WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **2333/19**
Applicant: **William Paul Thompson**
Respondent: **Hornsby Shire Council**
Date of Determination: **13 September 2019**
CITATION: **[2019] NSWWCC 304**

The Commission determines:

1. The applicant sustained injury to his left knee arising out of or in the course of his employment with the respondent on 14 August 2002.

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

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

4. The proposed left total knee replacement, and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of the applicant's employment with the respondent on 14 August 2002.

The Commission orders:

5. The respondent to pay the applicant's reasonably necessary medical expenses with respect to the proposed left total knee replacement, and associated expenses, pursuant to section 60 of the *Workers Compensation Act 1987*.

6. No order as to costs.

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

Glenn Capel
Senior Arbitrator

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

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. William Paul Thompson (the applicant) is 61 years old and was employed by Hornsby Shire Council (the respondent) as a driver/labourer from August 2001 to mid-2005. He obtained employment with the Central Coast Council (formerly Wyong Council) in July 2005 and he remains in its employ.

2. There is no dispute that the applicant injured his left knee on 14 August 2002. Liability was accepted by StateCover Mutual Ltd (the insurer) and I understand that it paid some weekly compensation and medical expenses.

3. It would seem that the applicant's treating surgeon, Dr Hanslow, sought approval from the insurer to perform a left total knee replacement in August 2018.

4. On 5 November 2018 and 27 November 2018, the insurer issued notices pursuant to s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act), disputing that it was liable for the payment of medical expenses on the basis that the proposed surgery was not reasonably necessary as a result of his injury on 14 August 2002. It cited s 60 of the *Workers Compensation Act 1987* (the 1987 Act).

5. On 12 March 2019, the applicant's solicitor sought a review of the insurer's decision. On 20 March 2019, the insurer issued a notice pursuant to s 287A of the 1998 Act and confirmed its previous position.

6. By an Application to Resolve a Dispute (the Application) registered in the Workers Compensation Commission (the Commission) on 5 May 2019, the applicant claims medical expenses for proposed medical treatment pursuant to s 60 of the 1987 Act due to injury sustained to his right knee on 14 August 2002.

ISSUES FOR DETERMINATION

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

   (a) whether the proposed left total knee replacement is reasonably necessary as a result of the injury sustained on 14 August 2002.

PROCEDURE BEFORE THE COMMISSION

8. 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

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

   (a) The Application and attached documents;
   (b) Reply and attached documents;
   (c) Application to Admit Late Documents received on 1 July 2019, and
   (d) Application to Admit Late Documents received on 2 September 2019.

Oral evidence

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

REVIEW OF EVIDENCE

Applicant's statements

11. The applicant provided two statements on 8 March 2018. He confirmed that he sustained a twisting injury to his right knee on 14 August 2002, when he was pushing and pulling asphalt. Over the following weeks, he experienced more pain and he had difficulty walking. On 4 July 2003, he was referred to Dr Incoll and he performed a left knee arthroscopy. The applicant achieved an excellent outcome from the procedure and his intense pain subsided significantly. He was able to return to work and undertake everyday activities in a normal fashion.

12. The applicant stated that in July 2005, he transferred to Central Coast Council and performed many of the duties that he did at the respondent. He injured his right knee on 10 March 2006 when he was pushing and pulling asphalt. The pain in his right knee steadily increased over the following weeks and he eventually had a right knee arthroscopy on 11 April 2006. This procedure alleviated his symptoms for a number of years before the pain returned. He eventually had a right total knee replacement on 18 January 2019.

13. In paragraph 11 of the statement attached to the Application, the applicant stated that he experienced regular intense pain day and night in his left knee and he found it difficult to sleep. His pain impacted on his ability to walk and undertake domestic and leisure activities. A number of doctors had recommended that he undergo a left total knee replacement.

14. In paragraph 11 of the statement attached to the Application to Admit Late Documents, the applicant stated that ever since his right knee injury, the condition in his left knee had worsened. He experienced regular intense pain day and night in his left knee and he found it difficult to sleep.

Diagnostic tests

15. The applicant's general practitioner, Dr Shariff, referred the applicant for x-rays and an ultrasound on 20 September 2002.The x-rays showed evidence of large joint effusion and minor medial and patellofemoral compartment degenerative changes. The ultrasound showed the large joint effusion and some thickening of the quadriceps tendon.

16. An MRI scan taken on 3 June 2003 showed a tear of the posterior horn of the medial meniscus and a possible loose body or meniscal fragment. There was medial and patellofemoral compartment osteoarthritis and a possible tear of the distal patellar tendon.

17. X-rays of both knees on 8 February 2018 showed severe bilateral medial compartment osteoarthritis and mild to moderate osteoarthritis in the patellofemoral and lateral compartments.

Reports and medical certificates of Dr Shariff and Dr Incoll

18. Dr Shariff reported on 16 May 2003. He advised that he saw the applicant on 31 August 2002 with a history of pain in his left knee that had troubled him since 14 August 2002. On 19 September 2002, the applicant complained on worsening pain and swelling, but the doctor noted that an ultrasound and x-rays did not reveal any abnormality. It seems that the doctor cleared the applicant to return to his pre-injury duties on 19 September 2002.

