WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-6395/19**
Appellant:	**Toplica Mihajlovic**
Respondent:	**Cage Guard Security Guard Services Pty Ltd**
Date of Decision:	**5 January 2021**
Citation No:	**[2021] NSWWCCMA 3**

Appeal Panel:	
Arbitrator:	**Marshal Douglas**
Approved Medical Specialist:	**Dr James Bodel**
Approved Medical Specialist:	**Dr Richard Crane**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 14 April 2020 Toplica Mihajlovic (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Neil Berry, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 31 March 2020.

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 WorkCover Medical Assessment Guidelines set out the practice and procedure in relation to the medical appeal process under s 328 of 1998 Act. An Appeal Panel determines its own procedures in accordance with the WorkCover Medical 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. The appellant while working for Cage Guard Security Guard Services Pty Ltd (the respondent) on 9 March 2016 fell forward on to his right knee whilst ascending a staircase, causing him to suffer injury to his right knee.

7. On 23 November 2017, the appellant was walking from his shower to the toilet when his right knee gave way, causing him to fall on the floor and injure his right shoulder and neck.

8. On 19 August 2019, the appellant's solicitors wrote to the respondent's insurer enclosing with their letter "a draft Application to Resolve a Dispute". The appellant's solicitors advised that this was to serve "as notice of claim" from the appellant. It would seem that the draft Application to Resolve a Dispute had annexures attached to it comprising in excess of 1,000 pages.

9. As the Appeal Panel understands it, the appellant's solicitors, by their letter notified the respondent's insurer that the appellant was claiming compensation for permanent impairment that the appellant claimed had resulted from his injury on 9 March 2016, including permanent impairment from the injuries he subsequently suffered on 23 November 2017 when his right knee gave way. Following the insurer receiving that letter, it posted the appellant on 18 November 2019 a notice under s 78 of the 1998 Act advising the appellant that it disputed having any liability to pay him the compensation he claimed.

10. The appellant then registered on 5 December 2019 an Application to Resolve a Dispute (ARD) with the Commission in which he sought a determination by the Commission of the claim for compensation he had made for permanent impairment resulting from his injury. He particularised in the ARD that the degree of his permanent impairment from his injury was of the order of 21% whole person impairment (WPI), comprising 3% WPI relating to the right lower extremity (right knee), 6% WPI relating to the cervical spine, 7% WPI relating to the right upper extremity (right shoulder), 3% WPI relating to the digestive system (upper gastrointestinal tract) and 3% WPI relating to the digestive system (lower gastrointestinal tract).

11. The Appeal Panel observes that in the notice the insurer provided the appellant on 18 November 2019, it disputed liability to pay the appellant compensation on the basis that the degree of the appellant's permanent impairment resulting from his injury did not exceed 10% WPI, which consequently meant that the appellant was not entitled under s 66 of the Workers Compensation Act 1987 to compensation for permanent impairment from his injury.

12. The appellant's disputed claim for compensation was referred to arbitrator Mr John Harris, who on 20 February 2020, ordered, with the consent of the parties, that there be an award for the respondent with respect to the appellant's claim for permanent impairment of the lower digestive tract. Arbitrator Harris also remitted the appellant's claim to the Registrar so that it could be referred to the AMS to assess the degree of the appellant's permanent impairment from his injury with respect to the following body parts:

> "Right lower extremity (knee)
>
> Cervical spine – consequential
>
> Right upper extremity – (shoulder) consequential
>
> Upper digestive tract – consequential"

13. Arbitrator Harris also recorded in the Certificate of Determination he issued on 20 February 2020 that the parties had agreed that the appellant's fall on 23 November 2017 was consequential to the appellant's right knee injury on 9 March 2016.

14. On 25 February 2020 a referral was issued to the AMS to assess the degree of the appellant's permanent impairment resulting from his injury. As mentioned earlier, the AMS issued the MAC on 31 March 2020 in response to the referral.

PRELIMINARY REVIEW

15. 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.

