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

Matter No:	**M1-1111/19**
Appellant:	**Mohammad Khaliqi**
Respondent:	**Inala**
Date of Decision:	**5 August 2019**
Citation:	**[2019] NSWWCCMA 104**

Appeal Panel:	
Arbitrator:	**Gerard Egan**
Approved Medical Specialist:	**Dr John Ashwell**
Approved Medical Specialist:	**Dr Brian Noll**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 20 May 2019, Mohammad Khaliqi (the appellant/the worker) made an application to appeal against a medical assessment (the appeal) to the Registrar of the Workers Compensation Commission (the Commission). The medical assessment was made by Dr Greg McGroder an Approved Medical Specialist (the AMS) in a Medical Assessment Certificate dated 1 May 2019 (the MAC).

2. The respondent to the Appeal is, from the papers, a body known as "Inala" (the respondent/the employer).

3. 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.

4. 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.

5. The WorkCover Medical 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 WorkCover Medical Assessment Guidelines.

6. 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).

The PAPERS

7. The following documents (with any attachments) are before the Panel:

    (a) The Application to Resolve a Dispute;
    (b) An Application to Admit Late Documents dated 13 March 2019;
    (c) The Reply;

(d) The amended referral to the AMS by the Registrar dated 26 April 2019 (the Referral);
(e) The MAC.

8. The AMS had all these documents except the MAC.

RELEVANT FACTUAL BACKGROUND

9. As the issues on appeal are restricted to the AMS's assessment of impairment from the right knee and surgical scarring, detailed background will be so restricted.

10. The appellant worked as a chef for the respondent. On 18 March 2016, he suffered injuries to his right knee when he fell while carrying a box of potatoes, striking the concrete floor with his knee. He says he dislocated his right patellae.

11. He came to a right knee arthroscopy by Dr John Fox, Orthopaedic Surgeon on 8 June 2016, but continued to have problems with his right knee pain.

12. He saw Associate Professor Leo Pinczewski, Orthopaedic Surgeon and non-operative treatment was recommended. Subsequently the appellant saw Dr John Nagamori, Orthopaedic Surgeon on 26 November 2016, who recommended surgical reconstruction of the right knee. He obtained a second opinion from Dr Ali Gursel, who agreed that surgery was appropriate.

13. On 18 October 2017, Dr Nagamori performed an arthroscopic patella stabilisation and a tibial tubercle osteotomy. Dr Nagamori described the procedure he performed thus: "Patella stabilization - tibial tubercle osteotomy, lateral release and MPFL reconstruction, arthroscopic chondroplasty trochlea". During the procedure, he noted "lateral trochlea grade IV wear and trochlea chondral flaps which were debrided. Patella showed grade I-II changes. The remainder of the knee joint was normal".

14. Over time, the appellant developed low back pain related to altered gait from his right knee injury and treatment. He saw Dr Sundaraj, a Pain Specialist for his back and knee pain. He continued to take painkillers and an anti-depressant.

15. The appellant describes continuing constant right knee pain, and low back pain which radiates into the "right buttock into the right knee, foot and big toe". He says he has difficulty sitting, lifting and carrying, or standing or walking for extended periods of time. He also says he cannot kneel or squat.

16. The appellant discloses previous injuries to the left knee, neck and back in a motor vehicle accident in late 2011. He says his neck and low back pain resolved in 2012 and he has not had any left knee, neck or low back pain since then.

17. The appellant's solicitors made a claim for lump sum compensation based on an assessment of impairment from Dr Alexander Woo. Dr Woo initially examined the appellant in August 2018, but did not consider the lumbar spine condition. In that report Dr Woo described the procedure undertaken by Dr Nagamori in October 2017.

18. Following further examination in November 2018, Dr Woo provided a report dated 6 November 2018. He noted an MRI scan of the lumbosacral spine on 21 September 2018 reporting "multiple disc bulging/ protrusions from L2/3 to L5/S1 levels" he noted the most prominent finding is "posterior disc bulging with right paracentral disc protrusion of L5/S1 and partial impingement of the right S1 nerve root".

