Our Ref: MMS:333444

Level 2, 230 Howick St
(PO Box 33)
Bathurst NSW 2795
P 02 6331 1533

150 Oberon St
Oberon NSW 2787
P 02 6336 1758

DX 3102 Bathurst

E info@mcmc.com.au
W www.mcmc.com.au

6 September 2019

SIRA review of the minor injury definition consultation
SIRA
Level 6
McKell Building
2 - 24 Rawson Place
SYDNEY NSW 2001

BY EMAIL ONLY

Dear Consultation Members

RE: SIRA REVIEW OF THE MINOR INJURY DEFINITION CONSULTATION

Please accept this letter as a submission relating to the above consultation.

Our submission deals with some anomalies concerning the definition of "minor injury" in the context of the objects of the *Motor Accident Injuries Act 2017* contained in section 1.3 of the Act.

THE STATUTORY SCHEME

Section 1.6(1)(a) of the Act prescribes that a minor injury is a soft tissue injury (but excludes an injury to nerves) or a psychological or psychiatric injury which is not a recognised psychiatric illness. Section 1.6(4) of the Act provides that the Regulation can include or exclude a specified injury as being a minor injury.

Clause 4(1) of Schedule 1 of the Regulation provides that an injury to a spinal nerve root that manifests in neurological signs (other than radiculopathy) is included in the definition of a minor injury.

Section 1.6(5) provides that the Guidelines may make provision for or with respect to the assessment of whether an injury is a minor injury for the purposes of the Act including the payment of statutory benefits beyond 26 weeks.

Clauses 5.8, 5.9, 5.10 and 5.11 of Part 5 of the Guidelines deal with soft tissue assessment of an injury to a spinal nerve root and minor psychological or psychiatric injury assessment.

Clause 5.8 of the Guidelines provides that in assessing whether an injury to the neck or spine is a soft tissue injury, an assessment of whether or not

radiculopathy is present is essential.

Clause 5.9 of the Guidelines prescribes the requirements for radiculopathy in that there must be 2 or more of the clinical signs identified in clauses 5.9.1, 5.9.2, 5.9.3, 5.9.4 and 5.9.5. The prescribed clinical signs are to be assessed in accordance with Part 6 of the Guidelines dealing with permanent impairment, see clauses 6.138, 6.139, 6.140, 6.141 and 6.142 dealing with radiculopathy which replicates the terms of clauses 5.9.1, 5.9.2, 5.9.3, 5.9.4 and 5.9.5. Table 6.8 in the Guidelines contains definitions of clinical findings for loss or asymmetry of reflexes, positive sciatic nerve root tension signs and muscle atrophy and/or decreased limb circumference but not for muscle weakness or reproducible sensory loss. Table 6.8 describes non-verifiable radicular complaints which do not by themselves constitute radiculopathy. Clause 6.142 of the Guidelines provides that a decision about the presence of radiculopathy can generally be made on clinical grounds and the diagnosis should not be made solely from electrodiagnostic tests.

ANOMALIES WHICH DO NOT SERVE THE OBJECTS OF THE ACT

1. **Spinal injury resulting in disc protrusion or prolapse causing nerve root compression.**

   This submission relates to a current claim. The claimant was involved in a motor vehicle accident on [redacted] in which the claimant sustained, inter alia, an injury to her cervical spine. Apart from disabling neck pain, the claimant experienced symptoms affecting her left upper extremity. The claimant was referred by her local doctor for an MRI scan of her cervical spine.

   The MRI cervical spine scan was performed on [redacted] The scan report records a history of a whiplash injury, neck pain and radiculopathy specifically referring to neurological symptoms emanating from the C8-T1 nerve root affecting the left arm. The report refers to a focal disc protrusion at C6/7 level with probable impingement of the transiting left C8 nerve root. This provided diagnostic verification of nerve root impingement affecting the C8 nerve root.

   The claimant's local doctor referred the claimant to a neurosurgeon for assessment.

   The neurosurgeon identified clinical signs of left C8 radicular symptoms including:

   i. Subjective weakness in the left arm.

   ii. Left C8 sensory changes.

   iii. Flexion of the neck could aggravate the symptoms.

   iv. Verification of left neural C7/T1 neural compression on imaging which was consistent with the symptoms.

