WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: 3854/19
Applicant: Bruce Adams
Respondent: SAS Water Solutions Pty Ltd
Date of Determination: 24 October 2019
Citation: [2019] NSWWCC 349

The Commission determines:

1. The L4/5 anterior to psoas fusion surgery proposed by Dr Bhisham Singh on 18 September 2018 is reasonably necessary as a result of the injury on 12 December 2014.

The Commission orders:

1. The respondent to pay the costs of and reasonably incidental to the proposed surgery pursuant to s 60 of the *Workers Compensation Act 1987*.

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

Rachel Homan
Arbitrator

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

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mr Bruce Adams (the applicant) was employed by SAS Water Solutions Pty Ltd (the respondent) as a service technician. On 12 December 2014[1], the applicant sustained an injury to his lumbar spine whilst at work. A claim for workers compensation was lodged and liability for the injury accepted.

2. The applicant underwent a L3/4 discectomy and rhizolysis surgery, performed by Dr Brian Hsu, on 20 January 2015. Dr Hsu performed a further surgery in the form of a L3/4 decompression and interbody fusion on 7 November 2017. Both surgeries were approved by the respondent's insurer.

3. On 18 September 2018, Dr Hsu's colleague, Dr Bhisham Singh requested approval for a third surgery in the form of a L4/5 anterior to psoas fusion. Liability for the further surgery was declined on 19 November 2018 on the ground that the surgery was not reasonably necessary treatment, pursuant to s 60 of the *Workers Compensation Act 1987* (the 1987 Act). Further declinature notices were issued pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) on 19 February 2019 and pursuant to s 287A of the 1998 Act on 7 August 2019.

4. The present proceedings were commenced by an Application to Resolve a Dispute (ARD) filed in the Commission on 1 August 2019 seeking the costs of and associated with the proposed surgery.

ISSUES FOR DETERMINATION

5. The parties agree that the following issue remains in dispute and requires determination:

   (a) Whether the L4/5 anterior to psoas fusion surgery proposed by Dr Singh on 18 September 2018 is reasonably necessary as a result of the injury on 12 December 2014, pursuant to s 60 of the 1987 Act.

PROCEDURE BEFORE THE COMMISSION

6. The parties appeared for conciliation conference and arbitration hearing on 30 September 2019. The applicant was represented by Mr Craig Tanner instructed by Ms Basema Elmasri. The respondent was represented by Mr Joshua Beren.

7. 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

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

   (a) ARD and attached documents;

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[1] The date of injury which appears on the declinature notices is "26 December 2014", which appears to be date on which the applicant first sought medical treatment at Blacktown Hospital. The applicant's evidence indicates, however, and it was accepted by the respondent for the purposes of these proceedings, that the injury occurred at work on 12 December 2014.

(b) Reply and attached documents;

(c) Report of Dr James Bodel dated 15 August 2019, attached to an Application to Admit Late Documents (AALD) filed by the applicant on 22 August 2019, and

(d) Reports of Dr Therese Roberts dated 20 August 2019 and Dr Alistair Ramachandran, dated 3 July 2019, attached to an AALD filed by the applicant on 30 September 2019.

9. An AALD filed by the applicant on 5 September 2019 was withdrawn.

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

Applicant's evidence

11. The applicant's evidence is set out in written statements made by him on 9 April 2019 and 26 July 2019.

12. The applicant stated that he injured his lower back on 12 December 2014 whilst working on the rooftop of premises at Macquarie Park. On 26 December 2014, the applicant was admitted to Blacktown Hospital Emergency Department with excruciating back pain. The applicant was referred to Dr Brian Hsu, an orthopaedic surgeon, and Dr Hsu performed a L3/L4 discectomy/rhizolysis surgery on 20 January 2015. After a period of intensive rehabilitation, the applicant's back pain improved and he was able to return to work in mid-2015.

13. Over time, the pain in the applicant's back recurred and his symptoms deteriorated. In October 2017, the applicant was admitted to hospital and underwent a L3/L4 decompression and interbody fusion surgery on 7 November 2017, performed by Dr Hsu. The applicant experienced some initial relief but, over time, the back pain worsened. The applicant began to experience shooting pain through his groin down his left leg into his ankle.

14. The applicant was referred back to Dr Hsu in response to his ongoing problems. The applicant was also referred to an exercise physiologist and underwent a cortisone injection on 5 September 2018. The injection provided relief for a few days. The applicant underwent a neurological study on 7 September 2018 and had a further injection 30 October 2018. Again, the effects of the cortisone injection lasted only a couple of days.

