WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **6053/20**
Applicant: **Frank Rodriguez**
Respondent: **Randwick City Council**
Date of Determination: **4 February 2021**
Citation No: **[2021] NSWWCC 38**

The Commission determines:

1. The application for a declaration pursuant to section 60(5) of the *Workers Compensation Act* 1987 that the proposed right total knee replacement constitutes reasonably necessary treatment in respect of injury to the right knee on 18 July 2017 is declined.

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

W Dalley
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 WILLIAM DALLEY, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Frank Rodriguez, suffered an injury to his right knee in the course of his employment with the respondent, the Randwick City Council, on 18 July 2017 (the subject injury). Mr Rodriguez suffered severe pain with swelling of the knee. Liability for the injury was accepted by the workers compensation insurer.

2. Mr Rodriguez was referred by his treating general practitioner to an orthopaedic surgeon, Dr David Broe, who carried out an arthroscopic repair in October 2017. Mr Rodriguez continued to have painful symptoms in the right knee. He moved to Western Australia shortly after the arthroscopy and treatment of his right knee was taken over by another orthopaedic surgeon, Dr Lam.

3. Dr Lam performed a right high tibial osteotomy but Mr Rodriguez continued to suffer pain and swelling. He developed wasting of his quadriceps and calf muscles despite physiotherapy. He continued to consult Dr Lam with painful symptoms. In December 2018 Dr Lam operated to remove the high tibial osteotomy fixation and replaced it with an alternative plate.

4. By March 2019, Dr Lam was proposing a graduated return to work by Mr Rodriguez in a less physical role, however Mr Rodriguez continued to suffer pain and sought a second opinion from a further orthopaedic surgeon, Dr Leys. In June 2019 Dr Leys recommended a pain management review to help reduce the symptoms. In June 2020 Mr Rodriguez commenced a series of radiofrequency ablation procedures which provided little relief.

5. Mr Rodriguez continued to suffer swelling and regular drainage of fluid from the knee was required. He continued to suffer pain. By July 2020 Mr Rodriguez was requesting total knee replacement but Dr Leys did not feel this was appropriate at that time. In August 2020 he consulted a further orthopaedic surgeon, Dr Young, who suggested that the only surgical option available was total knee replacement.

6. Mr Rodriguez was examined by an orthopaedic surgeon, Dr Gothelf, at the request of the insurer. Dr Gothelf expressed reservations about the proposed knee replacement. Based on the opinion of Dr Gothelf and Dr Leys, the insurer declined approval for the proposed right total knee replacement.

7. Mr Rodriguez commenced proceedings in the Commission seeking a declaration that the proposed right total knee replacement represents reasonably necessary treatment in respect of the subject injury pursuant to section 60(5) of the *Workers Compensation Act 1987 (*the 1987 Act*)*. The respondent maintained its denial of the claim.

ISSUES FOR DETERMINATION

8. The parties agree that the only issue in dispute is whether the proposed surgery, right total knee replacement, constitutes reasonably necessary treatment with respect to the subject injury.

PROCEDURE BEFORE THE COMMISSION

9. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

EVIDENCE

Documentary evidence

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

    (a) Application to Resolve a Dispute and attached documents;
    (b) Reply and attached documents, and
    (c) documents attached to Application to Admit Late Documents by the applicant.

Oral evidence

11. No application was made to adduce oral evidence or to cross examine any witness.

FINDINGS AND REASONS

12. Counsel for the applicant submitted that the evidence established that the proposed right knee replacement constituted reasonably necessary treatment.

13. Counsel for the respondent submitted that the applicant bore the onus of establishing, on the balance of probabilities, that the proposed surgery constituted reasonably necessary treatment. Whether proposed surgery constituted reasonably necessary treatment was a question of fact in each case to be determined in accordance with the principles outlined by Deputy President Roche in *Diab v NRMA*[1] (*Diab*).

14. In *Diab,* Roche DP said:

> "[88] In the context of s 60, the relevant matters, according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ at point (5) in *Rose* (see [76] above), namely:
>
> (a) the appropriateness of the particular treatment;
>
> (b) the availability of alternative treatment, and its potential effectiveness;
>
> (c) the cost of the treatment;
>
> (d) the actual or potential effectiveness of the treatment, and
>
> (e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective.
>
> [89] With respect to point (d), it should be noted that while the effectiveness of the treatment is relevant to whether the treatment was reasonably necessary, it is certainly not determinative. The evidence may show that the same outcome could be achieved by a different treatment, but at a much lower cost. Similarly, bearing in mind that all treatment, especially surgery, carries a risk of a less than ideal result, a poor outcome does not necessarily mean that the treatment was not reasonably necessary. As always, each case will depend on its facts.

