WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-373/19**
Appellant:	**Phillip Arthur Habbits**
Respondent:	**Chillana Pty Ltd**
Date of Decision:	**25 July 2019**
Citation:	**[2019] NSWWCCMA 99**

Appeal Panel:	
Arbitrator:	**Ms Deborah Moore**
Approved Medical Specialist:	**Dr Mark Burns**
Approved Medical Specialist:	**Dr David Crocker**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 23 April 2019 Phillip Arthur Habbits lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Tim Anderson, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 28 March 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 no request was made, and we consider that we have sufficient evidence before us to enable us to determine the appeal.

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 extensive from both parties. They are not repeated in full, but have been carefully considered by the Appeal Panel.

10. The appellant makes two principal submissions as follows:

> "a. The AMS assessment of DRE category II impairment, yielding 6% whole person impairment (lumbar spine) was in error [and] because of the presence of radiculopathy, he should have assessed a DRE category lll;
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> b. The AMS assessment of the criteria of interference with the ADL, yielding a further 2% ADL was in error. There is interference with self-care, he should have assessed ADL as further 3% assessment."

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 appellant was referred to the AMS for assessment of whole person impairment (WPI) in respect of the lumbar spine resulting from injuries on 6 January 2010.

15. The AMS obtained the following history:

> "Mr Habbits related that on 06/01/10, his tasking had involved taking raw cow hides to a chiller. These then had to be hitched onto a hook and hoisted up on a rail. It was heavy work and he would manoeuvre about 300 hides a week.
>
> On this occasion, he went into the chiller and found that one of the hides had fallen on the ground and was frozen. He set about trying to hoist it up onto the rail again and as he tried to bend down and pick it up, he experienced severe pain in his lower back. This radiated down the left leg.

> He was unable to continue with his occupation. He saw his Doctor and was referred to Specialist Orthopaedic Surgeon, Dr Stephen Ruff…It was recommended that he should not have surgery and that his clinical management should remain conservative.
>
> He has struggled on with great difficulty and over the succeeding years, there has been further gradual deterioration of his condition."

16. Present symptoms included severe pain in his lower back with reduced sensation in both lower limbs. He also complained of a "constant very unpleasant burning sensation over the soles of both of his feet."

17. As regards the appellant's prior history, the AMS said:

> "There is a history of dysfunction to his lower back in 1991. He came under the care of Specialist Neuro-surgeon, Dr John Matheson. It has been described that he had an extensive laminectomy and fusion from L2 all the way down to S1. On review of this situation and particularly with review of the available radiological reports, there is no evidence of any fusion. here is, however, evidence of hemi-laminectomies at L3/4 and L5/S1 on the left and of L4/5 on the right.
>
> There is also a history of three separate strokes although not a great deal of detail about these. In discussing these with him, he advised that there had always been weakness down the left side following the strokes."

18. The AMS also noted that Mr Habbits' general health was "not good" adding:

> "He has a history of an abdominal aneurysm which necessitated extensive surgery in late 2014. It looks as though this included a major artery graft. Further abdominal surgery was conducted about a year later…
>
> Many years beforehand in 1999, there was open heart surgery.
>
> In 1997, a spinal cord stimulator was inserted. The battery pack and control unit were located at the upper left flank. This was removed a couple of years later since it did not seem to be helping."

19. As regards ADL's, the AMS said:

> "Mr Habbits is divorced…He has two daughters…He and his youngest daughter live together. He relies on her a lot to assist around the house. He does his best to help but can only manage this by instalments. His daughter cuts the grass…He can drive for about half an hour with any level of comfort. For this assessment, he and his daughter drove. He described that this was a 740km round trip and that following this, he expected to be fairly sore."

20. Findings on physical examination were reported as follows:

> "**Back.** There was extensive surgical scarring which had healed very well throughout the length of the lumbar spine. There was associated tenderness in the middle of the scar in the midline. There was also mild tenderness over the sacro-iliac joints. The spinal curvatures were normal. There was no scoliosis or muscle spasm. On forward flexion, he could reach his mid-thighs with a Macrae-Wright movement of 3cm. This is stiff. 5cm is the lower limit of normal. All other movements of the lower back were absolutely minimal.

> **Lower Limbs**. He walked with an uneven gait with a slight dragging of the left leg and a mid-pace left heel strike. (This could be a relic from his cerebro-vascular issues.) He was able to stand on his heels and toes and could take a few paces but could not squat. The left leg was a little longer than the right. The left thigh was 2cm less in circumference than the right. The right calf was 1cm less. It was quite difficult to examine the lower limbs since this caused irritation in his lower back although no significant features were demonstrated with the hips, knees or ankles. Sensation to pin prick was globally reduced in the left leg. Nevertheless, reflexes were present, equivalent, brisk and quite easy to demonstrate at the knees (L4) and at the ankles (S1). For completeness, it was attempted to assess the Babinski (plantar) reflex in the light of the previous neurological features. This was unresponsive. The straight leg raise assessment was conducted in the sitting position on the edge of the couch. He was able to fully extend each knee without difficulty. Power of the extensor hallucis longus (L5) was equivalent."

