IMPAIRMENT INSIDER

ISSUE 7
FEBRUARY 2020

Return to WorkSA

Introduction

Welcome to the seventh edition of the Impairment Insider. In this issue we provide an update on the accreditation process, rating multiple scars, rating knee and ankle deformities, presbyacusis and look at some recent legal decisions.

We sincerely thank all assessors for your efforts in completing the training modules and case studies for accreditation.

It has been 10 years since many of our assessors completed substantial training (aside from refresher training when the revised Guidelines were released) and we felt it was important to ensure that it was adequately revisited. Given the worker choice of assessor in the Scheme, some assessors are not given the opportunity to practice the process as much as they would like, and a number had requested additional training. That said, we acknowledge that it was difficult for some and that the combination of the MAIAS and Return to Work scheme modules at the same time was found by some to be overwhelming. Many lessons were learned and we will review the process and seek further feedback when the time comes to undertake training in the future. In the meantime, we welcome all new and renewing assessors and we look forward to working with you.

We encourage you to get in touch with us for any support you require.

The topic for the next forum will be the assessment of impairments that can prove to be problematic, such as rib fractures, ankle impairments and using analogy, with guest presenter Dr Dwight Dowda. We will also provide a short update on Scheme decisions. That forum will be held on 2 April 2020. Please read on for details and don't forget to RSVP.

In the meantime, 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.

Wishing you all a happy new year.

Trish Bowe
Manager
Impairment Assessment Services

IMPAIRMENT INSIDER

Accreditation update

Thank you for your applications for accreditation for 1 July 2019 to 30 June 2022. We now have 136 accredited assessors. The list of accredited assessors is available on **our website**.

If any of your details are incorrect or you would like to provide additional information, such as other languages spoken or country visits, please email Kirstie at **wpi@rtwsa.com**.

If you have not yet completed your training and need additional support to do so, please contact us at **wpi@rtwsa.com** or **8238 5727**. Dr John Cross is also available to assist with the physical impairment assessment modules on **0407 988 498** or at **john.cross5@bigpond.com**.

Your comment on radiological findings

We often talk about the importance of being able to understand how the assessor has reached their determination of the person's whole person impairment. Sometimes it is not clear what radiological material provided has formed the basis for the assessment. If you are using radiological findings to formulate a rating, whether it be for the current or pre-existing impairment, it is important to cite the radiology you have used. This assists the decision-makers, be they self-insurers, claims agents or judges, in understanding the process.

Presbyacusis calculation for the over 80s

The calculations for age-based presbyacusis correction for clients who are over 80 are not provided for in the National Acoustic Laboratories (NAL) Report Table P. To assist hearing accredited assessors in the event that they receive a request for someone over 80, we have provided the calculations below. These are based on the formula provided in *Appendix 5 – Presbyacusis Correction Table, as corrected in the Impairment Assessment Guidelines (Ch 9, 9.10):*

	MALE	FEMALE
Age (years)	PLH (percent)	PLH (percent)
81	13.4	4.4
82	14.4	4.9
83	15.4	5.5
84	16.4	6.1
85	17.5	6.7
86	18.6	7.3
87	19.7	8.0
88	20.9	8.7
89	22.1	9.5
90	23.4	10.2
91	24.7	11.0
92	26.0	11.9

Range of motion and deformity of the knee and ankle

There has been some confusion among some assessors when applying Table 17-10 (knee) and Tables 17-11 to 17-13 (ankle/hindfoot) on page 537 of AMA5.

It has been suggested that varus/valgus deformity is added to ROM as it is included on the same page as the range of motion impairment tables and the page is headed up *"Range of motion impairment values for the lower extremity"* but this is incorrect. The impairment for deformity should instead be combined with any impairment for reduced ROM. Paragraph 3.18 on page 27 of the IAGs directs that when assessing using range of motion as the method of assessment, the impairments for the different planes of motion are added BUT paragraph 3.19 directs that varus and valgus deformities are combined with any other impairment.

Therefore when assessing a knee, the impairments for flexion and flexion contracture are added then combined with any impairment for varus/valgus deformity. Similarly, when assessing an ankle, the impairments for the plantar flexion and dorsiflexion/flexion contracture of the ankle are added to the impairments for inversion and eversion of the hindfoot but then combined with any impairment for varus/valgus deformity.