19. Dr Shariff reported that the applicant consulted him again on 25 March 2003. At that stage, the doctor referred him to Dr Incoll, who recommended surgery. Dr Shariff stated that the applicant's employment was a major contributing factor to his condition.

20. Dr Incoll reported on 1 May 2003. He recorded that the applicant noted the gradual onset of pain and swelling in his left knee when getting into and out of his truck in August 2002. The doctor noted that x-rays showed no significant changes and he suspected that the applicant had a medial meniscus tear. He recommended a left knee arthroscopy and sought approval from the insurer.

21. It seems that the surgery was undertaken on 4 July 2003 at the Berkeley Vale Private Hospital. The applicant was provided with a certificate for total incapacity from 4 July 2003 to 20 July 2003.

22. There is no operation report in evidence, but in his report dated 17 July 2003, Dr Incoll recorded that the applicant's wounds had healed. The doctor cleared him to return to work on restricted duties for two weeks as from 21 July 2003.

Medical Assessment Certificate

23. Dr Pillemer, Approved Medical Specialist (AMS), provided a Medical Assessment Certificate (MAC) on 11 July 2014. He recorded that there was no specific injury on 14 August 2002. Rather, the applicant noticed some discomfort in his left knee when raking asphalt. He had continued to experience on-going problems thereafter. The applicant had an arthroscopy on 1 May 2003 seemingly in the form of a partial meniscectomy. He was off work for a couple of weeks and then resumed his normal duties apart from truck driving.

24. Dr Pillemer noted that the applicant felt a twinge of pain in his right knee when pushing and pulling asphalt at the Central Coast Council on 10 March 2006. The applicant experienced increasing symptoms and he had similar surgery on his right knee on 11 April 2006. The AMS had access to an operation report from Dr Morton, who found an articular cartilage flap tear of the medial femoral condyle and a tear of the medical meniscus. Dr Morton's report is not in evidence. He was again off work for a couple of weeks and then returned to his normal work.

25. The applicant complained of on-going pain, swelling and clicking in both knees. He had difficulty negotiating stairs and he avoided crouching and kneeling. He was able to attend to household tasks and was able to drive although his knees were stiff when he alighted from his car. The applicant denied any prior issues before his work injuries.

26. Dr Pillemer noted that the diagnostic tests in December 2012 showed tri-compartmental osteoarthritis in both knees. This was more marked in the medial compartment where there was bone on bone contact (Grade IV osteoarthritis). The report regarding this x-ray is not in evidence.

27. Dr Pillemer assessed 20% whole person impairment of each lower extremity due to the Grade IV osteoarthritis in the medial compartments. He felt that a nine-tenths deduction was appropriate because the applicant had constitutional tri-compartmental osteoarthritis in both knees and because the nature and conditions of employment would have been an aggravating factor of the underlying condition. This resulted in an assessment of 2% whole person impairment of each lower extremity.

28. Dr Pillemer advised that he was troubled by the terms of the referral that only identified two frank injuries and did not include the nature and conditions of employment. He stated that the constitutional osteoarthritis could have been aggravated by the nature and conditions of employment and on the dates identified in the referral. He believed that any incident that

might have occurred on those dates would have been minor and he took this into account when assessing the degree of impairment.

29. The MAC of Dr Pillemer was the subject of an appeal regarding the extent of the deduction applied pursuant to s 323 of the 1998 Act. The Medical Appeal Panel determined that there was no error by the AMS and the MAC was confirmed.

Reports of Dr Hanslow

30. Dr Hanslow reported on 18 July 2018. She noted that the applicant presented with bilateral knee pain that had been present for the last few years on a background of a twisting injury to the left knee in 2002 [sic], followed by arthroscopy and meniscectomy, and a twisting injury to the right knee in 2006, followed by similar surgery. The applicant indicated that he had been pain free for 10 years and the doctor that the x-rays showed advanced arthrosis in both knees. She recommended bilateral arthroplasties.

31. In her report to Central Coast Council dated 26 September 2018, Dr Hanslow advised that the need for the right knee surgery had resulted from the twisting injury sustained by the applicant in 2006 that caused a meniscal tear. The applicant had an arthroscopy and meniscectomy and she advised that the natural history was the development of arthrosis.

32. Central Coast Council as a self-insurer accepted liability and paid for the procedure which was undertaken at the Gosford Private Hospital on 18 January 2019.

33. Dr Hanslow reported to the insurer on 18 October 2018. She advised that the applicant had developed symptomatic arthrosis in his left knee secondary to his work injury and prior surgery. She stated that the applicant's pain and disability had progressed following the meniscectomy due to arthrosis as was the natural history. The applicant had reached the stage where the applicant felt that surgery was indicated.

34. According to the undated quote provided by the doctor, her fees were $5,880. Additional fees would be charged by the hospital, anaesthetist and surgical assistant.

