IMPAIRMENT ASSESSMENT TRAINING

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MODULES IN DETAIL

2010 Module Program

AMA 4 Guides Impairment Assessment Training E-Newsletter

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CHAIRMAN'S MESSAGE

Overlaps: Who is entitled to assess what?

The legislation is clear that examiners must have been trained in the relevant module before undertaking an impairment assessment. This apparently straight-forward requirement is, however, at times ambiguous or difficult to interpret.

The Guides are set out in chapters which, in general, parallel areas of specialist expertise. However there are overlaps, cross-references, duplications (or near duplications) and examples of impairment tables appearing in a different chapter than might be expected.

Many of these points have been recognised since the Guides were first used in Victoria and have been the subject of specific mention in the teaching program from the outset. The Training Course Management Committee (TCMC) has the view that the modules as taught form the basis of the areas that examiners attending a module should be considered qualified to assess. However, some examiners received their training in the early days of the “Monash/Melbourne University” course and there has been no requirement for revision or refresher training. Thus, consider issues or conditions that have been included in a module training program but are outside the relevant chapter in the Guides: examiners trained in that module would be considered able to assess such items so long as the teaching had uniformly included instruction in these matters from the outset. Changing the training now would not necessarily reach those who attended previously.

It will not be intuitively obvious to examiners which of these items they are eligible to assess and which they may not. It is extremely frustrating to provide an assessment which one considers oneself competent to do only to have it rejected by the courts or other authorities. The TCMC is therefore attempting to produce a list of conditions of this type and to give some guidance as to the TCMC’s view of whether they may or may not be assessed by examiners with training limited to certain modules.

Here are some examples (not by any means a comprehensive list) to give examiners a feel for the types of difficulty that arise:

> Complete loss of sense of smell is assessed as 5% in the neurology chapter but 3% in the ENT chapter. From the outset,

neurology and ENT reference groups agreed that 5% should be preferred and thus ENT module attendees may use Chapter 4 for this purpose.
Chapter 4 expressly indicates that tables 20 and 21 are to be used in conjunction with table 68 of Chapter 3 to assess lower limb peripheral nerve impairments. The neurology module training from the outset made it clear that trainees could (and must) use relevant tables in Chapter 3 for peripheral nerve impairments. It has at times been overlooked that trainees in the lower limb module must refer to Chapter 4 (tables 20 and 21) to assess peripheral nerve impairments.

Those trained in the gastroenterology module have the intuitive feeling that they should be able to assess the spleen as an abdominal organ. However the method for assessing the spleen (including splenectomy) is in the chapter on "haematopoietic system" (Chapter 7), and, to the best of the TCMC's knowledge, assessment of the spleen has not been taught in the gastroenterology module from the outset. The insurers and courts are thus likely to reject assessments of spleen dysfunction or splenectomy unless the examiner has attended the haematology module.

Assessment of sleep disorders is a particularly difficult issue. In Australia, most sleep specialists have been trained primarily in respiratory medicine. Respiratory physicians may thus feel competent to assess impairment from sleep disorders, especially sleep apnoea. However the relevant table is Table 6 of Chapter 4, the neurology chapter, and the descriptors are similar to those used in other neurological tables. To the best of the TCMC's knowledge, assessment of sleep with instruction in the use of Table 6 of Chapter 4 has not been taught in the respiratory module from the outset. Thus, similar to the situation with the spleen, the insurers and courts are thus likely to reject assessments of sleep dysfunction unless the examiner has attended the neurology module. It could be proposed that a proper diagnosis of sleep apnoea requires the clinical and investigatory skills of a respiratory specialist acquainted with the requirements of chapter 5 as well as impairment assessment skills of someone trained in the neurology module who is knowledgeable in the field of central nervous system disorders. One might argue that proper assessment of sleep apnoea requires the clinical and investigatory skills of a sleep specialist and the impairment skills of someone trained in the neurology module.

The TCMC is in the process of consulting with all reference groups and will try to produce as comprehensive a list as possible of potential ambiguities in this area. It may then be possible to provide suitable ground rules in each case. Please feel free to assist by notifying your specialty reference group chairman or the AMA office directly of areas that you feel may fall into this category.

