WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-1409/19**
Appellant:	**Elena Martinez**
Respondent:	**Paraplegic & Quadriplegic Association of NSW**
Date of Decision:	**13 August 2019**
Citation:	**[2019] NSWWCCMA 111**

Appeal Panel:	
Arbitrator:	**Ms Deborah Moore**
Approved Medical Specialist:	**Dr Tommasino Mastroianni**
Approved Medical Specialist:	**Dr Brian Noll**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 19 June 2019, Elena Martinez lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Jonathon Negus, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 29 May 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 we consider that we have sufficient evidence before us to enable us to determine the appeal.

8. The appellant did not request a re-examination although the respondent did, but having considered all the submissions, we remain of the view that no further examination is required.

EVIDENCE

Documentary evidence

9. 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

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

11. In summary, the appellant submits that the AMS failed to provide any or any adequate reasons for the deduction he made from his final assessment, failed to consider all of the medical evidence, and made assumptions that were not sustainable given the whole of the evidence.

12. In reply, the respondent agrees with the appellant that the AMS has failed to justify why he made a 50% s 323 deduction but submits, inter alia, that there is sufficient evidence for any deduction to be greater than 10%.

FINDINGS AND REASONS

13. 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.

14. 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.

15. The appellant was referred to the AMS for assessment of whole person impairment (WPI) of the right upper extremity (shoulder) resulting from an injury on 22 November 2015.

16. The appellant was employed by the respondent as a personal carer. The AMS obtained a history that on that date, as the appellant was assisting another carer to lift a patient up the bed, they pulled on the pull sheet, and Mrs Martinez felt pain in the right shoulder.

17. The AMS added:

> "Her pain gradually worsened. She saw her doctor and was placed on light duties until the day before her operation (an arthroscopic rotator cuff repair) at the hand of Dr Biggs on 20 April 2016. In that intervening period, she underwent investigations with ultrasound and MRI.
>
> She had no relief of symptoms from the operation…
>
> She saw Dr Biggs again for her left shoulder which had started to hurt her while on light duties as she was unable to use her right shoulder at all and the filing work and various other jobs she was given were all done with her left arm which she felt was then over used. She had an MRI scan showing a partial tear of the rotator cuff and she had some steroid injections. This did give her temporary relief for a few months."

18. Present treatment was noted as follows:

> "She sees Dr Michael Hong (psychiatrist) on a monthly basis and has group therapy and he has also suggested further inpatient treatment. She is treated at Northside West Clinic in Sydney. She takes the current medications of Lovan, Phenergan, Norgesic, Panadol and Nurofen.

19. Present symptoms were noted as follows:

> "She describes pain throughout her neck and right side of her shoulder. It is constant pain, worse with any movement She struggles to sit for more than a few hours without pain causing her to get up but at the same time she describes needing to sleep sitting up as she cannot lie on her back. She is unable to lift and move her right shoulder in a functional way. She has difficulty with self-care such as toileting and showering and washing her hair as well as any housework. She is able to drive for only short distances and only uses her left hand."

20. The AMS then noted that the appellant "has a background of previous injury including while looking after [the same patient] she injured her right shoulder and neck around 08/11/2011." He added:

> "She saw her GP who sent her off for physiotherapy and gave her a script for Mobic. She once again had a period of light duties before going back to full duties in October of 2011 while also having injections into the right shoulder.
>
> On 29/12/2011 she was certified fit for usual duties with lifting restrictions. Her shoulder had improved and in March 2013 she was lifting 7kg at the gym with no pain. She went back to her normal duties and was doing well although she did get a recurrence on 16/03/2015 when she hit her right arm on a door in the home of [the same patient]. She saw Dr Joshi on 16/03/2015 and Dr La on 18/03/2015 but was okay for work until November 2015.
>
> She also describes a recent incident while shopping in Aldi at Gungahlin on 21/01/2018 where she stepped on a mango skin and fell. She injured her knees and broke a rib on the right side. This aggravated her pain in both shoulders. Dr Azra sent her for imaging and gave her a script for analgesia and sleeping pills. She feels that the fall aggravated her shoulder pain and also stopped her from being able to attend physio."

21. The AMS then set out details of the appellant's general health, noting:

> "She has been hospitalised for severe depression in mid-2017 by Dr Michael Hong as well as being prescribed antidepressants. She has seen Rehab Specialists such as Dr Robert Adler, Psychologists such as Daniella who she saw for 7 months, Psychiatrist, Dr Phillip Brown, and Dr Sindy Vrancic, orthopaedic Surgeon, in November 2017 who suggested she see a Pain Specialist. She has also had neuro-physiological studies at the request of Dr Pillemer."

