WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-4879/19**
Appellant:	**Shoalhaven City Council**
Respondent:	**Paul Edwards**
Date of Decision:	**3 March 2020**
Citation:	**[2020] NSWWCCMA 36**

Appeal Panel:	
Arbitrator:	**Ms Deborah Moore**
Approved Medical Specialist:	**Dr David Crocker**
Approved Medical Specialist:	**Dr Brian Noll**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 27 November 2019 Shoalhaven City Council lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Yiu-Key Ho, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 14 November 2019.

2. The appellant relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act):

   - the assessment was made on the basis of incorrect criteria,
   - the MAC contains a demonstrable error.

3. The Registrar is satisfied that, on the face of the application, at least one ground of appeal has been made out. The Appeal Panel has conducted a review of the original medical assessment but limited to the ground(s) of appeal on which the appeal is made.

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

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

PRELIMINARY REVIEW

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

7. As a result of that preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination because no request was made, and we consider that we have sufficient evidence before us to enable us to determine this appeal.

EVIDENCE

Documentary evidence

8. 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

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

10. In summary, the appellant submits that the AMS erred in three respects. Firstly, as regards his assessment in respect of ADL's, the appellant submits "The AMS should have added together the assessments in respect of the cervical spine and ADLs, which results in a figure of 7% WPI. He should then have deducted one tenth from this (in accordance with his own assessment of a deduction under section 323), resulting in a final figure of 6% WPI to the cervical spine."

11. Secondly, it is submitted that the AMS erred in his application of the provisions of section 323 with regard to the 1/10th deduction he made.

12. Thirdly, he "erroneously included an assessment of permanent impairment to the right elbow when the referral was in respect of the right upper extremity."

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

FINDINGS AND REASONS

14. The procedures on appeal are contained in s 328 of the 1998 Act. The appeal is to be by way of review of the original medical assessment but the review is limited to the grounds of appeal on which the appeal is made.

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

16. The respondent was referred to the AMS for assessment of the right upper extremity, cervical spine and scarring (TEMSKI) resulting from an injury on 16 September 2016.

17. The AMS obtained the following history:

> "He worked as a painter with Shoalhaven City Council for 12 years. He suffered an injury on 16 September 2016. He was lifting the concrete block of the security fencing and injured the right shoulder and the neck.
>
> He ended up with MRI of the right shoulder and the cervical spine on 25 November 2016, two months after the injury which showed a full thickness tear of the supraspinatus, about 1 cm, and moderate right C6 impingement.

He was first referred to Dr Jaeger in February 2017. He was noticed to have numbness of the right index and middle finger consistent with radiculopathy from a C6 nerve root. He was recommended to have injection which gave some relief. When reviewed on 1 May 2017, as the relief was not sustained, he was recommended to have surgery by Dr Jaeger to decompress right C4/5 and right C5/6 level to relieve the impingement on the right C5 and C6 nerve roots. However, his main problem at that time was the shoulder so he was reviewed by Dr Jansen as well, who also suggested him to have operation. The right arm radiculopathy more-or-less settled when reviewed by Dr Jaeger on 30 June 2017 and hence, cervical operation did not proceed. He had the right shoulder surgery done on 31 August 2017 with decompression, repair of the supraspinatus and bicep tenodesis. Unfortunately it was complicated with frozen shoulder.

He had steroid injection into the gleno-humeral joint and he had repeated MRI of the right shoulder on 14 November 2017 which confirmed frozen shoulder and all the cuff was intact after the repair. After discharge from Dr Jaeger in June 2017 he has not returned for review."

18. Present symptoms were described as follows:

> "The main problem is the right shoulder. It is sore and very stiff and he cannot move it so it is not strong. He also complained of pain in the neck together with stiffness on neck movement. The numbness is now centred round the little finger and ring finger, especially when he is resting the elbow on the arm support then the numbness is worse. He told me if he sleeps on the right side he notices pain in the right arm over the deltoid insertion area and due to favouring the use of the left arm because the right shoulder is so stiff, if lying on the left there is pain on the left shoulder."

19. Findings on physical examination were reported as follows:

> "On inspection there is significant muscle wasting of the right shoulder globally, not just in the deltoid but involves the supraspinatus and infraspinatus. The right shoulder has very stiff movement globally. Forward flexion is 90º, extension is 20º, abduction is 30º, adduction is 10º, external rotation is only 20º and the hand cannot even touch the face, internal rotation is 20º and can only touch the back of the hip, while the left shoulder has full range of movement in every direction. The cervical spine confirmed significant stiffness and there is muscle spasm. He probably has lost at least 50% of movement in every direction. Due to the stiffness and the weak shoulder, to assess the upper limb neurology becomes quite difficult but personally I do not think there are any features of radiculopathy. I can still elicit reflex jerks, more-or-less symmetrical to the other side. There is no loss of sensation in the C5 or C6 territory which should be on the radial side of the hand and lateral side of the arm and forearm. Instead he complained of numbness only on the little finger and ring finger. There are also features of ulnar nerve neuritis in the elbow because Tinel sign is positive when percussing the ulnar nerve in the cubital tunnel and there is some degree of weakness of the muscle supplied by the ulnar nerve on the right hand compared to the left. I will still grade it more than Grade 4 but it is weaker than the left hand which may have effect from the frozen shoulder causing global weakness of the right upper limb."

