WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-3925/19**
Appellant:	**Royal Fastform Pty Ltd**
Respondent:	**Sami Brown**
Date of Decision:	**11 March 2020**
Citation:	**[2020] NSWWCCMA 45**

Appeal Panel:	
Arbitrator:	**Jane Peacock**
Approved Medical Specialist:	**Dr Drew Dixon**
Approved Medical Specialist:	**Dr Mark Burns**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 13 November 2019, Royal Fastform Pty Ltd (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 15 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, 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.

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.

Medical Assessment Certificate

9. 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

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

FINDINGS AND REASONS

11. 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.

12. 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.

13. 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: 6 January 2014
> - Body parts/systems referred: Lumbar Spine
Right Upper Extremity
Left upper extremity
> - Method of assessment: Whole Person Impairment"

14. 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 Lumbar Spine	**6/1/2014**	**Chapter 4 Page 26-33**	Item 4.37, 4.27, Table 15.3, Item 4.34 to 4.36 AMA 5	**12%**	**N/A**	**12%**

2. Right Upper Extremity	**6/1/2014**	**Chapter 2 Pages 13-15**	Figures 16.40 to 16.46, Table 16.3, AMA 5AMA 5.	**4%**	**N/A**	**4%**
3. Left Upper Extremity – Shoulder & Wrist, nerve injury	**6/1/2014**	**Chapter 2 Pages 13-15**	Figures 16.40 to 16.46, Figures 16.10, Table 16.15, 16.3, AMA 5.	**8%**	**N/A**	**8%**
4.						
Total % WPI (the Combined Table values of all sub-totals)					**22%**	

15. In summary, the appellant submitted that the AMS erred in his failure to consider the opinion of Dr Breit, relied upon by the Appellant and also in his failure to apply a s 323 deduction.

16. Dr Breit's in his reports, which were filed in the appellant's case with their Response, assessed 13% WPI resulting from the injury and 13% WPI resulting from the nature and conditions of the worker's employment.

17. The appellant submitted that the AMS:

> "has made no attempt to address Dr Breit's findings in respect of causation and the appropriate section 323 deduction o be made to factor in the nature and conditions of the worker's employment (for which he has made no claim). Instead, he has made no s 323 deduction, regardless of the cause."

18. In summary, the respondent worker submitted that there has been no error and the AMS assessed impairment as a result of the injury referred to him. The appellant is inappropriately raising issues of causation on appeal. The Respondent submitted that there is no evidence that the AMS did not consider the opinion of Dr Breit. The Respondent submitted that the MAC should be confirmed.

19. 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. When considering the assessment of a deductible proportion under s 323 the AMS can only make a deduction if he considers in the exercise of his clinical judgment that the pre-existing condition, abnormality or injury has contributed to the level of permanent impairment assessed. Where the extent of the deduction would be too difficult or too costly to determine, the deduction will be one-tenth.

20. The AMS recorded the following history:

> "Mr Brown is a 54 year old right handed man who fell approximately 7 metres while performing formwork on the 3rd floor of a construction site. He sustained injuries to his neck, lumbar back, right and left shoulder and left wrist.

Ambulance records state that he was amnesic post his fall. He was carried by workmates on a stretcher to the ground floor where he was examined by the ambulance officers. He had initial Glascow Coma Scale of 14 out of 15. His Glascow Coma score became normal en route to the hospital.

He was admitted to the Royal Prince Alfred Hospital with x-ray evidence of fractures of the transverse processes of L2 to L4, not requiring operative intervention. He had a large haematoma associated with his left lumbar paraspinal region.

He was subsequently discharged from hospital to the care of his local practitioner where he was treated with physiotherapy and hydrotherapy.

He was referred to see Dr Simon McKechnie, Spinal Surgeon in Bankstown. On the 3 December 2014 he underwent a L4 perineural injection with no effect. He subsequently underwent surgical intervention under the care of Dr McKechnie in February 2015, in the form of a left L3/4 partial laminectomy, microdiscectomy and spinal rhizolysis. Unfortunately this surgery did not result in significant improvement and he continued to report back pain and pain radiating into the left leg.

He was treated post-operatively with physiotherapy. There was also referral to a psychiatrist because of memory issues.

Mr Brown was then referred to see Dr Chris Scott, Orthopaedic Hand Surgeon. At that time there were symptoms consistent with ulnar neuropathy at wrist level. He described tenderness over the ulnar side of the wrist with localised swelling and a positive tinel's sign, according to Dr Scott's report. There was also evidence at that time of a non-union of a styloid fracture. Dr Scott performed a left unlar nerve neurolysis on the 23 August 2018 at the Sydney South West Private Hospital with some improvement in the ulnar sided left wrist discomfort.

