Whole Person Impairment in the RTW scheme

Principles & Application: Impairment Assessment Guidelines

Background

- The *Return to Work Act 2014*, 1 July 2015
- Recovery and return to work
- Time-banded support for non-seriously injured workers
- Long term support for seriously injured workers
- Assessment of Whole Person Impairment is critical to the Return to Work scheme
  - Gateway to serious injury benefits
  - Access to statutory lump sum payments for economic & non-economic loss

Background

- Threshold serious injury is 30% WPI
  - Income support to retirement
  - Lifetime care and support
  - Non-economic loss lump sum (*not payable for psychiatric injury*)
  - Access to common law for economic loss
- Threshold for non-seriously injured workers is 5% WPI
  - Non-economic loss lump sum with a WPI of 5% and above
  - Additional lump sum for economic loss with a WPI of 5% to 29% (*not payable for psychiatric injury or noise induced hearing loss)*
- There can be only one assessment from one or more injuries arising from the same trauma *(appeal rights apply)*

Return To Work scheme Guidelines

The new edition - Impairment Assessment Guidelines (IAG)

- AMA4 used for assessing visual impairments
- GEPIC, incorporated into Impairment Assessment Guidelines, is used for psychiatric impairment (as used in Victorian system)
- The National Acoustic Laboratory (NAL) Guide - Hearing
- Excludes:
  - AMA5 Chapter 18 – Pain

The Guidelines and AMA5

- *The Impairment Assessment Guidelines* are published under the Return To Work Act (2014)
- *The Guidelines* are based on AMA5
- The SA *Guidelines* are definitive in the areas they address
- Where SA *Guidelines* are silent on an issue, AMA5 should be followed
- The Guidelines apply to assessments from 1 July 2015 (unless the assessment relates to a previously advised dispute)

Applying the Guidelines to each body system

- For each impairment consult **both:**
  - Impairment Assessment Guidelines, and
  - Guides to the Evaluation of Permanent Impairment 5th edition (AMA5)
- Both documents are complex and, unless very familiar with them, mistakes will be made
- Essential reading Chapters 1 & 2 AMA5

Desired Outcomes

- Accuracy of evaluation, i.e. valid and reliable
- Consistency in assessments
- Clarity of reporting
  - The report should include a transparent explanation of how assessment has been undertaken

Whole Person - *AMA5*

- WPI cannot exceed 100%
- Combine multiple injuries use the combined values chart (CVC) AMA5 pg 604
- Regional areas are given different weighting to reflect importance
- Second and subsequent impairments apply only to the remaining proportion after the other impairments have been applied
  - 40% WPI combined with 30%WPI
  - 30%WPI is of the remaining 60%WPI = 18%WPI
  - 40% WPI + 18%WPI = 58%WPI

Assessment requests

- Chapter 17 of the *Impairment Assessment Guidelines* outlines the Assessor selection process
  - The injury is stable (MMI) and an impairment assessment is required,
  - The workers must be given the opportunity to choose the assessor
  - Requests for assessments can only be received from claims agents, self-insured employers, ReturnToWorkSA or SAET
  - Case managers will prepare the requests in consultation with the worker

Assessment requests (cont.)

- Multiple impairments may require more than one assessor.

- The requestor must:
    - appoint a lead assessor
    - advise
        - Lead assessor who other assessors are
        - Other assessors who the lead assessor is

- All reports are to be sent to the requestor for compliance check who then sends the report(s) to the lead assessor who
    - consolidates all reports into final report (can bill for complex report)
    - attach other assessor’s reports

Assessment requests(cont.)

- All requests ***must: (Appendix 1, p117)***
  - include date of injury for each compensable injury being assessed
  - inform assessor if worker has previously received lump sum compensation for a prior injury
  - include all available relevant medical and allied health information
  - Advise the assessor which impairments are to be included or disregarded (assessed and deducted) in accordance with the RTW Act

Compliance arrangements

- Claims Agents all reports are sent directly to ReturnToWorkSA

- Self insured employers to advise the Assessor where their reports are to be sent.

An overview of the assessment process–Assessment report compliance review

Impairment Assessor does assessment

Request Assessment

Assessment is sent to RTWSA

Claims agent

‘Compliant’ assessment

ReturnToWorkSA

Discussion on selection

Determination

worker

Reflects the importance of WPIs to the scheme
Worker chooses assessor
Claims agent prepares assessment request
RTWSA does compliance review
Claims agent undertakes determination

Applying the Guidelines to each body system

- For each impairment consult **both:**
  - Impairment Assessment Guidelines, and
  - Guides to the Evaluation of Permanent Impairment 5th edition (AMA5)

Assessments – SA legislative requirements

- Assessors must not take into account (disregard) unrelated injuries or causes

- Once the final WPI has been assessed, assessors deduct any proportion relating to an unrelated injury or cause.

