WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-1758/19**
Appellant:	**Faustino Soriana Sapanlay**
Respondent:	**UGL Rail Services Pty Ltd**
Date of Decision:	**22 October 2019**
Citation:	**[2019] NSWWCCMA 148**

Appeal Panel:	
Arbitrator:	**Jane Peacock**
Approved Medical Specialist:	**Dr Roger Pillemer**
Approved Medical Specialist:	**Dr Margaret Gibson**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 23 July 2019 the State of New South Wales lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Robert Briet, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 26 June 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. The appellant sought that he be re-examined by an AMS member of the Panel. As a result of it's preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination because the Panel could discern no error by the AMS.

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.

Medical Assessment Certificate

9. 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

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

FINDINGS AND REASONS

11. 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.

12. 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.

13. The matter was referred by the Registrar to the AMS as follows:

> "The following matters have been referred for assessment (s 319 of the 1998 Act):
>
> - **Date of injury: 8 December 2006**
> - **Body parts/systems referred: Cervical spine, lumbar spine, upper extremities (shoulders), lower extremities**
> **Method of assessment: Whole Person Impairment"**

14. The AMS issued a MAC certifying as follows:

Body Part or system	**Date of Injury**	**Chapter, page and paragraph number in NSW workers compensation guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA5 Guides**	**% WPI**	**WPI deductions pursuant to S323 for pre-existing injury, condition or abnormality** (expressed as a fraction)	**Sub-total/s % WPI** (after any deductions in column 6)
1. Cervical spine	8/12/2006	Chap 4	Chap 15, para 15.6, table 15.5	7	1/10	6
2. Lumbar spine	8/12/2006	Chap 4	Chap 15, para 15.4, table 15.3	0	0	0

3. Right upper extremity	8/12/2006	Chap 1, para 1.36	n/a	5	0	5
4. Left upper extremity	8/12/2006	Chap 1, para 1.36	n/a	3	0	3
5. Left lower extremity	8/12/2006	Chap 3	Chap17	0	0	0
6. Right lower extremity	8/12/2006	Chap 3	Chap17	0	0	0
Total % WPI (the Combined Table values of all sub-totals)					**14%**	

15. The worker appealed.

16. The complaint on appeal was limited to the assessment for the cervical spine.

17. The AMS placed the appellant in DRE Category IV of his cervical spine with 25% whole person impairment (WPI) and added an additional 2% for Activities of Daily Living (ADLs), giving a total of 27% WPI.

18. He then added an additional 1% according to Table 4.2(2) for the second level operated on, giving a final total of 28% WPI.

19. The AMS then elected to make a three-quarters (75%) deduction for the cervical spine, as in his opinion the appellant has developed this impairment subsequent to the injury of the 8 December 2006. This left an assessment of 7% WPI for the cervical spine.

20. The AMS then made a one-tenth deduction for pre-existing condition which he justified on the basis of pre-existing neck complaints as evidenced by a cervical spine x-ray carried out in 2004 which showed significant pre-existing degenerative disease to be present. The AMS also notes that the history at the time of the request for the cervical spine x-ray in June 2004 was 'Investigation of pain in the neck'.

21. In summary, the appellant made submissions which included the following:

    (a) The legislation does not provide a deduction for post-injury or post-existing conditions or abnormalities. The appellant goes on to note 'The AMS deduction for post-existing condition is not in accordance with legislation nor with the WorkCover Guidelines'.

    (b) The appellant notes that the legislation does not provide '…for a double deduction, namely the further 10% applied by the AMS. Accordingly, this deduction is again incorrect'.

22. The appellant submitted that the correct approach to the assessment of the appellant's WPI was adopted by Dr Cochrane who found the worker suffered a WPI of 29% WPI with a deductible proportion of one-tenth resulting in an assessment of 26% WPI.

