WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **1060/19**
Applicant: **MOHAMED AL NAJJAR**
Respondent: **DIRECT FREIGHT (AUST) PTY LIMITED**
Date of Determination: **8 May 2020**
Citation: **[2020] NSWWCC 144**

The Commission determines:

1. The need for the applicant's cervical spine surgery proposed by Dr Darwish, comprising C4/C5 and C5/C6 anterior cervical discectomy and fusion and decompression of both C5 and C6 nerve roots, results from the work injury on 10 December 2015.

2. Respondent to pay the applicant's section 60 of the *Workers Compensation Act 1987* expenses and associated costs of the above surgery proposed by Dr Darwish.

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

Ross Bell
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 ROSS BELL, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. This Application to Resolve a Dispute (the Application) registered on 26 February 2020 is in respect of injury on 10 December 2015. The respondent insurer denied the claim in a Notice issued under s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act) dated 28 May 2018. The Application is for section 60 of the *Workers Compensation Act 1987* (1987 Act) medical expenses in respect of two-level discectomy and cervical fusion proposed by Dr Darwish.

2. Previous proceedings in relation to this injury were before the Commission in Matter 6219/16 and determined by a Certificate of Determination dated 9 May 2017 with Statement of Reasons. These proceedings were in respect of the same injury on 10 December 2015, when Mr Al Najjar (the applicant) was working as a truck driver for Direct Freight (Aust) Pty Ltd (the respondent). He suffered injury when a "pallet corner" fell from the back of the truck onto his neck and right shoulder region. Mr Al Najjar states that he felt immediate pain in the neck and right shoulder, feeling dizzy, and sat next to the truck for twenty minutes, after which he reported the injury to his employer, and took pain medication. Although Mr Al Najjar returned to work the following day continuing pain saw him consult his general practitioner, Dr Parveen.

ISSUES FOR DETERMINATION

3. The following issues remain in dispute:

    (a) Does the need for cervical surgery as proposed by Dr Darwish, result from the injury on 30 December 2015?

    (b) Is the proposed surgery reasonably necessary for the compensable injury?

PROCEDURE BEFORE THE COMMISSION

4. The parties attended a conciliation conference and arbitration hearing on 20 April 2020. 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

Oral evidence

5. There was no oral evidence adduced.

Documentary evidence

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

    (a) Application to Resolve a Dispute with annexed documents.
    (b) Reply with annexed documents.
    (c) Certificate of Determination and Statement of Reasons issued on 9 May 2017 in matter 6219/16.

SUBMISSIONS

7. The representatives made oral submissions at the arbitration hearing. I have taken the submissions into account, and they are referred to in the discussion below.

Does the need for the cervical surgery proposed by Dr Darwish result from the work injury on 10 December 2015?

Evidence

8. The previous determination of Arbitrator Batchelor includes findings in relation to the incident of 10 December 2015 at paragraphs 63-68. These include:

    (a) the "pallet corner" fell on Mr Al Najjar in the region of his right shoulder and neck;

    (b) Mr Al Najjar suffered injury to his cervical spine in the incident, in the form of the aggravation of a pre-existing degenerative condition of the cervical spine;

    (c) the evidence was insufficient to establish that this aggravation caused the disc protrusion at C4/5 level, and

    (d) the employment was a substantial contributing factor to the injury to the cervical spine.

9. There was no submisison that these findings can or should be reagitated or reconsidered. It is apparent that the issue in these proceedings is not injury but whether the need for surgery results from the injury as found by Arbitrator Batchelor.

10. The past medical history for the neck is that Mr Al Najjar had a problem in the late 1990s (possibly from 1997 or 1999) which seems to have been considered a soft tissue problem, and which was noted by the Arbitrator as "not major". The last clinical note referring to the neck prior to the injury of December 2015 appears to have been in January 2004.

11. Arbitrator Batchelor referred to the symptoms in the neck as reported and treated from the time of injury on 10 December 2015 up to his Determination. In his statement of 12 September 2018 Mr Al Najjar takes the history of the injury beyond the time of the previous Certificate of Determination. He states that his symptoms had not improved and he returned to his doctor who issued him with a WorkCover Medical Certificate with restrictions under which he continued to work. He says he worked with pain, and was referred for physiotherapy, an MRI of the neck, and further neurosurgical opinion. As reported by Dr Bentivoglio, the MRI of 2 December 2017 showed disc bulges between C3 and C6.

12. Mr Al Najjar was referred to Professor Mark Sheridan for a second opinion. He was then referred to Dr Balsam Darwish, neurosurgeon, who after review recommended C4/5 and C5/6 anterior cervical discectomy and fusion with decompression of both C6 nerve roots.

13. Mr Al Najjar was then referred to Dr Bentivoglio, neurosurgeon, who confirmed the need for fusion at both C4/5 and C5/6 levels.

