IMPAIRMENT INSIDER

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Return to WorkSA

Introduction

Welcome to the fifth edition of the Impairment Insider. In this issue we discuss the recent statements by the Tribunal about the assessment of pre-existing impairment, review some of the common reasons why assessors are contacted about their reports and provide clarification for the assessment of carpal tunnel injuries.

The independent review of the Return to Work legislation by the Hon John Mansfield AM QC is in full swing, with submissions being reviewed and a full report due before the end of June. The terms of reference and submissions are available on the Attorney-General's Department website under **Projects and Consultations**. If there is any impact on the assessment of whole person impairment for the scheme, we will share information in future issues, as any changes are formalised.

The Return to Work Act has been committed to the Treasurer, the Hon Rob Lucas MLC. We are yet to know whether Treasurer Lucas has any changes in mind for the Impairment Assessor Accreditation Scheme, which will be re-established in preparation for the next round of accreditation.

The topic for the next forum will be a general update on activities around

the scheme and matters recently before the courts. If you have any ideas for future forums, topics or examples you would like to discuss with your fellow assessors, we'd love to hear from you.

Trish Bowe
Manager
Impairment Assessment Services

Recent discussion forum

Our last discussion forum was with the psychiatric impairment assesors on 30 November last year. Thanks to everyone who attended for a GEPIC refresher with Dr Michael Epstein and to talk about issues they have encountered with assessment in this area.

If you would like an attendance certificate for that session, or a copy of the presentation, please get in touch with Kirstie at **wpi@rtwsa.com**.

Assessing by muscle atrophy in the lower extremity

Assessors are reminded that when opting to use muscle atrophy as the method of assessment of a lower extremity impairment, the following information should be included in your report:

- Your reason for selection of this method as a specific method of assessment in line with paragraphs 3.4 and 3.6 of the Impairment Assessment Guidelines.
- When a joint injury is being assessed, the clinical reasoning for using either or both calf/thigh atrophy.
- The actual measurements of the both calves/thighs as evidence of the muscle atrophy found on examination, rather than the difference between them.
- Confirmation that the assessment of muscle atrophy was done in accordance with the instructions on page 530 of AMA5 (i.e. measuring the circumference of both thighs 10cm above the patella and/or measuring the calves at the maximum level bilaterally).

Assessment of pre-existing impairment

It is commonly recorded in assessment reports that insufficient information was provided to enable an assessment of pre-existing impairment or that, as the pre-existing condition was asymptomatic prior to the subject work injury, no deduction should occur. Recent decisions at the SA Employment Tribunal have highlighted the need for impairment assessors to make every effort to arrive at an assessment for pre-existing impairment as it is a requirement of the Return to Work Act.

In the appeal matter of Department of Health and Ageing v Neilson [2017] SAET 136, the worker sought lump sum compensation for a left knee injury following a total knee replacement in the presence of a prior knee injury requiring ACL reconstruction surgery. The issue challenged on appeal was the failure by the Deputy President, at first instance, to make a deduction for the pre-existing left knee injury on account that he found the worker's knee to have been essentially asymptomatic prior to the subject work injury and that there was no other evidence on which to base an assessment. This was an error as an absence of symptoms and a return to work should not be equated to an absence of impairment. This was despite there having been a partial lateral meniscectomy and an anterior cruciate ligament laxity repair. Further, no consideration had been given to any pre-existing arthritis.

The Full Bench considered section 43A(9)(b) of the now repealed Workers Rehabilitation and Compensation Act, which states: -

(9) An assessment must take into account the following principles:–

(b) impairments from unrelated injuries or causes are to be disregarded in making an assessment;

The Full Bench held "It's purpose is to ensure that lump sum compensation for non-economic loss is payable only in respect of the degree of permanent impairment suffered as a result of a compensable injury and nothing else. The assessment of the degree of permanent impairment must not include any permanent impairment suffered as a result of an unrelated injury or cause. This informs how the expression 'are to be disregarded' is to be construed".