Naturally, a way to overcome potential difficulties is to attend the other modules that may overlap with your specialty; while only part of the subject matter may be directly relevant to you, it is always valuable to see how problems are assessed in other areas.

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Chair, AMA4 Guides Impairment Assessment Training Program

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AMA 4 NEWS

THE GEPIC: ISSUES THAT HAVE EMERGED WITH ITS USE

The GEPIC went "live" in late July 2006. It is now four years since its introduction and some issues have emerged. There has been some confusion about definitions, some errors in calculations, inconsistencies between symptoms, mental state, and the level of impairment and inappropriate use of rare exceptions. There have been continuing problems with the issue of secondary and non-secondary psychiatric impairment. The issue of the overlap between neurological and psychological injury continues to vex assessors. The GEPIC incorporated a means of refining the specific level of impairment in each class that appears to have been little used and some comments have been made about that.

CONFUSION ABOUT DEFINITIONS AND DESCRIPTORS

Assessment of impairment of Perception and Judgement appeared to be causing the most confusion. Bear in mind that perception only refers to disturbances of sensory perception as below. Anything outside that is not a disorder of perception. To help clarify matters with regard to judgement a more detailed list of the type of symptoms you may see in class one and class two has been prepared.

Perception
Perception: impairment of perception disturbs one or more of the five sensory modalities (hearing, vision, smell, taste and touch). This is frequently confused with a person's perception (that is, understanding or assessment) of a situation.

Class 2 impairment 10 - 20% include *persistent heightened, dulled or blunted perceptions of the internal and external world, with mild but noticeable interference with function and pseudo hallucinations.* Typical symptoms of this level of impairment include noise and light intolerance and intense flashbacks. It is for the assessor to determine as part of the mental state examination whether or not the person's perceptual experience is a true hallucination or a pseudohallucination. Intense flashbacks, to qualify as impairment of perception, require that the person experience hallucinations or illusions that lead to a sense of reliving the experience, with the person acting or feeling as if the traumatic event were recurring. An intrusive memory is not a flashback that would rate as a sensory impairment, nor are flashbacks simply memories of past traumas.

Class 3 impairments 25 - 50% include the *presence of hallucinations (other than hypnagogic or hypnopompic) that cannot be attributed to a transitory drug-induced state; obvious illusions (when associated with a diagnosable mental disorder).* As discussed above, very intense and frequent flashbacks, which lead to moderate impairment of perception, should involve hallucinations and/or illusions.

Judgement
The following list is indicative only but may give you some more understanding of impairment of judgement. The terms low range and

upper range are used here. For a more complete description of the concept of lower range, mid range, and high range refer to the GEPIC page 1569.

What is judgement?
Judgement is defined in the GEPIC as the ability to evaluate and assess information and situations, together with the ability to formulate appropriate conclusions and decisions. This mental function may be impaired due to brain injury, or to conditions such as schizophrenia, major depression, anxiety, dissociative states or other mental disorders.

Minimal impairment
Minimal impairment of judgement (less than 5%) includes:

1. indecisive at times as the result of a diagnosable mental disorder, leading to adverse personal consequences (these might be minimal, but need to be present for the indecisiveness to rate as a psychiatric impairment)
2. occasional faulty judgement
3. intermittent lack of insight
4. occasionally misjudging situations at work, in relationships, driving and with finances but with few consequences

Slight deficit – high range
Slight deficit at the high range of class one may still be transient but more severe when they are present or if present continually lead to some slight loss of function and treatment may be sought.

1. more indecision than is accommodated by self or others
2. judgement more erratic
3. some lack of insight that may lead to interpersonal problems
4. misinterpreting comments and behaviour of others at times
5. gambling becoming more of a financial problem
6. occasional failure to evaluate situations accurately leading to some actual or potential dangers

Class 2 – Mild deficit Upper range
More severe levels of impairment at the upper range of class two are continuous or intermittent and when intermittent are more severe. They are usually noticed by the person and/or by others and cause some distress and usually lead to some loss in personal efficiency. Such problems include:

1. frequently indecisive that may cause problems at work or in relationships
2. faulty judgement causing difficulty
3. frequent lack of insight leading to problems and occasional conflict
4. misjudging situations at work, in relationships, driving and with finances with some consequences
5. maintenance of behaviour that has already caused difficulty
6. misinterpreting comments and behaviour of others and responding inappropriately
7. occasional excessive gambling
8. failure to evaluate situations or implications leading to actual or potential risk of harm to self or others

ERRORS IN CALCULATION

General

1. Choosing the wrong median class
2. Choosing the right median class but a percentage that is outside that median class range
3. Choosing more than one class
4. Misunderstanding the rules regarding median classes 1.5, 2.5, 3.5.

