WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-387/19**
Appellant:	**ICM Services**
Respondent:	**Nikola Dabic**
Date of Decision:	**14 October 2019**
Citation:	**[2019] NSWWCCMA 146**

Appeal Panel:	
Arbitrator:	**Ms Deborah Moore**
Approved Medical Specialist:	**Dr John Garvey**
Approved Medical Specialist:	**Dr Mark Burns**

BACKGROUND TO THE APPLICATION TO APPEAL6

1. On 11 July 2019 ICM Services lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Neil Berry, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 13 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 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).

6. **PRELIMINARY REVIEW**

7. 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.

8. 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 no request was made, and we consider that we have sufficient evidence before us to enable us to determine the 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 are not repeated in full, but have been considered by the Appeal Panel.

11. The appellant makes two submissions as follows:

    a. The AMS failed to appropriately consider whether a deduction pursuant to Section 323 of the 1998 Act ought to apply in relation to both right shoulder and left shoulder, and;

    b. The AMS inappropriately found 1% whole person impairment (WPI) in relation to anal disease being internal haemorrhoids.

12. In reply, the respondent submits that no errors were made.

FINDINGS AND REASONS

13. 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.

14. 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.

15. The respondent was referred to the AMS for assessment of WPI in respect of both upper extremities (shoulders), the cervical spine, the upper gastrointestinal tract and the lower gastrointestinal tract and anus, resulting from an injury occurring “In or about 2009 to 21 July 2011.”

16. The AMS obtained the following history:

    > “He told me that he had been employed by ICM Services, a cleaning company, cleaning office buildings after they have been constructed. He has been employed by the same company for 15 years. He told me that over a period of time he had developed neck pain and pain in both shoulders.
    >
    > On the 9 May 2011, he was up on a step ladder and reaching up to clean cement columns when he experienced increased pain in the right shoulder and in the neck and to a lesser degree in the left shoulder…
    >
    > He came under the care of Dr Stuart Jansen, Orthopaedic Surgeon, and initially had surgery to the right shoulder. This was operated on arthroscopically in 2012 at the Victory Private Hospital in Wollongong. The left shoulder was operated on in 2014 and thereafter the left shoulder was more painful and a second operation had to be done.

Mr Dabic told me today that he developed epigastric pain and also alternating constipation and diarrhoea, although he went to the toilet each day. He apparently underwent endoscopy. He was treated with various medications and while his symptoms settled, they have not been completely abolished."

17. Present symptoms and treatment were described as follows:

"He continues to suffer pain in the neck and the pain and stiffness extends into both shoulders. With regard to his stomach he suffers occasional reflux and occasionally there is constipation, although usually he goes to the toilet twice a day with semi-loose stools.

He takes medications for pain, but could not remember which ones he was taking."

18. Findings on physical examination were reported as follows:

"Cervical Spine: There was tenderness to palpation in the midline. All movements of the neck were reduced to half range. There was no paraspinal muscle spasm, no muscle guarding and no alteration of spinal contour.

Upper Extremities: There were scars on both shoulders consistent with his arthroscopic surgery (please see the attached worksheets) for the range of movement in each shoulders. The elbows, wrists and hands were normal. Reflexes were intact. There were no neurovascular changes and no unilateral muscle wasting.

Abdomen: The abdomen was soft with no tender areas. There was no guarding, no rigidity, no rebound and no palpable masses. With the patient on his left side, anal inspection revealed no evidence of haemorrhoids."

19. The AMS then referred to special investigations as follows:

"Operation Report of Dr Andrew Malouf dated 7 August 2014 at Figtree Private Hospital:

Gastroscopy showed no hiatus hernia and no visible reflux changes; Biopsies were taken for disaccharidase. Biopsies from the stomach confirmed lactose deficiency causing his bowel habit changes. It was also noted that he had Helicobacter pylori which was treated.

Colonoscopy showed two sessile polyps in the rectum and hepatic flexure. EUA confirmed mostly internal haemorrhoids. He also had his haemorrhoids banded. Dr Malouf indicated that none of the claimant's gastrointestinal problems were related to his Workers Compensation issues.

X-ray and Ultrasound Right Shoulder dated 9 July 2011 shows a full thickness tear of the anterior supraspinatus muscle but no other significant changes. MRI Right Shoulder Arthrogram dated 12 November 2012 confirms the supraspinatus tendon repair with a degree of capsulitis. MRI Cervical Spine dated 21 October 2013 shows severe multilevel facet joint changes but no significant cord compression."

