# WORKERS COMPENSATION COMMISSION

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

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| **Matter No:** | **M1-3027/20** |
| **Appellant:** | **Mauricio Lopez** |
| **Respondent:** | **Leonel Veliz t/as Top Lift Scaffolding** |
| **Date of Decision:** | **11 February 2021** |
| **Citation No:** | **[2021] NSWWCCMA 29** |

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| **Appeal Panel:** | |
| **Arbitrator:** | **Mr John Harris** |
| **Approved Medical Specialist:** | **Dr Drew Dixon** |
| **Approved Medical Specialist:** | **Dr Brian Noll** |

### BACKGROUND TO THE APPLICATION TO APPEAL

1. Mr Mauricio Lopez (the appellant) suffered injury to the lumbar spine on 4 September 2016 in the course of his employment with Leonel Veliz (the respondent).

2. The appellant served a letter of claim dated 12 February 2020 seeking permanent impairment compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act).[1] The claim was based on the opinion expressed by Dr Habib for 18% whole person impairment (WPI) comprising 17% WPI for the lumbar spine and 1% for the skin.[2]

3. By letter dated 1 May 2020 the respondent disputed the extent of the claim based on the opinion expressed by Dr Robert Breit in a report dated 21 March 2020.[3] Dr Breit assessed the appellant at 14% WPI attributable to the lumbar spine and 1% in respect of the scar.[4] The doctor made a one-tenth deduction pursuant to s 323 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) resulting in an overall WPI of 14%.

4. The appellant commenced proceedings claiming permanent impairment compensation pursuant to s 66 of the 1987 Act for the lumbar spine and associated scarring.

5. The respondent filed a Reply to the Application (Reply) which limited the issues to the assessment of the degree of WPI as a result of injury.

6. The assessment of WPI is undertaken in accordance with the fourth edition of the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment* (fourth edition guidelines).[5] The fourth edition guidelines adopt the 5th edition of the *American Medical Association's Guides to the Evaluation of Permanent Impairment* (AMA 5). Where there is any difference between AMA 5 and the fourth edition guidelines, the fourth guidelines prevail.[6]

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[1] Application, p 12.
[2] Application, p 41.
[3] Reply, p 1.
[4] Reply, p 8.
[5] The fourth edition guidelines are issued pursuant to s 376 of the 1998 Act.
[6] Clause 1.1 of the fourth edition guidelines.

7. The assessment of WPI was then referred by the Registrar to Dr Richard Crane, an Approved Medical Specialist (AMS), who examined the appellant and provided the Medical Assessment Certificate dated 28 September 2020 (MAC). The relevant findings made by the AMS pertinent to the various grounds of appeal are set out later in these Reasons.

8. The AMS assessed the lumbar spine at 16% WPI and the skin (scar) at 0% WPI. A one-tenth deduction was made pursuant to s 323 resulting in an overall WPI of 14%.

**THE APPEAL**

9. On 22 October 2020, the appellant filed an Application to Appeal Against a Medical Assessment (the appeal) to the Registrar of the Workers Compensation Commission (the Commission).

10. On 12 November 2020, the respondent filed an Opposition to the Appeal.

11. The WorkCover Medical Assessment Guidelines (the Guidelines) set out the practice and procedure in relation to appeals to Medical Appeal Panels under s 327 of the 1998 Act.

12. The appellant claims that the medical assessment by the AMS should be reviewed on the ground that the MAC contains a demonstrable error and/or the assessment was made on incorrect criteria.

13. The Appeal was filed within 28 days of the date of the MAC. The submissions in support of the grounds of appeal are referred to later in these Reasons.

**PRELIMINARY REVIEW**

14. The Appeal Panel (AP) conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Guidelines.

15. As a result of that preliminary review, the AP determined, for the reasons provided, that a ground of appeal had been established.

16. The appellant did not seek a re-examination. Noting that the appellant did not seek a re-examination, the AP requested an updated coloured photograph of the scar so that the matter could be reassessed without the need for an examination.

