IMPAIRMENT INSIDER

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Return to WorkSA

Introduction

Welcome to the sixth edition of the Impairment Insider. In this issue we discuss a variety of topics from the recent Independent review of the Return to Work legislation to scarring, hearing loss, x-rays and hip assessments.

Work has begun preparing for the next accreditation period. A revised Impairment Assessor Accreditation Scheme has been prepared and the Minister's Advisory Committee and current assessors have been given the opportunity to provide feedback on it before finalisation in time for a call for applications late this year. It is envisaged that training will occur between April and June next year, prior to the expiration of the current accreditations on 30 June 2019. More information will follow over the coming months.

The topic for the next forum will be assessing hand impairments with guest presenters, Prof. Ted Mah, Orthopaedic Surgeon and Dr Beata Byok, Occupational Physician. We will also provide a short update on scheme decisions. That forum will be held in the new-year and we will send you an invitation closer to the date. In the meantime, if you have any ideas for future forums or topics / examples you would like to discuss with your fellow assessors, we'd love to hear from you.

Trish Bowe
Manager
Impairment Assessment Services

We would like to take this opportunity to wish you a happy and safe festive season.

IMPAIRMENT INSIDER

Report of the Independent Review

In June this year, the Hon. John Mansfield QC completed his independent review of the *Return to Work Act 2014* (The Act) and his report was tabled in Parliament in July.

The overall conclusion was that the experience in the Return to Work scheme generally compares favourably to the repealed Workers Rehabilitation and Compensation scheme, notwithstanding that the Return to Work scheme faces some challenges in achieving its objectives. The scheme is still very much in a transitional phase and this is reflected in the report and its recommendations, which focus on the administration and operation of the scheme rather than legislative change.

In relation to the assessment of whole person impairment, the key recommendation is that consideration be given to amending the Act and the Impairment Assessment Guidelines (IAGs) if the decision of Mitchell is upheld by the Full Court of the Supreme Court, and independently verified data collated after the Supreme Court's decision is delivered definitely indicates that the decision threatens the financial sustainability of the scheme. The hearing before the Supreme Full Court of the Supreme Court is listed on 12 February 2019 and at this stage it is unknown when the decision will be handed down.

The reviewer also recognised and expressed surprise at the limited use of Independent Medical Advisers by the South Australian Employment Tribunal to consider medical questions or issues.

A full copy of the report and summary can be found on the Attorney-General's Department website under **Projects and Consultations**.

Add or combine?

There are a few places in AMA5 methodology where you are required to add rather than combine. Here's a quick reminder of some of the most common ones:

- ROM within a joint
- Thumb
- When both digital nerves are involved in the same digit
- Ankle with sub-talar – dorsiflexion, plantar flexion, inversion and eversion are added (varus and valgus are combined)
- Ankylosis variation added to base rating
- Joint replacement points
- Add hand impairments for thumb and fingers to give a total hand impairment
- ADLs to base spine assessments

As always, we recommend the use of the worksheets in AMA5 on pages 436 and 437 for upper extremity assessments and on page 561 for lower extremity assessments as these provide direction on when to add and when to combine.

Testing requirements for hearing assessments

Regulation 67 on page 33 of the **Return to Work Regulations 2015** concerns Noise Induced Hearing Loss and describes procedures that apply to the testing of hearing loss that may be noise induced.

This regulation requires that the audiometric test that the worker has undergone be conducted by a medical practitioner, an audiologist or an audiometrist. The audiometric test must include air-conduction and bone-conduction pre-tone threshold measures with appropriate masking and must comply with a number of standards and practices, which are described in some detail. In addition to the audiometric test, the regulation requires that a legally qualified medical practitioner registered in the speciality of otorhinolaryngology carry out a physical examination of the worker along with any other investigation thought appropriate to determine whether the hearing loss is noise induced or due/partly due to other causes.