[1] [2014] NSWWCCPD 72

> [90] While the above matters are 'useful heads for consideration', the 'essential question remains whether the treatment was reasonably necessary' *(Margaroff v Cordon Bleu Cookware Pty Ltd* [1997] NSWCC 13; (1997) 15 NSWCCR 204 at 208C). Thus, it is not simply a matter of asking, as was suggested in *Bartolo*, is it better that the worker have the treatment or not. As noted by French CJ and Gummow J at [58] in *Spencer v Commonwealth of Australia* [2010] HCA 28, when dealing with how the expression 'no reasonable prospect' should be understood, '[n]o paraphrase of the expression can be adopted as a sufficient explanation of its operation, let alone definition of its content'."

15. The parties' respective submissions address the appropriateness of the proposed treatment, the availability of alternative treatment and the potential effectiveness of the proposed treatment.

16. Counsel for the applicant submitted that there was fundamental agreement among the treating orthopaedic surgeons that the pathology present in the right knee would ultimately require total knee replacement. Those opinions had been expressed since January 2018 when Dr Lam had first referred to this as a treatment option.

17. Three years later there has been no improvement in Mr Rodriguez's condition. Conservative measures having failed, the opinion of Dr Young should be accepted that the proposed surgery constitutes reasonably necessary treatment, there being no dispute that the requirement for treatment arises from the subject injury.

18. There was little evidence of any alternative treatment and conservative treatment over three years had failed to alleviate the disabling symptoms. Although Dr Young could not guarantee a successful outcome to the proposed surgery, there was a reasonable prospect that a total knee replacement would be likely to assist not only the physical symptoms but the psychological and emotional suffering which Mr Rodriguez was experiencing.

19. Counsel for the respondent submitted that there was evidence of alternative treatment in the reports of Dr Leys and Dr Gothelf. The effectiveness of the surgery was strongly in doubt. Previous surgery had not been effective in addressing the symptoms and reports of Dr Leys established that he was strongly of the opinion that the outcome was unlikely to be beneficial to Mr Rodriguez. Dr Lam did not appear to disagree with that proposition and Dr Gothelf did not support the replacement, suggesting conservative alternatives.

20. Counsel for the respondent did not dispute that total knee replacement may represent reasonably necessary treatment at some point in the future but submitted that the evidence before the Commission would not support a finding on the balance of probabilities that the proposed treatment was appropriate or likely to be effective at the present time.

21. As noted in *Diab*, the issue of whether the proposed knee replacement constitutes reasonably necessary treatment has to be decided on the particular facts of Mr Rodriguez's case as established by the evidence in the proceedings.

The applicant

22. The applicant in his statement details the treatment that he has received since the subject injury and his continuing pain and restriction of movement.

23. Mr Rodriguez listed the medication that he was taking including the opioid Tapentadol, the muscle relaxant, Dantrolene and the antidepressant, Lexapro. The listed medications appear to be only those prescribed for him as he says that he takes "five different analgesic medications on a daily basis", these presumably being over-the-counter products. Other medication listed by Mr Rodriguez relates to treatment of hypertension.

24. Mr Rodriguez said that he used a walking stick to assist his mobility. He was suffering from depression and anxiety. He said, “I have exhausted many avenues and I feel frustrated as I have suffered for so long.”

25. Mr Rodriguez’s account of his pain, his emotional state and his restricted mobility are largely supported by the reports of various medical practitioners who have examined him and I accept his evidence. The reports of Dr Leys make it clear that he wishes to undertake the proposed right knee replacement. It is reasonable to infer, and I accept that Mr Rodriguez believes that the proposed surgery will reduce his painful symptoms, improve his mobility and his mental state.

Investigations

26. X-rays taken in September 2017 were reported by Dr Brue as showing well preserved joint spaces throughout the joint. Dr Brue reported; “there is certainly no evidence of significant deterioration or arthritis. There is something significant irritating the lining of his joint causing marked synovitis and swelling.”

27. The operation report of Dr Brue details the findings on arthroscopy which Dr Brue carried out in October 2017. Dr Brue summarised his findings in a report dated 10 November 2017: “He had severe disseminated synovitis. He had an unstable posterior horn medial meniscal tear which was debrided. He had an associated parameniscal cyst which was decompressed. He did have some loose chondral debris.”

