WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **1939/20**
Applicant: **Donelle Young**
Respondent: **Vietnam Veterans Keith Payne VC Hostel**
Date of Determination: **1 July 2020**
Citation: **[2020] NSWWCC 217**

The Commission determines:

1. The applicant was injured on 7 January 2016.

2. The proposed surgery recommended by Dr Marc Coughlan on 27 June 2019 is not reasonably necessary.

The Commission orders:

1. There is an award in favour of the respondent.

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

John Wynyard
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 JOHN WYNYARD, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Donelle Young, the applicant, brings an action against Vietnam Veterans Keith Payne VC Hostel, the respondent, for a declaration pursuant to s 60(5) of the *Workers Compensation Act 1987* (the 1987 Act) that surgery proposed by Dr Marc Coughlan is reasonably necessary treatment for an injury sustained by the applicant on 7 January 2016.

2. The insurer issued a s 78 notice on 28 August 2019 which were reviewed pursuant to s 287A on 19 March 2020 and 1 April 2020.

3. An Application to Resolve a Dispute (ARD) and Reply were duly lodged.

ISSUES FOR DETERMINATION

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

    (a) Is the proposed surgery reasonably necessary.

PROCEDURE BEFORE THE COMMISSION

5. The matter was heard at teleconference by way of conciliation and arbitration on 27 May 2020. The applicant was represented by Mr Tye Hickey instructed by Ms Tolini Kakala. The respondent was represented by Mr Phillip Perry of counsel instructed by Mr Karlo Tychsen. 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 document, and
    (c) Application to Admit Late Documents and attached documents (ALD) from the respondent dated 20 May 2020.

Oral evidence

7. No application was made in respect of oral evidence.

FINDINGS AND REASONS

8. Ms Young's occupation was as an Assistant in Nursing (AIN) working at the respondent's Aged Care Nursing Home. It was common ground that Ms Young was injured on 7 January 2016 when, in company with other nurses, she lifted, by the use of a "Johnny belt", a resident of the Nursing Home who weighed approximately 130 kg.

9. Ms Young felt no symptoms during that lift, but about 20 minutes later when she went to open a cupboard, she felt a twinge in her lower back and a sharp stabbing pain. That was the origin of the onset of Ms Young's back problems that have continued to be symptomatic since that time.

10. It is also common ground that her GP, Dr Vijay Varsani undertook management of her condition.

11. Dr Varsani referred Ms Young for physiotherapy and organised MRI scans of the lumbar spine on 19 January 2016 and 23 February 2016. In her report of 3 July 2019[1] she noted that the results of those scans showed pathology at L4/5.

12. Dr Varsani said that she referred Ms Young to a neurosurgeon, Dr Hanson, who saw the MRI scans and recommended physiotherapy to continue. Dr Hanson also recommended that a pain specialist be brought in for management if her symptoms persisted.

13. Ms Young continued to have recurrent flareups and Dr Varsani reduced her hours in March 2016. She was referred to an exercise physiologist for back exercise programs. She had a CT guided cortisone injection on 2 March 2016 to her L4/5 disc with an initial positive response, but a subsequent deterioration to her usual level of symptoms.

14. During treatment Ms Young's pre-existing anxiety and depression regularly flared up, Dr Varsani said, and Ms Young was referred to a counsellor and prescribed antidepressants.

15. A workplace rehabilitation provider was brought into the picture to adapt Ms Young's workplace and duties but her progress remained poor. She was referred to Dr Marc Russo (Pain Specialist) on 29 June 2016. She tried a variety of medications and underwent a further course of injections.

16. Her back flared up on 3 October 2016 and she was taken to Gosford Emergency Department where she was started on Targin and Endone.

17. At pain specialist review on 13 October 2016 an intradiscal pulse radiofrequency neurotomy with PRP injections were recommended, and given on 4 November 2016. This caused an increase in Ms Young's symptoms.

18. Dr Varsani noted that after the failure of the injections, Ms Young required increasing doses of opioids to manage her pain and this was reviewed on 21 December 2016 with a view to reducing the opiate intake to Oxycontin 40 mg per day.

19. A further pain management program with Innervate Pain Management did not assist Ms Young's pain and Dr Varsani said Ms Young was declared unfit for work and referred to Dr Coughlan.