The Full Bench acknowledged that it can be difficult to quantify the degree of permanent impairment of an unrelated injury or cause in accordance with the Guidelines and AMA5 but stated "The assessor must do the best he or she can, on the evidence that is at hand. This is so because the Act mandates it."

In a further matter of Opie v RTWSA [2017] SAET 138, the worker sought lump sum compensation for a lumbar spine injury following spinal fusion to L4 – S1 against a background of a prior spinal fusion at L5 – S1, for which he had received a prior lump sum assessed under the Table of Maims method of assessment.

Two assessments were obtained; one which provided a deduction of 20%WPI for the pre-existing impairment and one which provided no deduction as the assessor found the worker to be essentially asymptomatic prior to the subject work injury.

The Deputy President considered section 22(8)(b) and (g) of the current RTW Act (which are repeated at paragraph 1.21 of the IAGs) and which state:

(8) An assessment must take into account the following principles:

(b) impairments from unrelated injuries of causes are to be disregarded in making an assessment;

(g) any portion of an impairment that is due to a previous injury (whether or not a work injury or whether because of a pre-existing condition) that caused the worker to suffer an impairment before the relevant work injury is to be deducted for the purposes of an assessment, subject to any provision to the contrary made by the Impairment Assessment Guidelines;

His Honour advised that, as the worker had undergone a prior spinal fusion, which is assessable under the Guidelines as 20%WPI, this ought to be deducted for the purposes of an assessment. His Honour noted in this regard that the RTW Act mandates the use of AMA5 and the IAGs and neither divides the lumbar spine into its various segments. It is the WPI following from an impairment to the lumbar spine as a whole that is considered. It should be noted that this matter is on appeal.

Paragraph 1.29 of the IAGs requires that there be objective evidence to support an assessment of pre-existing impairment and that the assessment must be determined by applying the methodology of the Guidelines. It is not addressed in the judgements how the assessor is to proceed with providing an assessment of pre-existing impairment where no objective evidence is available that satisfies the requirements of the Guidelines and AMA5, but what is apparent is that it is not sufficient for the assessor to disregard the request for an assessment of pre-existing impairment as being too difficult or because the prior condition was reported as asymptomatic. Instead, it is imperative that the assessor do the best they can, based on the available evidence, irrespective of whether the condition was or wasn't asymptomatic at the time of the work injury, because that is what the Act requires.

In the matter of Neilson it has been agreed that the worker should be referred to an Independent Medical Adviser for an opinion. The outcome of that assessment and approach the SAET takes in relation to the assessor's opinion may provide some clearer direction for assessors. In the meantime, it is recommended that assessors consider all available medical information provided to them and make every effort, where appropriate evidence exists, to apply the methodology of the Guidelines to calculate an impairment rating relating to the pre-existing condition.

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10 reasons why reports are returned

If you are finding that your reports are being returned with a request for clarification or further consideration, it could be due to some common issues. Here are ten of the more common problems that assessors encounter with some guidance on what you may need to check.

1 Criteria in AMA5 not met when assessing spinal injuries using the DRE method

A reduced range of motion is usually observed with spinal injuries. However, with the diagnosis related estimate (DRE) method, only asymmetric loss of range of motion is rateable. As directed in paragraph 4.15 of the IAGs, assessors must clearly articulate how the criteria in the AMA5 are met (or not met), using similar terminology to that used in AMA5. A mere statement that clinical judgement has been exercised in choosing a category will result in further clarification being sought, as it will not be clear to the reviewer if the AMA5 criteria have been met.

2 Radicular symptoms not being verifiable in spinal injuries

A statement that radiculopathy is present must be supported by reference to the criteria in IAG 4.19 p42. Objective clinical findings, reported in the examination section of the report, must match at least one major and one minor criterion. Otherwise the radicular symptoms are non-verifiable and DRE II would apply.