28. Mr Rodriguez underwent right knee aspiration on a number of occasions. A pathology report in evidence from January 2018 showed that aspiration had yielded; “200 ml of viscous translucent yellow synovial fluid.” Microbiology disclosed no bacterial infection. Dr Lam reported that radiographs of the knee showed “high grace [sic – grade] medial compartment arthritis on the right.” An attempt was made to obtain an MRI study of the knee which was reported:

> “On this single sequence, the ACL and PCL are shown to be intact with a very large joint effusion present. There is extensive change in the body and posterior horn of the medial meniscus suggesting maceration and there is loss of articular cartilage over the medial compartment with a stress fracture in the medial femoral condyle and medial tibial plateau. The patellofemoral articular surfaces are difficult to assess, there is probably at least some chondral wear over the femoral trochlea. The distal quadriceps and patella tendons appear intact. There is no soft tissue mass or large Baker’s cyst identified.”

29. The radiologist commented: “A very limited study but with a large effusion and a severe medial compartment degenerative disease with a stress reaction. No underlying tumour or large soft tissue collection.”

30. An x-ray of the right knee performed following the high tibial osteotomy by Dr Lam was reported in May 2018: “High tibial osteotomy is fixed by a plate and screws. Alignment is as shown. No bony complication is seen. There is a small effusion in the suprapatellar pouch. Moderate knee joint OA noted”.

31. A check x-ray of the osteotomy in July 2018 showed unchanged alignment with “evidence of interval healing”. The radiologist reported no complications related to the “metalware”. There was still evidence of joint fluid and unchanged moderate osteoarthritis in the medial compartment. A further comparison x-ray in October 2018 demonstrated interval consolidation.

32. Dr Lam carried out revision surgery in December 2018. An x-ray report of the right knee in March 2019, following that procedure, noted the "interim exchange of the proximal tibial plate and screws to a shorter plate and a few screws." Callus formation consistent with ongoing healing was noted. In comparison with the most recent earlier x-ray the radiologist noted: "mild degenerative change in the medial compartment of the knee is similar. Mild degenerative change in the patellofemoral compartment is also unchanged. Enthesopathy at the quadriceps insertion is present. No significant joint effusion."

33. A comparison x-ray in June 2019 was reported:

> "Since the previous examination, the metallic spacer plate with multiple screws at the medial high tibial osteotomy has been removed. There has been no change in appearance at the osteotomy site. Degenerative changes in the knee joint spaces, moderate at the medial compartment and mild at the lateral and patellofemoral compartments, are comparable to the earlier examination. There is no sizeable joint effusion."

34. In August 2020, Dr Leys noted follow-up x-rays which he said:

> "show full thickness chondral loss in the medial compartment of the knee with a relative preservation of the lateral compartment. There is as yet incomplete healing through the cortical window medially of the osteotomy, but what bridging bone there is, seems to be good and stout."

Dr Arif, General Practitioner

35. Following his move to Western Australia, Mr Rodriguez consulted a general practitioner, Dr Arif. The general practitioner's clinical notes from 4 April 2018 to 12 June 2019 were in evidence. The notes record ongoing pain in the right knee as well as ongoing anxiety and treatment of high blood pressure.

36. Dr Arif's notes were not referred to in submissions. They support the applicant's complaints of ongoing pain and deteriorated emotional state with the prescription of an antidepressant, Lexapro, as well as blood pressure medication. Dr Arif noted complaint of swelling in the knee following physiotherapy.

Dr David Brue

37. Reports from the initial treating orthopaedic surgeon, Dr David Brue, were in evidence. In his report to the then treating general practitioner Dr Brue noted the history and mechanism of injury. He noted that Mr Rodriguez had been in intense pain since the injury with the onset of "a very large knee swelling". He noted that Mr Rodriguez was struggling to walk.

38. On examination, Dr Brue noted "a large tense knee effusion" and restricted range of motion. Dr Brue aspirated 60 ml of clear fluid from the joint. He concluded that there was "a significant cartilaginous or inflammatory problem." Noting that Mr Rodriguez's claustrophobia rendered him unable to tolerate an MRI scan, Dr Brue proposed to evaluate the joint arthroscopically.

39. Dr Brue reviewed Mr Rodriguez on 26 September 2017. He noted the results of weight bearing x-rays (reported above). He commented: "He is still very symptomatic. Anti-inflammatories do not appear to be helping. At this stage I believe we need to intervene surgically."

