WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1- 4132/18**
Appellant:	**Qantas Airways Ltd**
Respondent:	**George Lambropoulos**
Date of Decision:	**29 November 2019**
Citation:	**[2019] NSWWCCMA 177**

Appeal Panel:	
Senior Arbitrator:	**Mr Glenn Capel**
Approved Medical Specialist:	**Dr Philippa Harvey-Sutton**
Approved Medical Specialist:	**Dr John Brian Stephenson**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 17 September 2019, Qantas Airways Ltd (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist (the Application). The medical dispute was assessed by Dr T Michael Long, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 20 August 2019 in respect of the thoracic and lumbar spines. Another AMS, Dr Garvey, issued a MAC on 20 August 2019 in respect of the upper and lower digestive tracts, anus and penis. The appellant does not take issue with Dr Garvey's MAC.

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, and
   - 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 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. George Lambropoulos (the respondent) sustained injury in a motor vehicle accident during the course of his employment with appellant on 3 July 2010. Liability was accepted by the appellant as a self-insurer, but precise details are unknown.

7. An Application was registered in the Commission on 10 August 2018. The respondent alleged that he sustained injuries to his cervical spine, thoracic spine, right shoulder and arm, left shoulder and arm, gastrointestinal tract and loss of sexual function. The appellant disputed that the respondent injured his shoulders, arms and a consequential loss of sexual function.

8. In a Certificate of Determination (COD) dated 2 November 2018, Arbitrator Egan determined that the respondent did not injure his shoulders and arms. The respondent lodged an appeal but was unsuccessful.

9. The matter was remitted to the Registrar for referral to two AMSs to assess the whole person impairment of the respondent’s cervical spine, thoracic spine, digestive system (upper, lower, and anal) and reproductive system (penis) due to injury sustained on 3 July 2010.

10. The AMSs, Dr Garvey and Dr Long, issued their MACs on 20 August 2019.

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 Workers compensation medical dispute assessment guidelines.

12. 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 it was satisfied that there was sufficient material available to the Appeal Panel to deal with the appeal.

EVIDENCE

Documentary evidence

13. 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.

Respondent’s evidence

14. The respondent relies on a number of statements, but these were poorly drafted and largely unhelpful. They also include references to injuries that were rejected by Arbitrator Egan. The respondent’s last and possibly most helpful statement was excluded from evidence.

15. Dr Sheehan reported on 28 November 2011. The respondent complained of only occasional tingling in his left hand, and the doctor found no clinical evidence of note.

16. The respondent’s qualified expert, Dr Guirgis, provided four reports between 30 May 2012 and 26 June 2018. He recorded clinical evidence of sensory loss corresponding with the C6 dermatome on 15 September 2014. On 27 June 2018, he recorded that there was also electrophysiological and radiological evidence of radiculopathy at C7/8.

17. Dr Guirgis diagnosed post-traumatic mechanical derangement of the cervical and thoracic spines and subacromial impingement in the shoulders. He assessed 15% whole person impairment of the cervical spine, 5% whole person impairment of the thoracic spine, 4% whole person impairment of the left upper extremity and 3% whole person impairment of the right upper extremity, for a combined total of 24% whole person impairment. The doctor allowed a one tenth deduction for pre-existing pathology in the respondent’s cervical spine.

18. There are a number of radiological reports in evidence. The CT scan dated 11 January 2010 showed evidence of a protrusions at C4/5 and C5/6 together with degenerative changes, but there was no evidence of impingement.

19. The MRI scan dated 13 July 2010 showed protrusions from C2/3 to C4/5 and projecting disc material at C5/6 with encroachment. The MRI scan dated 30 August 2012 showed spondylitic changes and stenosis at C4/5 and C5/6, with narrowing from C4 to C7.

20. The MRI scan dated 1 July 2014 showed mild congenital narrowing with spondylitic changes, stenosis and early cord compression at C5/6.

21. The MRI scan dated 18 November 2016 showed spondylosis with marked changes at C5/6 and the MRI scan dated 15 August 2017 showed degenerative spondylosis and narrowing with potential nerve impingement at C5/6. It was reported that the findings were similar to the 2012 scan. EMG studies dated 8 March 2017 showed mild radiculopathy at C7/8.

22. Dr Maniam provided a number of reports commencing on 2 December 2014. He initially found no evidence of any neurological abnormality, although he acknowledged that there was early cord compression at C5/6. It was not until his report dated 22 February 2017 that he raised the possibility of radiculopathy.

23. Dr Maniam commented that the MRI scan dated 18 November 2016 showed narrowing at C5/6 that would impact on the C6 nerve root. He noted that the EMG studies showed evidence of C7/8 radiculopathy and number of doctors had diagnosed C8 involvement.

24. In his report dated 11 May 2017, Dr Maniam confirmed that the respondent had radiological evidence of radiculopathy at C5/6 and C7/8. In his report dated 7 December 2017, he assessed 14% whole person impairment of the cervical spine and 5% whole person impairment of the thoracic spine, after a one-tenth deduction pursuant to s 323 of the 1998 Act.

25. There are a number of reports from Dr Drummond from 19 July 2010 to 18 September 2014. He confirmed that the respondent had injured his neck, but he only found evidence of neurological abnormality on one occasion in December 2013.

