WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **5891/20**
Applicant: **Rozalia King**
Respondent: **Coles Group Limited**
Date of Determination: **25 January 2021**
Citation No: **[2021] NSWWCC 28**

The Commission determines:

1. The applicant sustained an injury to her right shoulder in the nature of a biceps anchor lesion and impingement as a result of the nature and conditions of her employment with the respondent pursuant to s 4(b)(ii) of the *Workers Compensation Act 1987*.

2. Employment with the respondent was the main contributing factor to the injury.

3. Pursuant to s 60(5) of the *Workers Compensation Act 1987,* the arthroscopic biceps tenotomy/tenodesis and decompression surgery proposed by Dr Chandra Dave is reasonably necessary as a result of the injury.

The Commission orders:

1. Pursuant to s 60 of the *Workers Compensation Act 1987*, the respondent to pay the applicant's reasonably necessary expenses resulting from the injury upon production of accounts, receipts and/or valid Medicare Notice of Charge, subject to s 59A of the *Workers Compensation Act 1987*.

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

Rachel Homan
Arbitrator

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

A Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Ms Rozalia King (the applicant) was employed by Coles Group Limited (the respondent) from 2012 onwards. In 2015, the applicant was transferred to the Coles Camden store, where she worked at the checkouts on a full-time basis.

2. The applicant claims that during the course of her employment she performed duties involving repetitive manual activity and lifting and use of both her arms, particularly her right arm, causing an aggravation, acceleration, exacerbation or deterioration of a disease process in her right shoulder.

3. The applicant made a claim for compensation and, on 3 October 2018, provisional liability for medical expenses was accepted. The applicant was placed on light duties and continued to work.

4. On 22 March 2019, the respondent declined liability to pay the applicant's ongoing medical expenses under a dispute notice issued pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act).

5. On 12 August 2019, orthopaedic surgeon, Dr Chandra Dave, recommended that the applicant undergo arthroscopic biceps tenotomy/tenodesis and decompression surgery at the right shoulder.

6. A claim for compensation pursuant to s 60 of the *Workers Compensation Act 1987* (the 1987 Act) for the costs of and incidental to the proposed surgery and other incurred medical expenses was made by letter dated 18 June 2020.

7. On 9 October 2020, the respondent issued a notice pursuant to s 287A of the 1998 Act maintaining its decision to dispute liability.

8. The present proceedings were commenced by an Application to Resolve a Dispute (ARD) lodged in the Commission on 12 October 2020.

PROCEDURE BEFORE THE COMMISSION

9. The parties appeared for conciliation conference and arbitration hearing by telephone on 11 December 2020. The applicant was represented by Mr Phillip Perry of counsel, instructed by Mr David Hartstein. The respondent was represented by Mr Tony Baker of counsel, instructed by Ms Monica Nguyen.

10. 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.

ISSUES FOR DETERMINATION

11. The parties agree that the following issues remain in dispute:

    (a) whether the applicant sustained an injury in the nature of an aggravation, acceleration, exacerbation or deterioration of a disease process in the right shoulder as claimed, and

    (b) the applicant's entitlement to the s 60 expenses claimed, including the application of s 59A of the 1987 Act to the claim.

EVIDENCE

Documentary evidence

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

    (a) ARD and attached documents;

    (b) Reply and attached documents, and

    (c) documents attached to an Application to Admit Late Documents lodged by the respondent on 4 December 2020.

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

Applicant's evidence

14. The applicant's evidence is set out in a written statement dated 15 July 2020.

15. The applicant stated that she worked at the Coles Camden store for four days one week and six days the other week of a fortnight. The applicant's work on the checkouts required a lot of repetitive lifting and use of her arms. The applicant was right hand dominant and tended to scan most items with her right arm.

16. In around April or May 2018, the applicant noticed the onset of pain after work in her right elbow and right shoulder. The applicant initially ignored the pain but when it did not go away went to see her general practitioner, Dr Malak Makarious. Dr Makarious prescribed anti-inflammatories and the applicant reported the matter to her service manager.

17. The pain did not settle over the next few weeks and the applicant was given an ordinary medical certificate by Dr Makarious which she gave to the store manager. The store manager took the applicant off the registers and put her into the self-service checkouts in about July 2018. Dr Makarious eventually advised the applicant to report her injury as a worker's compensation matter.

18. After making a claim, the applicant was referred to Dr Patrick Wong by the respondent who provided her with a certificate of capacity. The applicant reported constant burning pain in her right shoulder and right elbow. Dr Wong diagnosed the applicant with right shoulder musculoligamentous strain and right elbow lateral epicondylitis and referred the applicant to physiotherapy. Liability for the injury was accepted with a deemed date of 15 June 2018.

19. On 11 December 2018 the applicant underwent an x-ray of her right shoulder.

20. In early February 2019, after becoming unhappy with the treatment she was receiving from Dr Wong, the applicant returned to Dr Makarious.

21. On 12 March 2019, the applicant underwent an ultrasound of the right shoulder which showed probable subdeltoid bursitis. Dr Makarious arranged a cortisone injection but it only made the condition worse.

22. At the time liability was declined in March 2019, the applicant was certified fit for full-time hours work with lifting restrictions. The applicant continued to work in the self-serve register area and was able to avoid heavy lifting in accordance with her restrictions. When it was busy the applicant was required to go back on registers.

23. On 4 June 2019, the applicant was referred to orthopaedic surgeon, Dr Samir Viswanathan. On 3 July 2019, the applicant underwent an MRI of the right shoulder which showed a Type II SLAP tear in the glenoid labrum with additional degeneration anteroinferiorly, mild AC joint osteoarthritis and chondrocalcinosis along the glenoid articular cartilage.

24. Dr Viswanathan advised the applicant to undergo surgery on 24 July 2019 and referred her to Dr Chandra Dave whom he considered was better equipped to deal with the type of surgery required. On 12 August 2019, Dr Dave recommended arthroscopic biceps tenotomy/tenodesis and decompression surgery.

25. The applicant said she experienced pain and restriction of movement in both shoulders particularly her right shoulder and right arm. The pain was aggravated by work duties. The applicant had particular difficulty using her right arm above head height to push, pull or lift any items.

Witness evidence

26. The respondent relies on a witness statement prepared by Mr Tim Daley, the applicant's store manager, dated 2 December 2020.

27. Mr Daley confirmed that the applicant commenced employment with the respondent in about 2012 and had worked as a member of the customer service team since then.

28. Mr Daley stated that the applicant was trained in her position via practical and theory-based training, refreshed every 12 months. The training covered safe work practices associated with scanning items and correct use of registers. Mr Daley confirmed the applicant worked a 38 hour week. Mr Daley described the applicant's duties as follows:

> "The Claimant's duties consist of main lane register use involving taking items from conveyor belt and scanning and packing the items into bags and providing them to customers, customer greeting and farewell, working in the assisted checkout area and some cleaning duties. Just prior to the Claimant producing her doctor's certificate, the Claimant was doing online shopping tasks involving pushing a trolley around the floor and collecting peoples shopping."