15. The applicant said he continued to experience a lot of pain and discomfort in his lower back and both hips. The applicant had shooting pain in his left thigh/leg and found it difficult to sit or stand for prolonged periods. The applicant was taking Targin, Panadeine Forte and Panadol Osteo. The applicant consulted his general practitioner, Dr Therese Roberts on a regular basis and had been referred to Dr Alistair Ramachandran at Painmed Persistent Pain Clinic at Norwest Private Hospital.

16. The applicant said Dr Ramachandran had indicated he could fix the nerve pain with a spinal cord stimulator. The applicant said that his orthopaedic surgeons had indicated that the stimulator would not fix the underlying problem at the L5 disc. The applicant said he trusted his treating doctors and hoped the surgery would improve his pain level and functioning. The applicant expressed fear that without the surgery his condition would not improve and he would not be able to get on with his life. The applicant said he wanted his pain levels to decrease and to get back to work.

17. The applicant said his injury was impacting on his personal life and mental health. The applicant had been diagnosed with depression and was hospitalised last year.

Applicant's treating practitioners

18. On 7 February 2018, adult and paediatric spine surgeon, Dr Brian Hsu wrote to the applicant's general practitioner, Dr Therese Roberts indicating that he had reviewed the applicant three months after his L3/4 decompression and fusion surgery. Dr Hsu said the applicant was progressing very well, his lower limb symptoms had resolved and his weakness was improving.

19. On 14 April 2018, Dr Hsu reported that he had reviewed the applicant again and he had excellent resolution of his preoperative back and leg pain and was making good progress with Chris Hughes, an exercise physiologist.

20. On 24 August 2018, Dr Hsu reported that he had reviewed the applicant on 16 August 2018. The applicant did not demonstrate significant pain but still had some weakness symptoms. As a result, Dr Hsu arranged for the applicant to undergo an MRI scan to assess for any residual compression.

21. The report of an MRI of the lumbosacral spine performed on 23 August 2018 indicated right L4/5 paracentral herniation contacting the origin of the right L5 nerve root.

22. On 30 August 2018, Dr Hsu's colleague, orthopaedic surgeon, Dr Bhisham Singh wrote to Dr Therese Roberts confirming that the MRI scan revealed L4/5-disc herniation, more so on the right side, which was most likely responsible for the applicant's symptoms of back and buttock pain on the right. Dr Singh indicated that he had arranged for the applicant to have neurophysiological studies of the lower limbs as well as a CT guided left L4/5 perineural injection as a diagnostic intervention.

23. A letter from Dr Singh, dated 18 September 2018 to Dr Roberts indicates that the applicant had been reviewed. The applicant had significant benefit from the left L4/5 perineural injection which gave him nearly complete relief of symptoms of back and leg pain for a period of three to four days. The applicant's pain was now returning and he had back pain symptoms in addition to radicular symptoms in both legs. A neurophysiological study had reported evidence of L4/5 and L3/4 radiculopathy. The applicant had an MRI scan of the lumbar spine which revealed collapse of disc height at L4/5 giving rise to lateral recess stenosis. Dr Singh said this was responsible for the applicant's symptoms. Dr Singh said the nonsurgical options were to accept permanent restrictions and trial chronic pain management. His surgical option was to have an extension of the fusion to L4/5. Dr Singh noted that the applicant was keen to pursue a more durable solution to his symptoms of back and leg pain. Dr Singh prepared an estimate of fees for surgery, requesting approval by the insurer, on the same day.

24. Accredited exercise physiologist, Mr Christopher Hughes wrote to Dr Hsu on 29 September 2018 indicating that the applicant had completed his current exercise physiology plan. The applicant's symptoms had increased in acuteness and frequency in recent weeks, given the diagnosis of an additional disc injury. The applicant was feeling frustrated and disheartened by the setback but was encouraged to continue his strong adherence to the plan to ensure he optimised his post-surgical rehabilitation.

25. On 15 November 2018, Dr Hsu wrote to Dr Roberts confirming that the applicant had developed adjacent segment disease following his L3/L4 decompression fusion and surgical intervention for the L5 level had been requested. Dr Hsu said he supported the request for surgery, which would involve an extension of the fusion from L3 to L5 and said he expected that the surgery would reproduce the very successful past injection results. This would lead to the applicant's pain and function improving.

26. In a report to the applicant's solicitors dated 10 December 2018, Dr Hsu said that the applicant developed back and leg symptoms from "evolution of his spinal injury to involve L4/5." Dr Hsu said following the L3/4 decompression fusion, the applicant developed new sciatica symptoms. A new MRI scan revealed L4/5-disc herniation. The applicant had significant benefit from a left L4/5 perineural injection which gave him the complete relief of symptoms of back and leg pain for three to four days. A neurophysiological study reported evidence of L4/5 and L3/for radiculopathy. Dr Hsu said he did not believe any further surgery at L3/4 would be of any benefit and no new pathology had arisen at that level. Dr Hsu said an injection would not likely be of sustained benefit. Dr Hsu stated that the proposed lumbar fusion surgery was necessary and would help the applicant's back pain and function. Other appropriate and conservative alternatives had been tried with only a short-lived response.

