Review 380

Review number: [redacted]

Claim number: [redacted]

Application by [redacted]

for a review under the Accident Compensation Act

Held at	[redacted]
Date of hearing	18 April 2017
Reviewer	[redacted]
Present	Mrs [redacted] (by telephone) Mr Tim Yates (advocate – by telephone) Mr Clinton Light (ACC)

Issue 1	Whether ACC correctly decided not to fund Mrs [redacted] lumbar surgery
Decision 1	**Dismissed**
Issue 2	Whether ACC correctly decided to suspend Mrs [redacted] entitlements
Decision 2	**Dismissed**

Costs	Sought
Action	Required.

Decision

I have considered whether ACC was correct to suspend Mrs [redacted] entitlements by its letter dated 27 May 2016 on the basis that her current symptoms are unrelated to her covered injury of left hip/ thigh sprain and neck sprain. Rather, ACC considers her current symptoms are caused wholly or substantially by degenerative changes in her spine. My decision in this matter is that the application is dismissed.

I have also considered whether ACC was correct to decline funding for Mrs [redacted] lumbar surgery by its letter dated 27 May 2016. My decision in this matter is that the application is also dismissed.

This means that Mrs [redacted] is unsuccessful in both her review applications.

I find that the medical evidence falls short of establishing that;

1. Mrs [redacted] ongoing symptoms are a result of an injury caused by her accident on 10 October 2013 or any other covered injury; and
2. Mrs [redacted] current condition for which surgery is sought was caused by her 10 October accident.

In reaching my decision, I have considered Mrs [redacted] evidence, Mr Yates' submissions, ACC's case file and submissions, the Accident Compensation Act 2001, and relevant case law.

ACC is to pay review costs.

Background

On 10 October 2013 Mrs [redacted] slipped on a wet kitchen floor, went backwards and landed on her left side. She has cover for a left hip/ thigh sprain and neck sprain as a result of that accident, although relevantly, the ACC claim form for cover also noted that Mrs [redacted] had a sore back following the accident[1].

She described her pain to ACC as being like 'shattered glass' in the hip joint, with pain into her groin and numbness in her left leg. She was deemed fully unfit for work.

On 15 October 2013 Mrs [redacted] suffered another fall when her left leg gave way. She was taken to Christchurch Hospital and was noted to have symptoms in her left hip radiating to her groin region but no back or knee pain. She had an X-ray of her pelvis and left hip which showed

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[1] Ms [redacted] was also subsequently diagnosed with a labral tear, however ACC declined to accept cover for this as it was agreed by the treating specialists and ACC that this was not the source of Ms [redacted] symptoms. As this is not a live issue, I have not discussed this diagnosis further as I do not consider anything turns on this.

no fractures or dislocation. She also had an X-ray of her lumbar spine which showed 'significant spondylolisthesis of L5 on S1 probably unchanged from 4/4/12[2]'.

Mrs [redacted] also suffered three further falls between 16 October 2013 and 30 October 2013 after her left leg gave way when she went to put weight on it after sitting down.

Symptoms persist

Unfortunately, Mrs [redacted] continued to suffer from significant back, hip and groin pain following her accident. To alleviate some of her pain, Mrs [redacted] underwent a series of ultrasound guided injections, however these made little to no difference to her symptoms.

On 5 February 2014, arthroscopic and sports injury surgeon, Mr Hamish Love, reported that given that the injections were not helping, he did not consider her symptoms were coming from her hip; rather they were coming from her lumbar spine. Mr Love therefore referred Mrs [redacted] to spinal and orthopaedic surgeon, Mr Kris Dalzell.

Mr Dalzell confirms L5 radiculopathy

Mr Dalzell assessed Mrs [redacted] on 12 March 2014 and recommended plain X-rays of her lumbar spine and an MRI scan. Following imaging of her spine, pelvis and hip, Mr Dalzell reported on 3 April 2014 that:

> the MRI scan shows some degenerative changes particularly at the L5/S1 level. She has isthmic spondylolisthesis with a grade I slip. There is foraminal narrowing particularly on the left side.

He also noted that there was most likely foraminal encroachment on the L5 nerve. He diagnosed Mrs [redacted] with left L5 radiculopathy due to isthmic spondylolisthesis at L5/S1 which caused nerve impingement.

Mr Dalzell then referred Mrs [redacted] to the Southern Obesity Clinic on 7 May 2015. In his referral note, Mr Dalzell wrote 'she has quite severe back pain and this radiates into her back, buttock and upper thigh' which he attributed to 'isthmic spondylolisthesis L5/S1' which 'causes significant nerve root traction on both the L5 nerve roots and the traversing S1 nerve roots'.

ACC suspends entitlements

On 27 May 2014 ACC decided there was no causal link between Mrs [redacted] ongoing incapacity and her accident of 10 October 2013. ACC decided that Mrs [redacted] hip/thigh sprain for which she had cover was spent and her current symptoms were caused by a degenerative condition in her back, namely isthmic spondylolisthesis, which was not a new personal injury.

Ms [redacted] seeks review, provides further medical report

On 30 June 2014 Mrs [redacted] applied for a review of that decision.

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[2] I consider this to be a typographical error and is a reference to the X-ray completed on 24 April 2012.

To support her case at review, Mrs [redacted] advocate, Mr Tim Yates, wrote to Mr Dalzell requesting further comment on the causal link between her current incapacity and the accident on 10 October 2013. Mr Dalzell reported on 19 February 2015. He reported the following:

- The fact that the ultrasound guided injections provided little to no relief immediately following the accident indicates her symptoms were not coming from her hip. Rather the symptoms came from the L5 nerve root.
- When Mrs [redacted] fell, it caused an abrupt anterolisthesis. Although the anterolisthesis of L5/S1 predated the accident, it is likely that this made Mrs [redacted] more vulnerable to suffering nerve impingement in the fall because anterolisthesis causes there to be diminished available space for the L5 nerve root.
- A nerve that is impinged will produce radicular symptoms that will reveal themselves at or close to the time it occurs and such symptoms are likely to continue. Nerve impingement cannot be asymptomatic.
- The common scenario with nerve root impingement is to have focal pain at the level of the impingement or the area immediately adjacent to it, with radicular symptoms or more distal symptoms occurring afterwards.

