WORKERS COMPENSATION COMMISSION

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

Matter No:	**M2-6296/19**
Appellant:	**Christopher Tesoriero**
Respondent:	**Stuart Robert Edmonds & David Noel Fox**
Date of Decision:	**25 August 2020**
Citation:	**[2020] NSWWCCMA 139**

Appeal Panel:	
Arbitrator:	**Mr John Harris**
Approved Medical Specialist:	**Dr Robin Fitzsimons**
Approved Medical Specialist:	**Dr Drew Dixon**

BACKGROUND TO THE APPLICATION TO APPEAL

1. Mr Christopher Tesoriero (the appellant) suffered injury in the course of the employment with the respondent on 30 June 2015.

2. The appellant claimed compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act) based on the reports of Dr John Bentivoglio dated 15 August 2018[1] and Dr Dudley O'Sullivan dated 20 August 2018 and 5 June 2019.[2] The doctors produced a combined assessment of 22% whole person impairment (WPI).

3. No liability issues were raised by the respondent[3]. The dispute between the parties was limited to the extent of the degree of permanent impairment.

4. The s 66 claim was referred by the Registrar of the Workers Compensation Commission to Dr Ross Mellick, an Approved Medical Specialist (AMS), who initially examined the respondent and provided a Medical Assessment Certificate dated 11 February 2020 (the former MAC). The AMS then assessed the appellant as having a 14% whole person impairment (WPI).

5. The respondent then appealed the former MAC.[4] The Registrar referred the matter back to the AMS pursuant to s 329 of the *Workplace injury Management and Workers Compensation Act 1998* (the 1998 Act). Dr Mellick provided a further Medical Assessment dated 11 June 2020 when he determined that the appellant had a combined WPI of 10% comprising 7% impairment of the right upper extremity and 3% for scarring (the MAC).

6. The assessment of WPI is undertaken in accordance with the fourth edition of the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment* (fourth edition guidelines).[5] The fourth edition guidelines adopt the 5th edition of the *American*

[1] Application to Resolve a Dispute (Application), p 14
[2] Application, p 20 and p 26
[3] Letter of offer dated 16 July 2019 (Application, p 5)
[4] M1-6296/19
[5] The 4th edition guidelines are issued pursuant to s 376 of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act)

Medical Association's Guides to the Evaluation of Permanent Impairment (AMA 5). Where there is any difference between AMA 5 and the fourth edition guidelines, the fourth edition guidelines prevail.[6]

7. The relevant findings by the AMS pertinent to the various grounds of appeal are set out later in these Reasons.

THE APPEAL

8. On 8 July 2020, the appellant filed an Application to Appeal Against a Medical Assessment (the appeal) to the Registrar of the Workers Compensation Commission (the Commission).

9. 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 (the Guidelines).

10. The appellant claims that the medical assessment by the AMS should be reviewed on the ground that the assessment was based on incorrect criteria and/or that the MAC contains a demonstrable error within the meaning of s 327(3) of the 1998 Act. The grounds of appeal were limited to error with respect to the assessment of the right upper extremity.

11. The Appeal was filed within 28 days of the date of the MAC. The submissions in support of the grounds of appeal are referred to later in these Reasons.

REVIEW

12. The Appeal Panel (AP) conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Guidelines. As a result of that preliminary review, the Panel determined that it should call for further written submissions: *Galluzzo v Little.*[7] Accordingly, a direction was to be issued to the parties in the following terms:

> "The Appeal Panel has met and issues the following direction to the parties:
>
> The Approved Medical Specialist (AMS) estimated "the length of the middle finger to have been reduced by approximately 20% and the length of the ring finger to be reduced by 10%".
>
> The parties are directed to make submissions on whether the AMS has made any allowance for loss of digital impairment by reason of the partial amputation of the ring and middle fingers as provided by Table 16-4 and Figure 16-5 of AMA 5 in addition to the assessment for sensory loss.
>
> 1. The Appellant is to file and serve written submissions by close of business 17 August 2020.
>
> 2. The Respondent is to file and serve further written submissions by close of business, 21 August 2020."

13. Written submissions were filed in accordance with this Direction.

14. The appellant requested a re-examination.

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[6] Clause 1.1 of the fourth edition guidelines.
[7] [2013] NSWCA 116 at [74].

