WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-578/20**
Appellant:	**Najah Al-Kanani**
Respondent:	**GMS Spares Pty Ltd**
Date of Decision:	**16 June 2020**
Citation:	**[2020] NSWWCCMA 104**

Appeal Panel:	
Arbitrator:	**Carolyn Rimmer**
Approved Medical Specialist:	**Dr Mark Burns**
Approved Medical Specialist:	**Dr Roger Pillemer**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 17 April 2020, Najah Al-Kanani (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr John Beer, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 20 March 2020.

2. The appellant relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act):

    - the assessment was made on the basis of incorrect criteria,
    - 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).

RELEVANT FACTUAL BACKGROUND

6. In these proceedings, the appellant is claiming lump sum compensation in respect of an injury to the cervical spine, left upper extremity and scarring that occurred in the course of his employment as a motor mechanic on 30 March 2017.

7. The matter was referred to the AMS, Dr Beer, in the Referral for Assessment of Permanent Impairment to Approved Medical Specialist dated 2 March 2020 for assessment of whole person impairment (WPI) of the cervical spine, left upper extremity and scarring (TEMSKI) as a result of the injury on 30 March 2017.

8. The AMS examined the appellant on 17 March 2020. He assessed 5% WPI of the cervical spine, 7% WPI of the left upper extremity and 1% WPI for scarring (TEMSKI). Therefore, this resulted in a total assessment of 13% WPI in respect of the injury on 30 March 2017.

PRELIMINARY REVIEW

9. 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.

10. The appellant did not request that he be re-examined by an AMS, who is a member of the Appeal Panel.

11. 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 was sufficient evidence by way of medical reports and clinical investigations in relation to assessment of the lumbar spine and urinary and reproductive system on which to make a determination.

EVIDENCE

Documentary evidence

12. 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.

Medical Assessment Certificate

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

SUBMISSIONS

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

15. The appellant's submissions include the following:

    (a) The AMS assessed 7% WPI of the left upper extremity and the appellant accepts this assessment.

    (b) In respect of the cervical spine, the AMS diagnosed the appellant as having suffered an aggravation of his cervical spine with some reported degenerative changes and a degree of C5/6 disc lesion irritating the C6 nerve root on the left.

    (c) The AMS stated that he found no evidence of radiculopathy and assessed the appellant as having suffered DRE Category II impairment with a base rate of 5% WPI.

    (d) In order to conclude whether radiculopathy is present or not, two or more of the following criteria should be found, being:

        (i) Loss or asymmetry of reflexes;
        (ii) Muscle weakness that is anatomically localised to an appropriate spinal nerve root distribution;

(iii) Reproduceable impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution;
(iv) Positive nerve root tension;
(v) Muscle wasting - atrophy; or
(vi) Findings on an imaging study consistent with the clinical signs.

(e) In the MAC on page 4, the AMS stated that “reflexes – are difficult to elicit. He is tense above the elbows. The biceps jerk on repeated testing could not be elicited in both elbows. Triceps jerk are +1 in both elbows. The supinator jerk is +1 ion the rights and not tested on the left because of pain in that area.”

(f) There is a reference to asymmetry at page 11 of the MAC in relation to range of movement of the cervical spine.

(g) At page 5 of the MAC, the AMS noted “no wasting of the shoulder joint matters” but no reference as to weakness in muscles potentially stemming from the neck injury.

(h) AMA 5 at Box 15.1 provides that atrophy is measured with a tape measure but it would not appear from the MAC that any measuring of limbs took place.

(i) The AMS did not fully and properly traverse the abovementioned six criteria during his examination in order to come to the conclusion that there was no evidence of radiculopathy. In not doing so, the AMS fell into error by applying incorrect criteria in coming to said diagnosis and assessing the Applicant as DRE Category II and not DRE Category Ill.

(j) Alternatively, if the AMS did in fact apply all the relevant criteria in diagnosing no radiculopathy, he was under an obligation to provide his reasoning as to how he came to that conclusion.

(k) In respect of ADLs the AMS at page 11 of the MAC said that he did not "feel there is any evidence of ADLs" and was of the opinion that "the disability with the ADLs is due to his forearm laceration injury."

