WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-4202/19**
Appellant:	**Warren Beeton**
Respondent:	**Sanrid Pty Limited**
Date of Decision:	**25 February 2020**
Citation:	**[2020] NSWWCCMA 30**

Appeal Panel:	
Arbitrator:	**Ross Bell**
Approved Medical Specialist:	**Dr Roger Pillemer**
Approved Medical Specialist:	**Dr Greg McGroder**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 7 November 2019, Warren Beeton 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 16 October 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).

RELEVANT FACTUAL BACKGROUND

6. It is convenient to extract the background recorded by the AMS at Part 4 of the MAC,

   "Brief history of the incident/onset of symptoms and of subsequent related events, including treatment:

Mr Beeton related that while working as a pastry cook, he had a lot of very heavy lifting. Many of the containers in which pastry were mixed were large, heavy industrial stainless-steel bowls. There was also frequent movement of flour bags, which weighed 25kg and containers of margarine, which weighed between 20 and 25kg. Many of these components had to be moved from upper shelves and returned to them. There was also the receiving of stock, which had to be stowed away. Although Mr Beeton was technically the senior member of the team, he often had to do a lot of this work himself.

In the events of October 1990, November 1995 and September 1997, it looks as though he sustained mild to moderate muscular strains of his lower back. There is no record of significant periods of time taken off work or significant clinical management.

The event of 05/02/01 was much more severe. After this, he had pain radiating down his left leg. He came under the care of Specialist Orthopaedic Surgeon, Dr Abe Isaacs. A decompressive laminectomy was conducted at the L5/S1 articulation in June 2001, which gave him limited improvement, although he was never able to get back to work.

It the intervening years, there has been gradual deterioration of his lower back. More recently, he has come under the care of Specialist Spinal Surgeon, Dr Hardeep Salaria. There was a proposal for fusion at the L5/S1 level with an anterior approach. This seems to be almost a redundant procedure since the L5/S1 disc has deteriorated to such an extent that L5 and S1 are effectively fused, although are described by Dr Salaria as not being robust enough to be classified as a physiologically stable fusion.

The deterioration of his lower back has continued. More recently, there has been slight forward slip of L4 on L5. It has also been described that there may be a need for further surgery to his lower back further down the track.

He has also had extensive assistance in pain management techniques under the care of Specialist Pain Management Physician, Dr Simon Tame. There was a trial of injections, which unfortunately did not help. In the clinical literature, it is described that he was instructed with his own exercise programme by an Exercise Physiologist and that it was intended that this should continue with his self-management programme. The self-management programme does not seem to have progressed."

PRELIMINARY REVIEW

7. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the WorkCover Medical Assessment Guidelines.

8. 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 for the reasons given below.

EVIDENCE

Documentary evidence

9. 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

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

SUBMISSIONS

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

12. The appeal concerns the assessment of the lumbar spine; specifically, the DRE Lumbar Category (AMA 5 Table 15-3).

Appellant

13. In summary, the appellant worker submits that the AMS has erred in allocating DRE Lumbar Category III when he should have found DRE Lumbar Category IV.

14. The appellant refers to Table 4.1 at page 26 of the Guidelines, as well as Table 15-3 at page 384 of AMA 5. Table 15-3 DRE Lumbar Category IV includes both surgical and developmental fusions, and it is the latter that has happened in the case of Mr Beeton, as accepted by Dr Bentivoglio and Dr Bodel.

15. The Guidelines at paragraph 4.37 do not modify Table 15-3 of AMA 5 to rule out developmental fusion as satisfying DRE Category IV. Category III does not apply in the case of a fusion, either surgical or developmental, and no priority is given in Table 15-3 to fusion as a result of surgery.

16. Mr Beeton should be assessed at 22% whole person impairment (WPI) for his lumbar spine.

Respondent

17. There was no error by the AMS, and the correct criteria have been followed. Paragraph 4.37 of the Guidelines requires that for DRE Category IV to apply there must be an operation for spinal fusion, successful or unsuccessful. The appellant has not had surgery for spinal fusion, and therefore does not satisfy the criteria for Category IV.

18. The appellant underwent a decompressive procedure which paragraph 4.37 directs the AMS to assess as Category III. There was no attempt at fusion, and the surgery did not cause fusion.

19. The appellant has failed to point to medical evidence that Mr Beeton experienced ‘developmental fusion’. There is no medical evidence of developmental fusion. Both Dr Bodel and Dr Bentivoglio refer to L5/S1 as having “spontaneously fused”, but neither refers to developmental fusion. Therefore, any possible fusion, if it occurred, is limited to being spontaneous fusion.

20. Even if it is established that Mr Beeton suffered a developmental fusion, paragraph 4.37 of the Guidelines mandates a Category III finding. The appellant does not satisfy the balance of Category IV in Table 15-3 of AMA 5.

