WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

Issued in accordance with section 294 of the *Workplace Injury Management and Workers Compensation Act 1998*

Matter Number: **907/20**
Applicant: **Jitendra Prasad**
Respondent: **Compass Group (Australia) Pty Ltd**
Date of Determination: **21 April 2020**
Citation: **[2020] NSWWCC 126**

The Commission determines:

1. The applicant sustained an injury to his left shoulder and developed consequential conditions in his neck and right shoulder arising out of or in the course of his employment with the respondent on 27 March 2013.

2. The applicant's employment was a substantial or the main contributing factor to his injury.

3. The applicant requires medical treatment as a consequence of his injury and the respondent is liable to pay reasonably necessary medical expenses.

4. The proposed anterior cervical discectomy and fusion of C4/5 and C5/6, and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of the applicant's employment with the respondent on 27 March 2013.

The Commission orders:

5. The respondent is to pay the applicant's reasonably necessary medical expenses with respect to the proposed anterior cervical discectomy and fusion of C4/5 and C5/6, and associated expenses, pursuant to section 60 of the *Workers Compensation Act 1987*.

A brief statement is attached setting out the Commission's reasons for the determination.

Glenn Capel
Senior Arbitrator

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OF GLENN CAPEL, SENIOR ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the **Registrar**

STATEMENT OF REASONS

BACKGROUND

1. Jitendra Prasad (the applicant) is 51 years old and commenced employment with Compass Group (Australia) Pty Ltd (the respondent) as a chef in July 2012. His services were terminated in November 2015.

2. There is no dispute that the applicant injured his left shoulder on 27 March 2013 and that he developed consequential conditions in his neck and right shoulder. Liability was accepted by AAI Ltd t/as GIO (the insurer) and weekly compensation and medical expenses have been paid to date.

3. On 12 June 2019, the applicant's treating neurosurgeon, Dr Kam, sought approval from the insurer to perform an anterior cervical discectomy and fusion of C4/5 and C5/6.

4. On 5 July 2019, the insurer issued a notice pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act), disputing that it was liable for the payment of medical expenses on the basis that it had insufficient information. It advised that it would review its position when it received further information from Dr Kam.

5. On 6 September 2019, the insurer issued a further notice pursuant to s 78 of the Act, disputing that the proposed anterior cervical discectomy and fusion of C4/5 and C5/6 was reasonably necessary as a result of the applicant's injury on 27 March 2013. It cited s 60 of the *Workers Compensation Act 1987* (the 1987 Act).

6. On 6 February 2020, the insurer issued a notice pursuant to s 287A the 1998 Act in similar terms and advised that it maintained its position.

7. By an Application to Resolve a Dispute (the Application) registered in the Workers Compensation Commission (the Commission) on 19 February 2020, the applicant claims medical expenses for proposed medical treatment pursuant to s 60 of the 1987 Act due to injury sustained on 27 March 2013.

ISSUES FOR DETERMINATION

8. The parties agree that the following issue remains in dispute:

    (a) whether the proposed anterior cervical discectomy and fusion of C4/5 and C5/6 is reasonably necessary as a result of the injury sustained on 27 March 2013 – s 60 of the 1987 Act.

PROCEDURE BEFORE THE COMMISSION

9. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

EVIDENCE

Documentary evidence

10. The following documents were in evidence before the Commission and taken into account in making this determination:

(a) The Application and attached documents;
(b) Reply and attached documents;
(c) Application to Admit Late Documents received on 3 April 2020, and
(d) Application to Admit Late Documents received on 6 April 2020.

Oral evidence

11. Neither party sought leave to adduce oral evidence or cross examine any witnesses.

REVIEW OF EVIDENCE

Applicant's statements

12. The applicant provided a detailed statement on 23 January 2020. He described the circumstances of his left shoulder injury and the development of his consequential neck and right shoulder conditions. He confirmed that he had left shoulder surgery in 2018, but this had not been of benefit. He continued to experience weakness and stiffness in his left shoulder, and pain and stiffness in his neck. He took medication and he had received physiotherapy treatment since 2015, but this only provided temporary relief for a few days.

13. The applicant stated that his neck and shoulder pain became quite debilitating and he was referred to Dr Kam in April 2019. He had a cervical discogram and Dr Kam recommended that he have an anterior cervical discectomy and fusion of the C4/5 and C5/6.

14. The applicant advised that he continued to experience significant pain in his shoulders and neck, which radiated down his arms to his wrists and three fingers of each hand. He had weakness in his arms and hands, and a restricted range of motion in his neck. His symptoms impacted on his ability to drive and sleep. He was no longer able to assist with household tasks because of his significant pain in his neck and shoulders. He was keen to have the proposed surgery.

15. In his statement dated 1 April 2020, the applicant stated that he recalled discussing the proposed surgery with his psychologist, Joseph Lien. At no stage did Mr Lien suggest that he should not proceed with surgery or that the decision would be unfavourably influenced by his psychological condition. His physical injury had impacted significantly on his quality of life and he relied on strong medication.

16. The applicant stated that he had considered the opinions of the doctors, including that of Dr Casikar. Dr Kam had explained the risks of no improvement or a worsening of his condition. There were also strong prospects of some improvement in his symptoms. He had faith in Dr Kam, and he wished to proceed with the operation. He did not believe that his psychological injury had influenced his decision.

Reports of Dr Gupta

17. Dr Gupta reported on 4 March 2016, 18 March 2016 and 22 April 2016. His focus was on treatment of the applicant's left shoulder injury. He noted that an MRI scan showed a significant partial thickness tear of the left supraspinatus tendon with bursitis, a tear of the subscapularis tendon and subluxation of the biceps. The applicant was also troubled by symptoms in his right shoulder that the doctor attributed to subacromial impingement.

18. Dr Gupta recommended conservative treatment. He arranged for a further MRI scan that showed a progression in the tear of the rotator cuff, so he recommended surgery. He also arranged for an MRI scan of the applicant's right shoulder that showed a partial thickness tear of the supraspinatus tendon with bursitis. He gave the applicant a right shoulder injection and prescribed physiotherapy.

