# WORKERS COMPENSATION COMMISSION

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

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| **Matter Number:** | **M1-1797/20** |
| **Appellant:** | **St Marys Rugby League Club Ltd** |
| **Respondent:** | **Jarrad William Reardon** |
| **Date of Decision:** | **18 February 2020** |
| **Citation No:** | **[2021] NSWWCCMA 35** |

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| **Appeal Panel:** | |
| **Arbitrator:** | **Ms Deborah Moore** |
| **Approved Medical Specialist:** | **Dr John Garvey** |
| **Approved Medical Specialist:** | **Dr Ross Mellick** |

### BACKGROUND TO THE APPLICATION TO APPEAL

1. On 2 October 2020, St Mary's Rugby League Club Ltd lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Damodaran Prem Kuma, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 4 September 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 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 none was requested, and we consider that we have sufficient evidence before us to enable us to determine this 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 erred in the application of an uplift for the impact on activities of daily living.

11. In reply, the respondent submits that no errors were made.

## 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 respondent was referred to the AMS for assessment of whole person impairment (WPI) in respect of the lumbar spine resulting from an injury on 19 June 2016.

15. The AMS obtained a detailed history of the circumstances of the injury. He noted that on 9 November 2017 Dr Davis did an L4/5 decompression, as well as a left L5 rhizolysis, and that “while the symptoms of radiculopathy improved, his back pain persisted.”

16. He added: “He continues with back pain and symptoms of left sided L5 radiculopathy.”

17. After documenting the respondent’s current treatment, the AMS then set out his current symptoms as follows:

> “He is unable to maintain any position in sitting or standing for an hour and claims that within 1 hour he will develop back pain and left sided leg pain. This can happen while he is sitting or standing, or even when he is sleeping, and he will need to get up and shift his position to relieve the pain. If he persists the pain in his back becomes very sharp and goes down the back of the left thigh and into the hamstrings. Night time is difficult for him as he can never get a full night’s sleep. He needs to wake up regularly to shift his position. He claims he wakes up every 2 hours and in total will wake up 4-5 times every night.

His activities of daily living are limited. He is able to walk for 1-2 hours, sit for 1-2 hours, stand for 1-2 hours and drive for 1-2 hours. If he exceeds these limits the pain in his back will become sharp and severe and radiate down his left lower limb. His lifting is only mildly affected and he claims that he can lift up to 30kg. Prior to the accident he was able to lift more than this.

He is unable to go back to the sports that he used to do. He used to enjoy golf but has only played golf about 4-5 times over the last 2 years. He still attends the gym around 3 times per week, but this depends on the days. He has good days and bad days. On good days he can do up to 1 hour at the gym. He claims in total he will go around 8-10 times per month. He does some walking on the weekend, usually at the beach, for about 1 hour. He has tried tennis but was unable to play. He helps his partner with the housework, however, this is limited as he is unable to do any task in the house which requires him to bend or twist. This includes the heavier work within the house."

18. As regards his social activities and activities of daily living (ADL's) the AMS said:

"He is engaged to be married. He has a 17-year-old son who does not live with him. His partner has a daughter and they live together in a two-storey townhouse with a garden.

He does not smoke. He drinks 4-6 standard drinks of alcohol per week.

He used to enjoy sports and has tried most activities but after this accident he is unable to. He loves his sport and used to play professional rugby league but after a sporting injury to his lower back in the 1990s he reduced his rugby league playing and switched over to touch football and has played at a national level representing Australia in touch football. Since the accident he has not been able to return to any of these sports."

19. Findings on physical examination were reported as follows:

"He presented as a very pleasant and cooperative person. He sat on the chair comfortably without shifting unnecessarily…

He walked with a normal gait. Visual examination showed a symmetrical body with no muscle wastage and no asymmetry on either side... He was able to stand on either foot with good balance. He was able to stand on tip toes and on his heels and walk on the same without restriction or discomfort. His squatting was limited to 60% of normal, but this was due to complaints of pain in his right knee. He was able to sit on his buttocks and get up unassisted. He was able to sit on the edge of the bed and extend both legs fully. He was able to sit on the bed and was able to reach the ankles with both hands…

In lumbar spinal examination he had full flexion. His extension was limited to 20% of normal movement. In lateral flexion he stopped short when moving to the right at 50% of normal movement, while on the left side he was able to flex and reach the lower end of the knee. In this movement he complained of pain in the left lumbar region and this was the reason why he could not move any more. He displayed full rotation equally on both sides.

