WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **1554/20**
Applicant: **Barry Atkins**
Respondent: **City of Canada Bay**
Date of Determination: **3 June 2020**
Citation: **[2020] NSWWCC 182**

The Commission determines:

1. The left shoulder surgery proposed by Dr Vijay Maniam on 7 June 2019 is reasonably necessary as a result of the injury on 2 December 2010.

The Commission orders:

2. The respondent to pay the costs of and incidental to the surgery pursuant to s 60 of the *Workers Compensation Act 1987*.

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

Rachel Homan
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 RACHEL HOMAN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mr Barry Atkins (the applicant) was employed by the City of Canada Bay (the respondent) as a team leader in maintenance from 2005 onwards. The applicant claims that on 2 December 2010 and as a result of the nature and conditions of his employment with the respondent, he sustained an injury to his right shoulder, left shoulder and neck. Liability for an injury to each of these body parts has been accepted by the respondent.

2. On 7 June 2019, the applicant's orthopaedic surgeon, Dr Vijay Maniam, sought approval from the respondent's insurer for the applicant to undergo a left shoulder arthroscopy. A report was prepared for the insurer in support of the request on 23 July 2019. On 7 August 2019, the respondent's insurer declined liability for the surgery in a dispute notice issued pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act). The decision to decline liability was maintained after internal review on 4 February 2020.

3. The present proceedings were commenced by an Application to Resolve a Dispute (ARD) lodged in the Commission on 20 March 2020. The applicant seeks compensation pursuant to s 60 of the *Workers Compensation Act 1987* (the 1987 Act) for the costs of and incidental to the surgery proposed by Dr Maniam.

PROCEDURE BEFORE THE COMMISSION

4. The parties appeared for conciliation conference and arbitration hearing on 19 May 2020. The applicant was represented by Mr Craig Tanner of counsel, instructed by Ms Aleisha Nair. The respondent was represented by Mr David Saul of counsel instructed by Mr Will Murphy.

5. 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

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

    (a) ARD and attached documents;

    (b) Reply and attached documents.

7. Neither party applied to adduce oral evidence or cross-examine any witness.

Applicant's evidence

8. There are a number of written statements prepared by the applicant in evidence before me. Relevantly to the present proceedings, the applicant's evidence is set out in a written statement made on 5 March 2020.

9. The applicant said he had read the report of the orthopaedic surgeon qualified by the insurer, Dr Roger Pillemer, but trusted his treating doctor and wished to proceed on the basis of his recommendation. The applicant said his treating doctor believed that surgery to his left shoulder was required. The applicant expressed frustration at the delay caused by the insurer insisting that he see a neurologist on Dr Pillemer's recommendation.

10. The applicant said he continued to experience ongoing pain and symptoms in his left shoulder and had been advised that the surgery would improve those symptoms.

11. The applicant said he was unable to reach his left arm above shoulder height. If he tried to do so, his arm would begin to shake and was very unstable. The applicant said that even holding his mobile phone in his left arm caused his arm to feel shaky and unstable after a short period. When shopping, the applicant had to hold the grocery bags in his right arm only. He had difficulty putting on shirts. The applicant could not lie on his left side without his shoulder aching. The applicant only drove with his right hand because holding his left hand on the steering wheel caused his shoulder to become sore after a while.

12. The applicant said he used heat packs, ice packs and a TENS machine on his shoulder in order to relieve some of the pain. The applicant also remained reliant on pain medication.

13. The applicant said he had experienced similar pain at his right shoulder previously and underwent the same surgery now being proposed. The surgery had significantly improved the applicant's symptoms. The applicant said he was hopeful that the proposed surgery would result in improved range of motion and relieve his pain.

14. The applicant said he had undergone a fusion surgery at his cervical spine as recommended by neurosurgeon, Dr Ralph Mobbs. The applicant said this provided some relief although his neck was not perfect. The applicant said he continued to have pain at the top of his neck and this was being investigated further by Dr Mobbs.