27. On 27 February 2019, interventional pain medicine specialist, Dr Alister Ramachandran, wrote to Dr Roberts indicating that he had done a comprehensive assessment of the applicant. Dr Ramachandran stated that following the 2017 surgery, the applicant had a good reduction in terms of his pain levels but persisted to have back and leg symptoms. The applicant reported constant pain in his low back and a typical neuropathic type pain in the left lower limb. The applicant's sleep was disturbed due to the pain levels and the resultant decline in overall functioning had impacted the applicant's psychological functioning. Dr Ramachandran indicated that the applicant had significant psychosocial overlay which included major depression and high levels of stress and anxiety. These needed to be addressed through an appropriate psychological assessment. Dr Ramachandran recommended a spinal cord stimulator trial as a minimally invasive technique. This was said to be based on the fact that there was evidence to support this therapy in pain that persists despite surgical intervention.

28. On 21 March 2019, Dr Singh reported that the applicant's insurer had not approved surgery but had approved chronic pain management including the use or trial of a spinal cord stimulation device. Dr Singh considered it reasonable to trial the device if it helped his symptoms. If the applicant's symptoms were not controlled by chronic pain modalities, he would need to consider surgery.

29. On 3 July 2019, Dr Ramachandran wrote to Dr Roberts. Dr Ramachandran said that the applicant had enquired about the spinal cord stimulator trial which had recently been approved by the insurance company for his pain management. Dr Ramachandran explained that it was in the applicant's best interest to complete all surgical interventions prior to considering the spinal cord stimulator. In the interim, whilst he waited surgery, Dr Ramachandran recommended that he maintain his current medication and incorporate physical therapy and psychological interventions.

30. In a report to the applicant's solicitors dated 4 July 2019, Dr Hsu confirmed that the applicant was suffering instability of the lumbar spine involving the L4/5 disc and was suffering from significant pain. Dr Hsu said a spinal cord stimulator would not treat the spinal instability or completely address the applicant's ongoing lumbar spine pain. Dr Hsu gave the opinion that the proposed lumbar fusion surgery at the L4/5 level was reasonably necessary treatment and more appropriate treatment as it would be more definitive.

31. On 20 August 2019, Dr Roberts reported to Dr Ramachandran that the applicant continued to experience low back pain. The applicant's current pain medicine regime did not seem to be working well for him. Dr Roberts was reluctant to keep increasing the applicant's narcotics and requested assistance in optimising the applicant's pain management.

Dr Bodel

32. The applicant relies on a medicolegal report prepared by orthopaedic surgeon, Dr James G Bodel dated 20 September 2018. Dr Bodel took a history of the injury, consistent with the applicant's evidence and noted that he had previously seen the applicant 18 months earlier. Since that time, the applicant had a spinal fusion done at the L3/4 level done by Dr Hsu in November 2017. The applicant had post-operative physiotherapy and slowly returned to work. The applicant had now been advised that he needed a further surgical procedure because a recent MRI scan showed that the L4/5 disc had collapsed and there was a large disc prolapse causing further nerve root tension. A further spinal fusion had been recommended. The applicant reported that he could not stand the pain any longer and was happy to proceed with that advice. The applicant had constant dull aching pain across the lower part of the back. The applicant had referred pain down the left leg, particularly to the inner aspect of the left knee and the sensation of spiders crawling on his leg. Prolonged sitting, bending, twisting or lifting aggravated the pain.

33. Dr Bodel stated:

> "Based on his clinical presentation, he does have nerve root irritability in the left leg and the further surgery as proposed is reasonably necessary as a consequence of the severity of the problems at L3/4 and L4/5."

34. Dr Bodel said the work injury was a substantial contributing factor to the applicant's current complaints.

35. In a further report dated 19 January 2019, Dr Bodel gave an opinion on the proposed lumbar surgery but appears to have erroneously referred to a proposal for surgery at L3/4 rather than L4/5.

36. On 18 April 2019, Dr Bodel wrote

> "At my recent re-examination on 18 September 2018, I did have access to the MRI scan of the lumbosacral spine dated 23 August 2018 and this clearly showed evidence of disc pathology both at the L3/4 level and at the L4/5 level. There has been a fusion at the L3/4 level and there is now a very large disc prolapse at the L4/5 level.
>
> I agree that this is probably a consequential condition associated with the fusion at the L3/4 level.
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> …
>
> In summary therefore, it is reasonably necessary to undergo the spinal fusion procedure as recommended by Dr Singh. I am satisfied that there is a causal link between the work-related injury and the need for that surgery at that level."