40. Dr Brue's findings on arthroscopic examination are noted above. At review on 10 November 2017 Dr Brue noted that Mr Rodriguez was progressing well. He was to continue taking anti-inflammatory medication and to be given a strength and conditioning program. Dr Brue noted that Mr Rodriguez was going to Western Australia but felt that he would be able to get back to work in approximately a month.

Dr Li-On Lam, Orthopaedic Surgeon

41. Following his move to Western Australia, Mr Rodriguez was referred to an orthopaedic surgeon, Dr Li-On Lam. Dr Lam first examined Mr Rodriguez in January 2018. A series of reports from Dr Lam were in evidence. Dr Lam recorded a history of a fall from a height but that inaccurate history was not commented upon in submissions and does not appear to be of any significance. Dr Lam noted complaints of increased pain in the knee medially. On examination, there was a poor range of motion with tense effusion in the knee although Mr Rodriguez had undergone aspiration the previous week. Dr Lam noted the x-ray reports but felt that an MRI scan under anaesthesia was required.

42. On review on 29 January 2018, Dr Lam noted that microscopy had not revealed any infection or formation of crystals. He noted that Mr Rodriguez had been unable to tolerate the full MRI scan but felt that the results were sufficient to rule out a synovial problem. Dr Lam noted continuing complaints of pain and discussed surgical options. He said: "We talked about the option of a high tibial osteotomy or knee replacement and as he was still running on that knee prior to the fall and his degree of arthritis allows for an osteotomy, this is my preferred option."

43. In a report to the insurer dated 28 February 2018, Dr Lam expressed the opinion that Mr Rodriguez had exacerbated right knee degenerative changes as a result of the subject injury. He noted that "a high tibial osteotomy is a relatively major procedure and recovery is measured in months. It will take approximately 3-4 months to return to part-time duties and perhaps 6-9 months to return to full duties."

44. Dr Lam reviewed Mr Rodriguez in March 2018 noting that valgus bracing had been beneficial. He discussed the risks associated with high tibial osteotomy and noted that the procedure gave Mr Rodriguez a good chance of returning to an active lifestyle.

45. Dr Lam performed the right high tibial osteotomy in March 2018. He reviewed Mr Rodriguez in May 2018. On review Dr Lam noted that Mr Rodriguez was continuing to suffer pain medially and was weight-bearing on one elbow crutch. Dr Lam noted wasting of the quadriceps and calf muscles. He noted that Mr Rodriguez was attempting to control the pain with paracetamol and was attending physiotherapy and hydrotherapy.

46. Dr Lam noted improved range of motion with the x-ray report showing early callus formation. He felt that it may take up to 12 months post-operative before Mr Rodriguez could become "really active on the limb". He prescribed Lyrica and Tapentadol for analgesia. In July 2018 Dr Lam referred Mr Rodriguez to a pain clinic noting continuing issues with pain control. On review at that time Dr Lam noted steady improvement with recovery. He prescribed physiotherapy and continuing analgesia. He commented "I think he has a pain syndrome and their in [sic] altered hair growth on the right leg which reflects this."

47. On review in October 201,8 Dr Lam noted "signs of slow but sure recovery". X-rays disclosed healing of the high tibial osteotomy site. Mr Rodriguez had increased range of motion of the knee. Dr Lam noted that Mr Rodriguez had concerns about the plate inserted in the knee which Dr Lam felt could be removed once the bone had healed. He noted the continuing support of the pain service.

48. In December 2018, Dr Lam noted that Mr Rodriguez was able to fully weight bear on the right although using a walking stick for longer walks. X-rays showed progress healing. He planned to revise the fixation by performing revision surgery. He noted that Mr Rodriguez had been presented with a holiday cruise by his daughter but was not fit to travel. Dr Lam operated on 21 December 2018 removing the high tibial osteotomy fixation and replacing it with a smaller plate.

49. Upon review in February 2019, Dr Lam noted a similar range of motion to the pre-operative state with continuing report of pain. Dr Lam felt that, despite the objections of Mr Rodriguez, he should be fit for a graduated return to work in four weeks' time. Dr Lam requested further progress x-rays and noted good healing at the next review in March 2019. He noted that Mr Rodriguez was "getting a significant amount of irritation of the hamstrings and with the soft tissues overlying the plate." He planned to remove the plate in May 2019.