19. The left shoulder surgery was disputed by the insurer, but at an arbitration hearing on 11 January 2018, the respondent agreed to pay for the procedure. This was carried out in March 2018.

20. The applicant continued to complain of pain in his left shoulder. Dr Gupta organised a further MRI scan on 23 July 2018, which showed a full thickness tear of the supraspinatus tendon. The doctor recommended further surgery, and this was performed on 1 September 2018.

21. In his report dated 1 February 2019, Dr Gupta recorded that the applicant's main issue was a stiff and painful neck, and he noted a positive Spurling test. This was the first reference to any neck symptoms.

Reports of Dr Kam

22. Dr Khan, the applicant's general practitioner, referred the applicant to Dr Kam on 9 March 2019. In the letter of referral, Dr Khan noted that the applicant had been troubled by neck and shoulder pain for six years. He had seen Drs Liew, Ganora, Gupta and Biggs, a psychologist, a psychiatrist and a physiotherapist.

23. Dr Kam reported on 8 April 2019. He recorded that the applicant suffered an acute onset of severe left shoulder and left upper extremity pain at work. The applicant had left shoulder surgery in March and September 2018. He had been troubled by ongoing pain in his neck, left shoulder and his left upper extremity into his elbows and fingers for six years. He also experienced right shoulder pain from time to time.

24. The applicant complained of a reduced range of motion in his cervical spine associated with suboccipital headaches, interscapular pain, and bilateral scapular pain. The doctor observed a restricted range of motion in the applicant's neck and global weakness in his upper extremities but there was no wasting. He noted that an MRI scan showed only minor pathology, so he arranged for a discogram and bone scan.

25. In his report dated 4 June 2019, Dr Kam noted that the discogram showed that the applicant's pain arose from the C4/5 and C5/6 levels. The applicant was uncertain whether he would have surgery, however, the doctor sought approval for an anterior cervical discectomy and fusion of C4/5 and C5/6 on 12 June 2019.

26. In a report dated 17 October 2019, Dr Kam noted that the applicant was struggling with on-going pain in his neck and shoulder, so he had recommended surgery. He was critical of the views of Dr Casikar and he claimed that this doctor had not appreciated the significance of the discogram findings. Dr Kam acknowledged that this was a controversial test, but he had recommended surgery as a last option for the ongoing pain which was impacting on the applicant's quality of life.

Reports of Dr Ganora

27. Dr Ganora provided a series of reports in 2015. The focus of those reports related to treatment for the applicant's left shoulder injury.

28. In his report dated 4 March 2015, Dr Ganora noted that the applicant had pain around the left anterior shoulder and pectoral area, which later extended to the suprascapular region and side of the neck. A cervical spine injection in October 2013 provided no relief, but a left shoulder injection had briefly relieved his pain. The applicant's neck movements were "relatively unrestricted", with pain at the extremes of rotation localising to the left subscapular region. He diagnosed a lower cervical intervertebral joint sprain and left shoulder girdle myofascial strain that had resulted in chronic pain.

29. Dr Ganora reported on 30 January 2019. He noted that the applicant's pain was localised to the left suprascapular region and left side of the neck, with pain radiating from the neck. On occasions, the pain radiated to the left wrist and ulnar three fingers. There was a limited range of movement in the left shoulder with pain at the extremes and there was restriction in cervical movements on rotation and side flexion.

30. In his report dated 6 March 2019, Dr Ganora indicated that an MRI scan only showed minor pathology on the applicant's cervical spine, which was a significant component of the applicant's symptoms. His pain was predominantly around the left shoulder and extended to the left side of the neck, rather than localised in the neck itself. He also had right shoulder pain.

31. On examination, there was no restriction of neck movement apart from pain at the extremes when activating the trapezius and levator scapulae muscles. Neurological testing of the upper limbs revealed no abnormality and the Spurling test was negative. There was marked restriction of active movement in the left shoulder with pain at the extremes.

32. Dr Ganora considered that the applicant's pain around the left shoulder and side of neck was related to the left shoulder injury and subsequent failure to respond to surgical and conservative treatment. He disagreed with the views of Dr Gupta that the pain came from the applicant's neck. The doctor was concerned about the level of opioid analgesia that the applicant was taking.

33. In his report dated 14 June 2019, Dr Ganora recorded that the applicant had experienced continuing chronic pain and limitation of shoulder function, and persistent neck pain. He had received physiotherapy since his shoulder surgery, but his symptoms had continued without improvement. The applicant complained of pain around the left shoulder extending to the left lateral aspect of the neck, together with right shoulder pain.

34. Dr Ganora confirmed that his observations were consistent with the applicant's reported function and severity of his symptoms. He considered that the applicant's pain around the left shoulder and side of neck was related to the left shoulder injury and the failure to respond to surgical and conservative treatment. He recommended pharmacological pain management, psychological pain coping therapy, physical therapy and surgical review.

Reports of Dr Walker

35. Dr Walker reported on 8 May 2013. The applicant complained of pain in the left side of his neck and head with radiation down to the ulnar forearm, and some pins and needles in the fourth and fifth fingers. The doctor noted that the MRI did not show any significant abnormality apart from some slight bulging of C5/6. An EMG of the left ulnar nerve was normal. The doctor recommended medication.

36. In a report dated 16 November 2015, Dr Walker advised that there was no evidence of specific pathology to explain the applicant's symptoms, although he conceded that the shoulder scan revealed a number of abnormalities. The current EMG and MRI scan showed no abnormality in the applicant's cervical spine.

Reports of Dr Watson

37. Dr Watson reported on 30 August 2013 and 27 September 2013. He recorded an unremarkable history and noted complaints of ongoing pain in the applicant's left shoulder with radiation from the cervical spine and mid cervical area extending to the suprascapular trapezium, the left shoulder, left arm, forearm, wrist and towards the shoulder blade in an unusual distribution.

38. Dr Watson diagnosed subacromial bursitis, and he confirmed that there was no evidence of any right shoulder pathology. He stated that there was no evidence that the applicant's symptoms related to the incident on 27 March 2013 and he considered that any aggravation had resolved. The doctor did not provide detailed reasons for his conclusion and he made no comment about the applicant's neck.

