WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-4675/19**
Appellant:	**Martin Allan Bagnall**
Respondent:	**Epic Wright Heaton Pty Ltd t/as EWH Food Services**
Date of Decision:	**3 February 2020**
Citation:	**[2020] NSWWCCMA 14**

Appeal Panel:	
Arbitrator:	**Catherine McDonald**
Approved Medical Specialist:	**Dr Drew Dixon**
Approved Medical Specialist:	**Dr Ross Mellick**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 14 November 2019, Martin Allan Bagnall lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr David Lewington, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 30 October 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, being that in s 327(3)(d). The Appeal Panel has conducted a review of the original medical assessment but limited to the grounds of appeal on which the appeal is made.

4. The Workers compensation medical dispute assessment guidelines set out the practice and procedure in relation to the medical appeal process under s 328 of the 1998 Act. An Appeal Panel determines its own procedures in accordance with the Workers compensation medical dispute assessment guidelines.

5. The assessment of permanent impairment is conducted in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment, 4th* ed 1 April 2016 (the Guidelines) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th ed (AMA 5).

RELEVANT FACTUAL BACKGROUND

6. Mr Bagnall was employed by Epic Wright Heaton Pty Ltd t/as EWH Food Services (EWH) as a delivery driver when he injured his neck and left shoulder on 6 January 2017 while unloading a truck. He was standing on a rung on the side of the truck, reaching for a box of condensed milk weighing 26 kg. The box fell, causing him to step down from the truck and take the weight of the box, jarring his left shoulder and neck. He underwent physiotherapy and a few months later saw Dr J Curtis, neurosurgeon. Dr Curtis recommended a cortisone injection and medication. In November 2017, when Mr Bagnall's symptoms were not improving, Dr Curtis recommended surgery.

7. On 19 April 2018, Dr Curtis undertook C4/5 and C5/6 anterior discectomies, removal of osteophytes and instrumented fusion.

8. The AMS assessed 21% WPI comprised of 20% in respect of the cervical spine and 1% in respect of the left shoulder.

PRELIMINARY REVIEW

9. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Workers compensation medical dispute assessment guidelines.

10. As a result of that preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination because there is sufficient information in the file to determine the appeal.

EVIDENCE

11. 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.

12. 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

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

14. In summary, Mr Bagnall submitted that the AMS was in error in failing to assess loss resulting from persisting radiculopathy when Dr P Darveniza, qualified on his behalf, and Dr C Harrington, qualified for EWH, had both done so. He also submitted that the AMS was in error in deducting "30%" for a pre-existing abnormality which was asymptomatic. He said that s 323 of the 1998 Act "requires" an assumption that the impairment is 10% which the AMS ignored. He submitted that there should be no deduction because the pre-existing condition was asymptomatic.

15. Mr Bagnall did not submit that the AMS was in error in the assessment of impairment resulting from the injury to his left shoulder. While we do not need to consider that aspect of the assessment, we note a typographical error in the certificate which we have amended.

16. In reply, EWH's insurer submitted that the AMS appropriately assessed Mr Bagnall for radiculopathy in accordance with paragraphs 4.27 to 4.29 of the Guidelines. It submitted that s 323(2) was not applicable because there was no lack of medical evidence and imaging studies provided objective proof of moderately severe multilevel spondylitic degenerative change. EWH submitted that the deduction should be more than three-tenths, though did not file a cross-appeal nor make any more detailed submissions.

FINDINGS AND REASONS

17. 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.

18. In *Campbelltown City Council v Vegan* [2006] NSWCA 284 the Court of Appeal held that the Appeal Panel is obliged to give reasons. Where there are disputes of fact it may be necessary to refer to evidence or other material on which findings are based, but the extent to which this is necessary will vary from case to case. Where more than one conclusion is open, it will be necessary to explain why one conclusion is preferred. On the other hand, the reasons need not be extensive or provide a detailed explanation of the criteria applied by the medical professionals in reaching a professional judgement.