19. After reviewing the treatment and imaging, Dr Woo noted on examination:

> "Right knee
>
> There was a 12 cm long anterior mid-line scar in the right knee. The scar was tender over the tibial tubercle. Screw heads were palpable over the tibial tubercle.
>
> There was 20°extension lag and flexion was restricted to 80°by pain, spasm and guarding.
>
> The right thigh circumference, measured 1Ocm above the upper pole of patella, was 43cm, similar to the left. This is suggestive of some muscle wasting because the right thigh is expected to be bigger in a right-handed person.
>
> The calf-circumference was 38cm on the right and 37cm on the left. He had a limping gait related to his ongoing right knee pain ….."

20. Dr Woo assessed the following impairments:

> "Right knee patellar dislocation with residual instability- 3% WPI. There was documented acute injury.
>
> Tibial tubercle osteotomy - 10% WPI.This is similar to proximal tibial osteotomy with good result.
>
> Pre-tibial scar - 2% WPI. There is contour change and minor limitation in the performance of few ADL.
>
> Lumbar spine DRE II - 7% WPI" [sic]

21. The respondent arranged for examination of the appellant by A/Prof Miniter in December 2018. He provided reports dated 19 December 2018 and 19 January 2019. A/Prof Miniter doubted the nature of the right knee injury and the reason for surgery, and the back condition. He doubted that there was any compressive neurological aspect to the back condition

22. The respondent did not dispute liability for either the right knee and scarring, or the lumbar spine and the matter was referred to the AMS leading to the MAC under appeal.

The MAC

23. The AMS noted his task to assess WPI as a result of the injury arising from the Right Lower Extremity, Lumbar Spine and scarring (TEMSKI). He noted the circumstances of injury and treatment. Only the assessments for the right knee and scarring are subject to appeal, so the review is restricted to those matters.

24. After reviewing the injuries, the AMS noted the detail of the right knee surgery by Dr Nagamori (although he incorrectly said it occurred in October 2016).

25. Specific details concerning the appeal will be considered below.

PRELIMINARY REVIEW

26. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the WorkCover Medical Assessment Guidelines.

Re-examination

27. The appellant seeks further examination of the appellant by an AMS Panel member principally to allow "a proper assessment of the scarring under the TEMSKI scale".

28. 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. The examination findings and reasons expressed by the AMS are sufficiently clear and the evidence is adequately set out in the materials before the AMS. The criteria applied by the AMS is tolerably clear. The Panel concludes that further examination is not necessary or desirable.

Hearing on the Papers

29. Neither party seeks an oral Assessment Hearing should occur. In all the circumstances, the Panel considers there is sufficient evidence in the materials before the AMS and the Panel to deal with the appeal without such a hearing in accordance with the *Registrar's Guideline: Appeal Against Medical Assessment.*

INDENTIFYING THE GROUNDS OF APPEAL

30. In *New South Wales Police Force v Registrar of the Worker Compensation Commission* [2013] NSWSC 1792 (*Police Force v Registrar*) at [52], Davies J held that the phrase "the grounds of appeal on which the appeal is made" in s 328(2) was "directed to greater particularity than simply categorising the appeal as being within one or more grounds in s 327(3)". Section 328(2) refers to the grounds restricted to those specified in the submissions accompanying the appeal (*Police Force v Registrar* at [49]). This approach was confirmed by His Honour in *The UGL Rail Services Pty Ltd (formerly United Group Rail Services Pty Ltd) v Attard* [2016] NSWSC 911; see also *Wilkinson v C & M Leussink Pty Ltd* [2015] NSWSC 69.

31. Both parties relied upon written submissions attached to the appeal application for the appellant and the opposition filed by the respondent. These will be dealt with below, according to the body systems under appeal.