16. Based on its preliminary review and for reasons provided below, the Appeal Panel determined that the MAC contained a demonstrable error. This meant that the Appeal Panel would have to assess the medical disputes that were referred for assessment.[1] The Appeal Panel considered that in order for it to be able to do that, it would need to examine the appellant. The Appeal Panel appointed AMS Dr James Bodel to do that. His report to the Appeal Panel on his examination of the appellant is set out below under findings and reasons.

EVIDENCE

17. 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

18. The matters the appellant raises in his appeal against the MAC involve the AMS's assessment of his impairment relating to his cervical spine and upper digestive tract. The AMS recorded the following findings in the MAC from his examination of the appellant's cervical spine:

> "The claimant demonstrated half the normal range of flexion, extension, rotation and lateral flexion to the left and right. There was no muscle spasm and no muscle guarding and no alteration of spinal contour and no evidence of any dysmetria."

19. The AMS recorded the following findings from his examination of the appellant's abdomen:

> "With the claimant supine, the abdomen was slight protuberant. There was diffused tenderness to palpation. There was no guarding, rigidity or rebound and no palpable masses and rectal examination was not carried out."

20. The appellant reported to the AMS that he suffers stiffness and pain in his neck aggravated by twisting and turning movements. With his stomach and bowel, he told the AMS he has alternating constipation and diarrhoea associated with bowel sounds and the passage of wind. He told the AMS that he also experiences a degree of epigastric discomfort.

21. The appellant informed the AMS that he takes Duloxetine, Lipitor, Maxigesic and Pantoprazole.

22. The AMS noted that the appellant's daughter helps the appellant with chores around the house.

23. The AMS noted that a gastroscopy Dr Koo did on 30 April 2018 was reported to reveal a normal oesophagus, no hiatus hernia or reflux oesophagitis, mild erythematous gastritis in the antrum, and a normal duodenum. The AMS noted that histology done on 1 May 2018 of biopsies taken during the gastroscopy revealed the presence of active chronic gastritis with helicobacter pylori. The AMS noted that Dr Koo subsequently performed a test of the appellant's breath which revealed eradication of the appellant's helicobacter pylori.

24. The AMS provided at Part 7 of the MAC a summary of the appellant's injuries and his diagnosis of them. The AMS said that he "would therefore consider that he has soft tissue injury to the neck" and that there was "evidence of helicobacter gastritis".

[1] See *Drosd v Workers Compensation Nominal Insurer* [2016] NSWSC 1053 at [56]; *Roads and Maritime Services v Rodger Wilson* [2016] NSWSC 1499 at [26]; *Hearne v Spamil Discretionary Trust* [2018] NSWSC1631 at [40].

25. Based on his findings from his examination of the appellant's cervical spine, the AMS correlated the appellant's signs with respect to his cervical spine with DRE Category 1, and accordingly assessed the appellant to have 0% WPI of his cervical spine.

26. The AMS assessed the appellant's permanent impairment with respect to the appellant's upper digestive tract to be 9% WPI, providing the following explanation for that assessment:

> "The first thing to be ascertained is the presence of absence of nutritional impairment. This is done by comparing the claimant's weight to his desirable weight using Table 6-1 on Page 120 of AMA5. The claimant's height is 181 cm and he should therefore have a desirable weight range of 66 - 83 kilograms and therefore at 96 kilograms he is well above his desirable weight range indicating that there is no nutritional impairment.
>
> The upper digestive tract is assessed according to Table 6-3 on Page 121 as modified by the NSW Workers Compensation Guides to the Evaluation of Permanent Impairment, 4th Edition and referring to Paragraph 16.9 on Page 78 is indicated that Table 6-3 is to be modified to read there needs to be 'symptoms and signs' of digestive tract disease. It is further indicated that while anti-inflammatory agents and analgesics can cause symptoms, in the absence of clinical signs or other objective evidence a 0% Whole Person Impairment should be assessed. In this man's case, Dr Koo's gastroscopy confirms that the claimant does have mild gastritis and the histology confirmed the presence of Helicobacter pylori and I would therefore be of the opinion that this patient has no rateable impairment in the upper digestive tract."