37. In a report of 8 July 2019, Dr Bodel expressed the opinion that the applicant did have instability at the L4/5 level. A spinal cord stimulator would not specifically address the instability at the L4/5 level. Dr Bodel concluded:

> "The proposed spinal fusion at L4/5 is reasonably necessary for the management of the consequential condition at that level following the fusion at L3/4.
>
> The spinal fusion at L4/5 as proposed is reasonably necessary for the management of the injury. The aim of that treatment in a medical sense is to alleviate the consequences of injury, decrease the pain to a more manageable level, maintain the workers state of health and hopefully prevent any deterioration in general. The spinal fusion as proposed is reasonably necessary for the management of the injury once all alternative more conservative approaches have been exhausted."

38. In his most recent report, dated 15 August 2019, Dr Bodel indicated that he had reviewed the opinion of the respondent's independent medical examiner, Dr Casikar and stated the following:

> "I note that you have indicated that Dr Casikar is of the view that there is no instability at the L4 /5 level.
>
> I disagree as there is clinical evidence of probable instability at that level because of the clinical findings and the abnormal appearances on scanning.
>
> I do agree that he does have a 'longstanding depression and failed back syndrome' but that does not necessarily exclude instability as a cause for part of the failed back syndrome.
>
> He then goes on to indicate that he feels that this gentleman may have a poor outcome with a fusion at L3/4 and L4/5 and, I agree with that in principle, that this is not an uncommon outcome and the poor nature of the outcome can indeed be influenced by the other factors such as the depressive illness.
>
> Even so, I am still of the view that all other measures have failed except for the use of the spinal stimulator and that it is still reasonably necessary to offer the fusion at this second level to diminish his pain profile.
>
> I disagree with the statement that the pain is '*due to non-organic conditions'."*

39. Dr Bodel remained of the view that fusion at the L4/5 level was reasonably necessary for the reasons previously expressed.

Dr Casikar

40. The respondent relies on a medicolegal report prepared by neurosurgeon, Dr Vidyasagar Casikar, dated 5 November 2018. Dr Casikar examined the applicant on 29 October 2018.

41. Dr Casikar took a history of the two previous spinal surgeries performed by Dr Hsu, stating that after the posterior fusion in November 2017, the post-operative result was very poor:

> "There was some improvement in his back pain, however the leg symptoms remained the same. Dr Hsu seemed to have indicated to him that it would get better after six months. Mr Adams indicated that even after a year, the problem has not improved. He still has severe neurological symptoms on the medial aspect of the left thigh extending to the left side of the groin, lower back pain, and the hip on the left side."

42. Dr Casikar noted that the applicant had been suffering from depression and had recently become suicidal, being admitted to Norwest Private Hospital.

43. Dr Casikar diagnosed L3/4 disc prolapse and failed back syndrome. With regard to the proposal for further surgery, Dr Casikar stated:

> "Further extensive spinal fusion (360° fusion) is difficult to justify. Just as the previous spinal fusion has failed, it is very likely that Mr Adams will have a poor outcome following this surgery. I believe that if he had had a re-microdiscectomy following the recurrence in 2016, he would have returned to the workforce. Unfortunately, the spinal fusion has made him unfit to get back to any kind of work. I believe that the further spinal fusion suggested by Dr Singh will similarly have a poor outcome. I would strongly recommend against a further spinal fusion. A rhizolysis at the L3 & 4 nerve roots under microscope magnification will give him a good outcome.

The right paracentral disc bulge at L4/5 segment is incidental. Mr Adams has no symptoms related to this."

44. With regard to causation, Dr Casikar stated:

> "Mr Adams' current symptoms and diagnosis are related to the spinal fusion. The initial microdiscectomy was necessary because of the work-related injury of 26/12/2014. This was consistent with the description of the injury. The recurrence of disc prolapse about a year later was not unusual. This happens in about 20% of cases. He required another microdiscectomy. I cannot justify a spinal fusion when a simple microdiscectomy was necessary. This fusion, in my opinion, was unrelated to his employment, and he presents a failed back syndrome. The suggestion for further spinal fusion is because of the complications of failed back syndrome. This will not succeed."

45. Dr Casikar said the two-stage lumbar fusion proposed by Dr Singh was difficult to justify considering the fact that there was no spinal instability. Nerve root compression could easily be managed by appropriate rhizolysis done under operative microscope magnification. Dr Casikar said the applicant should have a second cortisone injection and if this did not give him benefit he should have the rhizolysis. Dr Casikar said further spinal fusion would be a "disaster".