Review Decision – ACC to issue a new decision

A hearing of the review application was held in [redacted] on 27 February 2015. In a decision dated 27 March 2015, an independent reviewer quashed ACC's decision dated 27 May 2014 and issued directions to ACC to investigate further to determine whether there is a causal link between Mrs [redacted] current injury (L5 radiculopathy) and her accident of 10 October 2013.

The reviewer was uncertain as to the level of knowledge Mr Dalzell had of Mrs [redacted] medical history prior to his report of 19 February 2015. The reviewer therefore directed ACC to issue a new decision on the cause of Mrs [redacted] L5 radiculopathy and entitlement to weekly compensation after:

- obtaining any medical notes for Mrs [redacted] (including general practitioner and pain clinic notes) for the period 1 January 2012 – 1 October 2013 that refer to hip, back, groin or leg symptoms;
- obtaining any physiotherapy notes for Mrs [redacted] for the period 1 January 2012 – 10 October 2013 that refer to hip, back, groin or leg symptoms; and
- considering whether an injury suffered in the October 2013 accident, or any earlier covered injury, is causing or contributing to Mrs [redacted] current L5 radiculopathy.

ACC obtains past medical records

Following a request from ACC, in April 2015, the Canterbury District Heath Board provided ACC with some of Mrs [redacted] medical history notes. Further medical notes were received by ACC on 6 April 2017.

Medical notes show long history of back problems – 2003 back problems

On 24 March 2003 Mrs [redacted] was assessed by Dr Paul Wanty with 'recurrence of the same old problem felt in the same areas of her lumbar spine'. Dr Wanty, in a letter to ACC dated 23 April 2003, explained that at the time of assessing Mrs [redacted]

> her current problems are due to bending over forward in the course of her work which is an ongoing chronic situation for her.
>
> …I believe [redacted] low back pain has never totally resolved and has become a chronic situation for her.

Dr Wanty recommended an X-Ray which was conducted on 26 March 2003. Radiologist, Dr Hugh Roberts, commented on the X-ray, noting that Ms [redacted] had a five-year history of chronic lumbar pain. He recorded that 'there is quite marked loss of height at the L5-S1 disc and there is a very slight spondylolisthesis at this level'.

Mrs [redacted] was then referred to orthopaedic surgeon, Mr Grahame Inglis, who assessed her on 31 March 2003. Mr Inglis reported to Dr Wanty noting that Mrs [redacted]

> describes a long history of back pain. She relates back pain to the mid to late 80's. She has had recurring back problems since that time.
>
> …[redacted] relates to a recent onset of significant back pain…She had a previous episode similar to this, had to be taken to Christchurch Hospital about three or four years ago with severe back pain and an inability to walk. On this occasion her back was very severe, there was no radiation, no leg pain, no neurological symptoms.

In a letter to ACC dated 11 June 2003, Mr Inglis stated:

> I feel [redacted] back pain though is entirely nonspecific and unrelated to any specific injury or accident to her spine. She has pars defects with a minor forward shift of L5 in relation to S1 which also may be a contributor to her back pain. I do not feel [redacted] present predicament is directly the result of any injury that occurred on 17 October 1997 but is rather an ongoing evolving back dysfunction which will continue to be a recurring problem from time to time in the future'.

Symptoms persist - 2012

On 24 April 2012 Mrs [redacted] underwent a further X-ray of her lumbar spine, left pelvis and hip to assess the cause of her unresolved pain in these regions. Radiologist Dr N Anderson reported on the X-ray. In relation to Mrs [redacted] lumbar spine, he noted:

> Bony alignment is normal. There is moderate narrowing of the L4/5 disc space. There are the appearances of a "limbus vertebra" at the anterior superior aspect of L5 vertebral body. This is commonly considered to be due to a chronic anterior disc herniation. The remaining disc spaces are well preserved. No other abnormality seen.

The X-ray did not show any abnormalities in Mrs [redacted] hip or pelvis.

On 27 April 2012, Dr Wanty provided a referral to musculoskeletal pain physician, Dr John Robinson, primarily to assess her left ankle symptoms following a slip in 2009. However, in the referral note, Dr Wanty explained that she also had hip pain. It was a minor feature of her accident but was now becoming the dominant feature. He said:

> She complains of sharp pain in the anterior hip and has some left lumbar pain as well and can get pain down the outside of her leg to her foot.

Mrs [redacted] was assessed by Dr Robinson on 12 July 2012. Dr Robinson reported that Mrs [redacted] complained of left hip pain that was felt in the lateral aspect of her hip and radiated medially. He noted that

> there was little in the way of groin pain. There was no low back pain. The hip pain was precipitated and aggravated by walking and bending at work. It was also aggravated by lying on the left side.

ACC investigates further following review decision

Occupational specialist reports

Following the review decision of 27 March 2015, ACC arranged for Mrs [redacted] to see occupational physician, Dr Bill Turner on 29 July 2015.

Dr Turner provided a 15-page report on 3 August 2015. Of her current symptoms, he said:

> [redacted] reported that all her symptoms continue to be on the left side namely the left hip, left thigh and left shin to the mid shin level…She indicated that she is never pain free in the left hip. She described the pain in her left hip as already described as "shattered glass".