27. The AMS noted that Dr Anthony Greenberg, who is a general and gastrointestinal surgeon who provided a report dated 19 June 2019 to the appellant's solicitors to support the appellant's claim for compensation, advised that he had assessed the appellant had 3% WPI for the upper and lower digestive tract. The AMS said that he believed that the appellant's upper gastrointestinal tract symptoms were caused by helicobacter pylori and not by his medications. He said that Dr Koo's report had confirmed the findings of helicobacter gastritis. The AMS, given the context in which he expressed that belief, was indicating that he disagreed with Dr Greenberg's assessment.

28. The Appeal Panel observes that the AMS also assessed that the appellant's permanent impairment with respect to his right lower extremity was 4% WPI and that his permanent impairment with respect to his right upper extremity was 8% WPI.

29. The AMS said at Part 11A of the MAC that in his opinion the appellant did not suffer from any relevant previous injuries, pre-existing conditions or abnormalities. Accordingly, s 323(1) of the 1998 Act was not engaged.

30. Ultimately, the AMS's assessment of the appellant's degree of permanent impairment from his injury was that it was 12% WPI.

SUBMISSIONS

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

32. In summary, the appellant submitted that the AMS did not carry out any assessment to establish whether he had any neurological deficit relating to his cervical spine and did not consider whether radiculopathy of his cervical spine was present or not. The appellant noted that the clinical indication for the referral for his MRI included "pins and needles from the elbow down to the left index finger and thumb". The appellant submitted that those symptoms were consistent with the potential C7 nerve root compression. The appellant submitted that the AMS did not turn his mind to whether either radiculopathy or non-verifiable radicular complaints were present.

33. With respect to the AMS's assessment of the appellant's upper digestive tract, the appellant submitted that the AMS failed to expose his reasoning why he had assessed the appellant's permanent impairment to be 0% WPI. The appellant submitted it was unclear whether the AMS was attributing the appellant's symptoms entirely to helicobacter pylori.

34. In reply, the respondent submitted that it was open for the AMS to conclude based on the history he obtained and his findings on examination that there was nether neurological deficit, non-verifiable radicular complaints nor radiculopathy. The respondent submitted that on page 2 of the MAC there was evidence that the AMS had turned his mind to those matters because the AMS noted that the appellant had no pain down the left arm and no history of pins and needles in the right arm. The respondent submitted that the MRI was before the AMS but the AMS did not need to list every piece of evidence upon which he relied in reaching his conclusion. The respondent submitted that "it is appropriate to conclude that he considered that evidence in performing his assessment". The respondent submitted that based on the history the AMS obtained and his findings from examination there was no significant clinical findings in respect to the cervical spine and the AMS was not required to provide specific comments in the MAC on each of the relevant criteria for assessing DRE Category 1. The fact that the AMS did not comment on some of the criteria relating to the presence or otherwise of radiculopathy did not indicate that he did not consider all of those criteria. The respondent submits that the AMS's assessment of the appellant's impairment with respect to his cervical spine was a matter for the AMS's expertise.

35. With respect to the AMS's assessment of the appellant's impairment of the upper digestive tract, the respondent submitted that the AMS correctly assessed that there was no rateable impairment because the symptoms of which the appellant complained were associated with the impact of analgesics on the lower digestive tract and not the upper digestive tract. The respondent submitted that consistent with Table 6-3 of AMA 5 as modified by [16.9] of the Guidelines that in the absence of clinical signs or other objective evidence, 0% WPI should be assessed where symptoms arise from anti-inflammatory agents and analgesics. The respondent submitted that the AMS concluded that the appellant's ongoing symptoms of constipation and diarrhoea related to the lower digestive tract and the finding of gastritis was due to the presence of helicobacter pylori rather than being related to medications being taken by the claimant.

FINDINGS AND REASONS

36. 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.

37. In *Campbelltown City Council v Vegan* [2006] NSWCA 284 the Court of Appeal held that the Appeal Panel is obliged to give reasons.