26. Dr Vote reported on 3 September 2012 and 3 December 2012. He confirmed that there was no evidence of cord myelopathy and or significant radicular signs, but he considered that the respondent might develop these in the future. He advised that there were pre-existing degenerative changes in the respondent's neck, but they were asymptomatic. The doctor advised that the respondent had recovered from the injury in 2009 and the degenerative changes had been aggravated by the accident in July 2010.

27. Dr McKechnie reported on 12 May 2015. He recorded that the respondent had persistent neck pain radiating across his shoulders and left arm pain, with intermittent numbness and paraesthesia in two fingers of his left hand. He advised that these symptoms were consistent with radiculopathy due to stenosis at C5/6 and C6/7

28. Dr Cordato provided a series of reports. In April 2015, the doctor reported that the respondent had clinical evidence of reduced sensation in the C6 and T1 distributions in the left arm pain when he first saw the respondent on 24 July 2014. In March 2017, he performed EMG studies that confirmed left C7/8 radiculopathy.

29. On 26 July 2017, Dr Cordato reported that the respondent had begun to experience increased right arm pain, numbness and tingling involving a C6 distribution. On 8 September 2017, the doctor reported that an MRI scan had shown spondylosis at C5/6. The respondent had also complained of radicular symptoms in his right hand.

30. In his report dated 22 January 2018, Dr Cordato advised that the respondent had cervical radiculopathy affecting his upper limbs that was confirmed by the imaging and objective clinical examination. He assessed 17% whole person impairment of the cervical spine, 3% whole person impairment of the right upper extremity and 2% whole person impairment of the left upper extremity, for a total of 21% whole person impairment. He made no deduction for any pre-existing injury or abnormality.

31. In his report dated 29 June 2018, Dr Cordato confirmed that the respondent had clinical signs of cervical radiculopathy. There was an absent right triceps jerk, reduced biceps jerk and reduced sensation consistent with C6 pathology. He advised that the left-hand symptoms could also relate to C8 or ulnar neuropathy.

Appellant's evidence

32. Dr Stephen found no evidence of radiculopathy when he examined the respondent on 17 November 2010, 10 May 2011 and 25 February 2016. The respondent complained of pins and needles in the left arm at the first consultation, but only slight numbness in the two fingers at the second consultation.

33. At the last consultation, the doctor reported that the respondent had paraesthesia in the ulnar nerve distribution in the left forearm and fingers, as well as intermittent shooting numbness. Nevertheless, the doctor confirmed his previous opinion of non-specific mechanical cervical pain due to degenerative changes. He considered that the respondent had recovered from the effects of the accident.

34. Dr Howe reported no evidence of radiculopathy when he saw the respondent on 9 March 2011.

35. Dr Crocker reported to the appellant on 18 April 2011 and 26 November 2012. He found mild sensory disturbance in the respondent's left hand that was consistent with radiculopathy arising from C8.

36. Dr Ryan reported on 9 September 2013. He recorded complaints of altered sensation in the left little and ring fingers, which he thought could be construed as left-sided C8 nerve root compression.

37. There are a number of certificates that were issued by the Medical Assessment Service (MAS) in evidence.

38. Dr Burns provided a MAS Certificate 24 July 2013. He recorded details of the accident in October 2009 and he noted that the respondent's neck symptoms settled after six months and he was pain free before the accident on 3 July 2010.

39. Dr Burns recorded that the respondent had experienced tightening in his neck and pain radiating out towards both shoulders at the time of the accident on 3 July 2010. The respondent continued to have pain and discomfort in his left arm, and he noticed tingling in the fingers of his left hand. the doctor did not record any signs or symptoms of radiculopathy.

40. Dr Burns diagnosed an aggravation of pre-existing degenerative changes in the cervical spine, in particular at C5/6, and a soft tissue injury to the thoracic spine. He assessed 5% whole person impairment of the respondent's cervical spine under AMA4.

41. A further MAS Certificate was issued by Dr Wilding on 2 September 2015. He recorded a similar history of the resolution of symptoms following the actioned in October 2009. The doctor noted that immediately after the accident on 3 July 2010, the respondent had neck pain and pain radiating into shoulders, together with tingling and numbness in his left hand. His neck pain had continued, and he experienced shooting pain down his left arm to the little and ring fingers once per month.

42. Dr Wilding noted that there as diminished sensation on the ulnar border of the left forearm, left hypothenar eminence and volar aspect of the little and ring fingers, but reflexes were normal.

43. Dr Wilding diagnosed a musculo-ligamentous injury to the respondent's cervical and thoracic spines, soft tissue injuries to both shoulders. He considered that the left arm and hand symptoms were referred from the neck. He assessed 5% whole person impairment of the cervical spine in addition to losses in the shoulders under AMA4.

44. A MAS Review Panel was convened to review the shoulder assessments of Dr Wilding and it issued a certificate on 1 April 2016. The respondent was examined by Dr Buckley and Dr Gray. The respondent told the doctors that he had completely recovered from the effects of the accident on October 2009. They did not record a history of any radicular symptoms at the time of the accident on 3 July 2010.

45. The respondent complained of numbness in his left ring and little finger and pain in his left arm that occurred on a daily basis. The respondent also complained of a shooting pain that he experienced that started in his shoulder and extended to his fingers.

46. On examination, the doctors found no evidence of radiculopathy. They agreed with the description of the pathology shown in the MRI scan dated 1 July 2014. They noted that there was a reference to cord compression, but they found no evidence of myelopathy.

47. The doctors concluded that the respondent's neck injury was caused by the accident on 3 July 2010 and this was responsible for 5% whole person impairment. There was no impairment of the thoracic spine under AMA4.