   The left C8 sensory changes satisfy clause 5.9.5 in that the change is anatomically localised to an appropriate spinal nerve root distribution. However, it was necessary under the "minor injury" definition that the claimant have 2 signs identified in clauses 5.9.1, 5.9.2, 5.9.3, 5.9.4 and 5.9.5.

In fairness to the neurosurgeon, it is unlikely that clause 5.9 of the Guidelines prescribing the requirements for radiculopathy were known to the surgeon or considered even relevant to his treatment recommendations.

The neurosurgeon advised a left C8 nerve block which was performed but which did not relieve the symptoms except for a few hours. The presenting symptoms continued to affect the claimant significantly such that the claimant was unable to return to any employment.

As the nerve block was unsuccessful the neurosurgeon recommended a C7/T1 decompression and fusion.

The clinical findings were sufficient for the neurosurgeon to recommend surgery. The insurer did not seek any clarification from the neurosurgeon about any other clinical findings.

Greater education of the medical profession is required if claimants are to be fairly treated under the scheme and provided with "*early and appropriate treatment ... to achieve optimum recovery ... and to maximise their return to work or other activities*" (section 1.3(2)(a) of the Act).

Claimant's living outside major cities in NSW do not necessarily have ready access to specialist medical services and often encounter significant delays or difficulty in obtaining an appointment with a specialist in a major city or major hospital. This is relevant to delay in medical assessment and treatment beyond 26 weeks post accident.

The insurer determined that the claimant suffered the following injuries in the subject accident:

"Whiplash, left shoulder, C5/6 contacting and distorting spinal cord, focal disc protrusion C6/7 and acute stress disorder."

The insurer determined that these injuries were minor injuries as defined by section 1.6 of the Act, clause 4 of the *Motor Accident Injuries Regulation 2017* ("the Regulation") and Part 5 of the Motor Accident Guidelines ("the Guidelines").

The insurer declined further statutory benefits beyond 26 weeks from the date of the accident. The insurer did not make the claimant aware of the provisions of section 3.28(3) of the Act in its advice to the claimant declining liability beyond 26 weeks.

The insurer did not say in declining statutory benefits whether it would consider meeting the cost of the surgery pursuant to section 3.28(3) of the Act but we submit it should have.

Insurers should be required to take the terms of section 3.28(3) of the Act seriously in serving the objects of the Act.

The proposed surgery could not occur until after the 26 week post accident period by reason of operation waiting lists and the availability of the surgeon. The claimant was

faced with the prospect of requiring major spinal surgery but outside the 26 week post accident period. The claimant experienced significant distress faced with the need for major spinal surgery without the funds to meet same.

Without surgery, the claimant faced the prospect of unremitting pain and a permanent inability to return to any employment.

The claimant sought a second neurosurgical opinion in the hope of finding an alternative treatment short of surgery.

The second neurosurgeon found the claimant exhibited clinical signs of "*mild weakness of finger extension in the left hand consistent with a C7-C8 radiculopathy*" and "*sensory disturbance in the C8 dermatome*". The second neurosurgeon recommended a left C6-7 posterior cervical foraminotomy with removal of the disc fragment rather than a fusion. The clinical findings satisfied clause 6.138.4 and clause 6.138.5 respectively of the Guidelines such as to establish that the claimant had the necessary 2 clinical signs of radiculopathy.

The insurer subsequently accepted that the claimant's injury was "non-minor" based on the second neurosurgeon's clinical findings and agreed to fund the cost of the surgery.

The point of our submission is that if the claimant had not sought a second opinion the claimant would have been left with assistance from the scheme with unremitting symptoms and no ability to return to work or domestic chores which had to be taken up gratuitously by family members. It was only because the second neurosurgeon recorded "*mild weakness of finger extension in the left hand consistent with a C7-C8 radiculopathy*" in addition to left C8 sensory changes that changed the injury definition from "minor" to "non-minor".

The two examinations conducted by the neurosurgeons were only a matter of a few months apart and still within the 26 weeks period.

That is a somewhat capricious outcome and we doubt whether it was intended that the operation of the scheme would turn on capricious events.

What would the claimant's prospects be under the scheme if the second neurosurgeon had recorded only 1 of the required clinical signs but spinal surgery was still the treatment option?

What would the claimant's position be if the claimant underwent the spinal fusion procedure recommended by the original neurosurgeon? Would the multilevel structural compromise then change the definition of the claimant's injury to non-minor?