The MAC

19. The AMS briefly set out Mr Bagnall's present symptoms and said:

> "There is overall poorly localised tingling sensation in the left hand which he initially described as involving the whole hand but then mainly the index and middle fingers (suggestive of either C 6 or C 7 radicular distribution)."

20. The AMS noted that Mr Bagnall had fractured his right index finger 20 years ago. He set out his findings on examination of the cervical spine and said:

> "Neurological examination of the upper limbs revealed no focal neurological deficit apart from reduced sensation over the distal right index finger where there was scarring related to a previous fracture injury. In all other respects pinprick sensation was reported as equal on both sides, deep tendon reflexes were present and symmetrical and power was within normal limits."

21. He considered the investigations and noted:

> "M.R.I Scan Cervical Spine 6 February 2017: is reported to show moderately severe multilevel spondylitis degenerative change C 4 to C 7 most pronounced at C 4-5 in C 5-6; with mild broad based disc osteophyte complexes, uncovertebral spurring and foraminal narrowing worse on the left side."

22. The AMS summarised the injuries and diagnoses:

> "Neck and left shoulder injury 6 January 2017 with aggravation of cervical spondylosis and proceeded to decompression and cervical fusion at the C 4-5 and C 5-6 levels on 19 April 2018. Non-verifiable radiculopathy."

23. When providing the reasons for his assessment in respect of the cervical spine, the AMS said:

> "Cervical spine was assessed commencing with Table 4.1, Page 26 of the W.C.C Guides 4th Edition; Clinical Findings Definitions, Box 15.1, A.M.A 5, Pages 382 -383 and D.R.E Categories for Cervical Spine, A.M.A 5, Table 15.5, Page 392.
>
> Radiculopathy is assessed in accordance with Box 15 - 1 of A.M.A 5 (Page 382) and Paragraphs 4.27-4.29 of the W.C.C Guides 4th Edition.
>
> In the Cervical Spine there is D.R.E Category IV equivalent to 25% W.P.I (prior to adding A.D.L contribution or combining modifiers for the effects of surgery). This impairment relates to cervical fusion surgery in accordance with the W.C.C Guides 4th Edition, Page 29 Paragraph 4.37.

A 2% impairment has been added for A.D.L restrictions in accordance with Paragraphs 4.33 - 4.38, Pages 27 - 28 the W.C.C Guides 4th Edition. This yields a subtotal of 27% W.P.I.

There are modifiers for the Effect of Surgery including radiculopathy post-surgery in accordance with the W.C.C Guides 4th Edition, Page 29, Paragraph 4.37. Modifiers from Table 4.2 must be combined and the total amount from Table 4.2 combined with the total of the D.R.E category i.e combine all of the modifiers first, then combine that total with the bas figure (S.I.R.A/W.C.C Guidelines and Supreme Court Case Robbie Vs Strasburger). In this case there is 1% modifier for second spinal level. The 1% W.P.I combines with the previous 27% to yield 28% W.P.I.

The Total for Cervical Spine Impairment is 28 %."

24. The AMS considered the reports prepared by Dr Curtis. With respect to the report of Dr Darveniza he said:

> "Dr Darveniza, neurologist medicolegal report 29 April 2019: diagnosed "work-related symptomatic cervical spondylosis and injury to the left shoulder". He assessed cervical spine D.R.E Category IV, 25% W.P.I for cervical spine surgery with 6% for cervical modifiers, totalling 30% W.P.I for cervical spine, and 1% left upper extremity W.P.I based on restricted range of shoulder movement. No deductible proportion is offered.
>
> Although I believe the I.M.E has not used the correct methodology for the calculation of cervical spine 30% W.P.I, using the correct methodology yields the same figure. Importantly however, this figure is contingent on including a post-operative persisting radiculopathy (3% modifier for effects of surgery). On today's examination there was no evidence of radiculopathy.
>
> I disagree with the I.M.E regarding deductible proportion and as further detailed under section 11 of the certificate."