46. Dr Casikar prepared a further report on 30 July 2019. Dr Casikar expressed doubt over the diagnosis of instability made by Dr Bodel when flexion/extension studies had not been done. Dr Casikar reiterated his view that spinal fusion was excessive. Dr Casikar said spinal fusion in a patient who has a long history of depression has a very poor outcome:

> "The reason why Dr Hsu's spinal fusion has not improved Mr Adams is because of his depression and he has a well-established failed back syndrome."

47. Dr Casikar was asked whether the applicant had sustained a consequential condition and L4/5 as a result of his work injury. Dr Casikar responded:

> "Mr Adams has not suffered a consequential condition at L4/L5 level. Because he had a spinal fusion at L3/4, which in my opinion was unnecessary; he has now got an adjacent segment disease. This is a common complication of fusions in the lumbar spine. Therefore, the consequence of his pathology at L4/L5 is because of the fusion at L3/L4. Therefore, it is not due to the injury by itself. The injury produced a disc prolapse. The fusion at L3/4 was because of the decision by Dr Hsu to do a spinal fusion when a simple re-exploration and microdiscectomy was necessary."

48. Asked whether the proposed surgery at the L4/5 level was reasonably necessary as a result of the injury, Dr Casikar said:

> "I do not believe the proposed surgery at L4/5 is reasonably necessary as a result of the injury. It probably is necessary because of complications of the previous fusion which in my opinion was not indicated.
>
> …
> The outcome of this procedure would be as poor as his previous fusion. Doing multiple level fusions do not correct the pain when the origin of pain is due to non-organic conditions."

49. Dr Casikar further commented:

> "If Mr Adams has a spinal fusion or if he has a spinal cord stimulator, the results would be poor. I believe the primary problem here is not recognising the fact that Mr Adams has got a long history of depression and pain is one of the symptoms of depression. If Mr Adams had a simple re-exploration and removal of the recurrent disc prolapse and had standard management of his depression, it is very likely he would have returned to the workforce. Having committed to a spinal fusion which in my opinion was not indicated, Mr Adams is likely to have a series of spinal fusions in the future and many other forms of treatment with a progressively poor outcome. As long as his depression exists any form of treatment would be a futile exercise. I do not share the immense optimism of Dr Bodel and Dr Hsu that spinal fusion will correct all problems. It is well recognised that spinal fusions have very poor outcomes in the workers compensation background and when there is a history of long depression. It is very likely that Mr Adams will continue to have multiple forms of treatment for back pain with progressively poor outcomes."

Respondent's submissions

50. Mr Beren said the only issue in dispute was whether the surgery proposed was "reasonably necessary".

51. Mr Beren submitted that the report from Dr Singh dated 10 December 2018 was accepted as containing an accurate history of the applicant's symptoms and treatment. Mr Beren noted that Dr Singh indicated that the surgery proposed was "necessary" without indicating whether it was "reasonably necessary".

52. Mr Beren said Dr Singh had explained from a structural perspective why he considered the surgery necessary but there were other issues at play including a significant psychological overlay relevant to the question of "reasonableness". Mr Beren noted that the applicant had confirmed he had a diagnosis of depression requiring hospitalisation for treatment.

53. Mr Beren submitted that Dr Ramachandran had identified a range of treatments that he considered would be appropriate for the applicant. Dr Ramachandran reported that the applicant had major depression, high levels of stress, anxiety and catastrophisation, as well as suicidal thoughts. Dr Ramachandran recommended psychological interventions for the significant psychological overlay. Mr Beren submitted that Dr Ramachandran's opinion dovetailed with Dr Casikar's opinion.

54. Dr Casikar had given the opinion that the proposed fusion would fail because of the applicant's persistent depression, identifying this as a common cause for back pain. Dr Casikar considered the outcome would be poor, as with the previous fusion, as the pain was due to non-organic conditions. As long as the depression existed, any further form of surgical treatment would be futile.

55. Mr Beren noted that Dr Bodel had, in his supplementary report of 15 August 2019, commented on Dr Casikar's opinion and had agreed in principle that the applicant might have a poor outcome as a result of factors such as the depressive illness.

56. Mr Beren submitted that Dr Casikar had indicated that the depression should be treated first. Neither Dr Hsu nor Dr Singh had commented on the applicant's depression. Dr Ramachandran had also considered the depressive symptoms to be a significant component in the applicant's pain.

57. Mr Beren said there was a strong argument from the respondent that the surgery should not be deemed reasonably necessary until the depression was adequately treated. There was no evidence in the application or other documents that the applicant was in receipt of psychological treatment. There was no opinion from a psychologist or psychiatrist. In the circumstances, Mr Beren submitted that I could not be comfortably satisfied that the outcome of the proposed treatment would be anything other than poor.

