IMPAIRMENT INSIDER

ISSUE 11
JULY 2023

Introduction

Hello from the Impairment Assessment team and welcome to another comprehensive newsletter, full of useful information and takeaways I am sure you would agree.

Thank you to those who joined us at the last Impairment Assessor forum in late March. It was a lively and engaging evening and we look forward to sharing more with you this year.

Some changes in my team to be aware of: Jodie Yorke is the Manager Provider Programs working closely with and supporting the work of Sue and Cass and the rest of the Provider team in Scheme Support.

In other big news; the Minister has approved the review of the Accreditation Scheme. To conduct and coordinate this review, we have recruited Project Manager Simon Hynes to work with you all over the coming months to develop a refreshed Accreditation Scheme.

I can assure you that you will all have an opportunity to contribute to this important and exciting review of the Accreditation Scheme. You will get to meet Simon at the next forum in September at which time he will be very keen to hear your views.

Julianne Flower
Leader Scheme Support

This issue

IAG UPDATE

Another opportunity to have your say on the review of the Impairment Assessment Guidelines

In March, the Stakeholder Representative Consultation Group (SRCG) set up 12 sub-committees of medical experts to review the medical chapters of the Guidelines (Chapters 2 to 16).

The SRCG is grateful to the 55 doctors involved in these sub-committees for providing their time and expertise.

The work of the sub-committees is now drawing to a close. Some sub-committees have already provided a Recommendation to the SRCG and some have produced an early first draft of their Chapter.

All Recommendations and some first draft chapters will be made available to a wider stakeholder consultation in two phases during June and July 2023. During these phases, impairment assessors will have the opportunity to see the work of the sub-committees and provide feedback.

The chapter recommendations were released in June with more to come in July. It is important that impairment assessors provide feedback, whether you agree or disagree with the Recommendations. Throughout co-design, the SRCG has been conscious of elevating the voice and experience of the medical profession – particularly impairment assessors – in this review.

The outputs of the medical sub-committees will also be released to wider stakeholder audience for consultation and feedback.

The SRCG are continuing to look at the medico-legal and process issues in the Guidelines, and met in June for a half day workshop on Chapter 1. This work is continuing and is expected to be released in Phase 2 of consultation.

There will also be a full, formal consultation on a complete set of Guidelines, expected to be later in 2023.

As always, we encourage you to provide feedback to the SRCG, and you can do this by emailing the Secretariat Mia Bell at **mia.bell@rtwsa.com.**

DID YOU KNOW?

Impairment Assessment Services have a dedicated phone number.

The team can be contacted for general enquiries or to discuss a particular assessment you may require some further guidance on.

To contact the Impairment Assessment services team you can contact **08 8238 5960** or email **wpi@rtwsa.com.**

CASE STUDIES

Rating Carpal Tunnel Syndrome

Carpal Tunnel Syndrome (CTS) is arguably the most common entrapment neuropathy in the body. Whilst it frequently occurs in patients between 40 and 60 years of age, it does not discriminate and can be seen in patients as young as 30 or as old as 90.

CTS occurs when the median nerve is compressed against the under surface of the flexor retinaculum due to a reduction in the available volume or capacity of the carpal canal. This reduction in volume comes about due to a variety of causes; either primary (being the most common) due to swelling in the flexor tendons in the canal, or secondary to other disease processes or anatomical variations.

It is usually expected that where a worker presents early on within the disease process (i.e. within months of first noting symptoms), an excellent result, or at least substantial improvement, would be anticipated following definitive surgical release. Given the rapid access to treatment and the excellent results of decompression, it would be anticipated that in the majority of cases, persisting sensory impairment would most often fit the criteria in the lower sensory deficit grades of Table 16-10, AMA5. Similarly, thenar muscle wasting is rare in early presentations and therefore, arguably, cases involving muscle weakness would also be infrequent.

Awareness of potential inconsistencies between symptoms, signs and nerve conduction studies is particularly important when assessing and rating impairment. Where the severity of reported symptoms is greater than anticipated, or where there is little or no improvement in the preoperative symptoms/sensation, objective improvement in provocation signs and nerve conduction studies are important considerations.

The assessment of sensory impairment relies on the subjective delivery and response to light touch, monofilament, pin prick and 2PD stimuli. As worker experiences vary, relying on subjectivity brings about the potential to inflate impairment. The outcomes of all these subjective assessments should be considered concurrently along with the outcome of nerve conduction studies and the reported symptoms pre- and post-surgery.

