WORKERS COMPENSATION COMMISSION

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

Matter No:	**M1-4438/19**
Appellant:	**Vince Battiato**
Respondent:	**FDM Warehousing Pty Ltd**
Date of Decision:	**6 January 2020**
Citation:	**[2020] NSWWCCMA 1**

Appeal Panel:	
Arbitrator:	**Mr John Harris**
Approved Medical Specialist:	**Dr Drew Dixon**
Approved Medical Specialist:	**Dr Gregory McGroder**

BACKGROUND TO THE APPLICATION TO APPEAL

1. Mr Vince Battiato (the appellant) suffered injury in the course of his employment with FDM Warehousing Pty Ltd (the respondent). The appellant suffered a number of significant orthopaedic injuries when a gate, estimated to weigh in the order of 500 kilograms, fell on and trapped him for approximately five minutes.

2. The appellant served a letter of claim for permanent impairment compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act) for the left and right lower extremities, right upper extremity and associated scarring.[1]

3. The respondent replied to the claim by a counter-offer dated 9 August 2019.[2]

4. The appellant then commenced proceedings in the Commission claiming permanent impairment compensation. The assessment of permanent impairment was then referred by the Registrar to Dr Ian Meakin, an Approved Medical Specialist (AMS), who examined the appellant and provided the Medical Assessment Certificate dated 2 October 2019 (MAC). The relevant findings made by the AMS pertinent to the various grounds of appeal are set out later in these Reasons.

5. The AMS assessed the appellant as having a 14% whole person impairment (WPI) of the right lower extremity, 2% WPI of the left lower extremity, the right upper extremity (shoulder) was assessed at 5% WPI and the scar was assessed at 2% WPI. There was no deduction made pursuant to s 323 of the *Workplace Injury Management and Workers Compensation Act 1998 (the 1998 Act)*. The combined WPI was assessed at 22%.

6. The assessment of WPI is undertaken in accordance with the fourth edition of the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment* (fourth edition guidelines).[3] The fourth edition guidelines adopt the 5th edition of the *American Medical Association's Guides to the Evaluation of Permanent Impairment* (AMA 5). Where

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[1] Application, p 113
[2] Application, p 114
[3] The 4th edition guidelines are issued pursuant to s 376 of the s 376 of the *Workplace Injury Management and Workers Compensation Act 1998*

there is any difference between AMA 5 and the fourth edition guidelines, the fourth guidelines prevail.[4]

THE APPEAL

7. On 30 October 2019, the appellant filed an Application to Appeal Against a Medical Assessment to the Registrar of the Workers Compensation Commission (the Commission).

8. The WorkCover Medical Assessment Guidelines (the Guidelines) set out the practice and procedure in relation to appeals to Medical Appeal Panels under s 327 of the 1998 Act.

9. The appellant claims, in summary, that the medical assessment by the AMS should be reviewed on the ground that the MAC contains a demonstrable error and/or the assessment was made on the basis of incorrect criteria within the meaning of s 327(3)(c) and (d) of the 1998 Act.

10. The appellant did not contest the assessments made by the AMS for the right upper extremity and the skin (scar).

11. The Appeal was filed within 28 days of the date of the MAC. The submissions in support of the grounds of appeal are referred to later in these Reasons.

PRELIMINARY REVIEW

12. The Appeal Panel (AP) conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Guidelines. As a result of that preliminary review the AP determined, for the reasons provided subsequently, that some of the grounds of appeal had been made out.

13. The appellant did not request a re-examination by an AMS who is a member of the AP. The respondent requested that the appellant be re-examined on the ground of appeal that has been conceded. The AP addresses this issue later in its reasons.

EVIDENCE

14. The AP has before it all the documents that were sent to the AMS for the original assessment and has referred to portions of the evidence and taken them into account in making this determination.

15. The background to the injury and subsequent treatment is comprehensively set out in the MAC. We adopt this history. The AMS stated:[5]

> "Mr Battiato is a 52-year-old right handed man who was working on the 21 December 2016 for the Freight Distribution Management Group. He was engaged in third party warehousing and worked at one of two suburbs. On the day of injury, he had arrived to open the gates at work and noted that a large sliding front gate at the factory had been broken for the previous two months and had to be opened and closed manually. As he was opening one of the gates, a 500kg gate fell on to him flexing his legs up against his chest and he was trapped under the gate for 5 minutes before his cries aroused other staff who were able to lift the gate off. He was taken by Ambulance to Westmead Hospital, complaining of right shoulder pain, right knee and right lower leg pain and also thoracic pain. There was also discomfort over the anterior aspect of the left knee.