38. The criteria to establish whether a worker has radiculopathy are in [4.27]-[4.29] of the Guidelines. They are:

> "4.27 **Radiculopathy** is the impairment caused by malfunction of a spinal nerve root or nerve roots. In general, in order to conclude that radiculopathy is present, two or more of the following criteria should be found, one of which must be major (major criteria in bold):
>
> - **Loss or asymmetry of reflexes**
> - **Muscle weakness that is anatomically localised to an appropriate spinal nerve root distribution**
> - **Reproducible impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution**
> - Positive nerve root tension (Box 15-1, p 382, AMA5)
> - Muscle wasting – atrophy (Box 15-1, p 382, AMA5)

- Findings on an imaging study consistent with the clinical signs (p 382, AMA5)

4.28 Radicular complaints of pain or sensory features that follow anatomical pathways but cannot be verified by neurological findings (somatic pain, non-verifiable radicular pain), do not alone constitute radiculopathy.

4.29 Global weakness of a limb related to pain or inhibition or other factors does not constitute weakness due to spinal nerve malfunction."
(Bold as per original)

39. In order to ascertain whether or not the appellant had radiculopathy, the AMS was required to establish whether or not two or more of the criteria specified in [4.27] of the Guidelines existed and if so, whether at least one of those was a major criterion. The AMS's examination of the appellant's cervical spine therefore had to be done with a view to ascertaining whether or not these criteria were met. It was crucial for the AMS do so.

40. The findings the AMS recorded in the MAC relating to his examination of the appellant's cervical spine did not include what if anything he found with respect to numerous criteria listed in [4.27] of the Guidelines. Specifically, the AMS did not record in the MAC whether or not the appellant exhibited the following signs:

- loss or asymmetry of reflexes;
- muscle weakness that is anatomically localised to an appropriate spinal nerve root distribution;
- reproducible impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution; and
- positive nerve root tension.

41. Further, the AMS did not comment at all on the findings that were reported from the MRI scan of the appellant's cervical spine done on 15 November 2017.

42. The AMS's omission to record any findings with respect to the criteria listed at [40] above is consistent with the AMS having overlooked these critical features during his examination of the appellant.[2] Because of that, the Appeal Panel considers the MAC contains a demonstrable error and consequently must be revoked.

43. As mentioned earlier, because the MAC is revoked, the Appeal Panel must reassess the dispute referred for assessment, and to that end the Appeal Panel appointed Dr James Bodel to conduct an examination of the appellant.[3]

44. Dr Bodel did so on 8 December 2020, and subsequently provided the Appeal Panel with the following report:

"REPORT OF THE EXAMINATION BY APPROVED MEDICAL SPECIALIST MEMBER OF THE APPEAL PANEL

Matter No: **M1-6395/19**
Appellant: **Mr Toplica Mihajlovic**
Respondent: **Cage Guard Security Guard Services Pty Ltd**

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[2] See *SZCBT v Minister for Immigration & Multicultural Affairs* [2017] FCA9 at [26] and *Peachey v Bildon Pty Ltd (Quality Siesta Resort Ltd & Quality Hotel)* [2020] NSWSC781 at [50].
[3] See *Drosd's* case, *Wilson's* case.

Examination Conducted By: **Dr James G Bodel**
Date of Examination: **08 December 2020**

1. The workers medical history, where it differs from previous records

Mr Mihajlovic was assessed clinically by Dr Neil Berry, by way of a Medical Assessment Certificate for the Workers Compensation Commission. The examination was done on 17 March 2020 and the MAC was issued on 31 March 2020.

This gentleman indicates that he was employed as a Security Guard and Supervisor with *Cage Guard Security Guard Services Pty Ltd*. He commenced work with that company on a building site at Barangaroo. He came on site when the building was just rising up out of the ground. His injury occurred on 09 March 2016.

Review of the history today indicates that this is fairly accurately recorded in the previous Medical Assessment Certificate and I have nothing further to add in regards to the mechanism of the injury.

Mr Mihajlovic indicates that the matter was reported to the first aid manager at the end of his shift.