These factors will be important when rating impairment based on AMA5 Scenario 1, 2 or 3 for post- surgical decompression CTS.

It is noted that 2.11 of the IAG's provides modification to Scenario 2 in AMA5 (p 495). Where an assessor is utilising Scenario 1 for assessment, the assessor should provide clear reasoning with documented findings to support the choice of method. The assessor needs to bring to account the entire context of the clinical findings and nerve conduction response to surgery. Reports of reduction in pin prick sensation are subjective, and found in isolation would not constitute evidence of loss of protective sensation. Page 483 of AMA5 describes decreased protective sensibility as "a conscious appreciation of pain, temperature, or pressure before tissue damage results for the stimulus". A typical example of this would be evidence of a hand injury or burn (or reported near miss) due to the worker being unable to feel the stimuli.

The outcome of sensory testing in the asymptomatic ulnar nerve may also provide guidance as to the accuracy of sensory testing and may help confirm the validity of your assessment for CTS.

WPI Improvement Program - some changes we have made

As mentioned in **Issue 10 of the Impairment Insider newsletter,** since mid-2022 ReturnToWorkSA has been working with stakeholders to understand and improve the WPI process and experience. A couple of the main areas for which feedback was received were with regards to the difficulties faced by workers in the selection of a suitable assessor from the long list, and another in relation to the request letter.

Following this feedback, ReturnToWorkSA has been working with multiple stakeholders to provide improvements in these areas.

Assessor List

ReturnToWorkSA has improved the Whole Person impairment Assessor List, adding additional filters to assist workers in the selection of an assessor. The new format can be accessed on the **ReturnToWorkSA website.**

Changes include a newer appearance, which is more printer-friendly, and a mobile friendly version to allow easier reading on devices, such as mobile phones and tablets.

Filters have been added, which include:

- Body systems
- Worker postcode
- Maximum distance to assessor
- Language
- State
- Regional/interstate visits.

These filters are optional should a worker wish to apply any of them when considering their choice of assessor.

We encourage you to have a look at the new format and ensure our public listings are correct and current. Please notify us if your details require updating. This may include changes to your address, practice details, COVID-19 vaccination requirements or an update to your referral requirements. We also publish information about areas of special clinical interest, spoken languages and consultation in rural and remote areas.

If your details need changing, please send your request for changes to **wpi@rtwsa.com**

Request Letter

A new request letter format will be launched in August by our claims agents, Gallagher Bassett and Employers Mutual. This new format responds to feedback we received from Assessors at the ReturnToWorkSA November 2022 forum.

Visually, the format differs substantially to its current form to include:

- dot point summary points
- a table summary detailing what to assess.

We've also responded to your feedback regarding the length of the request letter and relevance of medical materials supplied. We have been providing training and support to our claims agents to improve requests.

We thank you for your feedback to date. Once this new format and approach is launched, we welcome additional thoughts and improvement opportunities. We know that we won't get perfect solutions the first time. Please continue to give your feedback so we can continue to improve. If at any time you have feedback, you can contact our Impairment Assessment Services team at **wpi@rtwsa.com** or by phone on **(08) 8238 5960.**

Extension lag vs flexion contracture in the assessment of a TKR

These terms are not interchangeable. It is not uncommon after injury for a joint to be left with loss of full active extension. This is due to weakness in the extensor muscles. The joint may have no stiffness at all and has full range on passive examination but lacks full active extension. This is an extensor lag and is described and measured as the angle of the amount of loss of active extensor motion.

In these situations passive extension may be normal. If passive and active loss of extension are the same, then that joint has a fixed flexion contracture. Attempts by the examiner to passively increase extension can not change the range of motion. However in both situations the active range of motion of the joint is the same.

Changes to the Fee Schedule

The original PIA fee schedule was established when the vast majority of assessments were conducted for a single injury date and involved only a small number of impairments. It has been acknowledged that over time, assessment requests have become much more complex involving multiple body systems and many impairments to be assessed.

As a result, an ad-hoc, informal arrangement was put in place that allowed for an assessor to seek agreement with the requestor to potentially split the assessments over two reports and charge two assessment fees. This has resulted in an inconsistent approach and some degree of frustration for assessors and requestors alike.

