WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-2647/19**
Appellant:	**Danutz Radu**
Respondent:	**Precise Payroll Services Pty Ltd**
Date of Decision:	**2 April 2020**
Citation:	**[2020] NSWWCCMA 67**

Appeal Panel:	
Arbitrator:	**Ms Deborah Moore**
Approved Medical Specialist:	**Dr David Crocker**
Approved Medical Specialist:	**Dr John Ashwell**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 6 November 2019, Danutz Radu lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Robin O'Toole, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 31 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).

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 the worker should undergo a further medical examination because we identified errors in the MAC of Dr O'Toole, not only in relation to the issue raised on appeal with respect to ADL's but more particularly to determine the presence of radiculopathy in circumstances where there was insufficient radiological material, and the worker had undergone a second operation.

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.

Further medical examination

9. Dr John Ashwell of the Appeal Panel conducted an examination of the worker on 16 March 2020 and reported to the Appeal Panel.

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

11. In summary, the appellant submits that the AMS erred in his assessment of both the cervical and lumbar spines, and also with regard to ADL's. There is no challenge to the assessment with respect to the right shoulder.

12. In reply, the respondent submits that no errors were made.

FINDINGS AND REASONS

13. 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.

14. 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.

15. The appellant was referred to the AMS for assessment of whole person impairment (WPI) in respect of the Lumbar Spine, Cervical Spine, Right Upper Extremity (shoulder) resulting from an injury on 7 May 2015.

16. The appellant was working as an interstate truck driver. On that date, as he was twisting to back out of the truck he slipped and fell to the ground.

17. The AMS added:

> "He was taken to Fairfield Hospital. He underwent imaging in the form of a CT scan of the lumbar spine. This demonstrated L4/5 retrolisthesis and facet arthropathy, and L5/S1 central disc protrusion.
>
> He came under Dr Renata Abrasko. It was recommended that he undergo surgery in the form of microdiscectmy of L5/S1. This was performed on 16/05/2015.

The day prior to his operation, 15/06/2015 he was referred for MRI of his neck following a fall in the hospital and striking his head. This did not demonstrate any acute cervical spine injury, but did demonstrate degenerative changes of the uncovertebral joints / foraminae at C3/4 and C4/5 bilaterally. He also underwent imaging of the right shoulder in the form of plain film X-ray. This demonstrated only some early degeneration of the acromioclavicular (AC) joint.

He advised that following the lumbar procedure he had cessation of his radicular symptoms as well an improvement in his back pain, but not full resolution.

He stated that in 2017, he had to move to Queensland so that he and his wife could live with her parents.

He came under the care of Dr Michael Bryant for his ongoing cervical and lumbar symptoms. He was referred for nerve conduction studies to investigate his ongoing numbness in the right arm. Dr Bryant reported that this testing was normal and recommended that he undergo C8 nerve root injection. This was undertaken and followed up with physiotherapy.

He stated that approximately one year ago he had a further flare up of his lumbar pain. He was referred for an MRI of the lumbar spine, which was performed on 16/01/2019 and demonstrated 'Significant disc disease limited to L5/S1 and compression of the traversing right S1 nerve roots at this level, possible irritation of the left S1 nerve roots.' The report indicates that the L4/5 disc was of 'normal signal and appearance'.

I think that it is important to note at this point in time that the initial operation was performed at the L5/S1 level, not the L4/5 level, and that the findings of the MRI do not demonstrate a 'recurrence' of L4/5 disc herniation. It is also important to note that in his report to Dr Chai in March 2017, Dr Bryant was of the opinion that the symptoms were due to the right S1 nerve and correctly identified that Mr Radu had undergone surgery to the L5/S1 level with Dr Abraszko.

Regardless, Mr Bryant underwent a further procedure in the form of L4/5 discectomy in April 2019."

18. The AMS then noted present treatment and symptoms.

19. He then said:

"With respect to his activities of daily living Mr Radu reported the following:

Self-Care: Unable to perform some activities of self- care without assistance, including bathing / showering, putting on underwear and putting on pants. His partner assists him with this. He stated that he is prevented from performing these tasks as a consequence of his pain, from both his neck and his back. It appears that this is largely motivational, as opposed to an disability secondary to his condition.

Household duties: Unable to perform some activities of household duties without assistance, including performing housework in general. He stated that his partner is doing everything around the house.

Hobbies: Unable to perform some outdoor duties or recreational activities, including hobbies of tennis and fishing. Of note: he has been able to return to gardening, which is a passion of his."

20. The AMS then reported his findings on physical examination before concluding as follows:

> “Cervical Spine musculoligamentous strain. The Impairment from the applicable DRE and relevant effects on ADLs results in 5% Whole Person Impairment.
>
> Aggravation of degenerative Lumbar spine, resulting in L5/S1 disc protrusion. The Impairment from the applicable DRE and relevant effects on ADLs results in 12% Whole Person Impairment.
>
> Right Shoulder musculoligamentous strain = 3% Whole Person Impairment.”