He consulted his local doctor complaining of pain involving the cervical spine, right shoulder, right knee and upper gastrointestinal tract. I confirm that he had an arthroscopy of the right knee done by Dr Dave which was of some benefit. He then had post-operative physiotherapy. He has however been told that he will eventually require a total knee replacement. There is no timeline indicated as to when this will be required or not.

He had various investigations of the neck and right shoulder but has had no specific treatment for the shoulder.

2. Additional history since the original Medical Assessment Certificate was performed

Due to the Covid-19 pandemic, it is now nine months since this gentleman was assessed by Dr Berry on 17 March 2020. Mr Mihajlovic indicates that he still has significant pain in each of the injured areas. He is very disappointed that it is taking so long for the issues to be resolved. His complaints are mainly in regard to the right shoulder, neck and the right knee.

3. Findings on clinical examination

I have assessed this gentleman in accordance with the WorkCover Guidelines.

He rises from the chair with difficulty and walks with a moderate right sided limp.

He complains of tenderness in the trapezius muscle at the base of the neck on the right-hand side. He has a reduced range of neck flexion, extension and rotation in all directions. This is most restricted on rotation to the left. There is definite asymmetry of neck movement with a restricted range of rotation and lateral tilting to the left. This is confirmed on repeated observation of these movements done actively by the patient.

As an observation of this clinical examination, I note that the appellant has taken issue with the fact that the Medical Assessment Certificate does not record '*the actual range of motion in relation to what flexion, extension, rotation and lateral flexion were in relation to the lumbar spine*' but does accept that Dr Berry recorded a loss of '*half*

normal range of flexion, extension, rotation and lateral flexion to the left and right' in regards to the cervical spine.

Today, he has some discomfort throughout the range of movement in the region of the right shoulder. He has localized tenderness over the rotator cuff on the right-hand side but not the left. There is a restricted range of shoulder movement on the right. The range of movement in each shoulder is recorded in the Table which follows:

Shoulder Movements	**Active ROM Measured RIGHT**	**Active ROM Measured LEFT**
Flexion	120°	180°
Extension	30°	50°
Adduction	10°	50°
Abduction	100°	180°
Internal Rotation	50°	90°
External Rotation	50°	90°

There is impingement in the right shoulder but no instability. There is no restriction of elbow, wrist or hand movement. I can detect no clinical sign of reflex abnormality or objective sign of sensory impairment in the upper limbs. There is no sensory loss in a dermatomal distribution. There is no measurable wasting in either arm or forearm. The dominant right side is a few millimetres greater in circumference than his left.

He has a good range of lateral bending and rotation of the thoracic spine. There is no impairment of straight leg raising.

There is tenderness in the region of the right knee over the anteromedial aspect. He has a restricted range of knee movement on the right-hand side. The range of movement in each knee is recorded in the Table which follows:

Knee Movements	**Active ROM Measured RIGHT**	**Active ROM Measured LEFT**
Flexion	120°	130°
Extension	-5°	0°

The ligaments are stable in both knees. There is tenderness over the medial joint line in the region of the right knee but no instability.

There is no restriction of ankle or subtalar movement. There is no clinical sign of radiculopathy in the lower limbs.

4. Results of any additional investigations since the original Medical Assessment Certificate

Nil.

5. Comment

This gentleman does have asymmetry of neck movement on clinical testing here today, and a restricted range of right shoulder movement. He also has a restricted range of right knee movement.

As a result of today's clinical findings, he has a DRE Cervical Category II level of assessable impairment in accordance with the description in Table 15-5 on Page 392 of AMA5. He has asymmetry of movement and guarding but no clinical sign of radiculopathy. The base rating for this category is a 5% Whole Person Impairment.

His Activities of Daily Living have been moderately compromised in accordance with Item 4.34 and Item 4.35 on Page 28 of the Fourth Edition of the WorkCover Guidelines, giving a 2% loading and a 7% Whole Person Impairment overall.

He has a rateable restriction of right shoulder movement. This is assessed using Figure 16-40 on Page 476, Figure 16-43 on Page 477 and Figure 16-46 on Page 479. The degree of recorded restriction of movement constitutes a 13% Upper Extremity Impairment which converts to an 8% Whole Person Impairment using Table 16-3 on Page 439.