Following extensive consultation over two years, including with the Australian Medical Association (AMA) and assessor groups, a new fee matrix structure (shown below) has been approved for the provision of WPI assessment reports effective 1 July 2023.

All assessments undertaken after 30 June 2023 (excluding NIHL and psychiatric assessments) will need to apply the fee matrix for invoicing, even if the request letter suggests the old fee applies.

The fee matrix is based on aligning the fees to the number of body systems and/or body parts being assessed. Whilst the previous fees of standard, moderate and complex remain, albeit with new criteria attached, the new structure includes the introduction of two new fees to reflect very complex (VC) and highly complex (HC) assessments.

In calculating the appropriate fee for the assessment being undertaken, the assessor will count the number of body systems and/or body parts being requested for assessment and apply this to the matrix. Assessors will no longer need to seek approval for additional report fees. If the number of body systems and body parts does not fall within the matrix, an additional assessment must be booked.

Number of body systems	Number of body parts: 1	2	3	4	5	6	7	8	9	10		
	1	S	M	M	C	C	VC	VC	HC	HC		Standard (S)	$1,113.80
	2		M	C	C	VC	VC	HC	HC			Moderate (M)	$1,392.40
	3			C	VC	VC	HC	HC				Complex (C)	$1,763.70
	4				VC	HC	HC					Very Complex (VC)	$2,261.00
	5					HC						Highly Complex (HC)	$2,575.00

Notes:

- Body system refers to 1 of the 15 body system chapters detailed in the Impairment Assessment Guidelines.
- Body part refers to gazetted list of body parts irrespective of the number of injuries to that part – this list will be included in the fee schedule.
- If combination of a number of body systems and injuries does not fall within the fee matrix, an additional assessment must be booked.
- Assessments for CRPS are considered a highly complex (HC) assessment irrespective of the number of body parts.
- A lead assessor report is considered, at minimum, a very complex (VC) assessment. If the combination of your requested injuries for assessment exceeds a VC, a HC may be charged.

Examples:

1. An assessor may be requested to provide assessments for:

Date of Injury	Injury / Condition
14/03/2017	Lumbar spine
7/06/2018	Left knee and surgical scarring
12/11/2018	Right knee and surgical scarring
TBC	Right ankle

In this example, there are three body systems (spine, lower extremities and skin), but five different body parts (lumbar spine, left knee, right knee, right ankle and scarring. With reference to the matrix this would be considered a Very Complex (VC) assessment.

2. An assessor may be requested to provide assessments for:

Date of Injury	Injury / Condition
12/08/2019	Right shoulder
14/03/2020	Right carpal tunnel syndrome and surgical scarring
31/05/2021	Right upper extremity CRPS and surgical scarring

In this example, there are two body systems (upper extremities and skin), but as the assessment includes CRPS, so is considered a Highly Complex (HC) assessment. As the right shoulder and nerve impairments will be incorporated in the assessment for CRPS, no additional fee is necessary.

A copy of the **PIA fee schedule is located on the ReturnToWorkSA website**.
If you have any questions, please contact us on **(08) 8238 5960** or **wpi@rtwsa.com.**

Medical expert peer reviewers required

Medical experts with an interest in conducting quality assurance reviews of reports, are being sought by the Motor Accident Injury Accreditation Scheme (MAIAS) Administrator.

To be eligible, applicants must have expertise in AMA5 or Guide to the Evaluation of Psychiatric Impairment for Clinicians (GEPIC).

As part of the MAIAS, Accredited Medical Practitioners conduct medical assessments and write expert reports on their findings. These are used to determine a person's eligibility for compensation in the South Australian Compulsory Third Party (CTP) insurance scheme.

Reports are sampled and assessed by peer reviewers to measure:

- compliance with accreditation obligations and legislation
- accuracy in assessment methodology and calculations
- timeframes for report delivery.

Information on the role and how to apply is available via a simple login on the **Tenders SA website.** Applications must be submitted by 2pm (ACST) on 21 July 2023.

For further enquiries, call 1300 303 558 or email **maias@sa.gov.au.** Visit **www.maias.sa.gov.au** for further information on MAIAS.

Workshop on pre-existing impairments - forum summary

The last assessor forum was held on 28 March 2023 at the Adelaide Pavilion with over fifty attendees. One of the key areas of focus for the evening was a presentation and workshop on deductions for pre-existing/unrelated impairments following the Supreme Court decision of ***Paschalis*** delivered in November 2021.

