WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-5612/20**
Appellant:	**Flavorjen Pty Limited**
Respondent:	**Timothy Yates**
Date of Decision:	**23 February 2021**
Citation No:	**[2021] NSWWCCMA 39**

Appeal Panel:	
Arbitrator:	**Brett Batchelor**
Approved Medical Specialist:	**Dr Mark Burns**
Approved Medical Specialist:	**Dr Drew Dixon**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 1 December 2020, Flavorjen Pty Limited (the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Mohammed Assem, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 16 November 2020.

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 (the 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 (AMA5).

RELEVANT FACTUAL BACKGROUND

6. Timothy Yates (the respondent/Mr Yates) claims lump sum compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act) as a result of injury arising out of or in the course of his employment with Flavorjen. Mr Yates' employment as a factory process worker involved him in primarily manually grinding and tampering coffee beans with a large metal rod. Within weeks of the commencement of his employment in August 2015 he began to develop numbness, swelling and pain in both hands and wrists. These symptoms gradually increased in intensity and he sought medical attention from his general practitioner, Dr Vincent Au. Mr Yates was prescribed non-steroidal anti-inflammatory medication and certified totally unfit to work since that time. The appellant's insurer, GIO accepted liability for Mr Yates' claim for compensation.

7. The respondent received regular hand therapy from a hand therapist without any long term benefits. An MRI scan of the cervical spine on 30 October 2015 revealed mild compression to the exiting left C7 nerves at C6/7 level cause by broad based osteophytes. There was mild compromise to the exiting C6 nerves bilaterally and minor compromise to the exiting left C5 nerve. Mr Yates was referred to a hand surgeon, Dr Tawfik, who diagnosed bilateral carpal tunnel syndrome and suspected double crush syndrome secondary to cervical spondylosis with potential impingement of the exiting C6 and C7 nerve roots.

8. Dr Tawfik performed a right carpal tunnel release and a nerve block injection into the cervical spine on 14 March 2015 which provided initial relief of symptoms, but recurrence thereafter. A left carpal tunnel release was performed on 13 May 2016, after which Mr Yates continued hand therapy. He was suspected of having complex regional pain syndrome (CRPS) and referred to rehabilitation physician, Dr Richard Liu, and occupational physician, Dr Ng. The respondent was then seen by neurologist, Dr Tisch who noted a variable tremor that he believed to be functional in origin. He has received psychological counselling, and psychiatric management from Dr Pulley who ceased all the antidepressant medication, anti-epileptic medication and anti-neuropathic medication that Mr Yates was taking. Dr Pulley prescribed medicinal marijuana without any significant benefit.

9. The respondent has been previously diagnosed as suffering from bipolar disorder managed by Dr Pulley. Following the right and left carpal tunnel releases, he had several falls resulting in hand fractures and surgical correction.

10. The respondent underwent an independent medical assessment by Dr James Bodel, orthopaedic surgeon, on 25 November 2019 who produced a report of that date[1]. Dr Bodel summarised Mr Yates' injuries as "Weakness, numbness and tingling in both wrists and hands", and summarised his occupational and medical history since the onset of complaints following his employment with the appellant. Dr Bodel noted that Mr Yates had developed a very complex set of injuries which included:

    (a) aggravated degenerative change in the cervical spine;

    (b) CRPS involving both upper limbs, mainly the right arm;

    (c) probable carpal tunnel syndrome in both wrists, and

    (d) rotator cuff pathology in the region of both shoulders.

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[1] Appeal Papers p 62.

11. Dr Bodel noted ongoing disabilities as pain and stiffness involving the neck and both upper limbs and a guarded prognosis. The clinical symptoms suggested to Dr Bodel that the CRPS was improving, but at testing on the day of examination Mr Yates still had florid signs of the condition. Dr Bodel said that the respondent is likely to continue to have symptoms indefinitely, but he did not anticipate further complications and was hopeful of further improvement over time.