23. The respondent submitted that there was no error by the AMS and the MAC should be confirmed.

24. The panel notes that the AMS took a detailed history as follows:

> "This gentleman was installing a vertical shock absorber onto a railway carriage that had been jacked up. He was standing underneath the carriage on a three-step ladder. The shock absorber weighed somewhere between 10 and 15 kg, it was a little awkward, he was having difficulties getting it in place when it slipped and fell hitting his chest. As a result, he fell off the ladder and thinks that he landed on his 'bum' on the floor. I am told he had pain in the back, the shoulders, the neck, and there was a headache. He found a room and lay down, called for some assistance and his supervisor took him to Concord Hospital. Following an assessment, he was discharged and his supervisor took him home.
>
> Dr De Leon, his usual GP, reviewed him the next day and he had some tests. There were two referrals, one to Dr Kam, a neurosurgeon, and the other to Dr Bokor, a shoulder surgeon.
>
> Dr Bokor saw him on 9 July 2007 and in his opinion the problem was 'probably a regional pain problem rather than a localised discrete shoulder injury.' He recommended a pain clinic but suggested to exclude any significant damage he would arrange for an MRI as well as a subacromial steroid injection, the latter not providing any benefit.
>
> The initial consultation with Dr Kam which was on 21 August 2007 states that the lumbar spine MRI does not show any significant abnormality and following his examination the provisional diagnosis of a muscle strain was made, going on to say that he could not identify any structural abnormality to suggest a surgical solution would be appropriate.
>
> Mr Sapanlay had some physiotherapy to various areas and in fact this has allegedly continued on a self-funded manner two to three times a month utilising a combination of Medicare treatments and private insurance.
>
> There was a change of GP to Dr Kwok and with that a referral to Dr Manohar which he thinks was in 2013 or 2014. He had a cervical MRI in December 2014 which tends to confirm that timing. There was a request for multiple injections which I gather the insurer did not approve and when funding for appointments ceased, the appointments ceased.
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> From the notes it is very apparent that he has had a cervical fusion and I attempted to determine how that came about unsuccessfully.
>
> I was told that he could not really recall why Dr Rao recommended the fusion, he had some neck injection which was no better, and physiotherapy was said to be of no benefit. He goes on to say that he did not understand the reason for the operation. He had pain in the neck, arm pain, and numbness which is a little better. Prior to the neck surgery his pain was said to be 10/10 and postoperatively 6-7/10 but he is also utilising Lyrica. The surgery was undertaken at Westmead Public Hospital as a hospital patient which indicates liability was not accepted by the insurer.
>
> I enquired about his knees which according to the Part 4 injury details in the RDA including the left and right leg.
>
> I was told that he has a left knee problem, he does not have a right knee problem. He is not sure when it started but said it was in the "last year or so" when he had pain. He was apparently seen by Dr Biggs, an orthopaedic surgeon, who was said to have aspirated the knee, and he thinks he had some physiotherapy as well.

I should point that the report by Dr Giblin, orthopaedic surgeon, for the applicant's solicitors in July 2015 makes no mention of any knee complaints.

Correspondence from Dr Biggs of 10 October 2018 stating that there was patellofemoral pain since May 2018 with no precipitant, the clinical findings reported tended to confirm that diagnosis. He injected the left knee, prescribed physiotherapy, and indicated than an MRI confirmed the menisci were intact as was the articular cartilage.
What appears to be the original neurosurgical outpatient's assessment at Westmead Hospital from 27 February 2017 indicated a long history of neck pain, right shoulder radiculopathy, and left-sided symptoms were denied. There was said to be mild numbness in the right arm, he could use a knife and fork but occasionally dropped a thing or two, and denied any bladder or bowel dysfunction or having walking problems. They found normal reflexes, no hyperreflexia, a negative Babinski, a negative Hoffman's, and a negative clonus commenting that the previous MRI from 2014 showed degenerative disease.

The report of that MRI indicates 'multilevel degenerative disc disease with disc-osteophyte complexes. Suspected thickening of posterior longitudinal ligament, possibly ossified, seen from C5 through C6/7 inclusively. Along with the presence of disc-osteophyte complexes, significant cord compression is seen to the left of the midline at C5-6 and centrally at C6-7 of similar severity to the prior study.' It also indicates 'right-sided foraminal stenosis is unchanged at the C4-5, C5-6 and C6-7 levels. Left-sided foraminal stenosis is unchanged on the left side at C6-7.'