25. With respect to Dr Harrington's report, the AMS said:

> "Dr Harrington, orthopaedic surgeon medicolegal report 8 August 2019: assessed D.R.E Category IV for cervical spine surgery and 29% W.P.I; and 2% W.P.I for left shoulder based on restricted range of motion.
>
> The I.M.E also found persisting radiculopathy post cervical surgery but arrives at a figure of 29% W.P.I (instead of 30% as per Dr Darveniza with the point of difference between the I.M.E's being Dr Harrington only assessed 1% for A.D.L contribution whereas was Dr Darveniza and myself have assessed 2% A.D.L contribution. On today's examination there was no evidence of radiculopathy."

26. The AMS said that a deduction under s 323 of the 1998 Act was warranted because Mr Bagnall suffered:

> "Cervical spondylosis with narrowing of nerve root intervertebral foramina contributing to the need for cervical spine surgery and directly contributing to assessment of impairment."

27. He provided his reasoning for making a three-tenths' deduction:

> "There is evidence of pre-existing cervical spondylosis which has contributed to need for cervical spine surgery and directly impacting on the assessment of impairment.

Clinically there has been aggravation of pre-existing cervical degenerative changes/cervical spondylosis. In this regard I note Dr Curtis, treating neurosurgeon's operation report 19 April 2018 confirms the need for removal of osteophytes (longstanding bony degenerative spurs narrowing the passageways of the exiting spinal nerves). I also note his preoperative assessment on 1 November 2017 with the bone scan showing activity at C 4-5 in C 5-6 with disco vertebral joints (long-standing degenerative changes). His clinical recommendation was to proceed with the cervical fusion and "removal of osteophytes freeing up his nerve". Other correspondence includes 14 July 2017 where he noted an M.R.I Scan taken only one month after the subject injury and which was reported to show bilateral foraminal narrowing at the C 4-5 and C 5-6 levels worse on the left, with impingement of both the exiting C5 and C6 nerve roots (indicating narrowing of the passageways of the exiting spinal nerves roots).

The actual M.R.I Scan of the cervical spine alluded to above was taken on 6 February 2017 and reported to show moderately severe multilevel spondylotic degenerative change C4 to C 7, most pronounced at C 4-5 in C 5-6 with mild broad-based disc osteophyte complexes, uncovertebral spurring and foraminal narrowing, worse on the left side. X-Rays of the cervical spine at the same time period showed similar changes.

I consider these spondylotic changes to be significant, necessarily would have predated the subject injury 6 January 2017, and have contributed to impairment.

In my opinion the above evidence is at odds with a 1/10th deduction under section 323.

On the other hand, I have noted that Mr Bagnall was asymptomatic prior to the injury on 6 January 2017 which caused aggravation of these pre-existing degenerative changes. On balance therefore I consider a 3/10 deduction both fair and consistent with the available evidence."

28. There is no dispute that Mr Bagnall should be assessed in DRE Cervical Category IV, assessed in accordance with AMA5 and the Guidelines as 25%.

29. The AMS assessed 2% WPI for the impact of the injury on the activities of daily living. That assessment might be seen as generous but it is not the subject of appeal and it must therefore stand and the resulting impairment is 27% WPI.

30. The AMS combined that figure with 1% WPI for surgery at a second spinal level. He adopted the correct methodology under the Guidelines, resulting in an assessment of 28% WPI before a deduction under s 323.

Radiculopathy

31. The Guidelines required the AMS to assess Mr Bagnall as he presented on the day of the examination.[1]

32. The principles of assessment of radiculopathy are set out at paragraphs 4.27 to 4.29:

> "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

[1] Paragraph 1.6.

- 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.

4.29 Global weakness of a limb related to pain or inhibition or other factors does not constitute weakness due to spinal nerve malfunction."