3 Claiming maximum value without sufficient testing in peripheral nerve injuries

The maximum value is not applied automatically when assessing peripheral nerve injuries – particularly when assessing median or ulnar nerves below mid-forearm from Table 16-15 AMA5 p492. For assessors to claim the maximum value, sensory testing must be done for the radial and ulnar palmar surfaces of all the relevant digits. This must be clearly articulated in the report. A reviewer cannot assume, because an assessor has chosen the maximum value, that all branches of the nerve are affected. In addition, when selecting the sensory and motor severity grade and relevant percentage from Tables 16-10 and 16-11 in AMA5, the rationale for the selected value must be provided in the report – refer to paragraph 2.12 on p17 of the IAGs.

4 Incorrect use of analogy

The AMA5 and IAGs allow the use of analogy where an impairment is not listed as a rateable condition. However, paragraph 1.56 on p11 of the IAGs directs that the assessor must stay within the body part/region when using analogy and the rateable joint or bone being compared must have a similar impairment of function with regard to activities of daily living. Assessors must clearly articulate how the loss of function in the non-listed condition is analogous to the loss of function in the listed condition. If a joint is being compared, the types of joint must be similar – for instance, an unrated condition in a fibrous joint with a limited range of motion is not analogous to the same (rateable) condition in a sesamoid joint with a large range of motion.

It is not uncommon for analogy to be used where there is, in fact, a rateable impairment in AMA5 or the IAGs that has been overlooked. Analogy can only be used when the impairment is not listed in the AMA5 and IAGs.

5 Calculation errors

Reports are often returned due to trivial calculation errors, often from misreading pie charts or audiograms. Sometimes the combined values chart has not been used correctly or the assessor is adding when they should be combining or vice versa.

Impairment of the hand joints is particularly complex and errors are made converting impairments from level to level. Attaching a copy of the worksheet (Fig.16-1a and 16-1b, pp436-437, AMA5) to the report is strongly recommended to enable verification. A similar issue exists when assessing feet and ankles, where the assessor often chooses to rate at the extremity (LEI) level rather than at the foot impairment (FI) level.

6 Application of clinical judgement without clear explanation of reasoning

The AMA5 and IAG acknowledge that assessors need to exercise clinical judgement when undertaking assessments. Some tables in AMA5 allow the assessor to select an impairment rating from a range (e.g. AMA5 Tables 16-10 and 16-11, p482-484) using clinical judgment, while for other tables clinical judgement cannot be used because the base value in the range must be selected (e.g. Tables 15-3, 15-4 and 15-5, p383-392), to which ADLs are then added. When choosing a rating using clinical judgement, a clear explanation or trail of reasoning needs to be provided to enable the various parties (report reviewer, case manager and worker) to understand how the rating has been selected.

7 Inappropriate combination of impairments

The cross-usage chart (Table 17-2, p526) in the AMA5 indicates which methods and resultant impairment ratings can be combined. Some reports have to be returned for further clarification because an assessor has combined assessment methods for the lower extremity, which cannot be combined. It is important for assessors to refer to this table to help avoid combining inappropriate methods. Attaching a copy of the lower extremity worksheet to the report is also recommended.

8 Methodological errors

Examples of this type include use of an AMA5 table or method where that table or method has been replaced with a modified version in the IAGs. Assessors are also not always using the most specific method in the lower extremity chapter where it is required e.g. using gait derangement, which is the method of last resort, or using muscle atrophy where other more specific methods are appropriate.

Please refer article in Impairment Insider Issue 4 for further information.

9 Typographical errors

Sometimes reports contain typographical errors. For example:

- using the incorrect gender throughout the report or changing the gender part way through;
- referring to a left knee/arm/hand/shoulder injury through most of the report, but then referring to a right knee/arm/hand/shoulder injury when no such injury exists.

It is important that reports are accurate. Reports may not be returned as 'not in accord' due to typographical errors alone, however, if a report is non-compliant for other reasons, typographical errors will also be pointed out.

We encourage assessors and/or their practice managers to proofread reports with these issues in mind before providing them to the requestor.

