WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-2539/19**
Appellant:	**Ben Matthews**
Respondent:	**Lis-Con Services Pty Limited (Administrator Appointed)**
Date of Decision:	**18 December 2019**
Citation:	**[2019] NSWWCCMA 193**

Appeal Panel:	
Arbitrator:	**Catherine McDonald**
Approved Medical Specialist:	**Dr Drew Dixon**
Approved Medical Specialist:	**Dr Philippa Harvey-Sutton**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 8 October 2019, Ben Matthews lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Robert Ivers, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 10 September 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, being that in s 327(d). 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. Mr Matthews was employed by Lis-Con Services Pty Limited (Lis-Con) when he suffered an injury to his right arm on 13 August 2015 whilst working as a concreter/steel fixer on the upgrade of the Tintenbar-Ewinsdale section of the Pacific Highway. His task was to drill holes into a concrete slab. He was injured while lying on the ground on his right side, with his right index finger on the trigger and the handle of the drill in his left hand. The drill bit struck steel

inside the concrete slab, stopped spinning and turned clockwise. His right wrist and arm rotated with the drill.

7. Mr Matthews suffered pain in his right wrist. He underwent treatment but the injury was not diagnosed as a tear in the triangular fibrocartilage complex of his right wrist until he saw Dr A Rando in February 2016. Dr Rando undertook a repair on 21 March 2016.

8. As a result of the injury, Mr Matthews developed carpal tunnel syndrome and ulnar nerve symptoms. Dr Rando undertook an arthroscopy, ulnar nerve release and carpal tunnel release on 17 January 2017. On 17 October 2017, Dr Rando re-explored Mr Matthews' right wrist and released the extensor digiti minimi tendon, which had become attached to the dorsal branch to the ulnar nerve, transferring it to the common extensor tendon of the little finger.

9. Over time, Mr Matthews developed pain and stiffness in his right shoulder and elbow.

10. Mr Matthews made a claim for permanent impairment compensation based on a report of Dr C Oates, occupational physician, dated 26 September 2018.

11. On 24 June 2019, a Commission arbitrator entered consent orders, remitting the matter to the Registrar for referral to an AMS to assess Mr Matthews' permanent impairment in respect of his right upper extremity (ulnar nerve, hand, wrist, elbow, shoulder.)

12. The AMS assessed 13% WPI, comprised of 8% UEI (upper extremity impairment) as a result of the right shoulder, 12% UEI in respect of the right wrist and 2% UEI in respect of the ulnar nerve. He made no assessment in respect of the right little finger and did not include a specific figure in respect of the right elbow. The combined assessment is 21% UEI which converts to 13% WPI.

PRELIMINARY REVIEW

13. 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.

14. 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 there is sufficient information in the file to determine the appeal.

EVIDENCE

15. 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.

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

SUBMISSIONS

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

18. In summary, Mr Matthews submitted, through his solicitor, Ms Watts, that the AMS applied incorrect criteria or made a demonstrable error in three areas of the assessment.
Mr Matthews submitted that the AMS had failed to assess a motor deficient in addition to a sensory deficit in his ulnar nerve . He submitted that the AMS had failed to make assessments in respect of his elbow, wrongly including an assessment of pronation and supination in his assessment of the wrist. He submitted that the AMS had failed to properly assess the impairment of his right hand, specifically his right little finger.

19. Mr Matthews submitted that that the Panel should either conduct an examination or adopt the figures in the report of Dr C Oates, qualified on his behalf.

20. In reply, Lis-Con submitted that the AMS had clearly and adequately explained his methodology in the assessment of the ulnar nerve, elbow, wrist and right hand. It rejected the submission that the assessment made by Dr Oates should be substituted.

FINDINGS AND REASONS

21. 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.

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. Mr Matthews did not make any complaint with the assessment made by the AMS with respect to

Ulnar nerve

24. When recording Mr Matthews' right wrist symptoms, the AMS said:

> "Mr Matthews states that the pain in the region of his right wrist, at rest, is at level 6, on a visual analogue scale, where 10 is the worst imaginable pain. At its worst, the pain may pass to level 9, on the same scale. The pain is worse with any twisting of his right wrist, particularly with supination with the elbow extended. He states that any repetitive vibration such as when using the lawnmower causes an exacerbation of the pain. He has difficulty driving using the car steering wheel and has difficulty walking the dog if there is any traction applied to his wrist. The pain is consistently over the ulnar aspect of the wrist in the region of the inferior radio ulnar joint and he describes a 'hot' sensation over the dorsal aspect of the wrist. The pain does not extend distally into the hand though there is some pain in the region of the elbow and common flexor mass. There was also pain and stiffness in the region of the right shoulder. There are pins and needles in the ulnar nerve distribution of the right hand and numbness over the dorsal aspect of the wrist."