The objects of the Act in promoting early treatment and maximising return to work and other activities cannot be served by the artificial definition of radiculopathy in circumstances where surgery has been recommended by specialist doctors.

In the alternative, consideration should be given to whether the 26 week period is too short and it should be extended to say 52 weeks.

2. **Delayed onset of symptoms.**

Following from the above case study, what would the claimant's position be if a second required clinical sign of radiculopathy developed outside the 26 week period and once the insurer had declined liability beyond 26 weeks and closed its file? This scenario is likely by reason of the known propensity of disc prolapses or protrusion to progress or worsen over time. There should be some mechanism to allow claimant's back into the scheme where an injury initially defined as "minor" subsequently becomes "non-minor". The current scheme assumes that all minor injuries should resolve within 26 weeks. Experience teaches us that the expected 26 week recovery does not always occur. Under the present scheme, accident victims with significant minor injuries which permanently affect a claimant's capacity to return to work or require treatment are no longer supported by statutory benefits after 26 weeks.

3. **Minor fracture without complication.**

Under the current definition, if the claimant in the above case study had also suffered a hairline crack fracture of a distal phalanx in a little finger with a complete and uneventful recovery of the fracture within weeks of the accident, the claimant's injuries would be defined as "non-minor" and the spinal surgery (fusion or discectomy) would have been covered under the scheme as would her entitlement to weekly statutory benefits beyond 26 weeks.

That outcome is capricious and could not have been intended by Parliament.

4. **No common law damages for minor injuries.**

Section 44 of the Act provides that no damages may be awarded to an injured person if the person's "only" injuries are minor. It is uncertain what Parliament meant by including the word "only". The word appears to be superfluous.

The mischief that section 44 creates in company with the current definition of minor injury is to deny a common law remedy where statutory benefits cannot assist. For example, a claimant with a minor injury who cannot return to pre-accident or any employment has no entitlement to damages. Significant soft tissue injuries affecting multiple body areas may prevent a labourer with little education from returning to manual work. If the same labourer also suffered a hairline crack fracture of a distal phalanx in a little finger with a complete and uneventful recovery of the fracture within weeks of the accident, the labourer's injuries would be non-minor and there would be an entitlement to damages for economic loss in the nature of loss of earning capacity even though the fracture itself did not cause any economic loss.

Further mischief arises where, in the above labourer's example, the labourer's minor injuries result in whole person impairment which exceeds 10% but there would be no entitlement to general damages for non-economic loss. If a hairline crack fracture of a distal phalanx in a little finger was also caused in the accident and which healed without any permanent impairment within weeks of the accident, the labourer would

have an entitlement to damages for non-economic loss which would be quantified, not by the fractured little finger, but by reference to the soft tissue injuries which were "minor".

We have regard to the other objects in section 1.3 of the Act, particularly section 1.3(2)(d) and section 1.3(2)(e). The current definition of "minor" injury could be redefined without significantly affecting the affordability and sustainability of the scheme. Those objects must be balanced with the objects in sections 1.3(2)(a) to achieve maximum recovery and maximise return to work and section 1.3(2)(b) to provide early and ongoing financial support. The current definition of "minor" injury does not adequately serve those objects.

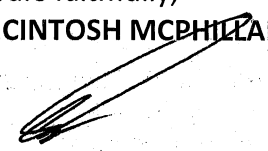
Having regard to the complex methodology underpinning the "minor" injury definition, we submit that medical practitioners should be better informed about the requirements of the definition.

We submit insurers should be required to actively advise claimant's about section 3.28(3) of the Act when advising of a "minor" injury determination and should actively support payment of statutory benefits for treatment of a 'minor" injury beyond 26 weeks in order to better serve the objects of the Act.

We submit that the current "minor" injury definition requires revisiting, at least in terms of spinal injuries so that an injury to a spinal nerve root that manifests in a neurological sign is a non-minor injury. It seems incongruous that an injury to a nerve other than a spinal nerve root is, without more, a non-minor injury. We suggest that the above case study highlights the incongruity.

We submit that an alternative to modifying the minor injury definition is to extend the period of entitlement to statutory benefits for minor injuries to a period longer than 26 weeks. This would address the apparent failure of insurers to actively promote the benefit intended by section 3.28(3) of the Act.

Yours faithfully,
MCINTOSH MCPHILLAMY & CO



Legal Practitioner Director: Michael Schwab