[4] Clause 1.1 of the fourth edition guidelines
[5] MAC, pp 2-3

The ambulance report states that there was obvious bleeding from head wounds. He was admitted under the care of the trauma team headed by Dr Balalla, Orthopaedic Surgeon.

There was a list of injuries including, a left comminuted patella fracture, a right tibial plateau fracture with displacement, a right fibular head fracture with knee joint effusion and suprapatellar lipo-haemarthrosis. There was also evidence of a right medial clavicular fracture and a right sternoclavicular joint anterior dislocation with a minimal subluxation of the right acromioclavicular joint. There was also radiological evidence of a right scapular body fracture and multiple right sided fractures, (ribs 1-4, 7 and 8), with underlying small right pneumothorax and bilateral consolidations. There was evidence of a flail chest on the right side. There was evidence of occipital scalp haematoma.

Mr Battiato remained an inpatient at the hospital until the 16 January 2017. Dr Balalla performed a number of surgeries. There was initially an open reduction of the left patella fracture via midline incision with the application of screws and tension bearing wiring. The proximal tibial plateau fracture (Schatzker grade 6), was treated initially with external fixator. There was evidence of a compartment syndrome following pressure gauge testing and the requirement for a two incision fasciotomy of the right lower extremity. All muscle was viable but swollen and there was no requirement of muscle excision.

An angiogram was performed to the right leg revealing that all arteries were intact. The right clavicular fracture was treated conservatively, as was the minimal subluxation of the acromioclavicular joint and the anterior dislocation of the sterno-clavicular joint at the time of initial presentation.

The external fixation apparatus was removed on the 10 January 2017, with a subsequent open reduction internal fixation of the tibial plateau fracture. All surgeries were performed at the Westmead Public Hospital under the guidance of Dr Balalla.

The tibial plateau was elevated with the aid of a Zimmer plate and application of locking screws. He also underwent an arthroscopy of the left knee on the 28 March 2017, in the form of a retropatellar chondroplasty.

Following discharge from Westmead Hospital on the 16 January 2017, he was transferred to the HSS Hospital at Bella Vista, where he spent 4 weeks with rehabilitation, manoeuvring in a wheelchair and learning to use crutches.

His shoulders were reviewed by Dr Kalman Piper, Orthopaedic Surgeon, who suggested no surgical intervention was required. There was a suggestion by Dr Piper that the anterior sterno-clavicular joint dislocation may require surgery but this was not performed and not deemed necessary at the time.

On the 16 March 2017, Dr Piper advised removal of the wires from the left patella which was performed on the 28 March 2017, although the three screws were left insitu. Dr Piper suggested a subacromial subdeltoid bursal steroid injection but this was not proceeded with. There was an infection in the area of the right shin diagnosed as cellulitis and treated accordingly with intravenous antibiotics.

There was removal of the tibial plate on the 30 May 2017 by Dr Balalla. Following discharge, Mr Battiato was able to return to modified work in approximately April 2017, four hours a day, one day per week. He performed computer and informal work from home. There was a false start at this time and he ceased coming into the office but resumed in June 2017 performing computer work. He was still on crutches at that time.

He came under the care of the Pinnacle Rehabilitation Group. He was treated by Dr Raj Sundaraj, Pain Specialist, at the Nepean Clinical School in mid-2018. He underwent 'Scrambler therapy', although Mr Battiato states that this had no effect. He was however, able to reduce his amount of opiate medications and ceased Lyrica. He is currently taking no medication for pain relief.

He has been treated by Mr Andrew Loveridge, Podiatrist at Rouse Hill, with successful orthotics. There has also been referral to Dr Abdal Khan, Psychiatrist, who has been treating Mr Battiato and reporting back to the local Practitioner, Dr Tim Schindler of Rouse Hill."

GROUND OF APPEAL – ASSESSMENT OF THE RIGHT LOWER EXTREMITY

Submissions

Appellant's submissions

16. The appellant submitted that the AMS erred by assessing the tibial plateau fracture in accordance with Table 17-33 of AMA 5 instead of Table 3-2 of the fourth edition guidelines. It was submitted that the assessment should be graded as "severe" in accordance with Table 3-2 of the fourth edition guidelines.

