WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **3483/20**
Applicant: **Paul Payne**
Respondent: **Albany International Pty Limited**
Date of Determination: **28 August 2020**
Citation: **[2020] NSWWCC 292**

The Commission determines:

1. The L5/S1 anterior lumbar interbody fusion proposed by Dr Omprakash Damodaran, Neurosurgeon and Spine Surgeon is reasonably necessary treatment as a result of the injury sustained by the applicant in the course of his employment with the respondent on 29 August 2008 within the meaning of section 60 of the *Workers Compensation Act 1987*.

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

Anthony Scarcella
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 ANTHONY SCARCELLA, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

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Lucy Golic
Acting Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Mr Paul Payne, is a 55-year-old man who was employed by Albany International Pty Limited (the respondent) as a machinist.

2. On 29 August 2008, at the respondent's premises, Mr Payne alleges that, whilst jumping on boxes he had been directed to break-up, he came down on a box that had a hard piece of wood underneath it and jarred his back and right hip.

3. Mr Payne resolved claims for permanent impairment compensation under section 66 of the *Workers Compensation Act 1987* (the 1987 Act) in respect of his lumbar spine against the respondent on 13 December 2013 and on 22 May 2017 resulting in a total whole person impairment (WPI) of 13%.[1]

4. On 4 December 2019, Mr Payne sought the respondent's approval to proceed with surgery by way of an L5/S1 anterior lumbar interbody fusion proposed by Dr Omprakash Damodaran, Neurosurgeon and Spine Surgeon.

5. On 24 December 2019, the respondent, through its insurer, AAI Limited trading as GIO (GIO) issued a Dispute Notice pursuant to section 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) disputing that the L5/S1 anterior lumbar interbody fusion proposed by Dr Damodaran was reasonably necessary treatment as a result of the injury sustained by Mr Payne on 29 August 2008 within the meaning of section 60 of the 1987 Act.[2]

6. On 6 April 2020, GIO issued a further Dispute Notice pursuant to section 78 of the 1998 Act again disputing that the L5/S1 anterior lumber interbody fusion proposed by Dr Damodaran was reasonably necessary treatment as a result of injury within the meaning of sections 59 and 60 of the 1987 Act.[3]

7. On 14 May 2020, Mr Payne, through his lawyers, requested a review of the decision contained in the respondent's Dispute Notice dated 24 December 2019 under section 287A of the 1998 Act.[4]

8. On 4 June 2020, GIO issued a Dispute Notice pursuant to section 78 of the 1998 Act maintaining its decision disputing that the L5/S1 anterior lumbar interbody fusion proposed by Dr Damodaran was reasonably necessary treatment as a result of the injury sustained by Mr Payne on 29 August 2008 within the meaning of section 60 of the 1987 Act.[5]

9. Mr Payne lodged an Application to Resolve a Dispute (ARD) dated 25 June 2020 in the Workers Compensation Commission (the Commission).

ISSUES FOR DETERMINATION

10. The parties agreed that the following issues remained for determination:

    (a) Is the L5/S1 anterior lumbar interbody fusion surgery proposed by Dr Damodaran reasonably necessary treatment as a result of the injury sustained by Mr Payne on 29 August 2008 within the meaning of section 60 of the 1987 Act?

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[1] Application to Resolve a Dispute at pages 18 and 29
[2] Application to Resolve a Dispute at pages 30-33
[3] Reply at pages 7-10
[4] Application to Resolve a Dispute at pages 34-35
[5] Application to Resolve a Dispute at pages 36-40

(b) Is Mr Payne precluded from obtaining an order from the Commission for payment of compensation for the proposed surgical procedure by operation of section 59A of the 1987 Act or is the proposed surgical procedure exempt under section 59A(6)(a)?

Matters previously notified as disputed

11. The issues in dispute were notified in the Dispute Notices referred to above.

Matters not previously notified

12. No other issues were raised.

PROCEDURE BEFORE THE COMMISSION

13. The parties participated in a telephone conciliation conference/arbitration on 18 August 2020. Mr Allen Parker of counsel appeared for Mr Payne and Ms Lyn Goodman of counsel appeared for the respondent.

14. I am satisfied that the parties to the dispute understood the nature of the application and the legal implications of any assertion made in the information supplied. I 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

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

    (a) ARD dated 25 June 2020 and attached documents;

    (b) Reply dated 16 July 2020 and attached documents.

Oral Evidence

16. Neither party sought leave to adduce oral evidence from or to cross-examine any witness.

SUBMISSIONS

17. The parties made oral submissions at the arbitration hearing which were sound recorded. The sound recording is available to the parties. I will refer to the parties' submissions under each relevant issue for determination set out below.

FINDINGS AND REASONS

Is the surgery proposed by Dr Damodaran reasonably necessary treatment as a result of the injury sustained by Mr Payne on 29 August 2008 within the meaning of section 60 of the 1987 Act?

18. Section 60(1) of the 1987 Act relevantly provides:

> "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)."

19. Section 60(5) of the 1987 Act relevantly provides:

> "The jurisdiction of the Commission with respect to a dispute about compensation payable under this section extends to a dispute concerning any proposed treatment or service and the compensation that will be payable under this section in respect of any such proposed treatment or service. Any such dispute may be referred by the Registrar for assessment under Part 7 (Medical assessment) of Chapter 7 of the 1998 Act."

20. There are two elements to section 60(1) of the 1987 Act that must be considered. The first element is "as a result of an injury received by a worker". The second element is that of "reasonably necessary".

21. Dealing with the first element, namely, "as a result of injury received by a worker", I am required to conduct a common sense evaluation of the causal chain to determine whether the L5/S1 anterior lumbar interbody fusion surgery proposed by Dr Damodaran is reasonably necessary treatment as a result of the injury sustained by Mr Payne on 29 August 2008 within the meaning of section 60 of the 1987 Act.

22. The issue of causation must be based and determined on the facts in each case and requires a common sense evaluation of the causal chain: *Kooragang Cement Pty Ltd v Bates*[6] (*Kooragang*). As I understand it, when referring to applying "common sense", Kirby, P in *Kooragang* was not suggesting that it be applied "at large" or that issues were to be determined by "common sense" alone but by a careful analysis of the evidence, including a careful analysis of the expert evidence: *Kirunda v State of New South Wales (No 4)*[7] (*Kirunda*). The legislation must be interpreted by reference to the terms of the statute and its context in a fashion that best effects its purpose.

23. *Murphy v Allity Management Services Pty Ltd*[8] referred to *Kooragang* and is authority for the proposition that an injured worker must establish that the injury materially contributed to the need for the treatment or the surgery.

