IN THE DISTRICT COURT
HELD AT WELLINGTON

Decision No. **[2010] NZACC 196**

IN THE MATTER of the Accident Compensation Act 2001

AND

IN THE MATTER of an appeal pursuant to Section 149 of the Act

BETWEEN **GARNETT BONSOR**

(AI 433/09)

Appellant

AND **ACCIDENT COMPENSATION CORPORATION**

Respondent

HEARD at WELLINGTON on 23 August 2010

APPEARANCES

Ms R Radich, Counsel for Appellant.
Ms D Lester, Counsel for Respondent.

RESERVED JUDGEMENT OF JUDGE M J BEATTIE

[1] The issue in this appeal concerns the correctness of the respondent's decision of 17 April 2009, whereby it declined to approve funding for left shoulder surgery sought by the appellant, it being contended that such surgery was not required to treat the appellant's covered personal injury, but rather it was to treat a pre-existing degenerative condition in his shoulder.

[2] The background facts relevant to the issue in this appeal may be stated as follows:

- On 1 September 2008 the appellant, then aged 67 years, tripped and fell over, falling heavily on his left arm and shoulder.
- He immediately commenced to experience significant pain in his left shoulder.

- Cover was granted to the appellant for an injury then described as left rotator cuff sprain.

- Despite conservative treatment, symptoms of pain and limited function continued and on 29 October 2008 the appellant's GP, Dr Hunter, referred him to Mr H A P Swan, Orthopaedic Surgeon, for assessment and treatment.

- X-rays and an ultrasound of the appellant's shoulder had been obtained and were available to Mr Swan when he conducted an examination of the appellant in March 2009.

- Consequent upon his examination and assessment of the appellant's shoulder injury, Mr Swan recommended surgery and in that regard he prepared an ACC Assessment Report and Treatment Plan for approval of elective surgery.

- The surgery requested for approval was subacromial decompression via an arthroscopic acromioplasty and repair of supraspinatous tendon tear.'

- Mr Swan's request was referred to the Corporation's Clinical Advisory Panel and the Panel, under the hand of Alistair Farr, stated as follows:

> "...the most likely cause for the client's condition requiring surgery is a long standing pre-existing outlet impingement syndrome with a probable contribution from age-related intrinsic tendon degeneration ..."

- Consequent upon that advice the respondent issued its decision of 17 April 2009 declining approval for funding of surgery.

- The appellant sought a review of that decision and for the purposes of that review a further report was obtained from Mr Swan.

- In a decision dated 17 September 2009 the Reviewer, Mr J Greene, confirmed the respondent's decision, he determining that the surgery was required to treat the appellant's shoulder pathology generally, rather than to treat a distinct personal injury caused by accident.

- It is the case that the appellant did undergo the intended surgery on 14 May 2009 and a report of that surgery has been introduced for the purposes of this appeal.

[3] The medical evidence to which the Court has been referred in relation to this appeal is as follows:

1. X-ray report of left shoulder dated 5 September 2008.

This X-ray was requested by the appellant's GP, Dr Hunter, and it stated, inter alia, as follows:

> There is anterior and inferior prolongation of the acromion along with a subacromial spur. Appearances would pre-dispose to rotator cuff impingement. Irregularity is seen at the insertional side of the supraspinatous tendon. This raises the possibility of a degree of rotator cuff pathology. No other bone or joint abnormality seen. Further assessment with an ultrasound scan may be of use.

2. Ultrasound Report of left shoulder dated 17 October 2008.

This ultrasound was also requested by the appellant's GP and the report stated, inter alia, as follows:

> Biceps Tendon: The tendon is intact. It is slightly thickened proximally, suggestive of tendionopathy. There is marked increased fluid in the bicipital sheath.
> Subscapularis: Normal, apart from sofme find foci of calcification at the insertion.
> Supraspinatus: There is marked thickening of the subacromial-subdeltoid bursa with a large amount of fluid on the bursa. This makes visualisation of the underlying tendon difficult, especially anteriorly. There is possibly a small full thickness tear at the insertion anterolaterally, measuring 9mm in length. The tendon elsewhere appears intact. On abduction of the arm, there is bulging of the bursa and marked restriction of movement.
> Infraspinatus: Normal.