Reports of Dr Johnson

39. Dr Johnson reported on 1 September 2014 and 24 September 2014. He recorded complaints of left shoulder and upper arm, and ongoing pain around the applicant's shoulder girdles with some weakness in the arm and paraesthesia affecting the ulnar aspect of left hand and forearm. The doctor observed tenderness at T1/T2, but there was a full range of movement in the shoulder. The movement of the neck was slightly reduced by pain and there was no obvious sensory change. The doctor commented that the applicant's complaints were "rather diffuse".

Reports of Dr Biggs

40. Dr Biggs reported on 16 July 2015 and 27 August 2015. He noted that the applicant injured his left shoulder whilst lifting at work in March 2013, and he had experienced ongoing cervicothoracic, periscapular and left shoulder pain. The doctor observed pain and spasm in the left paracervical musculature and left trapezial muscle belly with marked tenderness over the medial border of the scapula. There was also diffuse upper thoracic spine and left shoulder tenderness, with a restricted range of movement.

41. Dr Biggs gave the applicant a left shoulder injection that did not provide any immediate relief. The doctor felt that the applicant's left shoulder symptoms were referred from the cervicothoracic spine and periscapular region, rather than from his shoulder. He recommended non-operative treatment.

Report of Dr Wallace

42. Dr Wallace reported on 2 May 2016. He noted that the applicant experienced left shoulder pain on 27 March 2013. He injured his right shoulder when participating in a workplace assessment on 12 January 2016.

43. Dr Watson noted complaints of constant aching pain at the lateral deltoid region radiating to the interscapular region of the thoracic spine, intermittent paraesthesia in the ulnar three fingers of the left hand, weakness in the left arm and stiffness in the left shoulder. There was pain in the right deltoid and rotator cuff, and intermittent paraesthesia in the applicant's right hand. There were no complaints of any neck symptoms, although the doctor observed tenderness at C6/7 and T1, and a limited range of movement in the cervical spine.

44. Dr Wallace considered that the applicant had recovered from a minor rotator cuff strain, and he was not satisfied that the applicant had injured his right shoulder. The degenerative spondylosis in the applicant's cervical spine was constitutional, and he considered that the applicant's bilateral shoulder symptoms were related to referred pain from the neck. He stated that the proposed left shoulder surgery was not reasonable and necessary.

Report of Dr Giblin

45. Dr Giblin reported on 29 February 2016 and 9 August 2016. He noted that the applicant developed pain in his left shoulder region around the trapezius and anterior chest wall on 27 March 2013. He had been given a left shoulder injection, and Dr Liew had organised a cervical injection.

46. The applicant complained of pain in the left trapezius area, radiating down the left arm into the fourth and fifth fingers, pain in both shoulders and pain in the neck. Taping between the shoulder blades by his physiotherapist had provided some short lived relief.

47. Dr Giblin diagnosed a soft tissue injury to the trapezius (T4 syndrome) and left rotator cuff disease. The applicant had also injured his right shoulder during rehabilitation. The doctor stated that the applicant had developed secondary neck pain, but he did not provide a diagnosis.

48. Dr Giblin viewed a DVD, which is not in evidence, and stated that this did not cause him to alter his opinion regarding the applicant's left shoulder, but it appeared that he had recovered from his right shoulder injury.

49. Dr Giblin took issue with the opinion of Dr Wallace. He confirmed that the applicant developed a T4 syndrome and then secondary rotator cuff diseased in his left shoulder. He agreed that the proposed left shoulder surgery was reasonable, but he was concerned that pain focussed behaviour might impact on the success of the procedure.

Physiotherapy reports

50. In a report dated 2 April 2015, David Blackburn advised that the applicant had been troubled by left sided neck and shoulder pain from a work injury on 27 March 2013. The applicant had received extensive physiotherapy in the past with little effect.

51. Mr Blackburn commented that there was a restricted range of movement in the applicant's left shoulder and neck, with significant wasting of the left periscapular muscles. He suspected that the applicant's left shoulder pathology was causing overactivity of the left upper trapezius muscle and irritation of his cervical spine.

52. In his report dated 13 May 2015, Mr Blackburn indicated that he proposed to focus treatment on the 8th and 9th thoracic rings, with taping of the lower thoracic rings in order to resolve the applicant's lower left sided thoracic pain, and then move onto treatment of the cervicothoracic pain. In his report dated 2 June 2015, he stated that the applicant's thorax and cervicothoracic symptoms were possibly secondary to the left shoulder injury.

53. In a report dated 30 November 2015, another physiotherapist, Robert Standen, stated that the applicant had a significant decrease in the range of movement in his left shoulder and cervical spine.

54. Sandra Winterbottom reported on 25 January 2019. She recorded that the applicant had a restricted range of movement in his neck, thoracic spine and left shoulder.

55. In a report dated 1 May 2019, Mr Blackburn advised that the applicant had continued to experience left shoulder and neck pain, together with pins and needles in his hand and his little and ring fingers. There was a restricted range of movement in the applicant's left shoulder and neck, as well as neck stiffness. He noted that the relatively normal findings in the MRI scan were not suggestive of radiculopathy of lower cervical nerve roots. He stated that the applicant might have a frozen shoulder and possibly a thoracic outlet syndrome.

56. In his report dated 2 December 2019, Mr Blackburn stated that the applicant had continued to report ongoing left cervical spine pain extending into his shoulder and upper limb, and at times into his fingers. There was a global weakness and restriction of the range of motion in the applicant's cervical spine, whilst the left shoulder range of motion remained largely unchanged.

Diagnostic tests

57. The cervical MRI scan taken on 23 April 2013 showed mild bulging at C5/6 without impingement and some perineural cysts, especially at C7 where the nerve root had been displaced. The scan taken on 2 December 2013 showed multilevel disc osteophytes without cord contact.

58. The cervical MRI scan taken on 9 October 2015 showed minor degenerative changes, especially at C5/6, and perineural cysts. It was noted that there had been no significant change since the scan of 2 December 2013.