10 No deduction for pre-existing impairment

For more information about deducting for a pre-existing impairment, please refer to the article in this edition.

If you are unsure about the approach to an assessment, you are encouraged to contact Impairment Assessment Services for help to work through the process before the examination or before you submit the report, as required.

ReturnToWorkSA has a responsibility to ensure that the assessments are provided in accordance with the Impairment Assessment Guidelines to deliver the best possible fair and consistent outcomes. As you would be aware, worker's lump sum entitlements cannot be determined without a compliant assessment report, so if you are contacted by ReturnToWorkSA for some clarification or correction following submission of a report, your prompt attention will be most appreciated.

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Using digital x-rays

The use of x-ray films is important in establishing the level of arthritis in the lower extremities, particularly in determining cartilage loss associated with osteoarthritis. This can be measured by a properly aligned plain x-ray or by direct vision (arthroscopy), but impairment can only be assessed by the radiologically determined cartilage loss intervals in Table 17-31, (AMA5 (p544). Often the original x-ray films are no longer available for review.

Access to on-line x-rays through software systems such as InteleViewer, iRad or other similar systems available from the radiology companies, or provided on a storage device such as a CD or USB, are an appropriate means of accessing x-ray images. These can be used to determine the level of impairment in the absence of the original hard copy x-rays being available. Many medical practices now have access to these systems and some assessors are using them in their assessments.

There may also be times when case managers provide digital images of x-rays on CD which accompanies the impairment assessment request. Viewing these images is also an appropriate means of assessing the level of impairment and should also be utilised if they have been provided to you.

The importance of using the Impairment Assessment Guidelines

The Impairment Assessment Guidelines are much more than 'just a guideline'. In fact, the *Return to Work Act 2014* clearly states that an assessment must be made in accordance with the Impairment Assessment Guidelines, which are defined as those published under section 22 of the Act. They are, in fact, subordinate legislation. These Guidelines are not designed to provide suggestions, possible approaches or alternative options. Adherence to the instructions within the Guidelines is a requirement of the law.

The hierarchy of importance to impairment assessment is first the Act, followed by the Guidelines and then the relevant AMA Guide.

In some areas the Guidelines replace or modify the methodology from AMA5 (or AMA4 for visual). If assessors rely exclusively on the AMA Guide then mistakes will be made that will result in the report being considered to be not in accordance with the Guidelines. Assessors are encouraged to ensure that they have applied both the Guidelines and AMA5 appropriately to ensure that they provide a good level of certainty for the injured worker or are strong and defensible if challenged in the Tribunal.

Assessing Carpal Tunnel

(Revisited from PIA News, October 2009 - Issue 2 and May 2011 - Issue 6)

AMA5 is quite clear on the approach to be taken in assessment of entrapment/compression neuropathies. Page 493 of AMA5 states "Only individuals with an objectively verifiable diagnosis should qualify for a permanent impairment rating" with the diagnosis being made "not only on believable symptoms but, more important, based on the presence of positive clinical findings and loss of function". Further stating "…it is critical to understand that there is no correlation between the severity of conduction delay on nerve conduction velocity testing and the severity of either symptoms, or more importantly, impairment rating".

Page 495 of AMA5 provides a specific approach for assessment of carpal tunnel after an optimal recovery time post-surgery where the individual continues to experience symptoms and difficulties with ADLs. Three possible scenarios are provided.

However, the three scenarios do not address how to proceed when the findings include abnormal or diminished sensibility in the presence of normal nerve conduction studies (or when no data is available to the assessor on nerve conduction studies). Paragraph 2.11 on p17 of IAGs provides amendment to scenario 2 and allows for an assessment of up to 5%UEI for this scenario with justification required for the selection of assessment %. In addition, an assessment using the method in scenario 1 can proceed where positive clinical findings are found, but post-operative nerve conduction studies are not available.

NB - Assessment of carpal tunnel syndrome where no surgery has occurred is also undertaken using the method described in Scenario 1.

Any activities in which performance is affected should be specified in the report.