There is further correspondence although it is unfortunately incomplete from Westmead Hospital Outpatients dated 19 June 2017. He is described as having a 'slightly magnetic gait' also points out no abnormality neurologically.

The operation report by Dr Rao from Westmead Hospital indicates a fusion from C5 to C7 and that the indication was 'myelopathy'. The information available from the Outpatient Clinic makes no reference to clinical evidence of myelopathy, the operation was on 31 August 2017, and the letter from Dr Rao himself from 6 September 2017, a postoperative review, talks about a large number of clinical signs that were allegedly present prior to the operation.

I asked this gentleman how things have changed in the last eight years since his medical assessment certificate and impairment was determined by Dr Harrison in 2011. There has of course been the neck surgery and the left knee problems, I am told the shoulders are a little better but there is still pain and 'without my physio is not getting better.' I am also told that the low back pain has been getting a little better over the last eight years.

- **Present treatment:**

Physiotherapy.

- **Present symptoms:**

This gentleman has pain at the back of both sides of his neck. There is left arm pain going down the lateral aspect of the humerus, the dorsal forearm, and into the ring and little fingers both of which are numb. He said that there is some right arm pain somewhere 'here' patting the humerus. He indicated it was between the elbow and the shoulder, the pain is global.

He is complaining of bilateral shoulder pain, he cannot do anything overhead or get the hand behind the back, and needs his wife to dress him. He cannot lie on the side at night other than for a short period.

There is said to be low back pain and stiffness radiating in the posterior aspect of the thigh to the knee. He has pins and needles most of the time demonstrating the calves generally but later saying that the pins and needles are followed by cramps.

He confirms that only the left knee is symptomatic, it is painful particularly when walking, and it is mainly posterior. There is no swelling. He could walk half a kilometre, stairs are hard because of problems with balance and a sensation of dizziness. He cannot squat or knee and he can sit for 30 minutes. He can only lift 2 kg.

- **Details of any previous or subsequent accidents, injuries or condition:**

These are denied.

- **General health:**

This man has a number of problems including glaucoma for which he has had a right eye operation and he is still using eye drops on the left. He has been prescribed Lyrica and Panadol for pain, Somac for his stomach, and Flomaxtra for prostate issues. He is also on Ventolin and Seretide for his asthma.

- **Work history including previous work history if relevant:**

He has been a mechanical fitter all of his life having trained in the Philippines, coming to Australia in October 1990, and commencing work with the respondent in 1998.
He ceased work in mid-2007 and has not returned to any employment subsequently.

- **Social activities/ADL:**

This gentleman is married, he claims that prior to the accident he would provide some assistance for his wife who is not employed. She now states that she does all of the domestic duties. The children tend to come around on weekends and one of his sons will mow the lawn. He claims to be unable to go fishing and bushwalking."

25. The AMS recorded the results of his physical examination as follows:

"The Applicant conducted all movements in an active manner. Where passive movement has been induced it has been recorded in the examination findings.
No passive movements were performed beyond the limits of comfort.

Assessments were carried out in accordance with the SIRA and AMA Guides (5th edition).

This gentleman sat keeping his neck almost rigid while the history was being obtained. There was some evidence of anxiety and at various times he was tremulous. He was very protective and his wife was very solicitous, undressing him and then later dressing him while he was semi-passive only extending both shoulders to 30° while his shirt was removed.

He had a normal but very slow gait pattern, he could walk on tiptoes and on his heels.

Light axial compression of the skull produced neck and back pain, pseudorotation of the pelvis, low back pain. The scar from his cervical surgery was essentially invisible, he was globally tender in the posterior aspect of the neck extending into the trapezius. Movements were negligible in any plane.

There was said to be tenderness throughout the thoracic spine as well as the lumbar spine. In a seated position thoracic rotation was a quarter normal but he displayed much greater cervical rotation than noted on formal assessment.

