WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**6069/19**
Applicant:	**Dinaben Jogiya**
Respondent:	**State of New South Wales**
Date of Determination:	**14 February 2020**
Citation:	**[2020] NSWWCC 45**

The Commission determines:

1. The applicant sustained injury to her lumbar spine arising out of or in the course of her employment with the respondent on 29 March 2015.
2. The applicant's employment was a substantial contributing factor to her injury.
3. The applicant requires medical treatment as a consequence of her injury and the respondent is liable to pay reasonably necessary medical expenses.
4. The proposed lumbar spine surgery, namely a fusion at L4/5, and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of the applicant's employment with the respondent on 29 March 2015.

The Commission orders:

5. The respondent to pay the applicant's reasonably necessary medical expenses with respect to the proposed lumbar spine fusion at L4/5 as recommended by Dr Kam and associated expenses, pursuant to section 60 of the *Workers Compensation Act 1987*.

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

Carolyn Rimmer
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 CAROLYN RIMMER, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. On 20 November 2019, Dinaben Jogiya (Mrs Jogiya) lodged an Application to Resolve a Dispute (the Application) in the Workers Compensation Commission (the Commission). Mrs Jogiya's employer at the relevant time was the State of New South Wales (the respondent). The respondent was insured by QBE Workers Compensation NSW Limited as agent for iCare (the insurer) at the relevant time.

2. Mrs Jogiya claimed medical expenses for proposed medical treatment pursuant to s 60 of the *Workers Compensation Act 1987* (the 1987 Act) due to injury sustained on 29 March 2015

3. Mrs Jogiya, in the course of her employment with the respondent as a carer at Home Care Services NSW sustained an injury to her lumbar spine on 29 March 2015 when she was transferring a client to a shower chair.

4. There was no dispute that Mrs Jogiya injured her lumbar spine on 29 March 2015. Liability was accepted by the insurer and weekly compensation and medical expenses paid, including the costs of surgery on the lumbar spine on 9 November 2015.

5. On 16 September 2019, a claim was made for medical expenses, namely, a claim for proposed surgery at L4/5 of the lumbar spine.

6. On 12 December 2018, the insurer issued a notice pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act), disputing that it was liable for the payment of medical expenses on the basis that the proposed lumbar spine surgery was not reasonably necessary as a result of Mrs Jogiya's injury on 29 March 2015.

ISSUES FOR DETERMINATION

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

    (a) whether the proposed lumbar spine surgery, in the form of a fusion at L4/5 is reasonably necessary as a result of the injury sustained on 29 March 2015 (s 60 of the 1987 Act).

PROCEDURE BEFORE THE COMMISSION

8. The parties attended a conciliation conference and arbitration hearing on 3 February 2020.The proceedings in the Commission were sound recorded and a copy of the recording is available to the parties. Mrs Jogiya was represented by Mr P Stockley, who was instructed by Mr M Levenson of Masselos & Co. The respondent was represented by Mr J Beran, who was instructed by HWL Ebsworth.

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

FINDINGS AND REASONS

Mrs Jogiya's statement

11. In a statement dated 3 July 2019, Mrs Jogiya described sustaining an injury to her lumbar spine on 29 March 2015 while assisting a severely disabled client. She stated that following the injury, she consulted her general practitioner, Dr Renigeris and was referred to Dr Andrew Kam, neurosurgeon. Mrs Jogiya said that on 9 November 2015, Dr Kam performed an a L4/5 microdiscectomy and rhizolysis. Following the surgery and a period of rehabilitation, Mrs Jogiya returned to work on a part-time basis. Her employment with the respondent was terminated on 19 February 2016.

12. Mrs Jogiya stated that she continued to have some back pain and took Voltaren tablets and Panadol. She later obtained employment as an Administration Clerk at the Tile Factory Outlet and was able to work 38 hours a week.

13. Mrs Jogiya wrote:

    > "In 2018, I began to have increased back pain with good days and bad days. The pain increased down my left leg. I became concerned about the increasing pain which was interfering with my work and looking after my home. I again consulted Dr Renigeris."

14. Mrs Jogiya stated that she was referred back to Dr Kam and saw him on 25 October 2018. She said that Dr Kam recommended that she have further surgery, namely, a L4/5 fusion.

15. Mrs Jogiya wrote:

    > "8. In 2019 I continued to have further painful low back symptoms and pain in my left leg. From May I have reduced my hours from 8 to 7 hours per day, with a loss of pay. I am having difficulties coping even with my current hours. I am finding it necessary to take extra strong Panadol and prescribed medication when the pain is bad.
    > 9. I would like to proceed with the lumbar surgery recommended by Dr Kam as I do not believe I will be able to work much longer with increasing back and leg pain."