DISCUSSION and REASONS

32. The Appeal Panel is obliged to give reasons, the extent of which will vary from case to case: *Campbelltown City Council v Vegan* [2006] NSWCA 284. The power of review is far ranging but nonetheless confined to the matters set out in s 327(2) of the 1998 Act which can be the subject of appeal. The procedure on appeal is one of limited review, as set out in s 328.

33. In this matter the Registrar has determined that a ground of appeal under section 327(3) is made out.

34. Clause 1.1 of the Guidelines state that AMA 5 is adopted in most cases, but "(w)here there is any deviation, the difference is defined in the Guidelines and the procedures detailed in each section are to prevail". Clause 1.6 of the Guidelines provides that assessing permanent impairment involves clinical assessment on the day of assessment.

35. Clause 1.8 makes it clear that: "The degree of permanent impairment that results from the injury must be determined using the tables, graphs and methodology given in the Guidelines and AMA5, where appropriate". Section 1.5 of Chapter 1 of AMA5 (p 10) applies to the conduct of assessments and expands on this concept.

36. Clause 1.9 provides that if more than one method can use to establish the degree of a claimant's permanent impairment, the method that yields the highest degree of permanent impairment should be used. (This does not apply to gait derangement – see paragraphs 3.5 and 3.10 in the Guidelines).

37. Clause 1.23 of the Guidelines states:

> "Conditions that are not covered in the Guidelines – equivalent or analogous conditions.
>
> AMA5 (p11) states: "Given the range, evolution and discovery of new medical conditions, these Guidelines cannot provide an impairment rating for all impairments…. In situations where impairment ratings are not provided, these Guidelines suggest that medical practitioners use clinical judgment, comparing measurable impairment resulting from the unlisted condition to measurable impairment resulting from similar conditions with similar impairment of function in performing activities of daily living.' The assessor must stay within the body part/region when using analogy.
>
> The assessor's judgment, based upon experience, training, skill, thoroughness in clinical evaluation, and ability to apply the Guidelines criteria as intended, will enable an appropriate and reproducible assessment to be made of clinical impairment."

Ground 1: The Right Knee

The MAC findings regarding the Right Knee

38. The AMS recorded the appellant's complaints of pain in the knee even at rest, worse weight bearing which is problematic. The patella no longer dislocated. The appellant walked with a limp, and could not kneel, crouch, or squat. He described difficulty getting down stairs, more so than up.

39. Examination was performed after removal of a knee brace. The AMS noted the appellant walked with a "variable limp involving his right leg". There was no quadriceps wasting, but the left calf circumference was slightly less than the right. The AMS noted:

> "He displayed a variable range of movement of the right knee on formal assessment but overall this was through a full range to greater than 120 degrees. There was full extension. There was no instability. There was no effusion. Patella tracking appeared normal and was equal to that on the left."

40. The AMS recorded pain on patella glide with retropatellar crepitations. There was tenderness on the undersurface of the patella. There was no evidence of instability involving the left patella.

41. The AMS reviewed the radiology noting the initial lateral dislocation of the patella and chronic low-grade injury of ACL and MCL, and the later chronic features of a subluxed patella with a shallow femoral trochlea dysplastic in appearance. Minor fraying of the free edge of the lateral meniscus.

42. Post-surgery, the AMS noted the tibial tubercle osteotomy was fixed with three screws in good position. He summarised the injuries and diagnoses, noting the apparently successful patella stabilisation procedure but noted the appellant alleged on-going problems.

43. The AMS noted, under "consistency of presentation": "Some voluntary restriction of range of movement and symptom magnification were noted at times during his assessment".

44. The AMS said he based his assessment of impairment on the file review, the investigations, the history and "response to examination".

45. His assessment for the right knee was expressed as follows:

> "For the injury to the left [sic, right] lower extremity I have estimated 2% WPI".

