WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-2519/19**
Appellant:	**Johne Delinicolis**
Respondent:	**Melissa Pty Ltd**
Date of Decision:	**26 February 2020**
Citation:	**[2020] NSWWCCMA 31**

Appeal Panel:	
Arbitrator:	**John Wynyard**
Approved Medical Specialist:	**Dr James Bodel**
Approved Medical Specialist:	**Dr Mark Burns**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 2 December 2019, Johne Delinicolis lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Drew Dixon, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 5 November 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 WorkCover Medical 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 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 Guides) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th ed (AMA 5). WPI is reference to whole person impairment.

RELEVANT FACTUAL BACKGROUND

6. On 19 September 2019, a Statement of Reasons was delivered by an Arbitrator, as a result of which the delegate of the Registrar referred this matter to the AMS on 24 September 2019. An assessment was sought of WPI caused by injury to the cervical spine, left upper extremity (shoulder), and the right lower extremity on a deemed date of 14 April 2016.

7. Mr Delinicolis was employed on a full-time basis as a general hand with the respondent commencing employment on 26 September 2013. He was involved in the making of Turkish delight which involved repetitive and arduous work.

8. He noticed the onset of pain in his left shoulder around Christmas 2015 and he was unable to work after 14 April 2016. He was diagnosed as suffering from a calcific tendonitis and subacrominal bursitis. He came to surgery on 5 July 2016 where he underwent an arthroscopy decompression to his shoulder with excision of the calcific material, and rotator cuff repair with biceps tenodesis.

9. The day following his surgery Mr Delinicolis suffered an episode of arterial blockage affecting his right lower limb. He was admitted to RGH at Concord where he was found to have an occluded right external iliac artery, and came to a bypass graft.

10. The AMS assessed nil% WPI in relation to the cervical spine, 5% WPI in relation to the left upper extremity (shoulder) and 4% WPI in relation to the right lower extremity giving a combined value of 9%.

PRELIMINARY REVIEW

11. 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.

12. Mr Delinicolis did not seek to be re-examined by a Panel AMS and no re-examination is necessary, as, for the reasons given below, maximum medical improvement has not been reached.

Fresh evidence

13. Mr Delinicolis sought leave from the Panel to admit additional evidence. This consisted of:

    (a) A referral from Mr Delinicolis' general practitioner Dr Susana Tjandra dated 4 January 2020 addressed to Dr Graham Sceats, Consultant Cardiologist;

    (b) A Discharge Referral from Concord Repatriation General Hospital dated 30 December 2019.

14. Section 328(3) of the 1998 Act provides:

> "(3) Evidence that is fresh evidence or evidence in addition to or in substitution for the evidence received in relation to the medical assessment appealed against may not be given on an appeal by a party to the appeal unless the evidence was not available to the party before that medical assessment and could not reasonably have been obtained by the party before that medical assessment."

15. Mr Delinicolis did not refer to the first document of 4 January 2020 but we note that Dr Sceats was Mr Delinicolis' treating surgeon, and we note that the referral spoke of a "recent right leg thrombosis". We assume that the right leg thrombosis was the subject of the discharge referral of 30 December 2019. We admit the referral on that basis.

16. The second document we find also to be admissible. It related that Mr Delinicolis was admitted to Concord Repatriation General Hospital on 23 December 2019 and discharged on 30 December 2019. He presented suffering from right leg claudication and the diagnosis given was:

> "Class I right leg ALI – thrombosis R) EIA bypass."

17. The body of the report showed that Mr Delinicolis had been admitted for review of right leg claudication, and that on 24 December 2019 he underwent a (R) femoral artery exposure, thrombectomy, patchplasty and DSA.

18. The document was in the name of Dr Stephen Townsend and provided for a follow-up with Dr Aitken, Mr Delinicolis' treating vascular surgeon. The conclusion given on the Discharge document was[1]:

> "There is occlusion of the right iliofemoral graft, with distal reconstitution, probably from the right inferior epigastric artery. There are also suspected bilateral renal infarcts, suspicious for an embolic cause."

EVIDENCE

Documentary evidence

19. 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

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

SUBMISSIONS

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

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.

24. Mr Delinicolis appealed against the assessment regarding the cervical spine and the right lower extremity.

Cervical spine

25. With regard to the cervical spine, the AMS diagnosed the aggravation on the left side of the neck of previously asymptomatic lower cervical spondylosis with residual stiffness. He noted that Mr Delinicolis had complained that he suffered from neck pain and stiffness which caused disturbed sleep. His findings on examination were[2]:

> "i. There was stiffness of his neck with forward flexion decreased by one third, with pain on neck extension which was decreased by one third, and lateral rotation decreased by one third bilaterally as was lateral flexion.