21. The findings of the AMS were open to him and there is no error. The correct criteria have been applied. The MAC should be confirmed.

FINDINGS AND REASONS

22. 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.

23. 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.

Discussion

24. As extracted above the AMS says at Part 4,

> "There was a proposal for fusion at the L5/S1 level with an anterior approach. This seems to be almost a redundant procedure since the L5/S1 disc has deteriorated to such an extent that L5 and S1 are effectively fused, although are described by Dr Salaria as not being robust enough to be classified as a physiologically stable fusion."

25. At Part 7 the AMS summarises,

> "There was a proposal for an anterior approach for an L5/S1 interbody fusion, although this has been put on hold, since that articulation appears to have fused, although it has been described that this is not likely to be a 'robust fusion'."

26. At Part 10.c. when explaining the assessment, the AMS says,

> "This assessment is exactly the same as the original assessment of Specialist Orthopaedic Surgeon, Dr James Bodel in his report of 14/11/17.
>
> In his further report of 19/01/19, he assesses that because of the spontaneous fusion at L5/S1 that Mr Beeton is now in DRE IV for his WPI assessment. This view is also echoed by Specialist Neurosurgeon, Dr Peter Bentivoglio in his report of 04/03/19. With the greatest of possible respect to both learned specialists, I am at variance with this methodology. If there had been surgery with the intention of creating a spinal fusion and whether or not it had been successful, I would have been in full agreement with both specialists. In this particular instance, however, the surgical procedure was undertaken as a decompression at the L5/S1 articulation and not with the primary intention of fusion. If we consult the guidelines in SIRA Page 29, 4.37, it specifically states, 'Operations for spinal fusion (successful or unsuccessful) are considered under DRE Category IV'. Therefore, although L5 and S1 may have become fused, this was not the primary intention of the surgery and as a result, he should be assessed under DRE Category III."

27. The Panel notes the above explanation is not in accordance with Table 15-3 of AMA 5. Paragraph 4.37 of the Guidelines refers to "operations for spinal fusion (successful or unsuccessful) …". The procedure in June 2001 was a decompressive laminectomy, but since then a fusion has developed at L5/S1. This clearly meets the AMA 5 Category IV criteria,

> "Loss of motion segment integrity defined from flexion and extension radiographs as at least 4.5 mm of translation of one vertebra on another or angular motion greater than 15° at L1-2, L2-3, and L3-4, greater than 20° at L4-5 and greater than 25° at L5-S1 (Figure 15-3); may have complete or near complete loss of a motion segment due to developmental fusion, or successful or unsuccessful attempt at surgical arthrodesis."

28. That the intention for the surgery in 2001 was decompressive laminectomy is of no significance relative to the degree of impairment the subsequent fusion represents.

29. The respondent submits that there is no evidence for the appellant's submission about a "developmental" fusion and submits that a "spontaneous" fusion as it is expressed by Dr Bentivoglio and Dr Bodel is a different condition. The Panel considers on the evidence that while the fusion is not strictly "developmental"; that is, not related to childhood, it has nonetheless occurred over the years following the surgical procedure in June 2001. The surgical arthrodesis that had been considered is now redundant given the fusion that has occurred spontaneously over time. A clear inherent feature of this fusion is a complete loss of motion segment integrity described in Table 15-3 for DRE Category IV, which in this case does not require flexion and extension radiographs to establish what is clear in the April 2018 MRI.

30. There is ample evidence that fusion occurred at L5/S1 over the years following the laminectomy in June 2001. Dr Thong in his MRI report of 27 April 2018 reports that, "the L5/S1 disc has now fused". Dr Salaria in his report of 5 October 2018 reports the fusion seen in the MRI. Dr Bentivoglio in his report of 4 March 2019 notes the fusion that had developed, and Dr Bodel also notes this from Dr Bentivoglio's report.

31. The evidence of the April 2018 MRI and the medical opinion following is clear that fusion has occurred at L5/S1 as a result of the injury and the decompressive laminectomy in June 2001. This places the assessment squarely in DRE Lumbar Category IV.

32. Paragraph 4.37 of the Guidelines provides (emphasis added),

> "Effect of surgery: AMA5 tables 15-3 to 15-5 (pp 384, 389 and 392) do not adequately account for the effect of surgery on the impairment rating for certain disorders of the spine. The assessor should note that:
>
> - **Surgical decompression for spinal stenosis is DRE category III (AMA5 Table 15-3, 15-4 or 15-5).**
> - Operations where the radiculopathy has resolved are considered under the DRE category III (AMA5 Table 15-3, 15-4 or 15-5).
> - **Operations for spinal fusion (successful or unsuccessful) are considered under DRE category IV (AMA5 Table 15-3, 15-4 or 15-5)**
> - DRE category V is not to be used following spinal fusion where there is a persisting radiculopathy. Instead, use Table 4.2 in the Guidelines
> - Radiculopathy persisting after surgery is not accounted for by AMA5 Table 15-3, and incompletely by tables 15-4 and 15-5, which only refer to radiculopathy that has improved following surgery.
>
> Table 4.2 indicates the additional ratings which should be combined with the rating determined using the DRE method where an operation for an intervertebral disc prolapse, spinal canal stenosis or spinal fusion has been performed."

