WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1- 4472/19**
Appellant:	**Nenad Golub**
Respondent:	**Moon Painting Pty Ltd**
Date of Decision:	**13 February 2020**
Citation:	**[2020] NSWWCCMA 21**

Appeal Panel:	
Arbitrator:	**Ms Deborah Moore**
Approved Medical Specialist:	**Dr Roger Pillemer**
Approved Medical Specialist:	**Dr Margaret Gibson**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 13 November 2019 Nenab Golub lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Greg McGroder, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 16 October 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 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 that preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination because it was not requested, and we consider that we have sufficient evidence before us to enable us to determine the appeal.

EVIDENCE

Documentary evidence

8. 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.

SUBMISSIONS

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

10. In summary, the appellant submits that "the AMS has erred in finding inconsistency on presentation as the AMS does not explain how the Applicants presentation is inconsistent." This is in relation to the assessment of the right shoulder.

11. In reply, the respondent submits that "the AMS was correct in noting inconsistency, and correctly applied the provisions of the SIRA Guidelines to reach a finding of 2% WPI for the right upper extremity."

FINDINGS AND REASONS

12. 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.

13. 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.

14. The appellant was referred to the AMS for assessment of whole person impairment (WPI) in respect of the lumbar spine, the cervical spine and the right upper extremity (shoulder) resulting from an injury on 23 May 2017.

15. The AMS obtained the following history:

> "Mr Golub said he had no problems prior to 23 May 2017. He was loading a heavy weight onto the back of a truck when he fell and landed on his buttocks. He said that he jarred his neck, his lower back and both his shoulders. The main shoulder problems, however, involved his right.
>
> He saw his GP, Dr Tomka. He organised MRI scans. In the cervical spine they demonstrated significant spondylitic changes with discosteophyte complexes, most marked at C5/6 with potential impingement of the right C6 nerve root but no compression. In the lumbar spine, once again, there were significant spondylitic changes with discosteophyte complexes, most marked at L4/5 with potential impingement on the left L1 nerve root but no compression.
>
> He was sent for physiotherapy but symptoms persisted. He subsequently was referred to Dr Bazina, Neurosurgeon, in July 2017. She organised cortisone injections into the back in July and the neck in August and these didn't help. A bone scan was done in September 2017 which demonstrated significant degenerative changes in the cervical spine and the shoulders. Dr Bazina felt that there was no indication for surgery and recommended hydrotherapy.

With regard to his shoulders, he wasn't investigated with regard to the right shoulder until a MRI was performed on 20 June 2018 at the request of Dr Tomka. This demonstrated bursitis, a rotator cuff tear, and significant glenohumeral and AC joint arthritis. He has not been further investigated. He hasn't been referred to a specialist with regard to his shoulder. He said that the physiotherapist who treated him for his back and neck also treated him for his shoulder. He has not seen further specialists for opinions with regard to his neck or back condition."

16. Present symptoms were described as follows:

> "With regard to his neck, he said that he has pain there the whole time and this increases and decreases in intensity and sometimes this is for no reason. He finds that movement is a problem. He cannot look up at all. He cannot move his neck to the right as well as he can to the left. He has pain radiating down through his right arm and into his fingers. He has constant shoulder pain which also increases and decreases in intensity, sometimes for no reason. He has significant restriction of movement of both his shoulders. With regard to his lower back, the pain is there all the time and is made worse when he walks and after prolonged sitting. He gets a feeling of numbness down his right leg and the pain also radiates down his right leg. He cannot move his back to the left as well as he can to the right."

17. Findings on physical examination, as regards the right shoulder, were reported as follows:

> "On assessment of range of movement of the shoulders, the maximum that he displayed were on the right flexion to 50 degrees and extension 10 degrees. Abduction was 40 degrees and adduction 0 degrees. Internal rotation was 30 degrees and external rotation 80 degrees. Corresponding values on the left were 160 degrees, 40 degrees, 110 degrees, 50 degrees, 90 degrees and 90 degrees respectively. I couldn't detect any wasting involving the posterior shoulder muscles or the right upper arm. Generalised weakness was, however, demonstrated on the right relative to the left. Reflexes were difficult to obtain bilaterally but there was no inequality. He displayed a glove distribution of diminished sensation on the right relative to the left. There was tenderness to light touch around the cervical area globally and into the right shoulder globally."