NB – Table 17-10 also contains some overlapping for 10° valgus for the femoral-tibial angle. The comment in the middle of the table suggests 3° to 10° valgus is considered normal but then also provides a rating for 10° valgus as 10%LEI. Paragraph 3.20 corrects this and directs that the comment in the middle of the table should be amended to read *"Deformity measured by femoral-tibial angle; 3° to 9° is considered normal".* It may assist you to make this correction in your copy of AMA5.

Vertebral body fractures – IAG or AMA?

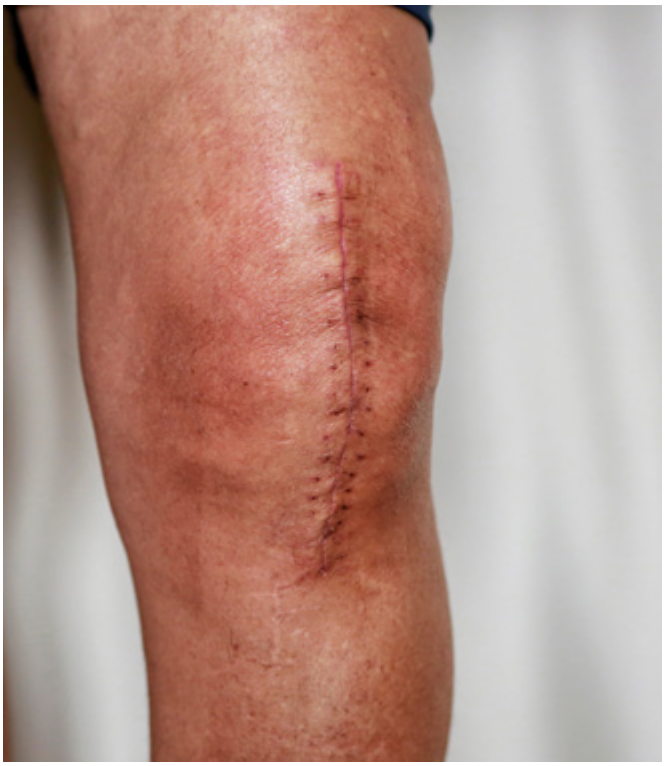
The Impairment Assessment Guidelines provide instruction on how assessors need to approach vertebral body fractures and/or dislocations at more than one vertebral level (4.22, p43). Please note that this instruction relates to multiple fractures. If you are dealing with single fractures, you should be applying AMA5 unchanged as per the DRE Tables on page 384, 389 and 392.

Rating multiple scars

Rating scars between previous and current injuries can sometimes be challenging. Skin, as a single organ, involves all non-facial scarring on the day of assessment and apportionment is necessary where other scarring is present. The assessor must rate all non-facial scars and deduct for scarring that pre-exists the subject work injury scarring. Here are some examples of how this should be approached.

Case 1 – surgical scarring in different years, no apportionment

A worker had a left shoulder rotator cuff repair in 2007 and a right shoulder arthroplasty in 2009 with scarring from both surgeries together assessed at 1%WPI. You are asked to assess both shoulders in 2010 and both scars are of equivalent appearance with similar features. The left shoulder has fully resolved and there is no other impairment to combine the scar with. The right shoulder has an impairment of 7% whole person impairment (WPI) from a slight loss of range of motion combined with the arthroplasty rating.



As you have assessed the overall skin assessment as 1% WPI, it is quite appropriate for you to opt to assess the 2007 skin assessment as 0%WPI and the 2009 skin assessment as 1%WPI. You would then combine the 1%WPI for the scarring with the 2009 shoulder impairment to give 8%WPI overall.

The numbers in the summary table would look like this:

Body part or system	**Impairment Assessment Guidelines Chapter, page, table/ figure**	**AMA5 Chapter, page, table/ figure**	**% WPI All assessed impairments**	**% WPI Pre-existing impairments**	**% WPI Work injury impairment**
1. Left upper extremity 2007			0%		0%
2. Right upper extremity			7%		7%
3. Surgical scarring			1%		1%
Totals (from Combined Values Chart AMA5)			**8% WPI Total all assessed impairments**		**8% WPI Total work injury**

Case 2 – surgical scarring in different years, with apportionment

A worker has a compensable right shoulder injury resulting in surgery in 2009. During the examination you discover that the worker also has a prior scar to his abdomen from prior surgery as a teenager. By reference to the TEMSKI table in the IAGs, you assess that the earlier abdominal scar fits the criteria under the TEMSKI table for 2% WPI assessment which is considered pre-existing impairment. Your assessment of both scars in 2010 still rates the skin as a single organ at 2%WPI (i.e. no additional impairment for the compensable right shoulder scar).