(l) Dr Uthum Dias, Occupational Physician, noting in his report dated 20 September 2018 that the appellant, "struggles to walk and stand for more than 10 minutes at a time due to worsening pain in his cervical region." Dr Dias continued by noting that the appellant "Finds that sitting becomes uncomfortable after 15 minutes due to neck pain" and "driving also becomes increasingly difficult to tolerate after 15 minutes due to neck pain." Dr Dias noted that the appellant had "been unable to run or jog on a pain free basis over the course of the past 18 months as a result of his cervical spine injury". Dr Dias also noted that the appellant has had to "pay a gardener to perform gardening duties on a monthly basis, as a result of his injuries”.

(m) The AMS noted that the appellant "cannot do the garden and lawn now chiefly because of his hand." While the appellant concedes that his activities of daily living have been impacted on by his left forearm injury as well, there was evidence before the AMS that his inability to perform gardening and lawn mowing post-accident was due to the plurality of his injuries, a fact not even dismissed by the AMS, who refer to this inability being "chiefly" because of his hand but not solely (MAC at page 3). This error qualifies as an application of incorrect criteria pursuant to s327(3)(c) as well as a demonstrable error on the face of the records, per s327(3)(d).

(n) The AMS should have at least awarded an additional 1% WPI for this portion of the appellant's ADLs.

(o) Reference was made by Dr Dias to the appellant not being able to contribute to cleaning duties at home or assist with child care activities as a result of his injuries. Although the left forearm injury impacted on his activities of daily living, the AMS fell into error in not acknowledging that the impact was as a result of the plurality of his injuries. The AMS should have assessed an additional 2% WPI for the impact his neck impairment has had on his home care.

(p) Alternatively, and on the basis that the AMS has properly considered these issues, he has fallen into error as he has failed to provide his reasoning as required.

(q) In respect of TEMSKI, the AMS assessed 1% WPI. The evidence before the AMS was that the scarring on his left arm is clearly visible to the naked eye, that there was a noticeable pigmentary contrast with the surrounding skin, has a mild to moderate contour defect, was tender to the touch and was associated with trophic changes. The scarring is visible if the appellant was to wear short sleeved shirts, and the fact that body hair tends to hide the scar to a certain degree, as noted by the AMS at page 4 of the MAC is irrelevant. Both of the medicolegal specialists commissioned on the appellant's behalf as well as the independent medical examiner for the insurer assessed 2% WPI. If the AMS was to diverge from other medical evidence before him, as he did in this instance, he was required to provide proper reasons for his assessment.

(r) The MAC should be revoked and the appellant's impairments of the cervical spine and scarring should be assessed once more by Dr Beer.

16. The respondent's submissions include the following:

(a) In respect of the cervical spine, the AMS properly placed the appellant in DRE Category II. The AMS examination was not in error to find a lack of 'objective evidence of radiculopathy', as that is judgement on examination of the AMS and a review of the evidence.

(b) The appellant's submissions did not address the criteria for placing the appellant in DRE Category III. The AMS would have needed to find either 'Significant signs of radiculopathy' or that the 'individual had clinically significant radiculopathy, verified by an imaging study' (per AMA 5 Guides p392). The AMS explained his clinical findings at Parts 4 and 7 of the MAC and did not find significant radiculopathy on assessment of the appellant.

(c) The AMS completed a thorough examination of the appellant. The AMS tested the appellant's range of motion in the cervical spine (page 3 and 4 of the MAC), reflexes (page 4 of the MAC), sensation in the upper limbs (page 5 of the MAC), and muscle wasting (page 4 of the MAC) and referred to imaging scans (page 5 and 6 of the MAC).

(d) Using his clinical judgement and after taking a history of symptoms and conducting an examination the AMS was satisfied there was no radiculopathy present on examination. There is no requirement that the AMS specifically address each of the criteria for radiculopathy in the Guidelines or for the AMS to eliminate symptoms that were not reported to him. The only symptom the appellant reported in relation to the cervical spine was pain.