29. Mr Daley said the company had operating procedures and policies in place to cover the safe operation of the tasks expected to be performed by the applicant. The applicant completed online courses and had observations completed on her on a quarterly basis to ensure she understood the policies and procedures. Mr Daley said:

> "I believe the Claimant was working within normal operating procedures before her injury. My understanding of those are that employees swap from left-hand to right hand scanning every two hours, use two hands to pick up bags and two hands in process of scanning items if required, to leave heavy items in trolley and utilise heavy item lookup button on registers."

30. Mr Daley said he first became aware of the applicant's injury on 11 July 2018 when the applicant presented a standard medical certificate indicating right shoulder tendinitis. Mr Daley said he clearly recalled asking the applicant if this was a work-related injury. The applicant and Mr Daley were in aisle seven walking towards the front of the store at the time. The applicant replied that it was not a work-related injury.

31. Mr Daley was however aware of the applicant's discomfort and to assist her, she ceased pick and collect activities, was instructed not to lift over 5 kg and was removed from the main lane registers. The applicant was appreciative but still suffering shoulder pain.

32. The applicant informed Mr Daley that she was going to make a work injury claim on 25 September 2018. The applicant mentioned that she had exhausted all of her government funded physiotherapy appointments. Mr Daley arranged for the applicant to see Dr Patrick Wong. On 3 October 2018, Mr Daley was notified that Coles had accepted provisional liability for the injury.

33. Mr Daley confirmed that the applicant continued to work full-time and her duties involved greeting and farewelling customers, processing customer items through the registers and observing and assisting customers through the self-service registers.

Treating medical evidence

34. There are in evidence a number of WorkCover certificates of capacity issued by Dr Makarious and Dr Wong as well as the clinical records of Dr Patrick Wong.

35. An initial report from JT Physiotherapy dated 9 October 2018 addressed to Dr Wong noted the following history:

> "She reports started to felt sore on R elbow and R shoulder around June 2018. it getting worse gradually and pain went up to 7/10 on both the R shoulder and R elbow. Symptoms worse when doing repetitive shoulder movement (work at Coles as register). On light duties normal hours now, able to cope. Scan indicate right tennis elbow and right shoulder rotator cuff tendinosis."

36. The applicant was advised to undergo physiotherapy two times weekly focusing on function, stretching and strengthening exercises.

37. An Allied Health Recovery Request report from JT Physiotherapy dated 23 October 2018 described the applicant's current signs and symptoms as:

> "Areas:
> 1. Right shoulder musculo-ligamentous strains
> 2. Right elbow lateral epicondylitis, tennis elbow
> patient report started to felt sore on R elbow and R shoulder around June 2018. reported but nil treatment at that time. it getting worse gradually and pain went up to 7/10 on both R shoulder and R elbow, Sx worse when doing repetitive shoulder movement
> Generalised VAS 6-7/10
>
> Functional Limitations:
> Able to drive for up to 15 mins
> Able to lift both arms up to 5 kgs
> Able to push and pull up to 10 kgs
> Able to perform minimal house chores
>
> Obs: rounded shoulder position,
> AROM:
> R shoulder mvts; 65% of max P1
> R elbow mvts; 70% of max
> Impingement:+ 've right shoulder
>
> Palp:
> TOP right rotator cuff group joint line, stiff and tight upper trap
> IMT ER + IR + weakness"

38. On 11 December 2018, the applicant underwent an x-ray at the right shoulder which detected no bone, joint or soft tissue lesion.

39. A further report from JT Physiotherapy dated 5 February 2019 provided an update as follows:

> "1. Right shoulder musculo-ligamentous strains patient stay at work and increased working hours and duty levels, she report R elbow continue improving with less pain. R shoulder sore and stiff when repetitive using it at work. quite sore, pain around 4-5/10. She is compliant with treatment and exercise given, in general, symptoms is all improving."

40. The report of an ultrasound performed on 12 March 2019 noted a clinical history of work-related rotator cuff tendinitis and recorded:

> "The rotator cuff tendons and the long head of biceps tendon delineate normally. No rotator cuff tear is detected. There is mild thickening of the subdeltoid bursa without basal impingement on abduction. The posterior labrum and humeral head contour appear normal. No glenohumeral joint effusion. The acromioclavicular joint appears normal.
>
> Comment: No rotator cuff tear is detected. Probable subdeltoid bursitis"

41. On 9 April 2019, the applicant underwent an injection to the right subdeltoid bursa under ultrasound. The report for the injection noted a clinical history of bursitis and commented that the subdeltoid bursa appeared 'normal' on preliminary imaging. The injection to the right subdeltoid bursa was well tolerated.

42. Dr Viswanathan prepared a report for Dr Makarious on 4 June 2019 which stated:

> "Thank you for your referral. Rozalia is a 47 year old woman who has had issues with her right shoulder for several months. Her problems essentially started in June last year when she had pain in her right shoulder she doesn't remember a particular injury as such. She works as a cashier for Coles and has been with Coles for the last seven years. She is on some restrictions for her job including not doing any heavy lifting or regular cashier work. She has an ultrasound showing an intact rotator cuff. She has been to see Dr Paul Miniter for a medical legal opinion who didn't think there was any pathology in her shoulder.
>
> In terms of her range of movement she has 180 degrees of forward flexion and abduction, internal rotation to her thoracic spine, external rotation to 90 degrees, good strength in her rotator cuff. She had some mildly positive impingement signs. The ultrasound did show some subacromial bursa impingement so I have suggested doing an MRI to have a look at this. She has had a cortisone injection it is unclear where this cortisone injection was delivered whether it was intraarticular or subacromial so I will review her with the MRI and then take it further. She is otherwise healthy, denies any other major medical issues."

43. The report of the MRI performed on 3 July 2019 found:

> "• No rotator cuff pathology Trace fluid in SNSD bursa, which may be a normal finding or may represent mild bursitis.
>
> • Type II SLAP tear in the glenoid labrum with additional degeneration anteroinferiorly.
>
> • Mild acromioclavicular joint osteoarthritis
>
> • Chondrocalcinosis along the glenoid articular cartilage"

44. On 24 July 2019, Dr Viswanathan reported:

> "Rozalia returned for review with the MRI scan which didn't show any rotator cuff pathology but it did show a SLAP 2 type tear in the glenoid labrum. The biceps tendon appeared to have a normal appearance and she has no joint effusion so sometimes it does need to be fixed perhaps a biceps tenotomy and a biceps tenodesis.
>
> I have referred her on to my colleague Dr Chandra Dave who may be able to help her with this. I perform rotator cuff repairs but intraarticular pathology I often refer on and we will see how she goes with this. I will keep you advised."