Medical Evidence

16. In a report dated 1 December 2016, Dr Endrey-Walder, general and trauma surgeon, noted that Mrs Jogiya had physiotherapy following the injury on 29 March 2015 before seeing Dr Kam. Dr Endrey-Walder reported that assessment by an Independent Medical Examiner (IME) recommended injection in the back before consideration for surgical intervention but Mrs Jogiya "was not keen on this".

17. Dr Endrey-Walder reported that Dr Kam performed a left-sided L4-5 micro-discectomy and rhizolysis for a large left para-central disc herniation, some sequestrated disc fragment migrating behind the vertebral body of L5. He noted that following the surgery Mrs Jogiya was seen at the Physiotherapy Department of Westmead Private Hospital and then was treated in the Clinic at Wentworthville.

18. Mrs Jogiya told Dr Endrey-Walder that present complaints included being unable to sit for very long because her back started hurting and her left leg went numb and that she got frequent cramps in her left calf, mainly at night. On examination, he reported that there was visible and palpable muscle spasm on both side of the lumbar spine and the left calf was 1.5 cms smaller in circumference than the right. Dr Endrey-Walder was unable to elicit the left ankle reflex and Mrs Jogiya reported diminished appreciation of fine touch sensation along the lateral aspect of the lower left leg and foot.

19. Dr Endrey-Walder expressed the opinion that Mrs Jogiya suffered an acute L4-5 intervertebral disc protrusion in the incident on 29 March 2015. He noted that she acknowledged that she would have some backache prior to the subject accident, which people in her line of work would get on occasions, but the symptoms were never sustained, never prevented her from continuing on full duties and she could recall no leg pain prior to the incident. Dr Endrey-Walder concluded that given her age, the initial CT scan of the lumbar spine highlighted very little in the way of significant underlying spondylosis or disc degenerative condition, and therefore he did not consider that there was pre-existing condition that might have predisposed her to the acute injury.

20. Dr Endrey-Walder noted that Mrs Jogiya was advised to have peri-neural or epidural injections prior to surgery, but expressed the view after looking at the MRI scan in particular, the size of the disc protrusion and its extension down at the back of the body of L5 vertebra that such treatment would have been unlikely to be more than of diagnostic value. He noted that she had a very reasonable result from the operation but unfortunately remained with clinical signs of permanent nerve damage, which was likely to be the result of the rather prolonged period of time between the injury and the operation (10 months).

21. In a report dated 25 July 2018, Dr Endrey-Walder noted that Mrs Jogiya remained under the general follow-up care of Dr Renigeris with whom she consulted regularly. He reported that in early 2017 Mrs Jogiya began experiencing increasing symptoms, increasing back pain and more numbness in the left leg. Dr Endrey-Walder noted that current symptoms included the inability to sit continuously for a longer period of time, severe cramps in the left leg and constant numbness in the left foot.

22. On examination, Dr Endrey-Walder reported palpable muscle spasm only along the right side of the lumbar spine. He wrote:

> “She was able to reach the mid-shin level with the fingertips as she bent her torso, once again clearly uncomfortable trying to attain the vertical, had difficulty with hyperextension. Her lower limbs measured of equal calibre at equivalent levels. She tolerated 70 degrees straight leg raising on the right, only 50 degrees on the left, complaining of a sensation of ‘heaviness’ in the leg. The left ankle reflex could not be elicited, the right one of good amplitude. She again complained of blunted sensation down the lateral aspect of the distal left leg.”

23. Dr Endrey-Walder noted that Mrs Jogiya had an MRI scan of the lumbar spine on 16 May 2017 and commented that there were "no worrisome features on the MRI scan that would suggest the need for further surgical intervention". He noted that Dr Kam, however, acknowledged that there may be a case for future CT guided left L5 nerve root injection if there was further deterioration, especially symptoms in the left leg suggesting sciatica.