17. The AP otherwise perceived a calculation error in the MAC. For those reasons, the AP issued the following Direction:

> "The appellant is directed to file and serve coloured photographs of the scar by close of business, 8 February 2021.
>
> The parties are further advised that there appears to be an error with respect to the additions set out at the top of page 5 of the Medical Assessment Certificate as there is a double counting of 2%, possibly for the effects of the activities of daily living.
>
> The Appeal Panel notes this as any reassessment must be "according to law": *Drosd v Nominal Insurer* [2016] NSWSC 1053.
>
> The parties may make any further submissions on this issue by close of business, 8 February 2021."

18. The AP has the power, pursuant to s 324 of the 1998 Act, to call for further information for the purposes of assessing a medical dispute.

**EVIDENCE**

19. The AP has before it all the documents that were sent to the AMS for the original assessment and has referred to portions of the evidence and taken them into account in making this determination together with the coloured photograph produced by the appellant pursuant to the direction issued by the AP.

**GROUND OF APPEAL – TABLE 4.2 modifiers for DRE Categories following surgery**

**Submissions**

***Appellant's submissions***

20. The appellant referred to paragraph 4.37 of the fourth edition guidelines and the definition of radiculopathy at paragraph 4.27.

21. The appellant noted he had ongoing radiculopathy following the first surgical procedure. This was clear from the report of Dr Bazina dated 10 July 2018 which reported herniation at the L3 nerve root and asymmetrical knee reflex.

22. The AMS reported that whilst there were ongoing symptoms following the two surgical procedures, there was no evidence of continuing radiculopathy. The appellant relevantly submitted:[7]

> "There is no requirement for the radiculopathy to be 'continuing' to qualify for the additional 3% impairment as envisaged by paragraph 4.27 of the Guidelines. It is simply a requirement that symptoms and radiculopathy be present after surgery."

23. It was submitted that this does not offend paragraph 1.6 of the fourth edition guidelines because it "involves a historical fact that the radiculopathy was present following surgery". This is because the AMS is required to consider the relevant medical history under paragraph 1.6.

***Respondent's submissions***

24. The respondent referred to the requirements of paragraph 4.27 and 4.28 of the fourth edition guidelines and noted the findings made by the AMS that these were not satisfied at the time of the examination.

25. The respondent submitted that the findings and conclusions were open to the AMS and based on his clinical examination.

**REASONS**

26. Radiculopathy is defined in paragraph 4.27 of the fourth edition guidelines. It is unnecessary to refer to the definition save as to note that there are three major and three minor criteria in defining radiculopathy. To satisfy the definition, the worker must have at least two criteria, one of which must be a major criteria.

[7] Appellant's submissions, 6(k)

27. Clause 4.37 of the fourth edition guidelines which includes Table 4.2 provides:

> "Effect of surgery: AMA5 tables 15-3 to 15-5 (pp 384, 389 and 392) do not adequately account for the effect of surgery on the impairment rating for certain disorders of the spine. The assessor should note that:
>
> * Surgical decompression for spinal stenosis is DRE category III (AMA5 Table 15-3, 15-4 or 15-5)
>
> * Operations where the radiculopathy has resolved are considered under the DRE category III (AMA5 Table 15-3, 15-4 or 15-5)
>
> * Operations for spinal fusion (successful or unsuccessful) are considered under DRE category IV (AMA5 Table 15-3, 15-4 or 15-5)
>
> * DRE category V is not to be used following spinal fusion where there is a persisting radiculopathy. Instead, use Table 4.2 in the Guidelines
>
> * Radiculopathy persisting after surgery is not accounted for by AMA5 Table 15-3, and incompletely by tables 15-4 and 15-5, which only refer to radiculopathy that has improved following surgery.
>
> Table 4.2 indicates the additional ratings which should be combined with the rating determined using the DRE method where an operation for an intervertebral disc prolapse, spinal canal stenosis or spinal fusion has been performed.
>
> Example 15-4 in AMA5 (p 386) should therefore be ignored.

Table 4.2: Modifiers for DRE categories following surgery

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

> In summary, to calculate whole person impairment (WPI) for persisting radiculopathy (as per definition) following surgery:
>
> * Select the appropriate DRE category from Table 15-3, 15-4, or 15-5;
> * Determine a WPI value within the allowed range in Table 15-3, 15-4 or 15-5 according to the impact on the worker's ADL
> * Combine this value with the appropriate additional amount from Table 4.2 to determine the final WPI."