Examination of the back showed linear lower midline scars consistent with his surgery performed by Dr Davis. He was still tender over this scar, as well as the lower lumbar vertebrae. He displayed tenderness with guarding and some spasm over the left lumbosacral muscles…

> Both knee jerks were depressed and could hardly be felt. Ankle jerks were present and equal. Sensory testing showed hypoesthesia over the left L5 distribution. Strength of ankle flexion and extension was good and equal on both sides, however, the left big toe was weaker in both extension and flexion when compared to the right big toe."

20. The AMS diagnosed "lumbar discogenic disease with left sided radiculopathy." He added:

> "He still has residual symptoms of radiculopathy in the form of sensory changes in anatomically localised appropriate spinal nerve root distribution, most especially the sensory loss involving the L5 distribution and weakness of extension of the left big toe when compared with the right. This also reflects an appropriate spinal nerve root distribution. He has absent knee jerks. This confirms radiculopathy… when there is surgical decompression by spinal stenosis it is considered to fall into DRE Category 3…
>
> Table 4.2 states where spinal surgery with residual symptoms of radiculopathy persist in the lumbar area this should have an additional 3%. The base rate for a DRE Lumbar Category 3 is 10-13% impairment using Table 15-3, page 384, AMA5.
>
> There is no problem with his personal hygiene. However, he is unable to play any more sports or games. He is also impaired in helping his partner with household chores as discussed earlier.
>
> He will therefore carry an additional 2% loading for limitation in activities of daily living to the designated value for a DRE Lumbar Category 3 and so will be worth 12% whole person impairment. When added to the modifier for DRE categories following surgery, as advised in Table 4.2, WorkCover Guidelines, page 29, this will be 15%."

21. In commenting upon the other medical opinions, the AMS said:

> "There is a medicolegal report from Dr Steven Rimmer, Orthopaedic Surgeon, dated 16/8/19. Dr Rimmer has placed him in Lumbar DRE Category 3 which he considered to carry a 10% whole person impairment. He deducted 1/10th for pre-existing causes. I have to disagree with this as there are no pre-existing causes. Mr Reardon has played competitive sport at a professional level and has also played touch football at a national level. He would not have been able to do this if there was any pre-existing injury. This continued right up until the time of the accident and injury. Furthermore, Mr Reardon is unable to play any sports and as stated in the history above is limited in helping his partner with domestic chores. This would give an additional 2% giving rise to a 12% whole person impairment. I therefore disagree with Dr Rimmer. He has not found any residual radicular symptoms. In my examination today he meets the criteria for residual radiculopathy.
>
> There is a medicolegal report from Dr G J McGroder dated 25/3/19. The history is similar to what I have obtained. His physical examination also has confirmed signs of residual radiculopathy and I agree with this and his methodology and assessment level which is the same as what I have found…"

22. The appellant submits that the AMS, in applying the criteria mandated by the Guidelines, erred in the application of an uplift for the impact on activities of daily living.

23. Paragraphs 4.33 - 4.36 of the Guidelines relate to the assessment of an appropriate percentage for the activities of daily living. Paragraph 4.33 provides that an "assessment of the effect of the injury on AOL is not solely dependent on self-reporting but it is an assessment based on all clinical findings and other reports." Paragraph 4.35 states that the base impairment is increased by:

- 3% WPI if the worker's capacity to undertake personal care activities such as dressing, washing, toileting and shaving has been affected.

- 2% WPI if the worker can manage personal care, but is restricted with usual household tasks, such as cooking, vacuuming and making beds, or tasks of equal magnitude, such as shopping, climbing stairs or walking reasonable distances.

- 1% WP/ for those able to cope with the above, but unable to get back to previous sporting or recreational activities, such as gardening, running and active hobbies etc.