24. Turning to the "reasonably necessary" element, Roche DP in *Diab v NRMA Ltd*[9] (*Diab*) set out the "standard" test adopted for determining if medical treatment is reasonably necessary in *Rose v Health Commission (NSW)*[10] (*Rose*):

> "3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of the injury.
>
> 4. It is reasonably necessary that such treatment be afforded a worker if this Court concludes, exercising prudence, sound judgement 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.

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[6] *Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796.
[7] *Kirunda v State of New South Wales (No 4)* [2018] NSWWCCPD 45 at [136].
[8] *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49.
[9] *Diab v NRMA Ltd* [2014] NSWWCCPD 72
[10] *Rose v Health Commission (NSW)* (1986) 2 NSWCCR 32

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."

25. Roche DP noted subsequent appellate authority with respect to the use of the words "reasonably necessary" and said:

> "86. Reasonably necessary does not mean 'absolutely necessary' (*Moorebank* at [154]). If something is 'necessary', in the sense of indispensable, it will be 'reasonably necessary'. That is because reasonably necessary is a lesser requirement than 'necessary'. Depending on the circumstances, a range of different treatments may qualify as 'reasonably necessary' and a worker only has to establish that the treatment claimed is one of those treatments. A worker certainly does not have to establish that the treatment is 'reasonable and necessary', which is a significantly more demanding test that many insurers and doctors apply. …
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> 88. 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:
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> (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.
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> 89. 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.
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> 90. 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.' "

26. I now turn to the application of the relevant legislation and the legal principles referred to above to the available evidence in this matter.

27. Mr Payne's principal submissions may be summarised as follows:

> (a) Mr Payne's lumbar problems commenced with his injury on 29 August 2008 as described in his statement dated 9 March 2017.

(b) Mr Payne consulted Professor James Van Gelder, Neurosurgeon, who recommended conservative treatment rather than surgical intervention.

(c) Mr Payne battled on at work with the respondent until his retrenchment and thereafter worked with two other employers, despite experiencing ongoing lumbar spine symptoms.

(d) On 28 June 2016, whilst employed by Central Coast Coolrooms Pty Limited, Mr Payne stated that his lumbar spine symptoms increased when, in a simple manoeuvre whilst delivering stock, he experienced excruciating pain in his lower back. He was admitted to Gosford Hospital and was again referred to Professor Van Gelder by his general practitioner. Professor Van Gelder again recommended conservative treatment rather than surgery.

(e) In 2017, Mr Payne stated that he was unable to tolerate his increasing lumbar spine symptoms and consulted Dr Damodaran, who proposed that he undergo an interior interbody fusion at L5/S1.

(f) Dr Damodaran explained to Mr Payne that the proposed surgery was a significant procedure and that its results can be variable. Mr Payne stated that he had carefully considered Dr Damodaran's advice and decided to proceed with the surgery. He was very keen to obtain some improvement in his condition and relief from his constant and severe lower back symptoms, which were having a substantial adverse impact on his activities of daily living and general lifestyle. Mr Payne has a clear intention to proceed with the proposed surgery.

(g) Mr Payne has a 13% WPI as a result of his injury whilst employed by the respondent on 29 August 2008.

(h) Dr Damodaran made the causal connection between Mr Payne's injury in the course of his employment with the respondent in 2008 and his current medical condition. Dr Damodaran recorded Mr Payne's symptoms to include significant back pain with bilateral leg pain; the leg pain is in the posterior aspect of the leg radiating down to the ankle; right-sided symptoms are worse compared to the left; and that he is unable to sit or stand for extended periods of time due to pain.

(i) Dr Damodaran opined that surgery is a reasonable option for patients for whom conservative management for discogenic back pain had failed. He opined that the best surgical approach is an anterior lumbar interbody fusion. He noted that the results of surgery can be variable and that it was a controversial topic. He added that Mr Payne's symptoms and imaging were consistent with discogenic back pain from the L5/S1 disc level.

(j) Dr Damodaran provided a balanced report and concluded that the proposed surgery is reasonably necessary.

(k) Dr James Bodel, Orthopaedic Surgeon, comes from a conservative background. Dr Bodel opined that Mr Payne's back is unreliable and that the proposed surgery is a reasonable and necessary treatment to consider. However, demonstrating his conservative background, Dr Bodel added that the surgery would be a large undertaking for someone who does not have significant sciatica and that he would be very reluctant to offer the surgery to Mr Payne at the present time because of the mechanical backache/disc injury. Mr Payne was keen to proceed because of his unreliable back and Dr Bodel accepted this reason as being understandable. Dr Bodel stated that he was satisfied that the surgery is reasonably necessary and that it relates back to the original injury in 2008, being a steady deterioration over time, which was part of the natural history of the original injury.

(l) The respondent relied on the report of Dr Bosanquet. Dr Bosanquet could not detect any motor or sensory deficit in Mr Payne's lower limbs. Further, reflexes, ankle jerks and jerks were brisk. Dr Bosanquet did not seem to take any history of Mr Payne's sciatic condition, which is inconsistent with the evidence of Dr Damodaran. Dr Bosanquet concluded that the proposed surgery would only address the changes at L5/S1 and that such a fusion would place stress on the levels above, where Mr Payne already has changes at L4/5 and at L3/4. Fusing the L5/S1 will not relieve his pain. Such a conclusion is inconsistent with the opinions of Dr Bodel and Dr Damodaran. It is common sense that any fusion would place stress on the levels above it. If Dr Bosanquet's view were to be globally accepted, then there would be no spinal fusions carried out.

(m) Dr Bosanquet was not convinced that Mr Payne had undergone an adequate trial of non-operative treatment with cortisone injections, particularly into the facet joints, bilaterally at L4/5 and L5/S1. However, the evidence is that Mr Payne had undergone 12 years of conservative treatment and experienced a deterioration of his symptoms. Dr Bosanquet was not convinced that the proposed surgery would relieve Mr Payne's pain and return him to the workforce. Both Dr Damodaran and Dr Bodel believe that, in the circumstances, having tried and failed conservative treatment for many years, Mr Payne is now left in the unfortunate situation of requiring the proposed surgery.

28. The respondent's principal submissions may be summarised as follows:

(a) Dr Bosanquet diagnosed chronic low back pain with multilevel spondylosis causing facet joint arthropathy and disc bulging. Mr Payne had disc bulging from L3/4 to L5/S1 from the outset, with the latter being the worst, and it is in that context that Dr Bosanquet stated his concern that the proposed surgery will only address the changes at L5/S1. He opined that such a fusion would place stress on the levels above where he already had changes at L4/5 and L3/4. Hence, fusing L5/S1 would not relieve his pain and return him to the workforce.

(b) Dr Bosanquet opined that, as he was concerned about the efficacy of the proposed surgery, other forms of non-operative treatment should be considered. He suggested a trial of cortisone injections into the facet joints, bilaterally at L4/5 and L5/S1. Mr Payne may have had some physiotherapy from time to time and medication over the years but there was nothing in the evidence that suggested that he had undergone any injections. What Dr Bosanquet is saying is that, in those circumstances, he should undergo the injections before considering the proposed surgery.