(e) The appellant submitted that no measuring of the limbs took place. This submission is incorrect. At Part 5 of the MAC, under sub-heading 'Cervical Spine' the AMS recorded: "Circumferential measurements – at 10cm proximal to the olecranon upper arms are 32cm right and 32.5cm left. At 7cm distal to the olecranon forearms are 30cm right and 29.5cm left."

(f) The AMS recorded his findings on examination and disclosed his reasoning process. His assessment of impairment was correct and he applied the correct criteria, consistent with his findings.

(g) In respect of the assessment of ADLs, the appellant repeatedly referred to the report of Dr Dias which reported difficulty, sitting, standing or driving due to cervical spine pain and that the appellant was unable to jog or run. The appellant also reported that he paid a gardener due to his 'injuries'. It was conceded that the appellant's activities of daily living have been affected by his left upper extremity injury. The AMS has explained the basis for finding that activities of daily living are impacted by the left upper extremity injury, and not the cervical spine pain.

(h) The AMS concluded the appellant was unable to garden or mow the lawns 'chiefly because of his hand'. The appellant told the AMS that he had no hobbies prior to the injury. Thus, the AMS made no assessment for the impact of the cervical spine injury on the appellant's activities of daily living.

(i) Based on the history taken by the AMS it was appropriate that no assessment was made for the activities of daily living.

(j) The MAC did not contain any demonstrable error and the AMS has correctly applied the criteria when assessing the appellant's cervical spine DRE Category and finding the ADL interference attributable to the left arm injury.

(k) In respect of scarring, the AMS reported the appellant as conscious of the scar which was on the lower third of the left forearm. The scar was visible but could be covered with a shirt sleeve. There were minimal trophic changes and it had negligible effects on the activities of daily living.

(l) An assessment of 1% WPI under Table 14.1 of the Guidelines was correct as seven out of the eight criteria in that Table were consistent with the assessment of the AMS. Reference to the criteria in Table 14.1 for an assessment of 2% revealed that only two of the eight criteria in that Table were consistent with the assessment of the AMS.

(m) The AMS was not bound by the assessments of other doctors and should use their medical expertise to make an assessment, based on the history provided to them, their examination findings and the supporting material. The AMS's assessment of scarring was open to the AMS and was not an assessment made on the basis of incorrect criteria or a demonstrable error.

(n) The AMS did not apply incorrect criteria when assessing the degree of permanent impairment and no ground of appeal is made out pursuant to s327(3)(c) of the 1998 Act.

(o) The MAC does not contain a demonstrable error and no ground of appeal is made out pursuant to s327(3)(d) of the 1998 Act.

(p) The MAC should be confirmed.

FINDINGS AND REASONS

17. 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.

18. 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.

19. The role of the Medical Appeal Panel was considered by the Court of Appeal in the case of *Siddik v WorkCover Authority of NSW* [2008] NSWCA 116 (*Siddik*). The Court held that while prima facie the Appeal Panel is confined to the grounds the Registrar has let through the gateway, it can consider other grounds capable of coming within one or other of the section 327(3) heads, if it gives the parties an opportunity to be heard. An appeal by way of review may, depending upon the circumstances, involve either a hearing de novo or a rehearing. Such a flexible model assists the objectives of the legislation.

20. Section 327(2) was amended with the effect that while the appeal was to be by way of review, all appeals as at 1 February 2011 were limited to the ground(s) upon which the appeal was made. In *New South Wales Police Force v Registrar of the Workers Compensation Commission of New South Wales* [2013] SC 1792 Davies J considered that the form of the words used in s 328(2) of the 1998 Act being, 'the grounds of appeal on which the appeal is made' was intended to mean that the appeal is confined to those particular demonstrable errors identified by a party in its submissions.

21. In this matter, the Registrar has determined that he is satisfied that a ground of appeal under s 327(3 (d) is made out in relation to the AMS's assessment of the appellant's cervical spine.

22. The Appeal Panel reviewed the history recorded by the AMS, his findings on examination, and the reasons for his conclusions as well as the evidence referred to above. The Panel accepted the findings on examination that the AMS made in the MAC.

Assessment of the cervical spine.