33. The respondent refers to the point above regarding “surgical decompression” as dictating to the AMS that Category III must be found. However, paragraph 4.37 is intended to make up for gaps in AMA 5 when assessing impairment where surgery has occurred. It does not operate to exclude impairment that exists as a result of surgery, intended or not, as with Mr Beeton’s fusion resulting from the decompression surgery in June 2001.

34. The respondent also refers to the point above regarding “operations for spinal fusion” as being inapplicable in Mr Beeton’s case because he has not had such surgery. This is true, but the assessment of his lumbar spine is not limited by the intention of the surgery of June 2001. Table 15-3 of AMA 5 at Category IV is applicable given the fusion that is now in place.

35. The AMS refers to the laminectomy of June 2001 but says because the intention of that surgery was not fusion the spine must be assessed now as Category III. However, as noted above, paragraph 4.37 is to cover gaps in AMA 5 in making assessments of body parts that have had surgery. It is not meant to exclude impairment resulting from unintended results of surgery. The fusion seen in the MRI of April 2018 has occurred over the years following the 2001 surgery and should be recognised under DRE Lumbar Category IV at Table 15-3. That is commensurate with the pathology and the degree of impairment. For the AMS not to do so is a failure to apply clinical judgement to the application of the relevant criteria and the Guidelines.

36. The submissions of the respondent and the reasons of the AMS reflect an inflexible approach to AMA 5 and the Guidelines which leaves no room for clinical judgement and results in an assessment which does not reflect the actual degree of impairment.

37. Paragraph 1.23 of the Guidelines refers to analogous conditions, and if it were not possible to find DRE Lumbar Category IV directly, this paragraph would be relevant,

    > “1.23 AMA5 (p 11) states: ‘Given the range, evolution and discovery of new medical conditions, these Guidelines cannot provide an impairment rating for all impairments… In situations where impairment ratings are not provided, these Guidelines suggest that medical practitioners use clinical judgment, comparing measurable impairment resulting from the unlisted condition to measurable impairment resulting from similar conditions with similar impairment of function in performing activities of daily living.’ The assessor must stay within the body part/region when using analogy. ‘The assessor’s judgment, based upon experience, training, skill, thoroughness in clinical evaluation, and ability to apply the Guidelines criteria as intended, will enable an appropriate and reproducible assessment to be made of clinical impairment.”

38. Even if the criteria in DRE Category IV were not met, and the Panel is of the view that they were, paragraph 1.23 operates to allow clinical judgement to ensure that the actual degree of impairment arising from an injury is reflected in the assessment.

39. For these reasons the Panel finds the AMS has based the assessment on incorrect criteria in taking paragraph 4.37 of the Guidelines to exclude the criteria for DRE Lumbar Category IV at Table 15-3 of AMA5; the Panel also finds that the assessment of DRE Lumbar Category III is a demonstrable error on the face of the Certificate.

Findings

40. If a ground of appeal is successfully made out and an error identified, the Panel must correct the error or errors found “applying the WorkCover Guides fully” (see *Roads and Maritime Services v Rodger Wilson* [2016] NSWSC 1499). The Panel can correct the assessment regarding the DRE Lumbar Category without recourse to further examination of Mr Beeton.

41. As discussed above, the Panel finds that the assessment falls under DRE Lumbar Category IV. This gives 20% WPI to which is to be added the 2% WPI additional for the impact on the activities of daily living, plus 3% WPI for radiculopathy in accordance with Table 4.2 of the Guidelines, as found by the AMS, giving 24% WPI.

42. The Panel is satisfied that the impairment is permanent, and the injury has reached maximum medical improvement. There is no subsequent injury.

Section 323 of the 1998 Act

43. The Panel notes that the date of injury referred was 5 February 2001 as alleged in Part 4 of the Application to Resolve a Dispute to which the Referral directs attention. The AMS has earlier dates of injury in his Certificate, but these were not referred for assessment.

44. There is evidence of pre-existing pathology in a CT scan of 26 September 1997 which was reported as showing, "L5/S1 posterior bulge with degenerative osteophyte."

45. The AMS says at Part 8.e. regarding pre-existing elements,

> "There is a history of pre-existing injury to his lower back, although all of these events appear to have been very minor and his was able to continue with his full and normal occupation up until the event of February 2001. It is therefore assessed that there is no significant pre-existing condition."