21. The total WPI was 19%.

22. The AMS concluded by commenting on the other medical reports.

23. The appellant submits that the AMS erred with respect to his assessment of the cervical spine because he “did not consider whether or not there should be an additional allowance… arising from the impact of the injury to the neck on the Appellant's ADLs.”

24. This submission has no foundation.

25. Part 4.36 of the Guidelines state that “For a single injury, where there has been more than one spinal region injured, the effect of the injury on ADL is assessed only once.”

26. In this matter, there is only one date of injury. An allowance for ADLs has been made in relation to the lumbar spine. Accordingly, the AMS correctly made no further allowance in respect of the cervical spine, such that we see no error as regards his assessment of the cervical spine.

27. Turning now to the issue in respect of the lumbar spine.

28. The appellant’s principal submission was that because Mr Radu underwent a second microdiscectomy, “that immediately entitles him to an additional 2% whole person impairment.”

29. The appellant added

> “The AMS, however, did not correctly consider whether or not radiculopathy was present. The AMS appears to describe this as ‘altered sensation loss’. He says however, that there were Inconsistencies in the examination findings that prevent the changes from meeting the criteria for ongoing radiculopathy…The AMS has not set out whether he could or could not determine a positive nerve root tension sign…Additionally, he has not explained whether or not there is muscle weakness that is anatomically localised to an appropriate spinal nerve root distribution…
>
> The second surgery to the lumbar spine affords at least 2% whole person impairment and the presence of radiculopathy would afford at least a 3% whole person impairment.”

30. The respondent submitted:

> “In relation to there being an allowance made for the second operation, we do note that the further surgery performed in April 2019 was at L4/5, rather than L5/S1. That is, it was at a different level and was a different procedure. This was noted on page 8 of the Medical Assessment Certificate. Further, part 4.37 of the Guidelines states that the additional ratings under table 4.2 are only combined with the DRE ratings where the

operations were in relation to an intervertebral disc prolapse, spinal canal stenosis or spinal fusion. In the Respondent's submission, the surgery does not fall within the ambit of part 4.37 of the Guidelines and it was therefore appropriate for the Approved Medical Specialist not to make any allowance in this regard."

31. At our preliminary assessment, we had some concerns as to whether the AMS had correctly considered the nature and extent of the two operations on the lumbar spine, and whether any radiculopathy was present.

32. For these reasons we considered that a re-examination was necessary.

33. Dr Ashwell of the Panel re-examined Mr Radu on 16 March 2020 and reported to the Panel as follows:

"Mr Danutz Radu attended the consultation by himself and without an interpreter but he had a good command of the English language and no difficulties in communication were evident.

He was born in Romania and came to Australia in 1986. He worked as a truck driver for twenty three years but has not worked since the accident.

Unfortunately, he did not bring any MRI films or reports with him. A copy of the operation report by Dr M Bryant dated 2/4/2019 was available and indicated that the second operation on his lumbar spine was also performed at the L4/5 level. This is verified by the finding of dense scar tissue over the nerve at L4/5, which would be as a result of previous surgery at that level.

History Relating to The Injury: I confirmed with him the previous history of the incident as recorded by the AMS. He was getting out of his truck at the time and slipped, falling into a grass ditch, landing on his bottom and right side. The following day he woke with pain in his low back and entire right side. There was no further change in his condition or treatment received since that date of consultation. He has not attended physiotherapy for the last two years. He did not attend a pain clinic. He stated his level of pain in his back and right leg remained the same after the second operation. His right leg was numb on the outer calf and outer foot after the first operation and the left on the outer calf after the second operation.

Present Symptoms: He has constant neck pain with reduced range of movement. He is no longer able to drive a car. He has intermittent paraesthesia down his right arm to the fourth and fifth fingers.

He has constant low back pain with intermittent pain down his right leg as an electric shock feeling to his foot. This makes his leg give way at times so he frequently carries a stick in his right hand. He has paraesthesia on the outer right calf and foot and the outer left calf.

He wakes four to five times a night due to the pain in his neck or back. He can stand for about 15 to 20 minutes, walk for 30 minutes and sit for 30 minutes maximum.

Present Treatment: He takes Panadeine forte as required. He takes regular Targin twice daily, lyrica twice daily and Naprosyn SR in the morning. He is also on Nexium and Cymbalta. He is not attending for any exercises or therapy.