He was able to forward flex very slowly and with a lot of shaking to the top of his knees, recovered more smoothly, and there was a symmetrical loss of extension. There was negligible lateral flexion in either direction.

In a seated position he was able to fully extend both legs however straight-leg-raising was restricted to 30° bilaterally with severe back pain claimed and at the same time he lifted his head off the bed to observe.

Neurologically there was global weakness, normal tone, and the entire left arm was said to have diminished sensation. Sensation in the lower extremities was normal as were reflexes which were also symmetrical. Romberg's test was negative as was Hoffman's test and there was no clonus. Babinski response was also normal.
As far as the legs were concerned, they were well aligned, I have already indicated no wasting, and there was no effusion in either side. There was no abnormality whatsoever in the right knee which displayed a full range of movement. On the left side there was said to be pain on light palpation of the anterior aspect of the knee but there was no crepitus, there was no tibiofemoral tenderness, but there was some discomfort at the back of the knee associated with a little bit of swelling which was probably a Baker's cyst. The knee was stable with negative meniscal provocation testing and the range of movements were from 0 to 130°.

The shoulders were restricted with complains of marked pain and there was generalised tenderness over the shoulder cowls extending down the shaft of the humerus to the elbows bilaterally. Movements were largely self-limited with complaints of extraordinary levels of pain but it was in the neck and trapezius, not the shoulders themselves. There was also evidence of inconsistency. On the left there was 90° elevation, 30° extension, 100° abduction, 40° adduction, and that was said to produce pain in the ribs. There was 80° external and 50° internal rotation.

On the right there was 90° elevation, 40° extension, 110° abduction, 30° adduction, 80° external, and 30° internal rotation.

Provocation testing for impingement and biceps irritation were associated with little resistance and a lot of pain in the shoulders and neck so that I did not consider they were valid. There was generalised weakness as already mentioned.

In a supine position however, there was 80° of active internal and external rotation bilaterally and attempts at gentle passive elevation met with resistance."

26. The AMS had regard to the radiological investigations relevant to the cervical spine as follows:

"7 June 2007 – Right shoulder ultrasound. This reports tendonitis, bursitis, and impingement with a 'suggestion' that an injection might be helpful.

24 July 2017 – Right shoulder MRI. There is evidence of a SLAP lesion with labral cysts as well as rotator cuff tendinosis.

20 September 2011 – Cervical MRI. There is multilevel spondylosis with congenital spinal narrowing and flattening of the cord but there is no abnormal signal indicative of myelomalacia. There are foraminal narrowing changes at multiple levels.

25 November 2011 – Cervical flexion and extension views down to the level of C6 only showed no instability.

15 June 2013 – Cervical MRI. There is no significant difference from the earlier cervical MRI.

5 December 2014 – Cervical MRI. There is no significant change from the prior studies.

22 October 2015 – Cervical X-ray. There are multilevel degenerative changes with foraminal stenosis and endplate osteophytes.

Right shoulder ultrasound bursitis, impingement, and tendinosis.

6 February 2016 – Yet another right shoulder ultrasound as before.
25 August 2017 – Cervical spine x-ray with flexion and extension views. There is no instability.

22 February 2018 – Cervical spine x-ray. There has been a C6 vertebrectomy with C5 to C7 fusion.

26 February 2018 – Cervical spine x-ray as per the x-ray above.

8 May 2018 – X-ray of the entire spine. Once again it shows the vertebrectomy and fusion, the thoracic spine has some degenerative changes, and there is evidence of facet arthritis in the lower two levels of the lumbar spine.

5 June 2018 – Cervical MRI ordered by the GP. There is a lot of degradation from the hardware as one would expect with degenerative changes above and below the C5 to C7 fusion.