45. Dr Dave prepared a report to Dr Viswanathan on 12 August 2019 providing a diagnosis of "biceps anchor lesion, impingement". The report recommended treatment in the form of arthroscopic biceps tenotomy/tenodesis and decompression. Dr Dave reported:

> "She describes pain anterolaterally and worse with her arm in internal rotation and crossing over. Her pain is mainly over the biceps area and her biceps anchor lesion test Speed and Yergason are positive. Obrien's test is positive also.
>
> I have reviewed the MRI scans and they show impingement of the rotator cuff as well as biceps anchor lesion. I agree with your assessment. She probably needs to have a biceps tenotomy and decompression. I will offer this to her. She is still keen on pursuing worker's compensation claim and will get back to me once this has been clarified."

46. Dr Dave prepared a medical report for the applicant's solicitors on 1 May 2020. Dr Dave recorded a history as follows:

> "Rozalia was initially seen by me on referral from my orthopaedic colleague, Dr. Sameer Viswanathan. The history was that she was a 47 year-old right handed lady who worked at the Coles store. Her job involved a significant amount of overhead lifting and repetitive movements on the registers. She initially described her pain around 2018 and subsequently has developed pain in her left shoulder as well."

47. Dr Dave described his findings on examination is set out in his previous reports and findings on MRI. Asked about the relationship between the applicant's condition and employment, Dr Dave stated,

> "She denies any other injuries except those from her work, it is possible for her to have cuff impingement and biceps anchor lesions from the course of her work with repetitive lifting of bulky items."

48. Dr Dave said the treatment he had recommended was necessary to get the applicant pain-free as a result of her repetitive injuries from work.

49. Dr Dave provided an estimate of fees on 11 June 2020 for service items MT800 and MR210 described as

> "SHOULDER, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of"

and

> "TENDON OR LIGAMENT TRANSFER, not being a service to which another Item In this Group applies"

50. In a further report to the applicant's solicitors on 26 August 2020, Dr Dave gave the opinion that on the balance of probabilities the applicant's work had been "a substantial contributing factor" in the applicant's shoulder condition.

Dr Bodel

51. The applicant relies on medicolegal reports prepared by orthopaedic surgeon, Dr James G Bodel dated 18 February 2020 and 16 April 2020.

52. Dr Bodel recorded a history of the applicant working for the respondent since June 2012. Prior to that, the applicant worked for a Franklins store doing similar checkout work. The applicant worked 10 days a fortnight from 9am until 4:30pm or 9am until 5:30pm. On Saturdays the applicant worked from 1pm to 9:30pm.

53. The applicant developed right shoulder girdle pain in about April or May 2018 gradually without specific accident. The pain steadily deteriorated and was eventually reported in June 2018. The applicant was treated with physiotherapy and trialled acupuncture. The applicant eventually had injections of cortisone which were of mild benefit for about a week.

54. An MRI scan done on the right shoulder showed evidence of bursitis and tendinitis and some chondrocalcinosis in the shoulder. Dr Viswanathan referred the applicant to Dr Dave who had offered an arthroscopic subacromial decompression biceps tenodesis.

55. The applicant was back at work doing her normal role but her supervisor was described as "fairly lenient", allowing her to do other duties.

56. Dr Bodel's examination revealed a restricted range of shoulder movement on the right side with a painful arc of movement in that shoulder. There was generalised wasting in the right shoulder girdle and tenderness over the rotator cuff anteriorly.

57. Dr Bodel made a diagnosis of rotator cuff pathology with bursitis and tendinitis in the region of the right shoulder. Dr Bodel said the applicant's pain in the right shoulder occurred as a consequence of the nature and conditions of her work leading up to June 2018.

58. Dr Bodel stated,

> "In this circumstance it is likely that this lady does have a disease process of gradual onset being underlying mild degenerative change in the rotator cuff leading to bursitis and tendinitis. Employment is a substantial contributing factor by way of aggravation to that pathology but is not the cause of it. There is clinical evidence of aggravation, acceleration, exacerbation and deterioration of that disease process."

59. With regard to the proposed surgery, Dr Bodel stated,

> "The surgical intervention as recommended is reasonably necessary for the management of the ongoing injury. She has been trialled on physiotherapy and injections of cortisone which did not help. She is still significantly incapacitated by a painful arc of movement and impingement and the surgery is the appropriate treatment. The need for this arises as a consequence of the injury that occurred at her workplace."

60. Dr Bodel considered the applicant's prognosis was reasonable and there was a very good chance that the surgery proposed would significantly improve the applicant's clinical function.

61. In his supplementary report, Dr Bodel reiterated his opinion that the nature and conditions of the applicant's employment had caused aggravation acceleration exacerbation and deterioration of the disease process at the applicant's shoulder. Dr Bodel commented,

> "Work in general is the main contributing factor to that aggravation, acceleration, exacerbation and deterioration."

Associate Professor Miniter

62. The respondent relies on medicolegal reports prepared by orthopaedic surgeon, Associate Professor Paul Miniter, dated 13 December 2018 and 4 August 2020.

63. In his first report, A/Prof Miniter took a history of the injury as follows:

> "She told me that she had developed pain in the right posterior triangle of the neck sometime in May or perhaps a little before. The nature and conditions of her employment have not changed. She has not had an injury at any time and simply began to develop pain in the posterior triangle radiating onto the upper aspect of the right shoulder. She has had some minor discomfort radiating down toward the right elbow but there have at no stage been symptoms of extensor tenosynovitis or of extensor tendon involvement at the right elbow. About two months ago, she was put onto light duties, taken off registers which is her normal job working full-time for Coles as she does. She told me that this has not made any real difference. She is now working in self-assisted checkouts only."

64. A/Prof Miniter recorded that the applicant had been seeing her general practitioner, receiving physiotherapy and acupuncture. There were no plans for other treatment and the applicant had no need for analgesia.

65. A/Prof Miniter's physical examination revealed no features of any seriousness, no features of impingement and no features of neurological involvement of the right upper extremity.

66. A/Prof Miniter gave the opinion:

> "I could see no evidence of serious pathology here. The complaints that she has have dubious origin and are likely to be a minor non specific musculoskeletal ailment. It is not likely to be associated with her work as the nature and conditions of her employment have not changed. I note that she is currently on significant restrictions which I do believe should be lifted."

67. A/Prof Miniter did not believe that the applicant had a work injury and could see no elements of the applicant's presentation that related specifically to the workplace. The cause of the applicant's symptoms was said to be unknown although it was accepted that the applicant may have some minor musculoskeletal ache.

68. A/Prof Miniter did not consider that any treatment was needed although the applicant was advised to engage in an exercise and fitness program.

69. In his supplementary report, A/Prof Miniter noted the subsequent history including an injection into the shoulder. A/Prof Miniter said

> "I am not certain of the reason for such an injection as she has at no stage had evidence of impingement and the MRI scan that was done in July 2019 was not indicative of any rotator cuff pathology. Suffice to say that she had no benefit from this injection."