59. The cervical MRI scan dated 22 February 2019 revealed minor herniation and an annular tear at C5/6 and herniation at C3/4 with cord contact.

60. The left shoulder MRI scan taken on 30 April 2015 showed tendinosis of the supraspinatus and infraspinatus tendons, but there was no evidence of any tear. The left shoulder MRI scan dated 20 July 2018 showed a tendinosis and a full supraspinatus tear, minor muscle belly atrophy and extensive subacromial bursitis.

61. A bone scan dated 9 September 2014 showed a mild uptake at T5, but no other significant abnormality. The bone scan dated 3 May 2019 showed minor enthesopathy in the left shoulder band and spondylosis in the upper thoracic spine. There was no evidence of fact joint arthritis or active discovertebral degenerative changes on the junctions of the cervical spine.

62. Finally, the discogram dated 28 May 2019 noted that pain was reproduced at C4/5 and C5/6.

Reports of Dr Anwar, Mr Lien and Dr Robertson

63. There are a number of reports from the applicant's treating psychiatrist, Dr Anwar, and his psychologist, Joseph Lien, in evidence. These clinicians confirm that the applicant suffered a Post-Traumatic Stress Disorder and an Adjustment Disorder with depression and anxiety as a result of sexual harassment by his female supervisor and bullying by a male manager at work.

64. In his report dated 6 December 2019, Dr Robertson indicated that the applicant had a Major Depressive Disorder caused by bullying at work. He assessed 24% whole person impairment.

65. In a report dated 6 April 2020, Mr Lien advised that the applicant had complained about his neck pain and had said that this was affecting his mood. The applicant told him about the nature of the proposed neck surgery and about his discussions with Dr Kam regarding the risks and benefits of the procedure. The applicant explained that he did not make the decision lightly and he had discussed the operation with his wife.

66. Mr Lien was satisfied that the applicant had the capacity and competency to make the decision regarding the proposed surgery and this was not adversely affected by his existing psychological injury.

Reports of Dr Poplawski

67. Dr Poplawski reported on 23 August 2019. He recorded a consistent history of the applicant's left shoulder and scapular injury, the consequential right shoulder condition caused by overuse when protecting his injured left shoulder, and the consequential neck symptoms radiating into his left shoulder, which were caused by the abnormal way the applicant had to use his left arm to limit his symptoms.

68. Dr Poplawski noted that the applicant was referred to Dr Biggs, who gave him a left shoulder injection without benefit. In March 2016, he was referred to Dr Gupta, who prescribed physiotherapy and further injection treatment. An MRI scan revealed a full-thickness tear of a portion of the supraspinatus tendon, so Dr Gupta carried out a left rotator cuff repair in March 2018. This procedure had not been unsuccessful, and a revision procedure was carried out in September 2018.

69. Dr Poplawski noted that the applicant continued to experience recurrent pain in his left shoulder and there was a limited a range of motion. He had problems with his right shoulder, and he had pain in his neck radiating to the left shoulder into the hand. He was referred to Dr Kam [sic], who organised a cervical discogram which reported disc disruption at the C5/6 and C6/7 levels and reproduced symptoms. Dr Kam [sic] had recommend surgery.

70. Dr Poplawski reported that the applicant had difficulty sleeping, sitting, standing, walking, driving and performing domestic tasks. On examination, the doctor observed paraspinal tenderness in the neck, more so on the left side, tenderness over the left trapezius muscle and in the supraclavicular fossa. There was reduced sensation over the lateral aspect of the left upper arm and forearm, and mild reduction in the thumb and index finger of his left hand. Range of motion in the neck was mildly reduced but extension was decreased to about 40°.

71. Dr Poplawski diagnosed a rotator cuff tear in the left shoulder requiring surgery on two occasions, together with consequential pain in the right shoulder and the cervical spine. The applicant still had persistent left shoulder symptoms, recurrent discomfort in the right shoulder and pain in the neck with radiation down the left arm and to the hand.

72. Dr Poplawski recommended conservative treatment for the applicant's right shoulder and neck symptoms, such as anti-inflammatory medication, physiotherapy and exercises for three to six months, because there was only a mild restriction of movement in the neck and no evidence of radiculopathy.

73. In his report dated 13 January 2020, Dr Poplawski noted that the applicant felt that his symptoms of neck [sic] pain and bilateral intermittent radiculopathy had become increasingly more troublesome. Dr Kam had told him that the chances of successful surgery was approximately 80%. The applicant's complaints and the doctor's findings on examination were similar. He noted moderate asymmetric reduction of range of motion in the cervical spine and mild global reduction of muscle power in the left upper arm.

74. Dr Poplawski confirmed his previous diagnosis and whilst he noted that surgery for cervical spondylosis was debatable and discography was a controversial form of testing, the fact that the discogram at the C4/5 and C5/6 levels reproduced neck symptoms was a good indicator that this was the source of the applicant's pain. Accordingly, he agreed that the proposed surgery was reasonable.

75. Dr Poplawski stated that caution was required due to the possibility of failure and complications from the procedure. Ultimately it was the applicant's decision, but he was prepared to take the chance in the hope that it could improve his symptoms and lifestyle.

Report of Dr Casikar

76. Dr Casikar reported on 14 August 2019. He noted that the applicant felt pain in his left shoulder following the work injury and he also had pain in the side of the chest. The applicant saw a number of doctors, including Dr Liew, who recommended a neck injection, but this provided no benefit. He had two operations on his left shoulder, but these did not assist his condition. He also had neck and right shoulder pain.

77. On examination, Dr Casikar noted that movements of the applicant's neck and left shoulder were reduced. Movements of the left shoulder were reduced, and there was tenderness over the left scapula. The doctor observed hypoaesthesia over the entire left upper limb and there was a full range of pain free movement in the right shoulder.

78. Dr Casikar diagnosed a soft tissue injury to the applicant's left shoulder and constitutional degenerative disease in the cervical spine. He stated that the applicant needed more concentrated physiotherapy to relieve his left shoulder symptoms.

