IMPAIRMENT ASSESSMENT TRAINING

AMA VICTORIA

AMA 4 Guides Impairment Assessment Training E-Newsletter Special Edition

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In The Courts

In our August edition a paper clarifying post-spinal surgery spinal impairment assessment following the handing down of the Mountain Pine Furniture P/L v Taylor appeal decision was promised . This paper has now been released by the Spine Reference Group.

Clarification Regards Post-spinal Surgery Spinal Impairment Assessment (September 2007)

In the initial instructions regarding spinal assessment for the Stream 1 Spine Impairment Assessment Course, the Spine Reference Group pointed out that there was an imminent Court of Appeal decision on how to assess spinal injuries which had been treated by surgery, and that we would release a clarification via the training authority (AMA Victoria) once this occurs.

The Court of Appeal judgment in the case of *Mountain Pine Furniture P/L v Taylor* delivered on 6 July 2007 upheld the judgment of Mr Justice Bongiorno (Supreme Court decision) that when an impairment assessment for the spine is conducted in accordance with AMA4, Chapter Three, DRE method, the effects of surgery must be disregarded.

On 15 August 2007, the Minister for Finance, Workcover and the Transport Accident Commission released a press release indicating the relevant statutes would be amended on the basis of equity. These teaching materials will have to be altered again once the amendments become law .

Until the foreshadowed amendments become law, the following instructions outline how spinal injury cases treated by surgery are to be assessed.

VWA and Public Liability Assessments

This decision and the following instruction impacts your practice as an Independent Impairment Assessor conducting assessments in accordance with the *Accident Compensation Act 1985* (VWA) and *Wrongs Act 1958* (Public Liability) in the following manner.

The Guides state:

"With the Injury Model surgery to treat an impairment does not modify the original impairment estimate, which remains the same in spite of any change in signs or symptoms that may follow the surgery and irrespective of whether the patient has a favorable or unfavorable response to treatment." (3/100)

The judgment ruled that the degree of impairment of the worker must be based on their pre-surgery state and the effects of surgery- whether successful or unsuccessful-should be ignored. The judgment indicates that an assessor must ensure that the effects of surgery are carefully noted so that they can be consciously disregarded.

If the worker's condition has improved following surgery then that improvement is to be disregarded.

Example: If a worker had documented radiculopathy before surgery and the surgery "caused" a resolution of the radiculopathy, the impairment would be DRE III (pre-surgical state).

If the worker's condition has become worse following surgery to the extent that they have a higher DRE Category impairment, the assessor must make a formal finding as to whether that change in condition leading to a higher impairment was actually "caused by" the surgery. If it was, then it is to be disregarded.

Example: If a worker had no documented radiculopathy before surgery and the surgery "caused" a radiculopathy, the impairment would be DRE II (pre-surgical state).

If the worker's condition has become worse following surgery as part of the natural progression of the pre-surgery state and not "caused by" the surgery, then any increase in impairment is to be regarded as part of the original impairment assessment and pre-surgical state.

Example: If a worker had no documented radiculopathy before surgery and following surgery there were clinical signs of radiculopathy, which the assessor is satisfied was not "caused by" the surgery, the impairment would be DRE III (regarded as pre-surgical state).

The term "caused by" comes directly from the judgment of Justice Bongiorno (which was subsequently confirmed by the Court of Appeal) who said that "in this instance the word follow is synonymous with caused by".

Please note that "caused by" the surgery does not require an assessor to make a finding based on negligence or error in the performance of the surgery, nor does it imply that the assessor made such a finding. The finding is simply a statement of opinion as to the cause of the worker's changed state following surgery, which is required as part of the process as indicated by the Court.

The judgment also noted that the assessor must assess the worker's condition at the time of his/her examination for the purposes of reaching a decision that the worker's condition has stabilised, so that a conclusion can then be made that the assessed (pre-surgical state) impairment is permanent.

For the purpose of Workcover and the Wrongs Act the impairment assessment process is therefore:

1. Document / identify the worker's pre-surgery state.

2. Does the worker's condition / injury fit the injury model? (DRE method of impairment assessment). ie: Is the worker's condition one of those listed in table 70? If so, then the injury model (DRE method) should be used.

3. Document the post-surgery state. Identify whether there are any changes in the worker's signs and symptoms post-surgery compared with the pre-surgery state.

4. If there is a change following surgery, decide whether the change (improvement or deterioration) was actually "caused by" the surgery so that it can be consciously disregarded.

5. Identify the worker's current status (ie: post-surgery). Is it stable? If yes, go ahead to assess impairment.

6. Assess the degree of impairment according to the worker's pre-surgery state.

To carry out the impairment assessment the assessor must have reliable medical information about the worker's pre-surgery state. If the assessor considers further information is required, then the necessary information must be obtained through the referring party.

There are a number of specific questions which arise from the Court's decisions.