48. Dr Breit reported on 6 July 2017. He recorded that the respondent experienced pain in the neck and shoulders as well as cramping and upper back pain. The respondent had pain in the centre of the neck to the mid thoracic spine, radiating to the shoulders and the ribs. There was shooting pain in the left upper arm extending along the ulna border of the forearm to the ring and little finger, together with pain and pins and needles in the left hand.

49. Dr Breit had access to the cervical MRI scan dated 11 November 2016 as well as scans of the respondent's shoulders. On examination, he reported global diminution and sensation in the left upper extremity, but he found that the depth of that loss was variable.

50. Dr Breit diagnosed cervical spondylosis with non-verifiable radicular complaints and assessed 6% whole person impairment of the cervical spine and made no deduction for any pre-existing injury or abnormality.

Medical Assessment Certificate

51. Dr Long provided his MAC on 20 August 2019. He recorded details of a prior injury on 30 October 2009, when the respondent experienced pain in his neck and shoulders whilst he was driving a tug that was pulling trailers. He was off work for two days and resumed duties on a graduated return to work for four months before he returned to his normal duties.

52. On 3 July 2010, the respondent was involved in an accident when the trailer that he was pulling was struck by a truck. He had severe pain in his upper neck and thoracic spine. He was off work for five months and then returned on a graduated return to work programme. His employment was terminated on 13 March 2013 as suitable duties were no longer available. The respondent took various forms of medication for pain relief and he developed indigestion and constipation. He was presently taking Panadeine Forte, Valium, Lyrica, Celebrex, Paracetamol, Nurofen. Mersyndol, Endep and Nexium.

53. Dr Long reported the respondent's symptoms as follows:

> "Present symptoms:
>
> - **Neck:** Continuous, posterior and low posterolateral pain 7/10 in severity, aggravated by moving his head and neck. This pain radiates in a shock-like manner into the lateral aspect of the right lateral forearm and the thumb, index and middle fingers. There is constant numbness and tingling in these fingers. The pain also *"shoots"* into the medial aspect of the left forearm, including the fourth and fifth fingers, where there is a tingling sensation. There is weakness in both hands for carrying objects and screwing and similar activities with the right and left hands.

- The pain in his neck is also associated with a low thoracic pain, less severe, although aggravated by movement and physical activity. This pain does not radiate further.

- **Indigestion:** Retrosternal and epigastric burning discomfort, associated with regurgitation into his mouth (water brash) when lying down at night. This discomfort is mostly controlled by regular taking of Nexium 20 mg daily.

- Troubled by constipation and abdominal bloating, controlled in part by taking Coloxyl and/or Senna and/or Movicol. He usually has a moderately firm bowel action daily. Occasionally, he has right anal bleeding noted on the paper and usually associated with anal pain when opening his bowels. He is not aware of any anal lumps.

- **Sexual:** Libido is diminished since sustaining the injury and subsequent events.

- **Micturition:** No abnormal symptoms.

- **Sleep:** Disturbed because of the pain in his neck and difficulty in finding a position of discomfort.

- **Emotional Factors:** These have been significant since the accident and magnified by his ongoing disability, pain and inability to find suitable employment."

54. Dr Long recorded his findings on examination as follows:

"FINDINGS ON PHYSICAL EXAMINATION

Mr Lambropoulos presented at short notice a day ahead of his appointment because of '*an administrative mix-up*'**.** The consultation continued for 60 minutes. He had to alter some personal arrangements in order to attend but was most co-operative and this continued throughout the consultation. He provided a clear history in an engaging manner with good eye contact. It was noted that he moved his head and neck stiffly and sat uncomfortably because of symptoms in his neck throughout the interview. He had difficulty in dealing with his upper body clothing because of evident painful restriction of movement of his shoulders. He walked without a limp or any support.

Weight: 111 kg **Height:** 172 cm

He was slightly corpulent.

<u>Head and Neck</u>:

Cervical Spine: Tenderness over the posterior cervical spine with prominent dysmetria.
Flexion was 60% of normal.
Extension was 10% of normal, associated with pain.
Lateral angulation right and left were each 10% of normal.
Rotation to the left was 50% of normal.
Rotation to the right was 70% of normal.
There was marked paravertebral muscular guarding.
There was no measured significant differential muscular wasting in the upper extremities.
There was no wasting of the small muscles of the hands and in particular in the left hand.
The following reflexes were recorded:

Reflexes	Right	Left
Biceps	+/-	+
Triceps	+/-	++
Brachioradialis	+/-	+
Finger	-	-

Sensation: There was diminished sensation to light touch and blunt pressure, the lateral aspect of the right forearm, thumb, second and third fingers (C5,6 dermatome). Diminished sensation in the left fourth and fifth fingers and medial aspect of the left hand. (C8 dermatome).

Thoracic Spine: Tenderness in the low thoracic region.
No dysmetria, although flexion and extension were restricted, consistent with his age.
Flexion was 90% of normal.
Extension was 90% of normal.
Rotation right and left was not restricted, although caused discomfort.
There was no paravertebral muscular guarding.
There was no related objective dermatomal or other sensory loss related to the thoracic spine.

Lumbar Spine: No tenderness or dysmetria.
Flexion and extension were each 100% of normal.
Right and left angulation was each 100% of normal.
Examination of the lower extremities did not reveal any neurological or other abnormality.