Report of Associate Professor Hope

35. Associate Professor Hope reported on 11 January 2019. He recorded that the applicant injured his left knee on 14 August 2002 when breaking asphalt. He had a partial meniscectomy in July 2003. The applicant injured his right knee in June 2006 [sic] and had a similar procedure in 2006. Recently his pain had increased and Dr Hanslow had recommended bilateral total knee replacements.

36. Associate Professor Hope recorded that the applicant's knees were asymptomatic prior to 14 August 2002. He now had stabbing pain on walking and mild pain when resting. He was troubled by weakness, instability and giving way. He could only sit for 30 minutes, stand for 10 minutes and walk for 20 minutes. His findings on examination were similar in both knees.

37. Associate Professor Hope diagnosed severe osteoarthritis in both knees and stated that the applicant was only fit for suitable duties. The Associate Professor advised that the severe left knee osteoarthritis was caused by the injury in 2002 [sic], which required partial removal of the medial meniscal shock absorber.

38. Associate Professor Hope stated that the need for the left total knee replacement arose as a direct result of the injury sustained on 14 August 2002. The applicant was symptom-free and the medial meniscus was injured at work. Once the meniscal shock absorber was damaged and removed, osteoarthritis inevitably developed some 15 years later. Accordingly, he considered that the proposed surgery was reasonably necessary, being the standard treatment for severe osteoarthritis.

39. Associate Professor Hope took issue with the opinion of Professor Cumming regarding the constitutional nature of the applicant's condition, on the background of meniscal tears in 2002 and 2006 [sic]. The Associate Professor confirmed that both knees conditions were work-related and the need for surgery was work-related.

Reports of Professor Cumming

40. Professor Cumming reported on 30 October 2018. He noted that the applicant developed left knee problems over a period of weeks without any specific injury, starting with catching followed by pain and giving way. The applicant was referred to Dr Incoll, who performed a meniscectomy. This procedure relieved his pain and he was off work for two weeks.

41. Professor Cumming noted that similar symptoms developed in the applicant's right knee in 2006 and Dr Morton performed a meniscectomy which was not as successful. It was not until 2012 that the applicant developed increasing symptoms in both knees. At that stage, he had x-rays and an MRI scan.

42. Professor Cumming recorded that the applicant had pain and stiffness in his knees. He had consulted Dr Hanslow and she had recommended bilateral knee replacements. He was still working for the Central Coast Council as a truck driver and he had some difficulty getting into and out of the vehicle.

43. Professor Cumming noted that the x-ray report dated 20 September 2002 showed minor medial and patellofemoral degenerative changes. He had access to the x-rays and scans taken in 2006, 2012, 2013, 2017 (all not in evidence) and 2018. He observed that the was early osteoarthritis and minimal loss of joint height in the medial compartment in 2006, but by 2012, there was a significant increase in the medial compartment osteoarthritis. By 2017 and 2018, there was significant osteoarthritis in the medial compartment and the applicant had tri-compartmental osteoarthritis.

44. Professor Cumming diagnosed bilateral knee osteoarthritis that had progressed from a mild condition in 2002 to advanced tri-compartmental osteoarthritis in 2017/2018. He considered that the applicant had previous problems with his knees with surgery undertaken to remove an ossicle in later childhood and the removal of a cyst on the lateral meniscus. The source if this history is not entirely clear as there is no reference to this in the body of the report.

45. Professor Cumming considered that the applicant's condition was constitutional in nature and there was no injury or aggravation, acceleration, exacerbation or deterioration of an injury. He stated that the applicant may have suffered a torn meniscus when playing sport and it was unusual that he had a fracture of the fibula in circumstances that he could not recall such an injury. He stated that meniscal damage was a common accompaniment of the osteoarthritic condition and surgery.

46. Professor Cumming conceded that removal of the total meniscus could result in increased load in the medial compartment, but he considered that there was no work-related meniscal injury, because there was no history of any injury. The Professor recommended bilateral total knee replacements, but there was no compensable injury or work-related impairment.

47. A supplementary report was requested from Professor Cumming regarding the issue as to whether the proposed surgery was reasonably necessary as a result of an accepted injury to the applicant's left knee on 14 August 2002.

48. In his report dated 28 June 2019, Professor Cumming confirmed that in his view, the pathology in the applicant's left knee was entirely constitutional. He noted that on review of the MAC and the other reports, there was no mention of a specific injury and the consensus was that the condition was constitutional. Therefore, he disagreed that there was any specific

injury and his opinion was similar to that of almost all of the assessors who had examined the applicant.

49. Professor Cumming explained that osteoarthritis presents initially as a unicompartmental condition related to the alteration in biomechanics in patients who have an unusual mode to the knee, normally in the form of a varus configuration in the medial compartment, which wears out and the load is thrown further forward, resulting in progressive bowleg and osteoarthritis of the medial compartment, followed by osteoarthritis in the lateral and patellofemoral compartments (tri-compartmental osteoarthritis).