79. Dr Casikar stated that the cervical surgery proposed by Dr Kam was not reasonably necessary due to the work related injury, which was only a soft tissue injury. He felt that the neck pain was part of the soft tissue injury to the shoulder, and there was no neurological abnormality on examination.

APPLICANT'S SUBMISSIONS

80. The applicant's counsel, Mr Tanner, submits that there is no dispute that the applicant injured his left shoulder and developed consequential conditions in his neck and right shoulder. The applicant described his neck symptoms in his statement. Dr Gupta noted that the applicant's main issue was a stiff and painful neck, and there was a positive Spurling test. Therefore, there was a formal diagnosis of the neck condition.

81. Mr Tanner submits that Dr Ganora agreed that there was pathology in the applicant's neck. The evidence of Dr Kam regarding the cause of the applicant's neck pain should be preferred. Dr Kam recorded that the applicant had severe pain and a reduced range of movement in his neck, so he arranged a discogram that was positive at C4/5 and C5/6. There was no dispute that the applicant suffers from spinal pain and based on this positive finding, Dr Kam recommended surgery. Further, he noted that the applicant had been troubled by chronic left shoulder pain and persistent neck pain since his shoulder operations.

82. Mr Tanner submits that Dr Casikar recorded no history of the applicant's neck pain and on examination, he observed a reduced range of neck movement and hypoaesthesia in the entire arm. This loss of sensation could be explained by cervical disc pathology. The doctor acknowledged that there were degenerative changes in the applicant's neck at the levels of the proposed surgery. There was clear pathology, confirmed by the discogram, and there was no dispute as to injury.

83. Mr Tanner submits that Dr Gupta considered that the applicant's pain was due to the left shoulder injury, but when the applicant still had pain following surgery, he thought that the pain might be coming from his neck.

84. Mr Tanner submits that Dr Casikar merely asserted that the proposed surgery was not reasonably necessary due to the work related injury, but he failed to explain his conclusion. His reference to "incidental spondylosis" seems to be an acceptance of a consequential condition, which has not been disputed.

85. Mr Tanner submits that the discogram was positive. Dr Casikar's recommendation of more intensive physiotherapy on the applicant's shoulder did not address the need for surgery. His comment that "further surgery to the neck is likely to have an additional burden to his existing problems" was a mere ipse dixit, because there was no explanation why that might be the case.

86. Mr Tanner submits that in his initial report, Dr Poplawski observed tenderness in the applicant's neck and a reduced range of movement and sensation, and yet he stated that there was no evidence of radiculopathy. He noted the MRI scan findings and acknowledged the consequential condition in the applicant's neck with radiation down the left arm, but only advised conservative treatment. The views of the treating doctor, Dr Kam, who has seen the applicant on a more regular basis, should be preferred.

87. Mr Tanner submits that Dr Kam noted in September 2019 that the applicant was struggling with his neck pain and he thought that surgery was an option. He was critical of Dr Casikar and stated that Dr Casikar did not appreciate the significance of the positive discogram. Dr Casikar needed to explain why the discogram was unreliable and why the surgery should not proceed.

88. Mr Tanner submits that in his further report, Dr Poplawski took issue with Dr Casikar's opinion and the fact that the discogram reproduced the applicant's neck symptoms was a good indicator that the pain was coming from C4/5 and C5/6. Therefore, Dr Poplawski accepted the diagnostic value of the discogram, even though it is a controversial diagnostic tool.

89. Mr Tanner submits that Dr Poplawski warned that the applicant needed to be aware about the success rate and the complications. Whether he has surgery was a matter for the applicant, and the procedure is supported by his doctors. He confirmed that the need for surgery had resulted from the applicant's left shoulder injury.

90. Mr Tanner submits that the physiotherapist confirmed in December 2019 that the applicant had cervical pain that radiated to his fingers and he was at a loss as to how to treat the applicant. Like Dr Kam, he agreed that surgery should be the last resort. Dr Ganora also noted that the applicant was adamant that the discogram relieved his pain, so the doctor suggested that this might be of relevance in deciding whether the surgery was appropriate.

91. Mr Tanner submits that in his most recent statement, the applicant makes it clear that he understands the nature of the surgery and that he wishes to proceed with the operation. The need for surgery is supported by the diagnostic tests and by Drs Kam and Poplawski. The only doctor to challenge the need for the surgery is Dr Casikar, but his opinion is flawed. On the basis of the authorities, the proposed surgery is reasonably necessary as a result of the applicant's accepted work injury.

RESPONDENT'S SUBMISSIONS

92. The respondent's counsel, Mr Baker, submits that the applicant has been treated by a number of specialists over the years. In April 2015, Mr Blackburn suspected that the applicant's left shoulder pathology was causing overactivity in the upper trapezius muscle, resulting in irritation in his cervical spine. The treatment focused on the left shoulder and the thoracic spine rather than the neck. Mr Standen also referred to T6 and T7 dysfunction with an improvement in the cervical range of motion.

93. Mr Baker submits that in March 2015, Dr Ganora reported that the applicant initially had pain in the left shoulder that subsequently extended to his neck. The neck injection was of no benefit.

94. Mr Baker submits that the contemporaneous evidence of Dr Walker recorded an unusual history of the onset of neck pain, but an EMG was normal. Dr Watson also recorded an unusual description of the applicant's symptoms, and he noted that there was a full range of motion in the neck. He diagnosed bursitis and saw no need for any operative or further treatment. These are the only reports from 2013.

95. Mr Baker submits that when Dr Johnson saw the applicant in 2014, the applicant complained of diffuse symptoms in the thoracic spine, and there were no complaints in regard to his neck. In November 2015, Dr Walker stated that there was no evidence of any neurological deficit and no evidence of any specific pathology. Therefore, the evidence from 2013 to 2015 does not disclose any features associated with neck pathology.

96. Mr Baker submits that Dr Giblin thought that the applicant had suffered a soft tissue injury to his trapezius and left rotator cuff, with secondary neck pain. He diagnosed T4 syndrome and stated that neck surgery was not anticipated.