Upper Extremities:

Shoulders: No differential muscular wasting or deformity.
No crepitation of movement in the right or left shoulders.
Right and left long head of biceps intact.
No abnormal sensory change about the right or left shoulders.

The following movements of the right and left shoulders were considered constant on measuring each three or more times with a goniometer:

Shoulder Movements	Active ROM RIGHT	Active ROM LEFT
Flexion	130°	140°
Extension	40°	20°
Abduction	120°	120°
Adduction	40°	40°
Internal Rotation	70°	70°
External Rotation	80°	80°

Elbows: No abnormality
No abnormality or induration about the left or right ulnar nerves at the elbows.

Wrists/Hands/Fingers: Normal.

<u>Lower Extremities</u>: No abnormality.

55. Dr Long provided a diagnosis as follows:

"• summary of injuries and diagnoses:

Mr George Lambropoulos, who is now 57 years of age, first injured his neck at work on 30 October 2009. Subsequently, he had a limited period of time before returning to graduated light duties, increasing to full duties. Although he had very slight residual discomfort in his neck, he continued working until he encountered a more significant injury at work on 3 July 2010 resulting in pain in his neck and lower thoracic back. Initially, he had radiation of the pain into the medial aspect of the left forearm and the fourth and fifth fingers. He also had pain in his right and left shoulders, although there was no direct injury to either the right or left shoulders.

He was off work for five months and then underwent a graduated return to part-time duties not involving his pre-injury work. It was difficult for the employer to find suitable duties and he was formally terminated on 13 March 2013.

In spite of conservative management, his symptoms have persisted and subsequently involved pain radiating into the medial aspect left arm hand and fingers and subsequently into the lateral aspect of the right forearm, right hand and radial fingers. There was associated sensory change with the pain in both his right and left upper extremities.

With his conservative management and taking of analgesics, including Panadeine Forte and anti-inflammatory drugs, including Nurofen and Celebrex, he developed symptoms of epigastric burning pain and reflux with water brash when lying down and at night there was abdominal distension and constipation. His symptoms required gastroscopy and colonoscopy, which were undertaken in 2013 and 2017. He continues to take Nexium 20 mg daily to control these symptoms, as well as Coloxyl, Senna and Movicol, to regulate and normalise his bowel function. He has also had some intermittent perianal pain and bleeding, associated with constipated stool.

He continues to have some pain in the lower thoracic back associated with physical activity, however, his major ongoing symptom affects his neck, right and left shoulders with pain in the right and left upper extremities."

56. The doctor gave his reasons for assessment as follows:

"**a. My opinion and assessment of whole person impairment**

My opinion and assessment of Whole Person Impairment is ………

In making that assessment I have taken account of the following matters: -

The history provided, clinical findings which were considered important in order to determine whether radiculopathy, as defined in the Guidelines, existed in the right and left upper extremities. He has verifiable radicular complaints involving the lateral aspect of the right forearm and radial fingers suggestive of a C5/6 nerve root compromise. There was significant corresponding diminished reflexes right upper extremity. In the left arm, he has pain and sensory change affecting the medial aspect of the left forearm, medial hand and left fourth and fifth fingers, suggesting a C8 nerve root lesion; but the reflexes left upper extremity are retained and active. There was no clinical evidence that the left ulnar nerve was compromised. Consideration was also given to the imaging studies and to previous consultant reports.

b. An explanation of my calculations (if applicable)

NSW Workers' Compensation Guidelines for the Evaluation of Permanent Impairment, 4th Edition, 1 April 2016:

Chapter 2: Upper Extremity; Pages 10-12;
Chapter 4: The Spine; Pages 24-30;
Page 27; 4.27 radiculopathy, which states in order to make this diagnosis one or two of the following must be present:

- 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;

As well as one of the following, if necessary, to complete the two requirements necessary to diagnose radiculopathy:

- positive nerve root tension;
- muscle wasting – atrophy;
- findings on an imaging study consistent with the clinical signs.

Examination of the cervical spine revealed marked dysmetria, tenderness, restriction of movement and paravertebral muscular guarding. Based on the present examination, he has reduced reflexes in the right biceps, right triceps and right brachioradialis, compared with more prominent present reflexes in the left upper extremity. Sensory loss in the right upper extremity corresponds with C5/6 dermatome involving the lateral right forearm and radial fingers. Sensory loss left arm was consistent with dermatomal loss C8.

Imaging studies are also consistent with radiculopathy in both the right and left upper extremity.

It is concluded that he has radiculopathy in the right upper extremity.
In the left upper extremity radiculopathy was not that definite. All reflexes were present, although on both sides the finger jerk of (T1) was absent. Objective sensory dermatomal loss was consistent for C8.

Overall, it is considered that the reproducible sensory change in the left upper extremity together with imaging studies are sufficient to diagnose radiculopathy of the left upper extremity.

Referring to AMA 5th Edition:

Cervical Spine: Table 15-6; Page 392; DRE Cervical Category III: Because of the radiculopathy – 15%-18% impairment of the whole person applies. *"Significant signs of radiculopathy…"*

Impairment: 15% Whole Person Impairment

Impact of activities of daily living, (ADL's):

He has difficulty with home care, but can manage personal care, referring to Pages 27 and 28; 4.33, 4.34 and 4.35.

Impairment: 2% Whole Person Impairment. This is combined with cervical spine impairment:

Total impairment of the Cervical Spine = 17% Whole Person Impairment

Thoracic Spine: Although he has ongoing pain and some tenderness in the lower thoracic spine; on examination, there was no dysmetria and only slight restriction of flexion and extension and right and left rotation, consistent with his age. There was no paravertebral muscular guarding and no evidence of radiculopathy or non-verifiable radicular complaints, referring to Page 389; Table 15-4.