20. She said that after several appointments, Dr Coughlan diagnosed L4/5 facet joint disease and recommended a radiofrequency abrasion of her L3/4 facets. This was unsuccessful and Dr Varsani noted that Ms Young had seen Dr Coughlan on 21 June 2019, who felt that as all conservative treatment options had unsuccessfully been explored, he recommended an L3/4 spinal fusion.

21. Dr Coughlan supplied a number of reports. On 30 March 2017 he first reviewed Ms Young and noted the available imaging of mild stenosis at L4/5.[2] In view of Ms Young being quite hyper-reflexic, he thought the imaging might suggest early myelopathy.

[1] ARD page 70.
[2] ARD page 118.

22. Dr Coughlan thought a SPECT bone scan should be obtained to look particularly at the facet joint of L3/4, L4/5 and the sacroiliac joints.

23. On 11 April 2017 Dr Coughlan reported again[3]. He noted that lumbar spine imaging showed a very mild lateral recess and canal stenosis of the L4/5. He thought that the annular tear which had been previously detected was slightly improved, but that there was "some degree of facet joint arthrosis of the L4/5 and to a lesser degree L3/4". Dr Coughlan noted that it was also evident on the SPECT bone scan, and that on the MRI scan there was "mild crowding of the nerve roots" at L4/5.

24. Dr Coughlan excluded any myelopathic involvement, and noted that Ms Young at that stage was taking Endone, Palexia and Voltaren.

25. Dr Couglan reported at that stage that there was no role for any surgical intervention on her cervical spine or her lumbar spine.

26. On 29 June 2017 Dr Coughlan reviewed Ms Young again noting that she continued to have very severe back pain with some numbness in her buttocks. He said that a SPECT bone scan confirmed "significant facet arthropathy at L3/4 with bilateral inflamed L3/4 facet joints". In this report Dr Coughlan said:

> "I would not recommend any invasive procedures given the relative structural abnormality of her lumbar spine".

27. Dr Coughlan recommended a radiofrequency lesioning of the facet joints[4].

28. The recommended radiofrequency lesioning was carried out on 31 July 2017 and was limited to the L3/4 level of the lumbar spine[5].

29. On 29 August 2017 Dr Coughlan reported that Ms Young continued to be in severe pain and very incapacitated. She also complained of bilateral leg pain and her condition, Dr Coughlan noted, was quite distressing for her. He noted that hydrotherapy was being continued every week but whilst it helped a little whilst in the water, the benefits seemed to be reversed as soon as she came out. She remained on Lyrica, Targone and Endone.

30. Dr Coughlan said:[6]

> "Her MRI scan does confirm very severe facet arthrosis at L3/4 and on her SPECT Bone scan the facet joints are very active at L3/4 with marked inflammation at that level"

31. Dr Coughlan then recommended radiofrequency nervation of the facet joints which he thought at that stage would be more appropriate intervention than an invasive procedure such as a fusion, which he acknowledged can cause significant adjacent segment disease.

32. In his next report of 1 March 2018, Dr Coughlan noted that Ms Young was significantly impacted by her chronic pain as she continued on Targon, Lyrica, Endone and Voltaren.[7]

33. At this stage she had been through the pain clinic with Dr Russo.

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[3] ARD page 120.
[4] ARD page 122.
[5] ARD page 123.
[6] ARD page 124.
[7] ARD page 126.

34. Dr Coughlan again advised that he could not foresee major surgical "targets". He thought there was significant facet arthropathy at L3/4 and because Ms Young was in severe pain stated that he would expedite a request to the insurer for radiofrequency denervation.

35. This did not occur until on 8 February 2019[8].

36. On 31 March 2019, Dr Coughlan noted that Ms Young continued to have very significant ongoing back pain with "marked facet arthropathy at L3/4". An updated MRI scan was suggested, and Dr Coughlan referred to surgery at L3/4, wondering if it was worthwhile, and describing it as a "last resort."[9]

37. An MRI scan carried out on 15 April 2019 made the following findings[10]:

> "At L3/4 , there are bilateral fairly prominent facet joint arthropathy with ligamentum fiavum thickening. There is a minor posterior annular bulge. Canel and neural foramina are patent, and the visualised L3 nerve roots exit uncompromised.
>
> L4/5 , there is a minor broad-based posterior disc bulge with an associated small left paracentral/foraminal posterior annular fissure. This Is seen previously but the posterior annular fissure appears slightly larger on the current study. …."