14. Mr Al Najjar reports that he has, "ongoing bilateral neck pain going down into both arms with numbness in all of my fingers. Neck movements are painful. I experience ongoing dizziness and headaches."

15. Dr Bentivoglio takes the history of the injury in his report of 8 August 2018 including the object falling onto Mr Al Najjar's neck and shoulder. He notes that in 2016 Dr Darwish had recommended C4/5 anterior cervical discectomy and fusion, but that the MRI of 2 December 2017 revealed the C4/5 disc bulge with cord compression, and disc changes at C5/6 with foraminal narrowing bilaterally with C6 nerve root compression. Dr Bentivoglio felt that by that stage the neck condition had not stabilised and that the "degenerative disease in his cervical spine and disc bulges is something that will slowly, but surely progress". Dr Bentivoglio was not then aware of what surgical intervention was being considered by Dr Darwish, but he considered that either a two level fusion at C4/5 and C5/6, or fusion at C5/6 and disc arthroplasty at C4/5.

16. Dr Bentivoglio notes, under "Your opinion as to causation", the history that all of the neck symptoms came on after the incident in December 2015 and that the "symptoms have been slowly but surely deteriorating as he had not had much in the way of treatment over the last two years."

17. In his "Supplementary Report" of 30 September 2019 Dr Bentivoglio explains that Mr Al Najjar has significant cord compression at the C4/5 level and bilateral foraminal narrowing at C5/6 which are the cause of the symptoms in the neck and arms. He notes that the symptoms in the neck and arms have continued since the December 2015 incident, and is of the view that the cause was the aggravation or exacerbation of pre-existing degenerative disease, which is also results in the need for the fusion at the C4/5 and C5/6 levels.

18. Dr Sheridan, to whom Mr Al Najjar was referred for a second opinion, notes in his short report of 23 February 2018 the injury, the MRI of 2 December 2017, and the symptoms in the neck and arms which he says are consistent with the MRI. He says that what he thought had been proposed; that is, fusion at C5/6, was reasonable, and was the result of the work injury.

19. Dr Darwish was of the view that the injury caused the disc protrusion at C4/5, contrary to the Arbitrator's finding that it did not, but Dr Darwish does record that the neck and arm symptoms developed after the December 2015 work injury. His opinion is that the work injury is either the direct cause of the symptoms or at least the major aggravating factor to a pre-existing condition which has since remained symptomatic. He says his proposed surgery is reasonably necessary, with 80% chance of improving the arm symptoms and 50% chance of significantly improving the neck pain.

20. The respondent relies on Dr Carney's report of 6 March 2019. Dr Carney notes the MRI of 2 December 2017, which he says showed some protrusion of the C4/5 disc in the presence of degenerative change and mild ossification of the postrerior longitudinal ligament (OPLL) between C3 and C6. Dr Carney says, "There is no significant cord or root compression." He is of the view that the MRI does not explain the symptoms and disability of numbness and weakness in the arms.

21. Dr Carney considers there were non-organic features in Mr AL Najjar's presentation and he found no myelopathy or radiculopathy on examination. He sees the MRI as showing long-standing degenerative changes, but no basis for the symptoms which he says are complicated by psychological features.

22. Dr Carney's diagnosis is, "... cervical spondylosis of longstanding and there is no evidence he suffered a significant disc injury in the subject accident of 10.12.2015. Also, his presentation at the moment is largely non-organic."

23. As to treatment Dr Carney considered there was no need for treatment at that time, although he did say that if a further MRI indicated increasing cord compression then surgery may be indicated "because of the risk of cervical myelopathy related to disc degeneration of OPLL." He says such surgery would not be reasonably necessary as a result of the work injury.

24. The MRI reported by Dr Niranjan Ganeshan on 2 December 2017 notes the OPLL between C3 and C5 [sic; 6?] and reports at C3/4, “Posterior disc bulge. Foraminal stenosis on the left with C4 root compression and minimal cord flattening.” At C4/5, “Posterior annulus tear and posterocentral disc protrusion with mild cord compression. No nerve root compression.” At C5/6, “Broad based posterior disc bulge with minimal cord flattening. Foraminal stenosis bilaterally with potentially C6 root compression.”

Discussion

25. In the familiar case of *Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452 the Court said, “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. … What is required is a commonsense evaluation of the causal chain.”

26. It has been indicated by the High Court since that the “commonsense” concept does not operate at large. All the evidence must be considered, with the onus of proof on the applicant throughout.[1]

27. Roche DP in *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49, noted the established authority[2] that there may be multiple causes of an injury, and also emphasised that the test with medical expenses is whether the injury was a “material contribution” to the need for the claimed treatment.

28. The respondent points to the evidence that the original surgery proposed was to be at only the C4/5 disc level but is now proposed for both C4/5 and C5/6 levels. It is also submitted as significent that before the surgery proposed changed to include the C5/6 level Mr Al Najjar has worked for another employer.