24. In a report dated 21 February 2019, Dr Endrey-Walder noted that Mrs Jogiya continued to perform administrative work on a full-time basis. He wrote:

> "On 25.10.2018, Dr Kam consulted with your client, noting that "It is now nearly two years since she had undergone surgery. She unfortunately has continued to suffer from ongoing lower back pain and leg pain bilaterally". The doctor quoted the more recent MRI scan of the lumbar spine showing a residual disc bulge at the L4-5 level, the level of the damage identified and operated on by the Surgeon in May 2016.
> Dr Kam also noted that 'she is struggling with her day to day activity ... Cannot continue with persevering with her symptoms and is hoping that we can provide her a solution surgically'. Dr Kam advised your client that surgical intervention would likely be by way of L4-5 fusion.
> On 27.11.2018, Dr Casikar reviewed your client on behalf of QBE, noting that "since a few months her back pain seems to have increased and both the legs are numb ... since the recent aggravation the problem is there in both the legs".
> On examination, Dr Casikar found that your client had an antalgic gait, had reasonable straight leg raising of both lower limbs but that "there was no evidence of dermatomal hyperaesthesia or motor weakness". He has particularly noted that his previous examination of your client, having shown hypoaesthesia over the L5 dermatome, as well as evidence of foot weakness, was no longer present."

25. Dr Endrey-Walder noted that Dr Casikar had not referred to the absence of the left ankle reflex which denoted nerve damage from the back into the left lower limb. He wrote: "Dr Casikar recommended that 'she could try cortisone injection at the L4/5 space', obviously not being aware of such an injection having been performed in June 2017 without giving your client any symptomatic relief."

26. Dr Endrey-Walder noted that the MRI of 27 September 2018 referred to evidence of previous micro-discectomy at L4-5, with a residual broad-based disc bulge with no evidence of neural compression. No other significant pathology was identified in the lumbar spine.

27. Dr Endrey-Walder reported that current complaints included great increase of pain in the lower back, numbness in both feet, cramping in the calves and ongoing difficulties in her job with prolonged sitting. On examination, he noted palpable muscle spasm along the right side of the lumbar spine, no sensory deficit in the lower limbs and an absence of the left ankle reflex.

28. Dr Endrey-Walder agreed with Dr Kam that Mrs Jogiya's back condition was essentially secondary to the single level disc degeneration and disc bulge at L4/5, for which the only reasonable therapeutic measure was a spinal fusion. He considered that there was a single level disc condition, probably causing a degree of early instability. Dr Endrey-Walder concluded that stabilising the single level damage in the back might help prolong her working life substantially.

29. In a report dated 7 August 2019, Dr Endrey-Walder reported that Ms Jogiya remained troubled with ongoing lower back pain in the years following the discectomy operation, and also referring to cramping in the left leg although the sciatic symptoms had eased following the operation. He noted that the main problem was the chronicity and sustained intensity of lower back pain.

30. Dr Endrey-Walder concluded that Mrs Jogiya's symptoms were due to the damaged L4-5 disc, the damage having occurred in the accident of 29 March 2015. He noted that the pathology was at a single level in the lumbar spine, and that her symptoms had not only not abated but increased in intensity, and confirmed the opinion in his last report that he was in full agreement with Dr Kam's assessment that the back condition was essentially secondary to the single level disc degeneration and disc bulge at the L4-5 level, for which the only reasonable therapeutic measure was fusion procedure. Dr Endrey-Walder confirmed that he also suggested that, in his opinion, a degree of instability in the lower back due to the disc damage was likely to be a contributing factor to her debility.

31. Dr Endrey-Walder acknowledged Dr Casikar's opinion of 27 November 2018 but did not support his contention that ongoing conservative measures, including trying cortisone injection at the L4/5 space, was going to result in any amelioration of Mrs Jogiya's condition. Dr Endrey-Walder noted that Dr Casikar might not have been aware of the CT guided injection Mrs Jogiya had in June 2016 with no beneficial effect.

32. Dr Endrey-Walder wrote:

> "This lady has had back pain since March 2015…
> I would argue a direct and logical relationship between the injury suffered in March 2015 and the necessity, after all this time, for some curative procedure. Short of a fusion procedure it is difficult to see what one can do for her."

33. Dr Andrew Kam, treating neurosurgeon, in a report dated 1 May 2015 noted that for the last four weeks Mrs Jogiya had physiotherapy and had been commenced on Lyrica with good results. He advised Mrs Jogiya to adopt a conservative approach as she has already achieved nearly 70% of improvement. He noted that if there was any further worsening of her symptoms, surgery could be considered as an option.

34. In the operation report dated 9 November 2015, Dr Kam wrote:

> "Clinical History
> Mrs Jogiya is a 57-year-old female who works as a carer, working with Homecare.
> She injured herself whilst at work on 29/3/15 when she was assisting a client with a shower chair. She had pulled and pushed him in the shower chair and experienced an acute onset of left sided buttock pain and leg pain. For the last 4 weeks she has had physiotherapy and has been commenced on Lyrica with good results. She now feels that she is 70% better. She describes the pain to be much improved but the numbness is persisting. Her sleep pattern remains broken because of this.
> INVESTIGATIONS
> The MRI scan of her lumbar spine does show a large left paracentral disc herniation with a sequestrated disc fragment migrating behind the vertebral body of L5. It appears to be compressing the L5 nerve root substantially.
> She was seen by the IME who suggested a cortisone injection. On speaking to Mrs Jogiya, she was not enthusiastic about the cortisone injection as she felt that this was only a temporary measure without any change in the structure of the disc bulge that is causing the nerve root compression.
> After failing conservative management, surgery was considered and recommended to Mrs Jogiya…. Consent was obtained to proceed with surgery."