70. A/Prof Miniter noted that there was no injury and the applicant was uncertain when her symptoms began. A/Prof Miniter noted that the applicant had been working for the respondent for a number of years but

> "at no stage has she been involved in activities at or above shoulder level. Her current employment is occasionally on registers but in the main has been involved in supervision."

71. A/Prof Miniter recorded his findings on examination:

> "There is a full range of shoulder movement with no evidence of capsulitis. Load applied to the rotator cuff does not reproduce her symptom complex. She has no convincing features of impingement. The tests for a bicipital root lesion are slightly positive and circumduction reproduces her symptom complex. There is no wasting of the infraspinatus and no evidence of a suprascapular nerve palsy clinically."

72. After reviewing the MRI scan of the right shoulder, A/Prof Miniter gave the opinion:

> "At this stage, it is true that she has evidence of a degenerative long head of biceps lesion. This is a degenerative lesion. It is not traumatic and it is not related to repetitive work. I am certain that the appropriate manoeuvre is not operative repair which I understand has been suggested by Dr Davé. The outcome from such surgery in this population is poor and it is possible that she will have no improvement in her symptom complex. If the cyst is symptomatic then aspiration or arthroscopic drainage is appropriate. It is NOT appropriate to consider repair in her age group. If she has persistent symptoms then an arthroscopic drainage of the cyst combined with biceps release is the treatment of choice and most likely to result in a good outcome.
>
> In my opinion, you are not responsible for the management of this lesion. However genuine it may appear, the lesion itself is a degenerative one and is not related to the provision of work."

73. A/Prof Miniter maintained his opinion that there was no work-related injury:

> "In my opinion, the workplace is not contributory. I have given my reasons in the past and I note the fact that she has not had an injury and that she at no stage has been involved in repetitive at or above shoulder activities. I am still of the opinion that the workplace matter is irrelevant."

74. A/ Prof Miniter made a diagnosis as follows:

> "She has a posterosuperior SLAP tear which is consistent with the insertion of the biceps into the upper aspect of the glenoid. This is consistent with her subjective symptoms today but it is different from her interpretation of the matter when I last saw her."

75. A/Prof Miniter considered that the proposed surgery from Dr Dave could be regarded as reasonably necessary but said it was "certainly not related to injury". A/Prof Miniter expressed the view that "surgical outcomes particularly in the workers compensation population are often marginal".

Activity Investigation Report

76. The respondent additionally relies on an Activity Investigation Report prepared by SureFact Australia, dated 4 December 2020. The report indicates that instructions were given to undertake a period of surveillance to establish the current level of activity of the applicant. Surveillance was conducted for a period of 25 hours on 9 November 2020, 19 November 2020, 24 November 2020 and 2 December 2020. The surveillance depicts the applicant driving, shopping, walking towards a vehicle carrying items including a water bottle a key and a handbag in her right arm and at one point reaching behind her neck with her right arm.

Applicant's submissions

77. Mr Perry submitted that the applicant's instructions were that she still wished to undergo the surgery and remained symptomatic in her right shoulder. The applicant had been able to continue to work for the respondent but her duties were restricted in the manner described in her written statement.

78. Mr Perry noted A/Prof Miniter's diagnosis of the applicant's condition in his report of August 2020 was that there was a posterior SLAP tear at the insertion of the biceps into the upper aspect of the glenoid. This diagnosis was consistent with the applicant's symptoms. A/Prof Miniter also gave the opinion that the surgery proposed by Dr Dave could be regarded as reasonably necessary. Mr Perry identified the procedure proposed by Dr Dave was a biceps tenotomy and decompression and submitted that A/Prof Miniter was aware of the procedure proposed.

79. Mr Perry referred to the report of the MRI scan, as well as the reports of Dr Viswanathan and Dr Dave which described a SLAP tear in the glenoid labrum. Dr Dave, a specialist in shoulder surgery reviewed the MRI scan and said it showed impingement in the rotator cuff as well as the biceps anchor lesion.

80. Mr Perry submitted that there was no issue that the surgery was reasonably necessary. The respondent's own medicolegal expert said the procedure proposed by Dr Dave was reasonably necessary. The question for determination was whether the pathology shown in the applicant's shoulder had been aggravated or accelerated by the applicant's work. Mr Perry submitted that the Commission would comfortably come to the conclusion that this question should be answered in the affirmative.

81. Mr Perry referred to the initial reports of right shoulder injury in the context of work in the clinical notes.

82. Dr Bodel had expressed the view that the applicant's work on the checkouts at Coles had aggravated a right shoulder condition and employment was the main contributing factor to an aggravation of the pathology.

83. The applicant's evidence was that her work required a lot of repetitive lifting and use of her arm. The applicant tended to scan most items with her dominant right hand. The type of work performed by the applicant was confirmed by Mr Daley's evidence as involving packing items into bags and providing them to customers.

84. Mr Perry submitted that there was plenty of evidence to support the view given by Dr Bodel and the applicant's general practitioners, as expressed in the certificates of capacity, on the causal link between the applicant's symptoms and her work for the respondent.

85. Referring to A/Prof Miniter's reports, Mr Perry submitted that there was no clear opinion that the applicant's work could not have caused her symptoms. The cause of the applicant's symptoms was described as "unknown" in the first report. In the supplementary report a diagnosis was given consistent with the other evidence. Dr Miniter did not address whether there had been an aggravation of the pathology in the right shoulder consistent with s (4)(b)(ii).

86. With regard to Mr Daley's evidence that the applicant initially denied her symptoms were work-related, Mr Perry submitted that the question of causation was one for a doctor. Mr Perry submitted that there was little value in Mr Daley's evidence on this issue.

87. Mr Perry submitted that the Commission would come to the conclusion that on the balance of probabilities that the work the applicant performed for the respondent had been the main contributing factor to the aggravation and exacerbation of a disease condition in the applicant's right shoulder. That condition had made a material contribution to the need for the surgery proposed by Dr Dave. Accordingly, a declaration would be made within s 60(5) that the surgery was reasonably necessary as a result of injury. Having made that declaration, the respondent would be directed to pay the applicant's reasonable medical and hospital treatment expenses for the right shoulder subject to s 59A.

Respondent's submissions

88. Mr Baker submitted that the applicant's description of her duties did not suggest a contribution from work to her condition. The items were scanned from **a** conveyor belt and placed into a bag below shoulder height. Customarily a checkout operator would push the bag towards the customer who would load the bag into their own trolley. Mr Daley had given evidence that the applicant was trained in safe work practices and safe handling of groceries and bags of groceries. Mr Baker noted that there was no evidence from either the applicant or Mr Daley of the applicant performing work overhead.

89. Mr Baker described it as "extraordinary" that there was no evidence from the applicant's initial treating general practitioner, Dr Makarious in relation to the applicant's case. The evidence suggested that Dr Makarious issued a standard medical certificate rather than a WorkCover certificate. The applicant initially denied that the condition mentioned in the certificate was work-related in response to a direct question from Mr Daley.