23. The AMS on page 6 of the MAC under "summary of injuries and diagnoses" wrote:

> "I find this worker sustained an aggravation of his cervical spine, some reported degenerative changes, and a degree of C5/6-disc lesion irritating the C6 nerve root on the left. This has subsided with respect to no pain in the neck now, with a degree of restriction of movement and some residual radiculopathy symptoms in the neck and shoulder. However, there is no evidence of radiculopathy."

24. In Table 2 attached to the MAC, the AMS wrote:

> "Cervical spine:
> There is no evidence of radiculopathy today. There is some pain with limitation of movement recording a degree of asymmetry present, resulting in DRE II according to page 392-chapter 15.6 table 15-5 DRE II = 5%. Also, there are signs of nonverifiable C6 radiculopathy persisting. I do not feel there is any evidence of ADLs. The disability with the ADLs is due to his forearm laceration injury."

25. The appellant submitted that the AMS did not fully and properly traverse the six criteria in Clause 4.27 of the Guidelines during his examination of the Appellant in order to come to the conclusion that there was no evidence of radiculopathy.

26. The appellant submitted, in the alternative, that if the AMS did in fact apply all the relevant criteria in diagnosing no radiculopathy, he was under an obligation to provide reasoning as to how he came to said conclusion.

27. Clause 4.27 of the Guidelines provides:

> "Radiculopathy is the impairment caused by malfunction of a spinal nerve root or nerve roots. In general, in order to conclude that radiculopathy is present, two or more of the following criteria should be found, one of which must be major (major criteria in bold):
>
> - **loss or asymmetry of reflexes**
> - **muscle weakness that is anatomically localised to an appropriate spinal nerve root distribution**
> - **reproducible impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution**
> - positive nerve root tension (AMA5 Box 15-1, p 382)
> - muscle wasting – atrophy (AMA5 Box 15-1, p 382)
> - findings on an imaging study consistent with the clinical signs (AMA5 p 382)".

28. Further, at Clause 4.28 the Guidelines provide that radicular complaints of pain or sensory features that follow anatomical pathways but cannot be verified by neurological findings (somatic pain, non-verifiable radicular pain) do not alone constitute radiculopathy.

29. The findings made by the AMS on clinical examination differed from the findings made by Dr Dias in his report dated 20 September 2018. Dr Dias stated that following the subject injury, the appellant suffered from chronic non-specific cervical pain with associated chronic C6 radiculopathy secondary to C5/6 disc protrusion. In his assessment, Dr Dias stated that the worker qualified for DRE cervical category III stating he had an objective clinical sensory radicular signs of the left C6 dermatome based on his examination on 20 September 2018.

30. Dr Bentivoglio, in his report dated 29 May 2019, noted that the repeat MRI scan in 2019 showed that the small disc protrusion at the C5/6 level had resolved and there was no significant compression of any of the nerve roots in his neck or spinal cord. He wrote:

> "Referring to the 5th Edition of the American Medical Association Guides for Whole Person Impairment for his cervical spine, Table 15-5, Chapter 15, he is a DRE Category 2. This gentleman has neck pain with radicular symptoms but I was not able to determine any evidence of a radiculopathy. The fact that he had a disc bulge in September 2017 and I examined him today in 2019 there was no evidence of any radiculopathy so I can only give him a Class 2, DRE Category 2, which is a 5% Whole Person Impairment."

31. Professor James Van Gelder, treating neurosurgeon, in a report dated 22 February 2019 noted that the recent MRI scan of the cervical spine was essentially normal. He wrote:

> "There is minor C5-6 disc bulging on the right side. The previous prominent disc herniation on the left side has resolved. There is striking improvement compared with the MRI scan in 2017."

32. Professor Van Gelder considered that the appellant should be managed according to nonspecific neck pain.

33. The Appeal Panel accepts that there is no requirement that the AMS specifically address each of the criteria for radiculopathy in the Guidelines or for the AMS to eliminate symptoms that were not reported to him.