15. The AP is not empowered to undertake a further assessment unless it has determined that there is an error. Based on the supplementary submissions the AP is satisfied that there is error. However, the Reasons of the AMS provide clear details of the sensory and physical losses in the middle and ring fingers. The AP can reassess the impairment based on those findings.

EVIDENCE

16. The AP has before it all the documents that were sent to the AMS for the original assessment and has taken them into account in making this determination. Where relevant, these documents are referred to in the Reasons of the AP.

SUBMISSIONS and REASONS

Ground of Appeal 1: Clause 2.5 of the fourth edition guidelines

Submissions

17. The appellant referred to the finding by the AMS of variability and no consistent significant impairment of the metacarpophalangeal or proximal interphalangeal joints and noted that the AMS utilised Figure 16-21 of AMA 5 to calculate abnormal range of motion of the DIP joint. It submitted in these circumstances that the AMS "ought to have utilised an alternative parameter of impairment evaluation as required by clause 2.5" of the fourth edition guidelines.

18. The respondent submitted that the AMS correctly applied AMA 5 and the fourth edition guidelines. The AMS found no impairment of the appellant's metacarpophalangeal and proximal interphalangeal joints in the middle and ring fingers on "repeated testing".

19. Reference was made to clause 2.5 of the fourth edition guidelines which provides that "if the assessor is not satisfied that the results of a measurement are reliable, repeated testing may be helpful in this situation".

Reasons

20. The AMS recorded the following symptoms:[8]

> **"Present symptoms:** Mr Tesoriero told me of persisting symptoms including loss of sensation involving the right middle and ring fingers and impaired movement of those fingers. In addition, the loss of sensation is described to be a "weird" feeling and is not specifically referred to as being painful. This altered sensation involves the distal and middle phalanges of both the middle finger and ring fingers. There is also some loss of length in both the middle and ring fingers. These consequences of the injury limit normal function. He reports that this impairs his ability to manage timber and a band saw.
>
> There is stiffness of the distal interphalangeal joints of the middle and ring fingers, in addition to shortness, which prevents him from playing guitar which he did on a regular basis. He indicates that the work of a cabinet maker requires normal finger movement and normal sensation in the fingers and these impairments accordingly represent an impediment to resuming that work."

[8] MAC, p 2

21. The findings by the AMS on physical examination were:[9]

> "There is scarring of the middle and ring fingers of the right hand together with loss of length of both of those fingers, and there is some deformity of nail growth.
>
> There was subjective impairment of the superficial modalities of sensation, touch, temperature, pin prick and impairment of two-point discrimination to between 7mm and 15mm.
>
> On testing the range of movement, there was a considerable degree of variability and no consistent significant impairment of the metacarpophalangeal or the proximal interphalangeal joints of the middle and ring fingers. There was limitation of movement of the distal interphalangeal joints of both of those digits.
>
> No pain was induced by contact with the middle or ring fingers of the right hand.
>
> I estimate the length of the middle finger to have been reduced by approximately 20% and the length of the ring finger to be reduced by 10%.
>
> There was no wasting of the intrinsic muscles of the hand or right arm, no abnormalities of movement proximally and no abnormality of the deep tendon reflexes in the upper extremities.
>
> There were no long tract or segmental signs in the lower extremities."

22. The reasons of the AMS relevant to assessment were:[10]

> "I find partial sensory impairment, two-point discrimination being between 7mm and 15mm. Therefore, using Table 16-5, the sensory quality impairment is 50% for both the middle and ring fingers. The sensory loss is in accord with involvement of both digital nerves. There is tranvserse impairement of sensation. Adjustment is made for the shortening of the middle and ring fingers. With reference to Table 16-7. Figure 16-21 is consulted in relation to assessing impairment of movement of the distal interphalangeal joints for both the middle and the ring fingers. Repeated testing established that there was no consistent measurable impairment of the proximal interphalangeal joints, nor of the metacarpophalangeal joints. The reduced movement of the distal joints was assessed using Figure 16-21. The measurements for sensory digital impairment were combined with digital impairment.
>
> Using Table 16-7, the percent of digital impairment of the middle finger is 20% and for the ring finger 23%.
>
> With reference to figure 16-21, the distal interphalangeal joint impairment of the middle finger is 39% and of the ring finger, 21%.
>
> Using the Combined Tables, this equates to 39% digital impairment for the ring finger and 51% digital impairment for the middle finger. Using Table 16-1, 51% digital impairment equates to 10% hand impairment and 39% digital impairment for the ring finger equates to 4% hand impairment.

