THE UNIVERSITY OF MELBOURNE

MONASH University

NEWSLETTER

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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Part A - RESPONSES FROM REFERENCE GROUPS

THE NERVOUS SYSTEM

***Q1* - The Guides state that an impairment percentage for loss of sensation involving the trigeminal nerve is combined with an estimated impairment percentage for pain or motor loss. It is noted that there is no Table to grade motor loss. Reference was made to grade motor loss using Table 6 from Chapter 9. However, this would only be relevant if there is an inability to chew and swallow. As motor impairment of the trigeminal nerve may affect speech articulation, how is this assessed?**

A - As the Guides allow for impairment of motor and sensory loss it is recommended such assessments be made as follows:

a) The motor function is to be assessed based on the restrictions of mastication and deglutition in accordance with Table 6 (Page 9/231) in Chapter 9.

b) Accepting that bilateral loss of facial sensation is uncommon, partial loss is to be assessed in keeping with category 1 of Table 9 (Page 4/145), i.e. 0-14%.

c) For neurological causes of dysarthria (with or without dysphagia) Table 12 (Page 4/147) of Chapter 4 can be used. For structural causes ENT section 9.3d (Page 9/232) is recommended.

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Q2 - **If medication used causes problems, e.g. sedation, would this rate as a sleep and arousal impairment under Table 6 of Chapter 4?**

A - For sedation to be included it must be considered permanent, and not be a transient effect likely to improve with continued use of the medication. If the effect is considered permanent, and the medication is required for long-term control of an accepted injury, and meets the criteria (including effects on cognitive function and activities of daily living), then the effect can be assessed under Chapter 4, Table 6 and combined with other relevant impairments.

THE SPINE

Q1 - **How should one assess nerve root impairment that results in foot drop, whereby the impairment assessed using Table 83 (Page 3/130) exceeds that of the DRE?**

A - On Page 3/94 the Guides state "The evaluator assessing the spine should use the Injury Model, if the patient's condition is one of those listed in Table 70 (p.108). That model, for instance, would be applicable to a patient with a herniated lumbar disk and evidence of nerve root irritation or radiculopathy. If none of the eight categories of the Injury Model is applicable, then the evaluator should use the Range of Motion Model."

Table 83 forms part of Section 3.3j which encompasses the Range of Motion model for assessing spinal injuries. There are only two situations in which the Range of Motion model is used:

1. When one is unable to clearly decide between two DRE categories, in which case the value obtained using the Range of Motion model is used to place it into the category approximating that figure. It is not used directly to calculate the impairment in this situation.

On Page 3/99 the Guides state "The physician uses the estimate determined with the Range of Motion Model to decide placement within one of the DRE categories. The proper DRE category is the one having the impairment percent that is closest to the impairment percent determined with the Range of Motion Model."

2. When an injured person's condition cannot be categorised in the DRE (or injury) system and a calculation is made on that basis. Using the Range of Motion section of the Guides requires that a number of conditions be met, including:

- The Injury Model is not able to be applied (Page 3/94)
- At least three measurements are made of each plane of motion (Page 3/115)
- Consistency and reproducibility criteria are able to be met (Page 3/112 & 115)
- That the specific steps for the use of this method (listed on Pages 115 & 116) are able to be satisfied.

LOWER EXTREMITY

Q1 - **How is avascular necrosis of the hip assessed?**

A - Lower Extremity assessment requires consideration of thirteen possible methods of assessment. No rating method is provided for avascular necrosis of the hip in Section 3.2i Diagnosis-based Estimates. However, this could be assessed under any of the sections referring to Limb Length Discrepancy, Muscle Atrophy, Manual Muscle Testing, Range of Motion, Joint Ankylosis or Arthritis. The assessor should consider each of these methods and select the most specific method matching the relevant criteria as it applies to the individual case. Gait derangement should only be used if the more specific methods cannot be applied to the injured person's condition. Any impairment assigned under gait derangement must meet the criteria set out on Page 3/75.

Where gait derangement is used "The lower limb impairment percents shown in Table 36 should stand alone and should **not** be combined with those given in other parts of Section 3.2. Whenever possible the evaluator should use the more specific methods of those other parts in estimating impairments."(Page 3/75)

Q2 - **If an impairment is allocated under skin loss (Table 67, Page 3/88) would a further impairment be assigned under the Skin Chapter (Chapter 13)?**

A - No. However, Table 67 refers to only specified areas and types of skin loss. If the injured person has skin losses not covered by Table 67 then Chapter 13 may be applied to the skin losses or other disorders. The particular losses that were assessed under Table 67 should be disregarded when performing an assessment under Chapter 13.

UPPER EXTREMITY

Q1 - **How is tennis elbow assessed using the 4th edition?**

A - Tennis elbow or lateral epicondylitis is a painful condition that can result in considerable disability with little impairment. Rarely the range of motion in the elbow will be reduced enabling an impairment to be assigned under Figures 32 and 35 of Chapter 3.