Dr Maniam

15. Orthopaedic surgeon, Dr Vijay Maniam prepared a report for the insurer dated 23 July 2019. Dr Maniam noted that the applicant had injured his right shoulder at work on 2 December 2010 and underwent biceps tenodesis, AC joint excision and subacromial decompression surgery on 15 November 2011.

16. Dr Maniam said he first examined the applicant's left shoulder joint in January 2014 when there was movement restriction and positive impingement signs.

17. In the period that followed, the applicant underwent surgery to his cervical spine and lumbar spine. The applicant reported that the pains in his left shoulder had been continual, were steadily worsening and were affecting his activities of daily living.

18. Examination of the left shoulder revealed signs of impingement and subacromial bursitis.

19. An MRI of the left shoulder performed on 21 May 2018 showed a partial thickness articular surface tear of the supraspinatus tendon; partial tear of the subscapularis tendon at the lesser tuberosity; subluxation of the long head of biceps tendon lying on the medial lip of the bicipital groove; tendinosis of the long head of biceps; and subacromial/subdeltoid bursitis.

20. Given the persistent and deteriorating problems in the applicant's left shoulder, Dr Maniam proposed the following surgical operation:

    (a) debridement of the supraspinatus and infraspinatus;
    (b) biceps tenodesis for subluxation;
    (c) subacromial decompression.

Evidence from the applicant's other treating specialists

21. There are in evidence a number of reports from the applicant's treating neurosurgeon, Dr Ralph Mobbs, dating from November 2016. Dr Mobbs noted that the applicant presented with persisting neck pain on a background of previous neck operations in 2016.

22. In a report dated 8 November 2016, Dr Mobbs recorded that he had performed examination of the applicant's cervical spine and upper limbs and reviewed a number of radiological investigations. Dr Mobbs ordered further studies.

23. In April 2017, Dr Mobbs reported that he had performed a plate removal at C5/6 and there had been significant improvements in the applicant's mechanical neck pain, especially low down in his neck. At that time, Dr Mobbs was not keen to intervene further in terms of fusions or disc replacements.

24. In August 2017, Dr Mobbs noted that the applicant's neck was still playing up especially at the top and presumably from C2/3 pathology. The applicant had been back and forth to interventional pain specialist Dr James Yu for injections. Dr Mobbs requested further MRI, x-ray and bone scan studies of the applicant's cervical spine.

25. In September 2017, Dr Mobbs reviewed those investigations and expressed the view that the applicant's problems were related to facet joint changes at the levels above and below his previous surgeries.

26. In January 2018, Dr Mobbs said he had spent almost half a day with the applicant on the last occasion and had spent an enormous volume of time on the applicant, trying to sort out his neck as he had really struggled and continue to do so. Dr Mobbs recommended further review with Dr Yu.

27. In April 2018, Dr Mobbs noted that the applicant had been in and out of pain management over the last nine months. If this was no longer giving him any relief, Dr Mobbs said he would be happy to consider surgical intervention.

28. Reports from Dr Yu are also in evidence. In a report dated 22 May 2017, Dr Yu noted that following surgery with Dr Mobbs in February 2017, the applicant had noted an improvement in his mechanical neck pain but continued to complain of lower cervical neck pain associated with the left shoulder and left upper limb pain.

29. A series of earlier reports from neurosurgeon Dr Andrew Kam are also in evidence and have been considered.

Dr Poplawski

30. The applicant relies on a medicolegal report prepared by orthopaedic surgeon, Dr Zbigniew Poplawski, dated 23 December 2019.

31. Dr Poplawski took a history of the applicant injuring his left shoulder on 2 December 2010. The shoulder became progressively more symptomatic over the years with further work activities. It now caused the applicant considerable discomfort, particularly with repetitive use and lifting activities. Dr Poplawski noted that the applicant had undergone a number of surgical procedures to his cervical spine.