He concluded that there are two diagnoses that would account for her hip pain symptoms:

- Iliopsoas myofascial pain syndrome which would account for her groin pain; and
- Nonspecific mechanical low back pain disorder due to her obesity which would account for her ongoing back pain.

He was unable to conclude that physical injuries have caused these conditions.

Dr Turner stated:

> Clearly she does have isthmic spondylolisthesis at L5/S1, which clearly predated the incident on 10/10/13 and all other four falling incidences that she had up to 30 October 2013. As Dr John Robinson noted in the X-Ray of her lumbar spine and hips on 24/4/12 that there was anterior movement at L5 on S1 confirming the spondylolisthesis predated the accidental events…In my opinion it is unlikely that she has significant injury pathology in her left hip.
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> …in my opinion the initial diagnosis was that she suffered a simple contusion in the fall. I am unable to conclude that the event on 10/10/13 caused the anterior labral tear nor am I able to conclude that she suffered an acute spondylolisthesis on this particular date. Her isthmic spondylolisthesis would have developed many years before and indeed is a finding that occurs in 3% of the adult population.

When asked whether there was a physical injury at the L5/S1 at the same level as the spondylolisthesis, Dr Turner concluded that this is not the case as Mrs [redacted] already had evidence of forward shift of L5 on S1 back in July 2012 at which time it was also mentioned she had left hip pain. He commented that he believed Mrs [redacted] hip and back pain are associated with each other. He said that there was no evidence that she would have suffered an abrupt spondylolisthesis. In support of this, he referred to the X-ray of 15 October 2013 which noted her spondylolisthesis is 'probably unchanged from 04/04/2012'.

He concluded by noting that her history of not only left hip pain but low back pain and a chronic pain syndrome for the right ankle and her obesity points towards pre-existing and non-injury factors as the cause of her condition.

He requested an ultrasound of her left iliopsoas to rule out iliopsoas tendinitis/tendonitis or tendinosis.

Ultrasound

An ultrasound was conducted on 11 August 2015 following which, Dr Turner provided an addendum to his report on 13 August 2015. He noted that the ultrasound was normal and as such, his report must stand. He said:

> ….it remains my view that the trauma that she experienced on 10 October 2013 and subsequently on the four further occasions when she fell has caused an exacerbation of her pre-existing condition and that there is no new injury cause for her symptoms emanating from these events.

BMA report

ACC then referred Mrs [redacted] file to its branch medical advisor for review and comment. Dr David Scott provided his comment on 2 September 2015. Dr Scott was provided with a summary of the clinical evidence including Dr Turner's report. He said he agreed with Dr Turner's opinion that there was no new injury causing L5 radiculopathy and it is more likely than not that the symptoms emanating from that level of Mrs [redacted] spine are wholly or substantially caused by degeneration.

Ms [redacted] re-visits Mr Dalzell

On 4 November 2015 Mrs [redacted] presented again to Mr Dalzell. Of that assessment, Mr Dalzell wrote that her symptoms remained unchanged and that she is still suffering from lower back pain, particularly left sided radicular symptoms in the L5 distribution. He requested plain X-rays and an MRI through the public health system.

X-Ray confirms spondylolisthesis is stable

An X-ray conducted on 25 November 2015 confirmed that Mrs [redacted] had long standing spondylolisthesis, however this was stable. It also showed 'new disc height reduction since 15/10/13'.

ACC internal report

ACC then referred Mrs [redacted] file for further internal comment. Mr Martin Shelton, Senior Analyst in ACC's Customer Service Technical Support, provided his opinion on 15 December 2015. Mr Shelton commented that the specialists all discount the hip pathology as a red herring, rather 'the focus has now gone on to whether or not the client has suffered a new or further injury to her L5/S1 disc where she has a pre-existing spondylolisthesis'.

Mr Shelton noted the two competing medical opinions of Dr Turner (who considers there has not been a new injury) and that of Mr Dalzell (who considers the accident caused Mrs [redacted] current symptoms and pathology).

Mr Shelton considered there was insufficient evidence to support a decision suspending Mrs [redacted] entitlement. He recommended ACC obtain further opinion from an orthopaedic specialist, particularly in relation to the mechanism of injury and whether nerve impingement will always arise because of an accident.

MRI confirms pars defect

On 2 February 2016, Mrs [redacted] underwent the MRI as arranged by Mr Dalzell. Radiologist Dr David O-Neill-Kerr commented that the MRI showed 'grade 1/2 spondylolisthesis at L5/S1 secondary to bilateral pars interarticularis defects. Marked left foraminal narrowing'.

Request for surgery funding

Mrs [redacted] was assessed again by Mr Dalzell on 22 February 2016 following the MRI and X-ray. Mr Dalzell reported that the MRI showed significant neural compromise at the L5/S1 level particularly. He diagnosed a pars defect at this level together with lost disc height and foraminal space. He considered Mrs [redacted] would benefit from lumbar fusion surgery.

On 24 February 2016 Mr Dalzell submitted an assessment report and treatment plan to ACC seeking funding for L5/S1 fusion surgery. Commenting on the causal link between the need for surgery and Mrs [redacted] covered injury, he said:

> [redacted] has had a long history of back problems and injured her back in a fall in October 2013. ACC have accepted [redacted] claim and the causal link has been established between her injury, symptoms and need for surgery. The surgery is to address the L5/S1 radicular symptoms, decompress the foraminal nerve root and removal of the disc material compressing the root and increase the foraminal size and stabilize the L5/S1 level.

BMA report

ACC referred the surgery request to its medical advisor, Dr Abi Rayner, who reviewed the file and commented on 4 March 2016. Dr Rayner suggested further questions be directed to Mr Dalzell in relation to the mechanism of injury and the cause of the delayed onset of symptoms.

Mr Dalzell responds

The questions suggested by Dr Rayner were posed to Mr Dalzell by ACC on 7 March 2016. It is unclear what additional information was provided to Mr Dalzell to allow him to make further comment[3].