38. On 21 June 2019, Dr Coughlan wrote an update saying that Ms Young had very significant ongoing back pain. He said:

> "She has quite severe arthropathy at L3/4. These consistently come up as the main pain generator on all her scans and certainly the facet joints are very degenerative on imaginings."

39. He noted that Ms Young was very frustrated and that she had tried and exhausted all conservative treatment options. Dr Coughlan recommended she consider an L3/4 fusion. His rooms supplied details of the proposed surgery on 27 June 2019. This was described as:

> "… an L3/4 XLIF procedure, followed by a secondary procedure the following day in the form of L3/4 posterior pedicle screw fixation."

40. In his report of 11 February 2020 Dr Coughlan reviewed the history of his treating relationship which had begun on 1 March 2017[11]. He said that he had requested approval from the insurer. He then said[12]:

> "I last saw Donelle on 6th December 2019, we discussed the need for surgery and that the main pain generator was the L3/4 although she does have multi-level changes on the imaging. The L3/4 is certainly the main issue and the one we need to address with surgical intervention…."

41. Dr Coughlan's diagnosis was "significant facet arthropathy at L3/4 with bilateral inflamed L3/4 facet joints".

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[8] ARD page 127.
[9] ARD page 128.
[10] ARD page 117
[11] ARD page 66.
[12] ARD page 67.

42. He concluded his report[13] by saying:

> "Firstly, I do believe the surgery is deemed reasonable and necessary to treat her work related condition. I have recommended an L3/4 lateral fusion with posterior screws. As I have said previously, the L3/4 level consistently came up as the main pain generator on all her scans. We have tried conservative measures without any effect. In my opinion, I believe the procedure will best address the severe arthropathy at L3/4. Donelle continues to struggle and has not progressed. I feel it would be most certainly worthwhile pursing the surgery with the aim of significantly reducing Donelle' pain so she can have a better quality of life."

43. The applicant retained the services of Dr James Bodel, Orthopaedic Surgeon, as her medico-legal referee. Dr Bodel provided two reports dated 26 September 2019[14] and 11 March 2020[15].

44. In his report of 26 September 2019 Dr Bodel took a consistent history of Ms Young's treatment and imaging. He noted that the MRI scans showed definite disc pathology at L4/5 with an annular tear at the beginning, which appeared to have progressed minimally over the years. Dr Bodel said that he had not seen any sign of nerve root compromise or nerve root compression at any level of the lumbar spine in either the MRI scans or any of the films that he had seen[16].

45. Dr Bodel noted that Ms Young was keen to proceed with the surgery that was recommended by Dr Coughlan.

46. Dr Bodel then referred to Dr Coughlan's remarks that I have reproduced at [37] above. Dr Bodel said:

> "The disc that looks abnormal is actually at L4/5 but I do agree that the facets at L3/4 do appear quite involved."

47. Dr Bodel agreed that the application had been denied by the insurer on the basis of a report by Dr Casikar. Dr Bodel said[17]:

> "I note that there is some dispute about the level, and that being the L3/4 pedicle screw fixation and the fact that the main pathology that I have seen appears to be at L4/5. I do accept the explanation given by Dr Coughlan but he has always confirmed that L4/5 was the main abnormal looking disc but that there is facet joint arthritis at L3/4. I would be surprised if he is recommending the fusion at L3/4 only and not at L4/5 as well. I was unable to confirm that opinion here in the documentation that you have provided."

48. Dr Bodel also said[18]:

> "The L4/5 disc appears the most symptomatic disc and the most abnormal disc where I would entertain a fusion as a treatment option."

[13] ARD page 68.
[14] ARD page 36.
[15] ARD page 44.
[16] ARD page 38.
[17] ARD page 38.
[18] ARD page 39.

49. Later on in his report Dr Bodel reviewed the treatment options that had been unsuccessfully applied to Ms Young. He said[19]:

> "All of the more conservative approaches to treatment have not helped. After further investigations and review, Dr Coughlan has recommended a spinal fusion at L3/4. He has not come to this decision quickly or lightly but has taken the decision because of a failure of the previous conservative approaches to treatment."