The numbers in the summary table would look like this:

Body part or system	**Impairment Assessment Guidelines Chapter, page, table/ figure**	**AMA5 Chapter, page, table/ figure**	**% WPI All assessed impairments**	**% WPI Pre-existing impairments**	**% WPI Work injury impairment**
4. Right upper extremity 2009			7%		7%
5. Surgical scarring			2%	2%	0%
Totals (from Combined Values Chart AMA5)			**9% WPI Total all assessed impairments**		**7% WPI Total work injury**

Case 3 – facial and body scarring

A worker was involved in a work-related motor vehicle accident and has scarring resulting from lacerations to their left knee, left arm and forehead. Para 13.4 of the Guidelines directs that all non-facial scarring is assessed together as one impairment. The knee and arm scars are rateable at 2%WPI using the Table for the Evaluation of Minor Skin Impairment (TEMSKI), Table 3.1 in the Guidelines.

However the facial scars are assessed using Table 6.1 in the ENT chapter of the Guidelines and assessments rated at 4% or less can be rated by non-Ear Nose and Throat (ENT) accredited assessors. In our example, the facial scars are also rated at 2%WPI using Table 6.1.

In summary, facial and non-facial scars are first rated separately, then combined with any other impairments in the summary table. Therefore, in the above example, the summary table would reflect an assessment for the skin at 2% WPI and a further assessment for facial scarring at 2%WPI, with a combined value of 4% WPI (if these were the only impairments).

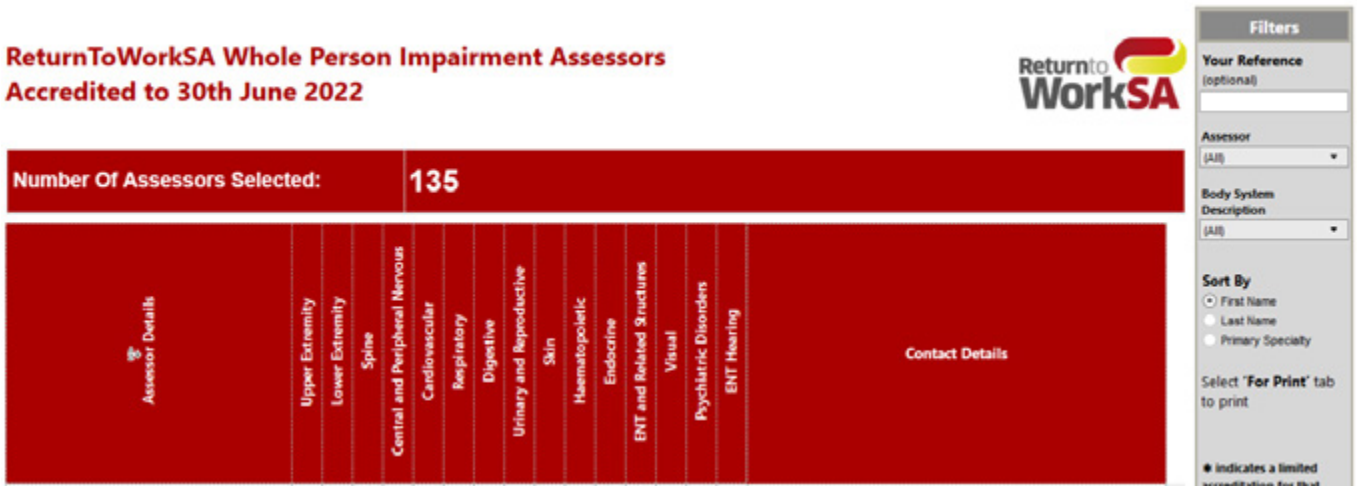
The numbers in the summary table would look like this (see next page):