34. Based on the history obtained by the AMS, the Appeal Panel were satisfied that the appellant's neck pain has subsided and the previous prominent disc herniation on the left side has resolved. Dr Dias assessed the appellant in September 2018 and there has been improvement in the appellant's cervical spine since that examination. Both Professor Van Gelder and Dr Bentivoglio did not find any evidence of radiculopathy in their examinations in 2019.

35. The Panel accepted the examination findings of the AMS and were satisfied that the AMS had considered all of the criteria listed in Clause 4.27 when he decided whether radiculopathy was present or not. The Appeal Panel noted that the appellant submitted that the AMS had failed to take measurements of the limbs as required but it was clear that the AMS did take measurements and recorded at Part 5 of the MAC:

> "Circumferential measurements – at 10cm proximal to the olecranon upper arms are 32cm right and 32.5cm left. At 7cm distal to the olecranon forearms are 30cm right and 29.5cm left."

36. The Appeal Panel was satisfied that the AMS completed a thorough examination of the appellant. The AMS tested the appellant's range of motion in the cervical spine, reflexes, sensation in the upper limbs and muscle wasting and referred to imaging scans. The AMS recorded his findings on examination, disclosed his reasoning process and his assessment of impairment was correct. The AMS applied the correct criteria, consistent with his findings. The Appeal Panel was satisfied that the AMS provided adequate reasons as to how he came to his conclusions.

37. The appellant submitted that the AMS should have at least awarded an additional 1 % WPI for the appellant's ADLs.

38. Under "Present symptoms" on page 3 of the MAC, the AMS noted:

> "He has numbness on the dorsal aspect of the thumb, index and middle fingers up to the laceration.
> Pain on the dorsal aspect of the index finger.
> Sometimes he gets a "shock" in the left elbow, pointing to the olecranon area.
> He has pain from the neck going down to the left elbow region.
> He has difficulty making a full fist with his left hand.
> He has pain pointing to the left lower cervical region, but it is not as severe as it was.
> He has symptoms going down to his shoulder and elbow."

39. Under "Social Activities/ADL" on page 3 of the MAC, the AMS wrote:

> "Home duties: He lives in a house with a garden and lawn. He cannot do the garden and lawn now chiefly because of his hand. He has someone to look after the garden and do the mowing of the lawn now. He helps his wife going shopping. He is not able and does not do anything around the house. He has had pain in his left hand below the scar with no improvement over the last 2 years or since the accident.
> Recreational activities: Nil he always has been working he relates."

40. In Table 2 of the MAC, the AMS said that he did not "feel there is any evidence of ADLs" and was of the opinion that "the disability with the ADLs is due to his forearm laceration injury."

41. The appellant submitted that there was evidence before the AMS that the appellant's inability to perform gardening and lawn mowing post-accident was due to the plurality of his injuries, and, in fact, the AMS referred to this inability being "chiefly" because of his hand but not solely. Although the left forearm injury impacted on his activities of daily living, the AMS fell into error in not acknowledging that the impact was as a result of the plurality of his injuries. The appellant argued that the AMS should have assessed an additional 2% WPI for the impact his neck impairment has had on his home care.

42. Dr Dias, in his report dated 20 September 2018, noted that the appellant, "struggles to walk and stand for more than 10 minutes at a time due to worsening pain in his cervical region." Dr Dias continued by noting that the appellant found that sitting becomes uncomfortable after 15 minutes due to neck pain, driving also becomes increasingly difficult to tolerate after 15 minutes due to neck pain and the appellant had been unable to run or jog on a pain free basis over the course of the past 18 months as a result of his cervical spine injury. Dr Dias also noted that the appellant has had to "pay a gardener to perform gardening duties on a monthly basis, as a result of his injuries".

43. The appellant submitted that Dr Dias added a 3% WPI rating for activities of daily living as he required his wife's help with dressing tasks as a result of his cervical spinal injury. The Appeal Panel noted that Dr Dias reported that the appellant "states that he requires help with some dressing tasks from his wife particularly with doing up buttons, due to pain and sensory dysaesthesla affecting his left hand. He is generally independent in all other tasks of self-care activities such as eating, showering, toileting and mobility." However, in the assessment of WPI at the end of the report, Dr Dias wrote: "Mr Al-Kananl requires help from his wife with dressing tasks, as a result of his cervical spine Injury, and radicular symptoms in his left upper limb, and therefore, he qualifies for the full 3% WPI addition".