50. On review in June 2019, Dr Lam recorded complaints of constant pain over the medial aspect of the proximal tibia. He noted that Mr Rodriguez was fully weight-bearing and there appeared to be no signs of infection. He noted that Mr Rodriguez was seeking a second opinion from Dr Toby Leys.

Associate Professor Graham Mercer, Consultant Orthopaedic Surgeon

51. Mr Rodriguez was examined by a Consultant Orthopaedic Surgeon, A/Prof Mercer, at the request of the insurer on 26 June 2018. A/Prof Mercer noted the history of injury and the surgery performed by Dr Brue. He was provided with copies of reports from Dr Brue and Dr Lam as well as physiotherapy records and x-ray reports. He noted that Dr Lam had recommended osteotomy which had been performed in March 2018. Mr Rodriguez was noted to have been seen by Dr Lam on 31 May 2018 when he was weight-bearing on one elbow crutch.

52. Mr Rodriguez complained that the pain was now worse than previously and that he needed to manage swelling by elevating the leg. He was taking large doses of analgesia including Tramadol. A/Prof Mercer noted that "On examination, Mr Rodriguez presented as very anxious and somewhat distressed. He needed to be 'talked down' from an aggressive assertion that he now needed a knee replacement – all other treatments having failed to date."

53. On examination, A/Prof Mercer noted decreased range of motion. Having discussed causation A/Prof Mercer reported: "Mr Rodriguez needs aggressive pain management by a pain management specialist and urgent and aggressive physiotherapy, preferably by case specific exercise physiologist to encourage mobilisation, reduce dependance on the crutch and improve muscle bulk." He regarded Mr Rodriguez as unfit for work in his present state.

Dr Toby Leys, Orthopaedic Surgeon

54. Dr Leys examined Mr Rodriguez on 19 June 2019 on referral from the general practitioner, Dr Arif. Dr Leys diagnosed: "Ongoing right knee medial knee pain with previous history of work injury in 2017 and multiple surgeries including high tibial osteotomy. Also an element of hypersensitivity and neuropathic pain."

55. Dr Leys noted the mechanism of injury and the subsequent treatment with complaints of ongoing pain in the medial aspect of the knee. On examination Dr Leys noted the healed surgical scar with medial swelling and tenderness at the proximal end of the scar but with no sign of any infection. Tenderness was reported around the medial joint line and the range of motion was restricted to 10 to 110 degrees.

56. Recent x-rays showed the removal of the plate with medial compartment arthritis. The osteotomy site was "largely healed but still with a medial cortical defect". Dr Leys reported:

> "There is quite a significant element of hypersensitivity and probably some neuropathic pain in the knee as well as the arthritic pain. This is a complex set of problems where he will likely ultimately require a total knee replacement but I am very reluctant to do so at this point in time given the combination of nerve type pain and hypersensitivity as well as recent surgeries which need to recover and heal further."

57. Dr Leys recommended pain management review. He suggested that a further period of time should be allowed for healing of the knee and review with Maquet x-rays. At review in August 2019 Dr Leys reported that the findings on x-ray were "consistent with a healing high tibial osteotomy" which he felt could be considered as healed. He noted complaints of the onset of left knee pain as well as continuing pain management issues with the right knee. Dr Leys reported: "I have grave reservations about any surgical intervention given the terrible pain response he has had to previous surgeries. I have explained this to him today, in that there will not be any surgical interventions on either knee until he has had pain management review." Dr Leys noted that Mr Rodriguez had been referred to a pain management specialist, Dr Majedi for review and advice.

58. Dr Leys again reviewed Mr Rodriguez on 3 February 2020. He noted improvement in the neuralgic pain with the current treatment plan. He noted "He is still getting mechanical pain in the knee, as we would expect." He reported:

> "On examination, the right knee does have a large effusion and Frank reports he does get this drained periodically. I have requested they do a cortisone injection next time around to reduce the recurrence rate of the effusions.
>
> I have had discussions with Frank once again about longer term treatments. We want to delay any surgical intervention as long as we can to get the risk of neurologic pain recurrence minimised. He will more than likely need knee replacements in the future but currently his symptoms are improving and allowing us to delay this, which the intention is to delay for as long as possible."

59. On further review in July 2020, Dr Leys reported continuing pain in both knees. He again noted improvement in pain levels and said, "his pain levels continue to be somewhat out of keeping with the degree of pathology". Dr Leys reported:

> "Frank is quite adamant that he wants knee replacements, however I am strongly of the opinion that any further surgical intervention is going to create more problems and complications for him and outweigh the potential benefits. We have had a long discussion today about this. The best I can offer Frank today is recommending continuing gentle exercise to maintain the strength and function in his knees and pain management strategies to minimise the pain as best he can.
>
> Frank is obviously not particularly happy with the situation but it has generally been my opinion since first seeing him that surgery is not going to be in his best interest."