Body part or system	Impairment Assessment Guidelines Chapter, page, table/ figure	AMA5 Chapter, page, table/ figure	% WPI All assessed impairments	% WPI Pre-existing impairments	% WPI Work injury impairment
1. Skin			2%		2%
2. Facial scarring			2%		2%
Totals (from Combined Values Chart AMA5)			**4% WPI Total all assessed impairments**		**4% WPI Total work injury**

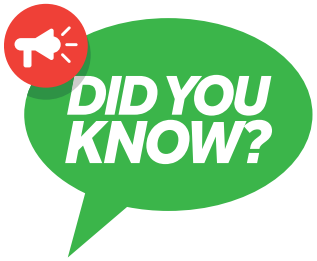
New Assessor Listing online

We recently upgraded the accredited assessor listing on our website. The new list has filter options so that users can select the relevant body systems they require, or change the order of the report.

The new listing can be found at **rtwsa.com.**



Did you know you can access previous editions of this newsletter?

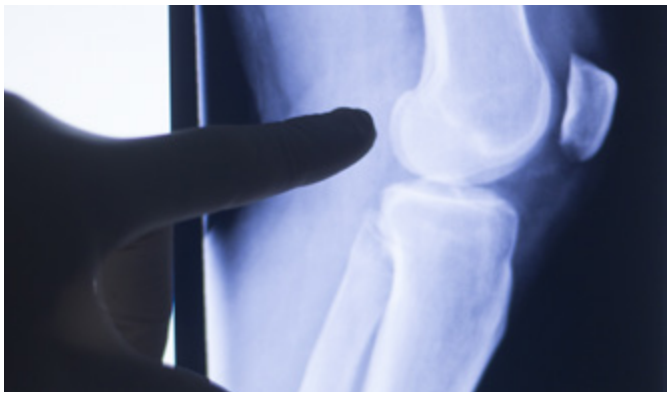


Have a question about how to manage a particular assessment? Try looking through some previous editions of the Impairment Assessor Insider in case we have clarified it earlier. The **impairment assessor news and resources page** on our website contains all previous editions published since the Return to Work scheme came into effect, as well as notices, templates and other resources. If you have an idea for an article or resource you would like to see on that page, please let us know at **wpi@rtwsa.com**.

Ordering additional radiological investigations

It is apparent that some assessors have arranged additional radiological scans to assist with their assessment of impairment, especially in relation to assessments of the lower extremity.

Assessors are reminded that paragraph 1.52 on page 11 of the IAGs directs *"The assessor should not order additional radiographic or other investigations purely for the purpose of assessing the degree of impairment"*. Paragraph 1.53 also on page 11 of the IAGs advises *"If, however, the investigations previously undertaken are not as required by the Guidelines or AMA5….or are inadequate for a proper assessment to be made, the assessor should consider whether to proceed with the evaluation without adequate investigations and advise the requestor accordingly"*. Paragraph 1.54 allows for the assessor to seek approval from the requestor to obtain additional investigations where such investigations are considered "*…essential for a complete evaluation to be undertaken and deferral of the evaluation would considerably inconvenience the worker"*.



As per paragraph 1.52, it is not the intention that assessors would seek additional investigations purely for the purposes of assessing cartilage interval. As assessors are all aware, there are risks associated with exposure to radiation which occurs during radiological investigation and therefore referral for additional investigations should only be undertaken when it is essential for the assessment and only where there is no undue risk associated with the scans. Examples of when additional scans might be required are in relation to assisting with arriving at a diagnosis and measuring compression in the case of spinal fractures.

Legal decision update

Mujakovic - Identifiable pathology should be present

The Tribunal decision, Fahir Mujakovic v Return To Work Corporation of South Australia, provides direction on how the words in the Impairment Assessment Guidelines (IAG) 'identifiable pathology should be present' is to be applied, when assessing sexual dysfunction.

In this case, the Guidelines and AMA5 were found not to have been complied with. The requirement in the "IAG" that identifiable pathology should be present for an impairment percentage to be given for sexual dysfunction, is not met where pathology is assumed but not identified. The assessor may not exclude or ignore potential causes of sexual dysfunction, both organic and non-organic, which have not been investigated and assume the cause, which in this case, was assumed to be the use of opioids.