33. Table 4.2 sets out the modifiers for DRE categories following surgery:

Procedures	Cervical
Spinal surgery with residual symptoms and radiculopathy (refer to 4.27 in the Guidelines)	3%
Second and further levels	1% each additional level
Second operation	2%
Third and subsequent operations	1% each

34. The AMS set out his neurological examination, albeit briefly. He found no focal deficit other than that resulting from a scar from an unrelated injury to Mr Bagnall's right hand.

35. The AMS considered the appropriate parts of the Guidelines in making his assessment. He considered that on the day of his assessment, there was non-verifiable radiculopathy which, in accordance with paragraph 4.28 of the Guidelines is not rateable.

36. Mr Bagnall's submissions stressed that the independent medical examiners qualified for both parties found radiculopathy. Dr Darveniza's report dated 20 April 2019 is relatively brief. He did not explain why he allowed 3% for residual symptoms and radiculopathy. The only relevant examination findings recorded were that:

> "the left triceps was depressed compared to the right but there was no wasting or weakness. There was subjective numbness of the third and fourth fingers of the left hand. There was no other sensorimotor or reflex disturbance in the limbs."

37. Those findings do not support a finding of radiculopathy under the Guidelines.

38. Dr Harrington's report is dated 8 August 2019. He recorded:

> "He has lost muscle bulk in his left arm. …His triceps jerk is present but reduced on the left when compared to the right. He has some altered sensation to two-point discrimination in the C6 distribution. There is no obvious weakness in his forearm."

And concluded:

> "Based on the clinical findings, there is evidence of persistent radiculopathy with reduced reflexes and altered sensation in the left upper extremity."

39. Dr Harrington did not correlate those findings to paragraph 4.27, though on the day of his examination, it appears that criteria sufficient to assess radiculopathy were observed.

40. The AMS considered the reports by Drs Darveniza and Harrington and contrasted his findings with those of Dr Harrington. The AMS was required to assess Mr Bagnall on the day he presented for examination and he did so.

41. The AMS was not bound by, or required to choose between, the opinions of the doctors qualified by the parties. In *State of NSW (NSW Department of Education) v Kaur*[2], Campbell J said:

> "In *Wingfoot Australia Partners Pty Ltd v Kocak* [2013] HCA 43; 252 CLR 480, the High Court of Australia dealt with the nature of the jurisdiction exercised by a medical panel under cognate Victorian legislation. The legislation is not entirely the same but it is broadly similar in purpose. Allowing for some differences, the High Court said at page 498 [47]:
>
> > 'The material supplied to a medical panel may include the opinions of other medical practitioners, and submissions to the Medical Panel may seek to persuade the Medical Panel to adopt reasoning or conclusions expressed in those opinions. The Medical Panel may choose in a particular case to place weight on the medical opinion supplied to it in forming and giving its own opinion. It goes too far, however, to conceive of the functions of the panel as being either to decide a dispute or to make up its mind by reference to completing contentions or competing medical opinions. The function of a medical panel is neither arbitral or adjudicative: It is neither to choose between competing arguments nor to opine on the correctness of other opinions on that medical question. The function is in every case to perform and to give its own opinion on the medical question referred to it by applying its own medical experience and its own medical expertise.'
>
> Not all of this, as I have said, is apposite in the context of the New South Wales legislation. In particular it is obvious that approved medical specialists are required to decide disputes referred to them by the process of medical assessment. Even so, it is not necessary that approved medical specialists should sit as decision makers choosing between the competing medical opinions put forward by the parties. Essentially, the function is the same as that described by the High Court in *Wingfoot Australia*. That is to say, their function is in every case to form and give his or her own opinion on the medical question referred by applying his or her own medical experience and his or her own medical expertise. It is sufficient, as their Honours pointed out at [55], that:
>
> > 'The statement of reasons… explain the actual path of reasoning in sufficient detail to enable the Court to see whether the opinion does or does not involve any error of law.'"