28. The fourth edition guidelines have the force of delegated legislation.[8] Accordingly, the general principles of statutory construction apply: *Collector Customs v Agfa Gevaert Ltd*[9] adopting Dixon J in *King Gee Clothing Co Pty Ltd v The Commonwealth*.[10]

[8] *Ballas v Department of Education* [2020] NSWCA 86 at [97].
[9] [1996] HCA 36
[10] [1945] HCA 23; (1945) 71 CLR 184 at 195.

29. The principles of statutory construction are well settled. As the plurality stated in *Military Rehabilitation Commission v May*[11], the "question of construction is determined by reference to the text, context and purpose of the Act", citing *Project Blue Sky Inc v Australian Broadcasting Authority*[12] and *Alcan (NT) Alumina Pty Ltd v Commissioner of Territory Revenue*[13].

30. The AP was not assisted by proper submissions on the construction of paragraph 4.37 and Table 4.2 of the fourth edition guidelines.

31. The appellant simply submitted that there "is no requirement for the radiculopathy to be continuing to qualify for the additional 3% impairment".[14]

32. The respondent did not address the submission.

33. Paragraph 4.37 allows for various modifiers in specific situations. The specific modifier in which the appellant seeks an additional 3% provides:

> "Spinal surgery with residual symptoms and radiculopathy (refer to 4.27 in the Guidelines)".

34. The word "residual" must be read in context with "symptoms and radiculopathy". The plain meaning of the word "residual" is that the symptoms are ongoing following the spinal surgery.

35. That interpretation is contextually consistent with other parts of paragraph 4.37. The opening part of the paragraph provides that disorders are assessed under DRE category III "where radiculopathy has resolved" following surgery. That portion of the paragraph is consistent with previous radiculopathy which has resolved following surgery. It does not provide when it has resolved, merely that it is no longer present. That sentence is inconsistent with the appellant's submission.

36. Furthermore, the following sentence in paragraph 4.37 is inconsistent with the appellant's submissions. The sentence provides:

> "Radiculopathy persisting after surgery is not accounted for by AMA5 Table 15-3 and incompletely by tables 15-4 and 15-5, which only refer to radiculopathy that has improved after surgery".

37. The concept that the radiculopathy is "persisting" and is not accounted for in AMA5 Table 15-3 suggests that it must be "persisting" at the time of the examination to obtain the additional 3%. That sentence is consistent with the requirement in the specific line that there be "residual symptoms and radiculopathy". The other reference to radiculopathy "that has improved" following surgery also supports that interpretation.

38. In our view, the plain meaning of paragraph 4.37 and the specific allowance for an additional 3% for radiculopathy in Table 4.2 requires that the radiculopathy is present at the time of the examination. That interpretation is otherwise consistent with paragraph 1.6 of the fourth edition guidelines which provides that clinical assessment is made of the worker "as they present on the day of the assessment".

39. We reject the appellant's submission that satisfaction of the additional 3% simply requires the existence of radiculopathy at any time following surgery even if it is not present on the day of the examination.

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[11] [2016] HCA 19 at [10].
[12] [1998] HCA 28 at [69]-[71].
[13] [2009] HCA 41 (*Alcan*).
[14] Appellant's submissions, [6(k)].

40. We note that the appellant's submission is otherwise inconsistent with the decision of the Appeal Panel in *Vella-Kuitkowski v Nepean Blue Mountains Health District*[15] (*Vella-Kuitkowski*).

41. In *Vella-Kuitkowski* the Appeal Panel stated:[16]

> "The purpose of the Table is otherwise clear, that is, it provides a slightly higher assessment in particular circumstances. One of the main reasons why further surgery to the lumbar spine is undertaken is to cure ongoing radiculopathy when it is not cured in the first operation."

42. We agree with those observations.

43. For these reasons, the AP is not satisfied that neither the application of incorrect criteria nor demonstrable error is established because the AMS did not allow an additional 3% in the circumstances where the radiculopathy had resolved prior to the examination.

44. The appellant did not submit that the radiculopathy was present at the time of the examination. Accordingly, there is no entitlement to an additional 3% for "residual symptoms and radiculopathy" as provided by Table 4.2.