90. Mr Baker submitted that the evidence thus indicated that the applicant had become symptomatic in the right shoulder without any relationship to work, obtained a standard medical certificate from her general practitioner and said outright to Mr Daley that the condition was not work-related. Mr Baker submitted that this evidence was significant in considering whether there was a causal relationship between employment and the shoulder condition.

91. Mr Baker noted that Dr Makarious referred the applicant for an ultrasound of her right elbow in August 2018 but there was no evidence of investigations of the right shoulder being requested by Dr Makarious initially.

92. It was not until 25 September 2018 that the applicant informed Mr Daley that she had suffered an injury related to work. On that occasion, the applicant indicated that she was making a WorkCover claim as she had exhausted her government funded entitlement to physiotherapy. No evidence of the treatment received by the applicant or the histories provided to the relevant practitioners prior to that date had been provided to the Commission. At all material times up until 25 September 2018, the applicant made no claim at all in relation to any issue related to her work although the respondent had done its best to assist the applicant. The applicant had been referred by her general practitioner under Medicare rather than workers compensation for physiotherapy. Mr Baker described this circumstance as 'instructive'.

93. The initial history reported to Dr Wong on 26 September 2018 was of a work injury around 15 June 2018 although only reported the previous day. Mr Baker submitted that there was no evidence of a frank injury on 15 June 2018 as suggested by this note.

94. Mr Baker queried why the applicant had started seeing a second general practitioner from 26 September 2018 instead of continuing to see Dr Makarious. Mr Baker submitted that it would create some disquiet that the applicant suddenly ceased to see her usual doctor, Dr Makarious.

95. Mr Baker noted that Dr Viswanathan was first consulted about a year after the applicant asserted the injury had occurred. Dr Viswanathan's examination showed full flexion and abduction and very good internal rotation and strength. Dr Viswanathan had noted that the applicant had undergone an injection but was unsure where.

96. Mr Baker noted that the report of the injection procedure attached to the Reply indicated that the injection was administered to the right subdeltoid bursa and that under ultrasound the subdeltoid bursa appeared normal. Mr Baker submitted that it appeared that by 9 April 2019 the bursitis observed on the initial ultrasound had cleared up.

97. Mr Baker referred to the report of the MRI and said it showed a degenerative condition in addition to the SLAP tear but no rotator cuff pathology. Dr Viswanathan was also certain, having reviewed the films, that there was no rotator cuff pathology and referred the applicant to his colleague Dr Dave.

98. Mr Baker submitted that Dr Dave took an incorrect history in so far as he considered the applicant's injury was initially treated as a worker's compensation matter. Dr Dave also appeared to consider that there was a particular injury in June 2018, which was incorrect. Unlike the radiologist and Dr Viswanathan who was a specialist in rotator cuff repairs, Dr Dave considered that there was impingement in the rotator cuff. Dr Dave also took an incorrect history that the applicant's job involved a significant amount of overhead lifting.

99. Mr Baker compared the ultrasound findings of 3 March 2019 with the findings of the subsequent MRI. On the earlier investigation the only abnormality was some possible bursitis. The only investigation that demonstrated the lesion subsequently referred to by Dr Dave was the MRI.

100. A/Prof Miniter's first report recorded symptoms for the first time in about May 2018. It was noted that the applicant had performed the same work for the respondent for over 12 years but suddenly developed symptoms in 2018. The change in the applicant's duties after reporting her condition did not result in improvement of the condition. A/Prof Miniter's examination showed no features of significance.

101. At the time of A/Prof Miniter's second report the applicant's presentation had changed. A/Prof Miniter took a history of no overhead work in contrast with the history relied on by Dr Dave. A/Prof Miniter considered the applicant had a degenerative condition to which the workplace was non-contributory.

102. Mr Baker submitted that the Commission would prefer the opinion of A/Prof Miniter as it accorded with the findings of the MRI. Although A/Prof Miniter considered the tear could be treated by the surgery proposed by Dr Dave it had nothing to do with employment. The difference between the opinions of A/Prof Miniter and Dr Dave lay in the different histories relied upon.

103. Mr Baker referred also to the reports of Dr Bodel. Mr Baker noted that Dr Bodel found significantly greater restrictions in movement upon examination than A/Prof Miniter, suggesting an improvement in the applicant's condition by the time she saw A/Prof Miniter on the second occasion.

104. Mr Baker noted that Dr Bodel's diagnosis of rotator cuff pathology stood apart from the diagnoses given by every other doctor. Dr Bodel made no reference to the bicipital issue addressed by Dr Dave and Dr Viswanathan. The impingement found by Dr Bodel was not clinically observable by the time of A/Prof Miniter's examination on 4 August 2020. The activity investigation report showed the applicant moving her right arm relatively normally, suggesting the restrictions noted by Dr Bodel had disappeared. Given that presentation, Mr Baker submitted that the Commission would have circumspection around the opinion given by Dr Bodel in support of surgery.
105. In his supplementary report Dr Bodel referred to the presence of degenerative disease and said this had been aggravated by work. Mr Baker suggested however that the history provided to Dr Bodel had been incorrect.

106. Mr Baker referred to the estimate of fees provided by Dr Dave and submitted that the quote added an additional component to the surgery previously proposed in the nature of a rotator cuff repair. Every doctor other than Dr Bodel found no pathology in the rotator cuff to be repaired.

107. Mr Baker submitted that there was a complete lack of proper history in the early parts of the case. There was no evidence from the treating general practitioner who saw the applicant for some considerable period of time prior to Dr Wong being seen. Large slabs of the evidence that would potentially support the applicant's case if they were available were not present. A *Jones v Dunkel* inference should be drawn. Mr Baker submitted that the radiological evidence, which was adopted by A/Prof Miniter, revealed degenerative changes. A wrong history of significant overhead lifting was relied on by Dr Dave and the other doctors had given opinions in support of the applicant's case.

108. Mr Baker submitted that the Commission would not be satisfied on the balance of probabilities that the necessity for surgery resulted from injury in the employment of the respondent.

Applicant's submissions in reply

109. Mr Perry submitted that the respondent's submissions ignored the fact that the applicant continued to work for the respondent and had done so for 12 years. The applicant's evidence was that there was nothing apart from her work for the respondent that could have caused her shoulder to become painful.

110. Mr Perry submitted that the respondent had suggested that the applicant had done something sinister in deciding to make a WorkCover claim after initially denying that her shoulder condition was work-related. Mr Perry submitted that the respondent seemed to invite the Commission to draw an inference from the absence of clinical records from Dr Makarious, that the true cause of the applicant's condition was being concealed. Mr Perry submitted that opinion evidence from Dr Makarious was, however, present in WorkCover certificates issued by Dr Makarious on 8 and 22 March 2019. In those documents it was recorded by Dr Makarious that the applicant had right shoulder tendinitis/bursitis due to repetitive work on checkouts.