[1] Appeal papers page 20
[2] Appeal papers page 32

ii. There was tenderness of the right trapezius muscle, the right supraclavicular brachial plexus was non tender and the cervical foraminal compression test and brachial plexus stretch test were negative.
iii. There was no gross neurological deficit or gross wasting of either upper extremity."

26. The AMS explained his reasons at [10a]:

> "That for his cervical spine where he has post traumatic stiffness without dysmetria, shoulder brachalgia with trapezial muscle pain without spasm and no radicular complaint with residual cervical facet arthralgia and possible aggravation of pre-existing cervical spondylosis is DRE I, 0% whole person impairment."

27. The AMS referred to the opinion of Dr McKechnie, Neurosurgeon, which was relied on by Mr Delinicolis. He said[3]:

> "Dr Simon McKechnie in his letter dated June 23, 2017 felt there was a small C6/7 disc protrusion and moderate C5/6 disc protrusion causing mild central and bilateral foraminal stenosis. He recommended physiotherapy and cortisone injections and that decompression may be required in the future. The claimant did not however, have radiculopathy today, in the left upper extremity."

Submissions

28. Mr Delinicolis submitted that the AMS "did not give due consideration" to either the history of the injury or the radiological and medical evidence. We were referred particularly to the MRI scan of 12 May 2017.

29. Mr Delinicolis referred to the opinion of Dr McKechnie and submitted that the Arbitrator in delivering his Statement of Reasons found that the medical evidence and opinion in the case was "not inconsistent" with the finding from Dr McKechnie.

30. Mr Delinicolis conceded that the AMS acknowledged the opinion of Dr McKechnie, but submitted that notwithstanding, the AMS had dismissed that opinion as he found that there was no evidence of radiculopathy in the left upper extremity.

31. Mr Delinicolis argued that the AMS had made a demonstrable error in view of his examination findings regarding restriction of movement. Mr Delinicolis referred to the examination findings of restriction in forward flexion, neck flexion and bilateral restriction of one third for neck extension and lateral rotation.

32. The respondent submitted that the AMS had provided detailed reasons as to his opinion, including a discussion of the opinions of other medical practitioners. Reference was made to AMA 5 and the criteria therein set out for the assessment of cervical spine impairment.

Discussion

33. The criteria for assessing WPI to the cervical spine are contained in Table 15.6 of AMA 5[4].

34. A cervical Class 1 assessment carries with it no entitlement to a WPI other than 0%. The criteria, as pointed out by the respondent, is:

> "No significant clinical findings, no muscular guarding, no documentable neurological impairment, no significant loss of motion, segment and integrity, and no other indication of impairment related to injury or illness; no fractures.

[3] Appeal papers page 36
[4] At 392

35. To qualify for a cervical category II, which gives an entitlement of up to 8% WPI, the criteria are:

> "Clinical history and examination findings are compatible with a specific injury; findings relating to muscle guarding or spasm observed at the time of examination by a physician, asymmetric loss of range of motion or non-verifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity.
>
> Or
>
> "Clinically significant radiculopathy and an imaging study that demonstrated a herniated disc at the level found on the side that would be expected based on the radiculopathy, but has improved following non-operative treatment."

36. There was a third category which is not presently relevant.

37. There is no merit in the submissions of Mr Delinicolis regarding his range of cervical movement. Whilst there was a loss of range of motion on lateral rotation and lateral flexion, the loss of motion was symmetrical, that is to say the range of motion had decreased by one-third on each side, and accordingly was not assessable as a DRE II category injury.

38. Whilst Dr McKechnie found radiculopathy in June 2017, by the time of the examination by the AMS on 21 October 2019, such signs were no longer apparent. An AMS is bound to assess a claimant as he/she presents on the day of the assessment.[5]

39. The observations of an Arbitrator in a Statement of Reasons is relevant to the question of injury, but not to the assessment process.

40. We accordingly confirm the assessment regarding the cervical spine.

Right lower extremity

41. The AMS made a diagnosis of arterial thrombosis of the right external iliac artery with a background of atheromatous plaque, treated by stentage.[6] In assessing Mr Delinicolis' entitlement, the AMS said[7]:

> "That for the lower extremity where the claimant has intermittent claudication without persistent oedema, reasonably perfused with palpable dorsalis pedis pulses, but with loss of posterior tibial pulses is from Table 17-38 Page 554, Class 1, 9 % lower extremity impairment, which equates to 4% whole person impairment (less one tenth for pre-existing atheromatous plaque) still giving 4% whole person impairment."