In any event, it appears Mr Dalzell responded to those questions by providing his previous opinion dated 19 February 2015 together with medical notes from his assessments with Mrs [redacted] on 4 November 2015 and 22 February 2016. These were sent to ACC on 22 March 2016.

BMA reports again

Dr Abi Rayner reported again on 29 March 2016. She wrote,

> There is no clear injury related pathology on MRI. While Mr Dalzell proposes a theoretical causal link, there is no clear evidence of injury to the area of spondylolisthesis that can be attributed to the fall. [redacted] back pain and possible radiculopathy must be considered pre-existing disease rendered symptomatic by the fall.

[3] I posed this question to Mr Light at the review hearing, however he was unable to answer with any certainty.

CAP report

ACC referred Mrs [redacted] file to its clinical advisory panel for review and comment. Orthopaedic surgeon, Dr Ray Fong, reported on 7 April 2016. Dr Fong noted Mrs [redacted] history of back problems dating back to the late 1980's and considered her back problems to be a 'long established gradual process condition'.

He noted that the spondylolisthesis is a developmental condition which has caused the degenerative disc condition at L5 S1 and as such, a direct causal link of the condition to the personal injury claim by accident cannot be established.

Second orthopaedic opinion

ACC then referred Mrs [redacted] file to another orthopaedic surgeon, Mr Howie, who reported on 13 May 2016. Mr Howie's opinion was based on Mr Inglis' notes of 23 April 2003, radiographs, MRI scan and Dr Fong's advice. He recorded:

> There is no acute lesion. These changes are long-standing dating back to 2003 with the usual increase in slip secondary to ongoing disc degeneration.

ACC declines funding for surgery and suspends entitlements

On 27 May 2016, ACC issued two separate decisions, one being ACC's decision not to fund Mrs [redacted] lumbar fusion surgery, and the other suspending all her ongoing entitlements. The latter decision was supported by a decision rationale which set out the basis for ACC's decision. ACC explained that its decisions were based on the opinions of Dr Fong and Mr Howie who both stated that Mrs [redacted] ongoing incapacity is not caused by her accident on 15 October 2013, rather her current symptoms are degenerative in nature.

Ms [redacted] disagrees with ACC's decisions

Applications for review of both decisions were made on 13 June 2016 by Mr Yates. The review applications were made on the basis that ACC was wrong in fact and law. The applications stated that it is Mrs [redacted] position that she suffered a physical injury on 15 October 2013 which superimposed onto her pre-existing pathology.

Mr Dalzell reports to Dr Wanty

Mr Dalzell assessed Mrs [redacted] again on 25 July 2016 and 19 September 2016. Mr Dalzell reported to Dr Wanty following those respective assessments. He confirmed her diagnosis of 'isthmic spondylolisthesis L5-S1 with significant radicular symptoms'. He did not comment on the cause of her symptoms but noted that Mrs [redacted] had her surgery funding declined by ACC and that she had a review hearing pending.

Mr Dalzell reports again

On 19 August 2016 Mr Yates wrote to Mr Dalzell requesting further comment on the issue of causation[4]. Mr Yates provided him with a copy of the reports from Mr Howie, Mr Inglis, Mr Wanty, Dr Turner, Dr Fong and Dr Rayner.

Mr Dalzell responded on 5 December 2016. He said:

1. There was no reason to change his opinion on the mechanism of injury from that set out in his report dated 15 February 2015. There is no doubt there is a pre-existing spondylolisthesis which is very common in the community, however this does not necessarily lead to symptomatic radiculopathy in the absence of trauma.
2. When there has been an abrupt change to the dimensions of the nerve spaces, the nerve doesn't have time to accommodate and often we will see radicular symptoms occurring. This is what has happened in Ms [redacted] case.
3. As the foraminal course was already narrowed but not causing a nerve compression, further narrowing necessary to cause an impingement of the nerve would not necessarily be visible on the MRI. This is because:

   > There is still some degrees of motion although it is abnormal at the L5/S1 level and the dynamic motion still present and the mal-alignment of the vertebral body of L5/S1 would potentially cause impingement upon the nerve root and therefore this may not be visible on the MRI scan as it would recall back to its original starting position or thereabouts.

4. The fall on the left side was a sufficient force to cause impingement upon the nerve root given the narrow foramen that although asymptomatic was present.
5. He does not consider Ms [redacted] has regional pain disorder.
6. The proposed surgery to decompress the L5/S1 nerve would not be needed if Mrs [redacted] had not injured the nerve in the accident. The accident caused her symptoms and the surgery is required to treat those symptoms. He is unable to identify any other cause for Mrs [redacted] symptoms, particularly as Mrs [redacted] was functioning well and without symptoms before the accident.

ACC clinical leader comment

ACC then sought comment on Mr Dalzell's report from its regional clinical leader. Dr Alastair Wilson provided comment on 9 December 2016, however his response was limited to Mr Dalzell's comment on whether there could be any cause, other than the fall, that could account for Mrs [redacted] symptoms.

On this point, Dr Wilson disagreed with Mr Dalzell. He said:

> I consider there is strong evidence of Mrs [redacted] significant pre-injury low back and left hip problem prior to the described fall, that this condition was aggravated by this event and

[4] Mr Dalzell's response refers to a letter dated 8 November, however I do not consider anything turns on this discrepancy.

> that there were no new symptoms resulting from it. There is also considerable evidence that she was not functioning well before this event

He recommended ACC obtain a copy of the questions posed to Mr Dalzell by Mr Yates and to seek specialist advice on the balance of Mr Dalzell's report.

CAP comments

ACC provided Dr Fong with Mr Dalzell's report and accompanying questions. Dr Fong provided his comments on 9 January 2017.