12. In his supplementary report dated 25 November 2019[2] Dr Bodel provided the following assessments:

    (a) cervical spine: DRE Cervical Category II- 5% whole person impairment (WPI) + 2% loading for compromise of Activities of Daily Living, giving 7% WPI;

    (b) right upper extremity, based on a finding of CRPS Table 17.1 p 81 of the Guidelines:

        (i) 10% upper extremity impairment (UEI) rateable restriction of right shoulder movement;

        (ii) 7% UEI rateable restriction of right wrist movement, and

        (iii) 10% UEI for residual median nerve compression of the wrist,

    for a total WPI of 15% using the Combined Values chart on p 604 of AMA5.

    (c) left upper extremity: 2% WPI as result of restriction of left shoulder movement.

13. On behalf of the appellant Dr Stephen Rimmer, orthopaedic surgeon, expressed the belief following an independent medical examination of Mr Yates on 16 March 2020 (report dated 23 March 2020[3]) that he had not suffered any injury to his cervical spine, right upper extremity or left upper extremity on 13 October 2013, the date of injury claimed. Although outside his field of expertise, the doctor said his condition is consistent with that of Parkinson's disease and suggested that a second opinion be obtained from a neurologist regarding the resting/intention tremor in the right upper limb, which the respondent claimed was then beginning to develop in the left upper limb. Dr Rimmer did not believe that the respondent has sustained any impairment as a result of his previous employment around the time of October 2013.

14. Mr Yates was examined by Dr Ross Mellick, neurologist, on 27 July 2020 (report dated 7 August 2020[4]). He noted that the tremor experienced by Mr Yates had been the main problem, noted to have become worse during the previous six months. Dr Mellick stated that the electrophysiological evidence supports the diagnosis of carpal tunnel syndrome and that details of the work that Mr Yates was doing prior to the development of the hand symptoms are in keeping with the accuracy of the diagnosis which informed the surgical decompressions that were done in 2015. The doctor disagreed with Dr Rimmer's comments regarding the diagnosis of Parkinson's disease and expresses agreement with the comments of the respondent's treating neurologist, Dr Tisch, regarding the absence of that disease. He noted that the main existing symptom of tremor developed subsequent to the surgery, that the magnitude of the tremor is considerable and is incompatible with normal upper extremity function that would be required with the type of work Mr Yates performed prior to October 2013. Dr Mellick said that the tremor regrettably obstructed the possibility of adequate testing of motor and sensory function in the right hand to enable a valid WPI to be assessed in relation to AMA5 and the Guidelines.

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[2] Appeal Papers p 70.
[3] Appeal Papers p 220.
[4] Appeal Papers p 207.

15. The respondent made a claim for lump sum compensation on GIO on 4 February 2020[5] in respect of the 23 % WPI assessed by Dr Bodel. The Permanent Impairment Claim form dated 31 January 2020[6] which accompanied the reports of Dr Bodel dated 25 November 2019 with that claim listed the body system(s) affected by the injury as "Cervical spine, left & right upper extremities." In a notice issued to the respondent by GIO dated 17 August 2020 pursuant to s 78 of the 1998 Act, GIO declined liability for the respondent's claim, relying on the assessments of Dr Rimmer and Dr Mellick[7].

16. The respondent commenced proceedings in the Commission seeking lump sum compensation where degree of permanent impairment is in dispute. In accordance with the Application to Resolve a Dispute (ARD) dated 28 August 2020 commencing those proceedings[8], the matter was on 19 October 2020 referred to Dr M Assem, AMS, for assessment in respect of the following body parts:

> "Cervical spine, Left Upper Extremity, Right Upper Extremity, Nervous System, Chronic Pain."

