WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-5723/19**
Appellant:	**Gary Robinson**
Respondent:	**Transdev NSW South Pty Limited**
Date of Decision:	**2 April 2020**
Citation:	**[2020] NSWWCCMA 68**

Appeal Panel:	
Arbitrator:	**R J Perrignon**
Approved Medical Specialist:	**Dr James Bodel**
Approved Medical Specialist:	**Dr Mark Burns**

BACKGROUND TO THE APPEAL

1. The appellant worker, Mr Robinson, appeals from the Medical Assessment Certificate of Approved Medical Specialist Dr Crocker dated 16 December 2019.

2. Mr Robinson was a bus driver. On 15 May 2018, he was leaving his place of work, and fell down the stairs, injuring his cervical spine, lumbar spine, left eyebrow, left wrist and both knees.

3. By a Medical Assessment Certificate dated 16 December 2019, Dr Crocker assessed a 9% whole person impairment (0% cervical spine; 6% lumbar spine; 2% left upper extremity – wrist; 0% right knee; 0% left knee; 1% scarring – left eyebrow). He found no loss or range of movement in the knees, and assessed the lumbar spine as falling within DRE category II, as he could identify no radiculopathy.

4. The appellant alleges error in respect of the assessment of the knees and the lumbar spine only. He says:

    (a) that each knee should have been assessed at 2% whole person impairment, using a diagnosis-based estimate having regard to crepitus, in accordance with the assessment of Dr Patrick, and

    (b) that radiculopathy should have been identified in respect of the lumbar spine, justifying a higher assessment falling within DRE category III.

5. On 17 January 2020, the Registrar by his delegate was satisfied that the ground of demonstrable error was made out in respect of the assessments of the knees, and referred the matter to this Appeal Panel for determination.

6. On 3 February 2020, the Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the *NSW workers compensation guidelines for the evaluation of permanent impairment* (*Guidelines*).

Submissions

7. The Appeal Panel has had regard to the written submissions filed by both parties. It is unnecessary to set them out here in full, but appropriate to summarise them as follows.

8. The appellant worker submits that the Medical Assessment Certificate demonstrates error and the application of incorrect criteria, for the following reasons.

    (a) Despite finding that injury aggravated pre-existing degenerative change in both knees, the Approved Medical Specialist gave no reasons for finding that no impairment "has arisen from the subject incident relating to arthritis".

    (b) In respect of the left knee, the Approved Medical Specialist found crepitus and clicking on movement. In circumstances where, as here, there was direct anterior trauma to the knees, crepitus and clicking justified a 2% whole person impairment, as assessed by Dr Patrick.

    (c) In respect of the right knee, the Approved Medical Specialist should have applied a patellar compression test, which would have confirmed the crepitus identified by Dr Patrick, likewise justifying a 2% whole person impairment.

    (d) In respect of the lumbar spine, the Approved Medical Specialist should have been satisfied that radiculopathy was present, justifying a DRE category III impairment, because:

        (i) He identified diminished sensation in the left lower limb in the L4 and L5 dermatomal distribution.

        (ii) He measured the girth of the left lower limb as less than the right, suggesting atrophy.

        (iii) The EMG and nerve conduction study attached to Dr Patrick's report demonstrated chronic dysfunction of the L4/5 nerve roots.

        (iv) A disc bulge at L4/5 compressing the nerve root was demonstrated on MRI scan dated 3 October 2018.

9. The respondent submits in summary as follows.

    (a) In respect of the knees, diagnosis based estimates – for instance, based on crepitus following direct anterior trauma to the knee – are not applicable in the absence of fracture, ligament injury, meniscectomy or joint replacement. As none of those applied here, there was no need to go beyond the range of motion method used by the Approved Medical Specialist.

    (b) In the absence of radiological evidence of cartilage loss, the SIRA Guides provide no basis for going beyond the range of motion method of assessment.

    (c) The reports of the neurophysiological study relied on by Dr Patrick and of the MRI scan dated 3 October 2018 both called for clinical correlation. None was to be found. In the absence of two correlating signs in accordance with page 27 of the Guidelines, the Approved Medical Specialist was justified in finding no evidence of radiculopathy, and gave adequate reasons.