Choosing Two or More Classes

1. You are forced to choose, to circle 2 or even 3 classes is not to choose and might render the assessment invalid
2. In this situation the lower of the classes circled will be the class.

Dealing with Intermediate Median Numbers

1. Where the median number is 1.5, 2.5, 3.5, 4.5
2. The rule is: promote the median number to the next highest class and the score is the bottom of that class.
3. So that 112333 = 2.5 = 3 = 25%
4. The GEPIC reads: *"When the Clinical Guidelines were developed, the Medical Panel considered that an appropriate and simple solution is to promote the median figure to the next highest class and allow, except in unusual circumstances, only the lowest percentage in that class."*
5. The only unusual circumstance the authors envisaged was if there was a marked skewing e.g. 112355, median class 2.5 and hence 3, in this example 30% might be appropriate. In practice this type of skewing never occurs. The more usual situation is 122333 where the median class is also 2.5 =3, but on a number of occasions the percentage impairment chosen has been 30% which is inappropriate.

CONFUSION REGARDING SECONDARY AND NON-SECONDARY IMPAIRMENT

The Legislation

Section 46B Transport Accident Act 1996:
In determining a degree of impairment of a person, regard must not be had to any psychiatric or psychological injury, impairment or symptoms arising as a consequence of, or secondary to, a physical injury.

Section 91(2) Accident Compensation Act 1985:
In assessing a degree of impairment under sub-section (1), regard must not be had to any psychiatric or psychological injury, impairment or symptoms arising as a consequence of, or secondary to, a physical injury.

Section 28LJ Wrongs Act 1958:

In assessing a degree of impairment of a person under this Part, regard must not be had to any psychiatric or psychological injury, impairment or symptoms arising as a consequence of, or secondary to, a physical injury.

Section 28LN of the Wrongs Act 1958 refers to a Certificate of Assessment and states

(1) Subject to section 28LNA and this section, an approved medical practitioner who makes an assessment of degree of impairment under this Part must provide to the person seeking the assessment a certificate of assessment.

(2) The certificate of assessment must state whether the degree of

impairment resulting from the injury satisfies the threshold level but must not state the specific degree of impairment.

(3) If not all the injuries to a person have stabilised, a certificate of assessment can only be provided under this section in respect of the person if the injuries that have stabilised are sufficient to determine a degree of impairment that satisfies the threshold level.

The threshold level for any psychiatric or psychological injury, impairment or symptoms is more than 10%.

The above legislation makes it clear that any psychiatric impairment that is not secondary to or consequence of a physical injury is counted for impairment assessment purposes.

There has been some confusion about the use of the word 'consequence'. For example, some assessors have taken this to mean that if a person has a marital breakdown contributed to by behavioural changes from a psychological work injury, then any impairment arising from the marital breakdown does not count as it is a consequence of the work injury. This is a misreading as the issue regarding ' consequence or secondary to' solely relates to whether or not there is a physical injury. On the other hand, if there is psychiatric impairment resulting from a marital breakdown due to behavioural changes after a physical injury, then that psychiatric impairment will be considered 'consequential' or secondary to the physical injury – even if mediated by a non-physical event (i.e., marital breakdown) - and therefore will not attract a rating.

Summary

1. The word primary or direct does not exist in the legislation.
2. Secondary only refers to impairment that is secondary to physical injury.
3. Errors include:
    - whole person impairment and non-secondary impairment the same when there is a physical injury. eg, a back injury with PTSD and depression, 20% WPI and "primary" 20%. In this case there is a secondary impairment so that WPI and primary impairment cannot be the same.
    - whole person impairment and non-secondary impairment different when there is no physical injury, eg WPI 30%, non-secondary impairment 20% where there is no physical injury. If there is no physical injury WPI and primary impairment will be the same.
    - note that in a Wrongs Act Assessment, only the Certificate of Assessment is required, there is no requirement to provide the table or any other calculations leading to your decision.