Mr Brown was also seen by Dr Daniel Rahme, Orthopaedic Surgeon, because of the continuing left shoulder symptoms.

There had been earlier injections by the late Dr George Kalnis to the left shoulder on one occasion and to the right shoulder on two occasions, with no resolution of the discomfort in either shoulder. The most significant symptoms, however, were on the left side.
On the 12 March 2018, at the Sydney Private Hospital, Mr Brown underwent further surgery via arthroscopic technique on the left side in the form of the excision of the outer end of the clavicle and decompression of the subacromial space. This surgery did not result in any major improvement and the left shoulder symptoms have continued to the present time.

There has also been a recent consultation with Dr Rahme, noting similar painful discomfort on the right shoulder historically associated with the fall injury at work and with x-rays and scans demonstrating a similar degenerative pathology effecting the acromioclavicular joint on the right side. There is also a continuing history of low grade cervical neck pain. Mr Brown last saw Dr Rahme in May 2018.

Mr Brown continues under the care of the local practitioner, Dr Manuel Argueta of Bankstown.

- **Present treatment**:
  Mr Brown is under no formal physical treatment at the present time. He continues to take Lyrica under the guidance of the local practitioner and Endone at night.

- **Present symptoms**:
  Mr Brown reports some intermittent discomfort in his posterior cervical neck which was present today.

He report continuing discomfort in his low lumbar back which is present all of the time and fluctuates in intensity.

He continues to have intermittent discomfort radiating into the left leg and involving the sole and 5th and 4th toe of his left foot. He states there are some intermittent similar symptoms on the right side but not present today. There are also no symptoms in the left leg today.

He continues to have discomfort over the pad of both the right and left shoulder, more significant on the right side, with pain mainly related to attempts at elevation of the shoulders. Mr Brown is concerned about having surgery on the right side when he has had limited improvement on the left side.

He also describes continuing discomfort over the ulnar side of the left wrist, with some continuing partial sensory loss on the volar aspect of the left 4th and 5th finger.

Mr Brown states that of the 3 major surgeries, the left wrist surgery has been the most successful. He states that he is therefore concerned about suggestions of further requirement for surgery on his lumbar back under the care of Dr McKechnie and surgery on the right shoulder under the care of Dr Rahme.

- **Details of any previous or subsequent accidents, injuries or condition**:

  Nil applicable.

- **General health**:
  Mr Brown has a past history of asthma. He continues to take Efexor medication for depression.

- **Work history including previous work history if relevant:**
  Mr Brown has not been able to return to his work since the day of the injury on the 6 January 2014. He states that his Workers Compensation payments ceased in December 2018.

- **Social activities/ADL**:
  Mr Brown states that he is a non-smoker and non-drinker of alcohol. He previously did participate in alcohol intake but stopped because of the diagnosis of a fatty liver.

Mr Brown was born in Iraq, arriving in Australia 17 years ago. At the time of the accident he had been working for his employers for a period of 3 years when the accident occurred. His work was a full-time post.
Mr Brown lives with his wife and 4 adult children in a home at Moorebank."

21. The Panel notes that the AMS has taken a history that there were no previous accidents injuries or conditions which is inconsistent with the clinical records which were in evidence before him which record long term repeat prescription for panadeine forte for what is described in the clinical notes of the general practitioner as "chronic back pain".

