at Table 14.1 of the Guides. The AMS applied chapter 14.6, the terms of which we have noted above, and the re-examination by Dr Noll confirms that indeed the scar was uncomplicated and standard for the surgery Mr Norton had undergone. The absence of any of the above criteria on examination establishes that the AMS was correct in his assessment.

55. With regard to the challenge made as to the WPI calculation, we confirm that DRE III is the appropriate category. Taking into account the information regarding activities of daily living obtained from Mr Norton at the time of the re-examination and the clinical findings we are satisfied that the appropriate allocation for the restriction in the activities of daily living is 2%, and accordingly that part of the MAC it is confirmed.

56. The re-examination however did not find any evidence of radiculopathy as defined in Chapter 4.27 of the Guides:[15]

> "4.27 **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).
>
> 4.28 Radicular complaints of pain or sensory features that follow anatomical pathways but cannot be verified by neurological findings (somatic pain, non-verifiable radicular pain) do not alone constitute radiculopathy."

57. It can be noted that Dr Noll found one of the major criteria in his examination. He found:

- There was no loss or asymmetry of reflexes.
- There was no muscle weakness.
- There was diminished sensation predominantly in the L4 dermatomal distribution.
- The nerve root tension tests were negative.
- There was no muscle wasting.
- There were no imaging studies which relate to the situation following the third surgical procedure.

[15] At 27

58. Although the MRI dated 11 March 2016 indicated the presence of L3/4 stenosis of the foramen (potentially causing L4 nerve root compression) no imaging study was undertaken following the third surgical procedure in November 2017. There were no other clinical signs of radiculopathy and thus the modifier at Table 4.2 of the Guides to which we earlier referred would not be applicable. Accordingly, the Panel specialists are not satisfied that the AMS was necessarily correct in allowing the 3% WPI available where a person has residual symptoms of radiculopathy following spinal surgery, and Mr Norton would consequently be entitled to 14% WPI.

59. However, although the Panel has power to correct errors that have not been the subject of appeal where it determines to set aside a MAC, such power is not available where a MAC is confirmed.[16] Although in the present case the Panel was compelled in the interests of justice to conduct a re-examination regarding Mr Norton's scarring, having done so we are satisfied that the AMS was correct in his assessment.

60. For these reasons, the Appeal Panel has determined that the MAC issued on 7 May 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.

G De Paz

Glicerio De Paz
Dispute Services Officer
As delegate of the Registrar

[16] See *Drosd v Workers Compensation Commission Nominal Insurer* [2016] NSW SC 1053 (*Drosd)*