MONASH UNIVERSITY
and
UNIVERSITY OF MELBOURNE

NEWSLETTER

THE UNIVERSITY OF MELBOURNE

for Impairment Assessment using the AMA Guides 4th Edition and prescribed methods

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.

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This Newsletter and future editions can be viewed at the website address below.

Dear Doctor

In this third edition of the newsletter further questions arising from the modules are answered.

The Editorial Group is thankful for the hard work and careful consideration of all members of the Reference Groups. We acknowledge their important and continuing contributions to both the training programs and the newsletter.

The clinical and technical aspects of this Newsletter are researched by experts in various specialties. These form the Reference Groups. The members of the Reference Groups have been chosen for their clinical, teaching and medical assessment experience and knowledge.

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CORE MODULE AND ADMINISTRATION ISSUES

Q1) Should the medical examiner contact the claimant's/worker's treating doctor to clarify any inconsistencies between his/her examination findings and earlier test results?

TAC AND WORKCOVER
If a medical examiner's findings are not consistent with those of earlier studies, the examiner should note the variance in his/her report. Alternatively the examiner, subject to the claimant's prior written permission, may contact the treating practitioner to resolve any disparities.

If the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the medical examiner should modify the impairment estimate accordingly, describing the modification and explaining the reason for it in writing.

Q2) Measuring Devices
Is the use of measuring devices such as goniometers and inclinometers mandatory?
Are specific brands of these devices recommended?

TAC & WORKCOVER
*1. As the Guides state that these tools are mandatory, they **must** be used where stipulated. Medical examiners are referred to pages 3/114 and 3/130.*
2. No specific brands are recommended. In order to ensure an accurate assessment, it is vital that any device used is appropriate and properly calibrated. Companies supplying inclinometers in Australia were provided in the spine module teaching notes.

Q3) Can the claimant's /worker's treating doctor make an impairment assessment?

TAC
Yes, if accredited by the Universities.

WORKCOVER
Yes, but as a general rule AMA 4 assessments commissioned by the worker or worker's representative will not be paid for by the Agent and will not be used to determine compensation entitlements.

Q4) How do you separate impairment from disability?

TAC AND WORKCOVER
The definitions are provided in p1/1-2. When defining impairment for TAC and WorkCover, the medical examiner must rate impairment only as printed in the Guides and taught in the modules. Examiners must not include any loading or variance for disability or effects on lifestyle.

Q5) Is there a definition of Daily Living Activities?

TAC AND WORKCOVER
Yes, a definition is provided in the glossary of the Guides at pages 316 and 317. This definition should be applied where the impairment assessment is based on daily living activities.

Q6) Who is responsible for paying for the impairment assessment report if impairment is less than the compensable level of 10%?

WORKCOVER
Providing the Agent has commissioned the Impairment Assessment, they are responsible for paying irrespective of the outcome. They are not responsible for paying for assessments commissioned by other parties.

TAC
Yes, regardless of the outcome, provided the report is reasonably required.

Q7) Do the medical examiners that supply impairment assessments to plaintiff lawyers need to do the course?

TAC
Yes.

WORKCOVER
Yes. However, only impairment assessments commissioned by Agents or provided by the Medical Panels are used to determine compensation entitlements.

Q8) If a claimant / worker discloses an issue that they do not want revealed, should the medical examiner inform the claimant/worker that this information must be included in the assessment?

TAC & WORKCOVER
*Before the examination actually begins, medical examiners should advise claimants/workers that they have to disclose **all relevant** information provided at the examination to whoever has commissioned the assessment. The decision as to what is relevant is one for the medical examiner, although if in doubt, the examiner should favour disclosure in their report.*

Q9) What should a medical examiner do if he/she identifies other unrelated conditions that require medical attention – e.g. melanoma?

TAC AND WORKCOVER

As the claimant/worker should already have a treating doctor, it is not appropriate that the examiner becomes directly involved in the claimant's/worker's medical management.

However there is nothing to prevent the examiner discussing these findings with the claimant/worker and recommending that they contact their treating doctor regarding the condition.

If there are any unrelated conditions in need of medical attention, they may be referred to in the report. The TAC/Agent will then pass this information onto the claimant's/worker's treating doctors.

If the examiner has a significant concern, she/he should contact TAC, the Agent or treating doctor to discuss the problem.

Q10) Will TAC or the WorkCover Agent advise the medical examiner of other impairment assessments arranged for the claimant/worker?

TAC AND WORKCOVER

TAC and the WorkCover Agent will include in the letter confirming the medical assessment details of other impairment assessments arranged for the claimant/worker.

ENT MODULE

Answers supplied by ENT Reference Group:
Mr H Millar, Mr P Freeman, Mr D McMahon and Mr R Webb.

Q1) How is impairment from vestibular equilibrium assessed under the Guides?

Answer

Objective clinical findings are required to classify a patient into Class 2 (table 5, chapter 9)and above and may include any of the following:

- *Disequilibrium as indicated by the Romberg test or heel-toe stepping;*
- *Spontaneous nystagmus;*
- *Positive Hallpike testing for positional vertigo. (It may be very difficult to undertake this test for physical and anatomical reasons eg neck injury.); or*

Vestibular function testing which may include positional testing with ENG recording, bithermal caloric testing or the entire battery of testing undertaken in a laboratory.