Reasoning of the Approved Medical Specialist

10. Approved Medical Specialist Dr Crocker examined the worker on 2 December 2019. He took a history of injury on 15 May 2018, including a twisting injury to the left knee and aches and pains in other body parts including the low back. He noted the worker came to surgery of the left wrist at the hands of Dr Yee in 2018, and that pain in the left wrist, knees and back continued. The worker complained to the Approved Medical Specialist of continuing low back pain, and of bilateral knee discomfort.

11. On examination, Dr Crocker recorded restrictions in lumbar range of movement and tenderness in the lumbar spine and left sacroiliac joint. He also recorded restricted ranges of movement in both knees.

12. He diagnosed at [7] an aggravation of pre-existing multilevel degenerative changes in the lumbar spine and aggravation of pre-existing arthritis in both knees, more so on the left.

13. In assessing a DRE Category II impairment in respect of the lumbar spine, he reasoned as follows at [10b] (emphasis added):

> "With respect to the region of the lumbar spine, asymmetry of range of motion is apparent in the absence of neurological dysfunction/radiculopathy. **Subjective sensory complaints are reported pertaining to the right lower extremity which are considered to be non-dermatomal and atypical in nature.** On this basis, a DRE Category ll rating has been determined, ie 5-8% WPI. Taking into account negative impacts upon activities of daily living, a 7% whole person impairment has been determined."

14. He deducted one tenth to take account of the pre-existing degeneration demonstrated by radiological investigations, yielding a 6% whole person impairment (lumbar spine).

15. He assessed a 0% whole person impairment in respect of the knees, reasoning as follows at [10b] (emphasis added):

> "With respect to both knees, there is nil limitation with active range of motion that would require a Whole Person Impairment greater than 0%. **I do not consider that diagnosis based estimates apply.** It is apparent that **there has been longstanding complaints referable to both knees on the basis of gouty arthritis. It is likely that there is also longstanding associated osteoarthritis. I do not consider that an impairment has arisen from the subject incident relating to arthritis**. Similarly, the footnote of the arthritis table of the AMA 5th edition guides does not apply. As such, there is a 0% WPI pertaining to each lower extremity pertaining to the knee joints."

Consideration and findings

16. As the appellant alleges distinct forms of demonstrable error in respect of the assessment of the lumbar spine and knees, the allegations of error with respect to each body system are considered separately below.

1. Assessment of the lumbar spine

17. As indicated, the Approved Medical Specialist assessed a DRE Category II impairment in respect of the lumbar spine, because he was not satisfied that radiculopathy was present. The appellant asserts that the evidence justified a finding of radiculopathy, indicating a DRE Category III impairment.

18. Paragraph 4.27 of the Guidelines provides:

> "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 (AMA5 Box 15-1, p 382)
> - muscle wasting – atrophy (AMA5 Box 15-1, p 382)
> - findings on an imaging study consistent with the clinical signs (AMA5, p 382)."

19. The Approved Medical Specialist did not identify loss or asymmetry of reflexes in either of the lower extremities. He found that both ankle reflexes were present with reinforcement, and thus present and symmetrical. He identified no muscle weakness localised to a spinal nerve distribution. He noted at [5] that, "Sensory system examination with the lower limbs demonstrated reported "sensitivity" with increased subjective sensation with light touch and point pressure testing to a diffuse distribution of the left thigh, lateral calf and foot." However, as indicated above, he concluded that this sensitivity did not accord with any dermatomal distribution.

20. On those circumstances, none of the three major criteria for radiculopathy was satisfied, and there was no basis on which the Approved Medical Specialist could properly have assessed greater than a DRE Category II impairment in respect of the lumbar spine.

21. We can identify no error in the assessment of the lumbar spine.

Ground 2: Assessment of the knees

22. AMA5 Chapter 17 applies to the assessment of permanent impairment of the lower extremities: Chapter 3 of the Guidelines. A variety of methods of assessment are possible: Guidelines, par 3.2.

23. As indicated, the Approved Medical Specialist adopted the range of motion method, finding that there was no restriction in motion of either knee which merited more than a 0% whole person impairment.