17. On 20 October 2020, after an exchange of emails between the solicitor for the appellant and the solicitor for the respondent in which the solicitor for the respondent consented to an amendment requested by the solicitor for the appellant[9], an "Amended Referral for Assessment of Permanent Impairment to Approved Medical Specialist" (the Amended Referral) was issued to Dr Assem listing injury to the following body parts on 13 October 2015 to be referred for assessment of WPI:

> "Cervical Spine, Chronic Regional Pain Syndrome (right arm), Left Upper Extremity (shoulder)."[10]

18. On 9 November 2020, Dr Assem examined Mr Yates and issued a MAC dated 16 November 2020 containing an assessment of 24% WPI as a result of injury to the cervical spine, right upper extremity and left upper extremity on 13 October 2013.[11]

PRELIMINARY REVIEW

19. 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.

20. 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 neither the appellant not the respondent requested re-examination of Mr Yates by an AMS who is a member of the Panel, and members of the Panel consider that there is sufficient information in the Appeal Papers with which to make its decision.

EVIDENCE

Documentary evidence

21. 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.

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[5] Appeal Papers p 51.
[6] Appeal Papers p 48.
[7] Appeal Papers p 57.
[8] Appeal Papers p 34.
[9] Appeal Papers pp 199-201.
[10] Appeal Papers p 33.
[11] Appeal Papers p 20.

Medical Assessment Certificate

22. 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

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

Appellant

24. In summary the appellant submits that the MAC contains demonstrable errors and assessment on the basis of incorrect criteria, as follows:

    (a) the assessment of impairment for the left upper extremity, in particular the left elbow, wrist and nerves, was not available to the AMS based on the terms of the amended 'Referral for Assessment of Permanent Impairment', and

    (b) the assessment for impairment for chronic regional pain syndrome (right arm) is an assessment based on incorrect criteria, and a demonstrable error, given the diagnostic findings of the AMS that the worker did not meet the criteria under Chapter 17 for a diagnosis of chronic regional pain syndrome.

25. The appellant does not appeal the assessment of the cervical spine and left shoulder.

26. The MAC contains a demonstrable error in respect of the terms of referral because the AMS was not referred the left upper extremity, specifically the elbow, wrist and nerves for assessment, but the AMS provided an assessment of those body parts.

27. The terms of the amended referral contained in the 'Referral for Assessment of Permanent Impairment' dated 20 October 2020 provide for the following parts to be assessed for injury on 11 August 2015:

    (a) Cervical spine;

    (b) Chronic Regional Pain Syndrome (right arm);

    (c) Left upper extremity (shoulder).

28. Part [10 b] of the MAC contains assessments for impairment incorporating: limitation in elbow motion, limitation in wrist motion and nerves. The assessment of the left elbow, wrist and nerves was [sic, not] within the ambit of the referral to the AMS.

29. The appellant submits this is a demonstrable error. The left elbow and left wrist cannot form any part of the assessment by the AMS, and as such his assessment of impairment of these body parts is a demonstrable error.

30. The appellant notes that the terms of referral were agreed between the parties and relate to the body parts/regions for which the claim for impairment was duly made. The referral of the left upper extremity was specifically limited to the shoulder, and the respondent made no objection to the terms of referral issued on 20 October 2020.

31. The claim for impairment relied upon an assessment in the left upper extremity by Dr Bodel who only assessed impairment of the left shoulder (ARD p 18).

32. The appellant submits that the AMS has erred in assessing the left elbow and left wrist and the MAC should be revoked.

33. The MAC contains an assessment on the basis of incorrect criteria and demonstrable error in relation to the assessment of ‘chronic regional pain syndrome (right arm)’, based on loss of range of motion of the right upper extremity.