25. The AMS said:

> "Tendon function of the right upper limb is normal, although there is inability to actively extend the small finger subsequent to the tendon transfer. Passive movement of the small joints of the ring and small fingers is normal. Strength of the upper limb muscles is normal with normal deep tendon reflexes. Sensory testing, using two-point discrimination does suggest mild dysaesthesia in the ulnar nerve distribution, though repeated testing appears to provide variable response. There is no intrinsic wasting evident today."

26. The AMS assessed Mr Matthews' ulnar nerve impairment:

> "Consulting table 16-10, I find that the ulnar nerve lesion is best described as grade 4 with a maximum 25% sensory deficit. Considering table 16-15, I find that the ulnar nerve to the hand has a total of 7% UEI impairment [sic]. The assessed impairment is (25% of 7%), which is 2% UEI."

27. Table16-15 of AMA 5 sets out the maximum UEI "Due to Unilateral Sensory or Motor Deficits or to *Combined* 100% Deficits of Major Peripheral Nerves." The table directs the assessor to grade Sensory Deficit or Pain by reference to Table 16-10a and Motor Deficit by reference to Table 16-11a.

28. Dr Oates assessed Mr Matthews on 26 September 2018. With respect to the ulnar nerve injury he found:

> "Decreased pin-prick sensation ulnar nerve territory of right hand into ring and little finger. Decreased strength of resisted adduction and abduction, particularly of the little and ring fingers."

29. Dr Oates said:

> "With respect to the ulnar nerve, there is a peripheral nerve lesion estimated at Grade 4 motor and sensory deficit or 25% of the maximum. 25% of 40% upper extremity impairment is 10% upper extremity impairment."

30. The AMS used the appropriate tables to grade the sensory deficit suffered by Mr Matthews.

31. The AMS did not observe any motor deficit as a result of the ulnar nerve injury because he found that strength in Mr Matthews right upper limb was normal.

32. The AMS was required to assess Mr Matthews as he presented on the day of the examination[1]. His findings were different to those made by Dr Oates who assessed Mr Matthews one year before the examination by the AMS. The AMS clearly set out his observations and drew the appropriate conclusions from them.

33. There is no error in the assessment made by the AMS with respect to the ulnar nerve.

Elbow

34. The AMS described the history obtained with respect to Mr Matthews' right elbow:

> "He states that the pain in the region of the right elbow, at rest, is at level 4 or 5, on the same scale and at its worst, may pass to level 8 or 9, also on the same scale. The pain is over the ulnar aspect and passes into the ulnar aspect of the forearm."

35. He accepted that Mr Matthews had suffered a consequential condition in his right elbow, stating:

> "I am not aware of a further or subsequent injury. I note that Mr Matthews is complaining of pain and stiffness in the region of his right shoulder and elbow, though I conclude that these areas were not injured at the time of the work injury. In general terms, the orthopaedic literature does not support the concept of an 'overcompensation' injury to a joint distant to an injured joint, though in this situation, I would conclude that prolonged immobilisation could have caused the pain and stiffness in the joints as described and consequently I conclude that it is likely that there is a relationship between the injury to the wrist and the symptoms referable to the shoulder and elbow."

36. The AMS recorded his examination findings:

> "Examination of the right elbow reveals a 10° loss of extension with 90° of flexion. This compares to movement between 0° and 140° of the left side.
>
> Measured movement of the right wrist is as follows:

[1] Guidelines paragraph 1.6 a.

	Right wrist	Left wrist
Dorsiflexion	50°	70°
Palmar flexion	50°	60°
Radial deviation	10°	20°
Ulnar deviation	10°	30°
Pronation	60°	80°
Supination	60°	70°”

37. The AMS said:

> “Consulting figure 16-31, 16-28 and 16-37, I have applied these values to the measured range of motion with the following result: (I note that pronation and supination is generally a function of the elbow, though this movement also occurs at the wrist, and I conclude that it is appropriate to assess function in this plane along with conventional wrist movement.)”

38. The Panel agrees that pronation and supination are commonly measured at the wrist even though they pertain to the elbow. Dr P Robinson, qualified for Lis-Con made his assessment in the same way.

39. However the AMS also observed a loss of extension and flexion with respect to the elbow and both of those losses are rateable. The AMS omitted to include an assessment with respect to the elbow and by doing so made an error.

40. The appropriate assessment, based on the observations made by the AMS is as follows.

41. Under Figure 16-37 60° pronation is assessed as 1% UEI and 60° supination is also assessed as1% UEI.

42. Loss of extension and flexion at the elbow joint is assessed under Figure 16-34. Loss of extension of 10° results in 1% UEI and loss of flexion to 90° results in 8% UEI.

