WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-2454/19**
Appellant:	**City of Fairfield RSL Memorial Club**
Respondent:	**Peter James Timbs**
Date of Decision:	**17 December 2019**
Citation:	**[2019] NSWWCCMA 187**

Appeal Panel:	
Arbitrator:	**Ms Deborah Moore**
Approved Medical Specialist:	**Dr James Bodel**
Approved Medical Specialist:	**Dr Brian Noll**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 13 September 2019 City of Fairfield RSL Memorial Club lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Ian Louis Meakin, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 20 August 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 issues on appeal, notwithstanding the appellant's request for a further medical examination.

EVIDENCE

Documentary evidence

8. The Appeal Panel has before it all the documents that were sent to the AMS for the original medical assessment and has taken them into account in making this determination.

SUBMISSIONS

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

10. In summary, the appellant submits that the AMS erred in his application of the provisions of section 323 of the 1998 Act.

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

FINDINGS AND REASONS

12. 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

13. 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.

14. The respondent was referred to the AMS for assessment of whole person impairment (WPI) resulting from an injury on 14 April 2014 as follows:

    "Right upper extremity (shoulder)

    Left upper extremity (shoulder) – consequential condition."

15. The AMS obtained the following history:

    "Some days prior to the 9 April 2014, Mr Timbs complained of some discomfort over the anterior aspect of the right shoulder and he consulted his long-standing practitioner, Dr Singh of Fairfield. Dr Singh organised an x-ray and ultrasound on the 9 April 2014. Mr Timbs was to return to see Dr Singh regarding these investigations, however an incident at work on the 14 April 2014 intervened. On that day Mr Timbs was putting a tray of glasses in a refrigerator about a metre off the ground when he felt an extremely sharp pain in the right upper arm and shoulder area. He was off work for a few days only.

    A further ultrasound was performed on the 17 April 2014 demonstrating an intrasubstance tear within the supraspinatus tendon as well as other areas of tendinitis within the rotator cuff structure…

Dr Dave` organised further investigations including an x-ray of the cervical spine and an MRI Scan of the right shoulder. This scan confirmed the full thickness tear involving the insertional fibres of the posterior two thirds of the supraspinatus tendon on a background of significant tendinopathy with delamination of articular surface fibres and further medial retraction of the fibres associated with mild to moderate supraspinatus tendon atrophy. There was also some tendinopathy involving the insertional fibres of the infraspinatus and supraspinatus tendon. There was also an undisplaced posteosuperior labral tear and degenerative change in the acromioclavicular joint…

On the 3 December 2016, at the Liverpool Private Hospital, Mr Timbs underwent an arthroscopic right shoulder procedure. This procedure was that of a rotator cuff repair according to Mr Timbs. Unfortunately, this surgery did not improve his clinical status and there was actually an increase in pain for a considerable time…

Mr Timbs had reported that there was a very occasional similar pain on the pad of the left shoulder but of a lesser intensity since early in 2015. This discomfort was very intermittent. It became more significant early in 2018. Mr Timbs was then complaining of pain and a feeling of stiffness with a decreased range of motion of the left shoulder of a similar nature to that noted on the right side but of a lesser intensity…"

16. After noting the respondent's present symptoms and findings on physical examination, the AMS then considered the radiological material before him. Relevant to the issue in dispute, he said:

"Right shoulder radiograph/right shoulder ultrasound study dated 9 April 2014 – Degenerate change in the acromio-clavicular joint and slight narrowing of the subacromion space suggesting some degenerative change of the rotator cuff. The main shoulder joint appears normal. The ultrasound demonstrates an intra-substance tear in the supraspinatus tendon extending over a distance of 1.3cm. The other tendons contributing to the rotator cuff are intact. There is a minor degree of tenosynovitis affecting the biceps tendon in the bicipital groove with a minor degree of bursitis in the subdeltoid region adjacent to the supraspinatus tendon. Abduction was restricted to approximately 50º and associated with impingement of soft tissues in the subacromial space – minor degree of degenerative change in the acromio-clavicular joint.

Right shoulder ultrasound dated 17 April 2014 – Mild synovial sheath effusion surrounds the mildly thickened biceps tendon in keeping with mild biceps tenosynovitis. The supraspinatus tendon is moderately heterogeneous in keeping with tendonitis – a 9 x 1mm intrasubstance tear within the anterior aspect of the supraspinatus tendon. Subscapularis tendon normal – there is a 3mm calcified focus within the infraspinatus tendon in keeping with mild calcific tendonitis. Mild to moderate thickening of the subdeltoid bursa with bunching of the bursa on abduction in keeping with the subdeltoid bursitis. The acromio-clavicular joint appeared normal.

