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AMA 4 Guides Impairment Assessment Training E-Newsletter

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CHAIRMAN'S MESSAGE

I wish all who read these newsletters my best wishes for the festive season.

Once again, we have completed an interesting and eventful year. Training courses have been well attended, especially stream 2 sessions. This is very pleasing as it reflects the wish of experienced assessors to keep up to date. For those who present the sessions, stream 2 audiences always produce lively discussion and always raise new and interesting points: these stimulating sessions are always a highlight for us.

As in previous years, there have been a number of court decisions that have an impact on how the Guides are interpreted. These decisions are welcome: the Guides were written by well-meaning doctors, not by Parliamentary draftsmen, and inevitably there are areas of ambiguity. Sometimes what appears to have been the intention of the Guides' authors may be challenged by precise legal interpretation of the wording in the Guides or in the legislation.

One advantage of the system in Victoria is that the current edition of the Guides has been in force for a long time now, and this has allowed a series of legal decisions to clarify a number of areas which were previously ambiguous. This process continues. Important recent decisions include clarification of assessment of multi-level spinal fractures.

Such developments emphasise the need for assessors to remain up to date. We believe that the newsletters and the stream 2 sessions are excellent methods to help achieve this target.

Articles which follow address the difficult technical issues of assessment of lower limb peripheral nerve injuries and lower limb joint ankylosis. The Training Course Management Committee is very mindful that our job is not (nor is it within our capacity) to interpret the law, but simply to provide some guidance as to the application of the Guides.

There is also an article to help assessors understand how their reports are used in the WorkSafe system.

We hope assessors find the articles helpful.

Associate Professor Richard Stark
Chair, AMA4 Guides Impairment Assessment Training

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AMA 4 NEWS

Lower limb peripheral nerve impairments

Table 68 of Chapter 3 addresses impairments from lower limb peripheral nerve dysfunction. There are pitfalls in the use of this table and errors in its use are not rare.

The table provides figures for complete impairment of the nerves named in it (similar to Table 15 for upper limb nerves). Unlike Table 15, there are separate ratings for sensory loss and dysaesthesia in Table 68. The accompanying text makes it clear that these should be assessed separately and combined. Some examiners seem to have missed this point and suggest (incorrectly) that only one of sensory loss or dysaesthesia should be rated: the text is explicit in debunking this view.

The ratings in Table 68 are graded using Tables 20 (for sensory function) and 21 (for motor function) from **Chapter 4**. This approach is made clear in the notes below Tables 20 and 21 (in Chapter 4), but for some reason these instructions are not mentioned in the text of the lower limb section of Chapter 3. Thus it may not be immediately apparent to those reading Chapter 3 in isolation how to grade these impairments.

The process of grading is therefore similar to that used for upper limb nerves but the method is made more obvious in the section on upper limb assessments as Tables 20 and 21 of Chapter 4 are (in effect) reproduced as Tables 11 and 12 in Chapter 3.

For example, a patient with a common peroneal nerve palsy who has mid grade 4 power and a mid class 3 sensory loss and high class 4 dysaesthesia would be assessed as follows (with rounding to nearest whole number):

- Motor:
  15% graded loss (Table 21, Ch4) of 15% (Table 68 Ch 3) = 2% WP
- Sensory loss:
  40% graded loss (Table 20, Ch4) of 2% (Table 68 Ch 3) = 1% WP
- Dysaesthesia:
  80% graded loss (Table 20, Ch4) of 2% (Table 68 Ch 3) = 2% WP

By combination, the total impairment is 5%.

The approach set out above is unequivocal and uncontroversial.

There are also, however, some oddities in Table 68 which cause genuine difficulty.

- The tibial nerve is omitted. The neurology training course has suggested that the appropriate rating could be calculated from the sciatic nerve and the peroneal nerve ratings by subtraction. This approach seems logical but has not been tested in court.
- The impairments for dysaesthesia calculated from combining

medial and lateral plantar nerves, sural nerve and common peroneal nerve exceed those from the sciatic nerve: thus the sum of the parts is greater than the whole! Examiners should try to determine whether the injury is in fact a lesion of the sciatic nerve per se or an injury to the individual branches listed in the table and assess accordingly.

- The descriptors in Table 20 of Chapter 4 are difficult to use when assessing sensory loss and dysaesthesia separately as some imply that both components are present. Thus a patient with complete loss of function of a nerve (eg after excision biopsy of a sural nerve) without dysaesthesia may not meet the criteria for 100% graded loss of sensory function (as defined in Table 20 of Chapter 4).