18. The AMS noted:

> "20 June 2018 – MRI Right Shoulder Large subacromial bursal effusion. 8mm irregular tear in the anterior supraspinatus tendon potentially full thickness or near full thickness involving the bursal surface. Mild glenohumeral joint OA. Anterior labral tear."

19. In summarising the injuries, the AMS said:

> "In a fall at work on 23 May 2017 Mr Golub aggravated spondylitic changes involving the cervical and lumbar spines. He has on-going multifactorial low back and neck pain but no evidence of radiculopathy.
>
> He also sustained injuries to the shoulders but an accurate diagnosis of his shoulder condition could not be made today based on his clinical presentation."

20. The AMS added:

> "He displayed marked symptom magnification and self-limitation of range of movement. When assessing range of movement of the shoulders it was noted that movement was at the glenohumeral joint only with no attempt to use accessory mechanisms to elevate the arms."

21. The AMS assessed 2% WPI for the right upper extremity. He explained his reasons for this assessment as follows:

> "With regard to the right shoulder, I refer to WorkCover Guidelines, Section 1.36 which states that range of movement cannot be used if there is voluntary restriction of range of movement. I refer also to Section 1.23 that states that if a condition isn't covered by the guidelines, an analogous condition is used. I subsequently refer to Section 2.16 which deals with impingement and this section states that in the absence of being able to use range of movement that a 2% whole person impairment is given for impingement. Under the circumstances, there is no deduction for a pre-existing condition."

22. In commenting on other medical opinions, the AMS said:

> "Dr J Bentivoglio, Orthopaedic Surgeon, submitted a medico-legal report dated 21 August 2019. My findings with regard to the cervical and lumbar spines are similar to those of Bentivoglio…He felt that the shoulder condition had not reached maximum medical improvement because the natural course of adhesive capsulitis is to resolve after a matter of years. I do not feel that clinically Mr Golub has adhesive capsulitis and the restriction of movement of his shoulders is voluntary. Under the circumstances, I used an analogous condition.
>
> Dr G Mendelsohn, Surgeon, submitted a medico-legal report dated 24 June 2017…[He] also measured restriction of range of movement of the right shoulder and deducted the restricted range of movement of the left shoulder from this. I do not think that this is valid because the left shoulder would not be considered uninjured. I also felt that there was voluntary restriction of range of movement and this means of assessment should not be used."

23. The AMS concluded noting "Significant spondylitic changes involving the cervical and lumbar spines and also the right shoulder osteoarthritis."

24. The thrust of the appellant's submissions is that the AMS "does not explain how the Applicants presentation is inconsistent."

25. After setting out the provisions of Section 1.36 of the Guidelines and noting portions of the MAC, the appellant then made reference to the decision in *Darren Charles Broadhead v The Bucketts Way Motel* [2016] NSWWCCMA 73 where the AMS made comments about the consistency of the worker's presentation. The appellant added:

> "It was found that the AMS's use of s323 of the 1998 Act for inconsistency on presentation was not in accordance with the provision as he did not explain how the presentation was inconsistent.
>
> Similarly the Applicant submits that Dr McGroder does not describe and explain the reason for using an analogous condition. Although he states that he the Applicant displayed marked symptom magnification and self-limitation of range of movement he does not explain what the Applicant was specifically doing or how his presentation was inconsistent."

26. As the respondent points out, Paragraph 1.36 of the Guidelines provides:

> "Consistency tests are designed to ensure reproducibility and greater accuracy. These measurements, such as one that checks the individual's range of motion are good but imperfect indicators of people's efforts. The physician must use the entire range of clinical skill and judgement when assessing whether or not the measurements or test results are plausible and consistent with the impairment being evaluated. If, in spite of an observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the physician may modify the impairment rating accordingly and then describe and explain the reason for the modification in writing".