22. As regards ADL's, the AMS simply said: "She was born in Chile and came to Australia in 1986. She is single, living in Canberra with her son, Edson. She has 2 other adult children, one of whom lives in Sydney."

23. Findings on physical examination were reported as follows:

> "She has well-healed, surgical scars consistent with an arthroscopic shoulder procedure on the right side. They have healed well with slight raised area and slight red coloration. She has no significant wasting of her supraspinatus but she is tender over both AC joints. Range of motion active is as follows:

MOVEMENT	RIGHT	LEFT
Flexion	35°	60°
Extension	0°	10°
Abduction	10°	58°
Adduction	0°	10°
Internal rotation	30°	0°
External rotation	0°	90°

She had full power in all her cuff muscles. I was unable to test impingement. She had restricted motion in rotation and lateral bend of her neck although her flexion and extension were all within the normal range. She had generalised tenderness from C1 through to T5 as well as tenderness in the paraspinal musculature. She also had a positive Waddell's test for axial compression of the neck. She had no demonstrable, abnormal neurology throughout the upper limbs. I tested both pin prick and light touch on both sides and all were normal and equal. All her deep tendon reflexes were normal and equal including the triceps reflex. She did demonstrate some generalised weakness in grip and wrist extension on the right side."

24. Special investigations were noted as follows:

> "Ultrasound scan demonstrating an injection into the right shoulder on 02/12/2015.
>
> Ultrasound from 01/12/2015 demonstrating a full thickness supraspinatus tear.
>
> MRI right shoulder from 10/02/2016 demonstrating severe supraspinatus tendinosis and bursal tear which is near full thickness.
>
> Left shoulder MRI from 21/06/2016 demonstrating intra-substance tear of subscapularis and tendinosis but no tear. I felt there was also significantly increased signal in the insertion of the supraspinatus into the GT.
>
> Nerve conduction studies from 01/08/2018 showed an incidental, mild, right-sided carpal tunnel syndrome."

25. In summarising the injuries and diagnoses, the AMS said:

> "I can find no evidence of a brachial plexus injury. She has features more consistent with a frozen shoulder on the right and a partial tear of her rotator cuff on the left shoulder.
>
> The range of motion of her right shoulder during my examination was significantly less than found at the examination of her treating surgeon in the months following the surgery or by Dr Pillemer. Professor Miniter found her unable to move the shoulder in any meaningful way that he could measure.
>
> I am therefore of the opinion that either the fall in 2018 has aggravated her right shoulder and left her with a frozen shoulder or it is not a physical pathology causing this lack of shoulder movement.
>
> She was consistent throughout the examination holding her right arm in a protected attitude close to her body with minimal rotation or abduction. She needed help for dressing and undressing and was consistent with this throughout the examination. Her abilities as described and demonstrated in the examination were not consistent with driving a car safely."

26. The AMS assessed 19% WPI. He said that a proportion of that WPI was due to a previous injury, pre-existing condition or abnormality. He noted that a subsequent injury had occurred adding:

> "The fall in Aldi on 21/01/2018 aggravated the pain in both her shoulders. It would appear that her right shoulder examination has been consistently worse for range of motion following this fall than before it."

27. He then said:

> "She has a significantly reduced range of motion which is less than that found following the operation and in subsequent reviews, prior to the fall on 21/01/2018.
>
> Therefore, impairment attributable to injury 22/11/2015 = 10% WPI."

28. The AMS then referred to "other medical opinions and findings submitted by the parties…" stating:

> "I agree with Professor Miniter in his report where he disagrees with Dr Pillemer's diagnosis of a brachial plexus injury. There are no findings from the history, clinical examination or imaging studies to back up this diagnosis. I do agree with Dr Pillemer that the diagnosis is not easy and it would appear that she presented an unusual picture of abnormal cutaneous sensation during his examination that was not present when examined by Professor Miniter or myself.
>
> I agree with Professor Miniter that a proportion of her right shoulder impairment is likely to not be caused by a physical process."

29. At paragraph 11, as regards any deduction for a pre-existing condition, the AMS then said, "There is no deductible proportion."