24. He also found the presence of arthritis. Table 17-31 provides a method of assessing the lower extremities by reference to the degree of cartilage loss with respect to, among other joints, the knee and patellofemoral joints. In the case of the patellofemoral joint, the footnote provides:

> "In an individual with a history of direct trauma, a complaint of patellofemoral pain, and crepitation on physical examination, but without joint space narrowing on x-rays, a 2% whole person of 5% lower extremity impairment is given."

25. Dr Patrick applied this footnote in assessing a 2% whole person impairment with respect to each knee. Dr Crocker dealt with Dr Patrick's assessment in the following way at [10c] (emphasis added):

> "Dr Patrick has indicated that a 2% WPI of the knees with a deduction of one-tenth in each case (with 2% remaining in each case after rounding) on the basis of the footnote of the arthritis table of the 5th edition of the AMA Guides. **I have indicated that it is my opinion that this is not applicable in Mr Robinson's case.** A final combined Whole Person Impairment of 23% has been determined."

26. In circumstances where arthritis was present in both knees, the Approved Medical Specialist diagnosed an aggravation of the pre-existing arthritis in both knees resulting from injury, there was crepitus on examination of the left knee, and the worker complained of medial discomfort in that knee a number of times per week, it was appropriate for the Approved Medical Specialist to give reasons why it was inappropriate to apply the footnote as Dr Patrick did, at least in respect of the left knee.

27. The highlighted passage at [25] above appears to refer to a previous finding in the Medical Assessment Certificate. That is to be found at [10b] in the following passage:

> "It is likely that there is also longstanding associated osteoarthritis. I do not consider that an impairment has arisen from the subject incident relating to arthritis. Similarly, the footnote of the arthritis table of the AMA 5th edition guides does not apply."

28. This passage does not purport to give reasons for not applying the footnote, unless the word "similarly" was intended to mean, "for similar reasons". If the Approved Medical Specialist so intended, it is not apparent from reading this passage why the mere presence of longstanding arthritis would preclude assessment by reference to arthritis, by applying the footnote. The meaning of the opinion expressed - "I do not consider than an impairment has arisen from the subject incident relating to arthritis" – is not clear, particularly in light of the finding that injury aggravated pre-existing arthritis in both knees.

29. For these reasons, we consider that the Approved Medical Specialist gave inadequate reasons for not applying the footnote to Table 17-31, in respect of the left knee. To that extent, error is demonstrated, and the Medical Assessment Certificate must be set aside.

Report of Dr Burns

30. Having identified error in the assessment of the left knee, the Panel referred the worker to Dr Burns for further assessment. Dr Burns examined the worker on 28 February 2020. His report appears below.

> **"1. The workers medical history, where it differs from previous records**
>
> Mr Robinson confirmed the history reported by the AMS, Dr Crocker. He clarified that the anterior bleeding referred to by Dr Crocker was to the anterior aspect of the left knee and was due to a graze. He reported no grazing or bruising to the right knee and believed the right knee pain commenced some time later when he was seeing Dr Charteris, his GP. He has no memory of a direct blow to the front of his right knee in the fall.
>
> Mr Robinson confirmed an history of gouty arthritis mostly affecting his big toes. He has though had two episodes affecting his right knee, one many years ago before this accident and one since this accident. On both occasions he had drainage of the knee. For the episode after the accident in 2018 he was admitted to Hawkesbury hospital for three days for treatment to the knee.

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

Mr Robinson reported that there has been little change since Dr Crocker's examination. His low back remains his main concern.

Current Symptoms:
He reported intermittent pain over the left side of his low back which is present 80-90% of the time. The pain radiates down his left leg and he reported numbness below the left knee into the foot. The numbness included the dorsum of all toes but not dorsum of the foot, the ankle or the sole of the foot. His back restricts gardening and housework, but he is fully independent in self-care.

With respect to his left knee he stated that it is "not too bad". He now rarely has pain over the lateral aspect of the knee and reported no anterior pain.

With respect to the right knee he has some recent pain, over the last few days. The pain involves the entire knee but settles with Panadeine Forte. He has noted no swelling in the knee.

