WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-255/20**
Appellant:	**David De La Blanca**
Respondent:	**Kingsfeld Excavations Pty Ltd**
Date of Decision:	**1 July 2020**
Citation:	**[2020] NSWWCCMA 117**

Appeal Panel:	
Arbitrator:	**Paul Sweeney**
Approved Medical Specialist:	**Dr Brian Stephenson**
Approved Medical Specialist:	**Dr Philippa Harvey-Sutton**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 23 March 2020, David De La Blanca (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Greg McGroder, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 2 March 2020.

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. Although there is some confusion in the referral to the appeal panel, it appears that, on the face of the Application, the Registrar is satisfied 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 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. The appellant suffered injury in the course of his employment when he slipped and fell on 22 March 2018. He has experienced widespread back pain and intermittent pain in both lower limbs since the injury. He has not returned to employment.

7. Following the injury, the appellant came under the care of Dr David Loh, a general practitioner. When his symptoms did not improve, he was referred to Dr Al Khawaja, a neurosurgeon, who prescribed cortisone injections and a continuation of conservative treatment.

8. The appellant was subsequently referred to Dr David Manohar, a pain specialist who performed multiple spinal injections and radio-frequency procedures followed by further physiotherapy, hydrotherapy and psychological treatment. Dr Manohar expressed the opinion that the appellant's pain was arising from the L4/L5 and L5/S1 level of the lumbar spine.

9. On 6 January 2020, the appellant underwent an MRI scan of his thoracic spine at the referral of Dr Loh. Dr Ryan Xia, radiologist reported on the scan as follows:

> "No significant spondylosis of the thoracic spine which is normal in alignment. The central canal and neural exit foramina are adequate.
>
> Mild bilateral T4-T7 costovertebral degeneration and disc desiccation in the mid thoracic spine."

10. On 14 January 2020, the appellant underwent a CT scan of the thoracic spine at the request of Dr Loh. The report of that scan by Dr Alvin Chan, radiologist stated that there was no significant disc protrusion in the thoracic spine and the thoracic nerve roots were noted to exit normally. The report continues:

> "On review of the bone windows, anterior wedging of several thoracic vertebral bodies is noted. There is a loss of anterior vertebral body height of up to 23% at the level of T7. They are of indeterminant ages. No discreet bony abnormality detected. The posterior elements are intact."

11. On 15 July 2019, Dr Eugene Gehr, an orthopaedic surgeon, provided a medicolegal report to the appellant's solicitors in which he assessed whole person impairment. Relevantly, Dr Gehr diagnosed a soft tissue injury of the lumbar spine with left radiculopathy and a soft tissue injury of the thoracic spine with dysmetria. He assessed WPI of the thoracic spine at 5% and WPI of the lumbar spine at 10%. After allowing 2% for the restriction of the activities of daily living, he opined that the appellant suffered 17% WPI as a result of the injury.

12. On 2 September 2019, Dr Thomas Silva, an orthopaedic surgeon, examined the appellant at the request of the respondent's insurer. Dr Silva did not accept that the appellant had an injury to his thoracic spine at the time of the incident. Nonetheless, he opined that the impairment of the thoracic spine was DRE Category I or 0% WPI. In respect of the lumbar spine, he accepted that the appellant was DRE Category II and, after allowing 2% for the activities of daily living, he opined that the appellant suffered 7% WPI.

13. The quite different opinions of Dr Gehr and Dr Silva on the quantum of WPI as a result of the injury gave rise to a medical dispute in accordance with s 319 of the 1998 Act. The Registrar referred the dispute to an AMS, Dr Greg McGroder, for assessment. It is his determination which gives rise to this appeal.

14. 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. As the panel was not persuaded that there was error in the determination of the AMS, it was inappropriate to consider a further medical examination.

EVIDENCE

15. The panel has before it all the documents which were sent to the AMS for the original medical assessment and has taken them into account in making this determination.