It was considered that the purpose of the requirement in the IAG, as a modifier of AMA5, is to remove reliance on subjective reporting and presentation and to introduce, as much as is possible, an objective measure of the cause of sexual dysfunction. Identifying the pathology also helps to determine whether the condition has reached MMI. This is partly because it may assist in determining whether treatment is available, which has a bearing on whether the condition is permanent and whether the conditions in Table 7-5 in AMA5 are met. As Deputy President Magistrate Cole states, *"…compliance with IAG and AMA5 is not optional"*.

Khan v Return To Work Corporation of SA – further claim for lump sum

This is a Full Court of the Supreme Court decision that raises two issues.

Prior to considering the issues, it is helpful to briefly set out some of the background.

The worker suffered with workplace injuries in January 2009, including an injury to his right knee. This was by way of an aggravation of his already pre-existing osteoarthritis. Based on the medical evidence, the worker had a considerable impairment affecting his right knee before his workplace injury. The worker was fully aware that surgery in the form of a total knee replacement was inevitable.

It is against this background that the worker agreed to compromise his claim for lump sum compensation by way of non-economic loss for his various impairments, which included the right knee for which the worker had a 9% whole person impairment ("WPI"), under section 43 of the now repealed *Workers Rehabilitation and Compensation Act 1986* ("the repealed Act") and reflected in consent orders made on 24 April 2013.

Following this, the worker complained that he continued to have serious problems with his right knee and as a result underwent total right knee replacement surgery on 27 May 2013, following which he made a further claim for compensation pursuant to section 43 of the repealed Act on the basis that he was suffering an increased WPI as a result of the surgery.

The two issues that this matter raised for consideration were:

1. Whilst it is clear that the *Return to Work Act 2014* ("the RTW Act") does not permit further claims for lump sum compensation for permanent impairment where there has been a deterioration in a body part, the worker argued that section 43 of the repealed Act did allow for such further claims.
2. The worker also argued that, if he had an entitlement to an assessment of impairment caused by the total right knee replacement, the impairment for the pre-existing osteoarthritis should not be deducted because, as he had undergone a total knee replacement, there was no residual knee component to allow for or take account of.

In relation to the first issue, the Full Court of the Supreme Court held that section 43 of the repealed Act provides only for a single award of lump sum compensation for the same compensable injury. There is no provision with respect to successive awards for increasing impairments resulting from pathogenesis of the same compensable injury.

It was, therefore, unnecessary for the Full Court of the Supreme Court to consider the second issue concerning how the worker's pre-existing condition might be taken into account if a subsequent claim were available.

This means that the majority decision of the Full Bench of the Tribunal still stands in relation to this issue. In this respect, the majority held that, if the worker had been allowed a further assessment, whilst it was true that there was no osteoarthritis present at the time of the post-surgery assessment, the degree of impairment for which the worker was seeking compensation would not exist but for the fact of the pre-existing condition and the part that it played in leading to the larger current impairment, so there should be a deduction.

Mitchell decision – combining impairments

The much discussed and long-awaited decision of Mitchell was handed down by the Full Court of the Supreme Court in April 2019. This decision relates to assessment under the now repealed *Workers Rehabilitation and Compensation Act 1986* ("the repealed Act"), however, it does have some application under the *Return to Work Act 2014* ("the RTW Act").

This matter deals with the issue of combining impairments for the purpose of establishing whole person impairment, where some of those impairments relate to conditions/ symptoms arising from opioid medication prescribed for the original injury following surgery.

The worker's original injury was a lumbar spine injury sustained in late 2008 and early 2009 for which he was assessed as having a 26% whole person impairment ("WPI"). This was comprised of a 25% WPI for the lumbar spine injury and a 1% WPI for surgical scarring.

The worker then made claims for lump sum compensation as a result of his ingestion of medication prescribed to him for pain control following the surgery in 2011 pursuant to section 43 of the repealed Act in respect of several subsequent impairments.

The Full Bench followed another Full Bench decision of *Martin*, which found that the negative impacts of medical treatment made necessary because of the original injury, performed with due care and skill, should be regarded as forming part of the original injury, and combined the impairments arising from the ingestion of opioids with the 26% WPI that had been assessed for the lumbar spine, which gave the worker an overall 70% WPI.

ReturnToWorkSA's appeal raised the question of whether the worker suffered with a single compensable injury or two or more compensable injuries arising from the same trauma, which would mean that the injuries could be combined pursuant to section 43(6) of the repealed Act. If the answer was the former, then section 43(6) would not apply. If the answer was the latter, there was a further question, which was whether the worker's compensable injuries arose from the same trauma.