22. The AMS conducted a physical examination and his findings are not the subject of complaint on appeal.

23. The AMS reviewed the special investigations as follows:

> "MRI Scan Cervical & Lumbar Spine – 10 February 2014 – Spectrum Imaging – Dr Laughlin Dawes. Evidence of previous left transverse process fractures from L1 to L4, with associated subcutaneous haematoma at that level. Mild concentric disc bulges without stenosis at L1/2 and L2/3. At L3/4 and L4/5 there is moderate broad based central disc protrusion with associated moderate canal stenosis at the L3/4 level. There is no foraminal narrowing but there is marked bilateral subarticular recess narrowing at the L3/4 level. At the L4/5 level, there is a mild left foraminal narrowing with no neural compression. At L5/S1, there is a mild broad based disc/osteophyte complex with no stenosis or narrowing. The scan of the cervical neck reveals mild broad based disc protrusion at C4/5 and C5/6 but no evidence of canal stenosis and evidence of mild bilateral foraminal narrowing due to uncovertebral joint arthropathy.
>
> MRI Scan Lumbar Spine – 23 April 2015 – (2 months after the operative procedure) – Dr L Dawes. Generalised disc disease in the lumbosacral spine with multiple disc herniation. Moderate to marked canal stenosis at L3/4 due to residual / recurrent disc herniation. Marked right subarticular recess narrowing at L4/5 with probable compression of the L5 nerve root, right side. Moderate right foraminal narrowing at L4.
>
> MRI Left Shoulder – 7 October 2015 – Medical Imaging Bankstown – Dr David Johnston. Small partial thickness tear of the anterior supraspinatus tendon on a background of tendinosis. Tendinsosis of the subscapularis tendon without a discrete tear. Mild to moderate degenerative change in the acromioclavicular joint – moderate subacromial subdeltoid bursitis – high signal in the posterosuperior labrum extending from the biceps labral anchor posteriorly consistent with a labral injury.
>
> MRI Lumbar Spine – 16 November 2015 – Medical Imaging Bankstown – Dr Rashidi Mbakada. Disc bulges noted at multiple levels with small annular tears at L2/3 and L3/4. At the L3/4 level there is impingement of the descending L4 nerve root and possible irritation of the exiting left L 3 nerve root. L4/5 impingement of the descending right L5 and exiting right L4 nerve root. Moderate bilateral facet joint degenerative change at L3/4 and L4/5. Mild to moderate facet joint degenerative change at L5/S1.
>
> MRI Scan Left Shoulder – 2 March 2016 – Medical Imaging Bankstown – Dr Georges Hazan. Insertional tear of the supraspinatus tendon measuring 8mm – enlarged from the 7 October 2015 scan. Type 3 SLAP tear – acromioclavicular joint osteoarthritis impinging upon the medial acromial arch. Small bony spur with lateral acromial arch impingement.
>
> MRI Cervical Spine – 2 September 2016 – Medical Imaging Bankstown – Dr Rashidi Mbakada. Bilateral uncovertebral and facet joint degenerative change at L3/4, L4/5 and L5/6 level and to a lesser extent at the C6/7 level.

MRI Scan Cervical Spine & Lumbar Spine – 27 July 2017 – Rayscan Imaging Liverpool – Dr Niranjan Ganeshan. Mild discovertebral changes with minimal cord compression at C4/5 with some foraminal narrowing with potential nerve root compression at the C4/5 level. Minor disc bulges at C3/4 and C5/6, without definite neural impingement. Minimal bulge at the C6/7 level without neural impingement. The scan of the lumbar spine reveals discovertebral changes throughout the lumbar spine – previous left hemi-laminectomy. No recurrent disc impingement on the L3 nerve root. There is some lateral recess narrowing at this level without L4 compression.

MRI Scan Left Shoulder – 8 January 2018 – Campsie Medical Imaging – Dr Craig Harris. Cuff insertional tendinopathy involving anterior fibres – no discrete tear – downsloping acromiom with coracoacromial ligament thickening – bursitis. Tendinopathy with moderate severity without tear of LHB. Acromioclavicular joint degenerative change of moderate severity without undersurface osteophytes. Labral degeneration most marked superiorly and posteroinferiorly with no discrete labral tear.

X-ray & Ultrasound Left Wrist – 8 January 2018 – Campsie Medical Imaging – Dr Craig Harris. Old ulnar styloid fracture ununited with adjacent synovitis surrounding the TFCC.

MRI Scan Left Shoulder – 8 January 2018 – Campsie Medical Imaging. Severe supraspinatus insertional tendinopathy with intrasubstance delamination. No full thickness tear – less marked tendinopathy elsewhere with no muscle atrophy. Down sloping acromion with coracoacromial ligament thickening with bursitis. Severe LHB tendinopathy without tear. Degeneration of the superior labrum without tear. A focal labral tear between 5 o'clock and 6 o'clock anteriorinferiorly with paralabral cyst formation – no displaced fragment. Severe acromioclavicular joint degenerative change with bone on bone articulation, synovitis and marrow oedema. Undersurface osteophytes encroaching on the supraspinatus outlet.

MRI Lumbar Spine – 23 July 2019 – Medical Imaging Bankstown – Dr Rashidi Mbakada. Previous partial L3/4 discectomy noted. Evidence of disc desiccation and residual moderate central posterior broad based disc bulge at this level resulting in mild spinal canal stenosis and impingement of the descending L4 nerve root in the lateral recess. There is also contact of the exiting left L3 nerve root in the neural foramen. Disc desiccation and moderate osteophyte disc complex at L4/5 impinging of the descending on the right L5 nerve root in the lateral recess and contacting both exit L4 nerve roots in the neural canal. Disc desiccation and mild disc bulge at L5/S1 contacting the exiting left L4 nerve root in the neural canal.