50. Professor Cumming considered that the applicant fell within 90% of patients who presented with osteoarthritis. There was no need to look for incidents or activities which initiated or aggravated the condition and resulted in the progression in the osteoarthritis, because the applicant had natural bowleg, which led to the onset of osteoarthritis.

51. Professor Cumming noted that the applicant had surgery which demonstrated pathology in the menisci, but he considered that this was part of the degenerative process. He stated that current orthopaedic opinion suggested that surgery was ill-advised and contraindicated in an osteoarthritic knee, as the procedure did not assist and could make the condition worse. Therefore, he believed that the proposed left knee replacement was not reasonably necessary as a result of the accepted injury on 14 August 2002. He stated that the fact that the insurer had accepted liability for the injury did not mean that the condition was work-related.

APPLICANT'S SUBMISSIONS

52. The applicant's counsel, Mr Tanner, submits that there is no dispute that the applicant injured his left knee on 14 August 2002 and that he requires a left total knee replacement. Dr Incoll recorded details of the applicant's meniscal injury, which was confirmed on the MRI scan, and he performed an arthroscopy. The medical certificates identified the date of injury as 14 August 2002 and referred to the applicant's left knee.

53. Mr Tanner submits that the AMS was requested to assess injuries to the applicant's left knee on 14 August 2002 and to his right knee on 10 March 2006. This is consistent with a concession of liability regarding the left knee injury and Dr Pillemer's assessments were deemed to be correct.

54. Mr Tanner submits that the AMS considered the diagnostic tests and these showed a change in the degree of the osteoarthritis from minor to moderate, consistent with an aggravation of the osteoarthritis post-surgery.

55. Mr Tanner submits that the x-rays of both knees in February 2018 showed tri-compartmental osteoarthritis, with severe osteoarthritis in the medial compartment. The onset of left knee problems could be traced to the injury sustained on 14 August 2002 and the subsequent surgery.

56. Mr Tanner submits that Dr Hanslow recorded details of the applicant's symptoms and noted that the pain had been present for the last few years. This was on the background of a twisting injury and a meniscectomy. She identified the relevance of the injury in 2002 and the need for an arthroplasty.

57. Mr Tanner submits that in her report dated 26 September 2019, Dr Hanslow indicated that the need for a right total knee replacement flowed from the previous right knee surgery. She stated that the natural history following surgery was to develop arthrosis and this had occurred in the applicant's case. Central Coast Council had approached the applicant's right knee claim differently and it accepted liability for the knee replacement surgery. Dr Hanslow

provided a similar report to the insurer regarding the condition in the applicant's left knee on 18 October 2018, but it did not accept liability.

58. Mr Tanner submits that Associate Professor Hope recorded a history of the left knee injury in 2002 and the right knee injury in 2006 [sic]. He noted that the initial investigations showed minor osteoarthritis, but he considered that the present severe osteoarthritis in both knees was work-related. He stated that the need for the left total knee replacement was due to the work injury in 2002.

59. Mr Tanner submits that Associate Professor Hope, a specialist knee surgeon, noted that Professor Cumming's opinion was at odds with the history of injury to the left knee on 14 August 2002 and to the right knee in June 2006 [sic]. He confirmed that the applicant was symptom-free prior to the incidents, both incidents resulted in meniscal tears requiring removal, and once the meniscal shock absorber was removed, osteoarthritis was inevitable 15 years later. He considered that the proposed surgery was reasonably necessary and was the standard treatment for severe osteoarthritis.

60. Mr Tanner submits that Professor Cumming was unaware that "injury" was not in dispute. He recorded that the applicant had surgery and this assisted with his pain. He had access to the diagnostic tests that showed a progression in the osteoarthritis from minor to severe, something that Dr Hanslow and Associate Professor Hope advised was a predictable outcome.

61. Mr Tanner submits that Professor Cumming stated that the applicant's condition was constitutional and there was no injury or aggravation, but he failed to address the frank incidents that were accepted by the insurers. He acknowledged that the removal of the total meniscus could result in increased load causing an aggravation, but he did not accept that there was any work-related meniscal problem or any injury. Professor Cumming's acknowledgement and the opinions of Dr Hanslow and Associate Professor Hope provide an accurate assessment of the cause of the applicant's current condition.

62. Mr Tanner submits that Professor Cumming stated that the applicant was suffering from the progressive natural history of bilateral medial compartment osteoarthritis that had proceeded to patellofemoral osteoarthritis, however, this was the consequence of the surgery in 2003 as confirmed by Dr Hanslow and Associate Professor Hope. Professor Cumming maintained his opinion in his supplementary report and then stated that the proposed surgery was not an accepted form of treatment, so there seemed to have been a change in orthopaedic science in the brief period between his two reports.

63. Mr Tanner submits that the only dispute identified in the notices issued by the insurer pursuant to s 74 of the 1998 Act related to whether the proposed surgery was reasonably necessary as a result of the accepted left knee injury on 14 August 2002. The notice did not place "injury" in issue. The dispute was based on the opinion of Professor Cumming, but his opinion was not tenable, given the acceptance of an injury by the insurer.