34. At Part 7 of the MAC the AMS noted the worker had developed symptoms suggestive of complex regional pain syndrome and observed:

> “*The predominant symptom was severe tremors involving his right upper extremity. There was no hypersensitivity, allodynia, swelling or colour changes observed at the time of my assessment. There was increased perspiration in both hands.* ***He did not satisfy the diagnostic criteria for CRPS1.***” (emphasis in submissions)

35. The demonstrable error by the AMS is stated at Part 9 [sic, Part 7] of the MAC where the AMS considered that ‘it was reasonable to provide an impairment rating for loss of motion, tremors involving his dominant right upper extremity and residual symptoms of carpal tunnel syndrome following surgical decompression’. This was a demonstrable error because the general assessment of the right upper extremity was not a body part which was referred for assessment to the AMS. The right upper extremity limitations were not within the ambit of the referral. The referral was for ‘chronic regional pain syndrome (right arm)’ for which an assessment of permanent impairment required a finding of chronic regional pain syndrome in accordance with the criteria established in Chapter 17 of the SIRA Guides 4th Edition.

36. The AMS concluded at Part 7 of the MAC that the respondent did not meet the diagnostic criteria for CRPS and referenced the SIRA Guides 4th Edition, Table 17.1, page 81.

37. The assessment of impairment due to pain is excluded by the Guidelines, other than by way of the assessment criteria established in Chapter 17.

38. The appellant submits that a diagnosis of CRPS was not found by the AMS, and therefore, an assessment based on range of motion in the right upper extremity is based on incorrect criteria and/or demonstrable error.

39. The appellant submits that the AMS findings applied under Chapter 17 of the SIRA Guides 4th Edition result in an assessment of 0% WPI for ‘chronic regional pain syndrome (right-arm)’.

40. The appellant submits that the MAC be revoked and that the assessment for ‘chronic regional pain syndrome’ must be 0% based on the findings of the AMS. The appellant submits that a new MAC should be issued by the MAP assessing 2% WPI (cervical spine 0% WPI and left shoulder 2% WPI) for the injury on 13 October 2015.

Respondent

41. In reply, the respondent submits that on 19 October 2020 a referral for assessment was made to Dr Assem, AMS, in respect of the body parts of cervical spine, left upper extremity, right upper extremity, nervous system and chronic pain. On 20 October 2020 an amended referral for assessment was issued in respect of the following body parts:

    (a) Cervical spine;

    (b) Chronic regional pain syndrome (right arm), and

    (c) Left upper extremity (shoulder).

    This was done on the basis that the respondent had consented to the amendment on 14 October 2020.

42. The respondent refers to section 325(2) of the 1998 Act which provides that an assessor is to give a certificate that is to:

    (a) set out details of the matter matters referred for assessment, and

    (b) certify as to the approved medical specialist's assessment with respect to those matters.

43. The respondent submits that expression "with respect to" is a phrase of wide import and ought not to be interpreted in such a way as to frustrate the proper assessment of the degree of permanent impairment that results from injury.

44. Attention is drawn to section 66(1) of the 1987 Act which provides that a worker who receives an injury that results in a degree of permanent impairment greater than 10% is entitled to receive lump sum compensation.

45. The respondent also draws attention to the claim for permanent impairment compensation made by letter dated 4 February 2020 enclosing a permanent impairment claim form dated 31 January 2020 specifying the "Body system affected by the injury is Cervical spine, left and right upper extremities".

46. The respondent filed an ARD in respect of "Lump sum compensation where degree of permanent impairment is in dispute" on about 28 September 2020 describing the injury as "gradual onset of symptoms affecting the neck, right and left shoulder and right and left arms, wrists and hands…" Permanent impairment was claimed in respect of the body systems of cervical spine, left upper extremity, right upper extremity, nervous system and chronic pain. These injuries were not disputed in the Reply.

47. The respondent refers to the two referrals for assessment in the case, the original one and the amended one. The respondent submits that the assessor, Dr Assem, assessed the impairment as he was required to do by the 1998 Act in accordance with the Guidelines. His assessment certificate is clearly referable to the body parts and systems in respect of which the claim was made (cervical spine, left and right upper extremities, etc) and is clearly within the original referral for assessment. The respondent submits that it is also within the amended referral because the words "with respect to" have "such an ambulatory effect".