24. The appellant added:

> “In the respondent's statement he claimed to have had a reasonable outcome from his decompression surgery and lost the symptoms that ran down into his leg, although continued to have ongoing lower back pain. With respect to his activities of daily living it was alleged that he was unable to perform certain tasks around the house, however such activities were not specifically identified. The respondent stated that he was able to perform short runs but was unable to undertake a long run.
>
> Dr Stephen Rimmer in his report dated 16 August 2019 noted that the respondent was performing full-time unrestricted employment as a Correctional Officer. The appellant submits that such occupation inevitably demands a high level of physical fitness and capacity. It was also confirmed that the respondent attended the gymnasium approximately three times per week "with ease". Bearing in mind such history in combination with the clinical findings, Dr Rimmer believed the respondent did not qualify for any uplift for the impact on activities of daily living.
>
> Dr Gregory McGroder in his report dated 25 March 2019 noted that the respondent had played occasional social games of golf and he participated in short runs. He had not returned to tennis, touch football and his gym work involved more upper extremities, however he attempted to build up strength in the legs. It was confirmed that the Respondent avoided heavier aspects of work in the house and yard.
>
> The AMS noted the respondent was able to walk for 1-2 hours, sit for 1-2 hours, stand for 1-2 hours and drive for 1-2 hours. If he exceeded such limits, his pain became sharp and radiated down the left lower limb. The Respondent's lifting was only 'mildly' affected and he was able to lift up to 30kg. He was unable to return to sports which he enjoyed (for instance golf). He attended the gym around 3 times per week. The worker assisted his partner around the house, although it was limited and he was unable to perform anything which required bending and twisting.
>
> The appellant is puzzled how the AMS, whilst claiming the worker's activities of daily living were "limited", established that he could lift up to 30kg and walk for up to 2 hours. Indeed the respondent was employed as a Correctional Officer without any form of restriction. He was capable to attending the gymnasium three times per week for up to one hour. He undertook walking on the weekend, usually at the beach for about one hour. The AMS whilst reporting that housework was limited, specific tasks were not precisely identified, leaving the appellant to speculate.

Having regard to the totality of the evidence, the respondent is only minimally compromised in terms of his activities of daily living. The history and findings are more consistent with an increase of 1 % WPI as opposed to 2% WPI. The respondent was able to manage personal care and from all accounts was able to perform 'usual' household tasks. It is conceded by the appellant that he was unable to get back to previous sporting or recreational activities."

25. At the outset, we note that WPI for ADL's is based on both self-reporting *and* all clinical findings and other reports. We also note the AMS' comment that "he was consistent in his presentation" and was also cooperative such that in our view, we see no reason not to accept the respondent's self-reporting, since it is also consistent with the clinical findings.

26. In his supplementary statement dated 30 January 2020, the respondent said:

> "I had a reasonable outcome from this surgery and I have lost symptoms that run down into my leg. I do however, continue to have ongoing low back pain…
>
> I do continue to struggle with activities of daily living because of my lower back.
>
> I am unable to [do] certain tasks around the house or undertake certain activities. I find it difficult to sit or stand for long periods of time. I can do a short run but not a long run. I have tried to play golf with my friends, but the twisting motion is awkward for me. I am able to do about half a dozen swings before I have to finish up. I used to be able to play football and tennis, but I avoid these sports now because they are too strenuous, and I don't want to risk a further back injury.
>
> I go to the gym to assist with strengthening my back, but I avoid heavy weight. I avoid lifting anything over 20 kilograms and usually stick to around the 10-kilogram mark and I find myself usually working on my arms and chest etc. If I do too much at the gym with the lower half of my body I find myself in pain.
>
> In the house, I can do some tasks. The main tasks that cause me difficulty are those that involve bending and twisting. I find myself in a lot of pain if I over-do it with whipper snipping and bending to pick up objects."

27. The respondent also points out in his submissions that although he did not specifically indicate what household tasks he could undertake at home, "one could assume the types of household tasks that require bending lifting, twisting and picking up objects are all indicated as restrictive actions" as he said in his statement. The respondent added: "Tasks in the house such as vacuuming, making beds and picking up objects all require bending and twisting."

28. The respondent also said:

> "There is also a note from after October 2018 in the clinical records that indicates as follows:
>
> 'Jarad will always has [sic] forward flexion can give him some discomfort in the future. Discussed to have an assessment by his physio about those remaining restrictions – lifting no more than 10kg with his arms, no bending of torso, no squatting – to see if he can perform any of them without aggravating his lower back pain. If there is still restriction, then those restriction may be his permanent restriction. He still cannot stand over 2 hours without feeling the back pain.'