35. Under “Procedure” Dr Kam wrote:

> “Using loupe magnification and a high-speed Midas Rex drill and Kerrison rongeur, a L4 laminotomy, foraminotomy and medial facetectomy was performed. The ligamentum flavum was resected to expose the epidural fat and dura. Epidural bleeding was secured with bipolar diathermy. Rhizolysis of the exiting and traversing nerve roots were performed. The left L5 nerve root was retracted to expose and identify the disc prolapse. A posterior annulotomy was performed. Soft disc was seen in the subligamentous space and removed. The disc space was also entered and loose nucleus pulposus was removed. The left L5 nerve root was seen to be well decompressed.”

36. Dr Kam under “Intraoperative Findings” noted that there was compression of the thecal sac and exiting nerve root by the disc prolapse.

37. In a report dated 8 June 2017, Dr Kam noted that Mrs Jogiya had undergone a successful left sided L4/5 microdiscectomy a year and a half ago and in 2016 had no real symptoms. He reported that more recently she had developed increasing numbness involving her left lower extremity.

38. Dr Kam wrote:

> “The repeat MRI scan of her lumbar spine did not show any obvious pathology. There is still plenty of room around the nerve root at the central canal, lateral recess and exit foramen. If there is any further deterioration, there may be a role for her to undergo further steroid injections into the L4/5 region on the left side.”

39. In a report following a consultation on 25 October 2018, Dr Kam noted that Mrs Jogiya continued to suffer from ongoing back pain and leg pain bilaterally. He reported that the most recent MRI scan showed a residual disc bulge at L4/5 level, with loss of disc height. He noted that Mrs Jogiya was struggling with day to day activities because of the ongoing pain and discomfort and said she could not persevere with her symptoms and hoped for a surgical solution. Dr Kam considered that if surgery were to address both the back pain and the leg pain, it would entail a L4/5 fusion and he would seek approval from the insurer to perform the surgery in the near future.

40. In a report dated 10 December 2018, Dr Kam noted the report of Dr Casikar and wrote:

> “I agree that the patient does have back pain to be the more dominant feature compared to 2015 when she had leg symptoms due to nerve root compression. The only abnormality she currently has is the L4/5 level. If Dr Casikar feels that she has not exhausted her conservative treatment over the last 2 years, he is more than welcome to advise on all the treatments that he feels is [sic] suitable for the patient.
> From my point of view there is not much left for Mrs Jogiya. The way she currently is, she is not going to return to gainful employment. Surgery is the only chance that she has to improve the situation enough for her to return to gainful employment, perhaps looking at a more sedentary role.”

41. In a report dated 27 August 2019, Dr Kam wrote:

> "Mrs Jogiva has been suffering from a work-related injury dating back to 2015 where she underwent a successful microdiscectomy operation.
> About 6-7 months following the successful surgery she developed increasing symptoms with a gradual increase in intensity and frequency, to the point where it has now been causing her ongoing pain and discomfort over a 2-year period, which has been resistant to non-surgical techniques. She has exhausted all conservative treatment to date and remains quite restricted in her activities. Being a carer prior to her injury, it is unlikely that she will be able to return to work in her current state.
> The recommendation for us to proceed with a fusion of the L4/5 level is to address the mechanical back pain generated by the changes identified at the L4/5 level. This is a progression of the initial injury that occurred in 2015. Despite her being 61 years of age, the precipitating event had been the work injury of 2015.
> Therefore, it is my opinion that the operation that I have requested is still related to the initial injury as her injury from 2015 has given her the progressive change identified at the L4/5 level, resulting in her inability to work due to mechanical back pain. It is my opinion, despite her age, the work injury has been the main contributor to her current state of pain."

42. In a report dated 21 August 2015, Dr Renigeris, treating general practitioner, noted that Mrs Jogiya was initially seen by Dr Kam on 30 April 2015. He reported that an MRI showed a large left paracentral disc herniation at L5 with compression of the L5 nerve root. Dr Renigeris noted that initially a conservative approach to therapy was taken which included 31 visits to physiotherapy and analgesia. He observed that initially, slight improvement occurred, but after that, nothing and Mrs Jogiya was unable to work. Dr Renigeris considered that it was obvious that if the goal was full duties, that surgery was required.