50. He noted again that Dr Coughlan's opinion was that the L3/4 disc was the "main pain generator" on the scans, and that the facet joints certainly looked very degenerative on imaging. Dr Bodel noted Dr Coughlan to be consistent in his recommendation for surgery at L3/4 level only. He said[20]:

> "The MRI scan of the lumbosacral spine dated 15 April 2019 reports that there is bilateral prominent facet joint arthropathy at the L3/4 level and a 'minor broad-based posterior disc bulge with an associated small left paracentral/foraminal posterior annular fissure' at the L4/5 level'."

51. Dr Bodel's diagnosis was of a "disc rupture of the L4/5 level." He said further in answer to questions from his retaining solicitors that the subject injury had caused an annular tear in the L4/5 level. He thought that there was an element of a disease process present. He noted that Ms Young had been asymptomatic prior to the subject injury and that the first MRI scan was done only two weeks after the event. He said[21]:

> "…. it is possible therefore that there may have been some degenerative change and dehydration of that disc prior to the event but I am satisfied that the annular tear probably occurred as a result of the event on 07 January 2016."

52. When asked his opinion as to future treatment, further down the page, Dr Bodel said[22]:

> "Future treatment needs are a difficult issue. I note that the insurer has indicated that they are not prepared to fund a spinal fusion at the L3/4 level. I do have some concern about the level that is being recommended but not necessarily the specific surgical procedure that has been offered. All along this gentleman's [sic] pathology appears to have been localised mostly at the L4/5 level and not at L3/4."

53. Dr Bodel acknowledged that the bone scan showed some increased uptake probably at L3/4 but he said:

> "I would be reluctant to consider any surgical intervention at the L3/4 level and not at the L4/5 level. This is a difficult call in my view to recommend a surgical fusion in this circumstance without hard objective evidence of neurological compromise. I was unable to identify any hard objective neurological signs of radiculopathy in either leg.
>
> I am not sure that the L3/4 level is the pain generator in this circumstance based on the medical evidence available here today."

[19] ARD page 40.
[20] ARD page 41.
[21] ARD page 42.
[22] ARD page 41.

54. In Dr Bodel's second report of 11 March 2020[23] he indicated that he had "carefully read the material provided through Dr Coughlan". Dr Bodel said:

> "I accept his explanation as to why he has recommended the L3/4 level only. I would still express a note of caution about dealing with the L3/4 level only and not the L4/5 level at the same time but I accept his recommendation for the L3/4 level fusion that he has indicated as reasonably necessary for the management of the injury."

55. A report was also by the applicant by Dr Paul Teychenné, Consultant Neurologist dated 17 September 2017[24]. In a typically thorough report Dr Teychenné noted that the MRI scan of the lumbar spine showed "T2 signal at L4/5 with a high intensity zone present in the posterior annulus"[25].

56. Dr Teychenné said that the history he took from Ms Young was of a twinge of pain half an hour after the lift over the lumbar spine at L4/5[26]. In his history he repeated that the area of pain indicated to him by the applicant was at L4/5[27].

57. Dr Teychenné noted that Dr Russo reported complaints by Ms Young of central low back pain of L4/5 and L5/S1[28]. He noted the MRI scan of 23 February 2016 which demonstrated a disc protrusion at L4/5 with the associated annular tear noted by all of the practitioners[29]

58. The respondent lodged reports of Dr Bentivoglio dated 21 April 2017[30] and 30 April 2018[31] , Dr Robin Mitchell, Occupational Physician, in his capacity as an Injury Management Consultant dated 8 May 2017[32] and Dr Vidyasagar Casikar, Neurosurgeon dated 8 August 2019 as its medico-legal referee.

59. In his report of 21 April 2017, Dr Bentivoglio took a consistent history of the injury and subsequent treatment experienced by Ms Young. He noted that at that stage Ms Young had been reviewed by Dr Coughlan on two separate occasions, the last being 11 April 2017. He noted the results of a bone scan at that time which showed facet joint changes at L4/5 and to a lesser degree at L3/4, noting that Dr Coughlan was not recommending operative intervention at that stage.

60. Dr Bentivoglio's opinion was[33]:

> "I do believe Donelle is suffering from pre-existing degenerative changes in her lumbar spine at L4/5 with facet joint changes at L3/4, L4/5 and to a lesser degree at L5/S1. I feel she has just aggravated this pre-existing degenerative problem."