31 August 2018 – Cervical CT. This again shows the fusion to be satisfactory."

27. The AMS summarised the injuries and his diagnosis as follows:

> "There has been a soft tissue injury to the cervical and lumbar spine both of which have evidence of pre-existing degenerative disease which is quite apparent on the original lumbar CT and the first available cervical investigation is only from September 2011. (I subsequently located an x-ray from 2004 as below.) The changes however suggest longstanding disease and there is a major component related to the congenital narrowing of the spine. There is also evidence of a SLAP tear in the right shoulder and a lot of the claimed shoulder pain and restriction is secondary to the cervical disability.
>
> As far as the knees are concerned this gentleman denies an injury to the right side and the history of pain which is probably patellofemoral in nature was of recent onset."

28. The AMS commented on the appellant's consistency of presentation as follows:

> "This gentleman's presentation is one of marked inconsistency as was noted by Dr Harrison in 2011. The degree of restriction and positive Waddell's signs as well as the variable ranges of movement and the invalidism that was presented today strongly colour the assessment."

29. The AMS considered that there was both a pre-existing and subsequent condition in the cervical spine, answering in the affirmative the questions posed in the MAC as follows:

> "(f) If so, please indicate which body part/system is affected by the previous injury, pre-existing condition or abnormality. **The spine**
>
> (g) Indicate whether there has been any further injury subsequent to the subject work injury. If this injury has caused any additional impairment this should not be included with the assessment of impairment due to the subject work injury. Yes , see below."

30. The AMS explained his reasons for assessment of the cervical spine as follows:

> "There is a statement by the worker dated 17 June 2018 regarding the claims of deterioration which are at variance with the information he has provided to me today. Furthermore, when one reflects on the results of the cervical fusion, that which this gentleman claims and that which is indicated by Dr Rao in his correspondence from September 2018 there is also some variance. It does not correspond to the information provided to me today, and that is also inconsistent with the details contained in the report by Dr Machart from February 2019. You will also note that even less movement noted in the shoulders and he described this being associated with clenching of the teeth and loud expressions of pain to the point that he could not test rotation in abduction.
>
> …
>
> As far as the neck is concerned there is now a two-level fusion that must be taken into consideration noting that previously there was an assessment of 0° WPI. There is no evidence of significant pre-existing degenerative disease.
>
> There is however significant narrowing of the spinal canal which is constitutional and together with aging and the inevitable degenerative disease it has been a subsequent event that has led to the requirement for surgery. Therefore, a major component of the impairment relates to the subsequent events however there is an accepted claim regarding the cervical spine, or at least mandated by the Workers' Compensation Commission. Therefore, the effects of subsequent aging and degeneration as well as the further impact of constitutional factors should reduce the cervical impairment by 75 percent noting that it is not a pre-existing condition but a subsequent condition.
>
> The shoulder impairment is once again confused and made difficult by a combination of inconsistency, invalidism, maximisation, and now a claim that a lot of the pain relates to the neck movement even though there is evidence of a SLAP lesion in the right shoulder."

31. The AMS provided an explanation for his calculations of the assessment of the cervical spine as follows:

> "SIRA Guides Chapter 4, AMA Guides Chapter 15 paragraph 15.6 Table 15.5 – There has been a 2 level fusion and therefore he has to be classified under DRE category 4 which is associated with baseline 25 percent WPI to which I would add 2 percent for ADLs but certainly no more. Having had two-level fusion the modifiers according to Table 4.2 must apply however there is no evidence of radiculopathy so that the total impairment is 28 percent WPI. Taking into account the quantum indicated above due to the subsequent events that leaves a final quantum of 7 percent WPI."

32. The AMS had regard to the other evidence including other expert's opinion that was before him and provided comment as follows:

> "Some 1200 pages of documents were reviewed.
> There were copious general practice notes both computer-based and handwritten, the copies of some of the latter were too faded to read. There are some 'progress notes' which appear to be from someone managing the claim.
> I have located a report of a cervical spine x-ray from 21 June 2004 with a history stating 'investigation of pain in the neck' and noting early degenerative disease between C5 and C7 with small associated anterior marginal spurs as well as degenerate changes in the facet joints and uncovertebral joints but no significant foraminal narrowing.