43. Dr Renigeris reported that the physiotherapist, Mr Shilson-Josling, had noted some pain improvement with treatment but was unable to reverse the left leg radiculopathy (numbness). Dr Regeneris recommended Mrs Jogiya undergo the surgery proposed by Dr Kam in 2015.

44. In a referral to Dr Kam dated 2 October 2018, Dr Renigeris noted that Mrs Jogiya presented with increased pain in the back with radiation to both legs. He was of the view that the MRI was inconclusive as to her radiculopathy and commented that she might have mechanical back pain. Dr Renigeris requested Dr Kam to assess her with a view to injections.

45. In a report date 27 November 2018, Dr Casikar, consultant neurosurgeon, referred to an earlier report dated 2 September 2016 and 29 March 2017 and noted that this report should be read in conjunction with the earlier reports. He reported that Mrs Jogiya was working as an administration clerk but in the last few months her back pain had increased and both legs were numb. Dr Casikar noted that she had seen Dr Kam who indicated that a fusion would help her back pain and "she could expect about 80% to 90% of her symptoms" [sic]. He noted that on the previous examination, Mrs Jogiya had hypoesthesia over L5 dermatome and there was evidence of foot weakness, but both those symptoms had now cleared completely. Dr Casikar made a diagnosis of back pain syndrome.

46. Dr Casikar was of the opinion that except for back pain Mrs Jogiya did not have any neurological symptoms such as sciatic pain. He was not convinced that a spinal fusion was the answer for this problem as she had not tried standard methods of management of back pain. Dr Casikar suggested that Mrs Jogiya would do well to do regular home-based exercises on the advice of the physiotherapist and she could try a cortisone injection at L4/5 space, which might give her some relief. He concluded that he would find it very difficult to support a spinal fusion merely because she complains of back pain and that there was no evidence of any spinal instability.

47. Dr Casikar expressed the opinion that Ms Jogiya has not suffered an aggravation to a pre-existing underlying condition nor a cessation of aggravation. He noted that degenerative disease was a genetically determined disease and that Dr Kam had indicated that there were degenerative changes at L4/5 space.

48. Dr Casikar considered that non-surgical management of chronic back pain had a better outcome regarding returning to work and need for medication. He noted that Dr Kam had indicated that all non-surgical methods have been tried but was not sure what Dr Kam meant by this. Dr Casikar opined that Ms Jogiya had not had any methods of treatment except medication by her family physician. Dr Casikar considered that it was very controversial as to whether Mrs Jogiya would get any benefits from surgery. Dr Casikar stated that the probability of back pain remaining as before and the need for medication being the same were "likely to be higher than the 80% relief" [sic] that Dr Kam had projected. Dr Casikar believed the home-based exercises and advice on managing back pain would keep Ms Jogiya in the workforce for a longer period and a spinal fusion would adversely impact her capacity to get back to her workplace.

49. Dr Casikar wrote:

> "In my opinion non-surgical management would have a better prospect. The neurological symptoms have recovered. The neurological examination is normal. MRI examination shows a broad-based disc bulge. There is no evidence of nerve root compression. Based on these facts I am not sure a spinal fusion is necessary. There is no evidence of an instability to justify a fusion. Following the fusion the probability of Ms Jogiya returning to work Is poor. Often following a spinal fusion injured worker does not get back to work at all, Therefore, it is necessary to realize that on the balance of probabilities the return to work may be a major issue if she was to have the fusion suggested by Dr Kam."

50. In a supplementary report dated 13 November 2019, Dr Casikar wrote

> "The spinal fusion suggested by Dr Kam is mainly to address degenerative disease of the lumbar spine. This is a genetic constitutional problem. This is not related to the workplace incident that Ms Jogiya suffered and the nature of her work has not produced degenerative disease.
> Therefore, while the preliminary surgery was acceptable, I do not accept that the degenerative disease and any treatment for degenerative disease is related to her employment.
> The need for surgery that Dr Kam indicates is mainly to address problems related to degenerative disease. Very often patients do complain of chronic pain because of degenerative disease. The surgery suggested by Dr Kam is one of the acceptable methods of treatment for degenerative disease however I would find it difficult to support the idea that this fusion is a compensable condition related to her employment."

Discussion

51. Mr Beran submitted that Mrs Jogiya needed to show that the injury materially contributed to the need for the lumbar spine fusion in accordance with the principles in *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49 (*Murphy*).Further, he submitted that the spinal fusion was not reasonably necessary treatment as there were alternative conservative methods of treatments that should be undergone prior to any fusion.