Applicant's submissions

58. Mr Tanner said the preponderance of medical opinion supported the applicant's claim for surgery, noting the opinions provided by Dr Hsu, Dr Singh and Dr Bodel, were distinct from the lone opinion of Dr Casikar.

59. Mr Tanner took me through the history set out in the applicant's statement and submitted that Dr Hsu's involvement in the applicant's treatment left him well equipped to understand the state of the applicant's back. His opinions were offered on the background of having operated on the applicant, unlike Dr Casikar.

60. Mr Tanner noted that both the previous surgeries were performed with the approval of the respondent. The respondent had accepted liability for the second procedure and considered at that point that the applicant was entitled to have his pain addressed. Mr Tanner contrasted this with the present position of the respondent that he should endure his pain.

61. Mr Tanner submitted that the respondent's entire case was based on the presence of a psychiatric condition, which it was submitted would lead to a poor outcome for the surgery. Mr Tanner submitted that the respondent would have to establish that there was no prospect of the applicant relieving his pain or ensuring stability of his lumbar spine if he proceeded with the surgery proposed. Mr Tanner submitted that there was no exploration by the respondent as to the reasons for the applicant's depression including whether it was caused by the applicant's pain, which would be addressed by the surgery. Mr Tanner submitted that there was no evidence from a psychologist or psychiatrist to support the respondent's declinature of liability on the basis of depression.

62. Mr Tanner submitted that any failed back syndrome was a consequence of the surgeries that were appropriately performed in 2015 and 2017. Mr Tanner submitted that Dr Casikar had conceded the causal relationship between the injury and the applicant's current condition.

63. Mr Tanner noted that Dr Casikar found there was no spinal instability whereas both Dr Hsu and Dr Bodel considered there was.

64. Mr Tanner noted Dr Casikar's opinion that the surgery outcome would be poor where the pain was due to non-organic conditions. Mr Tanner noted that Dr Casikar was not a qualified psychiatrist and submitted that there could be no suggestion that the applicant's pain was simply a delusion. Mr Tanner noted that in his first report, Dr Casikar had in fact recommended surgery albeit of a different form.

65. Mr Tanner noted the pathology shown in the MRI performed on 23 August 2018 and the reports of Dr Bodel and said there was a very clear medical explanation for the applicant's complaints. Dr Bodel gave the opinion that the applicant's problems were severe and related to nerve root irritability and the surgery in question would address those problems. The same opinion had been expressed by Dr Singh and Dr Hsu.

66. Mr Tanner noted that Dr Bodel agreed with Dr Singh that fusion was more likely to relieve the applicant's symptoms in the long-term than any other treatment. It was noted that the cortisone injection was of temporary benefit, which was a good indicator that the fusion was an appropriate form of treatment. Mr Tanner noted that the benefits of the surgery had been described by Dr Bodel and submitted that the applicant should not be expected to forego those benefits and endure his pain, particularly in view of his depression.

67. Mr Tanner submitted that Dr Bodel did not agree that there "would" be a poor outcome only that there "may" be a poor outcome but that should not deny the applicant of the possibility of a good outcome.

68. Mr Tanner concluded that the evidence involved a preponderance of opinion in favour of the procedure proposed including, the views of two treating surgeons and Dr Bodel's expert opinion. Mr Tanner submitted that Dr Bodel's opinions were based on a proper reading of the medical evidence in contrast to Dr Casikar's views. Mr Tanner said the evidence of depression would not satisfy me that the surgery proposed would not lead to better function and relief of the applicant symptoms. Mr Tanner sought an order that the respondent pay the costs of and associated with the proposed treatment.

Respondent's submissions in reply

69. Mr Beren noted Mr Tanner's submission that the respondent had not provided any evidence as to the applicant's depressive condition. Mr Beren said that this submission reversed the onus of proof but noted that a four to five-year history of depression was recorded in Dr Roberts' clinical notes. This suggested that the applicant's depression was pre-existing and not related to his present pain.

70. Mr Beren said Dr Casikar had stood firm in his position that the depression would lead to a poor outcome. Mr Beren submitted that Dr Casikar had agreed in his second report that surgery may be necessary but said the outcome was going to be poor because of the applicant's depression. Dr Bodel agreed with this in principle. Mr Beren submitted that the surgery should not proceed on the background of the applicant's current depression.

FINDINGS AND REASONS

71. Section 60 of the 1987 Act relevantly provides:

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

72. In *Diab v NRMA Ltd*[2] Roche DP, referring to the decision in *Rose v Health Commission (NSW)*[3], set out the test for determining if medical treatment is reasonably necessary as a result of a work injury:

[2] [2014] NSWWCCPD 72.
[3] [1986] NSWCC 2; (1986) 2 NSWCCR 32.