48. The respondent submits that there is nothing in the legislation or Guidelines that restricts an assessor to making an assessment in respect of the injuries or body parts as per a diagnosis described in the referral (CRPS) and, in any event, the amended referral refers to "(right arm)" and "Left Upper Extremity ". The respondent submits that it cannot be seriously doubted that Dr Assem's assessment is "with respect to" the right arm and left upper extremity (as well as the cervical spine). Dr Assem determined that, when he examined the worker, he did not display enough symptoms and signs to be assessed, in respect of his right and left upper extremities, by reference to chronic regional pain syndrome. However, he was clearly of the view that the worker had permanent impairment of those regions which could otherwise be assessed in accordance with the relevant legislation and guidelines. It was within his discretion, according to the respondent, to do so and indeed it was his duty to do so in an order for the worker to receive his proper entitlements.

49. The respondent submits that CRPS is a diagnosis, it is not a body part or system. If that diagnosis cannot be made but permanent impairment resulting from an injury exists, the respondent asks, "does the worker lose his entitlement to lump sum compensation?" The respondent asserts that the only question for determination is whether the MAC cannot possibly be described as being "with respect to" the matters referred. The respondent submits that there is no demonstrable error regarding the MAC as falling within such description and therefore no basis for referral of the matter to an Appeal Panel.

50. The respondent submits that in essence, on proper analysis, in this case there were in fact two referrals. He submits that the purpose of a referral is purely administrative, designed to direct attention of the assessor to the body parts or systems requiring assessment. The relevant parts or systems in this case, in terms of the Guidelines, were the upper extremity (Guidelines Part 2); the spine (Guidelines Part 4); the nervous system (Guidelines Part 5) and the evaluation of permanent impairment arising from chronic pain (Guidelines Part 17).

51. The respondent asserts that it is the duty of an assessor to assess the degree of permanent impairment resulting from an injury. The medical assessor is required to apply his expertise to make his evaluation. In this case he had to determine whether he could make an assessment in accordance with a diagnosis (CRPS) or otherwise. There is no purpose to be served in denying permanent impairment compensation to a worker because the terms in which the body parts or systems are described in a referral do not correspond with the body parts or systems requiring assessment as a result of the worker's injuries as described in his claim and where the only issue is as to the degree of permanent impairment.

52. The respondent submits that should the foregoing submissions not be accepted he should be referred under section 329(1) of the 1998 Act for further assessment by Dr Assem with the referral being in respect of the following body parts or systems: cervical spine; left upper extremity; right upper extremity; and nervous system and chronic pain.

53. Should those submissions not be accepted, and the matter be referred to an Appeal Panel, the respondent requests that the terms of referral should be as per the original referral to Dr Assem, that is, requiring the Appeal Panel to assess the following body parts:

> "Cervical Spine; Left Upper Extremity; Right Upper Extremity; Nervous System and Chronic Pain.

without the need for any re-examination of the respondent worker."[12]

FINDINGS AND REASONS

54. 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. An Appeal Panel is limited to determining error as alleged by the appellant but must assess in accordance with the Guidelines. Once error is made out, the Panel may "review" the MAC (*Siddik v Workcover Authority of NSW*[13] and *NSW Police Force v Registrar of the Workers Compensation Commission of New South Wales*[14]).

55. In *Campbelltown City Council v Vegan*[15] 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.

56. In *Skates v Hills Industries Ltd*[16] Adamson J in the Supreme Court held at [69]-[71] that the AMS is bound by the terms of referral to confine the matters determined to those which have been referred. In this regard her Honour noted the finding of Malpass AJ in *Aircons v*

[12] Appeal Papers p 18.
[13] [2008] NSWCA 116.
[14] [2013] NSWSC 1792.
[15] [2006] NSWCA 284
[16] [2020] NSWSC 837 (*Skates*).