52. What constitutes reasonably necessary treatment was considered in the context of s 10 of the *Workers Compensation Act 1926* in *Rose v Health Commission (NSW)* (1986) 2 NSWCCR 32 (*Rose*), Burke CCJ stated at [42]:

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

53. Further, His Honour added at [47]:

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

54. Burke CCJ considered the relevant factors relating to reasonably necessary treatment under s 60 of the 1987 Act in *Bartolo v Western Sydney Area Health Service* (1997) 14 NSWCCR 233 (*Bartolo*) and stated:

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

55. In *Diab v NRMA Ltd* [2014] NSWWCCPD 72 (*Diab*), Deputy President Roche provided a summary of the principles as follows:

> "In the context of s 60, the relevant matters, according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ at point (5) in *Rose* (see [76] above), namely:
>
> (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.
>
> 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'".

56. Whether the need for reasonably necessary treatment arises from an injury is a question of causation and must be determined based on the facts in each case. The accepted view regarding causation was set out in *Kooragang* where Kirby J stated at [463]:

> "The result of the cases is that each case where causation is in issue in a worker's compensation claim must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from' is not now accepted. By the same token, the mere proof that certain events

occurred which predisposed a worker to subsequent injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a common sense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation."

57. It is accepted that a condition can have multiple causes, but the applicant must establish that the injury materially contributed to the need for surgery. This was confirmed by Deputy President Roche in *Murphy*, where he stated at [57-58]:

> "Moreover, even if the fall at Coles contributed to the need for surgery, that would not necessarily defeat Ms Murphy's claim. That is because a condition can have multiple causes (*Migge v Wormald Bros Industries Ltd* (1973) 47 ALJR 236; *Pyrmont Publishing Co Pty Ltd v Peters* (1972) 46 WCR 27; *Cluff v Dorahy Bros (Wholesale) Pty Ltd* (1979) 53 WCR 167; *ACQ Pty Ltd v Cook* [2009] HCA 28 at [25] and [27]; [2009] HCA 28; 237 CLR 656). The work injury does not have to be the only, or even a substantial, cause of the need for the relevant treatment before the cost of that treatment is recoverable under s 60 of the 1987 Act.
>
> Ms Murphy only has to establish, applying the common sense test of causation (*Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796), that the treatment is reasonably necessary 'as a result of' the injury (see *Taxis Combined Services (Victoria) Pty Ltd v Schokman* [2014] NSWWCCPD 18 at [40] – [55]). That is, she has to establish that the injury materially contributed to the need for the surgery (see the discussion on the test of causation in *Sutherland Shire Council v Baltica General Insurance Co Ltd* (1996) 12 NSWCCR 716)."

58. According to *Murphy*, a condition can have many causes, and all that the applicant needs to show is that the injury materially contributed to the need for surgery. The weight of the medical evidence, in my view establishes, that Mrs Jogiya's injury has materially contributed to the need for surgery.

59. Dr Endrey-Walder agreed with Dr Kam that Mrs Jogiya's back condition was essentially secondary to the single level disc degeneration and disc bulge at L4/5, for which the only reasonable therapeutic measure was a spinal fusion. Dr Endrey-Walder also considered that the single level disc condition due to disc damage probably caused a degree of early instability and was likely to be a contributing factor to her debility. He concluded that Mrs Jogiya's symptoms were due to the damaged L4-5 disc, the damage having occurred in the accident of 29 March 2015.

60. Dr Kam noted that Mrs Jogiva had been suffering from a work-related injury dating back to 2015 where she underwent a successful microdiscectomy operation. However, he reported that about 6-7 months following the successful surgery she developed increasing symptoms with a gradual increase in intensity and frequency, to the point where it has now been causing her ongoing pain and discomfort over a two-year period. Dr Kam stated that the recommendation of fusion of the L4/5 level was to address the mechanical back pain generated by the changes identified at the L4/5 level and this was a progression of the initial injury that occurred in 2015. Dr Kam was of the opinion that the fusion operation requested was still related to the initial injury as her injury from 2015 had given her the progressive change identified at the L4/5 level. He expressed the view that the work injury has been the main contributor to her current state of pain.

61. Dr Casikar was of the opinion that the spinal fusion suggested by Dr Kam was mainly to address degenerative disease of the lumbar spine. He noted that this was a genetic constitutional problem and not related to the workplace incident that Ms Jogiya suffered. He considered that the need for surgery that Dr Kam indicated was mainly to address problems related to degenerative disease. Dr Casikar commented that very often patients do complain of chronic pain because of degenerative disease. He considered that the surgery suggested by Dr Kam was one of the acceptable methods of treatment for degenerative disease but found it difficult to support the idea that this fusion was a compensable condition related to her employment.