Dr P Max Majedi, Pain Medicine Physician

60. A report by Dr Majedi dated 25 May 2020 was in evidence. Dr Majedi noted that Mr Rodriguez had been referred to him in November 2019 with "persistent knee pain with elements of mechanical and neuralgic pain generators." Dr Majedi noted a degree of neurogenic inflammation together with compromised mental health and "global functional impact". The report details radiofrequency rhizotomy performed by Dr Majedi on that day.

Dr Uthum K Dias, Consultant Occupational Physician

61. Mr Rodriguez was examined by a consultant occupational physician, Dr Dias in March 2020. His report dated 9 June 2020 was in evidence. Dr Dias recorded the history and mechanism of injury in similar terms to those in Mr Rodriguez's statement. He noted that, despite the treatment, Mr Rodriguez continued to suffer debilitating symptoms of right knee pain with stiffness. He noted the surgery undertaken by Dr Lam and the radiofrequency ablation performed by Dr Majedi which had not assisted.

62. Dr Dias noted that Mr Rodriguez was continuing to receive pain management from Dr Majedi as well as consulting Dr Leys. He reported current symptoms:

> "At the present time Mr Rodriguez states that he struggles to walk for more than five minutes at a time. He uses a walking stick in his right hand side to aid his mobility. He struggles to stand for more than two minutes at a time. He can tolerate sitting to a normal degree at the present time. He struggles with driving for more than 10 minutes at a time due to right knee pain and discomfort. Mr Rodriguez struggles with walking up and down stairs or walking on uneven ground due to his condition affecting his right and left knees. Mr Rodriguez has been unable to run or jog since injuring his right knee in July 2017."

63. Dr Dias noted that Mr Rodriguez had been physically fit prior to the subject injury. He noted that there was a history of hypertension and intermittent dizziness and vertigo. Mr Rodriguez noted to be taking five different analgesic medications daily for management of the right knee pain as well as antidepressant medication.

64. On examination, Dr Dias observed reduced range of motion and neurological deficits. The right knee was mildly swollen with evidence of a small effusion. Dr Dias also noted symptoms in the left knee. Dr Dias's opinion as to prognosis was recorded as follows:

> "Mr Rodriguez's prognosis for improvement with respect to his compensable conditions affecting his right and left knees would have to be judged as relatively poor. He continues to suffer from ongoing debilitating symptomatology with respect to his injuries at almost three years following the date of the subject incident. At this stage, in my opinion, it is highly doubtful as to whether Mr Rodriguez's symptomatology and related disabilities with respect to his compensable condition would have resolved to the point where he is pain free or free from the functional compromise on a day-to-day basis in the foreseeable future."

65. Dr Dias' report did not address the question of whether total knee replacement would constitute appropriate treatment.

Dr Sam Young, Orthopaedic Surgeon

66. Mr Rodriguez was examined by another orthopaedic surgeon, Dr Sam Young, on referral from his general practitioner, Dr Arif. The report to the general practitioner dated 5 August 2020 was in evidence. Dr Young recorded the history and mechanism of injury and noted the course of treatment. He noted:

> "Investigations at that time showed extensive chondral damage throughout the medial compartment of the knee. Unfortunately despite his very reasonable interventions he has persisting knee pain. This is felt both medial and laterally, associated with intermittent effusions, stiffness within the knee and occasional instability."

67. On examination, Dr Young noted neutral alignment “concordant with his osteotomy.” He reported:

> “He has a well healed medially based surgical scar. Soft tissues look well healed. There is no sign of any infection and he denies that he has ever had any perioperative complications such as infection or thrombosis. He has a fixed flexion deformity of approximately 20 degrees and can only flex to 90 degrees before he experiences pain. He has diminished range of motion in the hip, but it is non-irritable. He has good strong pulses distally. His ligaments feel intact, as best as I can determine.”

68. Dr Young noted that follow-up x-rays showed full thickness chondral loss in the medial compartment of the knee with a relative preservation of the lateral compartment. The x-ray showed “as yet incomplete healing through the cortical window medially of the osteotomy, but what bridging bone there is, seems to be good and stout.”