64. Mr Tanner submits that according to *Murphy v Allity Management Services Pty Ltd*[1], all that the applicant needs to be shown is that the injury materially contributed to the need for surgery. There was an undisputed injury and surgery in 2003 and the medical opinions of Dr Hanslow and Associate Professor Hope confirmed that this would result in osteoarthritis. Even Professor Cumming acknowledged that surgery could cause osteoarthritis. Therefore, applying the principles of common sense, the applicant's left knee injury in 2002 and surgery in 2003 materially contributed to the need for the proposed surgery.

[1] [2015] NSWWCCPD 49 (*Murphy*).

65. Mr Tanner submits that there should be a finding that the proposed surgery is reasonably necessary as a result of the injury sustained on 14 August 2002 and the respondent should be ordered to pay for the cost of the surgery and associated expenses.

RESPONDENT'S SUBMISSIONS

66. The respondent's counsel, Mr Doak, submits that it is clear from the dispute notices that the nature of the dispute concerns the causal relationship between the accepted injury and the need for surgery. It was not suggested that there was any dispute in respect of "injury".

67. Mr Doak submits that it was unclear from the applicant's statement whether he was troubled by on-going pain after his surgery in 2003. According to Dr Hanslow, the applicant had pain for the last few years and he had been symptom-free for 10 years. Associate Professor Hope recorded no history of symptoms in the period 2003 to 2018, and he noted that there had been a recent increase in the applicant's pain.

68. Mr Doak concedes that the evidence of Professor Cumming was of limited use, given the manner in which he expressed his conclusion. However, in accordance with s 326 of the 1998 Act, the assessment by the AMS was conclusively presumed to be correct as to the degree of permanent impairment due to the work injury and the proportion due to a previous injury or pre-existing condition.

69. Mr Doak submits that paragraph 11 of the applicant's initial statement referred to the fact that ever since his right knee injury, the condition in his left knee had worsened. This comment was removed from the other statement without any clarification, so this needs to be taken into account.

70. Mr Doak submits that the AMS found that there was only 2% whole person impairment due to the injury on 14 August 2002. He had access to the diagnostic tests that showed a progression of the changes, but he explained that there was pre-existing osteoarthritis in 2002 and this was the basis of his assessment. He noted that the nature and conditions of employment would have caused an aggravation. Further, he recorded a history or gradual onset with no particular injury and an aggravation in 2002. Given the assessment by the AMS, it could not be said that the injury in 2002 materially contributed to the need for surgery.

71. Mr Doak submits that Associate Professor Hope indicated that the progression in the osteoarthritis was due to the removal of the shock absorber. The Associate Professor did not record a history of the applicant's symptoms and he merely noted the recent increase in pain. It was unclear how the injury in 2002 was related to osteoarthritis 15 years later.

72. Mr Doak submits that Associate Professor Hope only had access to the x-rays taken in 2018 and he did not identify the degenerative condition that the AMS confirmed was in existence in 2002. The Associate Professor indicated that the applicant's current condition was the direct result of his injury in 2002. He proceeded on the assumption that the entire meniscus was removed in 2003, but the evidence suggests that only a partial meniscectomy was performed, and he did not refer to the history recorded by the AMS. In the circumstances, no weight should be given to the report of Associate Professor Hope.

73. Mr Doak submits that the evidence of Dr Hanslow suffered from a similar problem. She did not take into account the pre-existing condition when she attributed the applicant's osteoarthritis to his work injury. This affected her opinion. Her opinion depended on the history, but the history that she recorded was incorrect and inconsistent with that obtained by the AMS. Without a proper history, the reports of Dr Hanslow are of limited value.

74. Mr Doak submits that the underlying osteoarthritic condition was the principal need for the knee surgery and was not related to the injury in 2002 and surgery. There should be an award for the respondent.

APPLICANT'S SUBMISSIONS IN REPLY

75. In reply, Mr Tanner submits that the respondent had no evidence that the applicant would have required surgery regardless of his injury in 2002. There was no need to address the different versions in paragraph 11 of the applicant's statements, as liability for injury was not in issue. There was no evidence to suggest that the applicant had developed a consequential condition in his left knee as a result of favouring his injured right knee. Even if there was a consequential condition, that did not mean that there was not a material contribution from the 2002 injury.

76. Mr Tanner submits that it was not necessary to show that the predominant cause of the condition was the workplace. All that was required was that there was an aggravation that progressed and materially contributed to the need for surgery. The assessment of 2% whole person impairment by the AMS did not mean that the injury had not materially contributed to the need for surgery. All that needed to be shown was that the injury and surgery accelerated the need for surgery. This was confirmed by Dr Hanslow and Associate Professor Hope, as well as Professor Cumming.

REASONS

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

77. Section 60 of the 1987 Act provides:

> "60 (1) If, as a result of an injury received by a worker, it is reasonably necessary that:
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> (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)".