17. The appellant also submitted that the AMS erred by failing to assess the "apparent shortening of the right leg". Reference was made to paragraph 17.2b of AMA 5 which provides for a leg discrepancy in cases of "shortening due to overriding or malalignment of fracture deformities".

18. The appellant referred to the left leg discrepancy of two centimetres which is to be assessed in accordance with paragraph 3.9 of the fourth edition guidelines. Pursuant to Table 17-2 of AMA 5 it was submitted that a diagnosis-based assessment can be combined with limb length discrepancy.

Respondent's submissions

19. The respondent accepted that the AMS had incorrectly used AMA 5 instead of Table 3-2 of the fourth edition guidelines. However, it did not accept that the assessment was commensurate with a "severe" grade of fracture and that "such a finding cannot be extrapolated from the body of the MAC and it would be open to an Appeal Panel doctor to assess less based on a lesser grade of fracture".[6]

20. In respect of leg length discrepancy, the appellant submitted that the AMS has "adequately explained his decision on the basis said discrepancy was apparent and not real or actual."[7]

21. The respondent submitted that the appellant must be re-examined by a member of the AP so that Table 3-2 of the fourth edition guidelines can be applied. It was further submitted that the MAP should "decline to add impairment based on limb length discrepancy".[8]

Reasons

22. Paragraph 3.28 of the fourth edition guidelines relates to the assessment of tibial plateau fractures and provides that Table 3.2 of the fourth edition guidelines replaces Table 17-33 of AMA 5.

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[6] Respondent's submissions, paragraph 4
[7] Respondent's submissions, paragraph 5
[8] Respondent's submissions, paragraph 6

23. Paragraph 3.28 of the fourth edition guidelines relevantly provides:

> "Tibial plateau fractures: Table 3.2 of the Guidelines, replaces the instructions for tibial plateau fractures in AMA 5 Table 17-33 (p 546).
>
> Table 3.2: Impairment for tibial plateau fractures
> In deciding whether the fracture falls into the mild, moderate or severe categories, the assessor must take into account:
>
> - the extent of involvement of the weight-bearing area of the tibial plateau
> - the amount of displacement of the fracture(s)
> - the amount of comminution present."

24. As the respondent properly conceded, the AMS erred by applying Table 17-33 of AMA 5.[9] Such an error falls within the meaning of an assessment made on the basis of incorrect criteria in s 327(3)(c) of the 1998 Act: see *Marina Pitsonis v Registrar of the Workers Compensation Commission of New South Wales*[10] applying Basten JA in *Campbelltown City Council v Vegan*.[11] For these Reasons it is unnecessary to also consider whether there has been a demonstrable error.

25. The appellant also submitted that the AMS erred by failing to assess for leg length discrepancy.

26. The appellant was reported by the AMS as walking with a limp noting the bowed appearance of the right knee.[12] The varus deformity of the right knee resulted "in an apparent shortening of the right leg of 2 measured centimetres".[13]

27. The AMS found that there had been "deterioration of the healed medial tibial surface with angulation of 15 degrees varus following treatment of this displaced tibial plateau fracture."[14]

28. The AMS relevantly concluded:[15]

> "I do acknowledge the apparent shortening of the right leg due to the varus deformity of the right lower extremity, centered on the knee when standing erect. This however is due to the medial plateau fracture pathology which is displaced and angulation and which will subsequently lead to the requirement of long-term arthroplasty due to secondary degenerative change."

29. Later in his reasons, the AMS stated that he agreed with Dr Breit that there is a "difference between real leg length shortening and apparent leg length shortening".[16]

30. Paragraph 17.2b of AMA 5 provides that, where applicable, leg length discrepancy impairment is combined with other impairments. The paragraph states that "shortening due to overriding or malalignment or fracture deformities" requires use of the combined vales chart set out in that paragraph. However, paragraph 3.9 of the fourth edition guidelines substitutes a table for assessing limb leg discrepancy.