32. Dr Poplawski recorded that the applicant experienced pain if he lay on his left side in bed, used his left arm repetitively or attempted to lift his arm to shoulder level. The applicant had difficulties involving gripping, lifting and carrying things with his left hand.

33. Dr Poplawski noted that an MRI scan of the left shoulder carried out on 21 May 2018 revealed a partial tear of part of the rotator cuff tendons, displacement of the long head of biceps tendon and evidence of subacromial/subdeltoid bursitis.

34. The applicant was referred to Dr Maniam who had operated on the applicant's right shoulder in November 2011. Dr Maniam had noted restricted range of motion and a positive impingement sign in the applicant's left shoulder in 2014.

35. As the applicant's left shoulder was not improving with conservative management, Dr Maniam had recommended arthroscopic surgery in the form of a supraspinatus and infraspinatus debridement, relocation of the long head of biceps tendon in its bicipital groove and subacromial decompression.

36. Dr Poplawski noted that the applicant had been seen by orthopaedic surgeon, Dr Pillemer on 5 September 2019. Dr Poplawski noted that Dr Pillemer was concerned about the possibility of a left supraclavicular nerve lesion on the basis of his clinical examination and suggested that this needed to be sorted out prior to any left shoulder surgery being considered.

37. Dr Poplawski took a history of the previous surgical procedures undergone by the applicant including arthroscopic surgery to the right shoulder by Dr Maniam in November 2011; fusion of the C3/4 disc space and disc replacement at C5/6 by Dr Andrew Kam on 11 January 2016; revision disc replacement surgery by Dr Kam on 20 April 2016; removal of C5/6 screws by Dr Ralph Mobbs on 24 February 2017; and C2/3 anterior cervical discectomy and fusion and C6/7 disc replacement by Dr Mobbs on 21 October 2019.

38. Dr Poplawski recorded his findings on physical examination, including his examination of the head and neck. Dr Poplawski noted paraspinal tenderness at the cervical spine, more marked on the left, and moderately reduced range of motion in all directions. Sensation was intact. Dr Poplawski recorded,

> "There was no decreased sensation over the distal supraclavicular nerve on either side and I could detect no tenderness over the left supraclavicular nerve as it enters the posterior triangle of the neck behind the sternocleidomastoid muscle."

39. Muscle power was noted to be globally reduced in the left upper limb, particularly in the shoulder girdle musculature and biceps muscle, with obvious wasting in those areas.

40. Dr Poplawski's examination of the upper limbs revealed:

> "There was tenderness present over the anterior and posterior aspects, the tip and the LHB tendons of both shoulders, more marked on the left, particularly in relation to the LHB tendon.
>
> There was a painful arc at 90° of abduction on the left and 110° of abduction on the right with a bilaterally positive Neer impingement test.
>
> Range of motion in the shoulders was as follows:

Range of motion	Left	Right
Flexion	100°	130°
Extension	40°	40°
Adduction	50°	50°
Abduction	90°	130°
Internal rotation	60°	70°
External rotation	70°	70°

> Dr Poplawski reviewed the MRI taken on 21 May 2018 and diagnosed partial tear, rotator cuff tendons, subluxation of long head of biceps tendon and subacromial/subdeltoid bursitis with impingement."

41. Dr Poplawski was asked to comment on the opinion of Dr Pillemer, expressed on 5 September 2019, and stated,

> "I could find no evidence of supraclavicular nerve lesion and in my opinion Mr Atkins's left shoulder problem is the result of the posttraumatic problem as outlined in the body of my report."

42. Dr Poplawski agreed that the surgery proposed by Dr Maniam was a "reasonable and necessary treatment to try and resolve his shoulder problem."

Dr Pillemer

43. The respondent relies on a medicolegal report prepared by orthopaedic surgeon, Dr Roger Pillemer, dated 5 September 2019.