MEDICAL ASSESSMENT CERTIFICATE

16. The parts of the medical assessment certificate given by the AMS that are relevant to this appeal are set out, where relevant, in the body of this decision.

SUBMISSIONS

17. Only the appellant made written submissions. They are not repeated here in full but have been considered by the panel.

18. In summary, the appellant alleged two errors. First, he asserts that the AMS had failed to consider the CT scan of the thoracic spine dated 14 January 2020 which reported "loss of anterior vertebral body height of up to 23% at the level of T7." The appellant continued:

> "In accordance with Chapter 4, page 27 of the NSW Workers compensation guidelines (the Guidelines), the total of less than 25% of vertebral height at the most compressed part of each vertebrae is in accordance with a DRE II assessment.
>
> This report was included in the Application to Resolve a Dispute but was not noted by the AMS and it was therefore assumed that it was not considered. The appellant submits that had it been included; the diagnoses and whole person impairment assessment would have been different."

19. Secondly, in respect of the lumbar spine, the appellant argued that the AMS had made a demonstrable error in not making a finding of radiculopathy. He asserted that he had reported symptoms of radiculopathy to medical practitioners after the injury and had continued "to experience these left leg and foot symptoms, despite treatment."

20. The appellant asserted that the AMS did not consider the MRI scan of 30 August 2019 which confirmed pathology in his lumbar spine, including a "posterior annular tear at L3/4". He also submits that the AMS was in error in not commenting on a possibly "positive sciatic stretch test".

21. The appellant submitted that he should be re-examined by a member of the panel and that the MAC should be revoked, and a new MAC issued by the panel.

FINDINGS AND REASONS

22. 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.

23. The role of the Medical Appeal Panel was considered by the Court of Appeal in the case of *Siddik v WorkCover Authority of NSW* [2008] NSWCA 116. An appeal by way of review may, depending upon the circumstances, involve either a hearing de novo or a rehearing. Such a flexible model assists the objectives of the legislation. However, in *Versace v Australia Best Tyres & Auto Pty Limited* [2016] NSWSC 1540 (2 November 2016) Schmidt J, held that the section did not permit the panel to review the determination of the AMS without first identifying error.

24. 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 the appeal to matters in respect of which the MAC is binding.

25. In considering the submissions of the appellant, it is necessary to bear in mind the nature of the statutory obligation of the AMS to provide reasons. It is evident from reasoning of the High Court of Australia, in *Wingfoot Australia Partners Pty Limited v Kocak 88 ALJR 52*, that it is only necessary for the MAC to explain the actual path of reasoning of the AMS in sufficient detail to enable a court or an appeal panel to determine whether there is error in its findings. In *Wingfoot* it was said that:

> "The function of a medical panel is neither arbitral nor 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 form and give its own opinion on the medical question referred to it by applying its own medical experience and its own medical expertise."

26. The reasoning in *Wingfoot* has been applied to medical assessments under the NSW Workers Compensation legislation: see, for example *El Masri v Woolworths Ltd* [2014] NSWSC 1344 (26 September 2014).

27. In the MAC, the AMS sets out in some detail his finding on clinical examination. In view of the errors which have been alleged in this appeal, it is appropriate to set out those findings, which are as follows:

> "Some pain behaviour was noted with sighing and grimacing to signal his pain and clutching at various body parts. He was wearing a lumbar brace. He walked slowly with a wide-based gait. He had difficulty walking on heels and toes and performing a squat for reasons unclear. Range of movement of the thoracolumbar spine was severely restricted in all directions and all movements were only one-fifth of the expected range in all directions. This included rotation and passive rotation from the knees re-produced his symptoms. With the lumbar segment of the spine immobilised it was noted that there was no asymmetry of movement of the thoracic spine, particularly noting rotation. Straight leg raising was 50 degrees on the right and 20 degrees on the left ceased due to back pain. Extending the left leg from a seated position reproduced his back pain but did not represent a positive neural tension sign. I couldn't detect any wasting or specific muscle weakness involving the lower extremities, although generalised weakness was demonstrated. Calf circumference at maximum was 40cm bilaterally and thigh circumference measured 10cm suprapatella 50cm bilaterally. There was a stocking distribution of diminished sensation from below the knee level. Knee, medial hamstring and ankle jerks were equal and normal. There was tenderness to light touch globally around the lumbar and thoracic back. Axial loading on the head and shoulders re-produced his back symptoms."