Social Activities: He lives in a residential house with his partner and son. He is able to manage his own self- care but only light housework. He can hang out clothes but not vacuum or mop. His son now mows the lawn since the accident. He can manage to look after his vegetable garden with a raised garden bed of approximately 6 by 1.5 metres. He walks his dog daily for about 30 minutes. He does not do any other physical activity. He has not been able to return to fishing since the accident. He mostly spends time on a computer, reads or does short walks around his 1400 metre square yard.

Examination Findings: All movements were conducted in an active manner by Mr Radu and he was advised to notify me if there was any increased pain whereupon movement would be discontinued.

He was right hand dominant. His height was 181 cm and weight 102 Kg. His right forearm was 1 cm larger in circumference that the left side.

He was able to undress and dress and get up onto and down from the examination couch by himself. The examination revealed some minor inconsistencies but testing was repeated for accuracy.

He walked slowly complaining of low back pain and being unsure of his right leg. He declined to attempt balancing on either leg. He initially declined to squat but was later observed to bend down with his knees at 90 degrees. He sat on a foot stool for putting on his shoes.

On examining his neck, there was localised tenderness and a positive axial compression sign. There was asymmetrical loss of movement and guarding with reduced rotation and lateral flexion to the right and also extension. There was no neurological deficit in his upper limbs with normal power, reflexes and sensation.

On examining the lumbar spine, there was tenderness and a positive axial compression sign. There was loss of the lumbar lordosis. There was a slightly dark 7cm longitudinal scar posteriorly. There was equivalent slight limitation of lumbar spine flexion and extension but full lateral flexion to either side. Reflexes were present and equal both sides. There was reduced sensation on the outer right calf and outer foot only and the outer left calf and heel area but not the rest of the foot. This was a patchy mixture of L5 and S1 nerve root distribution and was inconsistent with a specific dermatome. Power testing had to be repeated several times in different leg positions for accuracy but was eventually noted to be equal and full on either side. There was equal thigh and calf circumference when measured at the same level indicating no muscle atrophy. There was equal leg length. Straight leg raising was 80 degrees on either side with no nerve root tension.

Opinion: There were insufficient findings on clinical examination to support radiculopathy according to 4.27 of the Guides, with no criteria satisfied.

The two lumbar spine operations were performed at the same L4/5 level according to the operation reports by Dr Abraszko 16/6/15 and Dr M Bryant 2/4/19.

Assessment: Cervical spine DRE 2, 5% WPI (ADL can only apply to one level of the spine, 4.36 Guides)
Lumbar spine DRE 3, 10% plus 2% for ADL restrictions.
Combined with 2% for second operation (Table 4.2 Guides) equals 14% WPI.”

34. There has clearly been some confusion in the various medical reports, particularly those of the IME's as to the precise location of the spinal surgery, and it is perhaps understandable that the AMS was similarly confused.

35. The operation report from Dr Abraszko dated 16 June 2015 confirms that she performed a "L4/5 microdiscectomy from right."

36. In a report dated 2 April 2019 Dr Bryant said:

> "This is a note on Mr Radu, who has been admitted to St Vincents Northside today for his discectomy. As you will recall. he has had an L4-LS discectomy performed previously by Dr Abraszko down in Sydney. After some initial improvement he has had recurrence of his symptoms and has been found on an MRI scan to have a recurrent disc herniation at L4.-L5 on the right-hand side and to a lesser degree on the left as well."

37. We agree with the appellant that an additional 2% WPI should have been assessed because of the second operation.

38. Having specifically considered the issue of radiculopathy, Dr Ashwell was satisfied that the criteria set out in the Guidelines were not satisfied such that no allowance for radiculopathy was warranted.

39. For these reasons, the Appeal Panel has determined that the MAC issued on 31 October 2019 should be revoked, and a new MAC should be issued. The new 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 APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

A Shaw

Andrew Shaw
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **2647/19**
Appellant: **Danutz Radu**
Respondent: **Precise Payroll Services Pty Ltd**

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 Robin O'Toole 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 the Guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA 5 Guides**	**% WPI**	**Proportion of permanent impairment due to pre-existing injury, abnormality or condition**	**Sub-total/s % WPI (after any deductions in column 6)**
1. Lumbar spine	7/5/15	Chapter 4 Pages 24-30	Table 15-3 (page 384)	14%	Nil	14%
2. Cervical Spine	7/5/15	Chapter 4 Pages 24-30	Table 15-5 (page 392)	5%	Nil	5%
3. Right shoulder	7/5/15	Chapter 2 Pages 10-12	Chapter 16 Figure 16-40, Figure 16-43, Figure 16-36 Pages 438 - 521	3%	Nil	3%
Total % WPI (the Combined Table values of all sub-totals)					**20%**	

Deborah Moore
Arbitrator

Dr David Crocker
Approved Medical Specialist

Dr John Ashwell
Approved Medical Specialist

2 April 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*.

A Shaw

Andrew Shaw
Dispute Services Officer
As delegate of the Registrar