1. *How does an examiner determine the pre-operative condition of a spinal injury, where they have not seen the person before surgery and are faced with differing opinions in reports?*

From time to time assessors may be presented with multiple reports describing conflicting opinions regarding an injured person's pre-operative spinal related symptoms and signs. It is up to the assessor to make his/her decision in such cases on balance, based on their assessment of all of the available information.

This will require weighing up of the reports and making a decision as to what the injured person's impairment most probably was in the pre-operative period as close to the operation as possible.

In so doing, it is important for the assessor to describe their reasoning and the issues which they have considered. These may include (but are not limited to) which reports are contemporaneous to the immediate pre-operative time, consistency of information in reports, expertise of the examiners, and treating doctor and specialist reports.

In each case of assessment, it is up to the person performing the assessment to make the decision on such issues, but in doing so they must make their reasoning clear and transparent.

2. What is considered "spinal surgery"?

There is no definition in the Guides of "spinal surgery".

There are many procedures (both diagnostic and therapeutic) on the spine which would not normally be considered as spinal surgery. These include a variety of injection techniques (such as facet joint and epidural injections, diagnostic nerve blocks and nerve root injections) and procedures involving a variety of probes (such as radiofrequency denervation and thermonuclear

annuloplasty).

The view of the reference group is that surgery means a formal incision and either an open or arthroscopic surgical procedure resulting in anatomical change. Examples include, but are not necessarily limited to, laminectomy, discectomy, fusion and disc replacement procedures.

The reference group also considers that the surgical application of a "halo brace" to immobilise an unstable cervical fracture injury should be considered as spinal surgery.

In each case of assessment, it is up to the person performing the assessment to make the decision on such issues, but in doing so they must make their reasoning clear and transparent.

3. How do you assess injuries in different regions of the spine, one of which has been surgically treated?

In traumatic injuries it is not uncommon to have different regions of the spine affected. One injury may require surgery, where the injury of another spinal region may not require surgery. If the injuries apply to different spinal regions (refer last paragraph page 95), the impairment for each region must be assessed separately.

Section 3.3f (Specific Procedures and Directions) advises in point 8 on page 101 that "If more than one spine region is impaired, determine the impairment of the other region(s). *Combine* the regional impairments using the Combined Values Chart (p.322) to express the patient's total spine impairment. "

Example: A patient suffers a spinal injury which includes a central cord syndrome in the cervical spine, as well as a vertebral fracture injury in the lower thoracic spine. There is no fracture in the cervical region and no need for surgery at that level. The lower thoracic fracture required immediate surgery.

The decision in the case of *Mountain Pine Furniture P/L .v. Taylor*requires that t he thoracic injury would be assessed according to the thoracolumbar DRE applicable to the pre-surgery state. As surgery has not been performed on the cervical spine, the injury at that level would be assessed according to the cervicothoracic DRE applicable at the time of the impairment assessment. The impairments applicable to the DREs of the two regions would be combined to provide the final total spine impairment.

4. What about the assessment of related impaired bladder or bowel function in thoracolumbar or cervicothoracic spine injuries, when there is no pre-surgery verifiable lower extremity impairment which meets the criteria for DRE categories VI or VII or VIII? (see footnotes to Table 73 and 74 and references on page 105 and 107 of chapter 3)

In this situation the Guides require the impairment assessment for impaired bladder or bowel function to be carried out in accordance with Chapter Eleven (the Urinary and Reproductive Systems) and Chapter Ten (the Digestive System) respectively. Impairment is then combined with the DRE Category II – IV impairment.

It should be noted that in the reference group's opinion, this is a relatively rare situation.

Assessment of impairment in accordance with Chapters Ten and/or Eleven, need to be performed by assessors who have successfully completed the modules on the Urinary and Reproductive Systems and the Digestive system.

There are differing ways of interpreting what the footnotes and references apply to in terms of the *Mountain Pine Furniture P/L .v. Taylor*decision.

One view is that the use of the criteria of Chapters Ten and/or Eleven in conjunction with the DRE method or Injury Model would indicate their use is limited to impairment not "caused by" surgery

It would follow from this that the impairment due to the current or post surgical bowel or bladder impairment should be combined with the pre-surgery DRE Category impairment, only when the symptoms of impaired bowel or bladder were not "caused by" surgery. ie. the symptoms of impaired bowel or bladder function existed before the surgery.

A contrary view is: the bowel or bladder impairment in this situation is not related to how the DRE category impairment is determined pre or post-surgery and they are impairments assessed outside of the Injury (DRE) model, the bowel or bladder impairments should be combined with the pre-surgery DRE Category impairment, even if the symptoms of impaired bowel or bladder function only arose after surgery.

As there is no legal precedent in this situation and the Court decisions did not specifically address this issue, the spine reference group can not make specific recommendations – other than to give the above information.