97. Mr Baker submits that the applicant only complained of shoulder issues when he saw Dr Gupta in March 2016. The absence of neck complaints is consistent with the contemporaneous 2016 evidence. In 2018, Dr Gupta indicated that the applicant's symptoms were consistent with a significant rotator cuff tear and he performed two operations, which did not provide any improvement. In February 2019, the applicant complained of pain and stiffness in his neck, so the doctor suggested that the applicant have an MRI scan.

98. Mr Baker submits that Dr Kam recoded a different history and noted that the applicant had been troubled by neck pain for six years, and yet there was no evidence of wasting and the MRI scan showed only minor changes. There was no objective evidence of any pathology, only subjective.

99. Mr Baker submits that the use of discograms was in vogue in the 1980s, and the applicant's discogram was only taken at two levels. It is not a helpful test as it does not disclose what was happening at other levels. An injection would increase the pressure in the spine and not surprisingly, it would cause an increase in the pain. There was no reference to any referred pain into the applicant's arms that might confirm that this was the source of the complaint.

100. Mr Baker submits that it is surprising that Dr Kam was not provided with copies of the earlier medical reports that would have been relevant when assessing the applicant's pain in 2019. There is no evidence of consistent complaints and no positive EMG findings to confirm the presence of radiculopathy. The earlier recorded complaints described pain referred from the shoulder to the neck, rather than the reverse.

101. Mr Baker submits that in his report dated 17 October 2019, Dr Kam advised that surgery should be undertaken based in the positive discogram, but there was no evidence of pain reproduction in the shoulder as a result of the injection. This is inconsistent.

102. Mr Baker submits that Dr Kam was critical of the opinion of Dr Casikar. This disagreement was based on the findings of a discogram and a negative neurological assessment, in the absence of the reports from 2013. Dr Kam merely relied upon the history of unrelenting pain. The doctor did not advise what part of the disc he proposed to excise, and he did not say why the procedure was reasonably necessary on the background of the history.

103. Mr Baker submits that Dr Ganora reported symptoms of pain in the left shoulder extending to the neck, consistent with the other clinicians. He stated that the problem related to the left shoulder and he recommended medication, pain management and therapy, rather than surgery. The chronic shoulder condition was the cause of the applicant's incapacity.

104. Mr Baker submits that Dr Ganora noted that the MRI scan showed minor pathology in the applicant 's neck. He felt that the applicant's pain came from his left shoulder rather than his neck, and this was an accurate assessment by a doctor who had been involved in the applicant's rehabilitation for a long period. One cannot be satisfied on the facts and the evidence that the proposed surgery is reasonably necessary as a result of the applicant's work injury.

APPLICANT'S SUBMISSIONS IN REPLY

105. Mr Tanner submits that there is no dispute regarding the consequential condition in the applicant's neck. The timing of the onset of the neck symptoms was not decisive. The only relevant evidence to consider is what the doctors have to say about the applicant's ongoing symptoms following the two shoulder operations.

106. Mr Tanner submits that Dr Kam provided a diagnosis based on his understanding of the diagnostic tests. He only tested the two levels that he thought were responsible. If the respondent disputes the reliability of the test and considers that other levels are relevant, it needed to adduce evidence to that effect. Dr Kam and Dr Poplawski agreed that the discogram was a valuable diagnostic test. There was no need to address the radiculopathy as it had to be related to the applicant's neck pain.

107. Mr Tanner submits that Dr Casikar did not say that the applicant would not achieve any benefit from the surgery, and there were no submissions made by Mr Baker regarding the doctor's opinion. Neither Dr Kam nor Dr Casikar had access to the prior medical reports, so if this presented an issue, the respondent could have referred the evidence to Dr Casikar for comment.

108. Mr Tanner submits that Dr Ganora is a pain management specialist and he did not have access to the discogram when he expressed his opinion regarding surgery in March 2019. The treating neurosurgeon recommended surgery after reviewing the discogram. In December 2019, Dr Ganora accepted that the applicant's experiences during the discogram testing might be relevant to the decision regarding surgery.

Is the proposed treatment reasonably necessary as a result of the injury sustained during the course of the applicant's employment?

109. Section 60 of the 1987 Act provides:

> "60 (1) If, as a result of an injury received by a worker, it is reasonably necessary that:
>
> (a) any medical or related treatment (other than domestic assistance) be given, or
> (b) any hospital treatment be given, or
> (c) any ambulance service be provided, or
> (d) any workplace rehabilitation service be provided,
>
> the worker's employer is liable to pay, in addition to any other compensation under this Act, the cost of that treatment or service and the related travel expenses specified in subsection (2)".

110. What constitutes reasonably necessary treatment was considered in the context of s 10 of the *Workers Compensation Act 1926* in *Rose v Health Commission (NSW)*[1], Burke CCJ stated:

> "Treatment, in the medical or therapeutic context, relates to the management of disease, illness or injury by the provision of medication, surgery or other medical service designed to arrest or abate the progress of the condition or to alleviate, cure or remedy the condition. It is the provision of such services for the purpose of limiting the deleterious effects of a condition and restoring health. If the particular 'treatment' cannot, in reason, be found to have that purpose or be competent to achieve that purpose, then it is certainly not reasonable treatment of the condition and is really not treatment at all. In that sense, an employer can only be liable for the cost of reasonable treatment."[2]

[1] (1986) 2 NSWCCR 32 (*Rose*).
[2] *Rose*, [42].