"The standard test adopted in determining if medical treatment is reasonably necessary as a result of a work injury is that stated by Burke CCJ in *Rose v Health Commission (NSW)* [1986] NSWCC 2; (1986) 2 NSWCCR 32 (*Rose*) where his Honour said, at 48A—C:

…

3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of injury.

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.'"

73. The Deputy President also noted that the Commission has generally referred to and applied the decision of Burke CCJ in *Bartolo v Western Sydney Area Health Service*[4]:

"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."

74. Deputy President Roche found:

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

(a) the appropriateness of the particular treatment;
(b) the availability of alternative treatment, and its potential effectiveness;
(c) the cost of the treatment;
(d) the actual or potential effectiveness of the treatment, and
(e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective.

With respect to point (d), it should be noted that while the effectiveness of the treatment is relevant to whether the treatment was reasonably necessary, it is certainly not determinative. The evidence may show that the same outcome could be achieved by a different treatment, but at a much lower cost. Similarly, bearing in mind that all treatment, especially surgery, carries a risk of a less than ideal result, a poor outcome does not necessarily mean that the treatment was not reasonably necessary. As always, each case will depend on its facts."

75. The evidence presented by the applicant in this case, when read in isolation from Dr Casikar's opinions, provides a clear and coherent justification for the surgery proposed by Dr Singh.

[4] [1997] NSWCC 1; 14 NSWCCR 233.

76. The issue of injury is not in dispute nor is there any dispute as to the treatment history. It is apparent that following an injury at work on 12 December 2014 the applicant required surgery in the nature of discectomy and rhizolysis at L3/4 performed by Dr Hsu. As a result of this treatment, the applicant's pain improved and he was able to return to work. Over time, there was a recurrence of pain and, in November 2017, the applicant underwent a decompression and interbody fusion surgery at the same level with approval by the insurer.

77. Although Dr Casikar has described the outcome of this second surgery as poor, the reports of Dr Hsu suggest in fact that the applicant's back and lower limb symptoms of pain initially resolved although he continued to experience some weakness. Unfortunately, by the time he was reviewed in August 2018, the applicant appears to have demonstrated some pain and a continuation of the weakness symptoms prompting Dr Hsu to arrange a further MRI. That MRI revealed pathology at the adjacent L4/5 disc impacting on the right L5 nerve root.

78. There is in fact a consensus of opinion that the pathology at L4/5 resulted from the previous surgery at L3/4. Although in his initial report, Dr Casikar described this pathology as "incidental", by the time of his second report, Dr Casikar expressed the opinion that the pathology was related to the previous fusion. Dr Casikar expressed the view that the pathology was not related to the work injury because he did not think the fusion surgery had been appropriate but in this regard, appears to demonstrate a misunderstanding of the legal test for causation. I accept, having regard to the consensus of medical opinion, that the pathology at L4/5 arises as a result of the injury and the surgical treatment undertaken to address that injury.

79. Both Dr Singh and Dr Hsu have expressed the view that an extension of the fusion to L4/5 was necessary to address the pathology at that level. This view was expressed after trialling a left L4/5 perineural injection which gave near complete relief of the applicant's back and leg pain symptoms for a period of time. Neurophysiological studies were performed demonstrating L4/5 radiculopathy. Having regard also to the MRI result, Dr Singh and Dr Hsu considered this to be the applicant's only surgical option. The nonsurgical options were to accept permanent restrictions and trial chronic pain management.

80. The evidence indicates that the applicant had trialled forms of non-surgical treatment including completing exercise physiology plans through Mr Hughes. The applicant was referred to Dr Ramachandran. Although Dr Ramachandran initially recommended a spinal cord stimulator as a minimally invasive technique, in his most recent report, Dr Ramachandran indicated that the applicant should complete all surgical interventions before considering this option, a view with which I note Dr Casikar concurs. The respondent did not contend at hearing that the stimulator was presently an appropriate form of treatment. Dr Ramachandran recommended that the applicant maintain his current medication and incorporate physical therapy and psychological interventions.

81. In her most recent report, Dr Roberts indicated that the applicant's current pain medicine regime did not seem to be working well and she was reluctant to increase his narcotics prescriptions.