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[9] MAC, p 9
[10] [2008] NSWCA 88 (*Marina Pitsonis*) at [40]-[42], McColl and Bell JJA (as their Honours then were) agreeing
[11] [2006] NSWCA 284 at [94], McColl JA agreeing
[12] MAC, p 3
[13] MAC, p 4
[14] MAC, p 9
[15] MAC, p 9
[16] MAC, p 11

31. The AP agrees with the appellant's submission that impairment can be assessed for "limb length discrepancy" based on the facts as found by the AMS. The language in paragraph 17.2b of AMA 5 provides that "shortening due to overriding or malalignment or fracture deformities" falls within the meaning of "limb length discrepancy".

32. The respondent's submissions do not address the language in Table 17.2b of AMA 5. The respondent's submission that the loss of leg length is only "apparent" and "not real" does not assist in determining whether the appellant is entitled to be assessed for impairment pursuant to paragraph 17.2b of AMA 5.

33. The conclusion by the AMS is that the appellant has limb length discrepancy due to a displaced medial fracture causing angulation. The angulation of the displaced fracture means that there is a limb length discrepancy causing the appellant to walk with a limp.

34. The effect of the displaced fracture causing angulation is "malalignment" within the meaning of paragraph 17.2b of AMA 5. This means that the leg length discrepancy satisfies the criteria in paragraph 17.2b of AMA 5.

35. Such an interpretation gives effect to the ordinary meaning of the words: *Cody v J H Nelson Pty Ltd*[17], whilst acknowledging canons of statutory construction that the "question of construction is determined by reference to the text, context and purpose of the Act."[18]

36. The AP is satisfied that the AMS has erred by assessing on the basis of incorrect criteria and failing to apply the correct criteria in paragraph 17.2b of AMA 5 to the circumstances of the appellant's condition.

37. This ground of appeal is successful. Having found error, the AP is required to reassess according to law: *Drosd v Nominal Insurer.*[19] The reassessment of the right lower extremity is set out later in these Reasons.

GROUND OF APPEAL 2 – LEFT LOWER EXTREMITY

Submissions

Appellant's submissions

38. The appellant noted that the AMS assessed the left lower extremity in accordance with Table 17.31 of AMA 5 with respect to patellofemoral crepitus.

39. The appellant submitted that the AMS erred by failing to combine this with assessments under Table 17-33 of AMA 5 for the undisplaced patellar fracture and an undisplaced tibial plateau fracture.

40. The appellant referred to page 17 of the fourth edition guidelines that provides:

> "Footnote to AMA5 Table 17-31 (p 544) regarding patello-femoral pain and crepitation:
>
> This item is only to be used if there is a history of direct injury to the front of the knee, or in cases of patellar translocation/dislocation without direct anterior trauma. This item cannot be used as an additional impairment when assessing arthritis of the knee joint itself, of which it forms a component. If patello-femoral crepitus occurs in isolation (ie with no other signs of arthritis) following either of the above, then it can be combined

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[17] [1947] HCA17; 74 CLR 629 at 647-8 per Dixon CJ

[18] *Military Rehabilitation Commission* v *May* [2016] HCA 19 at [10] citing *Project Blue Sky Inc v Australian Broadcasting Authority* [1998] HCA 28 at [69]–[71] and *Alcan (NT) Alumina Pty Ltd v Commissioner of Territory Revenue* [2009] HCA 41 at [47]

[19] [2016] NSWSC 1053

with other diagnosis-based estimates (AMA5 Table 17-33, p 546). Signs of crepitus need to be present at least one-year post-injury."

41. It was submitted that the combined assessment of the left lower extremity should be assessed at 7% comprising the 2% awarded by the AMS, 3% for the undisplaced patellar fracture and 2% for the undisplaced tibial plateau fracture.

Respondent's submissions

42. The respondent made no submissions in respect of this ground of appeal.

Reasons

43. The reasons on this ground of appeal are provided in the absence of any concession of contrary submission. However, despite the absence of contrary submission, the appellant is still required to show error within the meaning of s 327(3) of the 1998 Act.

44. The reasons given by the AMS for his diagnosis of the left lower extremity were:[20]

> "In the left lower extremity there was a fracture of the left patella with displacement, treated with operative intervention and subsequent removal of the cerclage wires and longitudinal wires with retention of screws. The fracture is united and there is a stable range of motion of the left knee but with continuing intermittent discomfort and evidence of retropatellar crepitus."