Q2) Does partial nasal obstruction affect an impairment rating?

Answer

Complete nasal obstruction is allocated 10% WPI under table 5, chapter 9. Partial nasal obstruction, such as that arising from septal deviation can be a significant symptom and is not mentioned in the Guides. It is recommended that partial nasal obstruction be rated as 0 – 5% WPI under table 5, chapter 9.

LOWER EXTREMITY MODULE

Answers provided Lower Extremity Reference Group:
Mr N Cullen and Mr J Hooper.

Q1) The Lower Extremity Module directed that range of motion be assessed on one plane of motion rather than adding all the planes together for that joint. This is different from the way range of motion was taught in the Upper Extremity Module and its application under AMA 2nd edition. Why are there differences in the way this is applied?

Answer

Range of Motion (ROM) is treated differently when assessing the upper and lower extremities. For the upper extremity it is the primary methodology for establishing impairments. For the lower extremity it is only one of a number of methods that are aimed at providing the most appropriate match or best fit for the injury or condition. As such ROM is used as a secondary measurement and the tables are specifically designed so the most severe restriction in movement represents the total impairment for that joint under the ROM method.

Q2) The direction given under (tables 46-58) is to add impairment percentages for ankylosis in each joint. This is different to the wording in the example of joint ankylosis in the Guides whereby it directs the assessor to combine. In view of what appears to be an irregularity in the method of calculating impairment given in the Guides what is the correct method for assessment of ankylosis?

Answer

In the lower extremity [section 3.2f Joint Ankylosis] the text instructions are contradictory.

The direction given is 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 lower extremity impairment of less than 100%. However, with the knee adding theoretically can exceed

100%. The instructions (p 3/80, chapter 3) imply that maximum impairment of the lower extremity cannot exceed 100%. It is also stated with the ankle, the maximum that can be given is 62% lower extremity or 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 lower extremity impairment of 100%. The deformity reaching these figures would equate with loss of a leg but severe deformity of the ankle would not be considered as extreme and therefore assessed at a maximum of 62% lower extremity impairment.

Q3) Impairments from nerve deficits (table 68) excludes the tibial nerve. Although injury to the tibial nerve is not common if an impairment does exist how should this be assessed?

Answer

It should be highlighted that the 4th edition has excluded the tibial nerve from the lower extremity nerves. If injury to the Tibial Nerve results through trauma it should be assessed as outlined. This is calculated from the values already provided in the Guides (lower extremity percentages).

The difference between

	Motor	Sensory	Dysesthesia
Sciatic	(75)	(17)	(12)
Common Peroneal	(42)	(5)	(5)
Tibial	(33)	(12)	(7)

Q4) Can a definition of dysesthesia be provided?

Answer

Dysesthesia is defined as ...The impairment of sensitivity, a painful sensation or the sensation of pins and needles. The Guides state that sensory deficits and dysesthesia are subjective and must be carefully evaluated. To assist the examiner to determine impairment from peripheral nerve disorders it is recommended that dysesthesia should be assessed using the grading procedure outlined in table 11,p. 3/48.

Q5) If limb length discrepancy is a secondary condition, for example an impairment following arthroplasty, should it rate, considering only one approach for each anatomical part should be selected?

Answer

Limb length discrepancy is described as an impairment of a separate part of the leg in the context of the hip and knee. The Guides [Ch.3, p.3/84] also note that shortening is an exception to the rule as it is considered to be a different impairment.

If the discrepancy is not rated in the method used then the separate value should be combined. However note that in the case of the assessment of hip arthroplasty [table 65, p.3/87], length discrepancy is addressed, as is range of motion.

Q6) As muscular atrophy would be secondary to the primary injury should other more specific methods be used to measure impairment? The Guides (p.3/75) state that only one evaluation method should be used to evaluate a specific impairment although in some cases a combination of two or three methods may be required. Could examples be included of where more than one methodology can be used in an assessment?

Answer

*The Guides indicate that the **most specific method** should be used to evaluate an impairment. Therefore a diagnosis-based impairment would be considered to be more specific than atrophy, range of motion or strength. The latter also have a subjective basis.*

The example on internal derangement knee (meniscal tear rupture + anterior cruciate ligament) given in the lecture series addresses this issue.

*Although the flow chart contained in the lecture notes highlights muscle atrophy as a stand-alone assessment, an exception can be made to allow the combining of an impairment for leg length discrepancy for cases **other than those involving joint arthroplasty.***

Q7) Should X-rays be taken or arranged when assessing arthritis purely for medico-legal purposes? What is the expected practice where X-rays do not exist, should the examiner in such cases assess arthritis by the Range of Motion method?

Answer

Where an injury/impairment exists and the pathology is arthritis, either as an idiopathic or post traumatic condition, it is expected that useable X-rays will be available, particularly if the patient has received treatment or the condition has recovered sufficiently to be termed stable.