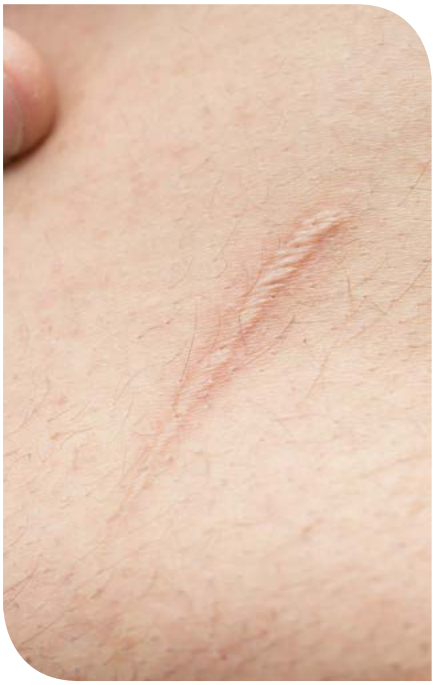
When assessing noise induced hearing loss, either for the purposes of an IME or WPI assessment report, the assessor should be familiar with these requirements so that they can ensure their report, and any test that is being used to determine the level of whole person impairment, meets them.

Rating minor scars

Assessors sometimes assume that scarring does not need to be rated when it is considered to be insignificant and/or a normal part of the injury. In accordance with paragraph 13.9 of the IAGs, it is appropriate, however, to specifically rate the scarring, even if 0% whole person impairment (WPI) is rated. Another common reason assessors do not rate scarring is because it has not been specifically mentioned in the request letter. This has been the subject of previous newsletter articles and assessors are reminded that it is expected that when providing assessments for lacerations or where surgery has occurred as a result of a compensable injury, the scarring will be described and rated.

In addition, where scarring has resulted from surgery or abrasions and the assessor is rating the skin under the Table for the Evaluation of Minor Skin Impairment (TEMSKI), this is not considered to be another 'body system' for billing purposes.

In accordance with paragraph 13.7 of the IAGs, if you consider the scarring to be more significant than 4% WPI and you are not accredited to provide assessments under the skin body system, a statement to this effect is sufficient with the scarring assessment left to be rated by an alternate assessor with the appropriate accreditation.



Assessing ROM after a TKR

A recent decision at the SAET provides some clarity in the method of assessment of range of motion in the knee after a total knee replacement.

In the matter of Ruddock v ReturntoWorkSA [2018] SAET 161, the application for review related to ReturnToWorkSA's decision to decline to make an interim decision to take the worker as a seriously injured worker as it was not satisfied that the degree of whole person impairment would likely be 30% or more.

The conclusion reached by ReturnToWorkSA was founded on two medical opinions based on the then status of the knee. ROM was found by both doctors to be between 5° and 110°. ReturnToWorkSA submitted that the point score for ROM in part 'b' of Table 17-35 on page 34 of the IAGs should be measured from 0°-110° which gives 22 points because there is already a 'built-in' deduction for flexion contracture in part 'd' in the table. To do otherwise would, in effect, be 'double deducting' for the flexion contracture. The worker, on the other hand, argued that the ROM point score should be taken from the actual ROM exhibited i.e. 5°-110°, which gives 21 points with a further 2 point deduction for flexion contracture applied in part 'd'.

In this case, this 1 point difference became the deciding factor between a fair outcome giving rise to a 20%WPI and a poor outcome giving rise to a 30%WPI.

In deciding the case, His Honour Deputy President Judge Gilchrist adopted a practical approach to the construction of the IAGs that avoids double dipping. He accepted ReturnToWorkSA's argument that where the IAGs speak of range of motion in connection with the function of the knee following a knee replacement, the point score is made by reference to the outer extent of the range only – i.e. measure ROM from 0°-110° which gives 22 points and apply the 2 point deduction for the flexion contracture in part 'd'.

Whilst an appeal against this decision may follow, ReturnToWorkSA considers this to be the appropriate approach to take in assessing ROM in a knee after a knee replacement.

