WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-4067/19**
Appellant:	**Rodney Egan**
Respondent:	**RK and Co Pty Ltd**
Date of Decision:	**10 March 2020**
Citation:	**[2020] NSWWCCMA 44**

Appeal Panel:	
Arbitrator:	**Jane Peacock**
Approved Medical Specialist:	**Dr Drew Dixon**
Approved Medical Specialist:	**Dr Margaret Gibson**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 22 October 2019 Mr Rodney Egan (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Ian Meakin, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 24 September 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):

   - deterioration of the worker's condition that results in an increase in the degree of permanent impairment,

   - availability of additional relevant information (being additional information that was not available to, and that could not reasonably have been obtained by, the appellant before the medical assessment appealed against),

   - the assessment was made on the basis of incorrect criteria, and

   - 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 the Appeal Panel's preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination.

Fresh evidence

8. Section 328(3) of the 1998 Act provides that evidence that is fresh evidence or evidence in additional to or in substitution for the evidence received in relation to a medical assessment appealed against may not be given on an appeal by a party unless the evidence was not available to the party before the medical assessment and could not reasonably have been obtained by the party before that medical assessment.

9. The appellant seeks to admit the following evidence:

   (a) referral for MRI scan from Dr Hu dated 21 October 2019 (MRI referral).

10. The appellant submits that the evidence is relevant to the question of the appellant's alleged deterioration of his condition since the issue of the MAC.

11. The Appeal Panel determines that the following evidence should be received on the appeal:

   (a) MRI referral.

EVIDENCE

Documentary evidence

12. 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. In addition, the Appeal Panel has the fresh evidence in the form of the MRI referral admitted into evidence by the Panel as referred to above.

Medical Assessment Certificate

13. 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

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

FINDINGS AND REASONS

15. 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.

16. 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.

17. The matter was referred by the Registrar to the AMS as follows:

"The following matters have been referred for assessment (s 319 of the 1998 Act):

- **Date of injury:** 3 September 2017
- **Body parts/systems referred:** Cervical spine
Right upper extremity (shoulder)
- **Method of assessment:** Whole Person Impairment"

18. The AMS assessed as follows:

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 S323 for pre-existing injury, condition or abnormality** (expressed as a fraction)	**Sub-total/s % WPI** (after any deductions in column 6)
1. **Cervical Spine**	3.09.2017	Chapter 4 Page 26-33	Table 15.5 AMA 5, Item 4.34 to 4.36 of the current Guidelines	0%	n/a	0%
2. **Right Upper Extremity (shoulder)**	3.09.2017	Chapter 2 Pages 13-15	current Guidelines and figures 16.40 to 16.46 AMA 5, and Table 16.3 AMA 5	9%	n/a	9%
Total % WPI (the Combined Table values of all sub-totals)					**9%**	

19. In summary, the appellant relies on the MRI referral. This referral dated 21 October 2019 is from the appellant's General Practitioner (GP) Dr Hu referring the appellant for an MRI scan of his cervical spine. On the basis of this referral the appellant submitted that the Panel should find that there has been a deterioration in the appellant's condition and that deterioration will result in an increase in his degree of impairment. Accordingly, it was submitted that the MAC should be revoked and a re-examination be undertaken of the appellant. In the alternative it was submitted that the Panel cannot confirm the MAC, given the fresh evidence showing a deterioration in the appellant's condition, the appellant's condition is not stable.

20. In summary, the respondent submitted that the appeal is without merit and that there is no evidence that shows a deterioration in the appellant's condition. The respondent submitted that the MAC should be confirmed.

21. The role of the AMS is to conduct an independent assessment on the day of examination. The AMS is required to take a history, conduct a physical examination, review the special investigations, make a diagnosis and have due regard to other evidence and other medical opinion that is before the AMS. The AMS must bring his clinical expertise to bear and exercise his clinical judgement when making an assessment of impairment and make such assessment in accordance with the criteria in the Guides.