46. His explanation included:

> "With regard to the right lower extremity, there are no diagnosis based estimates upon which to assess impairment. He does not have patella subluxation or dislocation with residual instability. He has not had a proximal tibial osteotomy. There is no impairment for muscle wasting and no impairment for restriction of range of movement.
>
> The only finding on which I could base impairment was according to the Arthritis Table 17/31, where with a history of direct trauma, a complaint of patellofemoral pain and crepitations that a 2% whole person impairment is allowed" [sic].

and

> "Dr A Woo, Orthopaedic Surgeon, supplied a medico-legal report dated 20 August 2018. Dr Woo noted the surgical procedure of Dr Nagamori. He noted that this included a tibial tubercle osteotomy. On his examination findings, he saw no evidence of patella dislocation. Despite this, in his impairment assessment he diagnosed residual instability and awarded 3% WPI under diagnosis based estimates. He also appears to relate this to a documented acute injury. For the tibial tubercle osteotomy he estimated 10% WPI and said that it was similar to a proximal tibial osteotomy with a good result but I disagree with this as the procedures are completely different. He also estimated 2% WPI for scarring for what I consider a routine uncomplicated surgical scar.
>
> Dr P Miniter, Orthopaedic Surgeon, supplied a medico-legal report dated 19 January 2019. In his assessment of impairment, he could find no evidence of impairment involving the knee or the back or for scarring. He noted that Mr Khaliqi had had a tibial tubercle osteotomy and not an anterior tibial osteotomy and this is correct. He could find no evidence of instability involving the patella. He could find no other features upon which to assess impairment".

The appellant's submissions: the Right Knee

47. The appellant submits that the AMS's conclusion that as the procedure performed by Dr Nagamori is not included in the diagnosis based estimates then no assessment of whole person impairment should be allowed is an error.

48. It is pointed out that, although the appellant has not had a proximal tibial osteotomy, Dr Nagamori undertook a tibial tubercle osteotomy, a lateral release, a MPFL reconstruction and an arthroscopic trochlea chondroplasty. The submission is that cl 1.25 [sic, cl 1.23] of the Guidelines "required" the AMS to assess impairment by analogy, as Dr Woo did because the 2% WPI assessed by a DBE method "does not adequately allow for proper assessment of impairment as required by paragraph 1.23 of the Guidelines".

49. The appellant points out the impacts on the appellant's activities of daily living (ADLs) (as referenced in cl 1.25), which were recorded by the AMS, included pain even at rest but worse weight bearing, inability to kneel, crouch or squat, and difficulty with stairs. There is no persisting dislocation, but there is an altered gait.

50. The appellant says that Dr Woo suggested that an appropriate method in assessment was to use an analogy to a "proximal tibial osteotomy with good result" which equates to 10% whole person impairment. While the AMS may disagree with that approach, he erred because:

(a) The appellant's impairment is similar (to that resulting from a proximal tibial osteotomy, and the AMS "was required under paragraph 1.23 of the Guidelines to evaluate the impairment by using analogy".
(b) He did not explain why the analogy was not appropriate.

The respondent's submissions: the Right Knee

51. The respondent submits that the AMS has provided an assessment in accordance with cl 1.23 of the Guidelines. He did so by applying his clinical judgment, experience, training and skill to determine that the appellant's right lower extremity impairment could be considered analogous with Arthritis, using Table 17-31 of the AMA 5, p 544.

52. It is also submitted that the AMS did provide reasons, saying that there were no diagnosis based estimates to use. He explained why he chose Table 17-31, AMA5 p 544 in the section of the MAC reproduced at [46] above. The MAC includes clear reference to the AMS's observations, special investigations and comments on the medical reports provided by the appellant and the respondent.

The Panel's conclusions: the Right Knee

53. The Panel notes that in explaining his approach, Dr Woo said the tibial tubercle osteotomy was similar to proximal tibial osteotomy with good result. The AMS addresses this and disagreed, saying "the procedures are completely different". The Panel agrees. The medical members of the panel indicated that a proximal tibial osteotomy is a procedure undertaken in patients with advanced osteoarthritic degenerative change of the knee joint associated with malalignment. The procedure involves transection of the proximal tibia with correction of the malalignment of the lower extremity aimed at altering the abnormal weight-bearing forces through the knee joint. A tibial tubercle osteotomy is a far lesser procedure which involves an osteotomy of the bony prominence to which the patella tendon is attached in relation to the anterior aspect of the proximal tibia. The position of the tibial tubercle is shifted slightly and fixed in its new position thereby altering the line of pull of the quadriceps muscle. The procedure is aimed at stabilising the position of the patella. The panel noted that the procedure had been successful in that there was subsequently no further evidence of patella instability.