20. After noting the radiological evidence before him the AMS added:

> "Mr Paul Edwards had a lifting injury and damage to the cervical spine and the right shoulder. He is now left with residual problems in the neck with pain and stiffness and then right frozen shoulder despite surgery and also has the problem of ulnar nerve neuritis in the elbow."

21. The AMS then set out his reasons for assessment as follows:

> "I believe this gentleman has aggravation of cervical spondylosis which was probably asymptomatic before the injury. There is pre-existing problems because the investigation already confirmed reasonable OA changes which would not happen just from one injury. The work injury is also affecting the right shoulder causing full thickness rotator cuff tear which failed to improve despite surgery because he has significant frozen shoulder. I also believe the nature of injury is causing some ulnar neuritis in the right elbow and he is still having problems at the moment although it has not been investigated or managed all the time."

22. The AMS then set out his calculations as follows:

> "To assess the permanent impairment in relation to the cervical spine using AMA Guide 5th Edition, Table 15-5, I believe this is a DRE Cervical 2. There is pain and loss of movement. I do not think there is any obvious features of cervical radiculopathy. When he first presented, Dr Jaeger mentioned the numbness is on the index finger and the middle finger corresponding to a C6 territory. He always complains recently about the numbness, it is on the little finger and the ring finger. There is global weakness and global muscle wasting from the severe frozen shoulder but they are not consistent with cervical radiculopathy. I would not classify him as DRE Cervical 3 because he has no features of cervical radiculopathy.
>
> He certainly has trouble with ADL because the shoulder has become so stiff and right upper limb has become so weak. Using WorkCover Guide 4th Edition, Section 4.34 at Page 28, there will be 2% extra for homecare difficulties.
>
> In relation to the right shoulder, using Figure 16-40, 43 and 46, 90º of flexion is 6% upper limb impairment, extension of 20º is 2%, abduction of 30º is 7%, adduction of 10º is 1%, external rotation of 20º is 1% and internal rotation of 20º is 4%. Altogether there will be 21% upper extremity impairment which will be equal to 13% whole person impairment.
>
> In relation to the ulnar nerve using Table 16-10, I will grade him as Grade 4 and in the range of 1-25% I will assess it as 10%. Similarly based on Table 16-11, I will grade a sensory loss as Grade 4 with a range of 1-25% and once again I will rate this as 10%. Using Table 16-15 combined motor and sensory deficit for the ulnar nerve in mid-forearm, maximum is 40% and in this case I will give him 4% upper extremity impairment as I rate that as 10% and which will be equal to 2% whole person impairment.
>
> For scarring, patient had no concern and it is not symptomatic and hence 0% under TEMSKI scale.
>
> When all these are combined together, this will give rise to a 21% whole person impairment."

23. The AMS then commented on the other medical opinions as follows:

> "I cannot agree with Dr Cossetto as explained above. I do not think he has cervical radiculopathy and that explains the difference and why I assessed him to be a DRE Cervical 2 instead of 3 according to Dr Cossetto. I gave him some impairment assessment for ulnar nerve neuritis. Furthermore, my functional assessment of the right shoulder is much worse compared to Dr Cossetto, which was assessed a year ago, and which explains why my assessment on the shoulder is worse compared to him. However, I believe there will be contribution of pre-existing problem in the cervical spine and it should be pre-existing but asymptomatic, so I think a deduction of 1/10th is appropriate and that will still leave behind a 5% whole person impairment despite 1/10th deduction. The final assessment remains 21%.

My assessment has more-or-less come to the same figure as Dr Cossetto but through different pathologies. I cannot agree with him for DRE Cervical 3 because I think the radiculopathy has settled but he has the problem of ulnar neuritis and his shoulder assessment by myself is much worse than Dr Cossetto, which explains why we came to more-or-less the same number at the end.

I cannot agree with Dr Breit in terms of deduction for pre-existing condition. He deducted half of the cervical spine which I think probably was excessive because the patient never complained about the cervical spine before the injury. Once again my assessment of the right shoulder function is worse compared to Dr Breit and that explains the difference. I also assessed another 2% of whole person impairment for ulnar neuritis which he has not included into the final assessment and that explains the difference."