[9] MAC, p 3
[10] MAC, pp 4-5

> Using Table 16-2, 10% hand impairment converts to 9% upper extremity impairment and 4% hand impairment equates to to 4% upper extremity impairment of the ring finger.
>
> Using Table 16-3, 9% upper extremity impairment equates to 5% whole person impairment for the middle finger and 4% upper extremity impairment equates to 2% whole person impairment for the ring finger, no deductions.
>
> With regard to scarring and with reference to Paragraph 14-1, page 74 of the WorkCover Guides, there is considerable scarring and impairment of nail growth. I find 3% whole person impairment for the scarring.
>
> Using the Combined Tables, 7 and 3 equates to 10% whole person impairment for the injury to the middle and ring fingers of the right hand.
>
> There is no assessable impairment of the nervous system other than the injury to the digital nerves already assessed above as part of the right upper extremity injury. There is 0% whole person impairment for the nervous system.
>
> Please note a revision of the calculation has been done and the correct amended total WPI is not 12% as has been suggested but 10%.
>
> *Worksheet /actual calculations attached?* No."

23. When commenting on the difference between the assessment made by the AMS and that found by Dr Bentivoglio it was noted that Dr Bentivoglio found assessable impairment of more proximal joints in both digits but the AMS could not identify assessable impairment of either the proximal interphalangeal joints of the metacarpophalangeal joints of the middle and ring fingers.[11]

24. The AMS also noted that Professor Cumming did not find assessable impairment other than in the distal interphalangeal joints of the middle and ring fingers. That finding coincided with the AMS save as to the extent of the degree of impairment.

25. The AMS observed that Dr O'Sullivan, Neurologist did not assess finger movement but assessed 8% WPI for sensory loss of the middle and ring fingers.

26. The AMS observed that there was "some inconsistency" with regard "to the various findings", presumably a reference to the findings by other doctors. The AMS added that there was "some inconsistency with objective findings and measurements made at the time I assessed Mr Tesoriero's sensory impairment and motor function."[12] The AMS then stated:

> "However, with repetition I consider to have [sic] achieved sufficient consistency to arrive at the figures here."

27. Clause 2.5 of the fourth edition guidelines relevantly provides:

> "Range of motion (ROM) is assessed as follows:
>
> - A goniometer or inclinometer must be used, where clinically indicated.

[11] MAC, paragraph 10c
[12] MAC, paragraph 10c

- Passive ROM may form part of the clinical examination to ascertain clinical status of the joint, but impairment should only be calculated using active ROM measurements. Impairment values for degree measurements falling between those listed must be adjusted or interpolated.

- If the assessor is not satisfied that the results of a measurement are reliable, repeated testing may be helpful in this situation.

- If there is inconsistency in ROM, then it should not be used as a valid parameter of impairment evaluation. Refer to paragraph 1.36 in the Guidelines.

- If ROM measurements at examination cannot be used as a valid parameter of impairment evaluation, the assessor should then use discretion in considering what weight to give other available evidence to determine if an impairment is present."

28. The AP does not accept the appellant's submission that the AMS incorrectly applied clause 2.5 of the fourth edition guidelines. Specifically, the clause provides:

> "If the assessor is not satisfied that the results of a measurement are reliable, repeated testing may be helpful in this situation."

29. However, the AMS stated that he found consistency following repetition. The AMS was entitled to base his assessment on these examination findings. He was not obliged in these circumstances to use his discretion to assess by alternative means.

30. We also observe that the AMS found no consistent measurable impairment of the proximal interphalangeal joints and of the metacarpophalangeal joints. The assessment using the range of motion was limted to the distal joints.