82. There is no doubt that the applicant has experienced significant psychological symptoms. The applicant has conceded this in his statement and it is evident from the clinical notes of Dr Roberts dating from 2016. Both Mr Beren and Mr Tanner submitted that there was no evidence from a psychologist or psychiatrist in these proceedings. Dr Roberts' records do, however, indicate treatment by a psychologist, referral to a psychiatrist and admission to hospital in relation to the applicant's psychological symptoms, together with treatment with anti-depressant medication. There is also evidence from a clinical psychologist, Mariella Occelli, suggesting a complex psychological history and a history of psychological treatment. Ms Occelli's reports and Dr Roberts' clinical notes suggest that chronic pain as a result of the

applicant’s back injury was one but not the only factor in the applicant’s psychological presentation. Ms Occelli’s reports suggest the applicant has undergone psychological therapy involving psychoeducation, introduction of emotion regulation techniques including mindfulness and cognitive behavioural strategies with some apparent improvement in symptoms.

83. Mr Beren relies on the evidence of the applicant’s psychological conditions and Dr Casikar’s reports to argue that the surgical procedure proposed by Dr Singh is not “reasonably” necessary at the present time.

84. Dr Casikar’s opinions are, however, highly problematic. In his initial report, Dr Casikar appears to take issue with the particular surgical procedure proposed suggesting a rhizolysis at the L3 and L4 nerve roots under microscope magnification would give the applicant a good outcome. Dr Casikar suggested that pathology at L4/5 was incidental and not was causing symptoms.

85. In his second report, however, Dr Casikar appeared to concede that the proposed surgery at L4/5 was necessary because of complications from the previous fusion surgery. Dr Casikar then erroneously expressed the view that the need for surgery did not result from the injury on the basis of his opinion that the previous fusion surgery was not appropriate.

86. Dr Casikar indicated that the proposed spinal fusion or indeed any form of surgical treatment would now be a futile exercise and would have a very poor outcome because of the applicant’s long history of depression. Dr Casikar suggested that the applicant’s symptoms of pain were the result of his depression or other “non-organic condition”.

87. The primary difficulty in accepting Dr Casikar’s opinion is that he does not engage sufficiently with the pathology shown in the MRI, the neurophysiological studies, the effect of the perineural injection at L4/5, or the clinical indications revealed in Dr Singh and Dr Hsu’s reports, all of which demonstrate a clear physical basis for the applicant’s symptoms of pain. It is also not apparent that Dr Casikar was apprised of the history of treatment for the applicant’s psychological conditions or their precise nature. The suggestion that the applicant’s symptoms of pain were non-organic in origin is simply not supported by the other medical evidence before me.

88. Dr Bodel and Dr Hsu have expressed the opinion that there was instability at L4/5 based on the clinical findings and the abnormal appearances on scanning. Dr Bodel concurs with the treating surgeons that the proposed spinal fusion at L4/5 is reasonably necessary and would aim to alleviate the consequences of injury, decrease the applicant’s pain to a more manageable level, maintain his state of health and hopefully prevent any deterioration in general. Dr Bodel accepted that alternative more conservative approaches, other than the spinal cord stimulator, had been exhausted. Although Dr Bodel did not disagree that there may be a poor outcome influenced by factors such as the applicant’s depressive illness, he remained of the view that it was reasonably necessary to offer the fusion at the present time to diminish the applicant’s pain profile.

89. I am satisfied on the evidence before me that the applicant has demonstrable pathology at L4/5 which the surgery proposed by Dr Singh aims to address. There is consensus between the applicant’s treating surgeons and the applicant’s independent expert that the particular treatment is appropriate and potentially effective. Other conservative treatments identified have been attempted and failed to improve the applicant’s pain or function. The evidence indicates to me that a spinal cord stimulator is not currently recommended until the applicant has pursued all surgical options.

90. Although Mr Beren has suggested that treatment of the applicant's symptoms of depression would be appropriate prior to the surgery being performed, there is indication in the evidence before me that the applicant is and has been undergoing appropriate psychological treatment. Having regard to Dr Bodel's most recent opinions and in view of the deficiencies in Dr Casikar's reports identified above, I am not satisfied that the presence of a long-standing history of depression would inevitably result in a poor outcome.

91. There is no doubt that the proposed surgery is expensive and attended by considerable risk. Having carefully considered and weighed all the evidence, I am satisfied that it is better that the applicant have the treatment proposed by Dr Singh and Dr Hsu and it should not be forborne.

92. I am satisfied that the L4/5 anterior to psoas fusion surgery proposed by Dr Singh on 18 September 2018 is reasonably necessary as a result of the injury on 12 December 2014, pursuant to s 60 of the 1987 Act. There will be an award for the applicant for the costs of and incidental to the surgery.

SUMMARY

93. The L4/5 anterior to psoas fusion surgery proposed by Dr Singh on 18 September 2018 is reasonably necessary as a result of the injury on 12 December 2014, pursuant to s 60 of the 1987 Act

94. The respondent to pay the costs of and reasonably incidental to the proposed surgery pursuant to s 60 of the 1987 Act.