61. In his later report of 30 April 2018 Dr Bentivoglio saw the most recent MRI scan of the lumbar spine of 31 January 2017. He thought the scan showed a mild focal annular tear at L4/5 which was partially healed. He thought she had bilateral facet joint disease without any neurological decompression.

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[23] ARD page 44.
[24] ARD page 46.
[25] ARD page 50.
[26] ARD page 52.
[27] ARD page 56.
[28] ARD page 50.
[29] ARD page 51.
[30] Reply page 1.
[31] Reply page 16.
[32] Reply page 8.
[33] Reply page 5.

62. Dr Robin Mitchell diagnosed "ongoing low back pain in the presence of a radiological stable L4/5 annular tear and disc protrusion without nerve impingement".[34]

63. Dr Mitchell reported that he had contacted Ms Young's GP, Dr Watson and was told that Dr Watson had been trying to encourage Ms Young to return to suitable duties for a long period of time without any great success. The repeated flares of her back pain have made the applicant concerned that she would get worse if she were to return to suitable duties[35].

64. Dr Casikar in his report of 8 August 2019 took a consistent history of the injury and subsequent management. Dr Casikar thought that MRIs dated 19 January 2016 and 23 February 2016 showed age related degenerative changes with facet arthropathy. His diagnosis was of a workplace aggravation to degenerative disease in the lumbar spine.

65. Dr Casikar thought that the aggravation had subsequently ceased and been "superseded by significant pain focused issues on a background of emotional problems".[36]

66. Dr Casikar did not support the proposed surgery recommended by Dr Coughlan, saying that it was difficult to justify based on evidence based studies. Dr Casikar said:

> "It is well recognised that in any spinal fusion on a background of degenerative disease and a Workers Compensation scenario has a very poor outcome".

67. Dr Casikar reviewed the other opinions obtained, saying[37]:

> "In short, most of the specialists, except Dr Coughlan, seem to have suggested that Ms Young should have non-surgical conservative management and input from a psychologist. These opinions are consistent with my opinion."

68. Dr Casikar gave a supplementary report dated 11 May 2020[38]. He noted some difference of opinion between Dr Bodel and Dr Coughlan as to which level should be fused. Dr Casikar conceded that those treatment options were standard for treatment of degenerative disease. D Casikar still would not support the concept that the need for surgery was necessary because of the workplace injury. He thought that Ms Young's complaints were "mainly" because of the constitutional degenerative disease in the lumbar spine.

69. Dr Casikar repeated his warning that spinal fusions on a workers compensation background had very poor outcomes.

70. He repeated that Ms Young's symptoms were "mainly" due to the degenerative disease.

SUBMISSIONS

Mr Hickey

71. Mr Hickey submitted that the issue for determination is relatively narrow. He submitted it was common ground that the treatment opinion regarding Ms Young's injury up to the consultation with Dr Coughlan in 2017 was that a surgical intervention had no role to play. The various alternative treatments that Ms Young had undergone were set out in the report of Dr Varsani of 16 January 2017, and that alternative treatment options, being medication, hydrotherapy, physiotherapy and pain management with Dr Russo had all been unsuccessful.

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[34] Reply page 12.
[35] Reply page 13.
[36] Reply page 25.
[37] Reply page 26.
[38] ALD dated 5 May 2020'

72. Mr Hickey referred to the involvement by Dr Coughlan over many years. Dr Coughlan had identified on 30 March 2017 that the facet joints at L3/4, L4/5 and also the sacroiliac joints were potentially involved, and a SPECT scan had been organised. Mr Hickey indicated that Dr Coughlan was initially of the opinion that surgery would not assist. Dr Coughlan said in his report of 11 April 2017 that the annular tear seemed to be slightly improved in the last MRI scan, but there was some degree of facet joint arthroses at L4/5 "and to a lesser degree L3/4".

73. Mr Hickey referred to the continuing reports from Dr Coughlan and the pattern that emerged of the failure of every treatment option that had been given to her, and his recommendation for denervation of the facet joints on 1 March 2018.

74. Mr Hickey submitted that it was the failure of the denervation procedure carried out on 8 February 2019 that led him to consider whether it was worthwhile looking at surgery.