Dr Fong commented that he believed there to be 'no credible scientific evidence to support that a lumbar spinal spondylolisthesis/slip would "recall" or return to its previous/ "original position" to render the "temporary"/transient slip to be invisible in the MRI scans'. Dr Fong further opined that the surgery request is for L5/S1 level instability on the basis of L5/S1 spondylolisthesis and not for "nerve compression".

He concluded by saying that he considered that the condition requiring surgery is wholly and substantially due to the pre-existing L5/S1 spondylolisthesis which is a developmental condition.

Mr Dalzell reports again

Mr Dalzell provided a final report on 12 April 2017. He reported that Mrs [redacted] has dynamic instability at the L5/S1 level which is resulting in radicular symptoms. He opined that:

> …the fall that Ms [redacted] sustained rendered the L5/S1 isthmic spondylolisthesis more unstable and therefore was the cause of the onset of her symptoms…There is no doubt that there was a pre-existing fibrous connection between the posterior elements of L5, however as we know this is not a congenital problem but a fall such as [redacted] has described can render it unstable and lead to the onset of symptoms.
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> This type of problem does not necessarily lead to pain unless there is some change in the stability at this level. The disc degeneration is secondary to this problem and its progressive but generally stems from an inability of the posterior elements of the vertebral body to restrain anterior translation.

Review hearing

Mrs [redacted] evidence

Mrs [redacted] attended the hearing by telephone and asked that I take her transcript of her hearing on 27 February 2015 be read and deemed to be her evidence, to which I and ACC agreed.

I have read the transcript and agree with the Reviewer's summary provided in the decision dated 27 March 2015. I have therefore repeated the below excerpt from that decision:

> 1. Although she had back problems in the distant past, those resolved when she lost weight. Ms [redacted] did not recall the X-rays of her lumbar spine in 2003 and 2004, and could not explain why she had had an X-ray of her lumbar spine on 4 April 2012. She said she could not remember that far back.

2. She did have some left hip pain following a 2009 white baiting accident in which she injured her ankle. She thought the hip pain was related to how she had fallen but the main problem after that accident was her ankle. She said that hip pain had resolved prior to the 2013 accidents. The injections she had were for her ankle problem. Ms [redacted] denied any hip or back pain in the period prior to her 2013 fall. She pointed out that she was active and able to manage heavy cleaning work until that accident.

3. She has worked as a commercial cleaner on and off for 18 years. She worked at Woodend School for 2-3 years prior to her 2013 accident. The work involved cleaning 10 classrooms.

4. The October 2013 injury incapacitated her for work. It felt like she had shattered glass in the hip. The discomfort and numbness in her legs started a short time later. The hip and left leg symptoms have persisted

I then queried Mrs [redacted] on her current symptoms. Mrs [redacted] said that her symptoms were much the same as they were following the accident, if not worse. She explained that she has pain in the same areas which includes her legs and back. Her leg will often go numb and she will lose feeling in it quite often. She is unable to lie on her hip, can't sleep, has difficulty walking and is unable to drive. She is on painkillers; however, these are becoming ineffective as she has been using them for so long.

Mrs [redacted] case

Mr Yates attended the hearing by telephone and provided written submissions prior to the hearing. He spoke to these at the hearing. His main points were:

Suspension of entitlements – review [redacted]

- Mrs [redacted] evidence is clear in that although she had previous episodes of back pain, these resolved quickly (consistent with soft tissue injuries) and she had been functioning without leg, hip or back pain prior to the accident on 10 October 2013. As such, weight should not be given to Mrs [redacted] history of back pain, particularly as her previous covered injuries were unconnected to the isthmic spondylolisthesis and her symptoms following the accident were entirely different to those she had experienced previously.

- It is not disputed that Mrs [redacted] has isthmic spondylolisthesis, the question to be considered is what caused Mrs [redacted] L5 radiculopathy. ACC did not have sufficient evidence on this prior to issuing its decision. This is because:

    - the reports it relied on (Dr Turner, Dr Fong and Mr Howie) all fail to comment on either the potential for Mrs [redacted] radiculopathy to be a separate injury or the cause of it, although there can be no argument they were not aware of her radicular symptoms; and

    - it failed to seek comment on the matters raised by Mr Dalzell in his report of 15 February 2015, namely the mechanism of injury causing an abrupt anterolisthesis or anterior translation of L5 on S1 and the advice that nerve compression produces symptoms when it happens and cannot subsist in an asymptomatic state.

As a result, ACC has failed to comply with the Reviewer's directions contained in her decision dated 27 March 2015 and did not have a reasonable basis to suspend entitlements.

- Notwithstanding this, ACC's decision is wrong in any event as the evidence shows that the accident caused an acute impingement of the L5/S1 nerve which is the cause of her ongoing symptoms. The evidence ACC sought to contest this simply fails to deal with the causal link (either directly or sufficiently).
- Weight should be given to Mr Dalzell's opinion as it is supported by the temporal connection between the accident and the appearance (and new characteristics) of the applicant's symptoms.

Declinature of surgery funding – review [redacted]

- The surgery proposed is needed to release/decompress the nerve at L5/S1 which was injured by the acute impingement suffered in the accident. Dr Fong's advice is unreliable on this point. He has erred on his opinion that the requested surgery is not related to nerve compression when the request for surgery funding clearly states that it is to 'decompress the foraminal nerve root'. If he has erred on this, it is likely he has erred on other points.

Costs

- Mrs [redacted] is eligible for an award of preparation costs for each review because the reviews concern two distinct issues.
- An award of preparation costs for one review would be contrary to the purpose of the Act which is designed to assist an applicant with the actual costs incurred by an advocate.