X-ray Left Wrist Joint – 23 July 2019 – Medical Imaging Bankstown – Dr Prasad Kundum. There is a negative ulnar variant. No recent bony fracture or dislocation is noted. Mild degenerative change seen within the radiocarpal joint. I reviewed this x-ray and I note that there is a non-union of the ulnar styloid fracture, not reported by Dr Kundum.

MRI Scan Right Shoulder – 14 August 2019 – Medical Imaging Bankstown – Dr Georges Hazan. Advanced arthritic change with capsular hypertrophy and bony oedema impinging upon the mid acromial arch. Tendinosis focally within the supraspinatus tendon. No associated tear. The long head of the biceps is unremarkable – infraspinatus tendon is normal. Small ganglion of the anterior aspect of the joint capsule in close association with the anteroinferior glenoid suggestive of glenoid labral tear inferiorly."

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

> "Mr Brown fell from scaffolding at work on the 6 January 2014 sustaining significant injury and has not been able to return to work. He continues to report discomfort in his cervical neck. He reports continuing discomfort in his low back with intermittent pain into the left leg, continuing despite decompression at the L3/4 level in February 2015.
>
> He continues under the care of his attending Neurosurgeon who suggested that more surgical intervention is potentially required. He also sustained a significant closed injury to the right and left shoulder with resulting reduction in active range of motion on both sides with continuing discomfort. He has had a surgical decompression relating to the osteoarthritis involving the left acromioclavicular joint with only minimal, if any, improvement of symptoms. He has similar pathology on the right side and it has been suggested by his attending surgeon, Dr Rahme, that surgical intervention is required on the right side.
>
> There has also been surgical intervention under the care of Dr Chis Scott, relating to the left wrist, on the 23 August 2018, because of ulnar nerve symptoms involving the left hand, due to ulnar nerve compression at wrist level (canal of Guyon). There has been a decompressive surgery performed with some improvement in the discomfort but some continuing partial sensory loss in an ulnar nerve distribution.
>
> There is also continuing restriction of active terminal range of wrist movement."

25. The AMS answered the question "Is any proportion of loss of efficient use or impairment or whole person impairment, due to a previous injury, pre-existing condition or abnormality?" by simply writing "N/A".

26. Later in the MAC the AMS addresses the deductible proportion under 323 as follows:

> **"DEDUCTION (IF ANY) FOR THE PROPORTION OF THE IMPAIRMENT THAT IS DUE TO PREVIOUS INJURY OR PRE-EXISTING CONDITION OR ABNORMALITY**
> There is no deductible proportion"

27. There is no explanation from the AMS as to why he considered there was "no deductible proportion".

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

> "Lumbar Spine:
> At the time of today's assessment, reference is made to the American Medical Association Guide for the Evaluation of Permanent Impairment, 5th Edition, and the New South Wales Workers Compensation Guidelines for the Evaluation of Permanent Impairment, 4th Edition.
>
> It is noted under Item 4.37 of the Current Guidelines, that surgical decompression for spinal stenosis is classified as a DRE Category III impairment. Therefore, with reference to Table 15.3, AMA 5, at the time of today's assessment the applicant demonstrates a DRE Lumbosacral Spine Category III Impairment – 10-13% Whole Person Impairment.

At the time of today's assessment, the applicant does not fulfil the definition of radiculopathy as set out in Item 4.27 of the Guidelines. There is no loss or asymmetry of reflexes or evidence of muscle weakness or reproducible sensory loss than can be localised to an appropriate spinal nerve root distribution. There is a negative sciatic nerve root tension sign on the right and left side and no asymmetrical muscle wasting. There are however current imaging studies demonstrating potential impingement of the lateral recess of distal lumbar nerve roots on the left side. The definition of radiculopathy as set out in the Guides is not met at the time of today's assessment, requiring 2 or more of a list of 6 clinical signs to be present.

Reference is also made to Item 4.34 to 4.36 of the Guides. Mr Brown has not been able to return to his work and is unable to participate in home care activities. He was able to remove items of clothing today. It is therefore my opinion that a 2% Whole Person Impairment may be added to the base impairment – 10 + 2 = **12% Whole Person Impairment.**

Right Upper Extremity
Shoulder
At the time of today's assessment there is a painful restriction of right shoulder movement.

Reference is therefore made to Figures 16.40 to 16.46, AMA 5.