Note: Exception for pre-existing compensable injury where worker has received a previous lump sum payment for that injury

- the dollar amount is deducted by the claims staff

Example

1. Example:
    - Worker had previous sport related L knee injury assessed as 4%WPI
    - L Knee injury at work – total WPI assessed as 10%
    - Assessor deducts 4%WPI for the sports injury
    - Worker rated as having (10% -4%) = 6%WPI as a result of compensable injury

PI report summary table - 1

Body part or system	Impairment Assessment Guidelines Chapter, page, table/figure	AMA5 Chapter, page, table/figure	% WPI All assessed impairments	% WPI Pre-existing impairments	% WPI Work injury impairment
1. Left knee	xxxxxxxx	xxxxxxxx	10%	4%	6%
(add extra rows if necessary) Total (from Combined Values Chart AMA5) n/a % WPI					Total work injury 6% WPI

Same event– multiple impairments – *1.19*

- Impairments resulting from more than one injury caused by the same trauma should be assessed together

Same event– multiple impairments

Example

- worker suffers 3 compensable injuries (fall at work) – L knee, L shoulder and lumbar spine in June 2012
- assessment requested for all three injuries in Jan 2016
- assessor will:
  - assess each injury(knee, shoulder and spine) and determine %WPI for each
  - use Combined Value Chart (CVC) to determine final %WPI
  - issue report outlining %WPI for each injury and final %WPI

PI report summary table

Body part or system	Impairment Assessment Guidelines Chapter, page, table/figure	AMA5 Chapter, page, table/figure	% WPI All assessed impairments	% WPI Pre-existing impairments	% WPI Work injury impairment
1. Left knee June 2012	xxxxxxxx	xxxxxxxx	10%	n/a	10%
2. Left shoulder June 2012	xxxxxxxx	xxxxxxxx	15%	n/a	15%
3. Lumbar spine June 2012	xxxxxxxx	xxxxxxxx	5%	n/a	5%
(add extra rows if necessary) **Total (from Combined Values Chart AMA5) 28% WPI**					Total work injury 28% WPI

Injuries – different dates - *1.18*

Example – injuries on different dates

worker suffers 2 compensable injuries –

- L knee (Jan 2012) , and L shoulder (June 2012)
- assessment requested for both injuries in Jan 2016

Assessor will:

- assess each injury (knee and shoulder) and determine %WPI for each injury
- issue report outlining %WPI for each injury
- Does **not** combine the two.

PI report summary table

Body part or system	Impairment Assessment Guidelines Chapter, page, table/figure	AMA5 Chapter, page, table/figure	% WPI All assessed impairments	% WPI Pre-existing impairments	% WPI Work injury impairment
1. Left knee Jan 2012	xxxxxxxx	xxxxxxxx	10%	n/a	10%
2. Left shoulder June 2012	xxxxxxxx	xxxxxxxx	15%	n/a	15%
(add extra rows if necessary) **Total (from Combined Values Chart AMA5) injuries on different dates therefore not combined % WPI**					Total work injury N/A % WPI

Aggravation, exacerbation

Scenario A:

Worker received compensation for prior injury- aggravation, exacerbation etc.(*para 1.30)*

- Worker suffered a lumbar spine injury in 2010 and received $10,000.00
- Injury aggravated in January 2016, results in further impairment

- Assessor:
  - assesses the spine and determines %WPI
  - issues report with final %WPI
  - <u>does not</u> deduct assessment of impairment caused by prior injury from final %WPI

This only applies when compensation has been paid under SA legislation.

The prior payment will be deducted by the claims agent from the lump sum otherwise payable in respect of the latest injury.

PI report summary table – scenario A

Body part or system	Impairment Assessment Guidelines Chapter, page, table/figure	AMA5 Chapter, page, table/figure	% WPI All assessed impairments	% WPI Pre-existing impairments	% WPI Work injury impairment
1. Lumbar spine Jan 2016	xxxxxxxx	xxxxxxxx	15%	n/a	15%
(add extra rows if necessary) **Total (from Combined Values Chart AMA5) 15% WPI**					Total work injury 15% WPI

Aggravation, exacerbation (cont.)