44. Dr Pillemer took a history of the applicant experiencing significant ongoing problems with his cervical spine, right shoulder and left shoulder since the injury on 2 December 2010. Dr Pillemer noted the history of treatment consistently with the other evidence and recorded that the applicant's treating orthopaedic surgeon had suggested surgery for his left shoulder in the form of biceps tenodesis, subacromial decompression and excision of his AC joints and debridement of a partial tear.

45. Dr Pillemer noted that the applicant's main concern at the present time was his cervical spine, which he felt was worse than ever. The applicant complained that his left shoulder symptoms had become progressively worse with time. The applicant indicated discomfort at the base of the neck, over the top of the shoulder and radiating down the upper part of his left arm. The applicant's symptoms were aggravated by any heavy lifting or attempting to lift above shoulder level. The applicant was unable to lie on his left side and the shoulder ached even when at rest.

46. Dr Pillemer recorded a physical examination as follows:

> "Mr Atkins was an adult male and it was interesting to note that he actually has a virtually full range of shoulder movements bilaterally but with some discomfort on the left side. Motor power was good in all groups tested.
>
> Importantly he does have hypoaesthesia to pinprick over his shoulder cowl in the distribution of the supraclavicular nerve, and this was distinct and present with repeated testing. He also has localised tenderness to percussion over the supraclavicular nerve as it enters the posterior triangle of the neck behind the sternomastoid muscle."

47. Dr Pillemer noted the findings of the MRI of the left shoulder carried out on 21 May 2018.

48. With regard to diagnosis, Dr Pillemer stated:

> "As far as diagnosis is concerned, while noting the changes on the MRI, clinically Mr Atkins does have very clear evidence of a supraclavicular nerve lesion on the left side as evidenced by the clinical findings. Importantly in addition, he has a full range of shoulder movement but with some discomfort.

> In my opinion then it is certainly possible that the majority of his symptoms in his left shoulder region are arising from a supraclavicular nerve lesion and I would suggest that this needs to be sorted out initially, prior to any surgery being carried out on his left shoulder.
>
> In my opinion the best approach would be for Mr Atkins to see a neurologist *with a specific request that a supraclavicular nerve lesion on the left side is being considered with distinct sensory loss and localised percussion tenderness*.
>
> Importantly this needs to be a consultation and not simply nerve conduction studies."

49. Dr Pillemer expressed the opinion that although the applicant had an underlying problem which had been asymptomatic for many years, the nature and conditions of the applicant's work and the injury described were a substantial contributing factor to the development of further problems with his left shoulder.

Applicant's submissions

50. Mr Tanner referred me to the report prepared by Dr Maniam for the insurer dated 23 July 2019 and noted the history of the condition in the applicant's left shoulder, Dr Maniam's findings on examination and the results of the MRI performed on 21 May 2018. Mr Tanner noted that the applicant complained of continual and steady worsening of his left shoulder pains.

51. Mr Tanner noted that Dr Poplawski took a history of the pain in the applicant's shoulder steadily worsening. The applicant had also described his symptoms in his statement, including being unable to reach his left arm above shoulder height, his arm beginning to shake and being unstable and a restricted range of motion.

52. Mr Tanner noted that Dr Pillemer and Dr Poplawski had provided conflicting opinions on the range of motion at the applicant's left shoulder. Mr Tanner noted that Dr Poplawski recorded a distinct difference in the range of left arm motion as compared to the right.

53. Although Dr Pillemer recorded a history of symptoms and difficulties affecting the applicant's left shoulder consistent with the other evidence, on examination he found virtually full range of shoulder movements. Mr Tanner said this was inconsistent with Dr Poplawski's examination and noted that, in contrast to Dr Poplawski, Dr Pillemer recorded no actual measurements of the applicant's range of motion.