Impairment: 0% Whole Person Impairment"

57. Dr Long had regard to the views of Drs Guirgis Maniam and Cordato, together with the certificate of the MAS Review Panel without making any comment regarding any differences with his opinion.

58. In respect of any deduction for a pre-existing injury or abnormity, Dr Long advised as follows:

> "**DEDUCTION (IF ANY) FOR THE PROPORTION OF THE IMPAIRMENT THAT IS DUE TO PREVIOUS INJURY OR PRE-EXISTING CONDITION OR ABNORMALITY**
>
> a. 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.
> The deduction is made on the basis of pre-existing degenerative changes in the cervical spine and these were noted to be extensive in plain x-ray of the cervical spine on 23 November 2009.
>
> There was insufficient evidence immediately prior to the motor accident of 3 July 2010 in order to determine a greater pre-existing impairment."

SUBMISSIONS

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

Appellant's submissions

60. In summary, the appellant's solicitor, Mr Ainsworth, submits that:

    (a) the MAC contains a demonstrable error, or the assessment was made on the basis of incorrect criteria, because the AMS determined that the respondent had radiculopathy and assessed 15% whole person impairment;

    (b) the MAC contains a demonstrable error because the AMS failed to forensically examine the clinical records and medical reports before him, or at all, and

    (c) the MAC contains a demonstrable error because the AMS seemed to include the impairment that resulted from the injury on 30 October 2009 in his assessment, but the respondent recovered from that injury and s 323 of the 1998 Act must be applied.

Radiculopathy

61. Mr Ainsworth submits that the AMS reported his findings and determined that the imaging studies were consistent with radiculopathy in the upper extremities without giving an explanation as to what imaging supported his opinion.

62. Mr Ainsworth submits that the MAS Review Panel found no evidence of radiculopathy in March 2016 and Dr Breit in July 2017 stated that the respondent made non-verifiable radicular complaints. The AMS did not comment on Dr Breit's report or why his opinion differed.

63. Mr Ainsworth submits that the AMS failed to express a view that the radiculopathy resulting from the nerve roots at different levels of the cervical spine resulted from the injury on 3 July 2010. This was on a background of the passing of nine years since the injury and the absence of radiculopathy noted by the MAS Review Panel three years ago.

Failure to consider clinical records and medical reports

64. Mr Ainsworth submits that the AMS referred to the respondent's medical reports, but he made no mention of the reports submitted by the appellant. This is relevant, because the doctor found verifiable radiculopathy, but he failed to identify how the condition had deteriorated since the respondent was examined by Dr Breit and the MAS Review Panel.

65. Mr Ainsworth submits that the AMS failed to give adequate reasons as to why he considered that there had been a deterioration in the respondent's condition. This constitutes a demonstrable error.

Section 323 deduction

66. Mr Ainsworth submits that the AMS failed to consider clinical records and medical reports and has fallen into error, as he appears to have included in his assessment the impairment that resulted from the injury on 30 October 2009.

67. Mr Ainsworth submits that the AMS noted that the respondent had extensive pre-existing degenerative changes in his cervical spine in the x-ray taken in November 2009, and there is significant evidence to support the contention that the respondent had a degree of whole person impairment due to his injury on 30 October 2009, including the MAS Review Panel Certificate issued on 10 March 2016.

68. Mr Ainsworth submits that the AMS failed to make an appropriate deduction pursuant to s 323 of the 1998 Act in respect of the injury sustained on 30 October 2009. He made a demonstrable error in considering that he was also required to assess the impairment as a result of the earlier injury.

69. Mr Ainsworth submits that a member of the Appeal Panel should re-examine the respondent and the available evidence on respect of the pre-existing conditions should be considered.

Respondent's submissions

Radiculopathy

70. The respondent's solicitor, Mr Hansen, submits that the AMS described the matters that he took into account to determine if radiculopathy existed. This included a history and clinical findings. The AMS considered the imaging and previous medical reports and he identified these in his MAC. The AMS conducted a physical examination and he took into account the documentation, radiological tests and other reports.

71. Mr Hansen submits that the AMS was provided with a copy of the MAS Review Panel report dated 10 March 2016, which assessed the respondent under AMA4. The AMS set out his findings and calculations in accordance with the Guidelines and he referred to the radiological studies before coming to a conclusion. There was no error by the AMS.

Failure to consider clinical records and medical reports

72. Mr Hansen submits that the AMS was required to assess the level of permanent impairment and provide reasons for his findings. The AMS provided details in the MAC. He was not required to determine whether there had been any deterioration the respondent's condition.

73. Mr Hansen submits that the AMS referred to the radiological evidence when coming to his conclusion. He indicated that the imaging studies were consistent with radiculopathy.

74. Mr Hansen submits that the AMS is not required to identify each document individually and the AMS indicated that he had considered all of the documentation.

Section 323 deduction

75. Mr Hansen submits that the AMS followed the Guidelines and came to a concluded decision. This is no reason why the findings of the AMS should be overturned. The MAS Review Panel and Dr Breit made no deduction for a pre-existing condition. The appeal should be dismissed, and the MAC confirmed.

FINDINGS AND REASONS

76. 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.