The presentation at the forum emphasised that the WPI assessment should be confined to the work injury and any previous or unrelated injury is required to be deducted from the assessment. This intent is reflected in Sections 22(8)(b) and 22(8)(g) of the *Return to Work Act 2014* which give effect to the same legislative intention, namely the guiding principle, which is that …

"Only a work injury, or an impairment to the extent that it is attributable to a work injury, is to be assessed and compensated."

Although the principles of Paragraph 1.29 of the Impairment Assessment Guidelines provides, amongst other things, that the impairment rating of the pre-existing injury be determined by applying the methodology in the IAGs, this decision highlighted that, ***"The Act does not mandate that an assessment of an unrelated injury or cause be subject to an assessment under the Guidelines in the same way as the relevant work injury must be assessed."*** Therefore, whilst difficult, the assessor must, estimate the degree of impairment that the unrelated injury or cause contributed to the overall WPI, relying upon the assessor's expertise and the available objective evidence (e.g., clinical evidence, medical records and reports, the worker's history, etc.).

The *Paschalis* decision has previously been reviewed in **Issue 9 of the Impairment Insider Newsletter.**

Participants were provided with a range of scenarios relative to each respective specialty and asked to consider key questions on how a deduction may be applied.

Below is a reflection of the discussions held by specialty for your information: -

Psychiatry: Scenario – prior history of depression and treatment
Discussion held suggested that for an assessment of pre-existing impairment to be given, multiple pieces of evidence would need to be provided such as GP clinical notes, family history, prior mental health history, any prior referrals to psychiatrist/psychologist and a, history of medications.

Upper extremities: Scenario – assessment of arthritis in the upper extremity
It was acknowledged that the IAGs/AMA5 methodology in the upper extremity is not conducive to assessment of arthritis, but discussions suggested that if multiple pieces of evidence are provided (such as documented history of prior injury, clinical notes and radiology), assessors could apply their clinical judgement to the objective evidence available to assign a percentage for a deduction.

Lower extremities: Scenario – assessment of arthritis on an MRI
It was acknowledged that the IAGS/AMA5 methodology relies on a standing plain x-ray and measured cartilage intervals, but discussions suggested that, whilst an MRI may not be conclusive evidence in isolation, it may be considered in conjunction with other pieces of evidence (such as arthroscopy findings) to apply a percentage for a deduction based on clinical judgement.

Spine: Scenario – Assessment of arthritis on medical imaging
It was acknowledged that the IAGs/AMA5 methodology in the spine is not conducive to an assessment of arthritis and the consensus was that medical imaging alone demonstrating degeneration in the spine was insufficient to provide an assessment of pre-existing impairment. Discussions suggested that medical imaging would need to be supported with other objective evidence (such as history of injury and clinical findings) for a deduction to be provided.

ENT: Scenario: assessment of mastication and deglutition due to medication use on the background of a prior dental clearance
The consensus was that an assessment of the impact on mastication and deglutition for a pre-existing condition is challenging without good dental records and a clinical history. Clear direction would be required from the requestor as to whether dentures should be in situ for the assessment and information about other conditions that may impact would also assist.

What does disregard mean?

Generally disregard means to pay no attention or ignore, but in the *Return to Work Act 2014* and in the IAGs, disregard means to deduct.

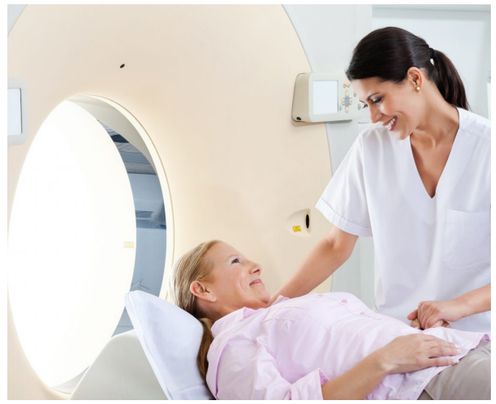
Medical Imaging and Whole Person Impairment Assessments

Medical Imaging is not only a useful diagnostic tool, but it may also help in rating the level of impairment as a result of work related and non-work related factors.