29. The respondent does not point to any evidence of further problems with the neck arising from subsequent employment, and there is no such evidence to break the clain of causation from the time of the aggravation on 10 December 2015. Dr Bentivoglio, in his report of 30 September 2019, refers to Mr Al Najjar coping with work as a tip truck driver.

30. Dr Bentivoglio addresses the progress of the neck condition in his report of 8 August 2018, saying that following the incident of aggravation that the “symptoms have been slowly but surely deteriorating”. In his report of 30 September 2019 Dr Bentivoglio says that the condition of the neck will progress and cause neurological compromise. He goes on to explain the original intention of Dr Darwish for C4/5 anterior cervical discectomy and fusion in 2016 has been amended by the further symptoms and changes seen in the MRI of 2 December 2017, including cord compression at C4/5 and changes at C5/6 of bilateral foraminal narrowing with bilateral C6 nerve compression. This is why Dr Bentivoglio sees both levels as being properly involved in the surgery, as does Dr Darwish.

31. The respondent submits that while both Dr Bentivoglio and Dr Darwish find cord compression at various levels the MRI report says there is no evidence of compression, and Dr Carney says there is no significant compression. Dr Carney mentions OPLL from C3 to C6 and is the only one to note this. Dr Carney, it is submitted, also finds only minor symptoms. This is inconsistent with the history of developing symptoms since the incident. That Mr Al Najjar has degenerative changes in the neck as recognised by Dr Carney is not controversial.

32. I note that the MRI report of 2 December 2017 records root compression at C3/4; mild cord compression at C4/5; and “minimal cord flattening” from the bulging disc at that level. The report also says in relation to the C5/6 level, “Foraminal stenosis bilaterally with potentially C6 root compression.”

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[1] *March v Stramare (E & M H) Pty Limited* [1991] HCA 12; (1991) 171 CLR 506; *Flounders v Millar* [2007] NSWCA 238.

[2] See *Comcare v Martin* [2016] HCA 43.

33. The respondent submits that the denial of liability is based on Dr Bentivoglio's finding that there was no radiculopathy or myelopathy and there is no explanation as to why there is a need for surgery involving the C5/6 level after the applicant had left the employment with the respondent. As noted, there is no evidence of any issues with the neck due to subsequent employment, and Dr Bentivoglio's view that the symptoms in the arms were non-dermatomal in nature do not negate his view that the proposed surgery is necessary as a result of the work aggravation. Dr Darwish in his report of 19 April 2018 considers the December 2017 MRI report of potential compression of both C6 nerve roots, "Over the last two years Mohamed developed pain and paraesthesia in both forearms in the distribution of both C6 dermatomes."

34. It seems to me that in the MRI report description, "Foraminal stenosis bilaterally with potentially C6 root compression" the use of the term "potentially" is likely to have been directed at the specialist for clinical examination to confirm or otherwise any nerve root compression.

35. The respondent's submisison that there is insufficient explanation for the involvement of the C5/6 level cannot be accepted, as the medical reports of Dr Darwish, Dr Bentivoglio, and to a lesser extent Dr Sheridan, explain this. It must also be remembered that the MRI of February 2016 revealed degenerative changes throughout the cervical spine,

> "C3-4 level.
> Low to moderate grade central canal stenosis by posterior soft disc bulging nudging the anterior cord.
> Minor neurocentral joint osteophytes left more than right with likely contact of the exiting left C4 nerve root and to a lesser extent on the tight.
>
> C4-5 level.
> Central posterior soft disc protrusion causes moderate to high grade central canal stenosis and altering of the shape of the cord with no altered signal ot syrinx.
> Neural foraminal stenosis bilaterally likely contacts the exiting ·C5 nerve roots.
>
> C5-6 level.
> Broad posterior soft disc bulging. Neurocentral joint osteophytes right more than left with likely compromise of the exiting right and to a lesser extent left neural foramina.
> Low to moderate grade central canal stenosis and apparent relative uniform attenuation of the cord but no abnormal signal or syrinx.
>
> C6-7 level.
> Reduction of disc height and hydration. Shallow posterior disc displacement. Low grade right neural foraminal stenosis, No left neural foraminal stenosis. No central canal stenosis."

36. This is the pathology that was before the Arbitrator for the determination of injury. It was the degenerative pathology noted in the medical reports for those proceedings, and the finding was, "aggravation of a pre-existing degenerative condition of the cervical spine". The Arbitrator also found that there was insufficient evidence to find that the aggravation of the degenerative changes in the incidnet included the disc bulge at C4/5.