43. Adding those assessments results in 11% UEI as a result of the consequential condition in Mr Matthews’ elbow.

Right wrist

44. The removal of the losses with respect to pronation and supination from the measurements of Mr Matthews’ right wrist function requires a recalculation of the assessment made by the AMS. The deduction of 1% in respect of pronation and supination results in an assessment of 10% UEI in respect of Mr Matthews’ right wrist.

Right hand

45. The finding made by the AMS with respect to movement of Mr Matthews’ fingers is set out at 24 above. He found that passive movement of the small joints of the ring and small fingers was normal, that strength was normal and there was no wasting. When making his assessment, the AMS said:

> “I note the weakness of extension of the small finger subsequent to the tendon transfer and also note that the joints are normal to passive movement. I find that the small finger weakness is not assessable under AMA 5.”

46. The AMS performed the task required of him and appropriately applied AMA 5. As noted above, the AMS did not observe any motor deficit in Mr Matthews upper limb. The extension lag observed at the little finger is due to the tendon transfer. There is, however, a full range or passive motion of the little finger – that is, there is no joint limitation of the MCP, PIP or IP joints of the finger. The AMS did not err in saying that the extensor lag was not assessable because there is no joint stiffness in Mr Matthews' little finger.

47. Mr Matthews urged the Panel to adopt the assessment made by Dr Oates:

> "There is loss of range of movement in the right ring and little fingers. At the MCP joint 10° loss of extension gives 7% impairment of the finger, and 70° flexion gives 11% impairment of the finger. At the little finger, 20° lack of extension gives 10% impairment of the finger and 90° flexion is 0% impairment. At the PIP joint 30° loss of extension gives 11% impairment of the ring finger and 90° flexion gives 6% impairment of the finger.
>
> For the little finger 30° loss of extension gives 11% impairment of the finger and 50° flexion gives 30% impairment of the finger. At the DIP joint, 10° loss of extension gives 2% impairment of the finger and 50° gives 10% impairment of the ring finger. In the little finger 10° loss of extension gives 2% impairment of the finger and 50° flexion gives 10% loss of the finger.
>
> Combining 11% by 7% gives 16% impairment of the ring finger at the MCP joint; combining 11% by 6% gives 16% impairment at the PIP joint of the ring finger; and combining 10% by 2% gives 12% impairment of the ring finger at the DIP joint. Combining 16% by 16% by 12% gives 38% impairment of the ring finger, which is 4% impairment of the hand.
>
> For the little finger MCP joint, 10% combined with 1% gives 11% impairment of the finger. At the PIP joint, 11% combined with 30% gives 38% impairment of the finger. At the DIP joint, 2% combined with 13% gives 15% impairment of the finger. Combining these gives 53% impairment of the little finger or 5% impairment of the hand.
>
> Adding 5% and 4% gives 9% impairment of the hand, which is 8% upper extremity impairment."

48. The submission that the Panel should adopt Dr Oates' assessment if error is made out is inappropriate. The AMS was required by s 322 of the 1998 Act to undertake an assessment in accordance with the Guidelines. The principles of assessment are set out in paragraph 1.6 and include that the AMS is required to make a "clinical assessment of the claimant as they present on the day of assessment." Paragraph 1.6(b) provides:

> "Assessors are required to exercise their clinical judgement in determining a diagnosis when assessing permanent impairment and making deductions for pre-existing injuries/conditions."

49. If the Appeal Panel finds error in the assessment made by the AMS, it is required to apply the legislation and the Guidelines to review the assessment and, in appropriate situations, to apply its own clinical judgement. If there had been an error which was not able to be corrected by reference to the findings made by the AMS, re-examination would have been necessary. It would be inappropriate for the Panel to adopt observations made by another practitioner.

Calculation

50. The assessments of upper extremity impairment are:

Shoulder	8%
Elbow	11%
Wrist	10%
Ulnar nerve	2%

51. Those assessments combine to result in 27% UEI which converts to 16% WPI under Table 16-3.

52. For these reasons, the Appeal Panel has determined that the MAC issued on 10 September 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*.

T Ng

Tina Ng
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **M1-2539/19**
Applicant: **Ben Matthews**
Respondent: **Lis-Con Services Pty Ltd (Administrator Appointed)**

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 Robert Ivers 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)**
Right upper extremity	13 August 2015		Chapter 16	16%	0%	16%
Total % WPI (the Combined Table values of all sub-totals)					**16%**	

Catherine McDonald
Arbitrator

Dr Drew Dixon
Approved Medical Specialist

Dr Philippa Harvey-Sutton
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*.

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As delegate of the Registrar