> Other than the previous Medical Assessment Certificate by Dr Harrison it is only the more recent medicolegal reports that are of significance given the cervical surgery.
>
> I have already commented on the report by Dr Machart from February 2019, I agree with the basic premise of his report although there are some errors in the calculation of the cervical impairment not the least being that more than one level was treated. There is an assessment by Dr Cochran a neurosurgeon on behalf of the applicant who does indicate evidence of embellishment which he chooses to describe as causing his assessment to be 'somewhat hampered by a degree of modification due to what I would consider likely central pain syndrome and associated distress or concurrent psychological condition.' He indicates there is no cervical radiculopathy. He also points out tremulousness, submaximal effort and other fear avoidance behaviours including indicating that his back was 'too sore' to move. Dr Cochran assessed the lumbar spine under DRE Category 1, the upper extremities were not assessed for impairment, and he has applied 1 percent for scarring which is essentially invisible and then 20 percent WPI for the cervical spine with a 1/10th deduction for pre-existing disease. While I agree there is a deductible component he has not taken into consideration the other factors which I have already mentioned.
>
> The other report which is considered reasonably recent is that by Dr Peter Giblin, an orthopaedic surgeon, from August 2018. The first and most obvious factor is to look at the range of movements displayed by this gentleman and they do not even vaguely resemble that which was noted by Dr Machart or by me. He also stated 'recently his left knee has become sore for no apparent reason.' I have already noted the similar history as have others. Dr Giblin apparently had difficulties finding reflexes and there was said to be decreased sensation at left C7 which is again contrary to the findings by me, by Dr Machart, and by Dr Cochran. He then goes on to assess the cervical spine under DRE Category 4 with 2 percent for ADL, no quantum for scarring, and makes a 1/10th deduction before adding the modifiers according to Table 4.2 instead of after adding the modifiers. He also found under DRE Category 2 for the lumbar spine which is contrary to all other assessors."

33. The AMS explained his reasoning for making a one-tenth deduction to take account of the pre-existing condition of the cervical spine as follows:

> "There is evidence of previous neck complaints although the general practice notes from that time are not available it was enough to justify a cervical spine x-ray which showed significant pre-existing degenerative disease in 2004 which has contributed to the impairment because this is a degenerative issue. In my opinion only the 1/10th rule applies."

34. The role of the AMS was to make an independent assessment of WPI of the cervical spine as a result of the injury on 8 December 2006. In doing so he has taken a detailed history, conducted a thorough physical examination (noting the inconsistency of the appellants presentation), had regard to the radiological evidence and the other available evidence that was before him.

35. The assessment of overall impairment is necessarily based upon the surgery that has been undergone on the neck. However, the ultimate assessment of WPI that the AMS must make is that which he considers to be as a result of injury on 8 December 2006.

36. The AMS did not consider the neck surgery undergone in 2017 some 11 years after the subject injury resulted from the subject injury. He was correct to exclude from assessment of impairment the impairment that he found to be as a result of subsequent injury. He set out a clear explanation of his reasons for this as follows:

"There is however significant narrowing of the spinal canal which is constitutional and together with aging and the inevitable degenerative disease it has been a subsequent event that has led to the requirement for surgery. Therefore, a major component of the impairment relates to the subsequent events however there is an accepted claim regarding the cervical spine, or at least mandated by the Workers' Compensation Commission. Therefore, the effects of subsequent aging and degeneration as well as the further impact of constitutional factors should reduce the cervical impairment by 75 percent noting that it is not a pre-existing condition but a subsequent condition."

37. The panel notes the assessment by the AMS was done in difficult circumstances, noting that there seems to be a fairly general consensus, as noted by the AMS: 'This gentleman's presentation is one of marked inconsistency as was noted by Dr Harrison in 2011'.

38. The Panel notes the appellant was previously referred for assessment by an AMS, namely Dr J M Harrison (orthopaedic surgeon) on 21 March 2011, over four years following his injury in December 2006, Dr Harrison placed the appellant in DRE Category I of his cervical spine with 0% WPI.