62. I accept the opinions of Drs Endrey-Walder and Kam and prefer their evidence to that of Dr Casikar. In particular, I have taken into account the fact that Dr Kam is the treating surgeon and has seen Mrs Jogiya on a number of occasions and is in a better position to provide an opinion on causation. Dr Casikar did not properly address the question of whether the microdiscectomy surgery in 2015 had either caused or contributed to the degenerative condition at L/4/5 and for that reason I have placed less weight on his opinion in relation to causation. Dr Kam stated that the fusion was required to address mechanical back pain generated by the changes identified at the L4/5 level. He considered that this was a progression of the initial injury in 2015 and the precipitating event was the work injury in 2015. I accept Dr Kam's opinion. Therefore, I am satisfied that the applicant's injury has materially contributed to the need for fusion surgery at L4/5.

63. The next question to consider is whether the fusion surgery is reasonably necessary as a result of the work injury.

64. The respondent has argued that the spinal fusion was not reasonably necessary treatment as there were alternative conservative methods of treatments, such as home based exercises and cortisone injections, that should be undergone prior to any fusion surgery.

65. I have considered the history of treatment after the injury on 29 March 2015. I note that prior to the microdiscectomy on 9 November 2015 Mrs Jogiya had numerous sessions of physiotherapy. Dr Renigeris reported that initially after the injury on 29 March 2015 a conservative approach to therapy was taken which included 31 visits to physiotherapy and analgesia. He observed that slight improvement occurred, but after that, nothing, and Mrs Jogiya was unable to work. Dr Kam, in May 2015, noted that Mrs Jogiya had been prescribed Lyrica and had physiotherapy treatment for the last four weeks. Dr Kam recommended that Mrs Jogiya adopt a conservative approach as she had improved. He noted that if there was any further worsening of her symptoms, surgery could be considered as an option.

66. On 9 November 2015 Dr Kam wrote noted that Mrs Jogiya was seen by the IME, who suggested a cortisone injection. Dr Kam reported that on speaking to Mrs Jogiya, she was not enthusiastic about the cortisone injection as she felt that this was only a temporary measure without any change in the structure of the disc bulge that was causing the nerve root compression. Dr Kam reported that after failing conservative management, surgery was considered and recommended.

67. Following the surgery on 9 November 2015, Mrs Jogiya had physiotherapy at the hospital and then at a clinic. Mrs Jogiya stated that she returned to work on a part-time basis but her employment with the respondent was terminated on 19 February 2016. She said that she continued to have some back pain and took Voltaren tablets and Panadol. Mrs Jogiya later obtained employment as an Administration Clerk at the Tile Factory Outlet and was able to work 38 hours a week. However, I note that she stated that she reduced her hours in May 2019 from eight to seven hours per day, with a loss

of pay. Mrs Jogiya said that she was having difficulties coping even with her current hours and found it necessary to take extra strong Panadol and prescribed medication when the pain was bad. She said that she wanted to proceed with the lumbar surgery recommended by Dr Kam as she did not believe that she would be able to work much longer with increasing back and leg pain.

68. There was some question about whether Mrs Jogiya had a cortisone injection at some stage after the surgery on 9 November 2015. I accept that Dr Endrey-Walder assumed that Mrs Jogiya had a cortisone injection in June 2017 and said that the injection did not provide any symptomatic relief. In June 2017, Dr Kam wrote: “If there is any further deterioration, there may be a role for her to undergo further steroid injections into the L4/5 region on the left side.” The use of the word “further” suggests that Mrs Jogiya had a steroid injection at some time.

69. Dr Regineris, in a referral to Dr Kam on 2 October 2018, requested Dr Kam to assess her with a view to injections.

70. There was no actual reference in the reports of the treating doctors, that is, Dr Kam and Dr Regineris, to an injection being performed in 2017 or 2018 apart from the reference to a further injection by Dr Kam in his report dated 8 June 2017. However, there is no doubt that the treating doctors were aware that a cortisone or steroid injection was a treatment option and I would infer that Dr Kam decided not to have such an injection performed or no further injection. It was possible that Mrs Jogiya decided not to have a cortisone injection as she did in 2015 for the reasons noted by Dr Kam in his operation report dated 9 November 2015.