MRI right shoulder/ x-ray cervical spine dated 7 June 2014 – Right shoulder: Full thickness tear involving the insertional fibres of the posterior two thirds of the supraspinatus tendon on a background of significant tendinopathy with delamination of articular surface fibres and further medial retraction of the fibres. Associated mild to moderate supraspinatus muscle atrophy. Tendinopathy involving the insertional fibres of infraspinatus and subscapularis. Small effusion in the gleno-humeral joint as well as within the subacromial/subdeltoid bursa. Severe degenerative change in the acromio-clavicular joint – undisplaced posterosuperior labral tear."

17. A number of later imaging studies were also included. Of note is an MRI scan of the left shoulder taken on 13 December 2017 which the AMS said showed: "There was no evidence of focal labral tear. The biceps tendon is within the groove with some fluid in the tendon sheath. There is severe osteoarthritis of the acromioclavicular joint with joint space loss and osteophytes with the overlying soft tissue demonstrating increased signal. There is an increased signal in the anterior fibres of the supraspinatus tendon insertion suggestive of

tendinosis. There is no evidence of focal tear. The infraspinatus and subscapularis tendons appear unremarkable. There is thickening of the subacromial bursa containing fluid."

18. The AMS summarised the injuries as follows:

> "Mr Timbs is a 60-year-old right handed man who presented with discomfort in his right shoulder, in early April 2014, with a scan of the shoulder performed on the 9 April 2014 (five days prior to the injury), demonstrating a normal shoulder joint but evidence of intrasubstance tear of significance in the supraspinatus tendon. There was also evidence of bursitis and the Radiologist commented there was restriction of abduction to 50° due to impingement at the time of the assessment.
>
> On the 14 April 2014, Mr Timbs sustained a work injury resulting in an increase in the pain in his right shoulder with an ultrasound performed on the 17 April 2014 (3 days after the work injury), demonstrating the existing pathology – a tear in the supraspinatus tendon. It was noted in the second scan that there was evidence of calcific tendinosis in the infraspinatus tendon, indicative of long-standing degeneration. Such findings were all confirmed by a subsequent MRI Scan on the 7 June 2014, noting evidence of muscle atrophy at the site of the rotator cuff tear suggested evidence of tendinopathy in other rotator cuff tendons along with significant degenerative change in the acromioclavicular joint…
>
> There has also been a history of a similar discomfort but of a lesser type, in the non-traumatised left shoulder, with the first symptoms being noted at the time of my assessment in September 2015. More significant symptoms occurred in 2018 with discomfort in a similar site and a resultant scan of the left shoulder being performed in December 2017 at the request of the local practitioner. This scan shows evidence of supraspinatus tendinosis with bursitis and acromoclavicular joint degeneration…
>
> Mr Timbs states that the onset of symptoms in his left shoulder has occurred because of the overuse of his left shoulder while attempting to guard and then rehabilitate the right shoulder. Such consequential injury is been [sic] accepted by independent medical specialists who have reported on his current clinical status. The proper diagnosis will be that of long-term rotator cuff impingement due to primary osteoarthritis of the acromioclavicular joint with subsequent rotator cuff tendinitis and then tear and the onset of secondary degenerative change."

19. When asked the question: "Is any proportion of loss of efficient use or impairment or whole person impairment, due to a previous injury, pre-existing condition or abnormality?" the AMS replied "Yes."

20. The AMS assessed 11% WPI in respect of the right shoulder and 8% WPI of the left shoulder, a combined total WPI of 16%.

21. He added:

> "I have elected to deduct a one tenth proportion of each impairment relating to section 323.
>
> Right Shoulder: At the time of today's assessment the applicant demonstrates an 11% WPI relating to the right shoulder. On applying a section 323, 1/10th deduction, there is a remaining 10% WPI at the time of rounding down. This is based on the history obtained that there was pre-existing discomfort in the right shoulder requiring assessment by the local practitioner in the days before the current work accident. It also relates to the ultrasound performed prior to the work accident which shows significant pathology that is the same as the pathology demonstrated in the ultrasound and MRI scan performed of the right shoulder in the weeks after the reported work accident and subsequent investigation. The repaired supraspinatus tear pre-existed prior to the work accident in a symptomatic state but it became more symptomatic at the time of the work accident on accepting the applicant's history.