111. With regard to the question of overhead lifting, Mr Perry submitted that the applicant was a long serving employee of the respondent. The applicant had said to Dr Dave that her duties included repetitive movements on the registers and a significant amount of overhead lifting. Mr Daley confirmed that prior to the injury the applicant was performing duties collecting shopping from shelves. Not all shelves were below the shoulder level. The applicant was also required to perform cleaning, which was likely to have included work at or above shoulder level. Mr Daley's evidence was also that the applicant packed goods into bags and provided them to customers. The bags would need to be lifted from the location at which they were packed in order to be provided to the customer.

112. Mr Perry submitted that the applicant had not been discredited in any way. The work history was consistent with the nature of the alleged injury. There was no evidence that the applicant had been injured outside work.

FINDINGS AND REASONS

Injury

113. Section 9 of the 1987 Act provides that a worker who has received an "injury" shall receive compensation from the worker's employer. The term "injury" is defined in s 4 of the 1987 Act as follows:

> **"4 Definition of 'injury'**
>
> In this Act:
> **injury:**
>
> (a) means personal injury arising out of or in the course of employment,
>
> (b) includes a disease injury, which means:
>
> (i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and
>
> (ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease, and
>
> (c) does not include (except in the case of a worker employed in or about a mine) a dust disease, as defined by the *Workers' Compensation (Dust Diseases) Act 1942*, or the aggravation, acceleration, exacerbation or deterioration of a dust disease, as so defined."

114. The first issue requiring determination is whether the applicant sustained an injury to her right shoulder in the nature of an aggravation, acceleration, exacerbation or deterioration of a disease process in the right shoulder pursuant to s 4(b)(ii) of the 1987 Act as claimed. It is the applicant who bears the onus of satisfying the Commission on the balance of probabilities that an injury has occurred.

115. As noted by the respondent, a difficulty arises for the applicant in discharging her onus as a result of the lack of contemporaneous medical records from the time the symptoms in her right shoulder were first reported. For reasons which are unexplained, the clinical records of the applicant's treating general practitioner, Dr Makarious are not in evidence. Whilst I accept that this circumstance weighs generally against the applicant's case, it must be considered in the context of the evidence as a whole.

116. A further challenge for the applicant arises from the apparent delay between the onset of symptoms and the identification of a causal relationship between the symptoms and her employment.

117. The undisputed evidence is that the applicant initially obtained a standard medical certificate from Dr Makarious and was referred for physiotherapy through Medicare. Although arrangements were made to accommodate the applicant's condition by the respondent, the evidence of Mr Daley is that the applicant had initially explicitly denied a causal relationship between the condition and the applicant's employment.

118. The respondent suggested that on the evidence before the Commission, neither the applicant nor Dr Makarious initially considered that there was a work injury. The applicant's evidence, however, is that Dr Makarious eventually came to the view that the applicant should make a worker's compensation claim. There is no contemporaneous evidence from Dr Makarious to corroborate the applicant's claim in this regard. The evidence of Mr Daley also raises the possibility that the applicant's claim was prompted by her Medicare funding for physiotherapy treatment running out. I do, however, accept that at least by March 2019, Dr Makarious had concluded that the condition was work-related. This is evidenced by the WorkCover certificates issued by Dr Makarious.

119. I also accept that the delay in the symptoms being linked to employment can reasonably be explained by insidious onset of symptoms without a specific injurious event.

120. The respondent submitted that the change of treating general practitioner from Dr Makarious to Dr Wong in September 2018 was unexplained and would prompt some disquiet. Both the applicant and Mr Daley have, however, given evidence that it was Mr Daley who arranged for the applicant to see Dr Wong once the injury was notified. The applicant claimed that she returned to Dr Makarious after becoming dissatisfied with the treatment received from Dr Wong. I do not, in these circumstances draw any adverse inference from the change in treating practitioner.

121. The early clinical records of Dr Wong are consistent with the applicant's evidence and I am satisfied that a broadly consistent history of the onset of symptoms has been provided by the applicant to the other doctors. Although the respondent's submissions suggested that Dr Wong's record of 26 September 2018 could be interpreted as suggesting a frank injury in June 2018, I am not satisfied in the context of the evidence as a whole that this is a proper interpretation of the clinical note. The initial WorkCover certificate prepared by Dr Wong on the same date describes an "overuse injury R shoulder girdle" said to be related to work by "repetitive scanning and lifting".

122. The reports of the physiotherapist to whom the applicant was referred by Dr Wong confirm that this was the history provided to them and that the applicant's symptoms were worse when doing repetitive shoulder movements at the register. The applicant was, however, able to cope with the lighter duties that had been provided to her.

123. The respondent's submissions also suggested that Dr Dave appeared to be under the wrong impression that there was a specific injury in June 2018. Although the initial letter from Dr Dave to Dr Viswanathan on 12 August 2019 did refer to the applicant hurting her shoulder at work, the subsequent report to the applicant's solicitors makes clear that Dr Dave took a history of repetitive injuries to the shoulder in the course of her work consistently with the other evidence.

124. In all the circumstances, I am satisfied that the applicant has reported a consistent history of a gradual onset of symptoms in around June 2018 without specific injury.

125. A further challenge for the applicant in discharging her onus arises from the difficulty in establishing a diagnosis of the shoulder condition. It appears that early on the matter was treated by Dr Wong and the applicant's physiotherapist as a musculoligamentous strain. An x-ray performed in December 2018 did not reveal any pathology of note.

126. The evidence suggests that the applicant's pain persisted despite physiotherapy and restrictions of movement were noted in the physiotherapist's records. An ultrasound in March 2019 suggested pathology in the nature of the subdeltoid bursitis which was subsequently treated by a cortisone injection. The applicant's evidence was that the injection did not provide any relief. As was noted by the respondent, the report of the injection noted that the subdeltoid bursa appeared normal.

127. It was then that the applicant was referred to Dr Viswanathan and underwent an MRI investigation. The MRI investigation revealed for the first time a Type II SLAP tear in the glenoid labrum with additional degeneration anteroinferiorly. Dr Viswanathan appears to have considered that this was a cause of the applicant's symptoms and may require surgery which his colleague Dr Dave was more qualified to assess involving as it did intra-articular pathology.

128. Dr Dave agreed with the assessment of Dr Viswanathan, diagnosing "biceps anchor lesion, impingement" for which he recommended treatment in the form of arthroscopic biceps tenotomy/tenodesis and decompression. It is this surgery which the applicant seeks to undergo.

129. The respondent's submissions took issue with the diagnosis of rotator cuff impingement by Dr Dave. Dr Dave was not, however, alone in considering impingement to be a cause of the applicant's symptoms. Dr Viswanathan in his report of 4 June 2019 indicated that his examination revealed some mildly positive impingement signs. The ultrasound had also shown some subacromial bursa impingement. It was these indications which prompted Dr Viswanathan to refer the applicant for MRI. Although the MRI was reported to not reveal any rotator cuff pathology it did reveal the Type II SLAP tear.