> This evidence is supportive of clinical opinion that the respondent was likely to have ongoing discomfort at forward flexion. This is consistent with a likely discomfort whilst bending. Tasks requiring bending have been noted by the Respondent in his statement as causing him difficulty. It is asserted this is indicative of a difficulty to perform household duties.
>
> It is submitted that the clinical findings are indicative of restrictions that account for a 2% WPI for ADL's."

29. In his report of 25 March 2019, Dr McGroder said:

> "He has constant low back pain which varies in intensity. It does not radiate to the lower extremities, although it tends to radiate into both gluteal areas. He has difficulty with fixed positions, particularly prolonged standing but also sitting and he also has trouble with prolonged walking… He has played occasional social games of golf and he goes for short runs but he cannot do any long or strenuous runs. He has not returned to playing tennis, touch football and his gym work involves more the upper extremities, although he tries to do what he can to build up the strength in his legs. He avoids the heavier aspects of work in the house and yard. He feels that his left leg is weaker than the right…
>
> Mr Reardon would be fit to continue his work as a VIP Host at St Mary's Leagues Club. He has, however, been moved to the bottle shop which is possibly less suitable for him…
>
> Mr Reardon would have to work with restrictions were he not performing VIP Host work. This would suggest a 10 kilogram lifting limit and he should avoid repetitive unsupportive bending to lift. He should avoid the maintenance of fixed or awkward positions of the spine.
>
> He will always be at risk of further injury to the lumbar back, despite having had a reasonable result from surgery. It is noted that he has on-going left L5 radiculopathy…
>
> Mr Reardon should avoid activities that are not within the restrictions that are outlined above. He would not be able to play contact sports as he was doing previously. He cannot play tennis, touch football, or do gym work or any activities that require physical contact or sudden jerking movements…
>
> I have added 2% for AD L's because of some difficulty with his activities of daily living."

30. In his report dated 16 August 2019, Dr Rimmer relevantly said:

> "There is no evidence of radiculopathy to either lower limb…
>
> He works full time as a correctional officer in the court system. There are no restrictions.
>
> As I stated above he has had a very successful surgical procedure with essentially no ongoing symptoms. He is not currently undergoing any forms of treatment.
>
> I do not believe he has any current incapacity.
>
> There is no effect on his ADL's, e.g. he is able to attend a gymnasium three times a week with ease."

31. In our view, Dr Rimmer's report is not only short on detail and content but inaccurate in several respects.

32. Both Dr McGroder and the AMS documented signs of residual radiculopathy.

33. In the absence of more detailed information, we cannot accept, as the appellant submits, that the respondent's occupation as a correctional officer *in the court system* is one that "inevitably demands a high level of physical fitness and capacity."

34. The respondent explained the nature of his activities at the gym, principally upper body work and some leg strengthening exercises. Dr Rimmer's comment that "there is no effect on his ADL's" appears to relate solely to the respondent's gym activities, and does not address any of the activities set out in the Guidelines such as the impact, if any, on the performance of household tasks or personal care.

35. The appellant's submissions focus heavily on the opinion of Dr Rimmer.

36. In our view, there is ample evidence, both lay and medical, to conclude that the impact on the respondent's ADL's is as assessed by the AMS.

37. A mere difference of opinion is not a proper basis for appeal. Actual error must be identified.

38. In this particular case, the decision is between 1% and 2% to be added to the baseline. Paragraph 4.35 of the Guidelines refers to "restrictions" on various activities. It does not specify the nature and extent of such restrictions, such that any restriction should be considered.

39. The appellant's submissions in our view amount to no more than 'nit-picking' as regards what the respondent can or cannot do. The clinical findings, in particular, the weak dorsi-flexion and the loss of sensation over the left L5 distribution is more than enough evidence to conclude that there is a significant restriction on the respondents ADL's.

40. For these reasons, the Appeal Panel has determined that the MAC issued on 4 September 2020 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*.

G Bhasin

Gurmeet Bhasin
Dispute Support Officer
**As delegate of the Registrar**