20. The AMS summarised the injuries as follows:

"This is a man who carried out heavy work as a cleaner, cleaning newly constructed buildings before they moved to the next stage. He has suffered injuries to the neck and shoulders. He also gives a history of altered bowel function from 2013. Endoscopy showed a Helicobacter infection and lactose deficiency which potentially resulted in his altered bowel function."

21. As regards the respondent's presentation, the AMS said:

"There was a degree of inconsistency on examining the claimant's neck. He had minimal clinical signs, but reduced his range of movement in all directions to just under half, not in keeping with his radiological findings or his clinical history…"

22. In assessing impairment, the AMS said:

> "**Cervical Spine**: The claimant has a history of developing neck pain some two years after ceasing work and after his initial surgery. Clinically, he has a markedly reduced range of movement with no evidence of muscle guarding, muscle spasm or asymmetry. I therefore refer you to the AMA 5th Edition of the Guides to the Evaluation of Permanent Impairment, Chapter 15, Table 15.5 on Page 392. The claimant shows no significant clinical findings, apart from a symmetrically reduced range of movement and I would therefore place him in DRE Category 1 and allow a zero Whole Person Impairment.
>
> **Right Upper Extremity (shoulder):** This should be assessed using the range of movement model and I therefore refer you to my attached worksheet and you will note that based on the range of movement that the claimant has an 8% Whole Person Impairment.
>
> **Left Upper Extremity (shoulder):** The claimant's left shoulder should be assessed on the range of movement model, please see the attached worksheet and you will note that the claimant is assessed as a 9% Whole Person Impairment.
>
> **Digestive Tract:** In assessing the digestive tract the first thing that should be assessed is whether there is nutritional impairment and this is based on assessing the claimant's weight against his desirable weight using the Height and Body Build Tables and therefore refer you to Chapter 6, Table 6.1 on Page 120. The claimant is 173cm in height and he would have a desirable weight range of 63.6kgs to 78.2kgs, therefore at 75kgs the claimant is well within the desirable weight range for his height and body build and would therefore be considered not to have any nutritional impairment.
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> **Upper Digestive Tract**: The upper digestive tract is assessed using the AMA 5th Edition of the Guides to the Evaluation of Permanent Impairment, Chapter 6, Table 6.3 on Page 121. The Table has been amended by the NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment to read that there should be 'symptoms and signs' of upper digestive tract disease in Class 1. In this man's case he has symptoms but on clinical examination there is no evidence of any clinical signs. I would therefore assign him to Class 1 and allow a zero Whole Person Impairment for the upper digestive tract.
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> **Lower Digestive Tract:** The colon, rectum and anus are assessed using Chapter 6, Table 6.4 on Page 128. It is noted that signs and symptoms of colonic or rectal disease are required for an assessment under this Table. In this man's case he has abdominal pain, he has alternating constipation and diarrhoea which his treating Surgeon Dr Andrew Malouf suggests may be due to his lactose deficiency rather than any medication intake. It also could be due to irritable bowel syndrome. His colonoscopy showed small polyps and diverticular disease but no evidence of any significant impairment related to medication intake or any other factor involved in the claimant's work injury. I would therefore be of the opinion that the claimant has a zero Whole Person Impairment for the lower digestive tract.
>
> In terms of the anus, the claimant is noted on colonoscopy and rectal examination to have significant internal haemorrhoids. I therefore refer you to Chapter 6, Table 6.5 on Page 131 and it would be accepted that the claimant does have signs of organic anal disease in terms of internal haemorrhoids. I would therefore place him in Class 1 and I would allow a 1% Whole Person Impairment."

23. The AMS then proceeded to comment on other medical opinions, stating as follows:

> "<u>Report of Dr Anthony Greenberg dated 8 July 2015</u>. He reports no abnormalities in the abdomen. He did not do a rectal examination and noted no perineal haemorrhoids. Despite a negative clinical assessment, he allowed a 5% Whole Person Impairment. I do not believe that he can justify the upper digestive tract and lower digestive tract assessments, however I agree on the colonoscopic findings of internal haemorrhoids that an assessment of 1% for the anal region is in keeping with the findings.

Report of Dr Brian Stephenson dated 5 February 2014. He assessed the cervical spine at DRE Category 2 allowing a 6% Whole Person Impairment. On examination today there was a symmetrical reduction in movement but no other clinical findings to justify DRE Category 2 assessment of the cervical spine. He assesses both upper extremities at 6%. It is possible that they have deteriorated since his assessment and my assessments are based on today's examination.