(c) Dr Bodel noted that the 2016 CT scan of Mr Payne's lumbar spine confirmed definite disc pathology at the L4/5 and L5/S1 levels. He noted that Mr Payne's symptoms further deteriorated from about 2016 and that he had been referred to Dr Damodaran, who recommended surgery. Dr Bodel opined that Mr Payne had suffered a disc injury at the lumbosacral junction as a result of the injury at work. He noted that Mr Payne was on the public waiting list to undergo decompressive surgery recommended by Dr Damodaran. Decompressive surgery is quite different to the proposed fusion surgery.

(d) Dr Bodel very clearly articulated his concern about Mr Payne undergoing the proposed surgery. He opined that it was a reasonable and necessary treatment to consider but that it was a large undertaking for someone who did not have significant sciatica. The MRI scan dated 23 September 2019 was referred to by Dr Bodel and it reported no nerve compression, that is, no sciatica. The scan reported slight right-sided disc pathology. The proposed surgery is serious surgery for only slight right-sided disc pathology. Dr Bodel was very reluctant

to offer the surgery to him at the present time because of the mechanical backache/disc injury. He then noted that Mr Payne wished to proceed with the proposed surgery as his back was unreliable and it was because of that, that Dr Bodel was satisfied that the procedure was reasonably necessary as a result of injury. Dr Bodel did not explain why.

(e) Dr Damodaran recommended the proposed surgery. However, Mr Payne had only been referred to him in 2017. He had only been treating Mr Payne for a relatively short time. On 18 October 2019, Dr Damodaran reported that Mr Payne was keen to undergo the proposed surgery given that he had failed conservative management. However, Dr Damodaran did not refer to the nature of the conservative management. He did not explain why the proposed surgery is reasonably necessary at this time, other than the fact that Mr Payne wants to undergo it.

(f) One could not be satisfied that Mr Payne has truly explored all the treatment options available to him before proceeding with the proposed surgery.

(g) The precise nature of the surgery proposed by Dr Damodaran is unclear, particularly in the light of Dr Bodel's reference to Mr Payne being on a public waiting list for decompressive surgery.

(h) In all the circumstances, one could not be satisfied that the proposed surgery is reasonably necessary at this time.

29. Mr Payne's submissions in reply may be summarised as follows:

(a) Mr Payne has a history of ongoing pain, disability and severe flare-ups since injury. They are not merely aches and pains. The flare-ups occur when undertaking minor or insignificant activities or manoeuvres. The proposed surgery would prevent this.

(b) Dr Bodel is a conservative doctor and his caution in relation to the proposed surgery is understandable. Despite that, he concluded that because Mr Payne's back is unreliable, he is satisfied that the proposed surgery is reasonably necessary and relates back to the original injury in 2008.

(c) Mr Payne relied on the principles referred to in *Rose* and *Diab*.

30. In evidence, there is a statement by Mr Payne dated 9 March 2017.[11] In his evidentiary statement, Mr Payne stated that, at the respondent's premises on 29 August 2008, whilst jumping on boxes he had been directed to break-up, he came down on a box that had a hard piece of wood underneath it and jarred his back and right hip. Following the injury, he consulted his general practitioner, who referred him for physiotherapy and then to Professor Van Gelder. Professor Van Gelder recommended conservative treatment but did mention that surgical intervention was a possibility at a later stage. He was unfit for work for about six weeks and thereafter, made a gradual return to work, two to three days per week on light duties over a period of another six weeks.

31. Mr Payne stated that, in about 2010, he was retrenched by the respondent. About one week later, he obtained employment with 3S Lighting Somersby as a full-time storeman. He worked there for about 4.5 years and during this time, his lower back symptoms continued at a moderate level. He recalled taking five days off work to undergo injections in his spine. He recalled that he had a week or two off work in 2013 when he suffered a flare-up of his lower back symptoms.

[11] ARD at pages 9-11

32. Mr Payne stated that in early January 2015, he commenced employment with Central Coast Coolrooms Pty Limited as a full-time storeman. On 28 June 2016, he was directed to deliver stock from the Somersby warehouse to a site in Sydney. He drove for about 1.5 hours. When he finished the trip and as he twisted to get out of the car and took a couple of steps, he felt excruciating pain in his lower back. He was unable to continue working and an ambulance was called. He was admitted to Gosford Hospital for four days where he was administered pain relieving medication and underwent physiotherapy prior to being discharged into the care of his general practitioner. Mr Payne stated that his general practitioner certified him unfit for work for about two months; arranged for him to undergo radiological investigations; prescribed a regime of physiotherapy; and referred him back to Professor Van Gelder. Professor Van Gelder examined him and recommended conservative treatment. He underwent physiotherapy at Woy Woy Hospital for about three to four months. He took pain relieving medication and rested. He was returned into the care of his general practitioner. After two months, he returned to his employment with Central Coast Coolrooms Pty Limited on normal duties, being careful to manage his lower back as best as he could.

33. In evidence, there is a statement by Mr Payne dated 22 June 2020.[12] In his evidentiary statement, he stated that, shortly after his proceedings in the Workers Compensation Commission in 2017, the symptoms in his lower back began to deteriorate without any specific or intervening event. Pain levels in his lower back increased significantly. He described periods where he was increasingly limited in his physical abilities, including, prolonged standing and prolonged sitting. He experienced pain radiating into both lower limbs and he developed a limp due to the pain in his lower back. It became increasingly difficult for him to complete his eight hour shifts at work due to the increased lower back pain.

34. In August 2019, being unable to tolerate the increased symptoms in his lower back, he stated that he consulted his general practitioner, who prescribed a course of anti-inflammatory medication, muscle relaxants and pain relieving medication. He was also referred for regimes of physiotherapy and to Dr Damodaran.

35. Mr Payne stated that Dr Damodaran examined him and reviewed his radiological investigations, which included an MRI scan and a bone scan. Dr Damodaran recommended that he undergo an interior interbody fusion at the L5/S1 disc level. It was explained to him that the procedure was a significant one and that results can be variable. However, Dr Damodaran advised that he believed that it was the best option to improve the severe symptoms associated with his lower back. Mr Payne stated that he considered Dr Damodaran's opinion and would like to proceed with the proposed surgery in an attempt to improve his condition and to provide him with relief from the constant and severe symptoms in his lower back that were adversely impacting his activities of daily living and general lifestyle.