INCONSISTENCY BETWEEN SYMPTOMS, MENTAL STATUS EXAMINATION AND CLASSES SELECTED

- It is not uncommon to see a list of significant symptoms, a mental status examination that appears to be almost normal and then a selection of classes that do not appear to relate to either.
- It is also common to see a mental status examination that indicates no problems with, for example, perception, and no complaints of

symptoms related to perceptual abnormalities given by the individual, but perception is scored in class 2.

THE OVERLAP OF NEUROLOGICAL AND PSYCHIATRIC IMPAIRMENT ASSESSMENT

This is a significant area of difficulty for most assessors.

For a person with an acquired brain injury following an accident there might be four components to be measured. These include the following:

- Cognitive impairment (using table 4 2 Mental Status Impairments in the AMA Guides)
- Behavioural changes as a result of the head injury (using table 4.3 Emotional or Behavioural Impairments). (In such cases the lower of the above two scores is discarded; both tables 4.2 and 4.3 are on page 4/142 AMA Guides Fourth Edition)
- Depression secondary to the symptoms of the head injury (GEPIC used but this impairment is secondary to physical injury and is discarded).
- Symptoms of trauma such as those leading to PTSD (GEPIC used and the score is counted)

Some psychiatrists have done the neurological module of impairment training and can score using chapter 4 as well as the GEPIC. Some have not done this module and therefore should confine their assessment to psychiatric impairments under the GEPIC and provide comment that a neurological assessment is warranted.

REFINING YOUR IMPAIRMENT ASSESSMENT

There have been concerns by interested parties that the ranges in class 2 (10-20%) and class 3 (25-50%) are quite large and that there needs to be some means of further refining scores, especially at the lower end of the range. With this in mind the authors of the GEPIC developed the concept of low range, mid range, and high range for each class. On page 1569 in the Victoria Government Gazette there is a table indicating the indicative ranges for each class.

In practice this has proved to be useful when looking at scores in individual classes and also when determining the final percentage score once the median class has been determined.

Although the authors of GEPIC consider that the use of the application of the range of descriptors for each class of psychiatric impairment is not a requirement of the impairment assessment process, it is none the less difficult for assessors to avoid applying this approach if their assessment is to be in accordance with GEPIC. The GEPIC is clear as to:

- *"In coming to the final rating of the whole person psychiatric impairment the assessor should consider the range of descriptors and/or equivalent symptoms that emerged during the interview, as well as the findings on mental state examination."*
- *"The assessor should assess the severity of each symptom or descriptor and/or the number of symptoms or descriptors present. As a result of this clinical assessment the assessor should use clinical*

judgement to determine where the final figure lies."

- *"The assessor should consider in which part of the median class these descriptors and/or equivalent symptoms would fall, e.g. if the individual assessed has symptoms which lie within median class 2, and these symptoms were relatively minimal in severity or there were only a few symptoms this indicates a final value in the low range for class 2 (10–12%)".*

These instructions contain a string of "should consider" "should assess" and in light of recent Supreme Court decisions regarding to what extent the Guides are to be applied it would be difficult to envisage that these instructions could be ignored in the application of the GEPIC. (See *H J Heinz Company Australia Ltd v Kotzman*).

CONCLUSION

The GEPIC has been in use for four years and appears to have been well received; anecdotally there is not a great deal of variation in the scores except in some areas such as with the overlap of neurology and psychiatry and when dealing with issues related to pain.

Some problems have emerged that have been discussed in his paper. There is assistance to assessors in refining their scoring with the GEPIC that appears to have been underutilised and assessors are encouraged to make more use of the table in the GEPIC on page 1569.

It is not envisaged that there will be any significant changes in the method of impairment assessment in the near future.

Prepared by Dr Michael Epstein on behalf of the Psychiatric Reference Group
(Psychiatric Reference Group: Michael Epstein, Nigel Strauss)

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MODULES IN DETAIL

2010 Module Program

Date	Module	Time / Duration
Monday 18 October	Respiratory (Stream 1 & 2)	6:30pm - 8:30pm
Wednesday 20 October	Hand & Upper Extremities (Stream 1)	6pm - 10pm
Thursday 28 October	Lower Extremities (Stream 1)	6:30pm - 9:30pm

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