44. Dr Bentivoglio in his report dated 29 May 2019 did not add any quantum for ADLs because of his neck pain, stating that any impairment of the ADL was due to the dysaesthesia of the left hand.

45. The Appeal Panel accepted that the appellant's activities of daily living have been affected by his left upper extremity injury. The AMS concluded that the activities in daily living were impacted by the left upper extremity injury. The Appeal Panel was satisfied after considering the evidence that the activities in daily living were impacted by the left upper extremity impairment and not, to any assessible degree, by the cervical spine injury.

46. The Appeal Panel accept the history obtained by the AMS and considered, on balance, that it was appropriate that no assessment be made for the activities of daily living. This assessment was a matter of clinical judgment, after consideration of the evidence, including the reports of Dr Dias and Dr Bentivoglio and examination of the appellant.

47. The MAC did not contain any demonstrable error and the AMS has correctly applied the criteria when assessing the appellant's cervical spine as DRE Category II and finding that the ADL interference was attributable to the left arm injury.

Scarring

48. The appellant submitted that the AMS should have assessed 2% for scarring (TEMSKI) as the evidence before the AMS was that the scarring on his left arm was clearly visible to the naked eye, there was a noticeable pigmentary contrast with the surrounding skin, a mild to moderate contour defect, the scar was tender to the touch and associated with trophic changes. The appellant argued that the scarring was visible if he was to wear short sleeved shirts, and the fact that body hair tended to hide the scar to a certain degree, as noted by the AMS, was irrelevant.

49. The appellant submitted that both Dr Dias and Dr O'Sullivan assessed 2% WPI for scarring and if the AMS was to diverge from other medical evidence before him, as he did in this instance, he was required to provide proper reasons for his assessment.

50. At Part 5 of the MAC on page 4, the AMS wrote:

> "Scarring:
> There is an 8cm scar on the radial aspect of the lower third of the left forearm.
> It is a slightly angled scar.
> He is conscious of the scar.
> Anatomic location of scar with clothing when not covered by shirtsleeve is usually and clearly visible
> Contour defect is minor
> Some parts of the scar contrast with the surrounding skin.
> There is a degree of pigmentary change/alteration to the skin but not marked.
> It is overgrown by hair which tends to hide the scar to a certain degree.
> The claimant can locate the scar.
> There are minimal trophic changes.
> Staple or suture marks = barely visible
> Negligible effects on activities of daily living.
> No treatment is required.
> Adherence – None"

51. Table 14.1 of the Guidelines sets out the criteria in TEMSKI (1% WPI) as follows:

    (a) Claimant is conscious of the scar(s) or skin condition.
    (b) Some parts of the scar(s) or skin condition colour contrast with the surrounding skin as a result of pigmentary or other changes.
    (c) Claimant is able to locate the scar(s) or skin condition.
    (d) Minimal trophic changes.
    (e) Any staple or suture marks are visible.
    (f) Anatomic location of the scar(s) or skin condition not usually visible with usual clothing/hairstyle.
    (g) Minor contour defect.
    (h) Negligible effect of any ADL.

52. Table 14.1 of the Guidelines sets out the criteria in TEMSKI (2% WPI) as follows:

    (a) Claimant is conscious of the scar(s) or skin condition.
    (b) Noticeable colour contrast of scar(s) or skin condition with surrounding skin as a result of pigmentary or other changes.
    (c) Claimant is able to easily locate the scar(s) or condition.
    (d) Trophic changes evident to touch.
    (e) Any staple or suture marks are clearly visible.
    (f) Anatomic location of the scar(s) or skin condition is usually visible with usual clothing/hairstyle.
    (g) Minor contour defect.
    (h) Minor limitation in the performance of a few ADL.

53. Dr Bentivoglio, in his report dated 29 May 2019, assessed 2% WPI for scarring but provided no examination findings in relation to the scar.