24. Dealing with the first ground of appeal, we agree with the appellant's submission.

25. The total impairment for the cervical spine was 7% and that following a deduction of 1/10th, this equals 6.3% rounded to 6%. The amount added for ADLs constitutes an integral part of the total figure. (The WorkCover Guides paragraph 4.33, page 27, indicates that the relevant AMA 5 tables provide a range of impairment for each DRE Category and that within this range 0%, 1%, 2% or 3% WPI is determined using the relevant information regarding ADLs in the ensuring paragraphs namely, paragraphs 4.34 and 4.35).

26. Thus we accept that the AMS erred in this respect, and the correct impairment for the cervical spine is 6% WPI.

27. Dealing with the second ground of appeal, the appellant makes the following submissions:

    (a) An MRI of the cervical spine dated 25 November 2016 reveals the worker had multilevel severe facet degenerative change with multilevel high grade bilateral foraminal stenoses and nerve root impingement. This scan was taken only two months after the work injury in September 2016;

    (b) Dr Robert Breit considered a 50% deduction was necessary in respect of the impairment assessment to the neck for "quite gross pre-existing cervical spondylosis." The worker's evidence from Dr Cossetto also believed the worker had previously asymptomatic underlying C6 nerve root impingement;

    (c) The AMS applied the one-tenth deduction after concluding the worker's pre-existing osteoarthritis was asymptomatic prior to the injury in September 2016. However, this is not the correct test. The test for assessing whether a deduction under section 323 applies is whether any prior injury or pre-existing condition or abnormality contributes to the degree of permanent impairment;

    (d) The AMS concedes the worker's osteoarthritis in the cervical spine revealed in the early scans could not have manifested with the subject injury alone. The appellant submits the AMS's opinion in this regard should have warranted a greater deduction than one tenth. It is irrelevant if the worker's osteoarthritis in the cervical spine was asymptomatic prior to the injury. This is not the correct test, as outlined above.

28. Reference is made to the decision in *Vitaz v Westform (NSW) Pty Ltd* [2011] NSWCA 254, which 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."

29. Equally however, 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* (our emphasis) of the earlier injury, pre-existing condition or abnormality."

30. In the present case, it would be expected that a man of the respondents age, 62, would demonstrate degenerative changes on radiological investigation.

31. The respondent denied any previous neck injury or symptoms, and there is no evidence to contradict this statement.

32. In these circumstances, we cannot see any error by the AMS in his 1/10th deduction since there is no clear evidence that the *actual consequences* of the pre-existing condition contributed in any significant way to the overall impairment.

33. In our view, it was open to the AMS to make only 1/10 deduction in the absence of any pre-existing symptomatic disorder of the cervical spine notwithstanding the extent of the previously asymptomatic degenerative changes.

34. Turning now to the third ground of appeal, the appellant submits the AMS erred in including an assessment of permanent impairment to the right elbow on the basis of ulnar nerve impairment. The AMS was not permitted to assess the right elbow as part of the "right upper extremity" since the worker only described an injury to the neck and right shoulder on 16 September 2016.

35. The appellant adds: "There is no allegation of injury to the elbow or permanent impairment to the elbow based on ulnar nerve impairment contained in the ARD."

36. We agree with the appellant's submissions on this point.

37. In our view, it was not open to the AMS to include an impairment of the ulnar nerve when assessing right upper extremity impairment as there was no claim made which related to this region.

38. In addition, there was no complaint made by the respondent in relation to the ulnar nerve was in either IME reports relied on by the worker and the insurer.

39. In these circumstances, the correct assessment for the right upper extremity is 13% WPI, and not 15% as assessed by the AMS.

40. In conclusion then, the total impairment is 18% WPI, made up of 6% for the cervical spine and 13% for the right upper extremity.

41. For these reasons, the Appeal Panel has determined that the MAC issued on 21 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 Shaw

Andrew Shaw
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **4879/19**
Appellant: **Shoalhaven City Council**
Respondent: **Paul Edwards**

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 Yui Key Ho 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 NSW workers compensation guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA5 Guides**	**% WPI**	**WPI deductions pursuant to S323 for pre-existing injury, condition or abnormality** (expressed as a fraction)	**Sub-total/s % WPI** (after any deductions in column 6)
1. **Right upper extremity**	**16/9/16**	**Ch. 2 Pg 10-12**	**Figure 16-40, 43 & 46**	**13%**	Nil	**13%**
2. **Cervical Spine**	**16/9/16**	**Ch. 4 Pg 24-30**	**Table 15-5**	**7%**	**1/10**	**6%**
3. **Scarring**	**16/9/16**	**Ch. 14 Pg 73-76**		**0%**	N/A	**0%**
Total % WPI (the Combined Table values of all sub-totals)					**18%**	

Deborah Moore
Arbitrator

Dr David Crocker
Approved Medical Specialist

Dr Brian Noll
Approved Medical Specialist

3 March 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 Shaw

Andrew Shaw
Dispute Services Officer
As delegate of the Registrar