36. On 22 July 2016, Mr Payne underwent a lumbosacral spine CT scan at the request of his general practitioner Dr Albert Cheung, Radiologist. Dr Cheung reported disc bulges at L2/3, L3/4, L4/5 and L5/S1. There was mild to moderate foraminal stenosis at L4/5 and L5/1, but no definite nerve root compression or significant canal stenosis detected.[13]

37. On 19 August 2019, Mr Payne underwent a lumbosacral spine CT scan at the request of his general practitioner by Dr Ka-Kit Chi, Radiologist. Dr Chi reported lumbar spondylosis, mainly affecting the L5/S1 disc; mild right L5/S1 foraminal stenosis with possible impingement of the exiting right L5 nerve; minor left L4/5 foraminal stenosis with possible irritation of the exiting left L4 nerve; disc bulges in the L3/4 and L4/5 levels mildly compressing the thecal sac; and arthropathy in both sacroiliac joints with partial ankylosis.[14]

[12] ARD at pages 12-13
[13] ARD at pages 59-60
[14] ARD at page 141

38. On 24 August 2019, Mr Payne's general practitioner referred him to Dr Damodaran for the opinion and management of chronic low back pain radiating to the right lower limb which had been non-responsive to all conservative measures over the past 10 years.[15] This history was consistent with Mr Payne's evidence. The lumbosacral spine CT scan dated 19 August 2019 was attached to the letter of referral.

39. On 5 September 2019, Mr Payne consulted Dr Damodaran, who reported back to the referring general practitioner.[16] Dr Damodaran reported that Mr Payne complained of bilateral radicular pain radiating down the posterior leg to the ankle; the right-sided symptoms were worse than the left side; the lower back pain was much worse than the radicular nerve pain; and that there was no lower limb numbness or weakness. He noted that Mr Payne had tried physiotherapy, exercise physiology and cortisone injections in the past with minimal improvement. Dr Damodaran opined that Mr Payne's axial back pain was likely discogenic from the L5/S1 level. He recommended that Mr Payne undergo a lumbar spine MRI scan and CT SPECT study. Dr Damodaran also noted that he had briefly discussed surgery as a management option with Mr Payne but preferred to await the outcome of the above-mentioned investigations prior to considering the surgical option.

40. On 23 September 2019, Mr Payne underwent a regional bone scan with CT SPECT study by Dr Sandeep Sharma, Radiologist.[17] Dr Sharma reported low-grade multilevel discovertebral disease in the mid to lower lumbar spine, most prominent at the L5/S1 level; low-grade bilateral facet arthropathy at the L4/L5 level; and early degenerative changes in the bilateral S1 joints and hips.

41. On 23 September 2019, Mr Payne underwent a lumbar spine MRI scan by Dr Mudit Gupta, Radiologist.[18] Dr Gupta reported mild lumbar spondylotic changes; disc bulges and facet arthropathy at the L2/3, L3/4, L4/5 and L5/S1 levels without nerve compression. At the L5/S1 level the mild central disc protrusion with bilateral facet arthropathy was causing thecal sac impingement and mild to moderate bilateral foraminal narrowing.

42. On 14 October 2019, Mr Payne consulted Dr Damodaran, who reported back to the referring general practitioner.[19] Dr Damodaran reported that Mr Payne presented with back pain since 2008 and had tried and failed all conservative options. He noted that the recent lumbar spine MRI scan demonstrated discovertebral disease and loss of disc height at L5/S1. He also noted that the CT SPECT study confirmed discovertebral disease at that level. He arranged for Mr Payne to consult Dr Robert Tang, Vascular Surgeon for vascular access and to determine whether he was an appropriate candidate for an anterior lumbar interbody fusion. Dr Damodaran commented on Mr Payne's keenness to proceed with the proposed surgical procedure and noted that he had researched the same. He placed Mr Payne on the Concord Hospital waiting list.

43. On 29 November 2019, Dr Damodaran provided an estimate of his fees to carry out the proposed L5/S1 anterior lumbar interbody fusion procedure to Mr Payne's lawyers.[20] Dr Damodaran drew attention to the fact that there would be separate accounts related to the procedure for the anaesthetist, assistant surgeon, vascular surgeon and for the hardware used in surgery. He did not provide a description of the hardware or how it was to be used.

44. On 6 March 2020, Mr Payne consulted Dr Bosanquet at the request of GIO's lawyers. In evidence, there is a report by Dr Bosanquet dated 12 March 2020.[21]

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[15] ARD at page 140
[16] ARD at page 137
[17] ARD at page 142
[18] ARD at page 143
[19] ARD at page 138
[20] ARD at page 158
[21] Reply at pages 31-37

45. Dr Bosanquet took a history from Mr Payne that was consistent with the evidence. He noted that Mr Payne's current treatment included a home exercise program with equipment and medication by way of Norgesic and Celebrex tablets about three times per week.
Dr Bosanquet reported Mr Payne's current symptoms to include constant low back pain. The low back pain varied in intensity and worsened on any activity. The low back pain increases with prolonged sitting, squatting or standing. Walking improves his symptoms. He experiences pain in both legs equally and posteriorly into his heels. There was no paraesthesia or numbness. There were no bowel or bladder symptoms.

46. On examination, Dr Bosanquet observed that Mr Payne was tender over the right sacroiliac region; his hands on forward flexion reached his knees; extension was well beyond neutral; rotation and lateral ending to both sides were full; straight leg raising on each side was to 60° before causing back pain; there was no motor or sensory deficit in the lower limbs; and reflexes and ankle jerks were brisk[22].

47. Dr Bosanquet referred to and reviewed the available investigative imaging referred to above and in addition, an x-ray of the lumbar spine on 27 October 2008, a CT scan of the lumbar spine on 27 October 2008, an MRI scan of the lumbar spine on 7 May 2009, an MRI scan of the lumbar spine on 22 January 2013 and a bone scan of the spine and pelvis on 26 March 2013.

48. Dr Bosanquet diagnosed Mr Payne with chronic low back pain with multilevel spondylosis causing facet joint arthropathy and disc bulging. He reported Mr Payne's prognosis as being guarded. Dr Bosanquet opined that Mr Payne had suffered a specific work injury in 2008 and that his symptoms had been generated by that work injury with further deterioration over time. He also opined that there were pre-existing degenerative changes at the time of Mr Payne's work injury and that he would apportion those as 50% to pre-existing degenerative changes and 50% to the work injury.

49. In response to the question as to whether the surgery proposed by Dr Damodaran was reasonably necessary, Dr Bosanquet responded as follows:

> "It is my concern that the surgery proposed by Dr Damodaran will only address the changes at L5/S1. Such a fusion places stress on the levels above where he already has changes at L4/5 and also L3/4. Hence fusing L5/S1 will not relieve his pain."[23]

50. Dr Bosanquet further opined:

> "As there are marked changes at L4/5 and to a lesser extent L3/4, these, if currently not generating pain, will do so post fusion of the level below."[24]

51. Dr Bosanquet considered that other forms of non-operative treatment should be considered because of his concern about the efficacy of the proposed surgery. He was not convinced that Mr Payne had had an adequate trial of non-operative treatment with cortisone injections particularly into the facet joints, bilaterally at L4/5 and L5/S1.