Some particular injuries, such as compression fractures to the spine, require medical imaging to help the assessor provide an impairment rating. However, an assessor should not order additional radiographic or other investigations purely for the purposes of assessing the degree of impairment.

The assessor should only request further investigations where such are considered essential for a complete evaluation to be undertaken. Where there is an alternate valid method of assessment, this should be utilised instead.

Throughout the life of the claim, a worker may undergo various tests and investigations, however, the results of these are not always readily available to the claims agents. At times, to try and reduce delays for the worker, you may be instructed to log onto the relevant imaging portal to view the imaging and documents.



Each diagnostic provider has their own protocols for accessing medical imaging. If you are unsure of any such protocols, it would be beneficial to speak to the relevant provider directly.

If an assessor is not comfortable accessing the relevant imaging portal to obtain the information required to complete the permanent impairment assessment as instructed, it should clearly be communicated to the requestor the information that you require to complete the assessment and the assessment could then be delayed until such time as the information is supplied.

The requestor will then be able to work with the provider to obtain the imaging in the format you prefer.

Legal Decision Update

Sweeney v Return to Work Corporation of South Australia [2023] SAET 25:

This is a decision of His Honour Deputy President Judge Crawley of the South Australian Employment Tribunal delivered on 24 March 2023.

This case concerned the compliance of an assessment for noise induced hearing loss for a non-economic loss lump sum entitlement and the method of deduction where some of the loss was from a non-compensable cause.

On 7 June 2021 the worker was assessed for the purposes of an independent medical examination by Dr Tomich.

Dr Tomich concluded that the worker presented with a moderately severe bilateral neurosensory hearing loss, which could not be attributed solely to the effects of her prior 15-year history of potentially hazardous noise exposure, whilst working as a manager at Isaacs Auto Electrical Marion. He arranged for some further testing to be carried out, including blood tests and imaging. On receipt of the results of the further testing he diagnosed the worker as suffering from a non-work-related condition of cochlear otoscleroris. He considered the appropriate method to assess the noise induced hearing loss component was to disregard the loss at 2000Hz and rely only upon the loss at 3000 to 4000Hz. Further, he stated he would reduce the loss at those levels by at least 50% to determine the noise induced hearing loss component. By using this method, he noted that the likely noise induced hearing loss was probably not greater than 7.7%.

The worker then underwent their assessment under section 22 of the ***Return to Work Act 2014*** ("the RTW Act") with Dr Hains. Dr Hains was of the opinion that the worker had a combination of noise induced hearing loss and hearing loss due to cochlear otoscleroris. Whilst he noted the method of assessment which had been suggested by Dr Tomich, his preference was to use what he described as the "risk tables", in particular a document clarifying the level of risk associated with different levels of noise, being a table within the Australian/New Zealand Standard (AS/NZS 1269.4.2014), Occupational Noise Management, Auditory Assessment.

By this method, Dr Hains arrived at the conclusion that the worker sustained a 4% WPI for noise induced hearing loss. In giving effect to this assessment, the Claims Agent determined that the worker fell under the threshold to be entitled to lump sum compensation.

The worker's representative arranged for the worker to be assessed by Dr Diamantis, who accepted that the audiology demonstrated that the hearing loss was not entirely consistent with noise induced hearing loss. He considered there was no clear-cut method for calculating the noise induced hearing loss component. He accepted during cross-examination that it was more probable than not that the worker suffered from cochlear otoscleroris. In carrying out his assessment, he concluded that by using the results at 3000 and 4000Hz he believed that a reasonable compromise regarding the noise component of the worker's loss had been reached. In cross-examination he agreed that the losses at 200Hz, 3000Hz and 4000Hz were all caused to some degree by exposure to noise and some other cause.

His Honour Deputy President Judge Crawley started by noting that it was a well-established principle that section 22 of the RTW Act provides a mechanism for a single assessment to be made of a worker's entitlements. That assessment would not be set aside simply because other opinions differ. It is necessary to establish that the assessment achieved was not undertaken in the prescribed manner or was plainly unreliable. The worker asserted that this was the case.

His Honour noted that section 22(8)(b) of the RTW Act requires that "impairments from unrelated injuries or causes are to be disregarded in making an assessment".

Paragraph 9.2 of the Impairment Assessment Guidelines ("the IAGs") then provides: The degree of hearing impairment not caused by exposure to noise is assessed and considered when determining the degree of noise induced/work-related hearing impairment. While this requires medical judgement on the part of the examining assessor, any non-work-related impairment should be recorded in the report.