Left Shoulder: At the time of today's assessment the applicant demonstrates an 8% WPI relating to the left shoulder. On applying a 1/10th deduction, there is a remaining 7% WPI at the time of rounding down. This section 323 deduction on the left side in my opinion is consistent with the scanned evidence noted on the 13 December 2017. There is also significant degeneration of the acromioclavicular joint along with degenerative impingement of the supraspinatus tendon at that time. There is no history of significant injury other than the consequential over use of the left shoulder at a time when the applicant was not performing rigorous work duties."

22. The AMS concluded:

"a. In my opinion the worker suffers from the following relevant previous injuries, pre-existing conditions or abnormalities:

(i) Pre-existing rotator cuff degeneration and acromioclavicular joint degeneration – Right and Left Shoulder.

b. The previous injury, pre-existing condition or abnormality directly contributes to the following matters that were taken into account when assessing the whole person impairment that results from the injury, being the matters taken into account in 10a, and in the following ways:

(i) There is historical evidence that the right shoulder was symptomatic in the days prior to the work injury, requiring medical consultation and an Ultrasound examination which demonstrated rotator cuff pathology, right side.

(ii) At the time of presentation of the significant discomfort of the left shoulder, scanned evidence showed long standing degenerative change, particularly affecting the acromioclavicular joint with secondary changes in the rotator cuff.

c. The extent of the deduction is difficult or costly to determine so in applying the provisions of s323 (2) I assess the deductible proportion as one tenth. (1/10th)"

23. The AMS commented upon a number of other medical opinions to which we will refer later.

24. As the appellant correctly points out, the AMS was required to determine any impairment resulting from the "frank injury" on 14 April 2014.

25. However, it is clear from the history obtained by the AMS, and reported by a number of other doctors, that the respondent had a symptomatic disorder in his right shoulder some five days earlier, namely on 9 April 2014.

26. As a result of those symptoms, the respondent consulted with Dr Singh that day who organised an x-ray and ultrasound on the same day.

27. The reports of those investigations were referred to by the AMS and noted by us above.

28. In summary, the ultrasound demonstrated significant pathology in the right shoulder which clearly pre-dated the "frank injury." We also note that at that time, the respondent clearly had difficulties with his right shoulder since he was unable to abduct to more than 50º.

29. This in our view shows that the respondent's condition was much more than "pre-existing discomfort" as reported by the AMS.

30. The principles pertaining to the deduction pursuant to s323 the 1998 Act are well established.

31. *Cole v Wenaline Pty Ltd* [2010] NSWSC 78 (*Cole*) is the perennially cited authority on the construction and application of section 323. In summary, Schmidt J said that the section "does not permit that assessment to be made on the basis of an assumption or hypothesis, that once a particular injury has occurred, it will always…contribute to the impairment flowing from any subsequent injury. The assessment must have regard to the evidence as to the actual consequences (our emphasis) of the earlier injury…"

32. Conversely, *Vitaz v Westform (NSW) Pty Ltd* [2011] NSWCA 254 (*Vitaz*) is cited as authority for the principle that "if a pre-existing condition is a contributing factor causing permanent impairment, (our emphasis) a deduction is required, even though the pre-existing condition had been asymptomatic prior to the injury."

33. In this case the respondent's right shoulder injury was symptomatic prior to the work injury, and there was extensive medical evidence before the AMS that indicated the worker had a significant pre-existing right shoulder condition.

34. Examples of this include the radiological material, the history given by the respondent, and in particular the clinical notes of Dr Singh.

35. Those notes demonstrate that the respondent presented on 26 March 2014, complaining of right shoulder pain "experienced over the last 1-2 weeks."

36. In addition, when the respondent saw Dr Singh on 14 April 2014, he recorded that the respondent sustained a "sudden aggravation of right shoulder pain with sudden movement of right arm at work today".

37. In short, Dr Singh was of the view that the incident on 14 April 2014 was by way of an aggravation of a pre-existing condition.

38. We also add at this point that the description of the injury as recorded by the AMS was of a relatively minor nature, Mr Timbs having been merely "putting a tray of glasses in a refrigerator about a metre off the ground."

39. Its relatively minor nature is also consistent with the opinion and report of Dr Singh referred to above.

40. Of course, we accept that the incident occurred, but such an activity in our view would be unlikely to produce a rotator cuff tear. The MRI scan performed about two months after the work injury showed significant degenerative changes in the rotator cuff which could only be due to a long-standing rotator cuff problem.

41. The AMS set out in some detail some of the reports he had before him which were on the whole unhelpful since accurate histories were often missing. We do not need to repeat his comments here.