Registrar of the Workers Compensation Commission of NSW & Anor[17]*.* At [20] in that case his Honour said at [20]:

> "The prescription contained in subsection (1) of s325 requires the approved medical specialist (AMS) to give a certificate as to the matters referred for assessment. It is significant that the provision appears to distinguish between 'a medical dispute' and 'the matters referred for assessment'. The statutory function of the AMS is to give a certificate as to those matters."

57. Section 325 of the 1998 Act is as follows:

> "(1) The approved medical specialist to whom a medical dispute is referred is to give a certificate (a ***medical assessment certificate***) as to the matters referred for assessment.
>
> (2) A medical assessment certificate is to be in a form approved by the Registrar and is to—
>
> (a) set out details of the matters referred for assessment, and
> (b) certify as to the approved medical specialist's assessment with respect to those matters, and
> (c) set out the approved medical specialist's reasons for that assessment, and
> (d) set out the facts on which that assessment is based.
>
> (3) If the Registrar is satisfied that a medical assessment certificate contains an obvious error, the Registrar may issue, or approve of the approved medical specialist issuing, a replacement medical assessment certificate to correct the error.
>
> (4) An approved medical specialist is competent to give evidence as to matters in a certificate given by the specialist under this section, but may not be compelled to give evidence."

58. At [70] in *Skates* the Court noted that the claimant in that case (through his solicitors) was given an opportunity to review the referral and make submissions as to whether it correctly stated the dispute to be referred. In this case the respondent's solicitor agreed to the amendment to the referral proposed by the solicitor for the appellant, perhaps relying on the assessment of the respondent's WPI by Dr Bodel. On examination of Mr Yates, Dr Bodel found signs consistent with the diagnosis of CRPS "…which does appear to be resolving over time."[18] He also then noted that:

> "…this gentleman has a tremor in the right upper limb. This appears to be intermittent and it does settle at times, but it is most evident when he is not actively trying to do any movement or concentrate on any particular aspect of the examination."

59. When commenting on relevant documentation on the same page of his report, Dr Bodel noted hat Dr Paul Ferris from the Shoalhaven Pain Management Centre indicated that when he first examined Mr Yates for treatment on 4 March 2019, he confirmed that at that time he had chronic bilateral upper limb pain and tremor following a work-related injury, associated with CRPS persisting post-surgery. Dr Bodel diagnosed the development in the respondent of a very complex set of injuries which included "…a complex regional pain syndrome

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[17] [2006] NSWSC 322.
[18] Appeal Papers p 66.

involving both upper limbs, mainly the right arm…"[19] In assessing Mr Yates' right upper extremity the doctor used Table 17.1 of the Guides[20], saying:

> "There are clinical signs also of the complex regional pain syndrome in the right upper extremity. This is assessed using Table 17-1 on Page 81 of the SIRA WorkCover Guidelines, Fourth Edition. There is a complex regional pain syndrome Type II present in this circumstance as there is evidence of the specific involvement of the median nerve on the right-hand side. I have followed the criteria mentioned in Table 17-1 on Page 81 and there is continuing pain which is disproportionate to the causal event that has led to the symptoms in the right upper limb. There are sufficient symptoms to satisfy Part 2 of the Table and signs to satisfy Part 3 of the Table. Part 4 indicates that there is no other diagnosis that better explains the signs and symptoms and that is the case in this circumstance.
>
> Following the regime therefore, for the assessment of a complex regional pain syndrome Type II, I have measured the ranges of motion and also the specific sensory loss involving the median nerve. There is no motor deficit in this circumstance."

Dr Bodel's assessments are set out above at [12]. The doctor assessed the left upper extremity as a result of loss of range of movement in the shoulder only.