75. Mr Hickey said that the evidence showed that the question of surgery was very much a last resort. He referred to the MRI scan of 15 April 2019[39] which showed pathology at L3/4 and L4/5.

76. Mr Hickey submitted that the opinion of Dr Bentivoglio on 30 April 2018 accepted all conservative measures had failed and he encouraged the L3/4 denervation suggested by Dr Coughlan.

77. Mr Hickey submitted that Dr Coughlan had given a clear and considered history of treatment and had outlined the numerous treatment options that had been trialled, all of which had failed. The request for approval of the surgery Mr Hickey observed did not come until June 2019 after which Dr Casikar was retained to comment on whether the surgery was reasonably necessary.

78. Dr Casikar did not support the proposed surgery, saying that the prospects of Ms Young thereafter getting back to any kind of employment would almost be non-existent. However, his diagnosis that the underlying degenerative changes were the source of the symptoms had not been supported by the other medical practitioners in the case, and indeed was at odds with other opinions that the pathology in Ms Young's back had been aggravated by the work she was doing.

79. I was referred to the s 78 notice which relied on Dr Casikar's opinion that any aggravation caused to the degenerative conditions had ceased, which again had no support elsewhere.

80. Dr Casikar's opinion could accordingly be treated as an ipse dixit, Mr Hickey submitted.

81. Mr Hickey then referred to the reports of Dr Bodel, anticipating that the respondent might well argue that Dr Bodel had dissented from the opinion of Dr Coughlan as to whether the proposed surgery was reasonably necessary.

82. Mr Hickey submitted that the report of Dr Coughlan of 11 February 2020 was significant in that it set out the reasons why he recommended a fusion at the L3/4.

83. Dr Coughlan was the treating neurosurgeon over three years, and had witnessed the failure of multiple treatment options. This report, Mr Hickey submitted, was Dr Coughlan's response to Dr Bodel's reservations. Dr Bodel's subsequent report of 11 March 2020 accordingly endorsed the proposed surgery once he had seen Dr Coughlan's explanation, Mr Hickey contended. Dr Coughlan's report showed that the focus was originally on the L4/5 disc, but that the pain generator was found to be at L3/4.

[39] ARD page 117.

84. Mr Hickey submitted that Dr Casikar's report of 11 May 2020[40] did not affect the debate.

85. Mr Hickey submitted that Dr Casikar's remarks about the spinal fusion and workers compensation were unsupported by any reference to "evidence based reports", and accordingly I could treat that comment as an ipse dixit. The same argument went to Dr Casikar's opinion that the aggravation had ceased.

86. I was referred to *Bielecki v Rianthelle Pty Ltd*[41] and a decision often quoted when dealing with s 60(5) of the 1987 Act *Diab v NRMA Ltd*[42], a decision of DP Roche.

87. An application of the relevant principles would satisfy me that the declaration sought should be made.

88. Mr Hickey submitted that it was not necessary to establish that the outcome of the surgery would be successful, what was needed was to show that there was a potential or to that effect. He submitted that Ms Young was a "desperate woman in a desperate situation".

Mr Perry

89. Mr Perry agreed that the decision of DP Roche in *Diab* was relevant and he referred to particularly at [88] and [89] of the learned Deputy President's decision, which is well known to the Commission.

90. Mr Perry referred to the application made by Dr Coughlan on 27 June 2019 and the description of the proposed surgery which was "an L3/4 XLIF procedure'. "XLIF", Mr Perry advised, stood for 'extreme lateral interbody fusion.'

91. Mr Perry referred to Dr Bodel's opinion in his report of 26 September 2019 that the disc pathology was not at L3/4, but rather at L4/5.

92. Dr Coughlan's reply of 11 February 2020, Mr Perry submitted, did not come to grips with Dr Bodel's opinion but simply repeated his earlier opinion.

93. Dr Bodel's reluctance to unconditionally endorse the proposed surgery created some difficulties for the applicant's case, Mr Perry submitted.

94. Mr Perry said that clinical examination favoured the L4/5 as the site of pain, and the report of Dr Teychenne indicated that all the scans taken implicated the L4/5 disc. Mr Perry submitted that although Dr Coughlan in his report of 11 February 2020 justified his decision on the basis that the L3/4 disc was the "main generator" he did not explain why that was so. He gave no explanation of why he came to that conclusion, and I would find that Dr Bodel had not accepted Dr Coughlan's explanation in his report of 3 March 2020.