54. Mr Tanner submitted that it was significant that Dr Pillemer had not suggested that the surgery proposed by Dr Maniam was not reasonably necessary. Rather, Dr Pillemer had speculated that the applicant may have a nerve lesion. Dr Pillemer had said it was "possible" but not "probable" that "the majority" of the applicant's symptoms arose from a supraclavicular nerve lesion and this needed to be sorted out initially.

55. Mr Tanner said Dr Pillemer had not given an opinion that surgery was not reasonably necessary. Dr Pillemer had only suggested that there may be another factor at play. Dr Pillemer did not suggest that the applicant's condition was wholly caused by that factor and did not suggest that the clear pathology shown in the MRI would not be addressed by the surgery proposed by Dr Maniam.

56. Mr Tanner noted that Dr Pillemer considered the best approach would be for the applicant to see a neurologist, that is, a doctor with a different specialty to Dr Pillemer, to explore what Dr Pillemer suggested was a mere possibility.

57. Mr Tanner submitted that Dr Poplawski had considered this possibility and found no evidence of a lesion. Mr Tanner submitted that Dr Poplawski's evidence contained a specific rejection of the thesis posed by Dr Pillemer.
58. Mr Tanner submitted that there was clear evidence of pathology at the applicant's left shoulder. The applicant's treating surgeon considered the procedure to be appropriate. There was an opinion from the applicant's medical expert saying the procedure was reasonably necessary as a result of the injury and there was no contrary opinion from the respondent's expert.

59. Mr Tanner referred me to the authorities in *Diab v NRMA Ltd*[1] and *Rose v Health Commission (NSW)*[2] (*Rose*) and, in particular, to the list of relevant matters set out by Burke CCJ in *Rose*.

60. Mr Tanner submitted that the evidence indicated that the treatment proposed by Dr Maniam was appropriate and noted that Dr Pillemer did not say the procedure was inappropriate.

61. Mr Tanner conceded that Dr Pillemer had given an opinion about the possibility of alternative treatment but did not provide an effective diagnosis.

62. Mr Tanner submitted that cost did not appear to be in issue.

63. Mr Tanner submitted that there was evidence that the procedure would be potentially effective in alleviating the applicant's symptoms.

64. Mr Tanner submitted that there was an acceptance by the applicant's expert that the treatment would be effective. Dr Pillemer did not suggest that the treatment would not be effective.

65. Mr Tanner submitted that there was very clear left shoulder pathology shown in the MRI investigation, which was not in dispute. Mr Tanner submitted that Dr Pillemer's opinion constituted a "red herring".

66. The surgery proposed by Dr Maniam consisted of three components intended to address the particular pathology shown on MRI in the shoulder. Mr Tanner said the relevant question was whether the particular surgery proposed was reasonably necessary to address that pathology.

67. Mr Tanner submitted that even if there was additional pathology, as suggested by Dr Pillemer, that did not mean that the applicant had no pain or restriction coming from his shoulder. All the respondent had posed was another explanation for some of the applicant's pain.

68. Mr Tanner noted that Dr Pillemer said it was "possible" that "the majority" of symptoms were coming from a lesion but this was beyond his area of expertise. Mr Tanner submitted that a neurologist may confirm the presence of a lesion but that did not mean there was not also pathology in the left shoulder requiring treatment. At best, Dr Pillemer's evidence did nothing more than introduce another possible cause of the applicant's symptoms in circumstances where there was undisputed pathology at the shoulder.

Respondent's submissions

69. Mr Saul submitted that the applicant was unable to satisfy the Commission, on the balance of probabilities, that the procedure proposed by Dr Maniam was reasonably necessary at the present time.

[1] [2014] NSWWCCPD 72.
[2] [1986] NSWCC 2; (1986) 2 NSWCCR 32.

70. Mr Saul submitted that Dr Pillemer had expressed a confident view in his report about the presence of an alternative condition, which he believed should be further explored. Mr Saul noted that no opinion or consideration had been given to the alternative condition by the applicant's treating surgeon and the applicant relied only on a "throw away line" in Dr Poplawski's report. Mr Saul said Dr Pillemer's view should at least be explored and commented on by Dr Maniam before an order was made that the surgery was reasonably necessary.