22. Here the AMS took a detailed history as follows:

> "Brief history of the incident/onset of symptoms and of subsequent related events, including treatment:
>
> Mr Egan is a 49 year old right-handed man, who left school at 16 and then took on an apprenticeship as a diesel mechanic. He changed to interior decorating and has remained in that industry for the past 10 years. Following the current work injury and his recovery, he was no longer able to perform his duties within the business and the business was wound up. Currently, Mr Egan is working 5 days a week on a wage basis as a site manager and supervisor.
>
> On 3 September 2017, he was standing on a three step ladder and when he came to step off it his foot became tangled up in the rungs and he fell to the floor landing on his right shoulder. He had severe pain over the pad of the right shoulder as well as some discomfort in the adjacent paracervical neck musculature.
>
> He saw his general practitioner and an MRI scan was organised on 10 September 2017. The scan demonstrated a large rotator cuff tear. He was referred to see Dr Michael Stening, orthopaedic surgeon, who he had seen some years before for an earlier surgery to the right shoulder. It is to be noted that in 2006 he sustained a trauma to his right shoulder resulting in a tear of the supraspinatus tendon which required open repair, which was performed at the Baulkham Hills Private Hospital at that time. Following rehabilitation Mr Egan states that he regained a full range of motion of his right shoulder with no clinical symptomatology.
>
> Dr Stening currently reviewed Mr Egan with a scan and arranged for surgery which was performed at the Hospital for Specialist Surgery on 27 September 2017. He underwent a rotator cuff repair with acromioplasty. The surgery was performed by reopening the original scar and utilising a direct lateral deltoid splitting incision with further excision of the subacromial bursa. The ruptured cuff edge was mobilised and repaired with bio-corkscrew anchors. He underwent a standard immobilisation with abduction pillow and followed Dr Stening's rehabilitation programme.
>
> On 7 February 2018, Dr Stening wrote to the local practitioner, Dr Hu, of Rouse Hill, stating that the right shoulder lacked only 10° of external rotation and 20° of internal rotation. The last visit occurred on 9 May 2018 with physiotherapy continuing and a plan to review him within 12 months which, according to Mr Egan, will occur over the next 1 to 2 months.

- Present treatment:
  Mr Egan is under no formal treatment at the present time other than attempting to continue to mobilise his right shoulder. He reports continuing discomfort and a significant restriction of active range of motion, particularly referencing flexion and abduction. There is also some continuing low grade intermittent posterior cervical neck pain low on the right side. Mr Egan also has difficulty sleeping on his right side.

- Present symptoms:
  At the time of today's assessment Mr Egan reports discomfort in his posterior cervical spine which fluctuates in intensity and can be intermittently not present. Mr Egan states that today there is no pain but he had pain a week ago. He reports, however, continuing discomfort over the pad of the right shoulder, experienced over the lateral aspect of the subacromial space. The pain is present all the time and fluctuates in intensity. The pain is particularly apparent when he attempts to lift his arm towards the horizontal.

- Details of any previous or subsequent accidents, injuries or condition:
  As stated there was a previous history in 2006 of rotator cuff tear on the right side with an open repair and subsequent rehabilitation but with regaining a full range of motion and no pain in the right shoulder. I found no historical documented evidence to doubt Mr Egan's given history.

- General health:
  Unfortunately, Mr Egan does not enjoy good health. In 2007 he was diagnosed with hypertension and a depressive illness. He also sustained a myocardial infarction and was hospitalised at Westmead undergoing cardiac stents. He was discharged with the use of Aspirin, Lipitor and a medication to control atrial fibrillation.

  Unfortunately, a further heart attack occurred recently and he was again hospitalised at Westmead Hospital, where he underwent a quadruple bypass 6 weeks ago with grafts being taken from his left volar forearm. He continues under significant medication and self-administered Clexane twice daily. He continues under the care of his attending cardiologist and has not returned to his work.

- Work history including previous work history if relevant:
  At the present time he is not working.

- Social activities/ADL:
  Mr Egan was born in Australia and is married and lives with his wife and 3 children aged 20, 16 and 15 in a home at Rouse Hill. Unfortunately, he smoked cigarettes, up to 15 a day, but ceased 8 weeks ago. He admits to a very minimal social alcohol intake only. He continues also under the care of his local practitioner, Dr Haibi Hu, of the Rouse Hill Health Care Centre. He attended a physiotherapist, Mr Paul Kuchin, of the P360 Performance Physiotherapy Group, after the current accident and subsequent surgery.

Mr Egan states that he can currently drive but relies mainly on his left arm to do so. He is limited in the physical activities he can do, both from the point of view of his right shoulder pathology and his recent cardiac status. In an earlier life he was involved in dirt bike racing, golf and fishing but has been unable to return to any of these activities. He currently is not able to carry out mowing of his lawn or performing gardening activities and requires help in these areas."

23. The panel notes that the AMS was aware the appellant was off work at the time of assessment in respect of his heart health.

24. The AMS conducted a thorough physical examination and recorded his findings as follows:

"Mr Egan is a man of stated age who states he stands 175 cm tall and weighs 79 kg. He states that he is right-handed. Mr Egan walks without a limp and uses no appliances.

On examination of the cervical spine, there is a full symmetrical range of painless movement in all planes including flexion and extension and lateral flexion and rotation to the right and left with no palpable evidence of paravertebral muscle spasm or guarding. As stated, he had some discomfort a week ago and the pain is experienced mainly on turning to the right.