## GROUND OF APPEAL – ASSESSMENT OF SKIN

### Submissions

#### *Appellant's submissions*

45. The appellant referred to the reasons provided by the AMS that the scar was "well healed" and "does not attract any impairment under the fourth edition guidelines".

46. It was submitted that there was no reasoning provided by the AMS in circumstances where both Dr Habib and Dr Breit assessed 1% WPI for scarring. The appellant submitted that the scar satisfied a number of criteria pursuant to Table 14.1 of the fourth edition guidelines and the phrase that it was "well-healed" was not an application of correct criteria.

#### *Respondent's submissions*

47. The respondent referred to the examination findings made by the AMS and the reference to paragraph 14.6 of the fourth edition guidelines. It noted that, in accordance with paragraph 14.6, a scar may be present and rate as 0% WPI.

48. The respondent submitted that the finding of 0% WPI was open to the AMS, based on his examination and no error was established.

### Reasons

49. The AMS findings on examination referred to a "7cm well-healed surgical scar" in the lumbosacral region.[17]

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[15] [2016] NSWWCCMA 144 at [62].
[16] At [63].
[17] MAC, p 3.

50. Later in his reasons for assessment the AMS stated:[18]

> "The well-healed surgical scar does not attract any impairment as indicated in the Guidelines, Chapter 14.6, page 73."

51. The assessment of minor skin assessment (TEMSKI) is undertaken in accordance with Table 14.1 of the fourth edition guidelines. The Table sets out a number of matters that are considered when assessing permanent impairment. Furthermore, the assessor is required to use the principle of "best fit" when assessing impairment.

52. Paragraph 14.6 of the fourth edition guidelines provides that "uncomplicated scars for standard surgical procedures do not, of themselves, rate an impairment."

53. The statement by the AMS that the scar is "well-healed" does not directly address the criteria provided by Table 14.1. Given that the satisfaction of a particular impairment is based on a "best fit" method where a scar will often have some, but not all of the criteria for a specific assessment, it is unknown what characteristics the scar has when it is described as "well-healed". The only specific comments made by the AMS are that the scar is of 7 cm in length and in the lumbo-sacral region. It may or may not have other features warranting an impairment such as being visible by way of colour contrast.

54. The AMS has a statutory obligation to provide reasons pursuant to s 325 of the 1998 Act. These principles were discussed in *El Masri v Woolworths Ltd*[19] (*El Masri*) a decision involving judicial review of a decision of an Appeal Panel, when Campbell J stated:[20]

> "As I have said, and at the risk of repeating myself unduly, the process is one of expert evaluation. Often when judgment of any type is called for, there will be a gap between expression of reasons and articulation of decision which cannot itself be fully articulated. That gap constitutes what might be called judgment. Although, as Ms Allars reminded me, *Wingfoot* does not necessarily apply to this case because it was a case where there was a statutory obligation to give reasons, and in this case the obligation to give reasons is implied by the general law as explained in *Campbelltown City Council v Vegan* [2006] NSWCA 284; (2006) 67 NSWLR 372, what their Honours said at [55] of *Wingfoot* must be applicable. Basically, the statement of reasons must explain that actual path of reasoning in sufficient detail to enable a court to see whether the opinion does or does not involve any error of law. Applying that standard, it is clear what was decided and why, as is the reasoning process that led to the decision, especially if one has regard to what was said by the Panel at paragraph 18 which I will not further set out."

55. The AP is unable to discern from the reasons what scar characteristics are present. This uncertainty is amplified by the opinions of the respective qualified doctors who both assessed 1% WPI for the scar based on the presence of suture marks and discolouration. Indeed, the description that the scar is well-healed is not inconsistent with a number of characteristics which could mean that the scar was otherwise assessable under Table 14.1.

56. The respondent's submissions that the assessment was open to the AMS does not adequately address the appellant's submissions that the reasons are insufficient and has otherwise not addressed relevant criteria.

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[18] MAC, p 6.
[19] [2014] NSWSC 1344.
[20] *El Masri* at [50].