71. Mr Saul noted that the applicant had sustained injury to a number of body parts and had brought proceedings in the Commission previously. The applicant had undergone multiple surgical procedures to his cervical spine and right shoulder. Mr Saul said this provided relevant context to the opinion of Dr Pillemer. Mr Saul referred me, in particular, to the reports of Dr Kam, Dr Mobbs and Dr Yu in relation to the treatment of the applicant's cervical spine. The applicant had complained since 2012 of neck pain going down the left side into his left shoulder which had not resolved with surgical treatment to date. Mr Saul submitted that this lent to weight to the proposition that Dr Pillemer was correct, in which case the respondent should not be held liable to pay for the surgery.

72. Mr Saul submitted that Dr Pillemer was well known to the Commission and provided opinions for both applicants and insurers in Commission proceedings. Mr Saul submitted that Dr Pillemer's opinion was supported by his examination of the applicant. Dr Pillemer found the applicant to have hypoaesthesia to pinprick over his shoulder cowl in the distribution of the supraclavicular nerve. Dr Pillemer said this was distinct and present with repeated testing. The applicant also had localised tenderness to percussion over the supraclavicular nerve. Mr Saul submitted that the record of Dr Pillemer's examination constituted clear evidence of a nerve lesion. Mr Saul submitted that Dr Pillemer had not proposed a hypothesis. Dr Pillemer's opinion was also supported by his finding of a near full range of motion, albeit with some discomfort.

73. Mr Saul submitted that the condition identified by Dr Pillemer should be ruled out or in prior to invasive surgery being performed. Mr Saul noted that it was the applicant's onus to show that the surgery was reasonably necessary at the present point in time.

74. Although noting that Dr Poplawski had commented on Dr Pillemer's opinion, Mr Saul described that comment as "poor" and lacking in detail. Dr Poplawski simply stated that he could find no evidence of a lesion. Mr Saul submitted that Dr Pillemer did find evidence of a lesion and, in the circumstances, Dr Poplawski's very brief opinion should not be accepted. Mr Saul submitted that this left only the evidence of Dr Pillemer and the silence of Dr Maniam.

75. Mr Saul submitted that the applicant was unable to prove his case on the balance of probabilities given the doubts raised by Dr Pillemer's report that the applicant's problems were coming not from his shoulder but from the nerve from his neck.

76. Mr Saul submitted that the Commission would be led into error if it considered only whether the surgery was reasonably necessary to treat the pathology shown in the MRI. Mr Saul said it was necessary to consider whether the surgery would relieve the applicant's symptoms. The applicant was clearly suffering problems in the region of his shoulder but there was a dispute as to whether those problems stemmed from the pathology shown on the MRI or the issue identified by Dr Pillemer. It was insufficient to simply identify the existence of pathology in the left shoulder.

77. Mr Saul submitted that there was no evidence that Dr Poplawski had conducted the same tests recorded by Dr Pillemer. The pinprick test administered, for example, clearly influenced Dr Pillemer's opinion. Dr Poplawski did not address whether he had performed that test in his examination.

78. Mr Saul noted that the respondent had offered, both at teleconference and during conciliation, to have the applicant examined by a neurologist to determine whether the condition identified by Dr Pillemer was present. That offer had been refused on both occasions by the applicant.

79. Mr Saul said there were other investigations and treatments that should be considered before it was possible to determine that the surgery was reasonably necessary. Although the applicant may be successful in the future in establishing that the procedure proposed by Dr Maniam was reasonably necessary, he could not succeed as at the present time.

FINDINGS AND REASONS

80. Section 9 of the 1987 Act provides that a worker who has received an 'injury' shall receive compensation from the worker's employer in accordance with the Act.

81. Section 60 of the 1987 Act relevantly provides:

> "(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)."