His Honour noted that all three medical specialists in arriving at the individual assessments relied upon their clinical judgement and expertise to determine the extent of any deduction.

His Honour stated that, where he was simply faced with a difference of clinical judgment, it cannot be said that the assessment made formally pursuant to section 22 should not be given effect to if the "one assessment rule" is to be applied. Dr Hains adopted one of the accepted methods of assessment. He used a risk table not shown by the worker to be inapplicable.

Accordingly, his Honour held that it could not be said that the assessment of Dr Hains was non-compliant with the requirements of the RTW Act and the IAGs and the decision of the Claims Agent was upheld.

Fitzgerald v Return to Work Corporation of South Australia [2023] SAET 41:

This is a decision of Her Honour Deputy President Judge Kelly of the South Australian Employment Tribunal delivered on 2 June 2023.

The worker was assessed with a 3% WPI for noise induced hearing loss. As a result the Claims Agent determined that the worker had no entitlement to a non-economic loss lump sum payment. The worker contended that the assessor fell into error by confining the calculation of WPI to losses between the frequencies of 2000 to 4000Hz and should have included losses between 500 to 4000Hz and that this would have led to a WPI above the 5% WPI threshold, so the worker could obtain a non-economic loss lump sum.

Dr Tomich assessed the worker under section 22 of the RTW Act. In his permanent impairment assessment report, Dr Tomich noted that there was a total hearing loss in the right ear and that the history provided by the worker pointed towards a diagnosis of Meniere's disease, which was not work related, with surgery to the right ear resulting in total hearing loss, but abatement of the vertigo. Dr Tomich assessed a 6.6% binaural hearing loss after adjustment for presbyacusis, equating to a 3% WPI. Dr Tomich confined his calculation of WPI to hearing loss between the frequencies of 2000 to 4000Hz.

Dr Fagan was asked for an assessment by the worker. Dr Fagan assessed a binaural hearing loss of 17.9%, which equated to a 9% WPI. It should be noted that Dr Fagan did not examine the worker.

Dr Fagan Believed that the losses at frequencies between 500 to 4000Hz should have been considered. Dr Tomich responded that due regard was given to the worker's occupation as an electrician and the intermittent nature of potentially hazardous noise exposure characteristic of such work. Dr Tomich considered there was no compelling evidence that the likely noise exposure was sufficient to warrant including the lower frequencies despite the lack of hearing protection. He said the audiometric pattern was inconsistent with noise damage at those levels. Dr Tomich also considered that the hearing losses at the lower frequencies in the left ear were more likely than not the product of Stage 1 Meniere's disease.

Dr Tomich was not persuaded to change his views under cross-examination and in the face of Dr Fagan's views to the contrary. He maintained from the audiograms that it was clear that there was something going on in the inner ear that was not consistent with noise induced hearing loss. Similarly, his views as to the insufficiency of evidence supporting noise induced hearing loss at lower frequencies did not change despite the evidence of the worker as to his noise exposure at work. Dr Tomich contrasted the worker's experience with that of the noise dose typical of a person working as a boilermaker.

Fitzgerald v Return to Work Corporation of South Australia [2023] SAET 41: *(continued)*

Dr Fagan disagreed with the proposition that Meniere's disease had impacted on the worker's left ear as opposed to his right.

When asked the question as to whether or not the differences between he and Dr Tomich were a matter of clinical judgment, in cross-examination and re-examination, Dr Fagan's response was that you assessed all of the relevant factors and then it became a matter of clinical judgment.

Her Honour Deputy President Judge Kelly noted that the law as to the question of whether a WPI assessment is determinative is now well settled. The position was succinctly described by the majority of the Full Court of the Supreme Court of South Australia in Paschalis v Return to Work Corporation of South Australia and Another [2021] SASCFC 44 at [159]. The Court said:… The Tribunal may consider other expert views when determining the approved assessor has erred but it is not free to disregard the assessment made by the approved assessor unless error is shown…

This principle is in keeping with the one assessment concept that there should only be one assessment that assesses the degree of permanent impairment arising from an injury. It is for the party alleging the error to establish that error, which in this case was the worker.