Current Treatment:
He is not under the care of any specialists at the current time. He sees Dr Charteris, his GP, monthly mostly for prescriptions. He is currently taking Panadeine Forte, two several times per week. He has some Endone but is not taking any. He has a TENS machine, supplied by the physiotherapist, which he does use. He also exercises occasionally but is not having formal physiotherapy.

3. Findings on clinical examination

Mr Robinson was 175cm tall and weighed 84kgs. He walked with a slight limp due to discomfort in his right knee.

Lumbar Spine:
He reported no tenderness on palpation and had a normal lumbar lordosis. There was no muscle spasm or muscle guarding.

Flexion and extension were 2/3rd normal range and symmetrical. Lateral tilt to the left was 2/3rd normal compared to ½ on the right. Straight leg raising was 50° bilaterally with a negative sciatic stretch test. He was noted to have tenderness in his right 4th and 5th toes on touching which he believed was due to his current shoes, which he rarely wears. Knee, ankle and medial hamstring reflexes were present bilaterally and symmetrical. Power and tone were also normal bilaterally and he was able to stand on his heels and toes.

Sensory testing was reported as showing some decrease in the sole of the left foot but was normal elsewhere. The circumference of both quadriceps (10cm above the patella) was 44cm on each side. The circumference of both calf muscles (mid-calf) was 35 cm.

Knees:
Examination of the left knee revealed no localised tenderness. Active range of movement was from full extension (0°) to 120° flexion. There was no instability in the cruciate or collateral ligaments. There was no joint effusion. There was no patellofemoral tenderness or crepitus. The knee was in 5° valgus angulation.

Examination of the right knee revealed tenderness over the medial joint line but not the patella. There was a small joint effusion (painless patella tap) and evidence of synovitis in the suprapatellar pouch. There was no patellofemoral tenderness or crepitus. Active range of movement was from full extension (0°) to 120° flexion. The knee was in 5° angulation. The findings were consistent with low grade gouty arthritis of the right knee.

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

Mr Robinson reported no further investigations since seeing Dr Crocker.

He did bring his investigations with him and I note that he had the following.

- CT Lumbar spine on 30 August 2018
- MRI lumbar spine 3 October 2018.

There were no investigations of either knee. "

31. The Panel adopts the assessment of the left knee and reasoning of Dr Burns, noting that his assessment accords with that of Dr Crocker.

Conclusion

32. For the reasons given, the appeal is allowed in part. The Medical Assessment Certificate of Dr Crocker dated 16 December 2019 is set aside and replaced with the attached Medical Assessment Certificate.

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: **5723/19**
Applicant: **Gary Robinson**
Respondent: **Transdev NSW South Pty Limited**

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

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

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)
Cervical Spine	15.5.18	Chapter 4 pp 24-30	Chapter 15, 15.6, Table 15-5, pp 392-395; DRE I	0%	--	0%
Lumbar Spine	15.5.18	Chapter 4 pp 24-30	Chapter 15, 15.4, Table 15-3, pp 384-388; DRE II	7%	1/10th	(6.3% rounded down to) 6%
Left Upper Extremity (wrist)	15.5.18	Chapter 2 pp 10-12	Chapter 16, 16.4g, Figs 16-26 to 16-31, pp 466-470; Table 16.3; pg 439	2%	--	2%
Right Lower Extremity (knee)	15.5.18	Chapter 3 pp 13-23	Chapter 17, 17.2f, Table 17-10, pp 533-538	0%	--	0%
Left Lower Extremity (knee)	15.5.18	Chapter 3 pp 13-23	Chapter 17, 17.2f, Table 17-10, pp 533-538	0%	--	0%
Scarring (TEMSKI)	15.5.18	Chapter 14 Table 14.1 (TEMSKI) pp 75-77	Chapter 8, 8.7, Table 8-2, pp 178-189	1%	--	1%
Total % WPI (the Combined Table values of all sub-totals)					**9%**	

R J Perrignon
Arbitrator

Dr James Bodel
Approved Medical Specialist

Dr Mark Burns
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