ACC's case

Mr Light attended the hearing on behalf of ACC. He provided written submissions prior to the hearing and spoke to these. His main points were:

- Mrs [redacted] current symptoms were not caused by a new injury on 10 October 2013. the accident. Mrs [redacted] current condition is instead due to a longstanding degenerative condition.
- Mrs [redacted] has a long history of back pain (dating back to the mid to late 1980s) and historical imaging shows marked loss of height at the L5/S1 disc and spondylolisthesis at this level. There has been no physical change to Mrs [redacted] spine as a result of the accident.
- The reports of Mr Love and Mr Dalzell in early 2014 do not attribute Mrs [redacted] symptoms to her accident, rather they state her symptoms are caused by her spondylolisthesis. Mr Dalzell's opinion should not be accepted and the opinions of Dr Turner, Mr Howie and Dr Fong should be preferred.
- In relation to costs, there should only be one award for the preparation for the hearing and one award for attending the hearing.

Relevant law

Suspension of entitlements

Section 117(1) of the Act provides that ACC may suspend entitlements if it is not satisfied, on the basis of the information in its possession, that a claimant is entitled to continue to receive the entitlement.

The "not satisfied" test was discussed in *Ellwood* [2007] NZAR 205. The initial obligation is on ACC to obtain sufficient evidence to clarify the position. If the evidence is unclear or in doubt, ACC will not have a sufficient basis to suspend entitlements.

Declinature of surgery funding

Clause 1 of Schedule 1 of the Accident Compensation Act 2001 provides that ACC is liable to pay or contribute to the cost of a claimant's surgery "for personal injury for which the claimant has cover".

Section 26 of the Act defines the term "personal injury". Personal injury includes physical injuries suffered by a person. Personal injury does not include injuries caused wholly or substantially by a gradual process, disease, or the ageing process.

The claimant has the onus of proving the need for surgery arises from the injury for which she has cover. In *Ambros v ACC* [2007] NZCA 304, the Court of Appeal explained how causation is to be assessed:

> …a court's assessment of causation can differ from the expert opinion and courts can infer causation in circumstances where the experts cannot. This has allowed the court to draw robust inferences of causation in some cases of uncertainty … However a court may only draw a valid inference based on facts supported by the evidence and not on the basis of supposition or conjecture.

Analysis

Mrs [redacted] has cover for some injury (a sprain) caused by her accident on 10 October 2013. It is not disputed that she has ongoing symptoms and that the requested surgery will likely assist with those symptoms. The question that I must determine however, is whether,

1. ACC was correct to suspend Mrs [redacted] entitlements because the injuries she suffered on 10 October were no longer the effective cause of her incapacity; and
2. Mrs [redacted] current symptoms requiring surgery were caused by an injury suffered in her accident on 10 October or whether her symptoms were caused wholly or substantially by a pre-existing degenerative condition.

As the two issues involve slightly different legal tests, I agree with Mr Yates' submission that they need to be considered separately and I will deal with the suspension decision before addressing the surgery decision.

Suspension decision

I have considered *Ellwood* and accept that the current test in relation to a decision made under section 117 requires ACC to have a reasonable and sufficient basis to suspend a claimant's

entitlements. This means the initial onus will be on ACC to show that the evidence was sufficient to allow it to be "not satisfied" that entitlements remained due when it issued its decision. Thereafter, the onus transfers to Mrs [redacted] to prove, on the balance of probabilities, that her current incapacity is causally connected to an injury suffered in the accident (see for example, *McDonald v ARCIC* [2002] NZAR 970).

Did ACC have a sufficient basis to suspend entitlements?

In relation to the initial onus on ACC, prior to issuing its decision ACC obtained copies of Mrs [redacted] past medical records for the period 2003 – 2012.

I do not agree with Mr Yates' submission that ACC had only requested and received all the relevant medical records shortly before this review hearing. I have reviewed the file and medical records and note a large portion of those records provided by the CDHB to ACC in April 2017 were also provided to ACC on 25 April 2015.

Prior to issuing its decision, ACC also sought specialist opinion from Dr Turner who assessed Mrs [redacted] Dr Turner provided a comprehensive and considered report which detailed Mrs [redacted] long and complex history of back symptoms, together with his opinion on the cause of her current symptoms. ACC also sought further comment from Mr Dalzell (although his response did not provide any new information), Dr Fong and Mr Howie.

I note Mr Yates' submission that he considered ACC did not have sufficient basis on which to base its decision because ACC 'failed to get the medical advisors to address the specific matter it was directed to consider by the reviewer, namely *whether an injury suffered in the October 2013 accident, or any earlier covered injury, is causing or contributing to Ms* [redacted] *current L5 radiculopathy*', however I do not accept this.

In his report, Dr Tuner responds to specific questions posed by ACC. At page 13 of this report, he repeats the question posed by ACC:

> You have asked if there is a physical injury at the L5/S1 at the same level as spondylolisthesis and what medical evidence persuades me that the client has sustained a physical injury in addition to or superimposed on the spondylolisthesis.

Given that Dr Turner was also provided with a copy of Mrs [redacted] file and he refers to the review decision in his report, he was aware of the suggested diagnosis of Mr Dalzell of L5 radiculopathy and was provided an opportunity to comment on this. He concludes however that he considers that Mrs [redacted] 'suffered a simple contusion in the fall' and that he was unable to conclude that 'she suffered acute spondylolisthesis on this particular date' or that the accident on 10 October 2013 or the subsequent four falling events, 'have caused any new personal injury', which I consider necessarily includes L5 radiculopathy.

Mr Howie also considered nerve impingement in his report of 23 April 2003 as evidenced by his statement that 'surgery by means of interbody fusion at L5/S1 is useful to decompress the L5 nerves', although he considered the cause to be developmental.

Although I agree with Mr Yates that none of the medical comment arranged by ACC deals directly with the issue of whether nerve compression produces symptoms when it happens, I do not consider this to be determinative of an 'insufficient basis', as the medical specialists have discounted that the nerve compression was caused by any new physical injury suffered in the accident in any event.

