[redacted]

Review 467

Review number: [redacted]

Claim number: [redacted]

Application by [redacted]

for a review under the Accident Compensation Act

Held at	[redacted]
Date of hearing	27 April 2017
Reviewer	[redacted]
Present	[redacted] with his wife [redacted] in support. Jane Hamilton for ACC (by telephone).

Issue	Whether ACC's decision dated 13 April 2016, declining funding for surgery (left total knee joint replacement) is correct.
Decision	I quash ACC's decision of 13 April 2016 and require ACC to make the decision again in accordance with my directions.

Costs	None claimed.
Action	ACC to comply with directions.

Decision

Mr [redacted] had a rugby accident in June 1991 and hurt his left knee. He also suffered other injuries to his knee between 1984 and 2004. Surgery funding was requested, on 11 February 2016, to treat osteoarthritis in the left knee by means of a left total knee joint replacement.

On 13 April 2016, ACC declined to fund the surgery, on the basis that the osteoarthritis was not caused by an accident on 16 February 2004. Mr [redacted] applied for a review of this decision.

I find that ACC has not taken relevant considerations into account when making its decision of 13 April 2016. I have therefore decided to quash ACC's decision, and require ACC to make the decision again in accordance with my directions.

I direct as follows:

1. ACC shall obtain a written opinion from an orthopaedic surgeon (who may be employed by ACC) in relation to whether the rugby injury on 15 June 1991 caused Mr [redacted] osteoarthritis in his left knee.
2. The orthopaedic surgeon shall be provided with a complete copy of the ACC claims file, including all letters from Mr [redacted] specialist (Mr Christopher O'Meeghan) and the clinical notes from the Hamilton 24 Hour Medical and injury Centre dated 15 June 1991, together with a copy of this decision.
3. ACC shall then issue a further decision on surgery funding with review rights.

Background

Covered Injuries

Mr [redacted] has had a number of ACC-covered accidents involving his left knee. They are listed below, together with the covered injury and the number of physiotherapy treatments:

- 15.6.1991 Rugby - Sprain or strain (20 PT)[1]
- 13.4.1994 Running - Sprain or strain (8 PT)
- 16.2.2004 Fell on knee - Contusion, knee and lower leg
- 17.7.2004 Tripped on kerb - Contusion, knee and lower leg (1 PT)
- 22.1.2016 Twisted knee getting out of car - Sprain, cruciate ligament (1 PT).

Summary of Accidents

A more detailed summary of those accidents, including injuries not covered by ACC, is set out below:

[1] PT – physiotherapy treatment.

1984 Cricket Injury

A handwritten GP note dated 13 February 1984 referred to a stiff, painful left knee following cricket the day before. The note was largely illegible.

1990 Knee Pain

A handwritten GP note dated 12 March 1990 mentioned left knee pain while running.

1991 Rugby Injury

Mr [redacted] had an accident on 15 June 1991 when he twisted his left knee at rugby. A handwritten note from the Hamilton 24 Hour Medical Injury Centre stated that he came off the field, weightbearing in pain. On examination there was reported to be an effusion, a tender lateral ligament, stable cruciate ligaments and painful flexion. The note said that there was a sprain of the left knee lateral ligament, with a partially illegible reference to "cartilage".

An x-ray of the left knee on 2 October 1991 detected no bony injury. Handwritten GP notes dated 6 May 1992 stated that the knee had "settled" and mentioned "physio".

A note on 23 July 1993 mentioned a Baker's cyst in the left knee.

1994 Running Injury

On 13 April 1994, Mr [redacted] was running, training for the Rotorua marathon, when he twisted his left knee. A GP note the following day referred to a painful left knee and "patello femoral syndrome". The GP recommended physiotherapy.

2004 Fall Injury

Mr [redacted] had an accident on 15 February 2004, when he fell on his knee at home.

He had a further injury on 17 July 2004, when he tripped on a kerb, resulting in a contusion of the knee and lower leg.

An x-ray on 18 February 2004 reported a "moderate degree of degenerative" change, with a normal patella.