Report of Dr Thomas Davis dated 17 June 2014. He initially assessed the neck as DRE Category 2 but on reviewing his report decided that this was not work caused. He assessed an 8% Whole Person Impairment for the right upper extremity and a 7% Whole Person Impairment for the left upper extremity which is in keeping with my findings.

Report of Dr Nicholas Talley dated 2 July 2018. He felt that there was no evidence of any work-related effects on the digestive tract and did not make an assessment of Whole Person Impairment. I have taken the view that the haemorrhoids potentially were aggravated by medication intake and are assessable at 1%."

24. Dealing firstly with the section 323 deduction issue, the appellant submits that the work injury the subject of assessment was confined to the period "2009 to 27 July 2011". Thus, it is submitted, "it was incumbent on the AMS to consider whether degenerative pathology identified in radiology reports post injury had pre-dated the subject work injury for the purposes of Section 323 of the 1998 Act."

25. Dr Davis in his supplementary report of 17 June 2014 considered that as regards to the right shoulder, a one tenth deduction ought to be applied for a "pre-existing, degenerative disease." With regards to the left shoulder Dr Davis considered similarly that a deduction of one tenth ought to apply in relation to "similar degenerative changes present and therefore section 323(2) applies".

26. It is noted that although the AMS referred to this report, he did not comment on Dr Davis' deduction under section 323.

27. The appellant also points out that, when referring to the radiology nearest in time to the work injury, namely 9 July 2011, the AMS merely reported that it showed "a full thickness tear of the anterior supraspinatus muscle but no other significant changes."

28. However, radiologist Dr Nikolich reported on 9 July 2011 that: "There is irregularity of the greater tuberosity consistent with degenerative irregularity. There is a small to moderate subacromial spur and there is mild to moderate degenerative change in the acromioclavicular joint…"

29. These findings, soon after the injury date, in our view are significant, and demonstrate clear evidence of a pre-existing condition.

30. The appellant makes a similar submission with regard to the left shoulder.

31. The radiological material closest in time to the subject work injury is dated 11 June 2013. The AMS did not refer to this radiology at all. However, radiologist Dr Blumgart said: "Some degenerative changes are present in the AC joint with synovial thickening and bony change with limited oedema at the peripheral margin of the clavicle…"

32. The AMS did not refer to the report of Dr Mastroianni dated 7 December 2017. Dr Mastroianni did not have (or did not refer to) any radiological material other than an MRI scan of the neck dated 21 October 2013. He made impairment assessments in relation to both shoulders based on his examination at the time. He did however state that, as regards the cervical spine: "In my opinion a one tenth deduction is applicable applying the provision of Section 323. There is congenital spondylosis. The underlying degenerative disease is a component of the current impairment."

33. Dr Stephenson however in his report of 5 February 2014 concluded: “There is no fractional deduction under Section 323, in my opinion.” Although he referred to various radiological reports, he, like the AMS, did not report them in full, as we have set out in the preceding paragraphs.

34. We also note that the respondent’s treating surgeon, Dr Jansen, reported on 15 May 2013: “Nikola has had x-rays. This shows some AC joint arthritis with a lateral acromial downslope…”

35. The respondent submits that the appellant has relied solely on the report from Dr Davis dated 17 June 2014. That report, it is submitted, “cannot be viewed in isolation [because] in his initial report of 15 April 2014, after considering the radiology in detail Dr Davis formed the view there was no s323 deduction. Similarly, in his later report of 21 June 2018, he made no s323 deduction for the upper extremities.”

36. This is not an accurate reflection of those reports. Dr Davis initially assessed impairment of both shoulders but simply made no comment as regards the operation of section 323. In other words, he didn’t “form a view” that no deduction was warranted: he simply made no comment about it.

37. We accept that, as Schmidt J said in *Cole v Wenaline Pty Ltd* [2010] NSWSC 78 “Section 323 does not permit that assessment to be made on the basis of an assumption or hypothesis, that once a particular injury has occurred, it will always, 'irrespective of outcome', contribute to the impairment flowing from any subsequent injury. The assessment must have regard to the evidence as to the actual consequences of the earlier injury, pre-existing condition or abnormality.”