In the right lower extremity, there is the restricted range of knee extension. This attracts a 4% Whole Person Impairment in accordance with Table 17-10 on Page 537.

There is no other rateable pathology.

The final level of Whole Person Impairment is determined by combining the 8% for the right upper extremity, 7% for the cervical spine and 4% for the right lower extremity. Using the Combined Values Chart on Page 604 of AMA5 this gives a total of a 17% Whole Person Impairment in this case.

There is no indication clinically of any pre-existing abnormality or condition and no basis for a deduction of pre-existing impairment on the basis of the medical evidence provided today.

Signed:

Date: 15 December 2020"
(Bold as per original)

45. The Appeal Panel considers that Dr Bodel's examination of the appellant was thorough and the findings he made from his examination are sound. The Appeal Panel adopts those findings. The Appeal Panel observes from Dr Bodel's examination of the appellant's cervical spine that he found no loss or asymmetry of reflexes, no muscle weakness, no reproducible impairment of sensation, no positive nerve root tension and no muscle wasting. Accordingly, the appellant does not have radiculopathy. Further, the appellant does not have radicular complaints, pain or sensory features following an anatomical pathway.

46. The Appeal Panel observes that Dr Bodel's ratings of the appellant's permanent impairment, based on the findings he made from his information of the appellant, are correct. Given that the Appeal Panel has adopted Dr Bodel's findings from his examination, the Appeal Panel consequently rates the appellant's permanent impairment with respect to the appellant's cervical spine, right lower extremity and right upper extremity as 7% WPI, 4% WPI and 8% WPI respectively.

47. With respect to the assessment of the appellant's permanent impairment regarding his upper digestive tract, the Appeal Panel adopts the findings of the AMS from his examination of the appellant. The Appeal Panel does so because it considers, based on what the AMS recorded in the MAC, that the AMS's examination of the appellant's upper digestive tract was thorough

and, consequently, his findings from his examination are sound. The Appeal Panel notes that the AMS found no signs of disease from his examination of the appellant's upper digestive tract. The Appeal Panel also notes that the gastroscopy Dr Koo did in 2018 revealed mild erythematous gastritis in the antrum. Subsequent histology revealed the presence of active chronic gastritis with helicobacter pylori but a subsequent breath test by Dr Koo revealed the helicobacter pylori had been eradicated. The Appeal Panel concludes that the gastritis was due to helicobacter pylori infection that has since resolved. In other words it is unrelated entirely to the appellant's injury and specifically his ingestion of analgesics as treatment for his injury.

48. Given the appellant has no signs of upper digestive tract disease from his injury his impairment from his upper digestive tract must be assessed as 0% WPI.

49. Accordingly, the Appeal Panel assesses the appellant's WPI resulting from his injury to be 17% WPI.

50. For these reasons, the Appeal Panel has determined that the MAC issued on 31 March 2020 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.

T Ng

Tina Ng
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **6395/19**
Applicant: **Toplica Mihajlovic**
Respondent: **Cage Guard Security Guard 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 Neil Berry 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 WorkCover Guides**	**Chapter, page, paragraph, figure and table numbers in AMA5 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. Right lower extremity	9/3/2016	Chapt 3	Chapt 17 P 537 Table 17-10	4%	-	4%
2.Cervical spine	9/3/2016	Chapt 4 [4.27]	Chapt 15 Table 15-5	7%	-	7%
3.Right upper extremity	9/3/2016	Chapt 2	Chapt 16	8%	-	8%
4.Upper digestive tract	9/3/2016	Chapt 16 [16.9]	Chapt 6	0%		0%
Total % WPI (the Combined Table values of all sub-totals)					**17%**	

Marshal Douglas
Arbitrator

Dr James Bodel
Approved Medical Specialist

Dr Richard Crane
Approved Medical Specialist

5 January 2021

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

T Ng

Tina Ng
Dispute Services Officer
As delegate of the Registrar