Right Knee Replacement

On 11 June 2013 orthopaedic surgeon Mr Christopher O'Meeghan wrote to Mr [redacted] GP, Dr Trevor Ryan, concerning Mr [redacted] right knee. He reported that Mr [redacted] had injured his knee about 12 years ago when his foot was locked in a scrum:

> Subsequent to this he had two arthroscopies and the last one was performed by Ian Brown who commented he had taken a fair bit out on the lateral side of his knee.

An MRI scan of the right knee on 26 June 2013 referred to a previous meniscectomy. The finding was of established and moderate arthritis within the lateral compartment, with complete loss of joint space, cartilage loss, meniscal deficiency and osteophytes.

Mr [redacted] had a right total knee joint replacement for post-traumatic osteoarthritis on 3 September 2013.

X-Ray

An x-ray of the left knee was performed on 25 January 2016 by Dr Gavin Davis, radiologist:

> No fracture or bony injury is identified. Normal bony alignment is maintained.
>
> The patient has established degenerative change in the knee.

Dr Davis concluded that there was "Relatively severe established degenerative change".

Specialist Review

Mr O'Meeghan wrote to Dr Ryan on 4 February 2016. He reported that Mr [redacted] had injured his knee when he twisted it getting out of his car on 29 January 2016. Since then there had been swelling and Mr [redacted] had used crutches to get around:

> He does not recall any particular injuries to his left knee although the exact details may have been lost in the passage of time…

Mr O'Meeghan reported that the left knee was swollen and there was an effusion. He reported his "diagnostic impression" as being left knee arthritis, with a possible meniscal injury.

Assessment Report and Treatment Plan (ARTP)

Mr O'Meeghan prepared an ARTP dated 11 February 2016. In relation to the causal medical link between the proposed treatment and the covered injury, he stated:

> Mr [redacted] has a (sic) several injuries to his left knee. The first that I have details of [is] from 1991. He twisted his left knee when playing rugby which caused him to come off the field and had pain with load bearing. Examination showed an effusion with a tender lateral ligament but apparent stable cruciate ligaments. No bony injury was detect[ed] at [that] point. He subsequently had another injury in 2004 when he fell on his knee and a further injury when he fell in April 1994 when [he] was running and missed his footing and twisted his left knee. I believe that x-rays at the time showed no bony injury. Therefore Mr [redacted] has sustained several injuries to his knee over the years which have involved twisting of the joint. He has now developed left knee arthritis predominantly in the lateral compartment. The question here is whether his arthritic change is on the basis of his multiple knee injuries over time. While it is difficult to be categorical about this as there has been no ligamentous injury nor meniscal tear, it is likely that these injuries would have caused articular cartilage damage resulting [in] his damage [and] resulting [in] his presentation. He has had a right total knee replacement as a result of post-traumatic changes so it is likely that the left knee is also related. As far as I am aware there are no other pre-existing conditions.

Mr O'Meeghan recommended a left total knee replacement.

ACC Medical Opinion

ACC obtained a medical opinion from Dr Ray Fong, medical advisor, dated 21 March 2016. The clinical comment contained details of Mr [redacted] previous accidents and covered injuries. It was noted that Mr [redacted] had cover for a sprain of the cruciate ligament of the left knee following his accident in January 2016.

Referring to the accident on 16 February 2004, Dr Fong commented:

> The evidence we have was that in 2004 the client suffered from [a] fall and hurt the left knee and was diagnosed to have a contusion to the knee/patella with tenderness in the patella region, although the patella is otherwise normal and tracks normally. The x-ray reveals no bony injury to the patella, however it reveals degenerative changes in the left knee joint, i.e. this [is] established OA of the left knee as in 2004. This has obviously progressed with time.
>
> …
>
> In summary, the client is suffering from OA of the left knee joint and the clinical information available indicates that OA was established in 2004. This is a gradual process degenerative condition that is likely to be pre-existing to the claimed accident of 16/02/2004.

Decision and Review Application

ACC wrote to Mr [redacted] on 13 April 2016, declining to pay for the requested surgery. The letter said that the surgery was required to treat osteoarthritis in the left knee, and that this condition was not caused by the accident on 16 February 2004.

Mr [redacted] applied for a review of this decision on 19 May 2016. The review application included documentation relating to Mr [redacted] earlier accidents, including handwritten GP notes.