78. What constitutes reasonably necessary treatment was considered in the context of s 10 of the *Workers Compensation Act 1926* in *Rose v Health Commission (NSW)*[2], Burke CCJ stated:

> "Treatment, in the medical or therapeutic context, relates to the management of disease, illness or injury by the provision of medication, surgery or other medical service designed to arrest or abate the progress of the condition or to alleviate, cure or remedy the condition. It is the provision of such services for the purpose of limiting the deleterious effects of a condition and restoring health. If the particular 'treatment' cannot, in reason, be found to have that purpose or be competent to achieve that purpose, then it is certainly not reasonable treatment of the condition and is really not treatment at all. In that sense, an employer can only be liable for the cost of reasonable treatment."[3]

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

79. Further, His Honour added:

> "1. *Prima facie*, if the treatment falls within the definition of medical treatment in section 10(2), it is relevant medical treatment for the purposes of this Act. Broadly then, treatment that is given by, or at the direction of, a medical practitioner or consists of the supply of medicines or medical supplies is such treatment.
>
> 2. However, although falling within that ambit and thereby presumed reasonable, that presumption is rebuttable (and there would be an evidentiary onus on the parties seeking to do so). If it be shown that the particular treatment afforded is not appropriate, is not competent to alleviate the effects of injury, then it is not relevant treatment for the purposes of the Act.
>
> 3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of injury.
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> 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.
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> 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."[4]

80. His Honour considered the relevant factors relating to reasonably necessary treatment under s 60 of the 1987 Act in *Bartolo v Western Sydney Area Health Service*[5] and stated:

> "The question is should the patient have this treatment or not. If it is better that he have it, then it is necessary and should not be forborne. If in reason it should be said that the patient should not do without this treatment, then it satisfies the test of being reasonably necessary."[6]

81. In *Diab v NRMA Ltd*[7], Deputy President Roche questioned this approach and cited *Rose* with approval. He provided a summary of the principles as follows:

> "In the context of s 60, the relevant matters, according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ at point (5) in *Rose* (see [76] above), namely:
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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.
>
> With respect to point (d), it should be noted that while the effectiveness of the treatment

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[4] *Rose*, [47].
[5](1997) 14 NSWCCR 233 (*Bartolo*).
[6] *Bartolo*, [238].
[7] [2014] NSWWCCPD 72 (*Diab*).

is relevant to whether the treatment was reasonably necessary, it is certainly not determinative. The evidence may show that the same outcome could be achieved by a different treatment, but at a much lower cost. Similarly, bearing in mind that all

treatment, especially surgery, carries a risk of a less than ideal result, a poor outcome does not necessarily mean that the treatment was not reasonably necessary. As always, each case will depend on its facts.

While the above matters are 'useful heads for consideration', the 'essential question remains whether the treatment was reasonably necessary' (*Margaroff v Cordon Bleu Cookware Pty Ltd* [1997] NSWCC 13; (1997) 15 NSWCCR 204 at 208C). Thus, it is not simply a matter of asking, as was suggested in *Bartolo*, is it better that the worker have the treatment or not. As noted by French CJ and Gummow J at [58] in *Spencer v Commonwealth of Australia* [2010] HCA 28, when dealing with how the expression 'no reasonable prospect' should be understood, '[n]o paraphrase of the expression can be adopted as a sufficient explanation of its operation, let alone definition of its content'".[8]

82. Whether the need for reasonably necessary treatment arises from an injury is a question of causation and must be determined based on the facts in each case. The accepted view regarding causation was set out in *Kooragang Cement Pty Ltd v Bates*[9]. Kirby J stated:

> "The result of the cases is that each case where causation is in issue in a workers compensation claim must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from' is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a common sense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation."[10]

83. Although the High Court in *Comcare v Martin*[11] raised some concerns about the common-sense evaluation of the causal chain in a matter that concerned Commonwealth legislation, the common-sense approach still has place in the application of the legislation to the facts of the case.

84. It is accepted that a condition can have multiple causes, but the applicant must establish that the injury materially contributed to the need for surgery. This was confirmed by Deputy President Roche in *Murphy*, where he stated:

> "Moreover, even if the fall at Coles contributed to the need for surgery, that would not necessarily defeat Ms Murphy's claim. That is because a condition can have multiple causes (*Migge v Wormald Bros Industries Ltd* (1973) 47 ALJR 236; *Pyrmont Publishing Co Pty Ltd v Peters* (1972) 46 WCR 27; *Cluff v Dorahy Bros (Wholesale) Pty Ltd* (1979) 53 WCR 167; *ACQ Pty Ltd v Cook* [2009] HCA 28 at [25] and [27]; [2009] HCA 28; 237 CLR 656). The work injury does not have to be the only, or even a substantial, cause of the need for the relevant treatment before the cost of that treatment is recoverable under s 60 of the 1987 Act.
>
> Ms Murphy only has to establish, applying the commonsense test of causation (*Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796), that

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[8] *Diab*, [88] to [90]
[9] (1994) 35 NSWLR 452; 10 NSWCCR 796 (*Kooragang*).
[10] *Kooragang* [463].
[11] [2016] HCA 43, [42].