Submissions

42. Mr Delinicolis submitted that the injury consisted of a complete occlusion of the right external iliac artery which required surgery. Mr Delinicolis kindly set out the relevant criteria applying to a Class II categorisation at Table 17-38 of AMA 5.

43. Mr Delinicolis relied upon the opinion of his medico-legal referee Dr Endrey-Walder who placed Mr Delinicolis into a Class II category. Dr Endrey-Walder found a total of 17% WPI in relation to the right lower extremity.[8]

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[5] Guides Chapter 1.6a
[6] Appeal papers page 33
[7] Appeal papers page 34
[8] Appeal papers page 110

44. Mr Delinicolis submitted that the AMS fell into error when he took a history of "intermittent claudication" but nonetheless placed Mr Delinicolis in a Class 1 category. It was submitted that Mr Delinicolis satisfied at least one of the tests for a Class 2 rating, as the terminology used in the Guidelines requires only one of the three categories to be satisfied.

45. Mr Delinicolis submitted that he should have been placed in Class 2 because he satisfied the test of "intermittent claudication on walking at least 100 yards at an average pace", which is one of the criteria for a Class 2 assessment.

46. The respondent submitted that Mr Delinicolis' submissions were too narrow as they were based upon a self-report that Mr Delinicolis had intermittent claudication on walking at least 100 yards. It was submitted that some caution should be expressed in relation to the worker's self-reporting. We were referred to evidence which indicated an ability to walk extensive distances without complaint.

47. In the alternative, it was submitted that if the Appeal Panel was satisfied that if intermittent claudication did exist that the appropriate entitlement would be at the bottom end of the scale provided between 10 – 39%.

48. The respondent also submitted that the extent of the deduction pursuant to s 323 of the 1998 Act should in any event be increased to not less than 50%, the AMS having found a deduction of 1/10th. This submission we understood to be based upon the existence of a 50% occlusion in the left iliac artery which was caused by a pre-existing disease itself related to the risk factors Mr Delinicolis had of smoking, blood pressure and high cholesterol level.

Discussion

49. With regard to the assessment of the right lower extremity the appropriate criteria are set out in Table 17-38 of AMA 5.[9] In fact the Table is repeated at Table 4.5 of AMA 5[10]. Both Tables are similar, but different Chapters of the Guides refer to the different Tables. Chapter 15 of the Guides, which relates to the cardio-vascular system, provides at Chapter 15.7 that AMA 5 Table 4.5 is to be applied. Chapter 3, which relates to the lower extremities, provides at 3.36 that Table 17-38 is to apply.

50. We propose to revoke the MAC in any event, as the additional evidence demonstrates that maximum medical improvement has not occurred, as will be seen. However the distinction between Table 17-38 and Table 4.5 is of sufficient moment that some comment is necessary.

51. A Class 1 assessment under both Table 17-38 and Table 4.5 gives the following criteria for an assessment between 0 – 9% lower extremity impairment:

> "Neither intermittent claudication nor pain at best
>
> Or
>
> only transient oedema
>
> And
>
> On physical examination not more than the following findings are present:
>
> Loss of pulses; minimal loss of subcutaneous tissues; calcification of arteries detected by radiographic examination; asymptomatic dilation of arteries or of veins, not requiring surgery and not resulting in the curtailing of activity".

[9] At 554
[10] At 76

52. However, a Class 2 assessment pursuant to Table 4.5 gives an entitlement of 10% to 39% lower extremity impairment. The criteria are:

> "intermittent claudication and severe usage of the lower extremity
>
> Or
>
> Persistent oedema of a moderate degree, controlled by elastic supports
>
> Or
>
> Vascular damage evidenced by a sign such as a healed, painless stump or an amputated digit showing evidence of persistent vascular disease, or a healed ulcer."

53. This to be contrasted with the criteria upon which the AMS has relied in Table 17-38. Class 2 there provides identical criteria or the last two alternative positions, but the first alternative requires:

> "intermittent claudication on walking at least 100 yards at an average pace."