42. We do note however that the AMS did not refer to some other reports such as that of Dr Burns dated 16 April 2018. Dr Burns said:

> "Mr Timbs reported that he had no previous accidents or injuries involving his neck, right shoulder or left shoulder before the current injury.
>
> I noted from the documentation that he had in fact reported previous pain in the right shoulder in early April 2014, several weeks before the current accident. At this time, Mr Timbs and his wife became adamant that this had already been sorted out legally and stated that these injuries were also part of the current claim. I noted though that I had been informed that his current claim is for a frank injury occurring on 14 April 2014.

Eventually, Mr Timbs did report that he developed pain and discomfort in the right shoulder which he believed was associated with his nature and conditions of work. This came on in early April 2014…"

43. This history is consistent with that obtained by the AMS, irrespective of Dr Burns' comments regarding the 'legalities' of the current claim.

44. Dr Breit's focus in his report dated 8 October 2018 was primarily on the consistency of the respondent's presentation having regard to other material before him.

45. However, he did make a number of pertinent comments. He said:

"A week before the stipulated date of injury there was some right arm pain and he did not think much of it but saw his GP who sent him off for an ultrasound and X-ray. However, before he returned for review the episode of 14 April 2014 intervened. He was simply putting a tray of glasses into a refrigerator about 1 metre above ground when he felt sharp pain in the right arm…"

46. In reference to a right shoulder x-ray performed on 9 April 2014, Dr Breit said:

"I disagree with the report, there are marked reactive changes at the greater tuberosity of the humerus, there is anterolateral acromial prominence and acromioclavicufar arthritis. The ultrasound reports partial thickness tear and limited movement which is repeated on the subsequent ultrasound of 17 April 2014."

47. When asked the question: "In your clinical opinion, has Mr Timbs original Injury stemming from the workplace Injury on 14 April 2014 now ceased?" Dr Breit replied: "In my opinion it ceased long ago, it was simply an aggravation of an underlying condition."

48. Again, his comments as regards an "aggravation" are consistent with the opinion of Dr Singh.

49. For these reasons, we agree with the appellant's submissions and consider that a deduction of 50% in respect of the right shoulder is appropriate.

50. As regards the left shoulder, the appellant makes similar submissions, noting, for example, as follows:

"The AMS also noted that the worker "at the time of presentation of the significant discomfort of the left shoulder, scanned evidence showed long standing degenerative change, particularly affecting the acromioclavicular joint with secondary changes in the rotator cuff…

On taking into account the appropriate assessment of impairment that ultimately related to the work incident on 14 April 2014, the assessment of the worker's consequential left shoulder injury arising from that work incident would have resulted in a greater deduction under s323. The evidence indicates a greater deduction of the left shoulder impairment was also required to reflect the pre-existing injury suffered by the worker that is unrelated to the consequential effects of the work incident."

51. We accept that the evidence before the AMS demonstrated pre-existing degenerative changes in the left shoulder.

52. Having said that, we note that the AMS explained his reasons for a 10% deduction as follows:

> "This section 323 deduction on the left side in my opinion is consistent with the scanned evidence noted on the 13 December 2017. There is also significant degeneration of the acromioclavicular joint along with degenerative impingement of the supraspinatus tendon at that time. There is no history of significant injury other than the consequential over use of the left shoulder at a time when the applicant was not performing rigorous work duties (our emphasis)."

53. Having regard to the principles relating to section 323 referred to above, we are satisfied that the AMS made an appropriate deduction in respect of the left shoulder because, as he said, the impairment related to the accepted "consequential overuse" of that shoulder.

54. For these reasons, the Appeal Panel has determined that the MAC issued on 20 August 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*.

R Gray

Robert Gray
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **2454-19**
Applicant: **Peter James Timbs**
Respondent: **City of Fairfield RSL Memorial Club**

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 Meakin 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 (Shoulder)	14/4/2014	Chapter 2 Pages 13-15	Figures 16.40 to 16.46, Table 3, Page 20, AMA 5	11%	One-half	6%
2. Left Upper Extremity (Shoulder)-consequential	14/4/2014	Chapter 2 Pages 13-15	Figures 16.40 to 16.46, Table 3, Page 20, AMA 5	8%	One-tenth	7%
3.						
4.						
5.						
6.						
Total % WPI (the Combined Table values of all sub-totals)						**13%**

Deborah Moore
Arbitrator

Dr James Bodel
Approved Medical Specialist

Dr Brian Noll
Approved Medical Specialist

17 December 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*.

R Gray

Robert Gray
Dispute Services Officer
As delegate of the Registrar