3. Assessment Report and Treatment Plan dated 17 March 2009.

This was Mr Swan's request for approval of elective surgery. He gave as his diagnosis, left rotator cuff tear. Mr Swan's clinical examination noted as follows:

> The left shoulder presented mild peri-articular muscle wasting but normal attitudes and contours otherwise. There was tenderness over the anterior rotator cuff but not elsewhere around the shoulder. Impingement tests in flexion and abduction were both positive. Tests for tendinitis were positive at 20° and 90° of abduction. The shoulder had a reduced range of motion with flexion 90° extension 50°, external rotation 50° and internal rotation 50° (hand to low lumbar spine) and abduction 180° with a painful arc from 100-140°.

He referred to the X-ray and ultrasound reports and he then stated as follows:

> His presentation would be most consistent with a left rotator cuff syndrome complicated by a probable full thickness tear in the supraspinatus tendon likely to have been initiated by his injury in September last year.
>
> Under the circumstances I have recommended subacromial decompression via an arthroscopic acromioplasty and repair of the tear as the best plan of management at this stage.

Mr Swan answered "yes" to the question of whether the treatment was for personal injury caused by accident for which the claimant has cover.

4. Report of Alistair Farr of respondent's Clinical Advisory Panel dated 17 April 2009.

Mr Farr firstly noted "I have not interviewed or examined the client. I accept the examination findings and diagnosis of the specialist who prepared the Assessment Report & Treatment Plan."

He then made the following comment about the application:

> A plain film report from 5/9/08 describes an anterior and inferior prolongation of the acromion with a subacromial spur. These findings are significant pre-disposing factors to an outlet impingement syndrome. The ultrasound scan report from 17/10/08 describes proximal biceps tendinosis, subscapularis calcification, marked thickening of the SA/SD bursa (which made visualisation of supraspinatus tendon difficult) and a small full thickness insertional tear. Bulging of the bursa and marked restriction of movement was reported. These findings are consistent within a significant outlet impingement syndrome.

Mr Farr concluded his advice by making the comment as set out in the Background Facts above.

5. Report from Mr Swan dated 19 June 2009 to appellant's counsel.

Mr Swan had the report from Mr Farr for reference and in that regard he noted as follows:

> He did not indicate that he had personally examined the X-ray or ultrasound films himself nor was there any indication that his opinion was based on any information or medical evidence with respect to the status or condition of Mr Bonsor's left shoulder prior to the injury.

Mr Swan noted that he had personally examined the X-ray and ultrasound films and he made the following comment about that difference:

> I have sixteen years of experience in treating shoulders and in the light of my training and experience, my assessment of the X-rays, which I personally examined, was that the acromion was the common type II acromion without enough anterior or inferior prolongation and without enough of a spur to warrant special mention. None of the features of the acromion process could therefore be described as "significant pre-disposing factors to an outlet impingement syndrome" and the lack of any such features highlights the dangers, which the ACC have been alerted to on more than one occasion, of the members of their clinical advisory panel basing their opinion predominantly on the basis of X-ray or ultrasound reports without examining the films themselves or examining the patient.
>
> The same comments would apply to the use of the ultrasound report where Mr Farr has taken a description of a biceps tendon which was found to be "slightly thickened proximally" to be a description of proximal biceps tendinosis. He chooses to ignore the findings of an increased amount of fluid in the bicipital sheath which, as the ? was taken only six weeks after the injury, is more likely to indicate a traumatic bicipital tendinitis. He also uses the finding of subscapularis calcification as evidence of a "significant outlet impingement syndrome" when the report is of "some fine foci of calcification at the insertion" which is of no clinical significance in this context as the subscapularis tendon is not one of the tendons involved in an outlet impingement syndrome. Mr Farr also ignored the large amount of fluid seen in the bursa which is more likely to be due to a traumatic bursitis and tendinitis six weeks after injury than a "longstanding pre-existing outlet impingement syndrome". Mr Farr also chose not to comment on or explain the presence of a small full thickness insertional tear in the supraspinatus tendon measuring 9 mm in length which, considering the force and mechanism of the injury and the severity of pain and dysfunction immediately following injury, would most likely have been caused by the injury on 1 September 2008.