Given the above, I do not consider ACC had any reason to look beyond the medical opinions of Dr Turner, Dr Fong and Mr Howie or the medical imaging (which confirms degenerative changes and shows no acute changes). I therefore find that it had sufficient evidence on which to base its decision.

The question then becomes whether the decision to suspend entitlements was correct.

Was that decision correct?

Whether ACC's decision is correct requires a consideration of causation; that is, whether there is a causal link between Mrs [redacted] current condition.

In considering causation, I am guided by the principles set out in *Ambros*. For Mrs [redacted] to be eligible for ongoing entitlements, there must be evidence that allows a robust inference to be drawn her current symptoms are caused by a personal injury suffered in the accident on 10 October 2013.

This involves a consideration of whether Mrs [redacted] suffered a further injury at L5/S1where she has pre-existing spondylolisthesis (which is undisputed), or whether the accident simply aggravated the pre-existing spondylolisthesis or made it symptomatic. In this circumstance, it is usual to rely on the medical evidence.

Summary of medical evidence

Mr Dalzell provides opinion that Mrs [redacted] has L5 radiculopathy due to isthmic spondylolisthesis at L5/S1 which caused nerve impingement/compression. This is supported by his surgery request which he considered was required to, amongst other things, decompress the foraminal nerve root and remove the disc material compressing the root.

Mr Dalzell considers that Mrs [redacted] fall caused an abrupt further anterolisthesis, resulting in compression of the nerve root. He said Mrs [redacted] was predisposed to such injury as she had some pre-existing spondylolisthesis, which causes there to be diminished available space for the L5 nerve root.

He considers that the fall on the left side on 10 October 2013 was of sufficient force to cause impingement and that the nerve impingement is itself, a new and distinct physical injury. In support of this proposition, Mr Dalzell explained that he 'agrees with the District Court's summary that nerve impingement is likely to produce symptoms and it is likely to either continue to be symptomatic due to 1) ongoing compression or 2) intrinsic nerve injury. Intrinsic nerve injury occurs when there is trauma to the nerve and damage'.

Mr Dalzell also considers Mrs [redacted] presentation of symptoms is consistent with nerve root impingement, that is, slow onset of leg symptoms with immediate hip and groin pain.

On the other hand, Dr Turner considers Mrs [redacted] has not suffered a new personal injury, rather, Mrs [redacted] back pain is the result of a pre-existing disease rendered symptomatic by the fall. He relies on the fact that Mrs [redacted] already had evidence of a forward shift of L5 on S1 in July 2012 at which time she was already suffering from hip pain. In this respect, I also note Dr Wanty's referral note of 27 April 2012 where he noted Mrs [redacted] also had pain down the outside of her leg to the foot. On 12 July 2012 Dr Robinson also reported that Mrs [redacted] complained of left hip pain which radiated medially.

Mr Howie and Dr Fong also consider that Mrs [redacted] symptoms are a result of a degenerative condition.

Dr Turner commented that her spondylolisthesis could not have occurred abruptly or acutely because of the 'significant spondylolisthesis of L5 on S1' noted 5 days after the accident on 10 October 2013 and which was probably 'unchanged' from the diagnosis in April 2012.

Mr Dalzell explained in his report dated 5 December 2016 why the imaging may appear unchanged. In that report, Mr Dalzell also disputed Dr Turner's diagnosis of regional pain disorder and noted that he considered Mrs [redacted] has specific pathology which is responsible for the radicular symptoms she is experiencing.

What do the Courts say?

I have considered what the Courts have said in relation to pre-existing conditions and pre-disposition to injury in the context of nerve impingement.

Mr Yates referred to the District Court case of *Lyth* [2012] NZACC 198 in support of his submission that nerve root compression is a class of injury for which cover is available under the Act.

That case has since been distinguished, and must be confined to its own facts as noted in *MacMillan* [2014] NZACC 154.

This principle established in *MacMillan* was confirmed in *Stevenson* [2014] NZACC 139, where the Judge also provided dicta in relation to the comments of Judge Beattie in *Lyth* and noted that 'any generic judicial observation…cannot take precedence over the specific medical evidence as to causation presented'.

Further, in *Ritchie* [2014] NZACC 162, the Judge, referring to *MacMillan*, said:

> I do not accept any suggestion that nerve root compression of itself is sufficient evidence of injury. Further, I agree with Judge Powell that the court must be satisfied on the balance of probabilities on the basis of all evidence available that the condition described is due to injury. I agree that one cannot substitute that duty by application of some general rule or principle. In examining this case I cannot assume the nerve root compression is due to injury.

I have also considered the High Court case *McDonald* [2001] NZAR 970 as referred to by Mr Light. In that case the High Court approved the test set out by the District Court in *Hill* (189/1998) and quoted:

> . . . personal injury caused wholly or substantially by the ageing process is not covered by the Act. If medical evidence establishes that there are pre-existing degenerative changes which are brought to light or which become symptomatic as a consequence of an event which constitutes an accident, it can only be the injury caused by the accident and not the injury that is the continuing effects of the pre-existing degenerative condition that can be covered. The fact that it is the event of an accident which renders symptomatic that which previously was asymptomatic does not alter that basic principle. The accident did not cause the degenerative changes, it just caused the effects of those changes to become apparent and of course in many cases for them to become the disabling feature.

The High Court said in *Cochrane* (CIV 2003-485-2099):

> An appellant may not establish causation simply by showing that the injury triggered an underlyinerg condition to which the appellant was already vulnerable (the 'eggshell skull'

principle) or that the injury accelerated a condition that would have been suffered anyway (the 'acceleration principle). The question is simply whether the necessary causal nexus continues to exist between the injury and the condition.