On examination of the upper extremities, there is no sensory loss in the right or left upper extremities. All deep tendon reflexes are present and symmetrically equal in the upper extremities and there are no abnormalities of tone. His right power grip was symmetrical with his left which is to be expected, bearing in mind the recent right shoulder surgery.

One notes the healed mid-line scar associated with bypass surgery. He also showed me today his left volar forearm where there is a significant longitudinal scar consistent with vascular harvest relating to the cardiac surgery. He reports no symptoms, however, associated with the left upper extremity.

On examination of the right and left shoulder girdle, one notes a slight wasting of right shoulder girdle musculature, which is obvious on inspection. One notes the healed scar consistent with the twice entered shoulder area for surgical endeavour. The scar measures 7 cm in length and is 1 cm wide in the mid-section. The scar is unsightly and is atrophic and sunken in the middle. The scar, however, is not tethered to the deeper structures and is not pigmented. The scar is consistent with the two surgeries described.

Active range of motion of the right and left shoulder girdle when measured with the goniometer reveals the following painful range with respect to the right shoulder. There is no pain in the left shoulder.

Shoulder Movements	**Right**	**Left**
Flexion	80°	180°
Extension	40°	50°
Abduction	70°	170°
Adduction	40°	40°
Internal rotation	60°	80°
External rotation	60°	80°

Limitation of movement on the right side is caused by pain at the level demonstrated. Mr Egan states that the range of motion in his right shoulder is not improving with the passage of time nor is the lessening of discomfort."

25. The AMS reviewed the special investigations as follows:

> **"X-Ray and Ultrasound Right Shoulder** – 6 September 2017, Rouse Hill Medical Imaging, Dr M Chew – Plain x-rays demonstrate flattened appearance of the greater tuberosity. The acromioclavicular joint is intact. There is a hook-like bone spur of the acromial under-surface.
>
> > The ultrasound demonstrates a mildly flattened appearance of the greater tuberosity suggesting impacted fracture with subtle depression. Suspicion of a partial tear of the subscapularis tendon noted as well as a suspicion of a full thickness tear of the supraspinatus tendon and of the infraspinatus tendon.
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> **MRI Scan Right Shoulder** – 14 September 2017, Norwest Medical Imaging, Dr M Chew – massive rotator cuff tear with full thickness tears of the supraspinatus and infraspinatus tendon with high grade near full thickness tear of the subscapularis constituting up to 90% of the cuff thickness – medial subluxation of the biceps tendon with moderate biceps tenosynovitis and an infrasubstance longitudinal split tear of the biceps. Superior humeral head migration/subluxation secondary to massive rotator cuff tear. Evidence of subacromial/subdeltoid bursa.
>
> There have been no scans following the rotator cuff surgery."

26. The AMS summarised the injury and diagnosis as follows:

> "Mr Egan is a 49 year old right-handed man, who in 2006 sustained a tear of the supraspinatus tendon treated by open repair by Dr Michael Stening with a good clinical result being able to maintain a full painless range of motion and continue his work.
>
> As a result of the current work accident on the 3 September 2017, he sustained a soft tissue injury of his cervical spine with intermittent discomfort but no neurological impairment in the upper extremities. He sustained a significant blunt injury to his right shoulder resulting in radiological evidence currently of a massive tear of the rotator cuff with retraction and superior migration of the humeral head. The current pre-operative scan shows significant stump retraction of the supraspinatus tendon in a scan performed 10 days after the injury. The widespread nature of the tears within the rotator cuff in the pre-operative scan suggests some longstanding features of degeneration and tearing. However, there is historical acceptance that Mr Egan was pain free just prior to the current accident with a full range of motion.
>
> There has been a repair of the rotator cuff. There are no details within the operative report of the '*condition*' of the torn rotator cuff or the adequacy of repair and there have been no post-operative scans to assist. There is, however, a significant painful restriction of active range of motion."

27. The AMS commented on Mr Egan's consistency of presentation as follows:

> "Mr Egan was most helpful at the time of today's physical examination and history taking and I detected no embellishment."