IMPAIRMENT INSIDER

Additional frequency use in noise induced hearing loss assessment

A decision was recently handed down regarding a noise induced hearing loss (NIHL) assessment. In the Berden decision([2018]SAET 27), the worker was dissatisfied that the impairment assessment did not include 1500Hz and sought to have an alternative opinion considered.

The IAGs provide that 'where the assessor is using frequencies outside the usual 2000-4000Hz NIHL frequencies, detailed explanation must be given'. In this case the assessor provided a considered explanation for not using the lower frequencies both in writing and in cross-examination.

His Honour Deputy President Judge Calligeros held that the non-inclusion of 1500Hz by the assessor in his impairment assessment report was sound and the application for review was dismissed. His Honour held that, whilst it was appropriate to consider whether an error was made in assessing the worker's impairment, it was not appropriate to second guess how the assessor exercised his discretion. As such, His Honour held that the Tribunal should not interfere in a case like this unless it is satisfied that the exercise of the discretion has miscarried.

While the Guidelines only require the assessor to explain why they have used the lower frequencies, it may assist the reader if the assessor also describes why they have chosen not to. Assessors are encouraged to provide as much rationale in their reports as possible, to assist the reader in understanding the conclusion reached.

Rating hip replacement results

When using Table 17-34 on AMA5 page 548 to rate hip replacement results, the point scoring system is achieved by adding all values obtained in section a to e inclusive. The higher the point score, the better the result.

When rating deformity (section d) in relation to total hip replacement, no deformity logically accounts for a better result than if deformity were present. The deformity section contributes to the final score of up to 100 points. The table is a little unclear, so logic must be applied to the task.

No fixed adduction deformity is to be rated by analogy to equate to the value indicated for less than

10 degrees (ie.1 point). Therefore <10 degrees fixed adduction is to be interpreted to include no fixed adduction deformity i.e. technically 0-9 degrees of fixed adduction attracts 1 point while 10 degrees and greater of fixed adduction would get a rating of 0. The same would be said for each of the five categorised deformities in section d in the table. Logically 0 degrees of fixation in any of those categories attracts 1 point rather than 0 points and this reflects the better outcome compared to fixation etc. exceeding the nil value. In effect, if each value has no deformity then the score for this section would be 5 points.

Hard copy v digital x-rays

The use of x-rays is often very important in impairment assessment and, over the years, there have been many discussions about which is better or more appropriate, but digital x-rays are becoming more common, and there are some important things to note when using them. Following on from our article in Edition 5 about using digital x-rays to assess arthritis, we sought some further guidance from The Royal Australian and New Zealand College of Radiologists.

A one-page summary was developed by the Chair of the College which explains this in more detail. A copy of that summary can be found on in **Impairment Assessor News and Resources**, or you can request a copy by emailing Kirstie at **wpi@rtwsa.com**.

If assessors do not find this of practical use, we may consider inviting a speaker to an impairment assessor discussion forum, so please do not hesitate to provide feedback.

Peripheral nerves in the lower extremity

Peripheral nerve assessments in the upper and lower extremity share the same methodology. However, in rating a lower extremity peripheral nerve, assessors often omit to select the severity grading and then inadvertently use the impairment rating given for total sensory &/or motor loss. Alternatively assessors simply apply the highest values for the appropriate severity grade from AMA5 Tables 16-10 (sensory) and/or 16-11 (motor) for application against the nerve impairment value.

For example, if the medial plantar nerve is affected, with a maximum motor impairment of 7% FI, the assessor must judge the severity of the weakness then turn to the upper extremity table 16-11 to select the appropriate severity grade and percentage multiplier within the range for the grade. This methodology is demonstrated in Example 17-17 (p552) for both sensory and motor impairments. Any impairment rating for dysesthesia can be combined with other sensory or motor ratings if applicable.

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This faster option also makes it easier to list the documents received/reviewed in your report as you can copy and paste the list from an electronic copy of the request letter.

We are happy to include your clinic's email address in our published list for your requests to be sent to. Please email Kirstie at **wpi@rtwsa.com** with the details.

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