82. In *Diab v NRMA Ltd*[3] Roche DP, referring to the decision in *Rose v Health Commission (NSW)*[4], set out the test for determining if medical treatment is reasonably necessary as a result of a work injury:

> "The standard test adopted in determining if medical treatment is reasonably necessary as a result of a work injury is that stated by Burke CCJ in *Rose v Health Commission (NSW)* [1986] NSWCC 2; (1986) 2 NSWCCR 32 (*Rose*) where his Honour said, at 48A—C:
> …
>
> 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] [2014] NSWWCCPD 72.
[4] [1986] NSWCC 2; (1986) 2 NSWCCR 32.

83. The Deputy President also noted that the Commission has generally referred to and applied the decision of Burke CCJ in *Bartolo v Western Sydney Area Health Service*[5]:

> "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."

84. Deputy President Roche found:

> "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.
>
> 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."

85. There is no dispute that the applicant sustained injury to his left shoulder in this case. Nor is there any dispute that the applicant experiences pain in the region of his left shoulder. The respondent has, however, raised a dispute as to the source of the applicant's pain. As a result, the respondent says the applicant has not established, at the present time, that the surgery proposed by Dr Maniam is reasonably necessary as a result of injury.

86. The respondent relies on the report of Dr Pillemer. Dr Pillemer's report sets out a history and records the applicant's complaints of symptoms in a manner that is consistent with the other evidence. Like Dr Maniam and Dr Poplawski, Dr Pillemer considered the results of the MRI performed on 21 May 2018. Dr Pillemer's clinical examination of the applicant, however, produced quite different findings.

87. In particular, Dr Pillemer found the applicant to have almost full range of shoulder movements on both sides, albeit with some discomfort on the left. Dr Pillemer also found hypoaesthesia to pinprick over the applicant's shoulder cowl in the distribution of the supraclavicular nerve. Dr Pillemer said this finding was distinct and present with repeated testing. Dr Pillemer additionally found localised tenderness to percussion over the supraclavicular nerve as it entered the posterior triangle of the neck behind the sternomastoid muscle. On the basis of these findings, Dr Pillemer considered it possible that there was a supraclavicular nerve lesion causing the majority of the applicant's pain. Dr Pillemer considered this should be investigated by a neurologist.

[5] [1997] NSWCC 1; 14 NSWCCR 233.

88. Dr Pillemer's findings as to range of movements may be contrasted with those recorded by Dr Poplawski and Dr Maniam. Dr Poplawski found impingement and set out his range of motion measurements, which showed a reduction in left shoulder motion compared with the right on flexion, abduction and internal rotation. I note that no measurements were recorded by Dr Pillemer for the purposes of comparison.

89. Dr Maniam said he found movement restriction and positive impingement when he first examined the applicant's left shoulder in 2014. In his more recent examination, Dr Maniam again found signs of impingement and subacromial bursitis.

90. The clinical findings of Dr Maniam and Dr Poplawski are consistent with the applicant's evidence. The applicant said he was unable to reach his left arm above shoulder height. If he tried to do so, his arm would begin to shake and was very unstable. The applicant said he had difficulty putting on shirts and driving with his left arm.

91. Although neither counsel addressed on this at arbitration, I note that an orthopaedic surgeon qualified by the respondent to provide a medicolegal opinion in relation to a previous dispute in regard to the applicant's neck injury, Dr John Bentivoglio, performed an examination on 24 April 2018, which revealed:

> "He had marked reduction of left shoulder movement and pain with passive movement of his shoulder in all directions. I do feel he has a significant left shoulder problem."

92. Dr Pillemer's finding of a near full range of movement thus stands apart from the other evidence.

93. With regard to Dr Pillemer's other clinical findings, I accept that there is no evidence before me that Dr Maniam conducted an examination that would potentially elicit findings consistent with a supraclavicular nerve lesion. There is no evidence that Dr Maniam has considered this possibility or that he has been asked to comment on Dr Pillemer's findings.