52. Contrary to the beliefs of Mr Payne and Dr Damodaran, Dr Bosanquet was not convinced that the proposed surgery would relieve the pain and return him to the workforce.

53. On 10 February 2020, Mr Payne consulted Dr Bodel at the request of his lawyers. In evidence, there is a report by Dr Bodel dated 10 February 2020.[25]

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23 Reply at page 35 at [5]
24 Reply at page 36 at [6]
25 ARD at pages 148-154

54. Dr Bodel took a history from Mr Payne that was consistent with the evidence. He recorded Mr Payne's current complaints to include a constant dull, aching pain across the lower part of the back; referred intermittent pain into both legs, with the right worse than the left; and that bending, twisting, lifting or straining of the back aggravated the leg pain. There were also complaints of stiffness in the back and with some numbness and tingling in the right leg consistent with sciatica. He noted that Mr Payne was currently taking Celebrex, Norgesic and non-prescription analgesic medication.

55. On examination, Dr Bodel observed tenderness on palpation at the lumbosacral junction of the right side and guarding; forward flexion with hands to the knees with increasing back and right buttock pain at that point and on extension; reduced range of lateral bending to the left; straight leg raising 80° on the left and 60° on the right; positive nerve root tension signs; the right calf is half a centimetre smaller than the left; right ankle jerk is diminished when compared to the left; weakness of plantar flexion on the right; sensory loss in the S1 distribution on the right; clinical signs of persisting radiculopathy; and no restriction of hip, knee, ankle or subtalar movement.

56. Dr Bodel diagnosed Mr Payne as having suffered a disc injury at the lumbosacral junction as a result of the injury at work in 2008. He noted Mr Payne's present condition of continuing back pain and right-sided sciatica. Mr Payne's prognosis remained guarded.

57. In response to the question as to whether the surgery proposed by Dr Damodaran was reasonably necessary, Dr Bodel stated as follows:

> "I note that the anterior interbody fusion from Dr Damodaran has been recommended. This gentleman's back is unreliable. This is a reasonable and necessary treatment to consider but it is a large undertaking for somebody who does not have significant sciatica. I would be very reluctant to offer it to him at the present time because of the mechanical backache/disc injury.
>
> He is keen to proceed because the back is unreliable. This is understandable and I am satisfied that it is reasonably necessary and it relates back to the original injury in 2008. He gives no history of any other accident or injury but just a steady deterioration over time which is part of the natural history of the original injury."[26]

58. In evidence, there is a report by Dr Sameh Shabayek, Mr Payne's current general practitioner prepared at the request of Mr Payne's lawyers.[27] He reported that he had been following-up Mr Payne since August 2019 for bilateral radicular pain radiating down the posterior leg to the ankle, worse on the right. The pain had started to affect his walking and he limped with an antalgic gait because of the pain. He reported that Mr Payne had tried non-surgical conservative measures that were minimally effective and included physiotherapy, exercise physiology and cortisone injections. Dr Shabayek recommended a course of anti-inflammatory medication, muscle relaxants and pain killers in addition to low lignocaine patches, physiotherapy and referral to a neurosurgeon.

59. Dr Shabayek observed that Mr Payne's chronic low back pain was persistent and had started to affect his daily life. He reported that Mr Payne's prognosis was uncertain. Dr Shabayek deferred to Dr Damodaran in relation to Mr Payne's need for surgical management.

60. In evidence, there is a report by Dr Damodaran dated 5 May 2020 prepared at the request of Mr Payne's lawyers.[28] Dr Damodaran took a history from Mr Payne that was consistent with the evidence. He took a treatment history which included physiotherapy, pain medications and multiple cortisone injections as well as conservative measures managed by Dr Marc Coughlin in 2013/2014. When he first reviewed Mr Payne in 2019, all conservative measures had failed.

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[26] ARD at page 153 at [10]
[27] ARD at page 157
[28] ARD at pages 155-156

61. As to the relationship between Mr Payne's employment and his medical condition, Dr Damodaran opined that since his injury in 2008, he had suffered ongoing back pain and neuropathic leg pain and it was very likely that the initial injury led to his subsequent problems. He reported Mr Payne's symptoms as significant back pain with bilateral leg pain. The leg pain being in the posterior aspect radiating down to the ankle, with right-sided symptoms being worse than the left.

62. As all conservative measures had failed Mr Payne, Dr Damodaran opined that the only option left for him was surgical treatment of his discogenic axial back pain. The imaging demonstrated that the pain was likely emanating from the L5/S1 disc space. Surgery may increase Mr Payne's current work capacity.

63. As to whether the surgery proposed by him is reasonably necessary as a result of Mr Payne's work injury, Dr Damodaran responded as follows:

> "Paul has discogenic back pain. There is also evidence of severe bilateral L5 nerve root compression due to loss of foraminal height. Surgery is a reasonable option for patients who fail conservative management for discogenic back pain. Best surgical approach is an anterior lumbar interbody fusion (ALIF). It is important to note that the results of surgery can be variable and this is a controversial topic. Paul's symptoms and imaging are consistent with discogenic back pain from L5/S1 disc level."[29]

64. There is no dispute that the earliest radiological investigations on 27 October 2008 demonstrated that Mr Payne had pre-existing changes at L5/S1.

65. I accept Mr Payne as a witness of truth, who did his best to provide a history of his injuries, his treatment and his complaints to his various treating doctors and the forensic medical specialists. The histories he provided of injury, treatment and complaints of symptoms were, in the main, consistent over a long period of time. Mr Payne impressed as a hard worker, who has successfully used his best endeavours to remain in the workforce despite continuing to suffer from gradually increasing ongoing pain, restrictions and episodic disabling low back pain.

66. Dr Bosanquet's concerns about the proposed surgery was twofold. Firstly, the proposed surgery only addressed the changes at L5/S1 and would place stress on L4/5 and L3/4, where Mr Payne already had degenerative changes, resulting in pain at those latter mentioned levels. Hence, fusing L5/S1 would not relieve his pain. Dr Bosanquet did not suggest that a multilevel fusion would relieve this concern. Secondly, he was concerned that Mr Payne had not undergone an adequate trial of non-operative treatment with cortisone injections particularly into the facet joints, bilaterally at L4/5 and L5/S1. I find that Dr Bosanquet's evidence avoided the issue as to whether the proposed surgery was reasonably necessary. He focused on the above-mentioned two concerns but did not specifically answer the question put to him as to whether the proposed surgery was reasonably necessary.