57. The concept of "demonstrable error" was discussed by the Court of Appeal in *Vannini v Worldwide Demolitions Pty Ltd* (*Vannini*),[21] where Gleeson JA observed that, consistent with the observations of Basten JA in *Mahenthirarasa v State Rail Authority of New South Wales*[22] a "demonstrable error must be apparent in findings of fact or reasoning contained in the medical assessment certificate, although the error may be established in part by reference to materials that were before the approved medical specialist".[23]

58. For these reasons, the AP accepts that there are insufficient reasons to enable the AP to determine whether the finding of 0% WPI involves any error of law. We are satisfied that demonstrable error is established.

59. The appellant also submitted that the assessment was made on the basis of incorrect criteria. Whilst it is unnecessary to decide, the reference to a well-healed scar does not address the relevant criteria in Table 14.1. In these circumstances it is also likely that there has been an application of incorrect criteria as discussed by the Court of Appeal in *Marina Pitsonis v Registrar of the Workers Compensation Commission of New South Wales*[24] applying Basten JA in *Campbelltown City Council v Vegan*[25].

60. This ground of appeal is upheld.

**GROUND OF APPEAL - SECTION 323 DEDUCTION**

**Appellant's submissions**

61. The appellant referred to the principles discussed in *Cole v Wenaline*[26] (*Cole*) and submitted that the pre-existing condition or injury must contribute to the assessed whole person impairment. The assessor must point to the "actual consequences of the pre-existing injury or condition or abnormality on the assessable impairment and how it contributes to the assessed whole person impairment."[27]

62. The appellant referred to his statement dated 5 September 2016 concerning his back condition following the May 2013 incident and he did not stop work and was able to continue to work.

63. The appellant otherwise referred to the observations by a previous AMS in 2016 who noted pre-existing "low grade symptoms" and submitted that the pre-existing condition or impairment did not contribute to the impairment.

***Respondent's submissions***

64. The respondent submitted that the AMS is not bound by the opinion of others and the assessment is a matter for the expertise of the AMS.

65. The respondent referred to the history recorded in the MAC of treatment in 2013 and the findings in the 2013 CT scan. It also referred to the findings made by the AMS that the injury was by way of aggravation of degenerative changes and that the "presence of this disease has been a contributing factor to the impairment leading to the need for spinal surgery".

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[21] [2018] NSWCA 324 (*Vannini*) at [90].
[22] [2008] NSWCA 101.
[23] *Vannini* at [86].
[24] [2008] NSWCA 88 (*Marina Pitsonis*) at [40]-[42], McColl and Bell JJA (as their Honours then were) agreeing.
[25] [2006] NSWCA 284 at [94], McColl JA agreeing.
[26] [2010] NSWSC 78.
[27] Appellant's submissions, [16].

66. In these circumstances, the AMS made a one-tenth deduction pursuant to s 323(2) of the 1998 Act. That finding was based on detailed reasons and open to the AMS. No error has been established.

**Reasons**

67. The AMS noted a history that the appellant consulted his general practitioner in 2013 complaining of low back ache.[28] The AMS also noted that the CT scan reported by Dr Kuan in May 2013 showed "a suspected small left foraminal disc protrusion at L3/4 with impingement of the left L3 nerve root".[29]

68. The AMS found that the injury was by way of "aggravation of pre-existing lumbar spinal discogenic disease". The following reasons on the s 323 deduction provided by the AMS were:[30]

> "The presence of this disease has been a contributing factor to the impairment leading to the need for spinal surgery."

69. Section 323(1) of the 1998 Act provides:

> "(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."

70. A deduction pursuant to s 323 of the 1998 Act is required if a proportion of the permanent impairment is due to previous injury or due to pre-existing condition or abnormality: *Vitaz v Westform (NSW) Pty Ltd* (*Vitaz*).[31]

71. A deduction can be made even though the worker is asymptomatic prior to injury. In *Vitaz* Basten JA stated:[32]

> "42. 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 in the neck region, that condition might be assessed at DRE II. Although the spondylosis 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.'

[28] MAC, p 3.
[29] MAC, p 4.
[30] MAC, p 7.
[31] [2011] NSWCA 254.
[32] At [42]-[43], McColl JA and Handley AJA agreeing.

> 43. 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."