27. The Respondent submits:

> "An analogy may be drawn with the decision of *Hayath Mohamed v Gliderol International Pty Limited* (M-009405/07. The MAP in this case found that 'while assessment by way of a diagnosis based on impingement (paragraph 2.16 of the Guides) is not generally to be used where there is a loss of range of motion, in the present case the Panel relies on that method of assessment by analogy only (paragraph 1.58 of the Guides refers) because of the gross inconsistencies in the worker's presentation (as provided for by paragraph 1.59 of the Guides)'. In this case, the Panel was satisfied that this approach was justified as the results of the range of movement testing were unreliable."

28. The Respondent further submits that:

> "The impairment rating suggested by the loss of range of movement as recorded by the AMS would be excessive, and thereby inconsistent with the relatively pathology demonstrated by the clinical examination of the Appellant worker. Furthermore, the AMS recorded no muscle wasting of the right shoulder…
>
> Dr McGroder was correct in finding inconsistency between the range of motion assessment and the lack of muscle wasting in the Appellant worker."

29. In conclusion, the respondent submits:

> "It was open to the AMS to rely on this provision for the AMS to adopt an analogous condition in assessing the Appellant worker's impairment. The basis for this reliance was correctly supported by the AMS noting marked symptom magnification and self-limitation of range of movement, along with no evidence of muscle wasting involving the posterior shoulder muscles or the right arm."

30. It is clear that the AMS was not able to use range of movement as a reliable test of impairment.

31. As a result, the appropriate method was to utilise an analogous condition, as the AMS did.

32. The task of the AMS was to assess impairment *resulting from a specific injury*, namely on 23 May 2017.

33. It is clear to us that the appellant had a significant long-standing pre-existing condition as noted on the MRI scan. In addition, we note an absence of complaints about the right shoulder until October 2017 when a KAIRROS report noted:

> "On 20 November 2017, I attended a Medical Case Conference with Dr Tomka, Mr Dellosa and Mr Golub. Dr Tomka provided an overview of Nenad's injuries…including: The right shoulder which Mr Golub has been referred for an MRI to investigate. Mr Golub reported the pain to be in the region between the shoulder blade and the spine, not so much the shoulder joint itself."

34. Dr Bazina, the appellant's treating surgeon, also referred only to the neck and back injuries, in addition noting bilateral hip osteoarthritis for which he was awaiting hip replacement surgery.

35. There is no reference in the general practitioners notes to any right shoulder complaints up to November 2017 when the notes cease. He does suggest that Mr Golub presented to his surgery on 30 May 2017 with problems with walking and spasm of neck muscles *'which propagated to both shoulder* [sic]…'. However in various WorkCover Certificates under the heading "Diagnosis of work-related injury/disease", the general practitioner has entered *'cervical and lumbosacral spine discopathy, right hip arthritis'*: again no mention of any shoulder problem.

36. In his MAC the AMS points out that Mr Golub's shoulders were not investigated until an MRI was performed on 20 June 2018. He notes that this demonstrated "bursitis, a rotator cuff, and significant glenohumeral and AC joint arthritis".

37. We accept that it is clear from the investigations that Mr Golub does have a very genuine shoulder problem. However, as we said, the AMS was required to make an assessment of impairment resulting from the specified injury. It seems to us that any aggravation of the undoubted pre-exiting shoulder condition was minor. So not only was there limited evidence as to the nature and extent of the shoulder injury on 23 May 2017, the AMS was also faced with significant inconsistent presentation.

38. In summary, the appellant submitted that the AMS did not explain what he was specifically doing or how his presentation was inconsistent.

39. However, the AMS does note there is no wasting and finds no objective findings to substantiate the degree of limitation.

40. The Guidelines advise that the assessor must use their entire range of clinical skill and *judgment* when assessing whether or not the measurements or test results are plausible and consistent with the impairment being evaluated.

41. And if the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the assessor can modify the impairment rating.

42. In our view, the AMS had a difficult task in assessing impairment of the right shoulder given the extent of the appellant's inconsistent presentation.

43. We consider that he clearly explained his reasons why the appellant's presentation was inconsistent such that we do not accept the appellant's submissions on this point.

44. For these reasons, the Appeal Panel has determined that the MAC issued on 16 October 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*.

J Burdekin

Jenni Burdekin
Dispute Services Officer
As delegate of the Registrar