45. The contemporaneous evidence refers to a fracture of the left patella.[21] The CT scan of the left knee dated refers to a displaced and distracted fracture of the left patella with extensive oedema and "no other subsequent fractures".[22]

46. Dr Balalla, Orthopaedic Knee Surgeon refers to a fracture of the left knee and left patella hardware.[23]

47. Dr Breit assessed the left lower extremity at 3% WPI on the basis of a healed undisplaced patella fracture.[24]

48. Dr Oates assessed the left lower extremity impairment at 3% WPI for the undisplaced patella fracture and 2% WPI for an undisplaced tibial plateau fracture.[25]

49. The AMS did not assess an undisplaced tibial plateau fracture of the left lower extremity. There is no scan or x-ray evidence to support the opinion provided by Dr Oates that there was a fracture of the left tibial plateau and it is unclear on what basis the doctor concluded that there was a tibial plateau fracture of the left, as opposed to the right, lower extremity.

50. We do not accept that the AMS erred in failing to assess a tibial plateau fracture that did not occur.

51. We otherwise accept the appellant's submission that the assessment of the patellar fracture provided by Table 17-33 of AMA 5 can be combined with the finding of crepitus in Table 17-31 of AMA 5. We accept that the note on page 17 of the fourth edition guidelines is satisfied, that is the appellant had direct injury to the front of the knee without an assessment based on arthritis.

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[20] MAC, p 7
[21] Application, pp 28, 30, 31, 36
[22] Application, p 40
[23] Application, p 103
[24] Application, p 121
[25] Application, p 12

52. The failure to assess the patellar fracture is also an assessment made on the basis of incorrect criteria.

53. The assessment made by the AMS for the left lower extremity is revoked. The correct assessment is 2% WPI under Table 17-31 of AMA 5 for the retropatellar crepitus with an additional 3% WPI under Table 17-33 of AMA 5 for the patellar fracture. This produces a combined assessment of 5% WPI for the left lower extremity.

54. There is no basis to make a deduction under s 323 in respect of this impairment.

REASSESSMENT

55. The AP is required to reassess the impairment of the right lower extremity. The reassessment of the left lower extremity has been undertaken in the reasons under the ground of appeal for that body part.

56. The AP is satisfied that we can properly perform the statutory function to reassess in the absence of a re-examination. We do not agree with the respondent's submission that the grade of the tibial plateau fracture requires reassessment for the reasons set out herein.

57. The AP adopts the assessments in respect of the right upper extremity and the skin. No submissions were made to the contrary.

58. The AP accepts that the impairment assessment of the tibial plateau fracture is undertaken in accordance with Table 3.2 of the fourth edition guidelines.

59. Paragraph 3.28 requires an analysis of extent of the involvement of the weight-bearing area, the amount of the displacement of the fracture and the amount of comminution present.

60. The CR scan of the right lower leg dated 16 January 2017 showed transverse comminuted fractures through the proximal tibia and fibula on the two lateral views.[26] The surgical report indicated multiple fracture fragments.[27]

61. The CT scan dated 16 January 2017 showed an acute comminuted intra-articular fracture through the right tibia extending into the meta-diaphysis.[28] This scan shows a fracture across the entire length of the tibial plateau.

62. The examination findings of the AMS showed a 15 degrees varus deformity of the right leg. That finding is extremely significant and relevant to all three criteria specified under paragraph 3.28 of the fourth edition guidelines when assessing the severity of the grade.

63. That assessment is otherwise consistent with other findings made by the AMS such as the "deterioration of the healed medial tibial surface with angulation of 15 degrees varus following treatment of the displaced tibial plateau fracture."[29]

64. The AP observes that Table 17-33 of AMA 5 uses angulation only in determining the relevant grade. Paragraph 3.28 of the fourth edition guidelines applies criteria in addition to angulation. Given the severity of the fracture the AP is satisfied that the grade is appropriately classified as severe within the meaning of paragraph 3.28 of the fourth edition guidelines.

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[26] Application, p 38
[27] Application, p 31
[28] Application, p 40
[29] MAC, p 9

65. The AP observes that Dr Breit, Orthopaedic Surgeon, qualified by the respondent, assessed the fracture as "severe" in accordance with paragraph 3.28 of the fourth edition guidelines.[30] The AP agrees with Dr Breit's conclusion. The nature of the significant fracture with the consequences identified by the AMS such as the degree of varus deformity warrants a classification of severe as defined in paragraph 3.28 of the fourth edition guidelines. This classification is assessed as 37% lower extremity impairment (LEI)

66. The AP adopts the assessments made by the AMS for the right ankle of 7% LEI and 6% LEI for sensory loss. No contrary submission was made in respect of these assessments and they are otherwise correct.