These oddities produce some genuine ambiguities in interpretation for which no definitive legal answer has yet been provided. In the meantime sensible assessment based on thorough clinical examination is recommended, together with a clear explanation of the reasoning involved.

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Assessment of Ankylosis in a Lower Extremity Joint

During the lower extremity module training session attendees experienced some difficulties with the case studies involving the assessment of ankylosed joints (section 3.2f). Confusion exists in two areas.

Firstly the text on pages 79, 80, and 81 specify a value for each lower extremity joint ankylosed in the neutral position. This value must be incorporated into the assessment value for each joint. Where the joint is in malposition, the values from the tables 46 through to 59 need to be included in the overall assessment of that part or joint.

Secondly the instructions on including multiple values are contradictory. Direction is given as follows:

- Hip Joint – combine ankylosis in each plane
- Knee Joint – add impairments in each plane
- Ankle Joint – add impairments in each plane

With the hip, combining impairments will always result in a whole person impairment less than 40%. However, with the knee adding theoretically can exceed 40%. The instructions (p3/80, chapter 3) imply that the maximum impairment of the whole person cannot exceed 40%. It is also stated with the ankle, the maximum that can be given is 25% whole person impairment. Therefore it is recommended that the examiner add all planar impairments until the maximum allowed impairment is reached.

To ensure consistency in the assessment of ankylosis of a lower extremity joint, it is recommended that planar impairments of the hip be added, but like the knee, with a maximum whole impairment of 40%. The deformity reaching these figures would equate with the loss of a leg but severe deformity of the ankle would not be considered as extreme and therefore assessed at a maximum of 25% whole person impairment.

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Elsdon v Victorian Workcover Authority [2012] VSC 347

http://www.austlii.edu.au/au/cases/vic/VSC/2012/347.html

Practitioners are advised of the decision of Justice Macaulay in the Supreme Court of Victoria, in the matter of Elsdon v Victorian Workcover Authority. The decision was handed down on 20 August 2012.

The matter involved a judicial review of a decision of the Medical Panel, certified on 2 August 2011.

Mr Elsdon injured his back in circumstances entitling him to lodge a workcover claim. The injuries were a fracture to the right transverse process of L1 and a fracture to the superior end plate of L2.

The Medical Panel determined Mr Elsdon's lumbosacral injuries fell within category II of the AMA Guides (4th ed) and therefore assessed his impairment to be 5% of the whole person.

Mr Elsdon maintained that once it was established he had suffered two fractures in adjacent vertebrae (as it was) then he was entitled to a lumbosacral impairment assessment pursuant to category IV, providing an assessment of 20%.

Mr Elsdon relied upon the decision of Justice Kaye of the Supreme Court, in the matter of Transport Accident Commission v Serwylo [20120] VSC 421. In Serwylo, the Court decided the lumbosacral impairment fell within DRE Category IV because the proper construction of Structural Inclusion (2), means that fractures or dislocations at multi levels of the lumbar spine are for the purposes of that structural inclusion, instances of multilevel spine segment structural compromise, and, it is the fact of fractures or dislocations at more than one level that differentiates Structural Inclusion (2) of Category IV from the corresponding structural inclusions in Categories II and III, which are only concerned with fractures at one level.

http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/vic/VSC/2010/421.html?stem=0&synonyms=0&query=serwylo

Mr Elsdon submitted that Serwylo was (and is) the applicable law and should have been followed by the Panel.

Justice Macaulay found the Medical Panel was bound to follow the decision of Serwylo. As it did not, it fell into jurisdictional error.

Therefore, practitioners should be aware that the established law in Victoria at present is that fractures at more than one level, by definition, satisfy the criteria of Structural Inclusion (2), regardless of the actual severity or nature of the fracture.

The decision of Justice Macaulay is being appealed in the Court of Appeal by WorkSafe. However, it will be some time before this matter is decided. In the meantime Justice Macaulay's decision must be applied to matters involving multilevel structural integrity.

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The Impairment Assessment report - the critical link between the Independent Impairment Assessor and WorkSafe

Purpose

Critical to the provision of expert examination and assessment

services provided by the accredited Independent Impairment Assessor (assessor) is the communication of the process and the resultant outcomes and opinions via the written report to the referring party.