69. Dr Young reported: “Unfortunately Frank is at a point where knee replacement surgery would be the only surgical intervention I could offer him”. Dr Young noted:

> “He presents some difficulties. He is young. He will have high demands compared to other joint replacements. He has prior surgical scars, which will need to be considered for planning. He has a slightly higher risk of infection secondary to this as well as risk of DVTs. I have counselled him that there is a high likelihood of stiffness afterwards if he does not adhere to physiotherapy as his range of motion going into his knee is quite poor.”

70. Dr Young recommended commencing physiotherapy straight away to build up the quadriceps muscles. He said “I will write to Max Majedi for his opinions as to whether it is safe to proceed with Frank’s knee replacement and whether there is anything we should be careful of in the perioperative period and how we should best manage his pain.”

71. Dr Young provided a surgical fee estimate for the performance of the total knee replacement at $4,860.

Dr Todd Gothelf, Orthopaedic Surgeon.

72. A further orthopaedic surgeon, Dr Todd Gothelf, carried out a “telehealth assessment” of Mr Rodriguez on 25 September 2020 at the request of the insurer following the request by Dr Young for approval for the right total knee replacement. Dr Gothelf noted the history of injury in the course of treatment. He considered the radiological reports and the reports of the treating orthopaedic surgeons, Dr Brue, Dr Lam and Dr Leys.

73. Dr Gothelf recorded the complaint of continuing pain and the severe effects that this had had upon Mr Rodriguez’s activities of daily living. He noted that Mr Rodriguez needed crutches when walking. There was apparent swelling in the right knee and quadriceps atrophy with quadriceps avoidant gait. There was a limited range of movement.

74. Dr Gothelf felt that the response to treatment with no improvement “was not consistent with what would be expected with a diagnosis of knee arthritis”. He noted that Mr Rodriguez had persistent significant pain and swelling and that pain management including radiofrequency rhizotomy had done little to help improve symptoms. He noted that Dr Leys had advised against any further surgery but that Dr Young was offering a right total knee replacement.

75. Dr Gothelf accepted that further treatment was currently related to the workplace condition but he said:

> "Based upon Mr Rodriguez's unusual presentation of persistent effusion and significant persistent pain response, I am not of the opinion that a right total knee replacement is the only appropriate intervention and do not feel that the outcome of this procedure would be predictable"

and

> "As Dr Leys has indicated, Mr Rodriguez has neuropathic pain with levels that seem to be excessive compared to the degree of pathology. Further treatment with pain management is indicated. Further evaluation with a rheumatologist may be indicated to investigate the cause of his ongoing significant symptoms. While I understand Mr Rodriguez's desperation for relief of his symptoms, it is still not clear that a total knee replacement is the clear answer to a resolution of all symptoms. With the unusual presentation of Mr Rodriguez's right knee condition and lack of predictability to any treatments, a timeframe for any recovery is not possible."

Discussion

76. The respective submissions of the parties have been noted above. The issue of whether the proposed right total knee replacement constitutes "reasonably necessary treatment" is to be considered in the light of the factors discussed in *Rose v Health Commission (NSW)*[2] (*Rose)* and *Pelama Pty Ltd v Blake*[3].

77. In *Ajay Fibreglass Industries v Yee*[4] Deputy President Roche said:

> "[67] Whether any particular treatment is reasonably necessary as a result of an injury must be assessed on a case-by-case basis with the Commission exercising 'prudence, sound judgement and good sense' (Rose). It is not solely a matter for statistical analysis, that will often be relevant. On balance, the Arbitrator concluded that there is a reasonable chance of a successful outcome from the proposed surgery and that it is better for Mr Yee to have the surgery than to forego it. That conclusion was open on the evidence and discloses no error".

78. Counsel for the applicant submitted that there was general agreement among the treating orthopaedic surgeons that Mr Rodriguez would ultimately come to a right total knee replacement. It should be accepted that the proposed surgery represented appropriate treatment. To the extent that there was evidence of any alternative treatment, that evidence was simply that pain management techniques should continue although the evidence indicated that alternative treatments had consistently failed to deliver relief. Although there was no guarantee of success, the proposed total knee replacement offered the prospect of improvement in the level of pain and incapacity. That being the case, the conclusion should be that the proposed right total knee replacement constitutes reasonably necessary treatment in respect of the subject injury.

79. Counsel for the respondent submitted that the evidence did not support a conclusion that the proposed surgery was accepted by the medical profession as appropriate and likely to be effective at the present time.