67. These assessments are combined in accordance the combined tables and total 45% LEI.

68. As the appellant correctly submitted, a diagnosis-based assessment can be combined with limb length discrepancy pursuant to Table 17-2 of AMA 5.

69. Paragraph 3.8 of the fourth edition guidelines relevantly provides:

> "When true leg length discrepancy is determined clinically (see AMA5 Section 17.2b, p 528), the method used must be indicated (eg tape measure from anterior superior iliac spine to the medial malleolus). Clinical assessment of leg length discrepancy is an acceptable method, but if full-length computerised tomography films are available, they should be used in preference. Such an examination should not be ordered solely for determining leg lengths."

70. The AMS referred to a "2cm apparent shortening of the right lower extremity".[31] It is unclear how the AMS made that assessment.

71. The bilateral leg length study reported by Dr Lam shows that the loss of length was 1.7 centimetres, that is 798 mm less 781 mm.[32] Consistent with paragraph 3.8 of the fourth edition guidelines, the full length computerised tomography should be used if they are available.

72. The opinion expressed by Dr Lam is based on an x-ray and not a CT scan. However, this is an objective measure of leg length discrepancy. Accordingly, the AP adopts the precise measurement of the limb length discrepancy shown in this x-ray.

73. The AP concludes that the malalignment has resulted in limb length discrepancy of 1.7 centimetres. Pursuant to paragraph 3.9 of the fourth edition guidelines, the limb length discrepancy is less than two centimetres and does not result in any assessable impairment.

74. The 45% LEI equates to an assessment of 18% WPI for the right lower extremity.[33]

75. The left lower extremity assessment is 5% WPI for the reasons set out earlier.

76. The respective WPI impairments are therefore:

    (a) Right lower extremity: 18% WPI;
    (b) Left lower extremity: 5% WPI;
    (c) Right upper extremity: 5% WPI, and
    (d) Skin (scar): 2% WPI.

[30] See Application, p 121
[31] MAC, p 5
[32] Application, p 87
[33] Table 17-3 of AMA 5

77. The overall combined assessment is 27% WPI.

78. We agree with the reasons provided by the AMS that there is no basis to make a s 323 deduction. No appeal or contrary submission was made by the respondent in respect of that finding.

79. We are satisfied, given the duration of symptoms, that the impairments are permanent and clearly result from injury

DECISION

80. For these reasons the Medical Assessment Certificate given in this matter is revoked and a new Medical Assessment Certificate is issued. The new Medical Assessment 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 MEDICAL APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

G De Paz

Glicerio De Paz
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL

MEDICAL ASSESSMENT CERTIFICATE

Matter No: **4438/19**
Applicant: **Vince BATTIATO**
Respondent: **FDM Warehousing Pty Ltd**

This Certificate is issued pursuant to section 328(5) of the *Workplace Injury Management and Workers Compensation Act 1998.*

The Appeal Panel revokes the Medical Assessment Certificate of Dr Ian Meakin and issues this new Medical Assessment Certificate as to the matters set out in the Table below:

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 AMA 5 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)
Right Upper extremity	21/12/17	Chapter 2, pp 10-12	Figures 16.38-16.46, Table 16.5	5%	N/A	5%
Right Lower Extremity	21/12/17	Chap 3, pp 16-25, Table 3.2, paragraphs 3.9 and 3.28	Chapter 17 Table 17.33, Table 17.11 and 17.12, Figures 17.8 and 17.3	18%	N/A	18%
Left lower extremity	21/12/17	Chap 3, pp 16-25	Chapter 17, Tables 17-1 – 17-3, 17-31,17-33 and paragraphs 17.2b and 17.2h	5%	N/A	5%
Skin	21/12/17	Table 14.1 p 74		2%	N/A	2%
Total % WPI (the Combined Table values of all sub-totals)					**27%**	

John Harris
Arbitrator

Dr Drew Dixon
Approved Medical Specialist

Dr Gregory McGroder
Approved Medical Specialist

6 January 2020

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

G De Paz

Glicerio De Paz
Dispute Services Officer
As delegate of the Registrar