31. The fact that a doctor's assessment differed from the AMS does not of itself amount to error: *Merza v Registrar of the Workers Compensation Commission*.[13] Furthermore, the AMS was entitled to rely on his own clinical expertise when assessing the respondent based on manual muscle testing. Given the specificity of the reasons provided by the AMS, the AP is clearly satisfied that he properly examined and clearly explained his findings.

32. The AP observes that the appellant submitted that the MAC contains a demonstrable error within the meaning of s 327(3)(d) of the 1998 Act. No relevant authority was cited in its submissions.

33. The concept of "demonstrable error" was discussed by the Court of Appeal in *Vannini v Worldwide Demolitions Pty Ltd* (*Vannini*),[14] where Gleeson JA observed that, consistent with the observations of Basten JA in *Mahenthirarasa v State Rail Authority of New South Wales*[15] a "demonstrable error must be apparent in findings of fact or reasoning contained in the medical assessment certificate, although the error may be established in part by reference to materials that were before the approved medical specialist".[16]

[13] [2006] NSWSC 939 at [51].
[14] [2018] NSWCA 324 (*Vannini*) at [90].
[15] [2008] NSWCA 101.
[16] *Vannini* at [86].

34. The meaning of incorrect criteria was discussed by the Court of Appeal in *Marina Pitsonis v Registrar of the Workers Compensation Commission*[17] applying the observations of Basten JA in *Campbelltown City Council v Vegan*[18] when his Honour stated that it "must refer to such matters as the tests set out in the Guidelines, where they are applicable".

35. Although we have found no error, the AP observe that both grounds of appeal and supporting submissions, whilst not expressed as error under s 327(3)(c) of the 1998 Act, are more correctly described as an allegation that the assessment was made on the basis of application of incorrect criteria.

36. In these circumstances we have considered both grounds under both s 327(3)(c) and (d) of the 1998 Act.

37. This ground is rejected.

Ground of Appeal 2: Clause 2.6 of the fourth edition guidelines

Submissions

38. The appellant referred to the finding by the AMS of a degree of inconsistency between the present findings and those documented by Dr Bentivoglio with respect to the proximal interphalangeal and metacarpophalangeal joints. It submitted that the AMS ought to have documented his findings on a "standard form" including that of AMA 5 figures 16-1a and 16-1b as recommended by clause 2.6 of the fourth edition guidelines.

39. The respondent submitted that the AMS "adequately explained the basis of his calculations with specific reference to the relevant tables" of AMA 5 and the fourth edition guidelines. This was set out in paragraph 10b of the MAC.

Reasons

40. The findings on examination are set out earlier in these Reasons[19]. We agree with the respondent's submission. The findings made by the AMS are clear and precise.

41. Clause 2.6 of the fourth edition guidelines provides:

> "To achieve an accurate and comprehensive assessment of the upper extremity, findings should be documented on a standard form. AMA5 Figures 16-1a and 16-1b (pp 436–37) are extremely useful both to document findings and to guide the assessment process."

42. Whilst there is no doubt that the AMS did not use the "standard form", his findings on measurement are precise and clearly articulated in the MAC. The relevant clause does not require that the AMS must use the standard form. Whilst the use of the form is recommended and "should" be used, if there are clear findings contained in the MAC then we do not accept that error has arisen. It is our view the normal meaning of "should" does not require that the standard form "must" be used.

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[17] (*Marina Pitsonis*) [2008] NSWCA 88 at [40]-[42], McColl and Bell JJA (as their Honours then were) agreeing.
[18] [2006] NSWCA 284 at [95], McColl JA agreeing.
[19] See paragraphs 21-22 herein

43. The fourth edition guidelines have been held to have the force of delegated legislation.[20] As the plurality stated in *Military Rehabilitation Commission v May*[21], the "question of construction is determined by reference to the text, context and purpose of the Act"; citing *Project Blue Sky Inc v Australian Broadcasting Authority*[22] and *Alcan (NT) Alumina Pty Ltd v Commissioner of Territory Revenue*[23].

44. Applying these principles, the ordinary meaning of "should" in the context of clause 2.6, does not require that the form "must" be read.

45. We do not accept that error is shown in this ground.

Supplementary Ground of Appeal: Failure to assess for partial amputation

Submissions

46. The appellant referred to the direction issued by the AP and submitted that the AMS had erred in not making any allowance for the loss of the digital impairment of the partial amputation of the ring and middle fingers.