46. Dr Bodel says there is no clinical indication of any pre-existing condition prior to the work injury, and no deduction indicated. He does refer to the 1997 CT scan,

> "… a CT scan from 26 September 1997 shows slight osteoarthritis in the facet joints and the lower lumbar segments with some degenerative change at the LS/S1 level but no major nerve root compression at that time."

47. Dr Bentivoglio addresses the issue in his report of 4 March 2019,

> "From the point of view of the work injuries in 1988, 1995 and 1997, I believe these were minor. He did not have any investigations; he had no treatment and he was not off work for any length of time. It did however reflect that he may have had early degenerative changes at the LS/S1 level which was significantly made worse on 5 February 2001. So one would have to say that the exacerbation in February 2001 was probably related to some pre-existing injury to the L5/S1 disc as manifested by back pain which he had in 1988, 1995 and 1997. So one could only surmise that he may have had a disc problem at that level as there was no evidence of any investigation but the nature of the chronic pain, he said was exactly the same low back pain that he had in 2001 but in 2001 he had associated sciatic pain as well.
>
> In 2001 it was worse because on this occasion he prolapsed the disc which caused jamming of the nerve. You only prolapse a disc if the disc has been injured so I assume it probably was injured in those lesser injuries as we have already discussed and it was made significantly worse by another injury in 2001, this time causing significant sciatica."

48. The Panel notes that Dr Bentivoglio appears not to have had the 1997 CT scan showing L5/S1 disc bulge and osteophyte before him. However, he applied a 1/10 deduction to the lumbar assessment under s 323.

49. For a deduction to be properly made under s 323 there must be evidence that there is a pre-existing injury; condition; or abnormality and that this element contributes to the impairment[1] and “assumption will not suffice”.[2]

50. In *Ryder v Sundance Bakehouse* [2015] NSWSC 526 Campbell J explained the requirement (emphasis in original),

> “What s 323 requires is an inquiry into whether there are other causes, (previous injury, or pre-existing abnormality), of an impairment caused by a work injury. A proportion of the impairment would be due to the pre-existing abnormality (even if that proportion cannot be precisely identified without difficulty or expense) only if it can be said that the pre-existing abnormality made a difference to the outcome in terms of the *degree* of impairment resulting from the work injury. If there is no difference in outcome, that is to say, if the *degree* of impairment is not greater than it would otherwise have been as a result of the injury, it is impossible to say that a proportion of it is due to the pre-existing abnormality.”

51. A pre-existing condition can be asymptomatic before the injury providing the evidence establishes that it existed before the injury and that it forms part of the impairment.[3]

52. There is a history of injurious events prior to the injury in February 2001, which was certainly much more serious than those previous events. However, the earlier problems were serious enough for Mr Beeton to be referred for a lumbar CT in September 1997, which showed a posterior disc bulge and degenerative osteophyte at L5/S1, the same level injured in February 2001.

53. In terms of the above authorities, the Panel finds on the evidence that the pre-existing condition at L5/S1 means that the degree of impairment is greater than it otherwise would have been. However, the proportion of the contribution cannot be precisely identified without difficulty. This invokes s 323(2) and 1/10 deduction is not at odds with the evidence discussed above.

54. Applying the 1/10 deduction to the initial assessment of 24% WPI gives 21.6 rounded to 22% WPI, as reflected in the Panel’s Certificate below.

55. For these reasons, the Appeal Panel has determined that the MAC issued on 16 October 2019 is revoked. A new Certificate is provided below.

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 De Paz

Glicerio De Paz
Dispute Services Officer
As delegate of the Registrar

[1] *Cole v Wenaline Pty Ltd* (2010) NSWSC 78.
[2] *Fire & Rescue NSW v Clinen* [2013] NSWSC 629.
[3] *Vitaz v Westform (NSW) Pty Limited* [2011] NSWCA 25

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Matter Number: **4202/19**
Appellant: **Warren Beeton**
Respondent: **Sanrid Pty Limited**

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

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

Table - Whole Person Impairment (WPI)

Body Part or system	**Date of Injury**	**Chapter, page and paragraph number in NSW Workers Compensation Guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA5 Guides**	**% WPI**	**WPI deductions pursuant to s 323 for pre-existing injury, condition or abnormality** (expressed as a fraction)	**Sub-total/s % WPI** (after any deductions in column 6)
Lumbar spine	05.02.01	Ch 4, Pg 24	Ch 15-3 Page 384	24	1/10	22
Total % WPI (the Combined Table values of all sub-totals)					**22%**	

Ross Bell
Arbitrator

Dr Roger Pillemer
Approved Medical Specialist

Dr Greg McGroder
Approved Medical Specialist

25 February 2020

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

G De Paz

Glicerio De Paz
Dispute Services Officer
As delegate of the Registrar