77. The role of the Medical Appeal Panel was considered by the Court of Appeal in the case of *Siddik v WorkCover Authority of NSW*[1]. The Court held that while prima facie the Appeal Panel is confined to the grounds the Registrar has let through the gateway, it can consider other grounds capable of coming within one or other of the s 327(3) heads, if it gives the parties an opportunity to be heard.

78. In *Campbelltown City Council v Vegan*[2], 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.

79. Though the power of review is far ranging it is nonetheless confined to the matters which can be the subject of appeal. Section 327(2) of the 1998 Act restricts those matters to the matters about which the AMS certificate is binding.

80. In this matter, the delegate of the Registrar has determined that he is satisfied that one of the grounds of appeal under s 327(3)(d) is made out. The Panel has accordingly conducted a review of the material before it and reached its own conclusion.

Radiculopathy

81. Clause 4.27 of Part 4 of the Guidelines sets out the requirements for a finding of the presence of radiculopathy. It provides:

> "**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):

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[1] [2008] NSWCA 116

[2] [2006] NSWCA 284

- **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)."

82. The Appeal Panel notes that the AMS quoted the Guidelines in his MAC, so he was aware of the requirements for a finding of radiculopathy.

83. The AMS reported that on examination, there was diminished sensation in the right forearm, thumb, second and third fingers, consistent with the C5/6 dermatome, and in the left fourth and fifth fingers and medial aspect of the left hand, consistent with the C8 dermatome. He found no evidence of sensory loss in the thoracic spine, lumbar spine or limbs.

84. Therefore, the AMS found evidence of "reproducible impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution". This is one of the major criteria under the Guidelines. This was on a background of a history of pain radiating into the medial aspect left arm hand and fingers and later into the lateral aspect of the right firearm, right hand and radial fingers.

85. The Appeal Panel notes that the AMS had regard to the radiological testing taken before and after the work incident. He recorded that the MRI scan dated 1 July 2014 was reported as showing "mild congenital narrowing of the cervical canal with superimposed multilevel spondylitic change with mild central stenosis and early cord compression at C5/6". The MRI scan dated 15 August 2017 showed "multiple level degenerative spondylosis leading to central canal narrowing and foraminal narrowing. Some of the foraminal narrowing on the right is severe, potentially causing nerve impingement. The central canal narrowing is most significant at C5/6".

86. The Appeal Panel notes that in his reasons for assessment, the AMS advised that the respondent had "verifiable radicular complaints involving the lateral aspect of the right forearm and radial fingers suggestive of a C5/6 nerve root compromise. There was significant corresponding diminished reflexes right upper extremity. In the left arm, he has pain and sensory change affecting the medial aspect of the left forearm, medial hand and left fourth and fifth fingers, suggesting a C8 nerve root lesion; but the reflexes left upper extremity are retained and active. There was no clinical evidence that the left ulnar nerve was compromised. Consideration was also given to the imaging studies and to previous consultant reports".

87. Therefeore, the Appeal Panel is satsified that the AMS adequately explained why the radiological tests were consistent with his findings of radiculopathy.

88. The Appeal Panel notes that a number of doctors, including Drs Guirgis, Maniam, Cordato and Crocker recorded complaints and observed clinical evidence consistent with radiculopathy. Further, the radiological resting showed pathology at C5/6 and C7/8 that could account for the respondent's symptoms. Even Dr Wilding observed diminished sensation in the respondent's left arm that originated from the neck.

89. The fact that the MAS Review Panel in April 2016 and Dr Breit in July 2017 found no evidence of radiculopathy is of no relevance. The assessment of permanent impairment involved a clinical assessment by the AMS on the date of the examination on 20 August 2019. The AMS is required to use his clinical judgment and training in determining a diagnosis and providing an assessment.

90. The AMS was requested to assess the degree of permanent impairment arising from the injury on 3 July 2010. He was not required to express an opinion on causation. There was no evidence of any causative event after the injury on 3 July 2010. Therefore, there was no error on his part in respect of this ground of appeal.

Failure to consider clinical records and medical reports

91. The Appeal Panel acknowledges that the AMS did not identify the reports submitted by the appellant, but the authorities confirm that an AMS is not required to do so.

92. In *Western Sydney Local Health District v Chan*[3], Adams J was called upon to determine whether a MAP had fallen into error when it determined that the AMS, Dr Parmegiani, had taken into account a supplementary medical report of Dr Snowden that was filed by the employer, in circumstances where the AMS had not expressly referred to the report in his MAC.

93. His Honour stated that it was the AMS was under no legal obligation to discuss the supplementary report and he did not accept that the lack of any comment about the report meant that the AMS had not considered it. He noted that the AMS was required under s 325 of the 1998 Act to set out the facts upon which the decision was based, and he had done so when "he stated that those facts were: The clinical examination and perusal of documentation submitted by the parties".[4]

94. His Honour stated:

> "It may be reasonable to suppose that, had he considered the report, he would have mentioned, at least, the fact that he differed from it, even if he did not feel the need to explain why, but that he had done so was manifest to the parties, who well knew what material was before him. I do not see that he needed to say anything more than he did on this point, namely that he had perused the material provided. It was not unreasonable, let alone 'illogical and irrational and not based on findings or inferences of fact supported by logical grounds' for the Panel to conclude, in effect, that Dr Parmegiani was aware of the supplementary and reduced assessment of Dr Snowden but simply did not feel the need to mention or discuss it, a view, which, plainly enough, they shared. Furthermore, the implicit conclusion that this was a reasonable or, at least, a not unreasonable approach was to my mind open to the Panel. Since Dr Parmegiani's task was to assess Ms Chan's condition based on his own clinical assessment of the material, it is an available inference that Dr Parmegiani did not feel it necessary to discuss (as distinct from mention) Dr Snowdon's supplementary report. The Panel thought this adequately explained why Dr Parmegiani did not refer to that report. It was not illogical or irrational for the Panel to have so concluded."