Alternative assessments are provided for in Section 3.1m, including joint crepitation, synovial hypertrophy, arthroplasty and strength evaluation. The first two of these should only be used when a range of motion assessment is inapplicable and arthroplasty only applies after surgery. Where Strength Evaluation is used, it is recommended that the normal unaffected limb be used to derive the % Strength Loss Index rather than the averages provided in Tables 31 and 32 (see Page 3/65). The Guides caution the assessor that "...the Guides for the most is based on anatomic impairment. The Guides does not assign a large role to such measurement". (Page 3/64).

PART B - Legal & process questions / answers

(supplied by the Transport Accident Commission and Victoria WorkCover Authority)

Q1 - **Can independent impairment assessors seek their own information directly from treaters or the injured person?**

A - TAC AND WORKCOVER

Yes, however this can only be done with the injured person's written permission.

TAC and WorkCover Agents will aim to provide all relevant background material to the independent impairment assessor prior to any examination taking place. Assessors should feel free to request TAC or the Agent to obtain any necessary information which is outstanding.

Q2 - **Release of medical reports**

a - Are impairment assessment reports released to the injured person as a matter of routine?

b - What happens in the event that the injured person has a psychiatric disorder?

A - TAC & WORKCOVER

The medical reports obtained to assess impairment are released when advising of a determination to the legal representative of an injured person.

B - TAC 7 WORKCOVER

b. If an injured person is not legally represented then reports are released upon request to the nominated treating medical practitioner.

The decision on release is made by TAC or the WorkCover Agent and may be directed by a court or tribunal. Impairment assessors should identify in their reports if they do not wish the report to be released directly to the injured person, stating the reasons why they consider the report should not be so released. The request and reasons are taken into account when a release decision is made.

Q3 - **Stabilisation – who makes the decision of when the injured person is referred for impairment assessment?**

A - WORKCOVER

An Impairment Benefit claim can be made 12 months after an injury occurs irrespective of whether the injury is stable.

Once liability for an injury has been established and the injured person's medical treatment history obtained, the Agent will consider whether the injuries have stabilised. If the medical reports indicate that an injury is not stable the Agent will delay making a referral for an independent impairment assessment until medical evidence is available which indicates that the injury is stable.

Q4 - **How should an injured person, whose condition is likely to deteriorate in the future, be assessed?**

A - TAC AND WORKCOVER

If the independent impairment assessor determines that the assessed impairment is likely to change by more than 3% Whole Person Impairment within the next year, the assessor should notify the WorkCover Agent or TAC of this opinion, with the completed assessment. If longer term deterioration is likely then the assessor should complete the assessment and comment in their report on the likely long term outcome. Assessors are referred to Page 315 of the Guides.

Q5 - **What should an independent impairment assessor do when assessment of an injured person identifies a previously unidentified injury?**

A - WORKCOVER

Agents are expected to assist injured persons in identifying all potentially compensable injuries which should be claimed for. Impairment assessors will be required to assess only the "claimed" injuries for which liability has been established. These will be detailed in the Agent's confirming letter to the assessor.

If an independent impairment assessor identifies an obviously compensable injury which has not been claimed, he/she should contact the Agent to ascertain if this injury also needs to be assessed.

Q6 - **What is the role of plaintiff solicitors in the WorkCover impairment process?**

A - WORKCOVER

Although in most cases injured persons are able to bring their Impairment Benefit claims without legal support, many will continue to engage lawyers. The roles performed by lawyers for these claims are to:

a - communicate with the Agent on the injured person's behalf;

b - provide advice on any dispute concerning liability for injuries;

c - assist in collation of an injured persons medical treatment history;

d - advise on potential common law rights;

e - provide general advice.

Q7 - **What should an independent impairment assessor do with communications received from an injured person's legal representatives?**

A - WORKCOVER

Independent impairment assessors should not communicate directly with an injured person's legal representative regarding the impairment assessment without the prior approval of the Agent. If an assessor receives a legal submission from a legal representative the assessor should forward the material to the Agent and conduct the assessment in accordance with the Guides and the training.

Q8 - **Can the injured person involve their treating medical practitioner in the selection of the independent impairment assessors?**

A - WORKCOVER

An independent impairment assessor is selected by the Agent. Injured persons may wish to seek advice from their medical practitioners about the specialty qualifications of the assessor selected relevant to their injury.

Q9 - **Should an independent impairment assessor consider an injured person as stable if their condition is only controlled with the use of medication?**

A - TAC AND WORKCOVER

Stability is a clinical judgment guided by the progress and the rate of change occurring during the course of the disease. The level of medication used in maintaining a stable state may be a factor in assessing the level of impairment.

In Chapter 12 determination of the class in which the impairment is placed is often guided by the level and type of treatment required. For example in section 12.6 injured persons with Type II diabetes are placed in either class 1 or class 2 depending on the need for treatment with "... oral hypoglycemic medication, either an oral agent or insulin."

On Page 2/9 the following statement appears: "In certain instances the treatment of an illness may result in apparently total remission of the patient's signs and symptoms. Examples include the treatment of hypothyroidism with levothyroxine and the treatment of type I diabetes mellitus with insulin. Yet it is debatable as to whether the patient has regained the previous status of normal good health. In these instances, the physician may choose to increase the impairment estimate by a small percentage (eg 1% to 3%) combining that percent with any other impairment percent by means of the Combined Values Chart (p322).

The application of this section of the Guides is dependent on there being total remission of the signs and symptoms with continuing use of medication.