MRI Scan

An MRI scan of the left knee was performed on 18 May 2016 by Dr G Coltman, radiologist. He concluded:

1. Established arthritis within the lateral compartment with widespread chondral loss and a functionless meniscus.
2. Intact cruciate ligaments.
3. Superficial chondral damage medially with intact medial meniscus.
4. Several intra-articular ossified loose bodies in the posterior aspect of the medial compartment.

Correspondence from Mr O'Meeghan

Mr O'Meeghan wrote to Dr Ryan in a letter dated 17 May 2016. He noted that Mr [redacted] had found a "succession of previous injuries" to his knee in his old medical details:

> A lot of these involve twisting injuries. On review today I get the distinct impression that he is lax in his anterior cruciate ligament and I think that it is worthwhile getting an MR scan and if this proves that there is indeed a cruciate ligament rupture, that his current presentation is on the basis of a post-traumatic problem and I will write to ACC in support of his application for cover. As it is, I think that there are sufficient injuries on record to cause post-traumatic arthritis.

Mr O'Meeghan also wrote to Mr [redacted] that day. Commenting on the rugby injury in June 1991, when Mr [redacted] twisted his knee and had to come off the field, he stated:

> The index injury of a twisting injury to the knee is compatible with producing ligament, cartilage and meniscal damage. MR scans were not routinely performed at that stage and whilst there may not have been [a] major meniscal problem, there almost certainly

> was damage to the articular cartilage and ligaments of your knee as evidenced by the effusion which implies tearing and bleeding of soft tissue. With the passage of time this is the genesis of developing post-traumatic arthritis.

Mr O'Meeghan also wrote to ACC in a letter of the same date (received by ACC on 6 June 2016):

> The initial injury that I have records of was in June 1991 when he was playing rugby and he sustained a twisting injury to his knee that caused him to be removed from the field. It was noted that he had pain over the lateral collateral ligament and also an effusion indication (sic) a significant soft tissue injury to the knee. The cruciate ligaments were noted to be normal but it is common for a significant ligament injury to be missed in the acute setting.

Mr O'Meeghan concluded:

> Given the nature of his injury and his ongoing symptoms for several months as evidenced by the reports in his GP notes which continued through to May the following year. It is likely that his current presentation of post-traumatic arthritis is as a result of the injury in 1991.

Mr O'Meeghan commented that the most recent injury was an "exacerbation" of the previous known post-traumatic arthritis, and the injury in 1991 was the "most likely" cause of the current presentation, with no indication that there was any other "systemic process" that might be contributing to the current presentation. Mr O'Meeghan also noted that the MRI scan confirmed arthritis with intact cruciate ligaments.

Further ACC Medical Opinion

ACC obtained a further opinion from Dr Fong dated 18 April 2017. Dr Fong noted that there was a clinical record on 12 March 1990 of left knee pain secondary to running: "This is prior to the accident on 15/06/1991 indicating the knee was symptomatic prior to that claim". He noted there was no documentation from the injury in 1990 and no ACC claim.

In relation to the accident in June 1991, he said (in part):

> The next record in the notes was on 19/06/1991 which notes there was an injury on 16/06 to the left knee and further ACC. No mechanism of injury or physical examination findings were documented…

Dr Fong also summarised the medical notes between 1992 and 1994, and the results of the various scans, noting that a Baker's cyst (diagnosed on 23 September 1993) is a "common complication from a degenerative problem in the knee with effusion and subsequent formation of the cyst". He said the presence of a Baker's cyst "in itself does not imply a traumatic aetiology".

Dr Fong noted the "moderate" degree of osteoarthritis present on the 18 December 2004 x-ray, and the "marked degenerative changes" in the next x-ray on 25 January 2016:

> …this is consistent with the natural history of osteoarthritis in the knee joint.

Dr Fong concluded:

> This functionless meniscus is a degenerative condition related to the osteoarthritis in the knee joint. This degenerative meniscus/degenerative meniscal tear is part and parcel of the osteoarthritis in the knee.

In summary, the client is suffering from longstanding osteoarthritis of the left knee joint. This is a gradual process condition which may have been symptomatically aggravated by the accident in 2004.

The 1990 to 1994 information does not support a direct causal link between the osteoarthritis of the knee to the 1991 accident.