Mr Swan then advised what his diagnosis of the appellant's condition was prior to surgery.

> Mr Bonsor's condition when I interviewed and examined him on 17 March 2009 and reviewed the X-rays personally was that he was suffering from a left rotator cuff syndrome (a painful condition of the bursa and/or rotator cuff tendons beneath the coraco-acromial arch) caused by a damaged subacromial bursa and a full thickness tear in the supraspinatus tendon. There was no history either on direct questioning or in his general practitioner's notes of any similar condition in the left shoulder prior to injury to substantiate that he had a "long standing pre-existing outlet impingement syndrome" which, by definition, would require him to have a history of long standing activity-related pain similar to my findings on clinical examination.

Mr Swan was then asked to advise whether he considered there was a causal link between the appellant's injury and his need for surgery and he responded as follows:

> As a result of the injury, the damaged subacromial bursa and the torn supraspinatus tendon are not only impinging against a relatively normal coraco-acromial arch but also causing functionally limiting pain on physiological loading as a result of the traumatic tear in the supraspinatous tendon. In the absence of any documented pre-existing shoulder problems requiring medical treatment, the mechanism and force of the injury and his immediate post-injury symptoms which have persisted despite conservative treatment are good clinical evidence that his current problems are wholly or substantially a direct result of his covered injury. Therefore, on the balance of probabilities, there is a causal link between his injury and the need for the surgery which has been requested to relieve those symptoms and repair the tear.

Mr Swan further commented as follows:

> The subacromial tissues are in a unique situation in the body operating as they do between two bones and there is ample clinical and epidemiological evidence that they undergo age-related changes so-much-so that we would be surprised if typical changes such as fine foci of calcification were not present in older patients. The degree to which those changes are present vary from case to case, but there is also good evidence that even the more advanced degrees are not necessarily symptomatic or functionally limiting so-much-so that even shoulders with quite large rotator cuff tears can be asymptomatic and feel fully functional. There is, therefore, no clinical or aetiological value in describing an injured shoulder in a 67 year old patient as having a "gradual process condition" as this could be quite normal for the age of that shoulder and not in the need of surgery. We do not operate on and nor are we usually consulted about asymptomatic shoulders.
>
> We do, however, see many patients suffering from pain and dysfunction in their shoulders following injury. The requests for surgery have been made for procedures to relieve the symptoms of pain and dysfunction. The symptoms of pain and dysfunction have been caused by the injury whatever the condition of the shoulder at the time of injury. By ACC's own admission and acknowledgement, if there was a gradual process condition (whatever that may be) it has been rendered or in other words "made to become" symptomatic by the injury. The need for surgery is therefore directly linked to the injury which made the shoulder symptomatic. Mr Farr has stated that he accepts my diagnosis which was "a left rotator cuff syndrome complicated by a probable full thickness tear in the supraspinatus tendon likely to have been initiated by his injury in September last year.

6. Operation Report from Mr Swan dated 14 May 2009.

Mr Swan reported on the operation he had carried out on the appellant that day, he advising that the operation was left arthroscopic acromioplasty and rotator cuff repair.

> Arthroscopy of the shoulder confirmed a full thickness tear in the supraspinatus tendon as suspected on the pre-operative ultrasound. The tear was in the anterior two thirds measuring 20 x 20 mm with a tongue shape. The rest of the shoulder was carefully examined and, apart from calcific deposits in the articular cartilage and labrum, the shoulder appeared arthroscopically satisfactory. Using the tear to gain entry to the shoulder the articular surface of the tear was abraded and debrided.
>
> Bursoscopy confirmed anterior impingement with an irregular acromial spur, broad, thickened and partially ossified coraco-acromial ligament and thickened subacromial bursa. A subacromial decompression was therefore performed via an acromioplasty, defunctioning of the coraco-acromial ligament and bursectomy.
>
> The exposed greater tuberosity at the site of the tear was decorticated and the tear repaired to the tuberosity using a Panalok bone anchor. An additional central transosseous suture and anterior tendon to tendon suture were used to achieve a satisfactory water-tight closure under moderate tension.