This article discusses claims made within the WorkSafe jurisdiction. (Please note the requirements of Transport Accident Act & Wrongs Act jurisdictions can differ in some areas). For claims made within the WorkSafe jurisdiction, the referring party is the impairment benefit specialist claims manager. The claims manager has specific knowledge of the injured workers injury, clinical history and impairment assessment requirements of a claim. The claims manager selects the assessor based on this detail, the needs of the worker and the expertise - both clinical and assessment - offered by the assessor. This referral partnership is central to ensuring the injured worker is afforded their legal right to have their claim for permanent impairment determined in accordance with the *Accident Compensation Act 1985*, and most relevantly, after taking into account the assessment/s of impairment provided by an accredited assessor.

The assessment

When the agent receives an impairment assessment, the claims manager reviews the assessment for a number of aspects which will assist in determining the level of impairment and managing other aspects of the claim.

The claims manager will first check claim records for any relevant medical data in the form of diagnostic results or treating doctor information that may have been received since the assessment has been commissioned. If so, they will send those records to the assessor and request further comment.

In reviewing the assessment the claims manager will first review the history given by the injured person to the assessor to ensure that it correlates with the existing claim records and medical data provided to the assessor as part of the referral. This will include treater information, other impairment assessments and independent medical examinations. The review at this point will ensure that only the impairment from the accepted injuries has been considered and, if applicable, whether any of that impairment has been contributed to by unrelated factors. *Although an opinion is not sought on the appropriateness of ongoing treatment, any extraordinary comments in the report that the assessor believes is important to the well being of the injured person will be forwarded directly to the treating doctor.*

From the assessment and claim records the claims manager will identify those clinical findings, x-rays, results of laboratory findings, types of surgery and limitations of daily activity that are likely to equate to an impairment rating when applied to the Guides. The assessment is reviewed to establish whether those findings have been applied to the Guides criteria and rated. The assessment will be checked for impairment ratings that are not supported by clinical findings, x-rays, results of laboratory findings, types of surgery and limitations of daily activity. The assessment will also be reviewed to ensure that any unrelated impairment has been appropriately disregarded in accordance with the Alcoa Holdings Limited & Anor v Lowthian & Ors [2011] VSC 245 (24 June 2011) Supreme Court decision.

If the medical data, history and assessment do not correlate then

claims manager must decide whether to alter the impairment percentage to reflect the findings or write back to the assessor requesting further information to explain the variance between the findings and the assessment.

Where there are multiple assessments for the same person the assessments are analysed in conjunction with each other to determine whether there is:

- any potential overlap or duplication of impairment
- a need to provide copies of each assessors report to the other assessors to assist with clarifying diagnosis or the application of the Guides under different organ systems.

The determination

The claims manager will ensure that any legislative modifications to the assessment are applied along with the Guides algorithms to all the individual impairment ratings. Impairment values for each organ system or function are combined to arrive at a whole person impairment percentage.

The claims manager will prepare a notice of entitlement for the injured person and their legal representative explaining:

- which injuries have been accepted for the purpose of the assessment
- the basis of the assessment of permanent impairment resulting from those injuries
- the calculation of compensation for non economic loss lump sum resulting from the assessment
- that if they agree with the above determinations then the agent will be obliged to pay the lump sum.
- if they don't agree then the agent will resolve those matters by referral to either the Accident Compensation Conciliation Service or Medical Panel.

A copy of the assessment will accompany the notice unless its contents are such that they should only be provided to the injured person in a setting with the support of a health professional. Under those circumstances the assessment will be provided to the treating medical practitioner or psychiatrist.

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Impairment Assessment Website Listing

Are your details listed on the Impairment Assessment website?

Check your details on the Impairment Assessment Practitioners listing by entering your surname into the search function. Check you are listed and that your practice details are correct, if not please forward your request to be added to the website, or your updated practice information to iat@amavic.com.au

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MODULES IN DETAIL

2013 Module Program

Module dates for the 2013 program will be available on the IAT

website early in the New Year.

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DISCLAIMER:

This Newsletter forms part of the material in the application of those Guides or methods as part of the Ministerially approved course for the Victorian WorkCover Authority (VWA) and Transport Accident Commission (TAC) under Section 91(1)(b) of the Accident Compensation Act 1985 and Section 46A(2)(b) of the Transport Accident Act 1986 and for the purposes of Part VBA of the Wrongs Act 1958 (personal injury).

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