111. Further, His Honour added:

> "1. *Prima facie*, if the treatment falls within the definition of medical treatment in section 10(2), it is relevant medical treatment for the purposes of this Act. Broadly then, treatment that is given by, or at the direction of, a medical practitioner or consists of the supply of medicines or medical supplies is such treatment.
>
> 2. However, although falling within that ambit and thereby presumed reasonable, that presumption is rebuttable (and there would be an evidentiary onus on the parties seeking to do so). If it be shown that the particular treatment afforded is not appropriate, is not competent to alleviate the effects of injury, then it is not relevant treatment for the purposes of the Act.
>
> 3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of injury.
>
> 4. It is reasonably necessary that such treatment be afforded a worker if this Court concludes, exercising prudence, sound judgment and good sense, that it is so. That involves the Court in deciding, on the facts as it finds them, that the particular treatment is essential to, should be afforded to, and should not be forborne by, the worker.
>
> 5. In so deciding, the Court will have regard to medical opinion as to the relevance and appropriateness of the particular treatment, any available alternative treatment, the cost factor, the actual or potential effectiveness of the treatment and its place in the usual medical armoury of treatments for the particular condition."[3]

112. His Honour considered the relevant factors relating to reasonably necessary treatment under s 60 of the 1987 Act in *Bartolo v Western Sydney Area Health Service*[4] and stated:

> "The question is should the patient have this treatment or not. If it is better that he have it, then it is necessary and should not be forborne. If in reason it should be said that the patient should not do without this treatment, then it satisfies the test of being reasonably necessary."[5]

113. In *Diab v NRMA Ltd*[6], Deputy President Roche questioned this approach and cited *Rose* with approval. He provided a summary of the principles as follows:

> "In the context of s 60, the relevant matters, according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ at point (5) in *Rose* (see [76] above), namely:
>
> (a) the appropriateness of the particular treatment;
> (b) the availability of alternative treatment, and its potential effectiveness;
> (c) the cost of the treatment;
> (d) the actual or potential effectiveness of the treatment, and
> (e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective.

[3] *Rose*, [47].
[4] (1997) 14 NSWCCR 233 (*Bartolo*).
[5] *Bartolo*, [238].
[6] [2014] NSWWCCPD 72 (*Diab*).

> With respect to point (d), it should be noted that while the effectiveness of the treatment is relevant to whether the treatment was reasonably necessary, it is certainly not determinative. The evidence may show that the same outcome could be achieved by a different treatment, but at a much lower cost. Similarly, bearing in mind that all treatment, especially surgery, carries a risk of a less than ideal result, a poor outcome does not necessarily mean that the treatment was not reasonably necessary. As always, each case will depend on its facts.
>
> While the above matters are 'useful heads for consideration', the 'essential question remains whether the treatment was reasonably necessary' (*Margaroff v Cordon Bleu Cookware Pty Ltd* [1997] NSWCC 13; (1997) 15 NSWCCR 204 at 208C). Thus, it is not simply a matter of asking, as was suggested in *Bartolo*, is it better that the worker have the treatment or not. As noted by French CJ and Gummow J at [58] in *Spencer v Commonwealth of Australia* [2010] HCA 28, when dealing with how the expression 'no reasonable prospect' should be understood, '[n]o paraphrase of the expression can be adopted as a sufficient explanation of its operation, let alone definition of its content'".[7]

114. Whether the need for reasonably necessary treatment arises from an injury is a question of causation and must be determined based on the facts in each case. The accepted view regarding causation was set out in *Kooragang Cement Pty Ltd v Bates*[8], where Kirby J stated:

> "The result of the cases is that each case where causation is in issue in a workers compensation claim must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from' is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a common sense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation."[9]

115. It is accepted that a condition can have multiple causes, but the applicant must establish that the injury materially contributed to the need for surgery. This was confirmed by Deputy President Roche in *Murphy v Allity Management Services Pty Ltd*[10], where he stated:

> "Moreover, even if the fall at Coles contributed to the need for surgery, that would not necessarily defeat Ms Murphy's claim. That is because a condition can have multiple causes (*Migge v Wormald Bros Industries Ltd* (1973) 47 ALJR 236; *Pyrmont Publishing Co Pty Ltd v Peters* (1972) 46 WCR 27; *Cluff v Dorahy Bros (Wholesale) Pty Ltd* (1979) 53 WCR 167; *ACQ Pty Ltd v Cook* [2009] HCA 28 at [25] and [27]; [2009] HCA 28; 237 CLR 656). The work injury does not have to be the only, or even a substantial, cause of the need for the relevant treatment before the cost of that treatment is recoverable under s 60 of the 1987 Act.

[7] *Diab*, [88] to [90].
[8] (1994) 35 NSWLR 452; 10 NSWCCR 796 (*Kooragang*).
[9] *Kooragang* [463].
[10] [2015] NSWWCCPD 49 (*Murphy*).

> Ms Murphy only has to establish, applying the commonsense test of causation (*Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796), that the treatment is reasonably necessary 'as a result of' the injury (see *Taxis Combined Services (Victoria) Pty Ltd v Schokman* [2014] NSWWCCPD 18 at [40] – [55]). That is, she has to establish that the injury materially contributed to the need for the surgery (see the discussion on the test of causation in *Sutherland Shire Council v Baltica General Insurance Co Ltd* (1996) 12 NSWCCR 716)."[11]

116. There is no dispute that the applicant suffered a consequential condition in his right shoulder and neck as a result of the accepted injury to his left shoulder.

117. According to the applicant, he gained no benefit from the two left shoulder operations and he has continued to experience pain in his shoulders and neck. He has been treated with physiotherapy and takes strong medication, but this has not provided any long term relief from his symptoms. His neck movements are restricted, and his symptoms impact on his day to day activities. He has thought hard about the surgery and is aware of the risks associated with the procedure.

118. It is true that the focus of the earlier medical reports was on the applicant's left shoulder pain. The complaints regarding the applicant's neck symptoms were described as "diffuse", and seemed to radiate from the left shoulder to the neck (Dr Watson), were located in the neck and shoulder (Dr Walker, Dr Giblin, Dr Ganora and the physiotherapists), or radiated from the neck to the shoulder (Dr Wallace and Mr Blackburn).

119. The MRI scans, bone scans and EMG scan showed no evidence of any abnormality. An injection in 2013 had no effect on the applicant's neck pain. In 2014, Dr Johnson referred to symptoms originating from the applicant's thoracic spine. Dr Biggs in 2015 thought that the applicant's problems stemmed from the cervicothoracic spine and periscapular region. Therefore, there are a number of differences in the histories and opinions of these clinicians.

120. However, any discrepancies are of little relevance, given that the respondent accepted liability in respect of the left shoulder injury and the consequential conditions in the right shoulder and neck. Further, any concerns that the doctors had in 2013 regarding the need for treatment has to be considered in light of subsequent history and the applicant's current condition.