The Full Court of the Supreme Court made it clear that the decision of the Full Bench of the Tribunal in *Martin* was wrong.

In relation to whether the worker suffered a single compensable injury or two or more compensable injuries arising from the same trauma, which would mean the injuries could be combined:

- The Full Court rejected the worker's submission that section 43(6) did not apply to his case because of the complications caused by the ingestion of opioid medication to relieve his symptoms of his lumbar spine following the surgery and his original back injury were all one compensable injury. It held that the impairments as a result of the worker's ingestion of opioid medication constituted distinct, subsequent compensable injuries.
- The Full Court rejected the worker's submission that the impairments from his medication related injuries were caused by the same trauma that caused his lumbar spine injury. It held that the impairments that arose from the medication related injuries arose not from the injury to his lumbar spine, but from his ingestion of opioid medication. The taking of the medication was the crucial and necessary event for the development of those impairments. As those events occurred subsequent to the events which resulted in the injury to his lumbar spine, it was not the case that those injuries arose from the same trauma as the lumbar spine injury.

The decision has application to the assessment of impairments arising from the ingestion of opioid medications under the RTW Act as it makes it clear that those impairments are not from the same injury or from the same trauma and are therefore not combined.

Invitation

Assessor Discussion Forum

Date: Thursday 2 April 2020

Place: ReturnToWorkSA
Ground floor
400 King William Street
Adelaide

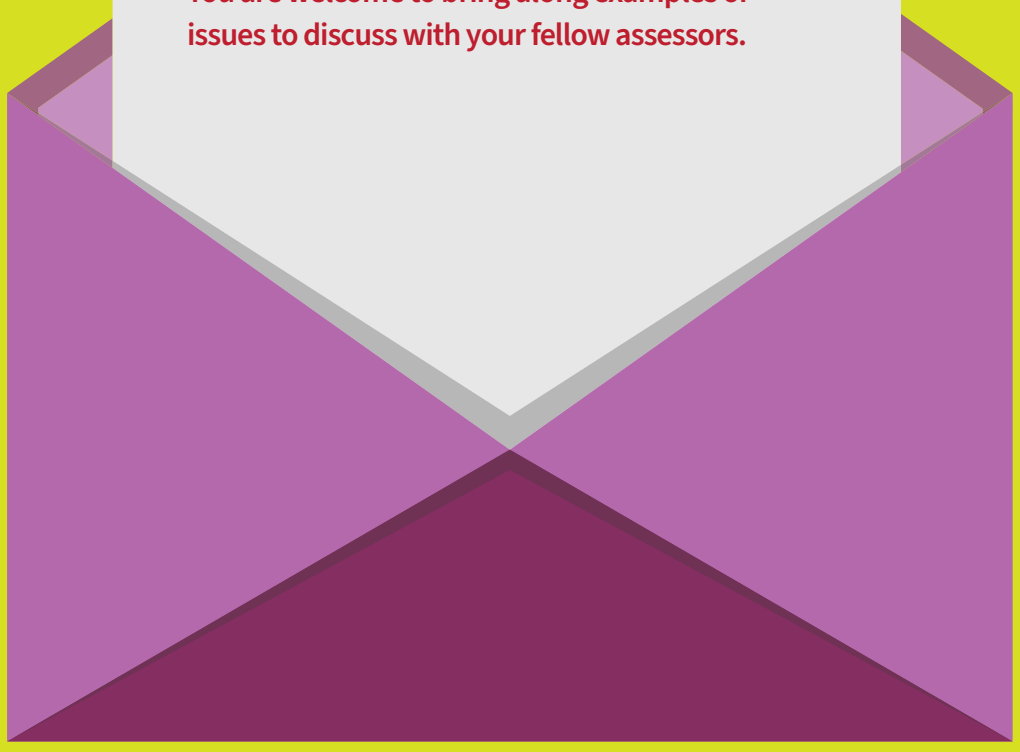
Time: 6:00 to 7:30pm

Topic: A few tricky bits (ribs, ankles, analogy etc.) and SAET decisions update

Guest presenter: Dr Dwight Dowda

RSVP: By 20 March 2020
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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