[4] Ms Radich, for the appellant, submitted that the opinion presented by Mr Swan should be accepted and she also referred to the comments which Mr Swan had made about the assessment made by Mr Farr.

[5] Ms Lester, counsel for the respondent, reasserted the submission that the surgery was required to treat a pre-existing condition in the appellant's left shoulder which had been rendered symptomatic by the fall, and that state of affairs is clearly identified in the X-ray.

[6] Counsel further submitted that the comment made by Mr Swan in his report of 19 June 2009, where he was considering the causal link between injury and accident, was in her opinion an incorrect statement of the law, when he stated that the mere fact of the shoulder becoming symptomatic identified a causal link to the need for surgery. Counsel finally referred to the fact that the covered injury was a left rotator cuff sprain and that this was not the reason for surgery.

DECISION

[7] In claims for funding by ACC for elective surgery, the onus is on the claimant to establish that the proposed surgery is to treat a condition caused by the injury for which the appellant has cover.

[8] The original claim for cover as lodged by the appellant's GP within a day or so of the accident was that of left rotator cuff sprain. It is the case that at the time a claim for cover is lodged the medical practitioner concerned is often only able to give a general diagnosis, and it is often not until after an investigative examination following radiological input, that a detailed identification of the injury sustained in the accident can be forthcoming. In that regard, therefore, I find that the fact that the cover was for left rotator cuff sprain does not mean that it is only that condition which can be stated as being suffered in the accident, and it is open for the Court to identify, based on the medical evidence submitted, precisely what the nature and extent of the injury suffered was.

[9] In the present case an in-depth diagnosis was carried out by Mr Swan, Orthopaedic Surgeon, an acknowledged specialist in this field, and it was his opinion that the full thickness tear of the appellant's supraspinatous tendon was likely to have been caused in the accident, which was the fall.

[10] It was Mr Swan's advice that the damaged subacromial bursa and the torn supraspinatous tendon, were impinging on a relatively normal coraco-acromial arch, and also causing the pain that it was the traumatic tear which was the cause of the pain.

[11] It was Mr Swan's advice that as it was the case that the appellant was experiencing no pain in his shoulder prior to the event, the post-injury symptoms were good clinical evidence that the appellant's problems were wholly or substantially a direct result of the full thickness tear of the supraspinatous tendon.

[12] Whilst it may be the case that for a 67 year old person the appellant was displaying some aspects of shoulder degeneration, I note that Mr Swan is of the opinion that despite those age-related conditions the appellant was fully functional, and those conditions were not the reason for surgery.

[13] This Court has now heard and considered a significant number of cases on appeal where the respondent's decision to decline to fund surgery is based essentially on the fact that the claimant's shoulder is displaying aspects of degeneration commensurate with age. The respondent is very quick to seize on that identified state of affairs and use it as a reason for declinature, and I find that the present case is such an example of that.

[14] Mr Farr has identified various aspects of the appellant's shoulder which are certainly those of a pre-existing condition, but the reasoning Mr Farr has given is clearly suspect when the comments of Mr Swan are noted, those comments being made by him as a consequence of him examining the appellant and actually examining the X-rays and the ultrasound, and which Mr Swan identifies as not disclosing evidence of a significant outlet impingement syndrome. Furthermore, he notes that the subscapularis tendon is not one of the tendons involved in an outlet impingement syndrome.

[15] The evidence of what in fact Mr Swan carried out by way of surgery, identifies that the primary task was the repair of the supraspinatous tendon, that this was central to the rotator cuff repair, and his surgery report identifies that the tear was repaired.

[16] Having regard to the evidence presented by the parties, I am satisfied that the surgery for which approval was sought, was surgery to treat an injury sustained by the appellant in the fall of 1 September 2008, and that in those circumstances the appellant was entitled to have that surgical procedure funded by the respondent as a treatment entitlement under the Act.

[17] Accordingly, the respondent's primary decision is quashed and the respondent is to make payment to the appellant of the cost of surgery which he

underwent on 14 May 2009. The appellant being successful I allow costs to the appellant in the sum of $2,500 together with any qualifying disbursements.

DATED this 2 day of November 2010

M J Beattie
District Court Judge