95. His Honour dismissed the employer's summons on the basis that the decision of the MAP was open on the material before it and this was entirely reasonable.

96. In this matter, the AMS was required to assess respondent "based on his own clinical assessment of the material" and he explained his reasons for his assessment. He indicated that "Consideration was also given to the imaging studies and to previous consultant reports". This is no different to the comments made by the AMS in *Chan*.

97. Dr Long was not required to comment on any deterioration or how it may have occurred. His task was to assess the respondent's whole person impairment as at the date of the examination. Therefore, the Appeal Panel is satisfied that there was no error on the part of the AMS in respect of this ground of appeal.

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[3] [2015] NSWSC 1968 (*Chan*).

[4] *Chan*, [15].

Section 323 deduction

98. Section 323 of the 1998 Act provides:

> "323 (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."

99. The principles regarding deductions pursuant to s 323 of the 1998 Act have been canvassed in a number of Supreme Court and Court of Appeal decisions. These warrant some comment.

100. In *Matthew Hall Pty Ltd v Smart* [5], Giles JA (Mason P and Powell JA agreeing) stated:

> "The background to the original s68A, in the decisions referred to in the passage next set out, was explained in *D'Aleo v Ambulance Service of New South Wales* (NSWCA, 12 December 1996, unreported). In that case the appellant had pre-existing degenerative changes to her back, although they were asymptomatic. It was argued that a pre-existing condition which was asymptomatic and had not resulted in any prior impairment in the sense of physical disability or incapacity was insufficient to attract s68A. Cole JA, with whom Handley JA and Cohen AJA agreed, said -
>
>> 'The terms of s68A(1) are in my judgment tolerably clear. The employer who is liable in respect of an injury causing permanent impairment of the back, neck or pelvis is not liable in respect of "any proportion of the loss that is due to" the factors referred to in (a) and (b). The circumstances referred to in (a) are those in respect of which compensation has been paid or is payable under Division 4. The approach of the courts in *Rodios v Trefel* [(1937) 11 WCR NSW 285], *King v Hayward* [(1943) 67 CLR 488] and *TAFE v Pitt* [(1993) 9 NSWLR CCR 309] is negated. However, the legislature went further by enacting (b). Prior non-compensable injuries, pre-existing conditions or abnormalities result in a deductable [sic] proportion being determined for which the employer liable in respect of the injury causing the permanent impairment of the back, neck or pelvis is not to be responsible. The words "any pre-existing condition" in my view include a degenerated back caused by the advent of age. Insofar as the permanent impairment of the back as found is due to that pre-existing condition, an appropriate deduction for the effects of the pre-existing condition is to be made. In the circumstances mentioned in subs (8), it is 10%.'
>
> In *Government Cleaning Service v Ellul* (1996) 13 NSW CCR 344 at 349 it had been said that s68A(1) was not concerned with any pre-existing condition or abnormality which was not causing any permanent impairment. Cole JA went on in *D'Aleo v Ambulance Service of New South Wales* to explain that, read in context, this meant that unless the pre-existing condition was a contributing factor causing permanent impairment, s68A(1)(b) had no application; so read, it was consistent with the view his Honour had earlier stated. In the result, therefore, it did not matter that the pre-existing condition had been asymptomatic, provided that the permanent impairment of the back as found was to some extent due to the pre-existing condition.

[5] [2000] NSWCA 284 (*Smart*).

> The same, in my view, must be said as to the current s68A(1). It does not matter that the pre-existing condition was asymptomatic, and if the loss is to some extent due to the pre-existing condition there must be deduction of the deductible proportion for that loss. But it is necessary that the pre-existing condition was a contributing factor causing the loss. And, of course, it is necessary that there was a pre-existing condition."[6]

101. In *Cole v Wenaline Pty Limited* [7], Schmidt J stated:

> "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. The extent that the later impairment was due to the earlier injury, pre-existing condition or abnormality must be determined. The only exception is that provided for in s 323(2), where the required deduction 'will be difficult or costly to determine (because, for example, of the absence of medical evidence)'. In that case, an assumption is provided for, namely that the deduction 'is 10% of the impairment'. Even then, that assumption is displaced, if it is at odds with the available evidence."[8]

102. In *Vitaz v Westform (NSW) Pty Ltd* [9], Basten JA discussed the principles regarding deductions pursuant to s 323 of the 1998 Act when reviewing the submissions made to the Appeal Panel in that matter and he stated:

> "The appeal to the Appeal Panel did not expressly identify an erroneous failure to give reasons. Rather, the submissions on the appeal, which appear to set out the grounds of challenge, complained that there can be no deduction under s 323, as a matter of law, in the absence of a pre-existing physical impairment. It was further submitted, by reference to the opinion of three medical commentators in a local publication:
>
> > 'If a worker develops permanent pain and symptoms due to work consistent with spondylosis (sic) in the neck region, that condition might be assessed at DRE II. Although the spondylosis (sic) is likely to have been degenerative, if there were no symptoms in the period prior to the work-related complaint, then there was no rateable impairment at that time. So, nothing would be subtracted from the current impairment'.
>
> That opinion contained a legal assumption which is inconsistent with the approach adopted by this Court in, for example, *D'Aleo v Ambulance Service of New South Wales* (NSWCA, 12 December 1996, unrep) (quoted by Giles JA, Mason P and Powell JA agreeing, in *Matthew Hall Pty Ltd v Smart* [2000] NSWCA 284; 21 NSWCCR 34 at [30]-[32] and, more recently, by Schmidt J in *Cole v Wenaline Pty Ltd* [2010] NSWSC 78 at [13]). The resulting principle is 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…"[10].