54. The AMS notes that there is no specific diagnosis based estimate for a tibial tubercle osteotomy. The appellant did not have a proximal tibial osteotomy, which, as indicated above is a far more significant procedure.

55. The AMS then notes that he found no patella subluxation or dislocation with residual instability.

56. He considers the possible methods of assessments, and notes that there is no impairment for muscle wasting and no impairment for restriction of range of movement in the appellant's case.

57. The AMS obviously considers Dr Woo's approach, but rejects that for a number of expressed reasons. These include: Dr Woo saw no evidence of patella dislocation, yet he diagnosed it and awarded 3% WPI for it; and said he disagreed with Dr Woo's assessment based on a (substituted or analogous) diagnosis of proximal tibial osteotomy with a good result because the (actual diagnosis of) tibial tubercle osteotomy is "completely different" and is part of a patella-femoral stabilisation procedure.

58. That is, he disagreed that it was a "similar condition" (which is required by cl 1.23) to a proximal tibial osteotomy. The Panel has already indicated above that it sees no error in this conclusion.

59. After considering these matters, the AMS reached the following conclusion:

> "The only finding on which I could base impairment was according to the Arthritis Table 17/31, where with a history of direct trauma, a complaint of patellofemoral pain and crepitations that a 2% whole person impairment is allowed" [sic].

60. Given the criteria taken into account by the AMS and that a suitable method was available to use without resorting to analogy, the Panel agrees that his method of assessment was appropriate.

61. The AMS was required to apply his clinical judgment on the day of assessment: *Glenn William Parker v Select Civil Pty Ltd* [2018] NSWSC 140; *Ferguson v State of New South Wales* [2017] NSWSC 887 at [23], Campbell J. He clearly did so, and did not adopt Dr Woo's judgement for clear reasons he set out.

62. Although the AMS undoubtedly applied his own clinical judgement, he did also note that Dr Miniter also could not find evidence of instability involving the patella. A/Prof Miniter also noted the appellant had a tibial tubercle osteotomy and not an anterior tibial osteotomy.

63. Clearly, the AMS did not consider that the actual tibial tubercle osteotomy was a similar condition to the suggested proximal tibial osteotomy. He did not consider the impairment from the actual tibial tubercle osteotomy would cause similar impairment of function to the suggested proximal tibial osteotomy.

64. Accordingly, addressing the appeal points:

    (a) The AMS did not agree that the appellant's impairment is similar to that resulting from a proximal tibial osteotomy, and he was not "required" under paragraph 1.23 of the Guidelines to the assess using that analogy; and

    (b) He explained why.

65. Further, when applying Table 17-31 of AMA 5, the AMS pointedly noted the footnote to the Table providing for 2% WPI for the right knee in the circumstances. The AMS's assessment based on arthritis is consistent with his observation that there was patellofemoral crepitus on examination plus a previous relevant history of an injury to the patellofemoral joint.

66. The appellant has not made out this ground of appeal.

Ground 2: Scarring - Right Knee

The MAC findings: Scarring

67. The AMS recorded:

> "There was a 15cm scar over the anterior aspect of the knee. It was of good colour match. There was no contour defect. There was no adherence. There were no suture marks visible and it would be considered an uncomplicated surgical scar.
>
> There was no quadriceps wasting, but the left calf circumference was slightly less than the right".

68. He noted Dr Woo's assessment of 2% WPI for scarring, and said he disagreed "for what I consider a routine uncomplicated surgical scar".