the treatment is reasonably necessary 'as a result of' the injury (see *Taxis Combined Services (Victoria) Pty Ltd v Schokman* [2014] NSWWCCPD 18 at [40] – [55]). That is, she has to establish that the injury materially contributed to the need for the surgery (see the discussion on the test of causation in *Sutherland Shire Council v Baltica General Insurance Co Ltd* (1996) 12 NSWCCR 716)."[12]

85. There is no dispute that the condition in the applicant's left knee is such that the proposed treatment is reasonably necessary. It is true that the applicant's history regarding the mechanism of injury differs in his statement and in the histories recorded by the doctors who have examined him. There is the suggestion of a frank injury and an injury of gradual onset over a period of a day or days.

86. However, "injury" is not in dispute and any discrepancies are of little concern. The injury was sustained 27 years ago, so it is not surprising with the passing of time that there are some inconsistences. I am also mindful of the fact that Professor Cumming described the applicant as "a most pleasant gentleman who presented his history without embellishment and was totally compliant during the interview and examination". Therefore, whether there was a frank injury or an injury caused over a period is of no relevance.

87. The x-ray report in September 2002 only recorded minor medial and patellofemoral compartment degenerative changes. Further, Dr Incoll, who saw the applicant in 2003, reported that the x-rays showed no significant changes. Therefore, the pre-existing condition was minimal and it was asymptomatic.

88. The applicant sought further treatment in March 2003. The extent of the arthritis was not disclosed in the MRI scan taken in June 2003, but one would have thought that if there had been significant changes, the radiologist would have identified these. There was evidence of a meniscal tear and Dr Incoll performed surgery.

89. According to the applicant's statements, he achieved an excellent outcome from the surgery in 2003 and his pain subsided significantly. Even though he was able to return to work and undertake everyday activities, he did not suggest that there was a total resolution of his symptoms. His symptoms obviously deteriorated, given that he again sought treatment in 2012 and at that stage diagnostic tests were reported to show evidence of bone on bone in the medial compartment of both knees.

90. The radiological tests in evidence show a progression in the level of osteoarthritis in the applicant's knees and those not before the Commission have been reported to show a progression. The most recent x-rays in 2018 showed severe bilateral medial compartment osteoarthritis, where the surgery was undertaken in 2003 and 2006, and mild to moderate osteoarthritis in the patellofemoral and lateral compartments.

91. It is true that the AMS made a substantial deduction of nine-tenths pursuant to s 323 of the 1998 Act, but what proportion was attributed to the constitutional pathology and what proportion was due to the nature and conditions of employment was not disclosed. Further, it is unclear whether he took into account the potential for the progression of osteoarthritis as a consequence of surgery. His assessment was also coloured by his opinion that the injury in 2002 was minor, however, the evidence shows that the mechanism of injury, be it frank or otherwise, was sufficient to cause a meniscal tear and result in surgery.

92. A finding in respect of the degree of impairment arising from an accepted injury does not necessarily mean that the injury did not result in an incapacity or did not materially contribute to the need for future surgery. The AMS was not requested to provide An opinion as to whether the proposed surgery was reasonably necessary as a result of the accepted injury, and even if he did so, any opinion would not be conclusive or binding on the parties.

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

93. Mr Doak submits that little weight should be given to the reports of Dr Hanslow because she did not obtain a correct history. Further, her history differed from that of the AMS. What the "correct" history is not entirely clear, but in any event, given that "injury" is not in issue, such a submission carries little weight. It should also be kept in mind that the treating doctor was not prepared to provide a medico-legal report, which is not unusual in this jurisdiction.

94. The applicant told Dr Hanslow that he had been pain free for 10 years. This history is somewhat confusing, as it may mean that he had no symptoms between 2008 and 2018, or he was pain free for 10 years from 2002 to 2012, when sought further treatment. In any event, the history recorded by Dr Hanslow and Associate Professor Hope of the onset of bilateral knee pain in the last few years or the recent increase is consistent with the deterioration shown in the diagnostic tests.

95. Mr Doak submits that Dr Hanslow and Associate Professor Hope did not take into account the pre-existing condition when they attributed the applicant's osteoarthritis to his work injury and prior surgery. That may well be true, because neither doctor had access to the x-rays taken in 2002, but those changes were only reported as being minor and their focus was on the cause of the applicant's current condition on the background of an accepted injury in 2002, remedial surgery in 2003 and the progressive deterioration in the osteoarthritic changes. There was certainly a factual basis and radiological evidence to support their conclusions. Further, Associate Professor Pope noted that the applicant was asymptomatic at the time of his injury in 2002.

96. Although Mr Doak submits that Associate Professor Hope proceeded on the assumption that the entire meniscus was removed in 2003, that is not the case. The Associate Professor confirmed on page 1 of his report that the severe left knee osteoarthritis was caused by the injury in 2002 [sic] and required partial removal of the medial meniscal shock absorber. Further, the timeline of 15 years suggested by the Associate Professor is not inconsistent with the deterioration that has occurred in the applicant's left knee in the period from 2002/2003 to 2018.