38. Equally however, *Vitaz v Westform Pty Ltd* [2011] NSWCA 254 is authority for the proposition that “if a pre-existing condition is a contributing factor causing permanent impairment, a deduction is required even though the pre-existing condition had been asymptomatic prior to the injury.”

39. Having carefully considered all of the evidence, we are satisfied that there is evidence of a pre-existing condition causing permanent impairment such that a deduction is warranted. In our view, the appropriate deduction is one-tenth which is consistent with the available evidence.

40. It is also consistent with the history obtained by the AMS that after some fifteen years of work with the appellant, “over a period of time he developed neck pain and pain in both shoulders.”

41. As regards the anal disease issue, the appellant submits as follows:

> “Internal haemorrhoids are not a permanent impairment, and are treatable with surgery. Following a successful haemorrhoidectomy for example, the condition is alleviated. The AMS did not appropriately turn his mind to whether the condition of internal haemorrhoids was “permanent”; and that if he did he would opine that it is not.
>
> Alternatively, had the AMS considered the worker’s internal haemorrhoids are permanent (which we say he would not), he ought to have turned his mind to whether the condition had reached maximum medical improvement (MMI). The appellant submits that the AMS would not have considered the condition of internal haemorrhoids had reached MMI as the condition would be liable to change with medical treatment.
>
> To put the issue another way, internal haemorrhoids would not be a condition “well stabilised and … unlikely to change substantially in the next year with or without medical treatment” as per 1.15 of the Guidelines.

On the issue of causation, the AMS noted only the following: “I have taken the view that the haemorrhoids potentially were aggravated by medication intake and are assessable at 1%”. That…opinion on causation is framed in guarded terms, and does not make a definitive causal connection. A “potential” “aggravation” by medication does not necessarily establish any causal link. Further it is not clear from the AMS’s opinion whether there already were internal haemorrhoids present prior to the work injury; and that some ingestion of medication had “aggravated” them. It is not clear to what degree, if that were the case, the medication aggravated the haemorrhoids. It was not clear which medication the AMS considered had aggravated the haemorrhoids. Nor is it clear, whether the medications taken which aggravated the haemorrhoids were medications relating to the accepted work injuries to the right and left shoulder.”

42. We accept these submissions for reasons that follow.

43. Internal haemorrhoids are not permanent, and “potential aggravation” and the mechanism of aggravation is not MMI. Haemorrhoids of this type may not be permanent and come and go depending on the dietary regime of the patient and the amount of straining at stool.

44. In our view, the haemorrhoids should be classed as 0% WPI because they are internal and trivial, and only detected on proctoscopy by Dr Malouf at surgery on 7 August 2014. They were not in existence by normal clinical examination of visual inspection as noted by the AMS. Dr Malouf also added that the respondent “specifically requested not to undergo any form of haemorrhoid intervention, which I'll respect.” In a later report dated 22 August 2014 he added: “I outlined that none of his findings relate to his Workers Compensation related issues.”

45. In short, the AMS did not find haemorrhoids on inspection. Curiously, the AMS added: “He also had his haemorrhoids banded” which seems to be an error because the respondent specifically refused such treatment from Dr Malouf.

46. For these reasons, the Appeal Panel has determined that the MAC issued on 13 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*.

G De Paz

Glicerio De Paz
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **387/19**
Applicant: **Nikola Dabic**
Respondent: **ICM Services**

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 Neil Berry 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.Cervical spine	9/05/2011		Chapter 15 Page 392 Table 15.5 DRE Category 1	0	0	0
2. Right Upper Extremity (shoulder)	9/05/2011		Chapter 16 figure 16-40, 16-43 and 16-46.table 16-3	8	1/10th	7
3. Left Upper Extremity (shoulder)	9/05/2011		Chapter 16 figure 16-40, 16-43 and 16-46.table 16-3	9	1/10th	8
4. Upper Digestive Tract	9/05/2011		Chapter 6 Page 121 Table 6.3 Class 1	0	0	0
5. Lower Digestive Tract	9/05/2011		Chapter 6 Page 128 Table 6.4 Class 1	0	0	0

6. Anal disease	9/05/2011		Chapter 6 Page 131 Table 6.5 Class 1	0	0	0
Total % WPI (the Combined Table values of all sub-totals)					**14%**	

Ms Deborah Moore
Arbitrator

Dr John Garvey
Approved Medical Specialist

Dr Mark Burns
Approved Medical Specialist

Dated 14 October 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*.

G De Paz

Glicerio De Paz
Dispute Services Officer
As delegate of the Registrar