71. In his most recent report dated 27 August 2019, Dr Kam noted that about six to seven months following the successful microdiscectomy operation Mrs Jogiya developed increasing symptoms with a gradual increase in intensity and frequency, to the point where it has now been causing her ongoing pain and discomfort over a two year period and which has been resistant to non-surgical techniques. He was of the opinion that Mrs Jogiya had exhausted all conservative treatment to date and remained quite restricted in her activities. He recommended a fusion at L4/5 level to address both the back pain and leg pain.

72. Dr Endrey-Walder did not support Dr Casikar’s contention that ongoing conservative measures and trying cortisone injection at the L4/5 space, was going to result in any amelioration of Mrs Jogiya’s condition. I accept that Dr Endrey-Walder noted that Dr Casikar might not have been aware of the CT guided injection this lady had in June 2016 with no beneficial effect and that there is no evidence apart from Dr Kam’s reference to a “further injection”, that such an injection was undertaken. However, in my view, a cortisone injection would not address the actual pathology in the lumbar spine. Dr Endrey-Walder concluded that stabilising the single level damage in the back might help prolong her working life substantially. He concluded that short of a fusion procedure it was difficult to see what could be done for Mrs Jogiya.

73. Dr Casikar considered that non-surgical management of chronic back pain had a better outcome regarding returning to work and need for medication. He noted that Dr Kam had indicated that all non-surgical methods have been tried but was not sure what Dr Kam meant by this. Dr Casikar opined that Ms Jogiya had not had any methods of treatment except medication by her family physician. Dr Casikar considered that it was very controversial as to whether Mrs Jogiya would get any benefits from surgery and the probability of back pain remaining as before and the need for medication being the same were likely to be higher than the 80% relief that Dr Kam had projected. Dr Casikar believed the home-based exercises and advice on managing back pain would keep Ms Jogiya in the workforce for a longer period and a spinal fusion would adversely impact her capacity to get back to her workplace.

74. However, in a supplementary report dated 13 November 2019, Dr Casikar noted that the need for surgery that Dr Kam indicated was mainly to address problems related to degenerative disease. Dr Casikar commented that very often patients did complain of chronic pain because of degenerative disease. Dr Casikar expressed the view that the surgery suggested by Dr Kam was one of the acceptable methods of treatment for degenerative disease.

75. On balance, I am satisfied that the fusion at L4/5 could help alleviate the pain experienced by Mrs Jogiya and stabilise her lumbar spine. The evidence from Dr Kam and Dr Endrey-Walder supported this conclusion. In particular, Dr Kam noted that was of the opinion that Mrs Jogiya had exhausted all conservative treatment. Although Dr Kam did not specify what that treatment was in his report, it is clear that over the years Mrs Jogiya had physiotherapy, pain medication and considered a cortisone injection or possibly had one cortisone injection. Dr Endrey-Walder concluded that stabilising the single level damage in the back might help prolong her working life substantially.

76. I prefer the evidence of Dr Kam and Dr Endrey-Walder to the evidence of Dr Casikar on the question of whether there were other acceptable treatment methods. Further, Dr Casikar conceded that a fusion was one of the acceptable methods of treatment for degenerative disease. The history of previous conservative treatment and opinions of the doctors as to potential treatment are obviously factors to be taken into account in determining if the proposed surgery is reasonably necessary. It was not clear if Mrs Jogiya had undergone steroid injections, but this was not a factor that really affected the weight I placed on Dr Endrey-Walder's report as injections do not address the pathology. I am satisfied that Dr Endrey-Walder and Dr Kam considered the history and potential benefits of conservative treatment as part of reaching their conclusions, which I accept, that the proposed fusion is reasonably necessary treatment.

77. The cost of the surgery for the fusion at L4/5 appeared to be in the vicinity of $20,000. Whilst this is costly, Mrs Jogiya has already reduced her working hours because of pain and the fusion, if reasonably successful, would prolong her working life as well as alleviate her pain. Without the surgery, it is possible that Mrs Jogiya may reduce her work hours further or even become unable to work because of pain.

78. I am satisfied that the medical evidence, on balance, supported the need for the fusion surgery proposed by Dr Kam. I am not persuaded that the same potential outcome could be achieved by a different treatment such as home exercises and steroid injections. To the extent that Dr Casikar argues that the ongoing pain is due only to degeneration and not to the injury on 29 March 2019, I reject that conclusion and for the reasons already given, prefer the opinions of Dr Kam and Dr Endrey-Walder on this issue.

79. I am satisfied on the balance of probabilities that the treatment proposed by Dr Kam, namely, a fusion at L4/5 and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of Mrs Jogiya's employment with the respondent on 29 March 2015.