95. Mr Perry referred to the diagnosis of Dr Mitchell, who found in his capacity as a rehabilitation consultation that the back pain was reported in the presence of a radiological stable L4/5 annular tear and disc protrusion without nerve impingement.

96. Mr Perry submitted that Dr Bodel's opinion of 3 March 2020 could not be seen as an endorsement of the procedure in view of the note of caution Dr Bodel sounded.

Response

97. In response Mr Hickey submitted that there was reference to L3/4 in the imaging reports. He submitted that Dr Bodel, Dr Teychenne and Dr Coughlan all identified pathology at L3/4.

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[40] ALD dated 5 May 2020.
[41] [2008] NSWWCCPD 53 (*Bielecki*).
[42] [2014] NSWWCCPD 72 (*Diab*).

98. Mr Hickey submitted that Dr Coughlan, having been treating the applicant since 2017, was familiar with her condition and his opinion ought to be accepted. He submitted that Dr Bodel did not precisely disagree with the proposed fusion, but proposed that the fusion be at two levels, from L3/4 to L4/5. He said the purpose of retaining Dr Bodel as a medico-legal expert was to give some context to Dr Coughlan's decision making.

99. Dr Bodel agreed with Dr Coughlan's reasoning and final analysis despite Mr Perry's submissions to the contrary.

DISCUSSION

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

> "(5) 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….".

101. The requirement that the worker demonstrate that such proposed treatment be reasonably necessary is to be found in s 60(1):

> "(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..
> (c) ….
> (d) …..
>
> the worker's employer is liable to pay… the cost of that treatment or service…"

102. Counsel both referred to *Diab.* Mr Hickey also referred to *Bielecki*, but I did not gain any further assistance from that case. In *Diab*, DP Roche considered the relevant authorities and summarised the relevant principles. He said at [76]:

> "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'."

103. At [88-89], the learned DP said:

> "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.
>
> 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."

104. The applicant has argued that the particular treatment, namely, an L3/4 XLIF procedure, followed by a secondary procedure the following day in the form of L3/4 posterior pedicle screw fixation, is appropriate, as all other treatment modalities have failed. This is a justification which is advanced often to rationalise what is usually an invasive surgical intervention, which is not without significant risk, and this is clearly the basis upon which Dr Coughlan is proceeding.

105. Dr Coughlan has not indicated that he expects the surgery to be effective, or to alleviate Ms Young's symptoms. When Ms Young was referred to him on 30 March 2017, he suspected that there might be present early myelopathy, as Ms Young was then hyper-reflexic. When he carried out further investigations he was able to exclude any myelopathic involvement.

106. He expressed the opinion on 11 April 2017, and again on 29 June 2017, that there was no role for any surgical intervention. On 29 August 2017 he noted that Ms Young continued to be in severe pain and very incapacitated. She suffered chronic pain and was taking powerful medications such as Targin, Lyrica, and Endone.

107. Physiotherapy, hydrotherapy and radiofrequency lesioning all failed to improve or alleviate her chronic pain. Nonetheless by 31 March 2018 Dr Coughlan still did not envisage surgery as a possible treatment option. He suggested, and obtained funding for, radiofrequency denervation which, although recommended on 1 March 2018, did not occur until 8 February 2019.

108. It was not until 31 March 2019 that Dr Coughlan first turned his mind to the question of whether surgery was worthwhile, as a "last resort." It can be seen from the evidence that Dr Coughlan recommended surgery at the L3/L4 level. It was also noted that Ms Young was keen to proceed to surgery.

109. Whilst a potentially poor outcome from surgery is not necessarily a reason to doubt whether proposed treatment will be effective, as the overall purpose of medical treatment is to alleviate suffering, each case must be decided on its facts. Neither Dr Coughlan nor Dr Bodel has made any convincing case that the proposed surgery will alleviate, or have the potential to alleviate Ms Young's symptoms. The highest the need for surgery has been put was that Dr Coughlan had not come to his decision quickly or lightly, but had recommended the surgery because of the failure of the previous conservative approaches. The failure of previous treatment is not of itself sufficient to establish that a particular treatment is appropriate.