60. At [7] of the MAC, Dr Assem found that the respondent did not satisfy the diagnostic criteria for CRPS. He went on to say:

> "He has prominent tremors involving his entire right arm as a complication of sympathetic dysfunction developing following the surgical procedure to both wrists. Although there may be a functional component, the tremors have been present for several years are now a permanent manifestation of his condition. He also has a global loss of sensation in both hands that probably occurred as a complication of sympathetic dysfunction, but the symptoms are more prominent in the median nerve distribution. I have therefore considered it was reasonable to provide an impairment rating for loss of motion, tremors involving his dominant right upper extremity and residual symptoms of carpal tunnel syndrome following surgical decompression."[21]

61. Dr Assem explained his assessment of the right upper extremity at [10 a] of the MAC[22]. He assessed:

    (a) limitation in right shoulder motion;

    (b) slight limitation in elbow motion;

    (c) limitation in wrist motion,

    for which he assessed 12 % UEI.

62. Dr Assem then noted that the respondent developed symptoms of sympathetic dysfunction which, because he found that they were slightly more prominent in the median nerve distribution, considered that the most appropriate method of determining the respondent's level of impairment was by way of analogy. He said that an analogous condition is for residual carpal tunnel syndrome present after surgery, giving 5% UEI. When this was combined with the 12% UEI, the result is16% UEI which is equivalent to 10% WPI.

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[19] Appeal Papers p 68.
[20] Appeal Papers p 71.
[21] Appeal Papers p 25.
[22] Appeal Papers p 26.

63. Dr Assem then assessed the tremors from which the respondent was suffering in accordance with AMA 5 table 13-16, p 338 to determine that he had a class 1 impairment involving the dominant upper extremity, giving 5% WPI. When this was combined with the 10% WPI referred to in [62], total WPI for the right upper extremity was assessed at 15%.

64. In the left upper extremity Dr Assem assessed limitation in shoulder motion, slight limitation in elbow motion and limitation in wrist motion plus sensory symptoms similar to residual carpal tunnel syndrome present after surgery. WPI for the left upper extremity was assessed at 10%.

65. Dr Assem assessed the cervical spine at 0% WPI.

66. The main thrust of the respondent's submissions is that the expression "with respect to" in s 325(2)(b) of the 1998 Act is a phrase of wide import and ought not be interpreted in such a way as to frustrate the proper assessment of the degree of WPI that results from an injury. The Appeal Panel does not accept that submission. Quite clearly, those words in subsection (2)(b) of s 325, refer to the "details of the matters referred for assessment" in subsection (2)(a). The details of the matters referred for assessment are set out in the Amended Referral, the terms of which are set out in [17] above. The AMS was asked to assess the "Cervical Spine, Chronic Regional Pain Syndrome (right arm) and Left Upper Extremity (shoulder)". Dr Assem found the respondent did not satisfy the diagnostic criteria of CRPS (Complex Regional Pain Syndrome).

67. The Appeal Panel notes the divergence between the Amended Referral and Table 17.1 of the Guides by the use of the word "Chronic" in the referral and the word "Complex" in Table 17.1. The medical members of the Appeal Panel draw no inference from this other than that the AMS was being asked to deal with CRPS. Dr Bodel found a complex regional pain syndrome involving both upper limbs and although the AMS does not refer to Dr Bodel's reports, he was clearly proceeding on the basis that it was CRPS that he had to consider when assessing Mr Yates. At [10 c] of the MAC, Dr Assem gives brief comments regarding other medical opinions and findings submitted by the parties. He refers to the examination of Dr Guy Bashford, rehabilitation physician, on 28 June 2016 and the absence of symptoms of CRPS other that the development of severe sweating in both hands and feet. He also refers to the diagnosis and report of Dr Davies, neurosurgeon, dated 27 November 2016 who found signs of CRPS in both upper limbs according to the Budapest criteria, which is a less demanding test for the diagnosis of CRPS than Table 17.1 of the Guides.

68. In short, the only referral of the respondent to the AMS was for a chronic regional pain syndrome in the right arm. There was no other referral in respect of the assessment of this limb.

69. The respondent's submissions proceeded on the basis that the AMS was being asked to evaluate permanent impairment arising from chronic pain with reference to Part 17 of the Guidelines (see [20] of the respondent's submissions[23]) and that the AMS had to determine whether he could make an assessment in accordance with a diagnosis (CRPS) or otherwise (see [21] of the respondent's submissions).