130. Dr Dave indicated in his report to Dr Viswanathan on 12 August 2019 that he had reviewed the MRI scans himself and formed the opinion that they did show impingement of the rotator cuff as well as the biceps anchor lesion. Dr Dave performed a number of tests including a Hawkins test which was positive for impingement.

131. In his report to the applicant's solicitors on 1 May 2020, Dr Dave maintained the dual diagnosis and said it was possible that both the impingement and the biceps anchor lesion were caused by the applicant's work with repetitive lifting of bulky items.

132. The respondent has submitted that the Commission would not accord weight to the opinion on causation given by Dr Dave as it was based on an incorrect factual history of the applicant performing a significant amount of overhead lifting in her work. This was described in the opening paragraphs of the report of 1 May 2020.

133. I accept that the applicant has not in her statement, nor has Mr Daley in his statement, described a significant amount of overhead lifting in the applicant's duties. Mr Perry has invited the Commission to infer that overhead work would have been performed in the course of the applicant's cleaning and online shopping tasks. While this may have been the case on occasion, I am not persuaded on the evidence that overhead lifting formed a "significant" part of the applicant's duties.

134. I do, however, accept on the evidence from the applicant and Mr Daley that the applicant's work did involve repetitive lifting below shoulder height. I accept that the applicant was prior to the injury required to repetitively lift items from a conveyor belt, scan them and lift them into shopping bags. The evidence of Mr Daley is that shopping bags were then "provided to" customers.

135. I do accept that there is some uncertainty as to the manner in which bags were "provided to" customers. The respondent has submitted that bags would have been pushed towards the customer. It is certainly common practice in many supermarkets that bags are placed in a caddy from which they are removed by customers themselves. I would be prepared to accept, however, that the applicant may also have lifted bags of items in order to provide them to customers.

136. In these circumstances, while Dr Dave's history of the applicant's work duties appears to be partially inaccurate, he was clearly aware that the applicant worked at the registers at a Coles store. Dr Dave has also based his opinion on the performance repetitive movements on the registers and the repetitive lifting of bulky items, which I accept did form part of the

applicant's duties. It was the latter duties, not overhead lifting, to which Dr Dave referred in his direct response to the solicitor's question on causation. I am satisfied therefore, that there remains a fair climate for the acceptance of his opinion.

137. I am not satisfied that there is a material inaccuracy in Dr Dave's history in so far as he referred the applicant's injury initially being treated as a worker's compensation matter. Liability to pay medical expenses was initially accepted by the insurer once the claim was made. I am satisfied that this is what Dr Dave was referring to.

138. In considering the weight to be afforded to Dr Dave's opinion it is relevant to consider the medicolegal opinion of Dr Bodel. Dr Bodel has given the opinion that the nature and conditions of the applicant's employment had caused an aggravation of degenerative pathology in the applicant's shoulder causing bursitis and tendinitis. Dr Bodel's report does not expressly deal with the Type II SLAP tear or lesion described by Dr Viswanathan, Dr Dave and later A/Prof Miniter. I am not persuaded, therefore that Dr Bodel has given a clear opinion on the causation of the precise condition for which surgery is proposed. The report is of limited assistance as a result.

139. It is also necessary to consider the opinions given by A/Prof Miniter. A/Prof Miniter's initial report was prepared prior to the ultrasound and MRI investigations and referrals to Dr Viswanathan and Dr Dave. A/Prof Miniter found no features of impingement on examination or any other evidence of serious pathology. A/Prof Miniter concluded that there was likely to be a minor non-specific musculoskeletal ailment.

140. A/Prof Miniter's supplementary report was prepared several months later, after the further investigations, including the MRI showing a Type II SLAP tear. A/Prof Miniter did not on that occasion find "convincing" evidence of impingement but did accept that the applicant's symptoms were consistent with the tear or lesion shown on the MRI. A/Prof Miniter commented that the applicant's subjective symptoms on the second occasion were "different from her interpretation of the matter when I last saw her".

141. The meaning behind this comment is, in my opinion, difficult to discern. A/Prof Miniter accepted that the applicant's symptoms were consistent with pathology revealed on the MRI scan. This does not suggest that the symptoms were purely subjective but in fact had an objective foundation. That the applicant's interpretation of her injury would have changed from the time of the initial examination can reasonably be explained by reference to the persisting symptoms, further treatment and further investigation undertaken in the intervening period.

142. A/Prof Miniter also appears to accept that the surgery proposed by Dr Dave is reasonable treatment for the pathology shown on the applicant's MRI scan although he did not consider the pathology to be work-related nor did he appear to consider the surgery to be reasonably necessary in the applicant's case by reference to his view that workers compensation patients often have marginal surgical outcomes.

143. With regard to the causation question, A/Prof Miniter relied on the absence of work at or above shoulder height. Whilst I accept this as accurate, it does not appear that A/Prof Miniter has expressly considered the repetitive movements and lifting that was performed by the applicant in her work on the registers. In fact, A/Prof Miniter appears to have been under the misapprehension that the applicant's work was mostly supervisory. This appears to be a reference to the duties performed in the self service area to which the applicant was assigned after she reported her shoulder condition. Both the applicant and Mr Daley confirmed that the applicant was, prior to her condition, predominantly working on the registers. I am not satisfied, therefore, that A/Prof Miniter has given full and proper consideration to the nature of the work actually performed by the applicant prior to the onset of symptoms.

144. Mr Perry has also submitted that A/Prof Miniter has not considered whether the pathology shown on the MRI could have been aggravated by the applicant's work. Instead the focus of his opinion has been on whether the pathology itself was caused by the applicant's work. I accept that this is a fair assessment of A/Prof Miniter's reports.

145. The foregoing assessment reveals that the medicolegal opinions from both Dr Bodel and A/Prof Miniter are problematic in different regards. There is, however, a consistent opinion expressed by Dr Viswanathan and Dr Dave, the applicant's two treating specialists, as to diagnosis. Dr Dave's opinion on causation is somewhat problematic because of the inaccuracy in the history recorded by him. Dr Dave's opinion is, however, broadly consistent with the opinions discernible on the face of the WorkCover certificates issued by Dr Wong and Dr Makarious that the repetitive work on the registers was causative of the applicant's symptoms. It is also broadly consistent with Dr Bodel's opinion on causation, although I am not persuaded that Dr Bodel was considering the exact same diagnosis. The applicant has consistently reported a worsening of symptoms with repetitive work at the registers and was right hand dominant.

146. Considering the evidence as a whole and notwithstanding the deficiencies in the evidence identified above, I feel a sense of actual persuasion that the duties performed by the applicant in the course of her employment with the respondent were the main contributing factor to the conditions diagnosed by Dr Dave and Dr Viswanathan.