67. Dr Bodel did not express an opinion as to whether the proposed surgery would place stress on Mr Payne's L4/5 and L3/4 levels. Whilst he felt that it was reasonable and necessary treatment to consider, he thought it a large undertaking in a situation where there was not significant sciatica and that he would be very reluctant to offer the surgery to him at the present time. However, as Mr Payne's back pain was "unreliable", he felt that his keenness to proceed with the surgery was understandable. Accordingly, Dr Bodel was satisfied that the proposed surgery was reasonably necessary. I found Dr Bodel's reasoning in this regard difficult to follow.

[29] ARD at page 156 at [10]

68. I reject the respondent's submission that the precise nature of the surgery proposed by Dr Damodaran is unclear, because of Dr Bodel's reference to Mr Payne being on a public waiting list for decompressive surgery rather than the proposed surgery. Dr Bodel identified the L5/S1 anterior lumbar interbody fusion surgery as the proposed surgery.

69. Dr Bodel did not express an opinion as to whether Mr Payne had undergone an adequate trial of non-operative treatment. However, he did note that Mr Payne had initially undergone conservative care with rest and analgesic medication and physiotherapy. Whilst Mr Payne's condition had improved with such treatment, it never completely resolved, and he experienced a number of flare-ups of pain with clinical evidence of radiculopathy. Dr Bodel noted that Mr Payne's symptoms had further deteriorated since a significant flare-up in 2016.

70. Dr Damodaran did not express an opinion as to whether the proposed surgery would place stress on Mr Payne's L4/5 and L3/4 levels. However, he opined that the imaging demonstrated that the pain was likely to be coming from the L5/S1 disc space and that Mr Payne's only remaining management option was surgical treatment. He opined that the proposed surgery may change his long-term prognosis if his symptoms improve.

71. On examination, Dr Bosanquet could not detect any motor or sensory deficit in Mr Payne's lower limbs and observed that his reflexes, ankle jerks and knee jerks were brisk. Such observations were inconsistent with those of Dr Bodel and Dr Damodaran. On examination, Dr Bodel found clinical signs of persisting radiculopathy. Dr Damodaran found clinical signs of radiculopathy, referring to bilateral radicular pain radiating down the posterior leg to the ankle with symptoms on the right side worse than symptoms on the left side. Dr Shabayek found clinical signs of radicular pain, worse on the right.

72. Neither Dr Bosanquet, nor Dr Bodel appeared to have obtained a complete history of the conservative management undergone by Mr Payne. On the other hand, Dr Damodaran took a history that Mr Payne had tried physiotherapy, exercise physiology and cortisone injections in the past with minimal improvement. Neither Dr Bosanquet, nor Dr Bodel referred to Mr Payne having undergone exercise physiology and cortisone injections. Dr Damodaran formed the view that all conservative measures had failed, there having been only minimal improvement in symptoms.

73. Dr Bosanquet and Dr Bodel are orthopaedic surgeons who were engaged by the parties to provide expert opinions. Even though Mr Payne has been under the management and care Dr Damodaran for, arguably, a relatively short period of time, Dr Damodaran is the treating neurosurgeon and spine surgeon and was in the best position to assess Mr Payne's medical management. I prefer the opinion of Dr Damodaran over those of Dr Bosanquet and Dr Bodel for the reasons referred to above.

74. Applying the principles referred to in *Diab* above, different treatments may qualify as 'reasonably necessary' and Mr Payne only has to establish that the treatment claimed is one of those treatments. The proposed L5/S1 anterior lumbar interbody fusion surgery is one of those treatments and I make the following findings:

    (a) Alternative treatment by way of conservative management which has failed over the last 12 years is unlikely to be effective and on the balance of probabilities, will result in Mr Payne continuing to suffer the ongoing pain and restrictions referred to in the evidence. Contrary to the respondent's submissions, Mr Payne's conservative treatment has consisted of courses of anti-inflammatory medication, muscle relaxants and pain killers in addition to low lignocaine patches; pain management (Dr John Prickett);[30] physiotherapy; exercise physiology; and cortisone injections with minimal improvement. Without the proposed surgery, it is likely that Mr Payne will continue to have episodic disabling low back pain. Whilst

[30] Reply at pages 11-12

there can be no guarantees in relation to the proposed surgery, I accept Dr Damodaran's opinion that it is the only remaining management option in a situation where symptoms are deteriorating and conservative management over a period of 12 years has had little effect.

(b) The evidence is that Mr Payne underwent cortisone injections into his back. Whilst the location of the injections was not identified, I assume that such injections were administered into, at least, the L5/S1 facet joint, based on the medical imaging, with minimal improvement. The alternative treatment of L4/5 and L5/S1 facet joint injections referred to by Dr Bosanquet are unlikely to be effective and on the balance of probabilities, will result in Mr Payne continuing to suffer the ongoing pain, restrictions and episodic disabling low back pain referred to in the evidence.

(c) There is no issue raised by the respondent as to the cost of the proposed surgery.

(d) The potential effectiveness of the proposed surgery is the best chance Mr Payne has of improving his current and longstanding gradually deteriorating symptoms, improving his quality of life and continuing in employment.

(e) The purpose and potential effect of the proposed surgery is to alleviate the consequences of the injury as far as possible.

(f) The evidence of Dr Damodaran supports the proposed surgery as being reasonably necessary and likely to be beneficial in the circumstances of this case.

(g) Mr Payne is very keen to undergo the proposed surgery.

75. Dr Bosanquet opined that Mr Payne's current symptoms had been generated by the work injury in 2008 with further deterioration over time. Dr Bodel was satisfied that the proposed surgery was attributable to Mr Payne's work injury in 2008. Dr Damodaran opined that the 2008 work-related injury very likely led to Mr Payne's subsequent back problems. Having conducted a common sense evaluation of the causal chain, I find that Mr Payne has established, on the balance of probabilities, that the work-related injury on 29 August 2008 materially contributed to the need for the proposed surgery.

76. Accordingly, I find that Mr Payne has discharged the onus of proving that L5/S1 anterior lumbar interbody fusion surgery proposed by Dr Damodaran is reasonably necessary treatment as a result of the injury sustained by Mr Payne on 29 August 2008 within the meaning of section 60 of the 1987 Act.

The operation of section 59A of the 1987 Act in Mr Payne's case

77. Section 59A of the 1987 Act provides:

"(1) Compensation is not payable to an injured worker under this Division in respect of any treatment, service or assistance given or provided after the expiry of the compensation period in respect of the injured worker.

(2) The compensation period in respect of an injured worker is:

(a) if the injury has resulted in a degree of permanent impairment assessed as provided by section 65 to be 10% or less, or the degree of permanent impairment has not been assessed as provided by that section, the period of 2 years commencing on:

(i) the day on which the claim for compensation in respect of the injury was first made (if weekly payments of compensation are not or have not been paid or payable to the worker), or

(ii) the day on which weekly payments of compensation cease to be payable to the worker (if weekly payments of compensation are or have been paid or payable to the worker), or

(b) if the injury has resulted in a degree of permanent impairment assessed as provided by section 65 to be more than 10% but not more than 20%, the period of 5 years commencing on:

(i) the day on which the claim for compensation in respect of the injury was first made (if weekly payments of compensation are not or have not been paid or payable to the worker), or
(ii) the day on which weekly payments of compensation cease to be payable to the worker (if weekly payments of compensation are or have been paid or payable to the worker).