Upper Extremity Shoulder	Right	Upper Extremity Impairment
Flexion	150°	2%
Extension	40°	1%
Abduction	150°	1%
Adduction	40°	0%
Internal Rotation	60°	2%
External Rotation	60°	0%
Total		**6% UEI Right**

Reference is made to Table 16.3, AMA 5. A 6% upper extremity impairment equates to a **4% Whole Person Impairment.**

LEFT Upper Extremity
Shoulder
At the time of today's assessment, the left shoulder demonstrates a painful restriction of terminal range of motion.

Reference is therefore again made to Tables 16.40 to 16.46, AMA 5.

Upper Extremity Shoulder	Left	Upper Extremity Impairment
Flexion	150°	2%
Extension	40°	1%
Abduction	140°	2%
Adduction	40°	0%
Internal Rotation	70°	1%
External Rotation	60°	0%
Total		**6% UEI Left**

Wrist
There is a terminal active range of motion loss of the left wrist. Reference is made to Figures 16.31 to 16.2, AMA 5.

Upper Extremity Wrist	**Left**	**Upper Extremity Impairment**
Flexion	50°	2%
Extension	50°	2%
Radial Deviation	20°	0%
Ulnar Deviation	20°	2%
Total		**6% UEI Left**

Wrist
Sensory Loss
At the time of today's assessment there is a partial sensory loss on the volar aspect of the left 5th and 4th finger consistent with distal ulnar nerve injury, following the surgical decompression of the canal of Guyon.

Reference is made to Figures 16.10, AMA 5 – a diminished light touch without abnormal sensation that is forgotten during activities, equates to a 25% sensory deficit.

Reference is now made to Table 16.15 – maximum upper extremity due to unilateral sensory nerve injury, partial sensory loss relating to ulnar nerve below mid forearm – 5th and 4th fingers = 7% upper extremity impairment. Such impairment is multiplied by the sensory deficit, 7 x 25 = 1.75% rounded up to 2% upper extremity impairment.

The above upper extremity impairments relating to the left upper extremity may be combined:
6 + 6 + 2 = 14% Upper Extremity Impairment

Reference is made to Table 16.3, AMA 5: 14% upper extremity impairment equates to an **8% Whole Person Impairment** left side.

Lumber Spine	12% WPI
Right Upper Extremity	4% WPI
Left Upper Extremity	8% WPI
Total	22% Whole Person Impairment

Scarring
Reference is made to the 4th Edition of the NSW Guidelines for the Evaluation for Permanent Impairment. It is noted that uncomplicated scars for standard surgical procedures do not of themselves rate an impairment."

29. The panel notes that there is no complaint on appeal about the overall level of impairment assessments for each body part referred to the AMS.

30. The AMS made brief comment on the other evidence that was before him as follows:

"I read with interest the reports prepared by Dr Chris Scott, Orthopaedic Hand Surgeon. He did note in his report of the 30 July 2018, that following the procedure to decompress the ulnar nerve in the canal of Guyon, that if there was persisting ulnar sided wrist pain, he would have to attend to the delayed styloid non-union. Mr Brown remains tender on that side.

Various reports from Dr McKechnie were read. At his last visit 6 weeks ago, Dr McKechnie discussed with Mr Brown the requirement for further decompressive surgery in the lumbar spine.

I read with interest the report prepared by Dr Tai-Tak Won, Rehabilitation in Sports and Pain Medicine Specialist, on the 26 October 2016. This report was performed after the spinal surgery but before the definitive surgery relating to the left shoulder and left wrist. At that time, Dr Won had evidence consistent with a DRE Lumbar Category III impairment but deducted a 1/10th for pre-existing clinical issues. I have no historical record of any pre-existing clinical issues relating to the lumbar spine. He noted at the time of his examination, a subjective impaired sensation to pain affecting the whole of the left lower limb both proximately and distally including the left foot which did not follow any dermatomal distribution. Mr Brown has described some symptoms into his left lower leg continuing since the surgery but there was no neurological impairment today. At the time of his examination, there was a very restricted active range of motion in the right and left shoulder with no clinical symptoms and signs associated with the right or left wrist however.

I read the report prepared by Dr Michael Ryan, Orthopaedic Spinal Surgeon, on the 13 April 2016. He assessed impairment after the lumbar spinal surgery but prior to any upper extremity surgery. He acknowledged the previous transverse process fractures from L 1 – L 4, which do not equate to any ongoing impairment, when not displaced as set out in Item 4.31 of the guides.

The reports of Dr Daniel Rahme make reference to the previous surgery of the left shoulder on the 12 March 2018. A recent clinical visit on the 4 September 2019, resulted in a comment from Dr Rahme that there was a requirement for right shoulder surgery.