28. After considering the radiological evidence, Dr McGroder expressed the opinion that the appellant had "multifactorial lower back pain". He stated that there may be "a possible discogenic element but no evidence of radiculopathy".

29. It is convenient to deal first with the allegation that the AMS erred in not accepting the presence of radiculopathy. The appellant asserts that there is a consistent record of complaints of pain in his left leg. But this is not determinative of radiculopathy. As the appellant contends, radiculopathy is defined in the Guidelines at 4.27. Relevantly the Guidelines state:

> **"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**
- **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."

30. Plainly, the guidelines dictate that a complaint of pain in a lower limb is an insufficient basis to establish radiculopathy. The complaints of leg pain made to a general practitioner are, therefore, of little assistance in establishing radiculopathy as it is defined in the guidelines. Such a finding can only be made on the basis of clinical signs enunciated in the guidelines.

31. In considering the opinion of Dr Gehr on the issue of radiculopathy, the AMS stated:

> "Dr Gehr estimated DRE Lumbar Category 3 because of the presence of radiculopathy. He noted weakness in the L5 distribution but I noted global weakness. He noted diminished sensation in the L5/S1 nerve distribution but I found this to be in a stocking distribution. He noted an absent left ankle jerk, although I found this to be present today and equal to the right. He noted a positive sciatic stretch test and even if this were the case it does not qualify for radiculopathy, according to WorkCover guidelines, section 4.27, because it is not a major criterion."

32. In this extract, the AMS makes it perfectly clear that he was unable to find clinical signs that the appellant had radiculopathy. He did not find one of the major criteria on a careful and well documented examination and it is doubtful if he found one of the minor criteria.

33. The appellant states that he has pain in his left leg and into the left foot. That may be true. However, it was *not* found by the AMS to be consistent with "an anatomically localised" nerve root distribution. The findings of the AMS of "global weakness" and loss of sensation in a "stocking distribution" are totally inconsistent with the appellant's submission. The guidelines emphatically state that global weakness does not constitute radiculopathy.

34. There is no basis to conclude that the AMS erred or applied incorrect criteria in performing his clinical examination of the appellant. While his findings may be different to Dr Gehr, that is no reason to reject them. His findings are, of course, similar to Dr Silva who examined the appellant on 12 September 2019.

35. The appellant next alleges that the AMS "did not consider" the MRI of the lumbar spine dated 30 August 2019. While the AMS does not specifically refer to that document, this argument does not advance the appellant's case. Dr Wong, the radiologist, comments that:

> "No definite evidence of exiting nerve root impingement is appreciated at the neural exit foramina or lateral recess level within the lumbar spine."

36. The AMS did refer to the report of the MRI scan of the lumbar spine of 20 April 2018. While that report refers to annular fissuring at L3/4, L4/5 and L5/S1 it also states:

> "No associated disc protrusion or mechanical neural impingement".

37. In the opinion of the medical practitioners on the panel, these radiological reports are consistent with the opinion of the AMS. They do not suggest the existence of nerve root impingement. On the contrary, they explicitly state that there is no “neural impingement.” Assuming they did, however, it would be necessary for the AMS to have found other clinical signs of nerve root impingement before accepting the presence of radiculopathy. The AMS did not record other clinical signs.