5. Are all spinal cord injuries assessed in accordance with Chapter Three?

Most spinal cord injuries can be assessed in accordance with Chapter Three (The Musculoskeletal System). Spinal cord injuries assessed in accordance with the DRE method are covered by the Court rulings– ie they must be assessed as they were pre-surgery.

The spine and neurology reference groups have agreed that in spinal cord injury cases, sometimes the expert assessor will also assess the impairment in accordance with Chapter 4 (The Nervous System) and then use the higher of the two assessments. In cases where Chapter 4 is used the correct assessment is of the post-surgical state, with the person being assessed as they are at the time of the assessment.

Example: A person with a ventilator dependent high cervical cord injury assessed under the DRE method (Category VIII combined with V results in an 81% whole person impairment), where as under the Chapter 4 (The Nervous System) assessment, Table 16 in Section 4.3c can result in a 90+% whole person impairment for "patient has no capacity for spontaneous respiration". In this case the person is best assessed under the Chapter Four.

6. What about spinal injury without surgery?

In cases of spinal injuries which have not been treated by surgery, the person's impairment must be assessed as they are at the time of the impairment assessment examination.

TAC Position on Assessments

NB. The following is the TAC position concerning assessments.

- The Transport Accident Act (TAA) specifies the requirement for stabilisation (Section 46A) in respect of an impairment determination.
- Subsection 46A(1) provides direction to the TAC in respect of how and when an impairment assessment is to be made and what is to be assessed, which is the stabilised injury. Unlike the Accident Compensation Act (ACA) the TAA relies upon the AMA Guides to delineate classes of injured persons between those who have a critical requirement for long term benefits and those whose need for long term financial assistance are not as critical on the basis of ongoing physical or psychiatric impairment.
- This requirement was the subject of a Supreme Court decision and careful analysis in *Bayliss v Transport Accident Commission* (2004) 9 VR 267 B.
- The TAC had sought the Court of Appeal's permission to intervene in the dispute in respect of *Mountain Pine Furniture P/L .v. Taylor*to allow further agitation of issues in regard to how TAC legislation operates in conjunction with the AMA Guides and specifically the Guides instruction in respect of spine impairments on page 100. Mr. Taylor's counsel opposed the request for intervention.
- The Court of Appeal rejected the TAC's application to intervene on the basis that the Taylor appeal was confined to Accident Compensation Act considerations. The appeal did not consider the legislation under which the TAC operates. The Court of Appeal's ruling rejecting the TAC's application to intervene is contained in the court transcript and forms no part of the court's judgment.
- As a result the Supreme Court's decision in *Bayliss v TAC* regarding the TAA's requirement for post stabilisation/surgical assessment of spinal impairment continues to be relevant and provides the appropriate legal guidance on this issue.
- The approach to be applied for spinal assessments using the injury model in the AMA Guides 4 th edition is to assess the injured person's current post surgical impairment after the injuries have stabilised – ie at the time of the injured person's assessment.

Modules In Detail

In the previous edition of this IAT Newsletter unfortunately a slight omission in some of the original text occurred. This error has the potential to cause confusion and so for clarification the article has been repeated here with the omitted text included.

Method Of Grading Motor And Sensory Loss In Peripheral Nerve Lesions

By Professor Richard Stark, Chair Neurology Spinal Reference Group

There is some confusion as to the correct method for choosing the percentage figure for grading motor and sensory loss in peripheral nerve lesions.

The correct procedure is to determine which grade or category of loss is appropriate for each relevant nerve using Tables 20 and 21 of Chapter 4 (which are, in effect, duplicated as Tables 11 and 12 of Chapter 3).

Thus a patient with Grade 4 power in the distribution of the median nerve above mid-forearm would, from Table 12 of Chapter 3, have between 1%

and 25% graded loss. The allocation for complete motor loss of this nerve is, from Table 15, 44% upper limb. The calculated impairment could therefore be anything between 0.44% (rounded to zero) and 11% of upper limb. While this may seem a wide range, Grade 4 power may range clinically from a barely detectable reduction of power to power just sufficient to overcome minimal resistance as well as gravity.

The example at the foot of the first column of page 49 appears to be the source of some confusion. In that example, the examiner chooses the maximum figure in the range (25% for Grade 4 power). Some have interpreted this to mean that the maximum figure should always be chosen. This interpretation is clearly incorrect for 3 reasons:

1. As indicated above, there can be a great difference in clinical effect between loss of power (or sensation) at the bottom end versus the top end of a defined grade.

2. If the Guides did not intend the ranges to be used, why were they provided (rather than a single percentage figure for each Grade)?

3. There are examples provided in which less than the maximum figure for a grade is used. For example on page 51 a sensory grade of 20% (not the maximum 25%) is used and on page 53 a motor grade of 40% (not the maximum 50%) is used.

The Neurology Reference Group has always taught that the full range of percentages for each grade is available for use and confirms this opinion.

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