21. Although the AMS did not have any investigations, he noted a report of an MRI scan of the lumbo-sacral spine dated 19 May 2017 which showed "Degenerative changes throughout with disc space narrowing. L3/4 and L5/S1 left sided laminectomy. L4/5 right sided laminectomy."

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

> "Mr Habbits gives a history of bending down and lifting heavy item at work in early January 2010 and hurting his lower back. At this assessment, he continues to have very gross low back dysfunction. There does not appear to be any radiculopathy features that can reasonably be attributed to this event. The situation is clouded by three previous cerebro-vascular features and a suggestion that this was mostly left sided. (This was also evident with his facial expression and facial creases.) Although the left leg was globally reduced to sensation, his reflexes were completely normal.
>
> The situation is also clouded by a previous injury to his lower back in 1984 with a subsequent surgical procedure in 1991. The accuracy of recording of this has not been all that good and at this assessment, it was identified that there had not been a fusion procedure which had previously been reported."

23. The AMS assessed 7% WPI. He explained his calculations as follows:

> "There is evidence of continuing injury to the lumbar spine although I am not persuaded that it can be demonstrated that he has radiculopathy associated with this particular event. That therefore places him in DRE Lumbar Category II in Table 15-3 on Page 384 of AMA-5. This provides a whole person impairment ranging between 5% and 8%, depending on the activities of daily living. For this, he would attract a further 2%, giving him 7%."

24. In commenting on other medical opinions, the AMS said:

> "Specialist Orthopaedic Surgeon, Dr Jonathan Negus, in his report of 23/03/18 has demonstrated left sided radiculopathy which therefore places Mr Habbits into DRE Category III. I was unable to demonstrate radiculopathy.

> Specialist Orthopaedic Surgeons, Dr John Bosanquet in his report of 17/03/17 and Dr Tony Smith in his report of 14/09/18 both conclude that Mr Habbits' current condition is best classified as DRE II. I would agree with this. I note that Dr Smith has not attributed any additional impairment for activities of daily living nor has any issue of deduction for pre-existing conditions been mentioned. On the other hand, Dr John Bosanquet advises that there is a further 2% for activities of daily living and that there is also a one tenth deduction for the pre-existing condition. I would completely agree with both of these issues."

25. In our view, the appellant's submissions amount to no more than a mere disagreement with the assessment of the AMS based on the report of his own IME, Dr Negus, and that is not a proper basis for appeal.

26. Dealing firstly with the lumbar spine assessment, we note that Dr Negus has himself described symptoms and signs which properly fit into a DRE category II. His findings on examination were reported as follows:

> "He had no guarding or spasm and he was tender from L4-L5 in the midline. He had no calf muscle atrophy. He was able to straight leg raise to 35' each side before he developed back pain. His lumbar spine flexed to 20° and extended 10° with 9° of left lateral and 11° of right lateral bend.
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> He had full power on both sides from L2-S1 and he was able to heel/toe walk. He had normal sensation at L 1, reduced on the left hand side at L2, L4, L5 and S1 and normal at L3 and S2. He had positive knee and ankle jerks, equal on both sides with equivocal plantar reflexes."

27. These findings are consistent with a DRE category II, not DRE III. In short, there was no evidence of muscle weakness or wasting, no sciatica and no sensory changes which may have placed Mr Habbits in a higher category. There was some evidence of reduced sensation, but it was global, and there was no radiological evidence of any neurological compromise.

28. The AMS' assessment was also consistent with that of both Dr Smith and Dr Bosanquet.

29. In short, it seems to us that *all* IME's made similar findings on examination such that we cannot see any error in the AMS' assessment.

30. As regards the assessment of ADL's, we accept that the AMS did not refer to aspects of self-care, as noted by Dr Negus and in the appellant's own statement dated 17 January 2019.

31. Mr Habbits said that he had "difficulty in stepping into shower, require assistance with dressing and putting socks on." He also added that he used a ride-on mower. His daughters assisted him with various activities.

32. The Guidelines in Chapter 4.34 provide a *guide* only for assessment of WPI in respect of ADL's. Three percent is appropriate where "a worker's capacity to undertake personal care activities such as dressing, washing, toileting and shaving has been affected."

33. We accept Mr Habbits' description of the difficulties he experiences in some aspects of self-care, but there is no evidence that he requires assistance with toileting or shaving, the former activity in our view being of considerable significance.

34. One of the difficulties in a case such as this is the limitation on certain activities of daily living imposed by Mr Habbits' other significant health issues as documented by the AMS. His abdominal surgery and the impact of his strokes must also be considered as factors which may impact on ADL's. It must be remembered that any impairment assessment of ADL's must result from the *injury* the subject of the assessment.

35. Considering the appellant's ability to undertake a number of other activities such as driving and using a ride-on mower, we are of the view that it was open to the AMS to assess 2% WPI for ADL's.

36. For these reasons, the Appeal Panel has determined that the MAC issued on 28 March 2019 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*.

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Ann MacLeod
Dispute Services Officer
As delegate of the Registrar