38. The appellant then argues that the AMS did not comment on Dr Gehr’s finding of a positive sciatic stretch test. It is quite clear, however, that the AMS specifically commented on this aspect of Dr Gehr’s examination. It is equally clear that the AMS did not record a positive sciatic stretch test on his examination. However, he makes the point that even if he accepted the presence of a positive sciatic stretch test, this alone would not lead to a finding of radiculopathy in accordance with the guidelines.

39. The appellant has failed to demonstrate error on the face of the MAC or that Dr McGroder applied incorrect criteria in his assessment of the lumbar spine.

40. The second error alleged by the appellant is the failure of the AMS to certify DRE III in respect of the thoracic spine. The appellant argues that this determination was necessary because of the CT scan of the thoracic spine dated 14 January 2020 which demonstrates “loss of anterior vertebral body height of up to 23% at the level of T7”.

41. Once again, the guidelines are relevant to this issue. Chapter 4.30 States:

> “**4.30** Vertebral body fractures and/or dislocations at more than one vertebral level are to be assessed as follows:
>
> - Measure the percentage loss of vertebral height at the most compressed part for each vertebra, then
> - Add the percentage loss at each level:
>   - total loss of more than 50% = DRE IV
>   - total loss of 25% to 50% = DRE III
>   - total loss of less than 25% = DRE II
> - If radiculopathy is present then the person is assigned one DRE category higher.
>
> One or more end plate fractures in a single spinal region without measurable compression of the vertebral body are assessed as DRE category II. Posterior element fractures (excludes fractures of transverse processes and spinous processes) at multiple levels are assessed as DRE III”

42. The appellant's submissions assume that the anterior wedging of the thoracic vertebral bodies demonstrated by the CT scan of 14 January 2020 result from the injury of 23 March 2018. No medical practitioner who has seen the appellant in this case, however, suggests that he suffered a fracture or wedging of the thoracic vertebral bodies in the subject injury. There is no medical evidence which attributes the radiological findings in the CAT scan to the injury. In the circumstances, it is unsurprising that the AMS did not address the CT scan. There is simply no medical evidence which asserts a causal relationship and compensation for category DRE III impairment of the thoracic spine was not claimed in the Application.

43. This is enough reason to reject the appellant’s argument that the AMS erred in his assessment of the thoracic spine. However, the panel also considered the circumstances of the appellant’s injury and medical treatment.

44. The panel is of the opinion that it is unlikely that the wedging of the thoracic vertebral bodies results from the injury of March 2018. By his statement, the appellant says that following the injury he experienced pain in his “lower back, left leg and right ankle.” He was able to drive home, but was subsequently referred to his employer’s general practitioner, who organised x-rays to negate a lumbar fracture.

45. Within days of the injury Dr Loh, the appellant's general practitioner, had recorded that he complained of “lower lumbar bone ache and bilateral buttock ache”. Dr Loh referred the appellant for an MRI of the lumbar spine. When Dr Manohar saw the appellant later in the year, he noticed that the appellant had significant lumbar pain. By 21 March 2019, he concluded that the appellant had significant pain arising from L4/L5 and L5/S1.

46. The history recorded above is not consistent with the occurrence of thoracic fracture at the time of the subject injury. While the panel accepts that the mechanism of injury may have caused thoracic back strain, there is no convincing evidence either from the appellant or from the doctors who treated him in the period following the injury of the occurrence of thoracic spinal fractures.

47. The panel notes that the appellant has a long history of back pain and been diagnosed with osteoarthritis of the lumbar spine before the subject injury. The radiological findings may be consistent with a similar condition of the thoracic spine. Finally, the panel notes that the report of the MRI scan of the appellant’s thoracic spine obtained by Dr Loh, shortly before the CAT scan, does not report the wedging shown in the CT scan.

48. For these reasons, the appeal panel has determined that the MAC issued on 2 March 2020 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 MacLeod

Ann MacLeod
Dispute Services Officer
As delegate of the Registrar