Her Honour noted that Dr Tomich had in his reports and oral evidence, given an explanation as to why he had not taken into account losses at the lower frequencies. Dr Tomich agreed that, in appropriate circumstances, losses at lower frequencies could be taken into account, but that was not the case in this case.

Her Honour found that Dr Tomich had not committed an error. He had considered all the relevant factors as to whether to include losses at the lower frequencies, but simply came to a different conclusion in the exercise of his clinical judgment to that of Dr Fagan.

In the circumstances, her Honour found that there had been no error demonstrated, so the determination of the Claims Agent should be confirmed.

Where to get legal decisions

Assessors sometimes ask us for decisions that we discuss in these editions, so here is a guide to help you find them.
This is the simple way to search for SAET decisions, but obviously you can also select Supreme Court options and search with other criteria if you know it.

1. Visit the AustLII website at www.austlii.edu.au
2. Select 'SA' from top black row
3. Select 'SA Employment Tribunal (SAET) 2015'
4. Search by worker surname

Consultation open on *Return to Work (Employment and Progressive Injuries) Amendment Bill*

The South Australian Government is currently consulting on the ***Return to Work (Employment and Progressive Injuries) Amendment Bill*** (Bill).

The Bill proposes a range of changes which are relevant to Permanent Impairment Assessors, including a statutory definition of stabilised, which would remove the need for and use of 'maximum medical improvement'.

Two exceptions to the requirement for an injury to have stabilised before proceeding to a permanent impairment assessment, have also been proposed.

You can **access the Bill here** and, if you wish to, provide the Government feedback at: attorneygeneral@sa.gov.au

Feedback is due by 25 August 2023.

SAVE THE DATE

Assessor Forum and Workshop

Place: Adelaide Pavillion
Veale Gardens
Corner of South Terrace and Peacock Road

Time: 4:00pm to 7:00pm

Food and light refreshments will be provided.

SEPTEMBER 6

GENERAL UPDATES

Invoicing – where to send

Invoices for impairment assessment reports are managed and paid for by the requestor, not by ReturnToWorkSA (except those reports requested by our EnABLE team).

To avoid any delays in processing your invoice, assessors are reminded to forward the invoice directly to the requestor by emailing it separate to the report (in word, PDF or image file format) using the following addresses:

Gallagher Bassett:	invoices@gb.rtwsa.com
EML:	accounts@eml.rtwsa.com
EnABLE:	EnABLE@rtwsa.com

Please ensure you have the claimant details clearly identified on the invoice. If you have approval for additional costs, this is best attached with your email to ensure prompt payment.

DID YOU KNOW?

Where ReturnToWorkSA requires clarification before your report can be marked as compliant, this is not considered a supplementary report.

Corrections and amendments to a report after initial submission are covered in the agreed PIA fee and do not attract an additional fee.

Supplementary fees apply where a request for further opinion after the fact has been made by the requestor.

New applications

We are currently accepting applications for the below listed body-systems

- Hematology
- Endocrinology
- Opthalmology
- Cardiovascular
- Gastroenterology
- Urology
- Respiratory

If you have any colleagues interested in applying to become an Accredited Permanent Impairment Assessor the Accreditation Scheme, please ask them to contact Amara on **(08) 8233 2277** or wpi@rtwsa.com for further discussion.

DID YOU KNOW?

The preferred and most secure way for you to submit your report is as a PDF.

Your submitted version should include your report and any attachments as one document (excluding invoice).

Assessor listing

To ensure our **public listings** are current, please notify us if your details require updating.

This may include changes to your address, practice details, COVID-19 vaccination requirements or an update to your referral requirements.

We also publish information about areas of special clinical interest, spoken languages and consultation in rural and remote areas.

Please email us at wpi@rtwsa.com or call our Impairment hotline on **(08) 8238 5960.**

A requirement of your accreditation is to maintain adequate insurance cover. If you have renewed this recently, please provide us with a copy of your certificate of public liability and professional indemnity insurance.

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 the ReturnToWorkSA 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 or call our Impairment hotline on **(08) 8238 5960.**

Questions, concerns or content suggestions

The whole person impairment process is extensive, complex and prone to change in light of significant legal decisions. We aim to make these newsletters engaging and relevant to current topics.

If you have any queries, concerns or content suggestions email us at wpi@rtwsa.com or phone our Impairment hotline on **(08) 8238 5960.**

www.rtwsa.com
13 18 55

Government of South Australia