97. Significantly, the Associate Professor stated that once the meniscus was damaged and removed, the development of osteoarthritis was inevitable. It is true that he referred to the removal of the damaged meniscus, but despite knowing that there was only a partial meniscectomy in 2003, the Associate Professor saw no reason to distinguish between a partial and total meniscectomy.

98. What we do know is that by 2018, there were Grade IV changes in the medial compartment which coincided with the operation site and the flow-on effect of the development of osteoarthritis in the lateral and patellofemoral compartments as described by Professor Cumming.

99. The only doctor to dispute the applicant's claim is Professor Cumming, but little weight can be given to his opinion because he has proceeded on the premise that the applicant did not sustain the work injury in August 2002 and there were other possible causes. Even Mr Doak accepts that the Professor's evidence was of limited use.

100. Professor Cumming's opinion is coloured by his views on causation of the accepted knee injury. In his initial report, he observed that there had been a progression in the level of osteoarthritis in the applicant's left knee and he agreed that the condition in the left knee was such that the proposed surgery was appropriate.

101. Significantly, Professor Cumming conceded that removal of the meniscus could result in increased load in the medial compartment, but he did not comment on the effect of a partial removal. His explanation regarding an initial unicompartmental condition related to an alteration in biomechanics which led to progressive bowleg and osteoarthritis of the medial

compartment followed by osteoarthritis in the lateral and patellofemoral compartments in my view seems to reflect what has happened to the applicant's left knee.

102. Even when the Professor was asked to put aside his views on causation and acknowledge that the insurer had accepted the applicant sustained an injury to his left knee in 2002, he maintained that the applicant's condition was constitutional, because there was no specific injury and the meniscectomy in 2003 was to address a degenerative condition. He also stated that the proposed surgery to address the osteoarthritic condition was ill-advised and contraindicated, but he gave no reasoned opinion why he had changed his opinion. Therefore, minimal, if any, weight can be given to his opinion.

103. The respondent disputes that the proposed surgery was reasonably necessary as a result of the accepted knee injury in 14 August 2002. It relies on the MAC, but the AMS did not deal with the current issue in dispute. The fact that the AMS apportioned nine-tenths of the impairment to the constitutional changes and the nature and conditions of employment does not mean that the injury in 2002 does not materially contribute to the need for knee replacement surgery in 2019. The work injury does not need to be the only cause or the substantial cause. All that the applicant needs to establish is that the work injury materially contributed to the need for surgery.

104. According to *Murphy*, a condition can have many causes, and this was acknowledged by the AMS. In my view, applying the common-sense test of causation in *Kooragang*, the weight of evidence from Dr Hanslow and Associate Professor Hope supports the applicant's case that his left knee injury in 2002 and surgery in 2003 materially contributed to the need for the knee replacement surgery.

105. In my opinion, the evidence supports the need for the operation to address the effects of the applicant's work injury. Conservative measures seem to have been exhausted and surgery is the only option. The only doctor to question the need for surgery is Professor Cumming, whose opinion I have rejected. Even he initially accepted that the operation was an appropriate form of treatment.

106. I am satisfied that the surgery has the potential to alleviate the applicant's symptoms, is an appropriate treatment and is likely to be effective. There seems to be no alternative forms of treatment and the cost is not unreasonable. This satisfies the relevant factors discussed in *Rose* and *Diab*.

107. The mechanism of injury sustained to the applicant's right knee in 2006, the initial surgery and the progression of osteoarthritis changes was similar and the Central Coast Council had no hesitation in accepting liability for the right total knee replacement in January 2019. Such action was entirely appropriate and the self-insurer should be commended for its decision. Sadly, the same cannot be said for the insurer in the present matter.

108. Rather than accept the opinions of two specialist knee surgeons, the insurer denied liability based on the opinion of a doctor who did not accept that there was any injury and even when he was informed that there was no injury dispute, he still maintained his opinion.

109. The insurer's decision to maintain the dispute based on flawed medico-legal evidence is unsatisfactory and could not be considered as appropriate in the circumstances. Although the insurer is not bound by the Model Litigant Policy, perhaps it should review the policy and consider applying its principles.

110. Accordingly, I am satisfied on the balance of probabilities that the treatment proposed by Dr Hanslow, namely a left total knee replacement, and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of the applicant's employment with the respondent on 14 August 2002.

Costs

111. There will be no order as to costs.

FINDINGS

112. The applicant sustained injury to his left knee arising out of or in the course of his employment with the respondent on 14 August 2002.

113. The applicant's employment was a substantial contributing factor to his injury.

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

115. The proposed left total knee replacement, and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of his employment with the respondent on 14 August 2002.

ORDERS

116. The respondent to pay the applicant's reasonably necessary medical expenses with respect to the proposed left total knee replacement, and associated expenses, pursuant to s 60 of the 1987 Act.

117. No order as to costs.