37. It is clear from the subsequent evidence including the worsening symptoms and the MRI of December 2017 that Dr Bentivoglio's prognosis that the symptoms would worsen proved to be correct. The respondent's submission that the applicant is attempting an "extension" of the original injury from C4/5 to include the C5/6 level cannot be correct when the degenerative changes in the cervical spine were found to have been aggravated in the incident of injury, and those degenerative changes included the C5/6 level in the first place.

38. Dr Sheridan's short report is of assistance for his reading of the December 2017 MRI even though Dr Sheridan was under the impression that Dr Darwish was proposing discectomy and fusion just at C5/6. Dr Sheridan's report pre-dates Dr Darwish's report of 19 April 2018 in which discusses the new MRI and this probably explains Dr Sheridan's confusion. Before the MRI Dr Darwish had been proposing fusion at C4/5, but when looking at the MRI Dr Sheridan likely assumed the level was to be C5/6. Nevertheless, Dr Sheridan was of the view that the symptoms of paraesthesia and numbness were consistent with the MRI showing what he considered nerve compression at C5/6.

39. In his report of 20 May 2019 Dr Darwish has expressed his opinion in the light of the correct weight of the object that fell on Mr Al Najjar. His opinion is that the incident in December 2015 caused the disc protrusion at C4/5, and while this is contrary to the finding of the Arbitrator in the previous proceedings, this is not the issue to be determined here, and his opinion as treating specialist on the issue of the work aggravation to the degenerative changes is consistent wih that of Dr Bentivoglio.

40. Although Dr Bentivoglio did not consider myelopathy or radiculopathy to be present, by the time of the report of 8 August 2018 he noted the December 2017 MRI and recorded "increasing neck pain, going into his right and left shoulder. He has also noticed numbness in his arms and hands in a non-dermatomal distribution. He feels both arms are weak, right side worse than the left."

41. From all of the evidence I find that Dr Bentivoglio's opinion together with that of Dr Darwish are the more compelling on the issue to be determined. Dr Carney does not consider the work incident to have been sufficient to cause the C4/5 disc bulge but he does not address the issue of work aggravation of the degenerative changes he notes in the neck. The MRI of 2 December 2018 revealed progression of the neck condition following the aggravation of degenerative changes on 10 December 2015, which in turn has made necessary the inclusion of the C5/6 level in the proposed surgical treatment. That the disc bulge at C4/5 was not caused by the incident of injury is not of any great significance. It is the history of symptoms and deceloping pathology following the aggravation to the neck caused by the "pallet corner" falling on Mr Al Njjar that tells the story.

42. There is no evidence of any intervening event after the aggravation on 10 December 2015 to break the chain of causation. As discussed above, there is nothing to suggest any injury in subsequent employment.

43. The evidence establishes that the injury on 10 December 2015 was a material contribution to the need for the surgery now proposed by Dr Darwish; the need for the surgery results from the injury.

44. For these reasons I find that the surgery proposed by Dr Darwish of *C4/C5 and C5/C6 anterior cervical discectomy and fusion and decompression of both C5 and C6 nerve roots* is reasonably necessary for the compensable injury of the aggravation, acceleration, exacerbation or deterioration of degenerative changes in the cervical spine on 10 December 2015.

Is the surgery proposed by Dr Darwish reasonably necessary?

45. The parties did not extensively submit on whether the surgery is itself reasonably necessary, but there is some overlap between the issues as presented by the parties, so it should be considered separately.

46. I also prefer Dr Bentivoglio and Dr Darwish on this issue to the opinion of Dr Carney as I do generally. On this issue Dr Carney does allow that, "If he has an up-to-date MRI scan which indicates increasing cord compression then he may be a candidate for surgical intervention in the future." My view is that the evidence is already of compression causing symptoms.

47. In terms of the relevant authorities[3] the proposed treatment is appropriate, as it is directed at the source of neck and arm pain and associated symptoms present since the aggravation, which have gradually worsened. Conservative treatment has not achieved improvement. Dr Darwish as treating surgeon is of the view that the procedure has 80% chance of improving the arm symptoms and 50% chance of significantly improving the neck pain.

48. The procedure is one well known and accepted by the medical profession. As to effectiveness, the objective is to reduce pain, increase mobility and prevent deterioration. It is surgery that, in terms of *Rose*, should not be forborne by Mr Al Najjar.

49. It follows from the above findings that Mr Al Najjar is entitled to s 60 of the 1987 Act expenses associated with the surgery proposed by Dr Darwish.

SUMMARY

50. The need for the surgery proposed by Dr Darwish results from the injury in the course of Mr Al Najjar's employment with the respondent on 10 December 2015; and the surgery proposed is reasonably necessary for the compensable injury.

[3] *Rose v Health Commission (NSW)* [1986] NSWCC 2 (*Rose*); *Diab v NRMA Ltd* [2014] NSWWCCPD 72; and *Pelama Pty Ltd v Blake* [1988] NSWCC 6.