121. It may well be that neck surgery was not needed or foreshadowed prior to 2019. This is consistent with the fact that no neck operations were performed. However, the need for surgery in 2019 and 2020 is a completely different matter.

122. It is clear from the evidence of Dr Gupta that he thought that the applicant's pain related to the rotator cuff pathology. Initially, he prescribed conservative treatment, but eventually he recommended surgery. The insurer disputed the need for the procedure, but it agreed to pay for the operation at an arbitration hearing in the Commission.

123. Dr Gupta confirmed that the applicant gained no relief from his pain. In February 2019, he observed a positive Spurway test for radiculopathy, a finding that could be consistent with neck pathology. He thought that this warranted further investigation.

124. The applicant saw Dr Ganora in 2015 and 2019. It must be kept in mind that he is a pain management specialist, so his focus would have been on conservative pain management rather than invasive treatment. The views of spinal surgeons would in my view carry more weight.

[11] *Murphy*, [57] to [58].

125. Dr Ganora's findings and treatment in 2015 focussed on the applicant's left shoulder injury. In 2019, the applicant's complaints and his findings were similar. He disagreed with Dr Gupta's opinion that the applicant's symptoms came from his neck. His views regarding the cervical surgery following the discogram findings is unknown, so his evidence is of little assistance.

126. There are only three doctors who have provided opinions regarding the current dispute. According to Dr Kam, the applicant had been troubled by neck and shoulder pain for six years. That history might not necessarily be correct when the histories in the reports compiled prior to 2019 are considered, but in the absence of the clinical notes of the treating doctors or reports encompassing the entire period, one cannot draw any conclusions adverse to the applicant's evidence.

127. Dr Kam recorded in some detail the nature of the applicant's complaints which were largely subjective in nature. This was on the background of an MRI scan that showed minor pathology in the applicant's cervical spine. He resorted to a discogram that confirmed that the applicant's pain was generated at C4/5 and C5/6. This finding convinced him that surgery was necessary if the applicant wanted to be relieved of his neck pain and improve his lifestyle.

128. The fact that Dr Kam is the treating specialist, who has seen the applicant on a number of occasions, carries some weight because he is in the best position to assesses and comment on the applicant's symptoms, treatment and progress. The surgery that he has proposed is a significant invasive procedure and I doubt that he would be recommending such an operation if he had any concerns about the outcome.

129. The applicant also has the support from Dr Poplawski for the procedure. Initially the doctor recommended conservative treatment, but on review in January 2020, when the applicant complained of increasing symptoms in his neck and intermittent radiculopathy, the doctor agreed that the cervical surgery proposed by Dr Kam was reasonable.

130. The only doctor to challenge the current need for surgery is Dr Casikar. His history was fairly brief, and he merely indicated that the applicant had neck and right shoulder pain. He failed to provide any detailed history of the onset of these symptoms. Although he indicated that there was no neurological abnormality, he reported a finding of hypoaesthesia over the entire left upper limb and a reduced range of neck movement. Therefore, there is an internal inconsistency in his report.

131. Dr Casikar suggested conservative treatment to relieve the shoulder symptoms. He commented that the applicant only suffered a soft tissue injury, however, given the radiological findings of tears in the supraspinatus and infraspinatus tendons in the left shoulder, which required surgery, it would seem that the applicant's injury was more serious than merely "soft tissue".

132. Dr Casikar stated that the applicant "does not require any surgery for his neck". He gave no reasons for this assertion. He stated that the surgery was not reasonably necessary because "The work related injury was a soft tissue injury". Again, he gave no reasons. His only diagnosis regarding the applicant's neck was "incidental cervical spondylosis" without any further comment.

133. Dr Casikar stated that the applicant's neck pain was part of the soft tissue injury to the shoulder, but he did not explain what he meant by this. He seems to suggest that because there were no neurological findings, there was no neck pathology, but I have already commented on the internal inconsistency in his report. In the circumstances, it is not surprising that Mr Baker made no submissions about Dr Casikar's report, and in my view, little, if any, weight can be given to the doctor's opinion.

134. It is true that the MRI scans have only shown minor pathology in the applicant's neck. It is also true that the use of a discogram as a diagnostic tool is controversial. The same was said about the use of thermography as a diagnostic tool in the 1980s. The difference between these two tests is that discograms are still used today by clinicians for the purpose of diagnosis, and according to Drs Kam and Poplawski, this test has a role to play in the diagnosis of the applicant's neck condition.

135. In my opinion, the evidence supports the need for the operation to address the effects of the applicant's consequential neck condition. Conservative measures seem to have been exhausted and surgery is the only option. The only doctor to question the need for surgery is Dr Casikar, whose opinion I have rejected. Further he has not advised whether the operation is an appropriate form of treatment.

136. The applicant told Dr Poplawski that according to Dr Kam, the chances of a successful outcome was 80%. I am satisfied that the surgery has the potential to alleviate the applicant's symptoms, is an appropriate treatment and is likely to be effective. There seems to be no alternative forms of treatment and the cost is not unreasonable. This satisfies the relevant factors discussed in *Rose* and *Diab*.

137. Accordingly, I am satisfied on the balance of probabilities that the treatment proposed by Dr Kam, namely an anterior cervical discectomy and fusion of C4/5 and C5/6, and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of the applicant's employment with the respondent on 27 March 2013.

FINDINGS

138. The applicant sustained an injury to his left shoulder and developed consequential conditions in his neck and right shoulder arising out of or in the course of his employment with the respondent on 27 March 2013.

139. The applicant's employment was a substantial or the main contributing factor to his injury.

140. The applicant requires medical treatment as a consequence of his injury and the respondent is liable to pay reasonably necessary medical expenses.

141. The proposed anterior cervical discectomy and fusion of C4/5 and C5/6, and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of the applicant's employment with the respondent on 27 March 2013.

ORDERS

142. The respondent is to pay the applicant's reasonably necessary medical expenses with respect to the proposed anterior cervical discectomy and fusion of C4/5 and C5/6, and associated expenses, pursuant to s 60 of the 1987 Act.