Impairments related to arthritis [table 62, p.3/83] must be based on weight bearing film to measure cartilage intervals.

When patients are referred for an assessment, it will be in their interest to make X-rays available. If a patient presents without x-rays the examiner should request the referring body [TAC / WorkCover Agent] to request copies from the patient's treating practitioner. If none are available, then a request for X-rays to be taken should be made via the treating doctor with a copy to the refering agent according to the specific instructions under section 3.2 of the Guides.

Q8) Should the assessor measure active or passive range of motion?

Answer

The Guides state that " The tables of chapter 3 are based on the active range of motion, which is determined with the patient's full effort and cooperation" (p. 3/14 chapter 3). However, the Guides suggest that an assessor "may check the range of passive motion by applying moderate pressure to the joint" (p. 3/15 chapter 3). Under the rules for evaluation "The physician must utilise the entire gamut of clinical skill and judgement in assessing whether or not the results of measurement or tests are plausible and relate to the impairment being evaluated" (p. 2/8 chapter 2).

Q9) Under what circumstances would the assessor rate partial motor loss based on the peripheral nerves using the grading tables?

Answer

It is recommended that tables 38 and 39 be used to assess loss of strength for peripheral nerve injuries for the lower extremity. However, circumstances will commonly arise where it may be preferable to use the nerve deficits (table 68) in conjunction with the loss of strength grading (table 12). This will occur where a patient's performance is inhibited by pain or fear of pain.

Q10) Under DRE (p.3/84) the comment is made that where a patient functions well following a hip replacement but requires prophylactic restrictions, a further impairment can be assessed. How is this assessed?

Answer

Assess whether the prophylactic restrictions are accident related and if so it would be appropriate to use table 65 to assess this restriction.

Q11) When assessing impairment of the knee under the 2nd edition certain disorders were combined with the restriction in range of motion. In the 4th edition knee disorders are rated under Diagnosis-based Estimates and appear to be stand-alone impairments. Would there be reason to apply more than one approach (e.g. Diagnosis-based Estimates plus Range of Motion) when assessing the knee eg for patellectomy?

Answer

Impairments assigned from the Diagnosis-based Estimates method are "stand-alone" and should not be combined with an impairment from loss in range of motion. The Guides state "The physician, in general, should decide which estimate best describes the situation and should use only <u>one</u> approach for each anatomical part".

In most cases Diagnosis-based Estimates will usually be more specific but the examiner does have discretion. If the examiner selects a method other than Diagnosis-based Estimates, then reasons must be given to support the choice of assessment.

Q12) How would an examiner assess patella replacement which does not appear to be included under the Diagnosis-based Estimates on page 3/85.

Answer

Patello-femoral resurfacing arthroplasty is increasing but long-term results are not available on current implants. Patella resurfacing occurs in conjunction

with total knee replacement. Assessment using the tables for total knee replacement assessment, (table 64, p.3/85) being functionally based would be reasonable.

Q13) The Guides list cruciate ligament laxity but does not state whether this is for posterior or anterior or both. If there is both anterior cruciate ligament loss and posterior ligament loss does the assessor allocate a separate impairment ie two separate impairment percentages?

Answer
Anterior cruciate ligament and posterior cruciate ligament are two separate structures and therefore should be rated individually and then combined.

Q14) If both lateral collateral ligament and medial collateral ligament are impaired, are individual impairment ratings allocated and combined?

Answer
Impairment of the lateral collateral and medial collateral ligaments are assessed separately. Both impairment figures are then combined to establish a total impairment for collateral ligament loss.

Q15) How does an examiner assess a loose hip prosthesis? Would that be a fair or poor result under hip replacement?

Answer
In most cases a loose prosthesis will be painful and disabling. The examiner should rate such a condition using table 65 (p.3/87) and grade the impairment using table 64 (p.3/85).

Q16) Why do we combine anterior cruciate ligament loss and menisectomy in the same joint combined (table 64, page 3/85)?

Answer
The anterior cruciate ligament and meniscus are considered two anatomical structures. If each is impaired, the individual part is allocated an impairment, which is then combined.

Q17) Can the impairments for pelvic fracture under table 64 (p.3.85) be combined with impairments from section 3.4 (p. 3/131)?

Answer
Examiners should select the most appropriate and specific descriptor from the two lists. Each condition should receive only one impairment rating. Multiple conditions should be combined.

Q18) Given the range of assessment methods for the lower extremity, do examiners have to include in reports how conclusions were reached, which methodology was selected, and why?

Answers
Reason should always be given where discretion is used to select what otherwise seems a less specific method of assessment.

If an explanation is not included in the report, or where unsupported statements are made, medical examiners can expect to be contacted for clarification.

Letters to the Editor

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Impairment Assessment Course 2000
ADVANCE NOTICE

A further Impairment Assessment Course, using the AMA Guides, 4th Edition and Prescribed Methods is planned for 20 - 23rd October 2000.

All Core and Elective Modules shall be covered. Registration for either the entire course or selected modules shall be available.

Those wishing to be placed on the mailing list for registration details please contact:

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