28. The AMS explained his assessment of impairment as follows:

> "Assessment of Impairment is performed with reference to the American Medical Association Guides for the evaluation of permanent impairment, 5th Edition and the NSW Workers Compensation guidelines for the evaluation of permanent impairment, 4th Edition.
>
> Cervical Spine:
> At the time of today's assessment, with reference to Table 15.5 AMA 5, the applicant demonstrates at the time of today's assessment a DRE cervical spine Category I impairment – **0% Whole Person Impairment.**
>
> The definition of radiculopathy as set out in Item 4.27 of the current Guidelines is not met. There is no loss or asymmetry of reflexes or evidence of muscle atrophy, muscle weakness or reproducible sensory loss that can be anatomically localised to appropriate spinal nerve distribution. There is no asymmetrical muscle wasting and there is no assistance from imaging studies relating to the cervical spine. The definition of radiculopathy is not met.
>
> At the time of today's examination, however, Mr Egan does not complain of cervical neck pain with there being pain only a week ago. His current restrictions at work and at home relate to his right shoulder and not to his cervical neck, therefore, I am making no reference to Item 4.34 to 4.36 of the current Guidelines – activities of daily living. It is my opinion that in isolation the cervical neck and soft tissue injury would have no effect on activities of daily living.
>
> Right Shoulder:
> At the time of today's assessment there is a significant restriction of active range of motion of the right shoulder. Therefore, with reference to the current Guidelines and figures 16.40 to 16.46 AMA 5, the following upper extremity impairment is noted:

Shoulder Movements	**Right**	**Upper Extremity Impairment**
Flexion	80º	7%
Extension	40º	1%
Abduction	70º	5%
Adduction	40º	0%
Internal rotation	60º	2%
External rotation	60º	0%
TOTAL		15%

> Reference is made to Table 16.3 AMA 5, a 15% upper extremity impairment equates to a **9% Whole Person Impairment.**
>
> The above impairments are combined, using combination of AMA 5:
>
> 9 + 0 = 9% Whole Person Impairment
>
> I have elected to make no deductions relating to Section 323 for a pre-existing impairment of the cervical spine or right shoulder, on accepting the Applicant's history."

29. The AMS made comment on the other evidence before him as follows:

> "I read with interest the report of Dr Zbigniew Poplawski, orthopaedic surgeon, 10 October 2018. This report notes wasting of the right shoulder girdle consistent with my findings. There is also a significant restriction of active range of motion with no neurological compromise of the right or left upper extremities. Dr Poplawski has assessed impairment of the cervical neck as 8% whole person impairment. He makes no reference to which DRE cervical category he utilises. He has also added a 3% whole person impairment for impact on activities of daily living and I have explained my reasons why I did not do likewise. He assessed 13% whole person impairment relating to loss of range of motion of the right shoulder. He did, however, subtract one-tenth relating to pre-existing clinical issues in the right shoulder.
>
>> I note at the time of his history taking he made reference to the 2006 pathology and open repair of the right shoulder, along with there being no clinical issues following successful rehabilitation until the current accident.
>
> Dr Robert Breit, orthopaedic surgeon, reviewed Mr Egan on 7 February 2019. He noted a non-symmetrical active loss of range of motion in the cervical spine with no tenderness. He noted a significant restriction of right shoulder movement and also commented on a loss of left shoulder movement being asymptomatic. I found no such loss. Dr Breit and I found very similar whole person impairment relating to the right shoulder. Dr Breit assessed the neck as demonstrating a DRE Category II impairment.
>
> I read Dr Stening's reports between 18 September 2017 and 9 May 2018. He noted also at the time of his last examination that there was evidence of wasting of the rotator cuff musculature but commented that there were no signs of a frozen shoulder and he was able to achieve '*good passive glenohumeral joint range of motion*'. Certainly at the time of today's examination I could not demonstrate a passive range of glenohumeral joint motion beyond the active range demonstrated."

30. The AMS considered that the appellant was stable for assessment.

31. The AMS assessed the appellant on 16 September 2019 and issued the MAC dated 24 September 2019.

32. The appellant now seeks to disturb the certification of the AMS on the basis of one piece of evidence being a MRI referral dated 21 October 2019 which states the following history:

> "He started chronic neck in Feb 2018. The pain got worse a few weeks ago after he returned to work. He has had mild tingling feeling on his right hand. O/e there is tenderness on posterior aspect of neck, on right side of paraspinal muscle. Cervical spine ROM limited by pain. Imp- chronic neck [pain with radiculopathy."

33. The panel notes the appellant relies only on MRI referral from the GP, approximately one month after the AMS examination and MAC. This is the extent of the evidence by which the appellant seeks to overturn the AMS's certification of permanent impairment. There is no additional statement of evidence from the appellant, there is no additional radiological evidence evidencing deterioration, there is no MRI film or report evidencing deterioration,

there is no report from the GP addressing deterioration, there is no expert medical report addressing deterioration. The evidence sought to be relied upon by the appellant is insufficient to support overturning the findings of the AMS on the day of assessment and his certification as to the degree of permanent impairment as a result of injury on 3 September 2019. The evidence is also insufficient for the panel to revoke the MAC and certify that the appellant is not stable for assessment. Accordingly, the panel will confirm the MAC.

34. For these reasons, the Appeal Panel has determined that the MAC issued on 24 September 2019 should be confirmed.

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*.

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Lucy Golic
Dispute Services Officer
As delegate of the Registrar