(3) If weekly payments of compensation become payable to a worker after compensation under this Division ceases to be payable to the worker, compensation under this Division is once again payable to the worker but only in respect of any treatment, service or assistance given or provided during a period in respect of which weekly payments are payable to the worker.

(4) For the avoidance of doubt, weekly payments of compensation are payable to a worker for the purposes of this section only while the worker satisfies the requirement of incapacity for work and all other requirements of Division 2 that the worker must satisfy in order to be entitled to weekly payments of compensation.

(5) This section does not apply to a worker with high needs (as defined in Division 2).

(6) This section does not apply to compensation in respect of any of the following kinds of medical or related treatment:

(a) the provision of crutches, artificial members, eyes or teeth and other artificial aids or spectacles (including hearing aids and hearing aid batteries),

(b) the modification of a worker's home or vehicle,

(c) secondary surgery.

(7) Surgery is **'secondary surgery'** if:

(a) the surgery is directly consequential on earlier surgery and affects a part of the body affected by the earlier surgery, and

(b) the surgery is approved by the insurer within 2 years after the earlier surgery was approved (or is approved later than that pursuant to the determination of a dispute that arose within that 2 years).

(8) This section does not affect the requirements of section 60 (including, for example, the requirement for the prior approval of the insurer for secondary surgery)."

78. Both parties referred to the decision of Wood DP in *Herborn v Spotless Services Australia Limited*[31] (*Herborn*), where the New South Wales Court of Appeal decision in *Pacific National Pty Limited v Baldacchino*[32] was considered and applied.

79. In *Baldacchino*, Macfarlan JA, with whom Simpson AJA and Payne JA agreed, found that a total knee replacement was an "artificial aid" within the meaning of section 59A(6)(a) of the 1987 Act.

80. It is worthwhile repeating the relevant legislative history set out by Macfarlan JA in *Baldacchino*:

> "***The legislative history***
>
> 6. Section 10(1) of the *Workers Compensation Act 1926* (NSW), on enactment, provided for compensation payable in respect of workplace injuries to include 'the cost of such medical, surgical and hospital treatment as may in the opinion of the commission reasonably be required to relieve the worker from the effects of the injury'. Subsection (2) stated that the 'treatment' was to include 'nursing, medicines, medical and surgical supplies, crutches, artificial members and other curative apparatus …'
>
> 7. Section 10(2) was amended in 1951 to provide (in (b)) that 'Medical treatment' included:
>
> > 'the provision of skiagrams [that is, x-rays], crutches, and artificial members, eyes or teeth and other artificial aids and spectacle glasses'.
>
> 8. Section 59 of the 1987 Act, on enactment, provided that 'medical or related treatment' for which compensation was payable included:
>
> > '(d) the provision of crutches, artificial members, eyes or teeth and other artificial aids or spectacles,
> >
> > …
> >
> > (g) the modification of a worker's home or vehicle directed by a medical practitioner having regard to the nature of the worker's incapacity.'
>
> 9. This Act was amended in 2012 to include s 59A which limited the period of time for which compensation was recoverable for work injuries. Section 59A was amended in 2015 to introduce qualifications to that limitation….
>
> 10. Neither the Second Reading Speech nor the Explanatory Memorandum relating to the 2015 amendment provides any assistance on the issue presently before this Court."[33]

81. Macfarlan JA then considered the decision of *Thomas v Ferguson Transformers Pty Limited* (*Thomas*),[34] a Court of Appeal decision which considered section 10 of the *Workers Compensation Act 1926* (the 1926 Act) as it stood following the 1951 amendments. *Thomas* was considered by the Court because it achieved some prominence at first instance, on appeal to the Presidential Unit of the Commission, as well as in submissions in the Court of Appeal in *Baldacchino*.

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[31] Herborn v Spotless Services Australia Limited [2020] NSWWCCPD 2
[32] *Pacific National Pty Limited v Baldacchino* [2018] NSWCA 281
[33] *Baldacchino* at [6]-[10]
[34] *Thomas v Ferguson Transformers Pty Limited* [1979] 1 NSWLR 216

82. In *Thomas*, the Court of Appeal was concerned with the form of section 10 of the 1926 Act as it stood after the 1951 amendments referred to above. The Court of Appeal held that the cost of the modification of a motor vehicle to enable it to be driven by the applicant, who was disabled by a workplace injury, and the cost of special driving lessons for the applicant were costs of the provision of "artificial aids" within section 10(2)(b). Mahoney JA dissented in respect of the latter finding because he considered that the evidence in the case before him was open to the inference that the lessons were to teach the applicant how to drive the motor vehicle, rather than specifically to use the modifications to it.

83. In *Baldacchino*, Macfarlan JA quoted the following passage from the judgment of Hutley JA, with whom Hope JA agreed, in *Thomas*:

> "**An artificial aid, in my opinion, is anything which has been specially constructed to enable the effects of the disability (the result of injury) to be overcome**. The other articles in the subclause, crutches, artificial members, eyes or teeth, are illustrations of this. Because of [the applicant's] injury, she has lost all capacity for natural progression. The modifications to the car have given her some capacity to transport herself. It was suggested that, on this basis, the car was an artificial aid, and every person whose capacity to walk was diminished could have a car supplied at the expense of the insurer. It is not necessary to decide whether this conclusion follows. **The essential quality of an artificial aid is that it is an aid specially tailored to the needs of a person, which flowed from the injury**. The artificial aid is specific to an injured person. These modifications have this quality. As an artificial aid is useless unless the person for whom it is provided can use it, the provision of an artificial aid includes the provision of instruction in its use (emphasis added)."[35]

84. As to whether *Thomas* is a relevant authority, Macfarlan JA said:

> " … in my view, *Thomas* remains a relevant authority, containing a useful explanation of what constitutes an 'artificial aid', notwithstanding that the present legislation is, to some extent, in a different form to that considered in that case. The only arguably material change in the form of the legislation has been the insertion in it of express reference to 'the modification of a worker's home or vehicle' as constituting medical treatment (s 59A(6)(b)). By this change, the legislature confirmed that the finding in *Thomas* reflected its intent that the injured worker's right to compensation in respect of the cost of such modification should not be subject to a time limit."[36]

85. Macfarlan JA agreed with a submission of the appellant that the expression "artificial aids" must work to ameliorate the effect of the person's disability, and that it may comprise a single object or a composite of objects operating together.[37] His Honour described the nature of a total knee replacement operation, including that the procedure involved the insertion of plastic materials and said:

> "Plainly these materials are designed to facilitate the movement and use of the knee after the operation, therefore easing the patient's disability. Their 'provision' (see s 59A(6)(a)) cannot occur without a surgical operation. The cost of the operation therefore falls within the statutory provision."[38]

[35] *Baldacchino* at [13]
[36] *Baldacchino* at [34]
[37] *Baldacchino* at [29]
[38] *Baldacchino* at [29]

86. In referring to submissions by the appellant relating to a total knee replacement, Macfarlan JA said:

> "Whilst it is a different means of alleviating a disability, there is no feature of the knee replacement which distinguishes it in principle, or character, from the other aids referred to."[39]

87. As to whether section 59A(6)(a) of the 1987 Act is beneficial in its operation, Macfarlan JA said:

> "As stated in *ADCO Constructions Pty Ltd v Goudappel* (2014) 254 CLR 1; [2014] HCA 18 at [29], to determine whether a statutory provision is beneficial, a court should not construe the legislation under consideration as a whole but instead direct attention to the particular provision in question. On this basis, s 59A(6)(a) is clearly beneficial because it restricts the operation of a limitation on compensation that is payable. As s 59(6)(a) in my view has a clear meaning (at least so far as is presently relevant), it is unnecessary to rely upon that conclusion but, if account is taken of it, it assists the respondent, not the appellant."[40]

88. In *Herborn*, Wood DP was satisfied the provision of a bone graft with pedicle screws and interbody cages to be implanted in a spinal nerve root decompression and fusion was an "artificial aid" for the purposes of s 59A(6)(a) of the 1987 Act.

89. Wood DP found that the purpose of the insertion of the pedicle screws and interbody cage was clearly intended to alleviate the appellant's disability, where the outcome was to maintain stability of the spine and thus reduce the appellant's disability. The surgery as a whole was intended to at least provide a degree of relief of the injured worker's symptoms. Any benefit from the surgery was expected to result in an amelioration of the injured worker's disability. The insertion of the combined fixture was a necessary element of the surgery and not merely incidental to the proposed major surgery.

90. I now turn to the application of the relevant legislation and the legal principles referred to above to the available evidence in this matter.

91. Mr Payne's principal submissions may be summarised as follows:

    (a) Dr Damodaran's quotation for the proposed surgery dated 29 November 2019 referred to the additional cost for the hardware used in the surgery and is consistent with the decision of Wood DP in *Herborn*. Accordingly, the proposed surgery falls within the exception in section 59A(6)(a) of the 1987 Act, being an artificial aid.

    (b) If the above submission is not accepted, then Mr Payne seeks a declaration that the proposed surgery is reasonably necessary.

92. The respondent's principal submissions may be summarised as follows:

    (a) Dr Damodaran's quotation for the proposed surgery dated 29 November 2019 provided an estimate of his fees to carry out the L5/S1 anterior lumbar interbody fusion procedure. He did not describe the hardware to be used in the surgery. He did not describe how the hardware was to be involved in the procedure. He did not refer to pedicle screws or a cage. Without an adequate description of what the procedure involves, one cannot submit that Mr Payne's case is on all fours with *Herborn* and therefore, a matter which is

[39] *Baldacchino* at [38]
[40] *Baldacchino* at [39]

exempt under section 59A(6)(a) of the 1987 Act. One cannot assume that the hardware referred to in Dr Damodaran's quotation refers to a cage and pedicle screws as in *Herborn*. The description of the proposed surgical procedure and the use of the hardware in the procedure is material that should have been before the Commission.

(b) Mr Payne was last paid weekly compensation on 16 September 2013. Therefore, prima facie, section 59A does apply in this case. The Commission cannot make an order that the respondent pay for the costs of the surgery.

93. Unlike in *Herborn*, none of the medical experts in this case explained the manner in which a L5/S1 anterior lumbar interbody fusion surgery is usually performed or is proposed to be performed, nor were the pieces of hardware and their respective functions described. Such explanation was essential evidence in both *Baldacchino* and in *Herborn*.

94. In his quotation for the proposed surgery dated 29 November 2019, Dr Damodaran named the surgical procedure and referred to additional costs for the hardware to be used in the surgery. He did not provide an adequate description of the procedure or identify the hardware or its function. Mr Payne asserted that the proposed surgery fell within the exception in section 59A(6)(a) of the 1987 Act, being an artificial aid and accordingly, bears the onus of proof in this regard. On the material before me, Mr Payne has failed to discharge that onus for the reasons stated above.

95. Mr Payne was last paid weekly compensation on 16 September 2013. Therefore, prima facie, section 59A of the 1987 Act applies in this case.

96. In *Flying Solo Properties Pty Ltd t/as Artee Signs v Colette*[41] (*Colette*), Roche DP explained the operation of section 59A of the 1987 Act. Relevant to Mr Payne's case, Roche DP held that workers will cease to be entitled to weekly compensation if having previously been entitled to such compensation, their right to receive actual weekly compensation comes to an end. That can occur because of the application of the legislation or because the worker has recovered from the effects of the injury. That is so, even though the right to receive actual weekly compensation may revive at a later time, as is dealt with in section 59A(3).[42]

97. In relation to section 59A(3) of the 1987 Act, Roche DP explained that, if by operation of either section 59A(1) or (2), a worker has ceased to be entitled to compensation under Division 3 of Part 3, their rights to such compensation is revived during a period when weekly compensation is again payable, but only in respect of any treatment, service or assistance given or provided during the period when weekly compensation is payable to the worker.[43] Section 59A(4) clarifies that weekly payments of compensation are payable to a worker for the purposes of the section only while the worker satisfies the requirement of incapacity for work and all other requirements of Division 2 that the worker must satisfy in order to be entitled to weekly payments of compensation.

98. Following the decision in *Colette*, section 59A underwent amendment, particularly in relation to the issue of the "compensation period."

99. For the reasons stated above, the Commission does not have the power to order the respondent to pay the cost of the L5/S1 anterior lumbar interbody fusion surgery proposed by Dr Damodaran at this time due to the operation of section 59A of the 1987 Act. As envisaged by section 59A(3), liability for the payment of the expense of the surgery would occur once Mr Payne enters hospital to undergo the treatment proposed and his entitlement to weekly payments is revived whilst he has no current work capacity (that is, whilst he is having and recovering from the surgery).

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[41] *Flying Solo Properties Pty Ltd t/as Artee Signs v Colette* [2015] NSWWCCPD 14
[42] *Flying Solo Properties Pty Ltd t/as Artee Signs v Colette* [2015] NSWWCCPD 14 at [70]
[43] *Flying Solo Properties Pty Ltd t/as Artee Signs v Colette* [2015] NSWWCCPD 14 at [76(f)]

CONCLUSION

100. My determination is set out in the Certificate of Determination attached to this Statement of Reasons.