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[2] [1986] NSWCC 2; (1986) NSWCCR 32.
[3] [1988] NSWCC 6; (1988) 4 NSWCCR 264.
[4] [2012] NSWWCCPD 41.

80. For the reasons set out below, I have come to the conclusion that the evidence does not establish that the proposed total knee replacement constitutes appropriate treatment which is likely to be effective at this point in time.

81. Dr Leys, who examined Mr Rodriguez on a number of occasions was strongly of the opinion that total knee replacement was not appropriate at that point in time. His opinion was that the proposed knee replacement would likely create more problems and complications and would outweigh the potential benefits.

82. The reports of Dr Lam do not assist the applicant's case in this regard. Dr Lam referred to the option of knee replacement as being an appropriate form of treatment although it is clear from his reports that he offered the high tibial osteotomy as the preferred option and did not suggest knee replacement when the osteotomy did not produce the hoped for result.

83. Counsel for the applicant correctly pointed out that Dr Gothelf's opinion that a right total knee replacement was not the only appropriate intervention was not decisive of the issue. I accept that submission.

84. It is necessary to take into account the continuing high level of pain suffered by Mr Rodriguez and the restrictions of his activities of daily living as well as his psychological state.

85. I accept that Dr Gothelf does not specifically rule out total knee replacement as an appropriate form of treatment but I prefer the evidence of Dr Leys which appears to me to be consistent with the fact that neither Dr Brue, Dr Dias, Dr Majedi or A/Prof Mercer provide support for the proposed treatment.

86. The single report of Dr Young in evidence does not provide unqualified support for the proposed knee replacement. As noted by counsel for the respondent, Dr Young says that total knee replacement is the only surgical option that he can offer to Mr Rodriguez. That opinion is limited to the range of surgical options available and does not address alternatives. Dr Leys explicitly states that he can offer no surgical option and recommends continued conservative treatment.

87. Dr Young notes that the proposed knee replacement presents "some difficulties". He notes the comparative youth of Mr Rodriguez at age 51 at the time of his report. He notes that Mr Rodriguez "will have high demands compared to other joint replacements" as well as noting that Mr Rodriguez has prior surgical scars which need to be considered for planning.

88. Significantly, Dr Young states that he intends to write to Dr Majedi to obtain his opinion "as to whether it is safe to proceed with Frank's knee replacement and whether there is anything we should be careful of in the perioperative period and how we should best manage his pain."

89. Although the applicant was granted leave to apply for a direction for production of interstate documents from both Dr Leys and Dr Majedi, no evidence was adduced as to whether Dr Majedi had agreed that it was safe at the present time to proceed with the proposed surgery.

90. Dr Leys has clearly considered the pain and incapacity suffered by Mr Rodriguez. He provides the reasons for concluding that the knee replacement is not appropriate treatment at the time of his consultation with Mr Rodriguez, noting the "combination of nerve type pain and hypersensitivity as well as the recent surgeries which need to recover and heal further".

91. Both Dr Leys and Dr Gothelf express reservations as to the effectiveness of the treatment, noting that previous surgical intervention, although appropriate, has been followed by increased reports of pain and incapacity.

92. Both Dr Leys and Dr Gothelf suggest persistence with conservative treatment in the form of analgesia and pain management techniques in order to delay as long as possible the necessity for total knee replacement.

93. Mr Rodriguez's injury has been considered by four orthopaedic surgeons, Dr Brue, Dr Lam, Dr Leys and Dr Gothelf, none of whom have suggested that a total knee replacement constitutes appropriate and effective treatment at this point in time. Dr Leys provides cogent reasons why the proposed surgery is not appropriate and unlikely to be effective. In this he receives support from Dr Gothelf.

94. The cost of the proposed procedure was not addressed as a relevant factor in submissions and has no bearing on the outcome.

95. Although I accept that Mr Rodriguez suffers a high level of pain and incapacity as a result of the injury to his right knee and suffers psychologically, doing my best to exercise prudence, sound judgment and good sense, I could not be satisfied on the whole of the evidence that the proposed total right knee replacement constitutes appropriate treatment at this point in time, nor could I be satisfied that there are reasonable prospects that the treatment will be effective in relieving Mr Rodriguez's symptoms.

96. For these reasons I could not be satisfied that the proposed right total knee replacement constitutes reasonably necessary treatment in respect of the subject injury. On the evidence it is not appropriate to make the declaration sought by the applicant pursuant to section 60 (5) of the 1987 Act.