54. It was this criterion that the respondent relied upon. The respondent sought to resist the challenge to the Class 1 assessment made by the AMS by referring to the report of Dr Sarah Aitken, Mr Delinicolis' treating vascular surgeon. In her report of 1 November 2016[11] Dr Aitken reported to Mr Delinicolis' GP, Dr Aravanis, by way of follow up to the external iliac bypass surgery. She said that despite having multiple aches and pains all over his body from the various procedures, she could not find anything directly related to the graft failure. She said:

> "Certainly he has no symptoms of claudication and is walking multiple kilometres every day"

55. In her following report of 6 June 2016, she allowed the question of the causal link between the thrombosis and the shoulder surgery was "a difficult question to answer" but she said from a temporal point of view there was a relationship. She discussed the situation where a person with fairly minimal atherosclerotic disease could suffer an iliac thrombosis when placed in a "beach chair position" which is similar to the position of a patient undergoing shoulder surgery.[12]

56. She noted that Mr Delinicolis was complaining of some residual paraesthesia in his foot, which she thought would be a permanent feature. She recorded that he also was complaining of intermittent buttock claudication which she thought should be further investigated.

57. On 20 June 2017, Dr Aitken saw Mr Delinicolis again and the CT angiogram at that time confirmed a moderate stenosis in the distal portion of his external iliac graft as well as the stenosis at the origin of the internal iliac artery. These were both likely to be reactive changes following the surgery. She said[13]:

> "Otherwise in terms of his existing arterial disease I think we can continue to just monitor it for now especially given that he is having very little symptoms that we can truly attribute to claudication."

[11] Appeal papers page 124
[12] Appeal papers page 125
[13] Appeal papers page 126

58. On 7 December 2017, Dr Aitken again reviewed Mr Delinicolis she noted that he remained much the same as he was on 20 June 2017.

59. On 18 July 2018, Dr Aitken supplied a medico-legal report to Mr Delinicolis' solicitors. She said:[14]

> "The additional vascular surgery has impacted upon Mr Delinicolis's capacity to recover from additional surgery. Long term, the presence of an iliofemoral bypass graft can be complicated by recurrent stenosis due to intimal hyperplasia, requiring repeat surgery/intervention. Functionally, at the time of last review on 07/12/2017, Mr Delinicolis was limited in walking distances to 1km. There are no restrictions placed upon his exercise capacity."

60. It can be seen from the reports of Dr Aitken that Mr Delinicolis was able to walk multiple kilometres every day in November 2016 but that by 18 July 2018 he was restricted to walking one kilometre. There is no reason to disbelieve the accuracy of the histories contained in Dr Aitken's reports, and we reject the respondent's attack on the credit of Mr Delinicolis. It is correct that he was able to walk extensive distances without complaint, but that was a matter of early history which was overtaken by his subsequent deterioration.

61. The Panel is unable to make any logical sense of the dichotomy between Table 4.5 and Table 17-38, but in any event the hospitalisation in December 2019 indicates that Mr Delinicolis' condition is not stable. We note that he is to see Dr Sceats and we are confident that further tests will need to be made to establish Mr Delinicolis' present condition. The Panel AMSs would observe that the condition of Mr Delinicolis' right leg is serious and should be properly investigated.

62. In view of the recent developments a determination cannot be made and, as both Tables provide for up to 5 classes of entitlement ranging from 0 – 100% impairment of the lower extremity, it is too early to see what Mr Delinicolis' final position will be.

63. Therefore, we revoke the MAC. We confirm the finding by the AMS as to the cervical spine but find that Mr Delinicolis has not reached maximum medical improvement regarding the claim for the right lower extremity.

64. We would note in passing that the respondent sought to challenge within its submissions the finding by the AMS of a 1/10th deduction in relation to the lower extremity, arguing that a higher deduction of 50% was apposite. Such submissions constitute an attempt to appeal and cannot of themselves be contemplated due to the procedure set down by s 327 of the 1998 Act, which requires the Registrar's approval before the matter can come before an Appeal Panel.

65. For these reasons, the Appeal Panel has determined that the MAC issued on 5 November 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*.

R Gray

Robert Gray
Dispute Services Officer
As delegate of the Registrar

[14] Appeal papers 129

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **2519/19**
Applicant: **Johne Delinicolis**
Respondent: **Melissa 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 Drew Dixon 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 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)**
Cervical spine	Deemed 14.4.2016	Chapter 4 page 24	Table 15-6 page 392	0	-	0
Left upper extremity (shoulder)	Deemed 14.4.16	Chapter 2.5 page 10	Pages 476-479	5	nil	5
Right lower extremity	Deemed 14.4.16	Chapter 3.37 Chapter 1.15	Table 17-38	Maximum medical improvement not reached	-	-
Total % WPI (the Combined Table values of all sub-totals)						**Not assessable**

John Wynyard
Arbitrator

Dr James Bodel
Approved Medical Specialist

Dr Mark Burns
Approved Medical Specialist

26 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*.

R Gray

Robert Gray
Dispute Services Officer
As delegate of the Registrar