In assessing impairment using the method in scenario 1, sensory loss may not apply to all radial and ulnar palmar surfaces of the first 3.5 digits and in this case the maximum of 39% is not applied automatically. Upper extremity impairment ratings can be added for each involved surface of each digit (table 16-15 p 492) and summated. Assessors should specify which digits are involved in their report for ease of verification and provide rationale for their selection of severity rating from Tables 16-10 and 16-11 in AMA5 (see common error 3 in this edition). For assessments of sensory testing where the worker still complains of numbness in the digits and has normal two point discrimination, details of the objective type of sensory testing should be described (e.g. Semmes-Weinstein monofilament testing or pin-prick). For motor loss, the advice given in table 16-11 (b. Procedure) should be followed (p 484), in which tests for muscle weakness and the musculature involved should be described in the report to allow for transparency in the ratings allocated. Of note is that, for compression neuropathies, additional impairment values are not given for decreased grip strength because the radial nerve is also involved in these assessments.

Clinical example

One year after a right wrist median nerve decompression, a worker presents for permanent impairment assessment reporting occasional pain and residual numbness of his thumb and index finger and difficulty with fine tasks such as buttoning and tying shoelaces.

Nerve conduction studies are arranged. The right median distal motor and sensory latencies are prolonged with findings in keeping with persistent carpal tunnel syndrome.

Examination

Sensory examination revealed a moderate reduction of sensation to both light touch and pin-prick to the thumb and forefinger and reduced two point discrimination of 9mm for the radial and ulnar palmar surfaces

of the thumb and index finger. Motor strength assessment involved testing for weakness of thumb adduction, flexion and opposition. Thumb opposition was mildly reduced while adduction was 6cm and flexion normal.

Analysis

Nerve involved: median nerve below the mid-forearm (table 16-15).

Severity of sensory deficit: Grade 3 (table 16-10) selected due to occasional pain, diminished light touch and two point discrimination that interferes with some ADLs with 32% (middle of low end of class 3) selected on the basis of symptoms being mild, rather than moderate to severe within this class.

Sensory impairment rating: Maximum sensory assessment from Table 16-15 calculated as 27% (7+11+5+4 as not all branches of the median nerve were effected) multiplied by 32% = 8.64% upper extremity impairment rounded to 9% UEI.

Severity of motor deficit: Grade 4 (Table 16-11) selected due to findings of complete active ROM against gravity with 20% (high end of class 4) selected on the basis of moderate weakness in the thumb particularly in adduction.

Motor impairment rating: the maximum of 10% is applied (table 16-15) multiplied by 20% = 2% upper extremity impairment.

The sensory rating of 9 UEI is combined with the motor rating of 2% UEI = 11% UEI, or 7% WPI.

Multiple assessments – when can you do 2 reports?

The permanent impairment fee schedule for a complex report is applied to an assessment that is a complex assessment of a single body system or multiple injuries involving more than one body system or a lead assessor report. Most assessment requests for multiple injuries will attract a complex assessment fee. This is consistent with other jurisdictions' fee schedules.

In rare cases, assessors may be asked to assess an extensive list of injuries in the one request. This was seen more commonly in the lead up to the new scheme's commencement and predominantly in relation to transitional claims. At times as many as 8-10 separate assessments were being requested. It was agreed that, in this circumstance, the assessment could be split over two reports and two assessment fees could be raised, subject to the agreement of the requestor. This was a concession made to acknowledge the amount of work assessors were being asked to do, over and above what was considered to be reasonable. Sometimes this may have required the assessment to be undertaken over two separate appointments and again two separate fees could be raised.

Generally it would not be expected that any request of more than three injuries would automatically be split over two reports. If you consider that the request you have received is over and above that which would normally fit within the description of the complex assessment fee for multiple assessments, please contact the requestor to discuss.

Have you returned your Assessor Declaration form?

Thank you to everyone who has returned their Assessor Declaration Form which was sent out in November 2017. This declaration helps us ensure, on the Minister's behalf, that all of our assessors continue to meet the requirements of the scheme and that we have all of your up to date details.