94. Dr Poplawski has, however, addressed this in his report. Although the respondent was critical of the lack of detail or explanation in Dr Poplawski's report, I am satisfied that he did perform an examination which attempted to elicit signs of a nerve lesion. Dr Poplawski indicated that sensation was intact. In particular, there was no decreased sensation over the distal supraclavicular nerve on either side. Dr Poplawski also said he could detect no tenderness over the left supraclavicular nerve as it enters the posterior triangle of the neck behind the sternocleidomastoid muscle. Dr Poplawski did not say what tests he used, but I am satisfied from the description of his findings, and having regard to his qualifications, that appropriate tests were administered.

95. I do accept the respondent's submission that the applicant has complained of neck pain going down the left side into his left shoulder which had not resolved with surgical treatment to date. It has been suggested that this circumstance lends weight to Dr Pillemer's views.

96. The applicant's neck-related symptoms have, however, been extensively investigated by two neurosurgeons, Dr Kam and Dr Mobbs. Dr Mobbs, in particular, has indicated that in 2018, he spent almost half a day with the applicant and had spent an "enormous volume of time" on the applicant's case. There is nothing in the material to suggest that Dr Kam or Dr Mobbs found any evidence suggestive of a supraclavicular nerve lesion. Equally, however, I accept that they have not expressly addressed this possibility or ruled it out in the reports before me. There is no evidence of the applicant being examined by a neurologist as recommended by Dr Pillemer, and the applicant has declined the respondent's offers to fund such an examination.

97. The question remains, whether in all the circumstances and on the current evidence, the applicant has established on the balance of probabilities that the surgery proposed by Dr Maniam is reasonably necessary as a result of the injury.

98. I am satisfied that the weight of evidence indicates that the applicant has impingement and restriction of movement in the left shoulder, in addition to pain. Dr Maniam and Dr Poplawski considered their clinical findings to be consistent with the pathology shown on the MRI. The 2018 MRI showed a partial thickness articular surface tear of the supraspinatus tendon; partial tear of the subscapularis tendon at the lesser tuberosity; subluxation of the long head of biceps tendon lying on the medial lip of the bicipital groove; tendinosis of the long head of biceps; and subacromial/subdeltoid bursitis. Notwithstanding Dr Pillemer's views, I accept the opinions of Drs Maniam and Poplawski that the pathology shown on the MRI is causing symptoms, which the surgery proposed by Dr Maniam is intended to alleviate.

99. It may be that the applicant also has a supraclavicular nerve lesion. I accept that Dr Pillemer found strong evidence of this on his examination. His findings were not, however, reproduced on Dr Poplawski's examination. None of the other specialists involved in the applicant's case have suggested this possibility despite extensive investigation of the applicant's symptoms. In the circumstances, I am not satisfied that the possibility of a supraclavicular nerve lesion is such that it renders the surgery proposed to the applicant's left shoulder not reasonably necessary at the present time. Whilst it might be helpful for the applicant's overall treatment to rule that pathology in or out, I am not satisfied that the surgery proposed to the applicant's shoulder should be deferred to investigate this further.

100. I am satisfied that the particular procedure proposed by Dr Maniam is appropriate and potentially effective treatment for the consequences of the applicant's injury. No issue has been raised as to the cost of the treatment. I am satisfied that the treatment would be potentially effective in alleviating the applicant's symptoms of pain and restriction. I am satisfied that the procedure is broadly accepted by medical experts as appropriate, noting that Dr Pillemer has not indicated otherwise. Dr Pillemer has simply considered that the alternative diagnosis should be considered first.

101. For the reasons given above, I am satisfied on the balance of probabilities that the surgery proposed by Dr Maniam is, at the present time, reasonably necessary as a result of the injury for the purposes of s 60 of the 1987 Act.

102. There will be an award for the applicant.