47. The appellant referred to the findings of the AMS that assessed loss of the middle finger by approximately 20% and the loss of the ring finger by 10%. It was submitted that failure to include the loss be corrected by the AP and combined with the other losses.

48. The respondent conceded that there was no reference in the MAC for shortening of the middle and ring fingers pursuant to either Table 16-4 or Figure 16-5 of AMA 5. It was noted that the Application to Appeal and the submissions in support did not include a reference to either Table 16-4 or Figure 16-5 of AMA 5.

Reasons

49. Whilst it is correct that the appellant did not rely on this ground of appeal in its initial appeal submission, the matter has now been raised. The submissions are part of "the grounds of appeal on which the appeal is made": *Midson v Workers Compensation Commission.*[24]

50. Further there is no prejudice to the respondent from allowing the late raising of this ground. The partial amputation of both fingers was assessed and quantified by Dr John Bentivoglio for the appellant and Professor Cumming on behalf of the respondent. The findings on examination by the AMS of the length of amputation are extremely similar to the assessments made by Dr Bentivoglio and Professor Cumming.

51. It is clear that the AMS erred in failing to assess the partial loss of amputation of the middle and ring fingers in accordance with Figure 16-5 and Table 16-4 of AMA 5.

52. For this reason, the application of incorrect criteria is established. This ground of appeal is upheld. The matter requires reassessment according to law: *Drosd v Nominal Insurer.*[25]

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[20] *Ballas v Department of Education* [2020] NSWCA 86 at [97].
[21] [2016] HCA 19 at [10].
[22] [1998] HCA 28 [69]-[71].
[23] [2009] HCA 41 (*Alcan*).
[24] [2016] NSWSC 1352 at [82]
[25] [2016] NSWSC 1053

REASSESSMENT

53. The AP applies the precise calculations of the AMS set out at paragraph 10(b) of the MAC subject to combining the loss of length of the fingers set out at paragraph 5. The additional assessment is made in accordance with Figure 16-5 and Table 16-4 of AMA 5.

54. The appellant has the following losses:

    (a) Middle finger 20% (amputation) x 20 (sensory loss) x 39 (DIP joint movement) = (combined) 61% middle finger = 12% impairment of the hand.

    (b) Ring finger 10% (amputation) x 23 (sensory loss) x 21 (DIP joint impairment) = (combined) 45% ring finger = 5% impairment of the hand.

55. Hand impairments are added (section 16.1D instruction) 12% + 5% = 17% hand impairment = 15% upper extremity impairment = 9% WPI.

56. There was no ground of appeal concerning the assessment of the skin. The AP adopts these findings.

DECISION

57. For these reasons, the MAC is revoked, and a new Medical Assessment Certificate is issued. The new Medical Assessment 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 MEDICAL APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

L Funnell

Leo Funnell
Dispute Services Officer
As delegate of the Registrar

APPEAL PANEL

MEDICAL ASSESSMENT CERTIFICATE

Matter No: **6296/19**
Applicant: **Christopher Tesoriero**
Respondent: **Stuart Robert Edmonds & David Noel Fox**

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

The Appeal Panel revokes the Medical Assessment Certificate of Dr Ross Mellick 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 fourth edition guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA5**	**% WPI**	**WPI deductions pursuant to s 323 for pre-existing injury, condition or abnormality (expressed as a fraction)**	**Sub-total/s % WPI (after any deductions in column 6)**
Right Upper limb	30.6.2015	Chapter 2 Pages 10 - 12	Chapter 16, Pages 443-518 Table 16-4 , 16-5 and 16-7; Figures 16-5, 16-7	9%	Nil	9%
Nervous System	30.6.2015	Chapter 5	Chapter 13(d)	0%	N/A	0%
Skin	30.6.2015	Chapter 14, Pg 74, Table 14.1		3%	Nil	3%
Total % WPI (the Combined Table values of all sub-totals)					12%	

John Harris
Arbitrator

Dr Robin Fitzsimons
Approved Medical Specialist

Dr Drew Dixon
Approved Medical Specialist

25 August 2020