I read with interest the report prepared by Dr Paul Darveniza, Neurologist, at the St Vincents Clinic, dated 11 October 2018. He notes that Mr Brown has noted worked since the accident and sleeps poorly because of pain. He notes a continuing history of low back pain. Dr Darveniza noted at the time of his examination there was no neurological impairment of the lower extremity. He noted the history of surgery to the left wrist area and continuing numbness in the 4th and 5th finger, without wasting or weakness of ulnar supplied nerve supplied muscles which was similar to my clinical findings today. He notes continuing neck pain. He notes a restricted range of motion continuing in both the right and left shoulder. He assesses whole person impairment of the cervical spine at 0% WPI. He noted a 10% whole person impairment relating to the lumbosacral spine – DRE lumbar category III and added 2% for activities of daily living. He notes a significant impairment relating to the right and shoulder restricted range of motion and also the sensory ulnar nerve impairment on the left side. Dr Darveniza opines a combined impairment of 26% WPI. He also makes a comment that Mr Brown continues under psychiatric care and is on anti-depressant medication which may account for his complaints of erectile dysfunction."

31. The appellant complained that the AMS did not comment on the opinion of Dr Briet the IME qualified on their behalf. The panel does not consider that this constitutes an error by the AMS in this case. He stated at the beginning of his MAC that he had been referred for the assessment the response and the documents attached. Dr Briet reports were attached to the response. The AMS was not required to address each piece of evidence. He was required to assess the impairment that resulted from the injury referred to him. He was not required to delve into issues of causation and consider whether impairment resulted from an unclaimed and undetermined injury resulting from the "nature and conditions" of employment.

32. The AMS was however required to consider whether there should be a deductible proportion for any pre-existing condition, abnormality or injury. He merely stated that the deductible proportion was "N/A" and that there was no deductible proportion. The AMS failure to explain why he considered there was no deductible proportion in the circumstances of this case where on the available evidence (radiological and in the form of the clinical notes from his treating general practitioner) there was clear evidence of pre-existing condition, abnormality or injury affecting the lumbar spine constitutes an error.

33. On the available evidence, the panel considers that there has been a contribution to the level of permanent impairment assessed from the pre-existing condition, abnormality or injury in the lumbar spine which needs to be taken into account.

34. In respect of the lumbar spine, the available evidence includes the following:

(a) Dr Ryan, an AMS assessed the worker and provided a MAC dated 13 April 2016 in which he recorded that the worker reported no previous back injury or back pain. Dr Ryan did not review any investigations of the lumbar spine.

(b) Dr Wan, an AMS who assessed the worker and provided a MAC dated 28 October 2016 recorded: "Mr Brown denies any significant accidents, injuries or other relevant conditions sustained prior to the subject accident. He also denies any significant accidents, injuries or other relevant conditions sustained since the subject accident."

(c) Dr Wan recorded the findings of the MRI scan of the lumbar spine dated 10 February 2014 as follows:

" MRI Lumbosacral spine showed transverse process fractures involving the left L1 to L4. There was a small haematoma in the subcutaneous space at L2/3 level, with surrounding oedema. There was a moderate canal stenosis at L3/4, and moderate right subarticular recess and right foraminal narrowing at L4/5. There was a moderate to large broad-based central disc protrusion at L3/4 and L4/5. There was no bone oedema to suggest vertebral fractures elsewhere."

It is noted that no mention was made of the cause of the L3/4 moderate canal stenosis or the right foraminal narrowing at L4/5. Degenerative changes as a possible cause were not reported.

(d) Dr Wan referred to various reports of Dr McKechnie, treating Neurosurgeon, including the following;

1. 3 December 2014; "referred him for a CT guided left L4 perineural cortisone injection which was unsuccessful". "Given his persistent pain in the MRI findings I offered him surgery in April 2014. Surgically I have recommended a left L3/4 partial laminectomy, microdisectomy and rhizolysis. I last reviewed his progress on the 19th November, 2014. He was still complaining of back and left leg pain. He continued with physiotherapy and hydrotherapy ... "

2. 17 December 2014: "In a report dated 2 February 2015, Dr McKechnie stated that he reviewed Mr Brown on that day. Clinically, Mr Brown was unchanged through the left leg. He was walking slowly with the aid of one stick. The proposed spinal surgery had been approved by the insurer."

3. 9 March 2015: "Dr McKechnie stated that he reviewed Mr Brown on 5 March 2015, about a month following his lumbar spinal surgery. Mr Brown still had residual back and neck pain, and the wound had healed well. There was no evidence of an infection. He was referred for a course of hydrotherapy and physiotherapy and was still unfit to return to work."