There are still a few outstanding and we need them to continue your accreditation, so please send your form back as quickly as possible and contact us if you have any issues or if you do not wish to continue your accreditation. If you don't think you have received one or you are not sure if you have returned it, please email Kirstie at **wpi@rtwsa.com**.

Do you want your requests emailed?

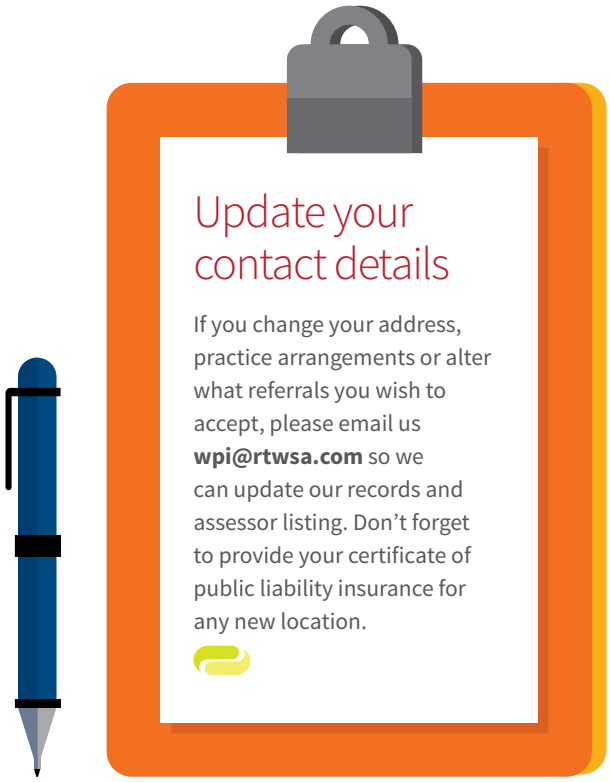
This faster option also makes it easier to list the documents received/reviewed in your report as you can copy and paste the list from an electronic copy of the request letter.

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.

Are you using the latest template?

Some assessors are not using the most recent template with the new summary table, which is available on the resources page on **www.rtwsa.com**. Please make sure you are using the correct version, as required by the Guidelines and the Accreditation Scheme.

If you have questions about any of these articles, please contact the team at **wpi@rtwsa.com**.



Update your contact details

If you change your address, practice arrangements or alter what referrals you wish to accept, please email us **wpi@rtwsa.com** so we can update our records and assessor listing. Don't forget to provide your certificate of public liability insurance for any new location.

Return to Work SA

(Please replace with your own letterhead)

Date

Requestor's name
Company
Address
City / Suburb

Whole person impairment assessment report – physical injuries

Name of injured worker
Date of birth day month year
Claim number
Date of injury

Dear

My qualifications to make this report are

Further to your letter of xx month xxxx, I saw worker's name on xx month xxxx at location for a whole person impairment assessment and report.

The worker attended unaccompanied/with [name of support person] *(please select appropriate)*.

An interpreter was not present at the consultation/An official interpreter [name and NAATI number] was present and assisted throughout the consultation.

I explained my role as an accredited assessor of whole person impairment, and also that my report from this assessment would be sent to ReturnToWorkSA.

You have requested an assessment of whole person impairment for the following work injury(ies) (chronologically):

-
-
-

You have requested that I assess and combine the following impairments *(please select the appropriate)*

1

ReturnToWorkSA Impairment Assessment report template – effective 23 March 2017

Invitation

Assessor Discussion Forum

Date: Thursday 24 May 2018

Place: ReturnToWorkSA
Ground floor
400 King William Street
Adelaide

Time: 6:00 to 7:30pm

Topic: Scheme and SAET decisions update

RSVP: By 11 May 2018
Email **wpi@rtwsa.com** or call 8238 5727

You are welcome to bring along examples or issues to discuss with your fellow assessors.

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13 18 55

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