70. Part 17 of the Guidelines provides for the evaluation of permanent impairment arising from chronic pain. Clause 17.2 states:

> "For chronic pain assessment using AMA5 and the Guidelines, exclude AMA5 Chapter 18, on pain (p 565-91)."

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[23] Appeal Papers p 17.

71. The Appeal Panel rejects the respondent's submissions that there were two referrals to the AMS. The Amended Referral dated 20 October 2020 negated the earlier referral dated 19 October 2020. It was the Amended Referral on which the AMS was obliged to proceed and assess the respondent.

72. The Appeal Panel does not accept the respondent's submission that the use of the words "with respect to" in s 325(2)(b) of the 1998 Act allows the AMS to assess the respondent with reference to injury in the body parts and systems in respect of which the claim was originally made in the ARD, namely, cervical spine, left upper extremity, right upper extremity, nervous system and chronic pain. The AMS is bound by the terms of the referral of the matter to him.

73. The Appeal Panel finds that the MAC contains a demonstrable error in that the AMS has assessed the left upper extremity by reference to loss of range of motion in the left elbow and left wrist, and for sensory symptoms, when the referral was for the left shoulder only.

74. The Appeal Panel finds that the MAC contains a demonstrable error and that the assessment has been made on the basis on incorrect criteria in respect of the assessment of the right upper extremity. Having found that the respondent did not satisfy the diagnostic criteria for CRPS, the AMS was not at liberty to go beyond the terms of his referral and determine permanent impairment by way of analogy in accordance with paragraph 1.6 of the Guidelines. Paragraph 1.6 d is as follows:

   > "The referral for an assessment of permanent impairment is to make clear to the assessor the injury or medical condition for which an assessment is sought – see also paragraphs 1.43 and 1.44 in the Guidelines."

75. The Amended Referral dated 20 October 2020 was quite clear in what was being referred to the AMS for assessment.

76. The appellant does not take issue with the assessment of the AMS of the cervical spine and submits that the assessment of the AMS for the left upper extremity (shoulder) of 2% WPI should be accepted. This is the same degree of WPI as found by Dr Bodel for loss of movement in the left shoulder, although he found 4% UEI, compared to the finding of the AMS of 3% UEI. Both 3% UEI and 4% UEI are equivalent to 2% WPI. The Appeal Panel finds that the respondent has suffered 2% WPI as a result in injury to the left upper extremity.

77. The Appeal Panel finds that the respondent suffered 0% WPI as a result of chronic regional pain syndrome (right arm).

78. For these reasons, the Appeal Panel has determined that the MAC issued on 16 November 2020 should be revoked, and a new MAC should be issued. The new 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*.

A MacLeod

Ann MacLeod
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **5612/20**
Applicant: **Timothy Yates**
Respondent: **Flavorjen 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 Mohammed Assem 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 the Guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA 5 Guides**	**% WPI**	**Proportion of permanent impairment due to pre-existing injury, abnormality or condition**	**Sub-total/s % WPI (after any deductions in column 6)**
Cervical Spine	13 October 2015	Paragraph 4.27; paragraph 4.35; p 27	Table 15-5, p 392	0%	0%	0%
Chronic Regional Pain Syndrome (right arm)	13 October 2015	Table 17.1, p 81		0%	0%	0%
Left Upper Extremity (shoulder)	13 October 2015		Figures 16-40, 16-43, 16-46, pages 476-479	2%	0%	2%
Total % WPI (the Combined Table values of all sub-totals)						**2%**

Brett Batchelor
Arbitrator

Dr Mark Burns
Approved Medical Specialist

Dr Drew Dixon
Approved Medical Specialist

23 February 2021

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 MacLeod

Ann MacLeod
Dispute Services Officer
As delegate of the Registrar