Analysis of evidence, case law and the Act

I have considered the medical evidence, case law and the Act and have found, on balance, that the evidence falls short of establishing that Mrs [redacted] current symptoms are due to a new injury caused by her accident of 10 October 2013. It is more likely that her current condition is wholly or substantially caused by a gradual process of wear and tear, which is excluded from cover under the Act and confirmed by case law (see section 26 and *McDonald*)

In reaching this conclusion, I am guided by the medical evidence and the opinions of Dr Turner, Mr Howie and Dr Fong, which I prefer over those of Mr Dalzell, for the following reasons:

- Although I agree with Mr Yates' submission that nerve root compression is an injury for which cover *can* be had under the Act, as noted above, each case must be decided on its own facts. Looking at the medical evidence in this case, I do not consider there to be sufficient evidence that the nerve root compression was caused by a new injury suffered in the accident on 10 October 2013.

- Mr Dalzell asserts that radiculopathy is never asymptomatic and is evident from the moment that it happens, which he considers is what occurred in Mrs [redacted] case. He has asserted that the basis for a connection between Mrs [redacted] accident on 10 October and her current condition was an absence of her symptoms before the fall, i.e. there is a temporal connection. However, I do not accept that Mrs [redacted] was without pain prior to 2013 and I am not minded to accept Mrs [redacted] evidence in this respect, given her uncertainty and lack of memory surrounding her medical history prior to the accident. I find it difficult to accept that she is unable to remember why she had an X-ray in 2012, yet can clearly remember she was without pain prior to the accident. The medical evidence clearly establishes that Mrs [redacted] was experiencing hip and leg pain prior to her accident on 10 October (see notes from Dr Wanty and Dr Robinson) and that she had a long history of such pain. Further, when giving evidence, it wasn't until she was prompted by Mr Yates that she mentioned her leg and groin pain; rather, her focus was on her hip and back pain, which has clearly been longstanding prior to the accident.

- Although I am satisfied Mr Dalzell had sufficient evidence of Mrs [redacted] history of back, hip and groin injuries when he provided his report of 5 December 2016, which confirms his position noted in his report of 19 February 2015, his opinion is the minority opinion amongst the specialists. I do note that he is an orthopaedic specialist and Dr Turner is an occupational medicine specialist, however Dr Turner's opinion is supported by both Mr Howie and Dr Fong who are also orthopaedic surgeons.

- Dr Turner, Dr Fong and Mr Howie do not consider that Mrs [redacted] is suffering from nerve root compression or impingement as a result of the covered injury or accident, despite having knowledge that this is what Mr Dalzell has diagnosed. Instead, they consider that medical evidence shows significant degeneration dating back to 2003 (and indeed it is noted that Mrs [redacted] had been experiencing pain since the 1980's) and this is the cause of her current symptoms. I also consider the respective comments of Dr Wanty and Mr Inglis back in 2003 that her back problems will 'become a chronic situation for her' and would 'be a recurring problem for her' rather pertinent.

- Further, the radiological reports do not support acute nerve root compression, rather, the imaging reports following the accident confirm her imaging is unchanged from prior to the accident. There is also clear evidence of forward slip of L5 prior to the accident.

Taking these matters together I find, on balance, that Mrs [redacted] ongoing symptoms are not due to any injury suffered on 10 October 2013. Instead, I find the comments and analysis provided by Dr Turner, Dr Fong and Mr Howie to be more consistent with Mrs [redacted] previous symptoms and available imaging. As such, I agree with them that her ongoing problems are most probably caused by degenerative changes rather than as a result of any new injury suffered in the accident in October 2013. I therefore find ACC's decision suspending Mrs [redacted] ongoing entitlements is correct.

Declinature of surgery

ACC's decision declining Mrs [redacted] surgery requires consideration of whether, on balance, Mrs [redacted] symptoms requiring surgery were caused by are the result of a covered personal injury or whether her spondylolisthesis 'together with lost disc height and foraminal space' (as diagnosed by Mr Dalzell) was caused wholly or substantially by a gradual process of wear and tear.

If it is the former, then ACC must fund Mrs [redacted] surgery. If, however, the evidence indicates the latter, then ACC is not liable. This is because a personal injury caused wholly or substantially by gradual process or disease is excluded from cover under section 26 of the Act.

As noted above, I find that Mrs [redacted] pre-existing degeneration is the likely cause of her ongoing symptoms and is the cause of the changes to the various levels of her lumbar spine, for which surgery is requested to treat. Accordingly, I do not consider there to be a causal link between Mrs [redacted] covered injury and her need for surgery and find ACC's decision declining to fund surgery to be correct.

Costs

At the hearing, Mr Yates submitted that Mrs [redacted] was entitled to an award of hearing preparation costs for each of her reviews. ACC objected to this on the basis that the two reviews involved a consideration the same or similar issues, therefore only one award of preparation costs is suitable.

I agree with Mr Yates. In his written submissions, which he spoke to at the hearing, he has clearly dealt with the issue of suspension of entitlements and the legal test of a "sufficient basis", which is a separate and distinct issue to that of causation as required for the surgery funding decision. I also note the decision of *Nielsen* (190/2006) where the District Court permitted costs for preparation of two issues, despite there being only one review, and one hearing.

Accordingly, under the Injury Prevention, Rehabilitation, and Compensation (Review Costs and Appeals) Regulations 2002, I award the following costs sought by Mrs [redacted]

Lodging application (x2)	$233.88
Preparation for hearing (x2)	$701.66
Appearance at hearing (1 ¾ hours)	$263.10
Total	$1,198.64

I also award the actual cost of Mr Dalzell's report up to $935.54

[redacted]

Reviewer

Date: 16-May-2017

Appeal rights: All parties to the review have the right to appeal to the District Court; see the attached letter for more information.