The appellant's submissions: Scarring

69. The appellant says the AMS:

    (a) Failed to "adequately use the TEMSKI scale" by concluding the appellant had an "uncomplicated surgical scar" rating 0% WPI; and
    (b) Did not adequately outline his reasons for assessing 0% WPI.

70. It is submitted that although the AMS observed a 15cm scar the knee, with good colour match, no contour defects, no adherence, and no visible suture marks he failed to consider or comment on the other TEMSKI descriptors including whether: the claimant is conscious of the scar; the claimant can easily locate the scar; there was any trophic changes evident to touch; the location of the scar is visible with usual clothing; were any limitations in the performance of ADL does the claimant experience as a result of the scar. Presumably, this is alleged to be the application of incorrect criteria. In support, and as an alleged error, the appellant submits that given the size of the scar, and that (it is asserted) the "claimant is clearly conscious of the scar (and) is easily able to locate the scar", the AMS fell into error. It is also submitted that the scar is in a location which is visible with shorts, being usual clothing

71. Although the appellant does not specify what the assessment should have been, the above submissions suggest a 1% or 2 % WPI allowance is contemplated.

The respondent's submissions: Scarring

72. The respondent submits that the AMS provided detailed reasoning for assessing 0% WPI, by noting the features as to contour, colour, adherence, suture marks and that it would be considered an uncomplicated surgical scar.

73. In doing so, he applied the "best fit" principle as required by cl 14.8 of Guidelines.

74. As such the respondent argues that the AMS did not apply incorrect criteria and the MAC does not have a demonstrable error.

The Panel's conclusion: Scarring

75. Clause 14.6 of the Guideline provides:

> "14.6 A scar may be present and rated as 0% WPI.
> Note that uncomplicated scars for standard surgical procedures do not, of themselves, rate an impairment."

76. Clauses 14.8 and 14.9 of the Guidelines provide:

> "14.8 The TEMSKI is to be used in accordance with the principle of 'best fit'. The assessor must be satisfied that the criteria within the chosen category of impairment best reflect the skin disorder being assessed. If the skin disorder does not meet all of the criteria within the impairment category, the assessor must provide detailed reasons as to why this category has been chosen over other categories.
>
> 14.9 Where there is a range of values in the TEMSKI categories, the assessor should use clinical judgement to determine the exact impairment value."

77. The concept of "best fit' is reinforced as a footnote to Table 14.1.

78. Dr Woo noted also noted a 12cm long mid-line scar on the front of the right knee. He said the scar was tender over the tibial tubercle (the site of the osteotomy). He said there was "suggestive" wasting because the appellant is right handed and the right and left thigh measurements were equal. Dr Woo explained his assessment on the basis of two descriptors in the Table: contour change; and "minor limitation in the performance of few ADL". It is not apparent from any of the evidence how the scar (as opposed to other symptoms from the knee (or back)) impacts ADLs.

79. While the AMS could have recited all descriptors within the possibly relevant categories of TEMSKI, it is clear enough that the overall picture is presented in the MAC. The scar is a significant size and it may be assumed that it is visible with usual clothing, that the appellant can locate it, and may even be conscious of it (however, the appellant does not say so in his statement as recently as February this year, nor does any other clinical or medico-legal assessor). Given the findings by the AMS, it is most likely that the AMS examined for the relevant descriptors in TEMSKI, and the presumption of regularity would reinforce this. That being so, and assuming, in the appellant's favour, that the three features of visibility, ability to locate the scar and consciousness of it, the Panel concludes that the AMS description of an uncomplicated surgical scar, without any further features, renders 0% WPI the best fit.

80. This ground of appeal is not made out.

DECISION

81. The appellant has not established that the AMS applied incorrect criteria or that the MAC contains a demonstrable error.

82. For the reasons set out in this statement of reasons, the decision in this matter is that the Medical Assessment Certificate given in this matter is confirmed.

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*.

REGISTRAR

A Vermeulen

Anneke Vermeulen
Dispute Services Officer
As delegate of the Registrar