Review hearing

Applicant's case

Mr [redacted] provided written submissions prior to the hearing. He reiterated O'Meeghan's view that the twisting injuries to his left knee were compatible with producing ligament, cartilage and meniscal damage which, with the passage of time, was the genesis of developing post-traumatic arthritis.

Mr [redacted] also spoke at the hearing. The main points were:

- He was a very sporting person. He has run two marathons, played rugby for 45 years and run lots of half marathons. He has probably punished his body a bit.
- He twisted his knee playing cricket in 1984. It took a while to heal.
- It was in 1991 playing rugby that he really injured his left knee. He played as a hooker. The scrum collapsed and he was underneath it. During physiotherapy, his knee would squeak and grind. The physiotherapist asked if he had injured his cruciate ligaments.
- His right knee was also injured playing rugby.
- He completed the marathon in Rotorua in 1994, wearing a knee brace and tapes. He was able to run, as long as it was in a straight line, as the rugby injury was to the side of his knee.
- He has had a lot of injuries and they are going to cause osteoarthritis. His right knee has suffered from the same problem. His left had been injured for how many years and slowly got worse. From 1991 to now (or to 2004) is a long time.
- He had to rely on his left knee more because of his right knee problem. Mr O'Meeghan had also told him that he had twisted his knee so much it caused the osteoarthritis.

ACC's submissions

Ms Hamilton provided oral submissions at the hearing. The main points were:

- There is no evidence the accidents caused osteoarthritis.
- The indication in 1991 was of tenderness over the lateral ligament. This does not support a significant injury. An MRI was performed in 2016 to see if the anterior cruciate ligaments had been disrupted. The MRI scan showed the ligaments were intact, which excluded a traumatic cruciate ligament injury.

- Mr O'Meeghan commented, in his letter of 17 May 2016, that it was worth getting an MRI scan to see if there was proof that there was a cruciate ligament rupture, in which case his current presentation would be on the basis of a post-traumatic problem, and he would write to ACC to support Mr [redacted] application. The MRI showed the cruciate ligaments were intact, excluding an accident causing a cruciate ligament injury. Mr O'Meeghan did not write anything further following the MRI scan, which shows lateral side cartilage loss and a functionless meniscus. Mr O'Meeghan did not suggest damage to the meniscus had caused osteoarthritis, he just said that if there was a cruciate ligament injury he would write in support, and it did not.
- As to the 1984 cricket accident, there is no record. ACC can only look at covered injuries.
- Symptoms in the left knee were present prior to the 1991 accident. 1991 to 2004 is a long time, but it does not prove the osteoarthritis was caused by an accident. There is no evidence to establish that. There are documented injuries but no evidence to support that is why the osteoarthritis happened. Mr O'Meeghan does not suggest the MRI scan supports a personal injury that could cause osteoarthritis. There have been accidents, but a normal x-ray in 1991, and no evidence to support structural damage in the knee to cause osteoarthritis. In relation to the 1991 knee effusion noted by Mr O'Meeghan, many things can cause an effusion, including osteoarthritis.
- The right knee is different from the left knee. There was a meniscectomy performed on the right knee, so there was a traumatic meniscal tear. Then there was a further operation. So, treatment had caused osteoarthritis in the knee. There was post-meniscectomy arthritis.
- There was no evidence of a bony injury to cause osteoarthritis, rather than being a normal degenerative osteoarthritis.

Relevant law

Section 20(2)(a) of the Accident Compensation Act 2001 (the Act) provides cover for personal injury caused by accident to the person. Section 20(2)(g) of the Act provides cover for a personal injury caused by a gradual process, disease or infection consequential on personal injury for which the person has cover.

In relation to entitlements such as surgery funding, the claimant must establish on the balance of probabilities that the need for treatment arises from the covered injury (*Johnston v ACC* [2010] NZAR 673). There is no presumption that a personal injury was caused by an accident (section 25(3)).

Analysis

The issue is whether a covered accident has caused the osteoarthritis in Mr [redacted] knee which now requires surgery.

ACC's case

I agree with many of Ms Hamilton's submissions.

Specifically, I agree there is no evidence of a bony injury to cause osteoarthritis. The June 1991 rugby injury was the focus of Mr O'Meeghan's correspondence. The x-ray on 2 October 1991 was normal.