54. Dr Dias, in his report dated 20 September 2018, wrote:

> "Inspection of Mr AI-Kanani's left forearm revealed an L-shaped scar over the distal one third in the dorsoradial aspect of his left forearm. The proximal limb of the scar measured 5cm in length, and the distal limb of the scar measured 2.5cm in length. The proximal limb of the scar was well healed and had a mild to-moderate contour defect. The scar was tender to touch, with associated trophic changes. There was skin widening associated with the scar and the proximal limb of the scar was clearly visible to the naked eye. The distal limb of the scar did not have a contour defect and was much less visible to the naked eye. There was no tethering of either limb of the scar to underlying structures.
> …
> In relation to the residual scarring over the dorsoradial aspect of Mr Al-Kanani's distal forearm, in my opinion, using the line of best fit on the TEMSKI Table, on page 74 of the New South Wales Workers' Compensation Guidelines, Mr AI-Kanani qualifies for a 2% whole person impairment rating. Mr Al-Kanani's scarring over the dorsoradial aspect of his left forearm is clearly visible to the naked eye, has a noticeable pigmentary contrast with the surrounding skin, has a mild to moderate contour defect, is tender to touch, and is associated with trophic changes. The scarring would be visible if Mr Al-Kanani were to wear short sleeve shirts. In my opinion, using the Line of Best Flt on the TEMSKI Table, Mr AI-Kanani qualifies for a Skin Whole Person Impairment Rating of 2%."

55. The appellant underwent surgery on his left arm on 30 March 2017. Dr Dias examined the appellant on 20 September 2018, only 18 months after the operation. The AMS examined the appellant on 17 March 2020. The Appeal Panel considered that there may have been some improvement in the scar in the period since the examination by Dr Dias.

56. The TEMSKI is to be used in accordance with the principle of "best fit". The skin disorder should meet most but does not need to meet all of the criteria within the impairment criteria in order to satisfy the principle of "best fit". The assessor must provide detailed reasons as to why that category had been chosen over other categories.

57. The AMS in Table 2 of the MAC wrote:

> "TEMSKI Scarring:
> According to the worker today it is mainly the pain in the area of the scar that is noticeable to him. Considering what is mentioned in my examination I feel 1% is rated."

58. The Appeal Panel noted that the AMS set out detailed findings in relation to the scar and the five categories of impairment that needed to be considered in the assessment.

59. The Appeal Panel was satisfied that the appellant would have been conscious of the scar, some parts of the scar contrast with the surrounding skin and there was a degree of pigmentary change, the appellant was able to locate the scar, there was a minor contour defect, there were minimal trophic changes, suture marks were barely visible, the location of the scar if not covered by shirt sleeves was usually and clearly visible, there is no evidence that any treatment is required, there appeared to be negligible effect on activities of daily living and there was no adherence.

60. Looking at the five categories of impairment and nine criteria in Table 14.1, it was clear that the eight of the criteria in TEMSKI (1% WPI) were present whereas only five of the criteria were present in TEMSKI (2% WPI).

61. The Appeal Panel, applying the principle of 'best fit', concluded that an assessment of scarring under TEMSKI (1% WPI) was appropriate in this case after considering the evidence. The Appeal Panel was satisfied that the criteria within the category TEMSKI (1% WPI) best reflected the scar being assessed. The scar appeared to meet eight of the nine criteria within the 1% impairment category, whereas in the category TEMSKI (2% WPI) only five criteria were met, namely, the appellant was conscious of the scar, there was a minor contour defect, the location of the scar if not covered by shirt sleeves was usually and clearly visible, there is no evidence that any treatment is required, there was no adherence.

62. While the AMS provided detailed findings in relation to the scar and the Appeal Panel considered that such findings provided sufficient and proper reasons for the assessment.

63. In conclusion, the Appeal Panel did not consider that there has been an incorrect application of relevant assessment criteria, that is, the relevant Guidelines or any demonstrable error in the AMS's assessment.

64. For these reasons, the Appeal Panel has determined that the MAC issued on 20 March 2020 should be confirmed.

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE REASONS FOR DECISION OF THE APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

A Shaw

Andrew Shaw
Dispute Services Officer
As delegate of the Registrar