147. Dr Dave has not explicitly addressed whether the conditions constitute a disease or an aggravation of a disease. Having regard to the evidence as a whole, including Dr Bodel's report to the extent that it is relevant, I am satisfied on the balance of probabilities that the right shoulder conditions constitute an injury in accordance with s 4(b)(ii) of the 1987 Act.

Whether the proposed surgery is reasonably necessary as a result of the injury

148. Section 60 of the 1987 Act relevantly provides:

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

149. In *Diab v NRMA Ltd*[1] Roche DP, referring to the decision in *Rose v Health Commission (NSW)*[2], set out the test for determining if medical treatment is reasonably necessary as a result of a work injury:

> "The standard test adopted in determining if medical treatment is reasonably necessary as a result of a work injury is that stated by Burke CCJ in *Rose v Health Commission (NSW)* [1986] NSWCC 2; (1986) 2 NSWCCR 32 (*Rose*) where his Honour said, at 48A—C:
> …
>
> 3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of injury.

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

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.'"

150. The Deputy President also noted that the Commission has generally referred to and applied the decision of Burke CCJ in *Bartolo v Western Sydney Area Health Service*[3]:

> "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."

151. Deputy President Roche found:

> "In the context of s 60, the relevant matters, according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ at point (5) in *Rose* (see [76] above), namely:
>
> (a) the appropriateness of the particular treatment;
> (b) the availability of alternative treatment, and its potential effectiveness;
> (c) the cost of the treatment;
> (d) the actual or potential effectiveness of the treatment, and
> (e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective.
>
> With respect to point (d), it should be noted that while the effectiveness of the treatment is relevant to whether the treatment was reasonably necessary, it is certainly not determinative. The evidence may show that the same outcome could be achieved by a different treatment, but at a much lower cost. Similarly, bearing in mind that all treatment, especially surgery, carries a risk of a less than ideal result, a poor outcome does not necessarily mean that the treatment was not reasonably necessary. As always, each case will depend on its facts."

152. With the exception of the supplementary report of A/Prof Miniter there is a consistency of opinion that the surgery proposed by Dr Dave is reasonably necessary treatment for the applicant's injury. A/Prof Miniter's contrary opinion appears to be based, in part, on his view that there was not a work-related injury. For the reasons given above, I have not accepted that opinion.

153. A/Prof Miniter also appears to have accepted that the treatment may generally speaking be reasonably necessary treatment for the pathology revealed on the MRI. He did not, however, consider the treatment to be reasonable treatment for the applicant, apparently because of her status as a worker's compensation claimant. I am not satisfied that this opinion constitutes a sufficient basis for the rejection of the opinions consistently given by Dr Viswanathan, Dr Dave and Dr Bodel.

[3] [1997] NSWCC 1; 14 NSWCCR 233.

154. The surveillance material lodged by the respondent raises questions as to whether there may have been an improvement in the applicant's condition such that the surgery proposed by Dr Dave in August 2019 may no longer be reasonably necessary. I accept that the surveillance material does show the applicant moving her right arm above shoulder height on at least one occasion. As noted by the respondent, A/Prof Miniter's examination of the applicant in August 2020 also appeared to show greater range of movement compared to the examination recorded by Dr Bodel in February 2020.

155. There is, however, no medical opinion to suggest that there has been an improvement in the symptoms, particularly those associated with the biceps anchor lesion, so as to render the surgery proposed by Dr Dave no longer reasonably necessary. Mr Perry confirmed that it was his instructions that the shoulder remained symptomatic and that the applicant still wished to undergo the surgery that had been recommended to her by Dr Viswanathan and Dr Dave.

156. An issue was also raised by the respondent's submissions at hearing as to the nature of the surgery being proposed having regard to the surgical quote provided by Dr Dave. The quote refers to the surgical item numbers. Item number MT 800 describes shoulder reconstruction or repair "including" but not limited to repair of the rotator cuff. The surgery that is proposed has at all times been described as an arthroscopic biceps tenotomy/tenodesis and decompression.

157. I am satisfied on all the evidence that an arthroscopic biceps tenotomy/tenodesis and decompression surgery, as proposed, is reasonably necessary as a result of the injury found by me above.

Entitlement to s 60 expenses

158. Section 59A of the 1987 Act sets a limit on the period in which compensation for medical and related treatment expenses is payable to an injured worker. Section 59A relevantly provides:

> **"59A Limit on payment of compensation**
>
> (1) Compensation is not payable to an injured worker under this Division in respect of any treatment, service or assistance given or provided after the expiry of the compensation period in respect of the injured worker.
>
> (2) The compensation period in respect of an injured worker is—
>
> (a) if the injury has resulted in a degree of permanent impairment assessed as provided by section 65 to be 10% or less, or the degree of permanent impairment has not been assessed as provided by that section, the period of 2 years commencing on—
>
> (i) the day on which the claim for compensation in respect of the injury was first made (if weekly payments of compensation are not or have not been paid or payable to the worker), or
>
> (ii) the day on which weekly payments of compensation cease to be payable to the worker (if weekly payments of compensation are or have been paid or payable to the worker), or
>
> (b) if the injury has resulted in a degree of permanent impairment assessed as provided by section 65 to be more than 10% but not more than 20%, the period of 5 years commencing on—

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

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

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

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

159. The applicant has continued to work full hours for the respondent notwithstanding her injury. The applicant was provided with light duties when she reported her shoulder symptoms and, consistently with the evidence of Mr Daley, it appears she has continued to be allowed to perform duties which accommodate her shoulder condition. As a result, there is no evidence before me that the applicant has claimed or been paid weekly compensation.

160. No assessment of the degree of permanent impairment has been performed.

161. In these circumstances, s 59A(1) provides that compensation under s 60 is not payable to the applicant after the two-year period commencing on the day on which the claim for compensation in respect of the injury was first made. The date of claim appears to have been 25 or 26 September 2018, meaning the 2-year period would have ceased on 25 or 26 September 2020.

162. As a result, both parties accept that the Commission currently lacks power to order the respondent to pay the costs of and incidental to the surgery proposed by Dr Dave. Such compensation may later become payable if weekly compensation becomes payable to the applicant as a result of a period of incapacity following the performance of such surgery.

163. For present purposes, there will only be an order for the respondent to pay the applicant's incurred s 60 expenses in respect of the right shoulder injury subject to the operation of s 59A(1) of the 1987 Act.

SUMMARY

164. The applicant sustained an injury to her right shoulder in the nature of a biceps anchor lesion and impingement as a result of the nature and conditions of her employment with the respondent pursuant to s 4(b)(ii) of the 1987 Act.

165. Employment with the respondent was the main contributing factor to the injury.

166. The arthroscopic biceps tenotomy/tenodesis and decompression surgery proposed by Dr Chandra Dave is reasonably necessary as a result of the injury.

167. Pursuant to s 60 of the 1987 Act, the respondent to pay the applicant's reasonably necessary expenses resulting from the injury upon production of accounts, receipts and/or valid Medicare Notice of Charge, subject to s 59A of the 1987 Act.