I also accept that symptoms were present in March 1990, prior to the rugby injury. That could suggest there was a pre-existing degenerative condition in the knee at that stage (although Dr Fong has not explicitly said so - he only remarked that this showed the knee was symptomatic prior to that event).

There may be some weaknesses in Mr O'Meeghan's opinion. In the ARTP he said that there had been no ligamentous injury or meniscal tear, although it was likely that the various injuries would have caused articular cartilage damage, resulting in osteoarthritis. In contrast, in his letter to Mr [redacted] on 17 May 2016, Mr O'Meeghan indicated that there was "almost certainly" damage to the ligaments of Mr [redacted] knee as a result of the 1991 rugby injury, as well as articular cartilage.

Further, I accept Ms Hamilton's submission that, in his letter of 17 May 2016 to Dr Ryan, Mr O'Meeghan indicated that if there was a cruciate ligament rupture, it would suggest the osteoarthritis was post-traumatic. As noted by Ms Hamilton, the MRI scan of 18 May 2016 reported intact cruciate ligaments, and Mr O'Meeghan merely confirmed the findings of the MRI in his letter to ACC.

I accept that many of the accident events appear to be relatively minor - resulting in sprains rather than structural damage. The possible exception is the rugby injury, which resulted in 20 physiotherapy treatments paid for by ACC, and a knee which apparently did not settle until May of the following year. Mr O'Meeghan referred to the ongoing symptoms as evidence of a post-traumatic arthritis, in his letter to ACC of 17 May 2016.

I also agree that the history of Mr [redacted] right knee injury does not necessarily help to establish that the osteoarthritis in the left knee was post-traumatic. The osteoarthritis in the right knee seems likely to have been caused by repeated surgery.

Finally, I agree that ACC can only take covered accidents into account when deciding on entitlements. There was no ACC claim made in relation to the 1984 cricket injury. Funding for surgery cannot be based on an injury for which there was no cover. In any event, the June 1991 accident has been the focus of enquiry by Mr [redacted] specialist.

The rugby accident

Crucially, only Mr O'Meeghan commented on the clinical findings in the Hamilton 24 Hour Medical and Injury Centre notes, relating to the June 1991 rugby accident. His view was that the effusion implied "tearing and bleeding of soft tissue", which in time was the "genesis of developing post-traumatic arthritis". Mr O'Meeghan has consistently maintained that the twisting injury likely caused cartilage damage.

In contrast, Dr Fong seems to have been under the impression that there was no mechanism of injury or documented examination findings for this accident, and noted the normal x-ray. Dr Fong therefore did not have an opportunity to consider the significance of those findings. The medical notes, in fact, make reference to a twisting injury, a tender

lateral ligament and an effusion, and some kind of reference to cartilage. The clinical notes suggest that Mr [redacted] suffered a significant injury. It follows that this important piece of evidence does not appear to have been fully considered by ACC. Although Ms Hamilton suggested that a knee effusion could be caused by osteoarthritis, and she may be right, the point needs to be addressed by way of medical evidence, rather than by submission.

As an aside, Mr O'Meeghan's reliance on there being a cruciate ligament rupture was, perhaps, not quite as absolute as Ms Hamilton may have suggested. In his letter of 17 May 2016 to Dr Ryan, Mr O'Meeghan made it clear that there were, whatever the state of the cruciate ligaments, "…sufficient injuries on record to cause post-traumatic arthritis". On that basis, it is not fatal to Mr [redacted] case that the cruciate ligaments were intact.

Conclusion

I understand ACC's decision in this case and accept much of the argument which Ms Hamilton presented. However, the clinical findings of 15 June 1991 could be significant, as Mr O'Meeghan indicated. ACC does not appear to have fully considered this evidence.

ACC is required to make decisions on reasonable grounds having regard to all the circumstances (section 54 of the Act). Before ACC makes a decision on surgery funding, this aspect of the evidence needed to be fully considered by ACC's medical advisors. For this reason, I have decided to quash ACC's decision of 13 April 2016 and require ACC to make the decision again.

Costs

No costs were claimed.

[redacted]

Reviewer

5 May 2017

Appeal rights: The applicant and ACC each have the right to appeal to the District Court; see the attached letter for more information.