30. The appellant has raised a number of issues with the MAC, summarised as follows:

    (a) The AMS failed to provide any or any adequate reasons as to why he assessed 19% WPI but assessed impairment attributable to the injury on 22 November 2015 at 10% WPI;

    (b) The AMS failed to consider all the medical opinions provided;

    (c) The AMS failed to identify the assessment by the 'treating surgeon' upon which he relied in forming his opinion;

    (d) The fall at Aldi on 21 January 2018 preceded the assessment by Dr Pillemer on 16 July 2018;

    (e) The AMS failed to indicate why in his opinion the deterioration following the injury and subsequent surgery did not account for the appellant's condition rather than the fall at Aldi;

    (f) The AMS failed to refer to the assessment of Dr David Duckworth dated 25 July 2016 and the fact that he noted that the appellant had 'developed a postsurgical stiff shoulder';

    (g) The AMS failed to consider the opinions of Dr Vrancic, the appellant's treating specialist;

(h) The AMS incorrectly assumed that the only two possible causes for the appellant's condition were that there was deterioration after the fall at Aldi or that it was not physical pathology causing the lack of shoulder movement. The AMS should have considered that the deterioration was caused by the initial injury.

31. The respondent's submissions focussed principally on the degree of the deduction made by the AMS.

32. We agree with many of the appellant's submissions for reasons that follow.

33. To begin with, although the AMS said at paragraph 8 of the MAC that a proportion of the WPI was due to a previous injury, pre-existing condition or abnormality, he subsequently said (at paragraph 11) that there was no deductible proportion. These statements are clearly inconsistent and cannot stand.

34. In our view, there was ample evidence of prior injuries to the right shoulder as documented by the AMS at paragraph 4 of the MAC.

35. Dr Pillemer in his report dated 16 July 2018 noted the history of an injury to the "neck and right shoulder region back in 2011 while working with the same patient…" He added: "she went on to restricted duties at that stage for about two years and symptoms never really settled 100%..." Dr Malhotra in his report of 1 August 2018 also said: "In 2013 Elena had an injury with the same patient in which [the] C6 and C7 nerve was trapped and the tendons were inflamed…" Dr Miniter also noted the injury on 5 August 2011.

36. In her statement dated 8 February 2019, the appellant also described in some detail her prior injury in 2011 and subsequent symptoms and treatment. It appears that she was symptomatic and treated for at least two years. She also said that her symptoms returned after resuming full duties following a period of some two years on light duties. She did however say that she was 'managing' her pre-injury duties from about mid-2013.

37. We also observe that the injury on 22 November 2015 appears to have been of a relatively minor nature. The injury is described as follows in the MAC: "They were getting ready to lift him up the bed and as they pulled on the pull sheet Mrs Martinez is felt pain in the right shoulder." A similar history is provided in the appellant's statement.

38. An MRI scan dated 10 February 2016, some seven weeks after the work-related injury, revealed evidence of severe supraspinatus tendinosis with an extensive bursal surface tear – reported to be "near full thickness". Note was also made of degenerative changes in relation to the subscapularis tendon and glenoid labrum. The MRI scan provides evidence of a significant pre-existing degenerative disorder of the rotator cuff. Given the fact that the MRI scan was undertaken seven weeks after the work-related injury we are of the view that it would be appropriate to assume that the degenerative changes noted would have predated the work-related injury. In our view, it would also be reasonable to assume that the tear of the rotator cuff would not have occurred in the absence of the pre-existing degenerative changes.

39. Although we accept that there is no evidence to indicate that the right shoulder was symptomatic in the period immediately prior to the work-related injury there is a clear previous history of right shoulder pain on several occasions.

40. 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. (*Vitaz v Westform (NSW) Pty Ltd* [2011] NSWCA 254).

41. In summary, having carefully considered all of the evidence, we are of the view that the pre-existing condition was a contributing factor causing permanent impairment, and a deduction of one-fifth is appropriate.

42. Turning now to the submission regarding the claimed failure by the AMS to provide any or any adequate reasons as to why he assessed 19% WPI but assessed impairment attributable to the injury on 22 November 2015 at 10% WPI, we agree with this submission entirely.

43. The AMS simply said:

> "She has a significantly reduced range of motion which is less than that found following the operation and in subsequent reviews, prior to the fall on 21/01/2018.
>
> Therefore, impairment attributable to injury 22/11/2015 = 10% WPI."

44. It appears that the AMS based his conclusion solely on the appellant's range of motion at the time of his examination, but this of itself is not a satisfactory explanation or reason for his assessment of 10% WPI attributable to the work injury.

45. It also ignores a number of other medical opinions which the AMS does not appear to have taken into account, another submission by the appellant with which we agree.