110. As to the availability of alternative treatment, I note the suggestion by Dr Casikar that psychiatric intervention should be considered. I note also that the applicant has been referred to psychologists as part of the pain management treatment by Dr Russo. However, in view of the intransigence of Ms Young's condition, a further investigation of that modality of treatment might be a further option for alternative treatment. It is certainly true that the many forms of alternative treatment undertaken by Ms Young thus far have been unsuccessful.

111. No submissions were made regarding the proposed cost of the surgery.

112. Consideration of the actual or potential effectiveness of the treatment in this case also raises the question of whether medical experts accept that the treatment was likely to be effective. In considering the latter aspect, it is not unusual that there will be a difference of opinion between the treating surgeon and the expert retained for medico-legal purposes by the insurer. It is in this regard that the opinion of the medico-legal referee retained by the worker becomes of some relevance.

113. I reject the opinion of Dr Casikar that spinal fusion procedures have poor outcomes in a workers compensation "scenario." Dr Casikar did not refer to any academic or other material – particularly opinions from medical experts – that supported his claim. However, as I have indicated, there is no evidence in any event that the proposed treatment would have any potential, let alone any actual, effectiveness.

114. There is no unanimity on the applicant's case that this particular proposed treatment is accepted as being either appropriate or likely to be effective. Although Mr Hickey sought to minimise the effect of Dr Bodel's reservations, I do not accept that Dr Bodel does support Dr Coughlan's opinion that the proposed surgery is reasonably necessary.

115. The evidence clearly indicates the implication of the L4/5 disc as being abnormal, and Dr Bodel diagnosed that a disc rupture at that level had been caused by the subject incident. He set out his reservations plainly in his report of 26 September 2019. Dr Bodel's opinion that it was the L4/5 level that was implicated in the injury was supported by Dr Bentivoglio, Dr Mitchell and Dr Teychenne . I do not accept Dr Teychenne's opinion regarding myelopathy. Once Dr Coughlan had investigated and discounted that suggestion, no other medical practitioner apart from Dr Teychenne has made any reference to cord involvement.

116. Dr Bodel described future treatment needs as a "difficult issue." He then expressed concern that Dr Coughlan was suggesting that it was the L3/4 level that was to be fused when "all along" the pathology had been localised mostly at the L4/5 level, not at L3/4.

117. Mr Hickey's answer to that criticism was to claim that Dr Bodel changed his mind when he saw the explanation from Dr Coughlan dated 11 February 2020. I do not agree, with respect. Dr Coughlan simply reiterated that the L3/4 level was "certainly" the main issue which required surgical intervention. He repeated that it was that level that was the "pain generator" on all the scans.

118. Dr Coughlan did not explain why he had reached that conclusion and I do not accept that Dr Bodel was satisfied with Dr Coughlan's reasoning. Although Dr Bodel politely stated that he accepted Dr Coughlan's explanation, he nonetheless went on to say that he "still" cautioned against dealing with the L3/4 level only. Dr Bodel's comment thereafter that he accepted Dr Coughlan's recommendation as being reasonably necessary for the management of the injury I regard as a professional courtesy, and in view of his continued reservations, not an endorsement that the proposed surgery was either appropriate, effective, or accepted. Although Dr Coughlan repeated in his report of 11 February 2020 that the L3/4 level was the "pain generator", Dr Bodel had already said in his report of 26 September 2019 that he would be reluctant to consider any surgical intervention at the L3/4 level and not the L4/5 level.

119. Dr Bodel said, as I have indicated at [53] above:

> "…This is a difficult call in my view to recommend a surgical fusion in this circumstance without hard objective evidence of neurological compromise…. I am not sure that the L3/4 level is the pain generator in the circumstances based on the medical evidence available here today."

120. It should finally be observed that the purpose of obtaining a second opinion from a medico legal referee is to enable that referee to give an objective assessment of an applicant's case. It is not, as was suggested by the applicant's counsel, to "give some context" to Dr Coughlan's determination. Dr Bodel clearly disagreed with Dr Coughlan's proposal and the applicant has consequently been unable to meet her onus.

121. There will be an award for the respondent.

SUMMARY

122. The Commission determines:

    (a) The applicant was injured on 7 January 2016.

    (b) The proposed surgery recommended by Dr Marc Coughlan on 27 June 2019 is not reasonably necessary.

123. The Commission orders:

    (a) There is an award in favour of the respondent.