(e) Dr Wan then quoted from an IME report by Dr Casikar for the insurer dated 12 May 2014:

"In a report dated 12 May 2014, Dr Vidyasagar Casikar, a neurosurgeon, stated that he assessed Mr Brown on that day, at the request of the insurer (The assessment was
done prior to the spinal surgery by Dr McKechnie). On examination, Dr Casikar found that Mr Brown walked with a walking stick with a slight antalgic gait. There was a resolving haematoma in the back. Dr Casikar reported, "The neurological examination of the lower limbs suggested an SLR ranging between 50' to 60". There was no dermatomal hypoaesthesia ... The deep tendon reflexes were normal".

(f) Dr Wan concluded that Mr Brown's lumbar spine is DRE III (due to surgery for spinal canal stenosis not radiculopathy). He makes a deduction of 1/10th for pre-existing degenerative changes relying on a CT scan after the injury to support the deduction.

(g) A review of the clinical notes of Bankstown Medical Centre from 24 January 2011 to 17 February 2016 provide substantial evidence of a previous injury to the lumbar spine with left sided sciatica as follows: (emphasis in original)

1. "24 Jan 2011 CHRONIC LUMBAR BACK PAIN SINCE MVA 2 YRS AGO MOVED FROM COFFS HARBOUR HAS SCIATICA LT SEEN BY A NEUROSURGEON. CTC LUMBAR SPINE"

2. "21 March 2011 -PRODEINE FOR BACK PAIN, NEEDS DENTAL WORK SEEN NEUROSURGEON"

3. "3 June 2011 - low back pain has radiated down the left side of the leg, from the last week pain increased, say l0/10"

4. Further consultations concerning chronic back pain on 20 June 2011, 7 July 2011, 9 September 2011, 21 November 2011, 6 February 2012, 10 April 2012 and 6 June 2012. Has been on narcotic analgesics for the entire period and receiving a Centrelink benefit.

5. "12 June 2012 - today in the morning pt was Involved in a car crash he was the driver /hit on passenger side caused his head to move sideways now having localised pain in the left side of the neck.

o/e tenderness of the neck, all movement restricted, Whip lash Injury grade II"

No mention made of back injury or aggravation.

6. "3 December 2012 - lumbar back pain recurrence, flexion limited by pain, panadeine forte"

7. 8 July 2013 and 21 October 2013 - further appointments to provide prescriptions of Panadeine Forte for ongoing back pain.

8. "28 November 2013 - MVA YESTERDAY HIT FROM BEHIND ON MARION ST WEARING SEATBELT NOW PAIN NECK TOOK PANADEINE FORTE 0/E ALL MOVT NECK RESTRICTED BY PAIN WHIPLASH XRAY C SPINE STILL PAIN ENDONE"

9. "24 December 2013 - On disability pension for back pain."

35. The Panel notes that the GP's clinical records contain evidence of the respondent worker suffering chronic low back pain with left sciatica from a previous MVA in about 2009. The respondent worker was on ongoing narcotic analgesics for this condition from 2011 until the subject work injury. It is noted that his GP stated he was on a disability pension for this back pain less than three weeks before the subject work injury. The Panel notes that the Respondent worker has tended not to report his previous chronic back condition to the AMS's who have assessed him for the purpose of his compensation claim in respect of the subject injury.

36. The panel also notes that the spinal operation was for ongoing radicular pain but no real evidence of radiculopathy. This was not due to the lateral process fractures but was almost certainly due to his pre-existing injury at L3/4 causing spinal canal stenosis.

37. The pre-existing condition, abnormality or injury in the respondent's worker lumbar spine has contributed to the need for the operation, upon which the assessment of the level of permanent impairment is based, and has therefore contributed to the level of permanent impairment assessed and is required to be taken into account. The AMS erred in this regard because he did not do this and he did not explain why he was making no deduction under section 323 for the lumbar spine in the face of the available evidence about the pre-existing chronic low back pain with left sided sciatica.

38. For these reasons the panel considers that on the available evidence a deduction must be made under section 323. As the extent of the deduction would be too difficult or too costly to determine, the deduction will be one-tenth.

39. The assessment for the lumbar spine will accordingly be 12% less 1.2% gives 10.8% or 11% after rounding

40. In respect of the left shoulder, there is evidence that the worker landed on his left side in the fall and reported left shoulder pain. The GP notes mention left shoulder pain on 6 January 2014 from the hospital discharge referral. It gradually deteriorated and by July 2015 he was reporting increased pain and a reduced range of movement. An x-ay and ultrasound of the left shoulder dated 2 July 2015 revealed the following;

"X-RAY AND ULTRASOUND LEFT SHOULDER
Clinical History: Decreased abduction. pain.
Radiologist
Dr Mahesh Kulkan
FRANZCR FRCR(UK)
11868692

Findings: In the shoulder the glenohumeral alignment Is maintained. The AC joint shows moderate degenerative changes. The bone density is borderline The soft tissues are unremarkable.
The biceps tendon is intact. No gross biceps effusion. The rotator cuff tendons show a normal configuration and are Intact. The sub deltoid bursa is significantly thickened. There is some impingement on the bursa on dynamic assessment.