103. This principle was confirmed in *Ryder*, where Campbell J was called upon to review a MAC and the decision of a Medical Appeal Panel confirming the AMS's deduction of 10% pursuant to s 323 of the 1998 Act.

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6 *Smart*, [30] – [32].
7 [2010] NSWSC 78 (*Cole*)
8 *Cole*, [30].
9 [2011] NSWCA 254 (*Vitaz*).
10 *Vitaz*, [42] – [43].

104. His Honour confirmed that whether there was a pre-existing condition that contributed to the post injury impairment was a question of fact[11]. Further, it was inappropriate to assume that if there was a pre-existing condition or injury, it must contribute to the impairment[12]. He continued:

> "……. Where the issue is whether any proportion of the permanent impairment resulting from the work injury is due to a pre-existing condition, it is not necessary that the condition, pre-injury, of itself, would have given rise to a rateable percentage impairment by application of the diagnosis-related evaluation of impairment prescribed by the WorkCover *Guides*.
>
> In the present context, the critical question is the causation question which, expressed by adapting the terms of the statute is whether a portion of the 15 per cent whole person impairment Ms Ryder suffered as a result of her work injury was due to a pre-existing condition or abnormality i.e. degenerative disc disease. The argument advanced on behalf of Ms Ryder is effectively that the proportion must be capable of assessment in accordance with the *WorkCover Guides* for s 323(1) to be satisfied. With respect, this overlooks the requirement that the section must be read as a whole and in its legislative context. Although s 323(2) does not use the word 'proportion' it addresses the idea that in some, perhaps many, if not most, cases it may be 'difficult or costly to determine' the relevant proportion. In that event, a rule of thumb ('assumption') of 10 per cent is to be adopted.
>
> I acknowledge that the express words of s 323(1) require that some definite part, even if it is difficult or costly to assess in precise terms, of the impairment has been caused by, in this case, a pre-existing condition. But the interpretation adopted by the Court of Appeal is that the section is engaged if the pre-existing condition, or previous injury where applicable, is a concurrent necessary condition, with the work injury, of the *degree* of permanent impairment."[13]

105. Mr Ainsworth submits that the AMS appears to have included in his assessment the impairment that resulted from the injury on 30 October 2009. The reasoning for this submission is not entirely clear.

106. It is true that the AMS was aware of the presence of extensive degenerative changes in the respondent's cervical spine as reported in the x-rays dated 23 November 2009 and the CT scan dated 11 January 2010. The extent of these changes may have resulted in a degree of whole person impairment, but there was no assessment undertaken at that stage.

107. The various certificates issued by MAS related to the accident on 3 July 2010 are of assistance regarding the extent of any pre-existing injury or abnormality.

108. Both Dr Burns and Dr Wilding assessed 5% whole person impairment as the result of the accident on 3 July 2010. Neither considered that there was any impairment due to a pre-existing injury or subsequent causes.

109. The MAS Review Panel Certificate recorded a similar history of recovery from the 2009 accident and of the respondent being pain-free at the time of the accident on 3 July 2010. The views of the Review Panel mirrored those of Drs Burns and Wilding.

110. Although Mr Ainsworth submits that the AMS thought that he was also required to assess the impairment as a result of the earlier injury, this is not apparent from the MAC. The AMS advised that "There was insufficient evidence immediately prior to the motor accident of 3 July 2010 in order to determine a greater pre-existing impairment."

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[11] *Smart,* [33].
[12] *Cole*, [28] – [30].
[13] *Ryder*, [41] – [43].

111. The size of any deduction pursuant to s 323 of the 1998 Act needs to take into account the evidence of advanced pre-existing degenerative changes, but these were asymptomatic at the time of the injury on 3 July 2010. The evidence confirms that the respondent had recovered from the effects of the earlier work incident.

112. Drs Guirgis and Maniam considered that a one-tenth dedication was appropriate, whereas Drs Cordato, Burns, Wilding and the doctors on the MAS Review Panel saw no reason to apply a deduction to their assessments. Therefore, the views of these doctors are similar to those of the AMS.

113. Even the appellant's own qualified specialist, Dr Breit, saw no reason to make any deduction. Therefore, Mr Ainsworth's submission is at odds with the appellant's own evidence.

114. The Appeal Panel is satisfied that the extent of the pathology shown in the early diagnostic tests was sufficient to play a causative role in the ultimate degree of whole person impairment. In the circumstances, a minimum deduction of one-tenth in accordance with s 323(2) of the 1998 Act was warranted.

115. In the Appeal Panel's opinion, it was open to the AMS to assess the degree of the appellant's whole person impairment and the s 323 deduction in the manner that he did, and this discloses no error on his part.

116. For these reasons, the Appeal Panel has determined that the MAC issued by Dr Long on 20 August 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*.

A Jackson

Ann Jackson
Dispute Services Officer
As delegate of the Registrar