46. Although we accept that Dr Biggs thought that there was eventually some improvement in the appellant's condition following the surgery, we note that Dr Duckworth in his report dated 25 July 2016 addressed to the insurer said:

> "She now has ongoing stiffness and pain affecting her shoulder and it appears she has developed a post-surgical stiff shoulder. She has also now developed a problem in her left shoulder. She now has poor function in both shoulders, difficulty driving and cannot dress or shower. She is not working and she is not able to do light duties. She is on antidepressants for pain.
>
> On examination today she had diffuse pain around both shoulders. She had a limited range of motion…
>
> The prognosis for Ms Martinez is guarded… She has a difficult problem affecting both shoulders with chronic pain. She may always have some difficulty with overhead use of the arm, heavy lifting and repetitive use of her arms out to the side".

47. Dr Vrancic appears to have taken over treatment of the appellant in about 2017. In a report dated 20 November 2017 she said:

> "As part of the post-operative protocol she underwent rehabilitation and immediately had significant pain and stillness which has not changed since her post-operative period. She has been diligent with regards to exercises but continues to have no function in her right arm, constant pain and inability to use her right shoulder. She has recently moved to Canberra to be closer to her family as she has been unable to do any type of work due to the pain and stillness in her shoulder.
>
> Today, she carries her right arm and does not use it in any way during the consultation. Her elbow is still as she constantly is splinting her right arm. She has significant muscle spasm of her scapular stabilisers which settled once I placed her in a sling. There is global tenderness to light touch. There is hyper-aesthesia/dysaethesia over the whole arm. There are no colour changes…

> Given that it has been 2 years since her injury and 18 months since her surgery and that her pain and stillness has not changed in any way throughout this period, the diagnosis of adhesive capsulitis is highly unlikely. The natural history of a true frozen shoulder is that it progresses through 3 stages over an 18-month period but Elena has not progressed at all, rather she has stayed in the painful phase the entire time. Her shoulder is not behaving like a true frozen shoulder. I fear that the most likely problem is a complex pain syndrome affecting her right shoulder...
>
> A referral to a pain specialist is recommended as I feel this is a pain syndrome. As it has not changed in 18 months to 2 years I fear it is unlikely to change and there is unlikely to be any surgery that I could offer to make any difference to her shoulder."

48. In short, Dr Vrancic was of the opinion that the chronicity of the appellant's symptoms and overall condition could be explained by physiological factors.

49. The AMS said that the appellant's condition was due to "either the fall in 2018 [which] has aggravated her right shoulder and left her with a frozen shoulder or it is not a physical pathology causing this lack of shoulder movement."

50. The AMS therefore essentially conceded that the appellant suffered from a frozen shoulder, as suggested by Dr Duckworth in particular. In our view, the appellant's treating doctors accept that the deterioration in her condition following the surgery is as a result of her injury.

51. We should add that, although the appellant herself said that she felt that her symptoms had been aggravated by the fall at Aldi, there is simply insufficient medical evidence to conclude that any structural damage or change in pathology occurred following this incident.

52. If in fact any aggravation occurred, in our view it was minor, and did not contribute in any significant measure to the appellant's overall condition resulting from the injury on 22 November 2015.

53. It is noted that Dr Pillemer also said: "On specific questioning, even before the fall, she had significant restrictions with regard to her right arm."

54. The AMS observed that the appellant was "consistent throughout the examination holding her right arm in a protected attitude close to her body with minimal rotation or abduction. She needed help for dressing and undressing and was consistent with this throughout the examination."

55. It is noted that the appellant's presentation to Dr Vrancic in November 2017 was quite similar to that of the AMS. Dr Pillemer also said: "It was noted that she holds her right arm very protectively at her side…"

56. In these circumstances we cannot see any reason not to accept the AMS's clinical findings and therefore his assessment of 19% WPI.

57. Applying the one-fifth deduction we have determined; this leaves a total of 15.2% rounded to 15% WPI.

58. For these reasons, the Appeal Panel has determined that the MAC issued on 29 May 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: **1409/19**
Applicant: **Elena Martinez**
Respondent: **Paraplegic & Quadriplegic Association of NSW**

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 Jonathon Negus and issues this new Medical Assessment Certificate as to the matters set out in the Table below:

Table - Whole Person Impairment (WPI)

Body Part or system	Date of Injury	Chapter, page and paragraph number in the Guidelines	Chapter, page, paragraph, figure and table numbers in AMA 5 Guides	% WPI	Proportion of permanent impairment due to pre-existing injury, abnormality or condition	Sub-total/s % WPI (after any deductions in column 6)
1.Right upper extremity	22/11/15		16-40 16-43 16-46	19%	One-fifth	15%
Total % WPI (the Combined Table values of all sub-totals)					**15%**	

Ms Deborah Moore
Arbitrator

Dr Tommasino Mastroianni
Approved Medical Specialist

Dr Brian Noll
Approved Medical Specialist

13 August 2019

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