COMMENT:
Features are those of sub deltoid bursitis with Impingement. No signs of a rotator cuff tear or tendonopathy. AC joint is degenerative."

He was referred to the late Dr Kalnins, Orthopaedic Surgeon who ordered an MRI scan of the left shoulder dated 7 October 2015. This revealed the following;

"MRI LEFT SHOULDER
History: Left shoulder pain. AC OA.
THE LEADER IN LOW DOSE IMAGING
Examination Date, 07/10/2015
Patient ref: 156913
Technique: Sagittal T1, T2 FS with coronal PD, PD FS and axial PD, PD FS sequences. Field strength = 1.5T.

Findings:
There is tendinosis of the anterior supraspinatus insertion with a small partial thickness articular surface tear extending over a width of 4mm. The Infraspinatus and teres minor tendons are intact. Tendinosis of the subscapularls Insertion is present without a discrete tear. The long head of biceps tendon is intact. Moderate high signal is present in the posterosuperior labrum which extends from the biceps labral anchor posteriorly. No definite labral tear however can be identified. The inferior glenohumeral ligament is intact. There is no joint effusion or evidence of loose bodies. Mild to moderate degenerative change is present in the acromioclavlcular joint with a small effusion. Only minor adjacent bony oedema is present. The coracoclavicular, coracoacromial and coracohumeral ligaments are intact. Mild to moderate fluid is present in the subacromial/sub deltoid bursa. There are no bone contusions.

COMMENT:
1. Small partial thickness tear of the anterior supraspinatus tendon on a background of tendinosis.

2. Tendinosis of the subscapularis tendon without a discrete tear.

3. High signal in the posterosuperior labrum extending from the biceps labral anchor posteriorly consistent with a labral injury although the exact morphology is difficult to assess.

4. Mild to moderate degenerative change in the acromioclavicular joint.

5. Moderate subacromial/sub deltoid bursitis."

41. The panel notes that whilst some degenerative changes are noted in the investigations 18 months after the fall, there is evidence of a discrete left shoulder injury in the fall and no evidence of pre-injury shoulder pain. This level of degenerative change could have occurred in the 18 months after the accident and there is no evidence that it occurred before the work injury. Accordingly, the panel considers that the AMS was correct to make no deduction under section 323. The panel will confirm the MAC in respect of the assessment of 8% WPI for the left upper extremity with no deduction.

42. In respect of the right shoulder, the panel similarly considers that there is no evidence to support a deduction and the panel will confirm the MAC in this regard. Accordingly, the Panel will confirm the assessment of 4% WPI for the right upper extremity with no deduction.

43. A combination of 11% WPI for the lumbar spine with 8% WPI for the left upper extremity and 4% WPI for the right upper extremity gives a total impairment assessment of 21% WPI as a result of injury on 6 January 2014.

44. For these reasons, the Appeal Panel has determined that the MAC issued on 15 October 2019 should be revoked and a new MAC should be issued. A 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 APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

L Golic

Lucy Golic
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **3935/19**
Appellant: **Sami Brown**
Respondent: **Royal Fastform 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 Ian Meakin 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 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 Lumbar Spine	**6/1/2014**	**Chapter 4 Page 26-33**	Item 4.37, 4.27, Table 15.3, Item 4.34 to 4.36 AMA 5	**12%**	**1/10**	**11%**
2. Right Upper Extremity	**6/1/2014**	**Chapter 2 Pages 13-15**	Figures 16.40 to 16.46, Table 16.3, AMA 5AMA 5.	**4%**	**Nil**	**4%**
3. Left Upper Extremity – Shoulder & Wrist, nerve injury	**6/1/2014**	**Chapter 2 Pages 13-15**	Figures 16.40 to 16.46, Figures 16.10, Table 16.15, 16.3, AMA 5.	**8%**	**Nil**	**8%**
Total % WPI (the Combined Table values of all sub-totals)					**21%**	

Jane Peacock
Arbitrator

Dr Drew Dixon
Approved Medical Specialist

Dr Mark Burns
Approved Medical Specialist

11 March 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*.

L Golic

Lucy Golic
Dispute Services Officer
As delegate of the Registrar