42. The assessment of cervical spine impairment made by the AMS on the basis of the findings recorded at his examination is correct.

Section 323 deduction

43. The deduction of three tenths of the amount assessed in respect of the cervical spine made by the AMS was excessive.

44. The AMS considered that the spondylitic changes observed on x-ray and MRI taken soon after the injury were significant and he stressed that one component of the surgery was the removal of osteophytes. He accepted, however, that Mr Bagnall was asymptomatic before the injury.

[2] [2016] NSWSC 346.

45. Section 323 relevantly 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."

46. Mr Bagnall's submission that the section requires the AMS to assume that the deduction is 10% is a misreading of the section. The bald submission that there should be no deduction because the condition was asymptomatic also cannot be accepted.

47. In *Cole v Wenaline Pty Ltd*[3] Schmidt J said that the task of the AMS under s 323 was to determine:

> (a) The extent of the impairment;
>
> (b) Whether the pre-existing condition contributed to the impairment, and
>
> (c) If it did, the proportion of the impairment that was due to the pre-existing condition.

48. In *Ryder v Sundance Bakehouse*[4] Campbell J said:

> "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 the 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 the 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.[5]"
>
> …
>
> "Section 323 as I have already said, requires there to be a deduction for any proportion of the impairment that is due to any pre-existing condition. This is an essential element of the section; indeed it is the pith of it. It is not enough to simply identify that there is a pre-existing condition and that there has been a subsequent impairment and therefore make a deduction under this section because of the existence of the pre-existing condition. Such reasoning fails to consider a necessary condition of the operation of the section; that a proportion of the permanent impairment is due to the pre-existing condition."[6]

[3] [2010] NSWSC 78.
[4] [2015] NSWSC 526.
[5] At [45].
[6] At [54].

49. The AMS did not provide reasons to justify the extent of the substantial deduction he made.

50. The injury Mr Bagnall suffered was an aggravation of spondylitic degenerative change. It follows that the degenerative change contributes to the impairment. He was asymptomatic before the injury. The extent of the contribution would be difficult to determine. A deduction of one-tenth is not at odds with the medical evidence and is appropriate in this case.

51. For these reasons, the Appeal Panel has determined that the MAC issued on 30 October 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*.

A Jackson

Ann Jackson
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **4675/19**
Applicant: **Martin Allan Bagnall**
Respondent: **Epic Wright Heaton Pty Ltd t/as EWH Food 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 David Lewington 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	6 January 2017	D.R.E Method: Chapter 4, Page 26, Table 4.1. A.D.L Impact: Pages 27-28, Paragraphs 4.33 4.36. Effect of Surgery: Page 29, Paragraph 4.27, Table 4.2. Radiculopathy: Chapter 4, Page 27, Paragraph 4.27	Cervical Spine Impairments: Chapter 15, Page 392, Table 15-5.	28%	1/10	25%
2. Left Upper Extremity (Left Shoulder)	6 January 2017	Conditions Affecting Shoulder: Chapter 2, Page 11, Paragraphs 2.14 to 2.16. Motion Impairment: Page 12, Paragraph 2.20 and Page 10, Paragraph 2.5.	Shoulder Motion Impairment: Chapter 16, Flex-Ext - Page 476, Figure 16-40; Abd-Add - Page 477, Figure 16-43; I-E Rot – Page 479, Figure 16-46.	1%	Nil	1%
Total % WPI (the Combined Table values of all sub-totals)						**26%**

Catherine McDonald

Arbitrator

Dr Drew Dixon
Approved Medical Specialist

Dr Ross Mellick
Approved Medical Specialist

31 January 2020

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE MEDICAL ASSESSMENT CERTIFICATE OF THE APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

A Jackson

Ann Jackson
Dispute Services Officer
As delegate of the Registrar