72. Basten JA referred to the reasoning of other Court of Appeal decisions including the decision in *Matthew Hall Pty Ltd v Smart*[33] (*Smart*). In *Smart* Giles JA stated:

> "The same, in my view, must be said as to the current s 68A(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."

73. In *Vannini v Worldwide Demolitions Pty Ltd*[34] Gleeson JA stated that an Appeal Panel, when considering the reasoning of an Approved Medical Specialist on the question of causation under s 323, was required to determine "whether any proportion of the impairment was due to any previous injury, or pre-existing condition or abnormality" and if so, "what was that proportion".[35] In relation to the answer to this question, his Honour stated:[36]

> "The first question involved an assessment by the Panel, substantially of fact by reference to the evidence, although in part informed by the exercise of a clinical judgment. Such an assessment may be characterised as an evaluative judgment or conclusion based on findings of fact. Nonetheless, the legal criterion applied to reach that conclusion on causation demands a unique outcome, rather than tolerates a range of outcomes. Accordingly, the reasoning and finding of the medical specialist attracts the correctness standard of review by a Panel."

74. Gleeson JA observed that a finding as to the degree of proportion of permanent impairment due to a previous condition or abnormality "involves matters of degree and impression". The present case involves the former, that is whether there should have been any deduction, as opposed to the issue as to the extent of the deduction.

75. The appellant did not refer to the reasons provided by the AMS and did not submit that they were insufficient or inadequate. It otherwise did not address whether they were wrong.

76. The appellant correctly submitted that the pre-existing condition must contribute to the impairment and referred to some of the evidence, such as the appellant's statement where he stated that there was no follow up treatment and that he continued to work after the initial consultation in 2013.

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[33] [2000] NSWCA 284 at [32], Mason P and Powell JA agreeing.
[34] [2018] NSWCA 324 (*Vannini*) at [90].
[35] At [90].
[36] At [91].

77. The appellant has not contested the finding by the AMS that the appellant was suffering from pre-existing degenerative disease and the injury was by way of aggravation to the underlying condition. That conclusion was based on the May 2013 CT scan and is consistent with the opinion expressed by Dr Meakin in November 2016 that there is "no doubt [that] there was pre-existing pathology at that level as noted on scans in May 2013 with lesser symptoms".[37]

78. Dr Meakin examined the appellant in November 2016 for the purposes of providing the Commission with an opinion as to whether the surgery proposed by Dr Bazina was reasonably necessary as a result of the injury on 4 September 2015.[38] The history recorded by Dr Meakin was that the appellant had mild midline low back pain with left leg radiation "for some years". The prior symptoms were also described to be of approximately two and a half years duration of low-grade discomfort with intermittent left leg pain.

79. Dr Meakin opined that there was "no doubt" that there was pre-existing pathology at the L3/4 level.[39]

80. In a report dated 12 November 2015, the treating Neurosurgeon, Dr Bazina, referred to the 2013 CT scan and opined that the pathology had "remained unchanged in the last 2 years" but that the symptoms had worsened.[40]

81. The opinions provided by Dr Meakin, Dr Bazina and the AMS establish that there was pre-existing pathology at the L3/4 level consistent with the findings reported on the CT scan dated 27 May 2013.[41]

82. The applicant had prior low back pain and left sided radicular symptoms in 2013. Indeed, the history reported by Dr Meakin is that the symptomatology was ongoing, albeit mild of some two and one-half years duration.

83. The appellant's submissions do not appear to dispute that he had a pre-existing condition at the L3/4 level. Indeed, the treating neurosurgeon opined that the pathology following the injury was unchanged from two years previously.

84. The appellant correctly submitted that the pre-existing condition must contribute to the impairment. However, no submissions were directed to the brief reasons provided by the AMS on this issue.

85. The AMS concluded that the "pre-existing disease had been a contributing factor to the impairment leading to the need for spinal surgery."

86. The AP agrees with the views expressed by the AMS that the pre-existing condition at L3/4 contributed to the need for the surgical procedures. This is because the appellant had pre-existing pathology at that level. That pathology showed herniation on the left-hand side which was causative of both the prior and post injury radicular symptoms. The appellant had a weakened and diseased disc at L3/4 which, on the balance of probabilities, made that disc more susceptible to injury, and if injured, more susceptible to greater problems and the need for surgery at that level.