39. The available evidence after the injury in 2006 includes the following:

- physiotherapy reports in December 2006 noting 'widespread pain, neck, shoulders, back', but the next entry on 28 February 2007 notes simply 'back pain', without any mention of neck symptoms. Similarly, the entry on 12 April 2007 notes that the back pain has improved and once again there is no mention of neck symptoms.

- There is a referral from the appellant's general practitioner on 13 June 2007 to Dr A Kam (neurosurgeon) noting the injury to the low back and the right shoulder on 8 December 2006 without any mention of any neck injury.

- Similarly, there is a report of Dr A Kam (neurosurgeon) of 21 August 2007 noting symptoms in the low back and right shoulder, again with no mention of any neck symptoms.

- There is a Statutory Declaration from the appellant of 10 July 2007 noting severe pain in the low back, upper back and both shoulders, and also noting 'my neck was also uncomfortable but not as bad as my back'.

- There are reports of Dr J G Bodel (orthopaedic surgeon) of 3 May 2007 noting injury to the low back without any mention of neck symptoms. On examination, he notes 'good range of neck movement'.

- In his report of 18 October 2007 Dr Bodel notes symptoms in the right shoulder and neck but under the heading "Complaints" does not make any mention of neck symptoms. There is also no mention of the neck in his discussion.

- In his report of 28 October 2008, he notes the current complaints are of pain and stiffness in the right shoulder but no complaint of neck pain, but he does note that there was some neck stiffness on examination.

- It is only in Dr Bodel's report of 9 February 2011 that he notes that the appellant now indicates that he also injured his neck at the time of his injury on 8 December 2006. However, under the heading "Current complaints" Dr Bodel does not mention any neck symptoms and places the appellant in DRE Category I of his cervical spine (0% WPI).

- There is a report of Dr WGD Patrick of 29 July 2008 who notes the injuries and suggests that there is also some neck discomfort and indicates that the appellant was seen by Dr Kam for back and neck symptoms, but as noted from Dr Kam's report, this was not the case.

- The appellant was assessed by AMS Dr Harrison in March 2011 as DRE 1 (0% WPI) as a result of injury on 8 December 2006.

40. There is no clinical evidence available that explains why the surgery was undertaken. Certainly, there is simply no clinical evidence available that shows that the surgery was undertaken as a result of the subject injury. The AMS does note an operation report by Dr Rao from Westmead Hospital indicating the fusion from C5 to C7 and that the indication was 'myelopathy'. There is no suggestion on the available evidence as to what the cause of that myelopathy was, although the cervical MRI on 20 September 2011 showed '…multilevel spondylosis with congenital spinal narrowing and flattening of the cord but there is no abnormal signal indicative of myelomalacia. There are foraminal narrowing changes at multiple levels'. There is no available evidence that suggests that these changes would be related to the injury on 8 December 2006.

41. The AMS has provided adequate reasons why he excluded three-quarters of the impairment assessment to take account of the subsequent development of neck symptoms and the surgery that was required in 2017 some 11 years after the injury and which was not on the available evidence considered by the AMS to have taken place as a result of the injury. The Panel considers that this approach was open to the AMS on the evidence and can discern no error by the AMS.

42. The AMS has made a deduction of one-tenth to take into account the contribution to the level of impairment he assessed (7% WPI) as a result of injury (after the exclusion of the impairment that the AMS considered resulted from the subsequent condition leading to surgery in 2017 some 11 years after the subject injury). The available evidence is noted by the AMS to show a cervical spine that was symptomatic prior to subject injury. The AMS pointed to the cervical spine x-ray on 21 June 2004, some 2½ years before the injury in December 2006, was referred for 'Investigation of pain in the neck' and showed degenerative changes to be present. The Panel can discern no error in the deduction of one-tenth made by the AMS under s 323.

43. For these reasons, the Appeal Panel has determined that the MAC issued on 26 June 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*.

G Bhasin

Gurmeet Bhasin
Dispute Services Officer
As delegate of the Registrar