87. We expressly agree with the conclusion reached by the AMS that the pre-existing pathology at L3/4 was a contributing factor to the need for the surgical procedures. It was the surgical procedures which resulted in the appellant's impairment.

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[37] Application, p 43.
[38] Application, p 43.
[39] Application, p 43.
[40] Application, p 52.
[41] Application, p 83.

88. We observe that the AMS applied the one-tenth deduction pursuant to s 323(2) of the 1998 Act. No submission was made by the parties that, in applying that provision, there was an error if it was otherwise appropriate to make a deduction.

89. For these reasons, the AP is satisfied that no demonstrable error or application of incorrect criteria is established.

**REASSESSMENT**

90. Having found error, the AP is required to reassess according to law: *Drosd v Nominal Insurer.*[42]

91. The AP has only found error based on the assessment of the skin. The ground of appeals alleging error of the assessment of the lumbar spine is rejected. For the purposes of our reassessment, we repeat and adopt the findings made by the AMS for the lumbar spine.

92. The appellant's condition satisfied DRE III of the lumbar spine which is 10% WPI. There was no dispute on the appeal submissions that he is entitled to a further 2% WPI for the activities of daily living and a further 2% under Table 4.2 due to a second surgical procedure.

93. To facilitate an expeditious reassessment of the skin, the AP called for photographs of the scar pursuant to s 324 of the 1998 Act.

94. The appellant produced a colour photograph which shows a 7 cm scar in the low back. The scar has hypertrophic changes and there is colour change with areas of pigmentary change. The appellant could easily locate the scar and be conscious of it. The location is visible in a swimming costume but not when wearing a shirt. The scar has visible suture marks.

95. There are other matters which would be consistent with either 0% or 1% WPI such as no treatment is required and no effect on any ADL due to the scar. Any contour defect would be minor, if at all.

96. The AP accepts that reasonable minds may differ in whether the scar should be assessed at 0% WPI or 1% WPI. Further paragraph 14.6 of the fourth edition guidelines provides that uncomplicated scars for standard surgical procedures do not, of themselves, rate an impairment. However, whilst the scar is "well-healed", it is not uncomplicated probably due to the second surgical procedure.

97. Applying all the factors we assess the scar at 1% WPI.

**DECISION**

98. The MAC is revoked, and a new Medical Assessment Certificate is issued. The new Medical Assessment Certificate is attached to the statement of reasons.

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

R Gray

Robert Gray
Dispute Services Officer
**As delegate of the Registrar**

[42] [2016] NSWSC 1053.

# WORKERS COMPENSATION COMMISSION

## APPEAL PANEL
## MEDICAL ASSESSMENT CERTIFICATE

**Injuries received after 1 January 2002**

**Matter No:** **3027/20**
**Applicant:** **Mauricio Lopez**
**Respondent:** **Leonel Veliz**

This Certificate is issued pursuant to section 328(5) of the *Workplace Injury Management and Workers Compensation Act 1998.*

The Appeal Panel revokes the Medical Assessment Certificate of Dr Richard Crane dated 28 September 2020 and issues this new Medical Assessment Certificate as to the matters set out in the Table below:

| **Body Part or system** | **Date of Injury** | **Chapter, page and paragraph number in fourth edition guidelines** | **Chapter, page, paragraph, figure and table numbers in AMA5** | **% WPI** | **WPI deductions pursuant to s 323 for pre-existing injury, condition or abnormality (expressed as a fraction)** | **Sub-total/s % WPI (after any deductions in column 6)** |
|---|---|---|---|---|---|---|
| Lumbar Spine | 5.9.15 | Paragraphs 4.27 and 4.36 | Chapter 15, pages 384, Table 15-3 | 14% | 1/10th | 13% |
| Skin | 5.9.15 | Chapter 14.6, Table 14.1 | | 1% | nil | 1% |
| **Total % WPI (the Combined Table values of all sub-totals)** | | | | | 14% | |

**John Harris**
Arbitrator

**Dr Drew Dixon**
Approved Medical Specialist

**Dr Brian Noll**
Approved Medical Specialist

11 February 2021

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

R Gray

Robert Gray
Dispute Services Officer
**As delegate of the Registrar**