Scenario B:

Worker has not received compensation for prior injury

- Worker suffered a lumbar spine injury in 2011 – no non-economic payment made
- Injury aggravated in January 2013, results in a new claim and further impairment
- Assessor:
  - – assesses impairment from prior injury and determine %WPI
  - – then assesses impairment from the 2nd injury and determines %WPI
  - – issues report outlining the %WPI for each injury
  - – must not use **combined values chart unless the request asks for one**

PI report summary table – scenario B

Body part or system	Impairment Assessment Guidelines Chapter, page, table/figure	AMA5 Chapter, page, table/figure	% WPI All assessed impairments	% WPI Pre-existing impairments	% WPI Work injury impairment
1. Lumbar spine 2011	xxxxxxxx	xxxxxxxx	5%	0	5%
2. Lumbar spine 2013	xxxxxxxx	xxxxxxxx	7%	n/a	7%
(add extra rows if necessary) **Total (from Combined Values Chart AMA5) separate years so not combined % WPI**					Total work injury n/a% WPI

Overview

- Has medical stability been reached – MMI
- Assessor accredited for the relevant body system
- Has the appropriate consultative process been applied in selecting the Assessor
- Referrer has checked that all necessary information has been supplied to the Assessor (Appendix 1 page 117, IAG)
- Compliance check of the report

Changes to IAG

- Upper extremity
- Lower extremity
- Spine
- Central Nervous System
- Complex Regional Pain Syndrome

Changes - *Upper extremity*

- Use the contra- lateral side as a baseline where appropriate- para. 2.2
- Forequarter amputation has a rating of 70%WPI (i.e. > 60% WPI) para. 2.4
- Process for assessing & recording ROM measurements
  - to interpolate (active) ROM measurements where necessary and round to a whole number - para 2.5

Changes – *Upper extremity*

- New para. 2.8
  - Combine in the same category of impairment e.g. %UEI, %HI, %DI
  - First combine regional impairments of the same limb (%UEI)
  - Then convert to %WPI
- When using the combined table, all values must be in the same units

Changes – *Upper extremity*

- New para. 2.11 carpal tunnel syndrome impairment after surgery
  - Modifies scenario 2
  - Normal sensibility and opposition
  - Findings do not fit Scenario 1
  - ***Does not require a nerve conduction study***
  - Maximum rating not to exceed 5% UEI- with reasons

Changes – *Upper extremity*

Epicondylitis of the elbow - new clause 2.20:

- Rated as 2% UEI (1 % WPI).
- Symptoms ***must*** have been present for at least 18months
- Localised tenderness at the epicondyle ***must*** be present
- Provocative tests ***must*** be positive.

- Epicondylitis with an associated loss of range of motion (ROM)
  - diagnosis based estimate is not combined with ROM
  - The method giving the highest rating is used.

Changes - *Upper extremity*

- Resection arthroplasty T16-27 (p 506, AMA5)
  - distal clavicle (isolated) = 5%UEI (previously 10%UEI – AMA5)
  - proximal clavicle (isolated) = 8%UEI (previously 3%UEI – AMA5)

- Sternoclavicular joint Table 16-18, p 499 AMA5
  - increased to 25%UEI or 15%WPI (previously 3%UEI – AMA5)

Changes – *Upper extremity*

Resurfacing procedures new para. 2.21

- No additional impairment for resurfacing procedures used in the treatment of
  - localised cartilage lesions
  - defects in major joints.

Changes – *Lower extremity*

- New para. 3.2
  - “in general the method that most specifically addressed the impairment should be used”
- The importance of comparing with the contralateral side is emphasised (e.g. if assessing varus/valgus deviation)

Changes – *Lower extremity*

- Modified paras. 3.4 - 3.8
  - In the Lower Limb, there may be several valid assessment methods.
  - The most specific method(s) should be used.
  - If there are several equally specific methods, the one(s) giving the highest rating should be selected

- Table 17.2 (AMA5 p526) shows which methods may be combined and which may not

Changes – Lower extremity

- New para. 3.19
- In knee ROM, the assessor should combine (not add) a flexion/ extension rating with any varus/valgus rating. Table 17-10 (AMA5 p537)
- Deformity measured by the tibio femoral angle- 3 to 9 degrees is normal (AMA5 3-10 degrees)

Changes – *Lower extremity*

New para. 3.22 corrects ankle ROM Table 17-11 (AMA5 p537) for flexion contracture

- Ranges are:
- Mild 1 -10 degrees
- Moderate 11 – 19 degrees
- Severe flexion contracture 20+ degrees

Changes – *Lower extremity*

- Table 3.1 (ankylosis of the ankle in optimum position) has been modified

Joint	Whole person	Lower extremity	Ankle or foot
Hip	20%	50%	–
Knee	27%	67%	–
Pantalar	***19%***	***47%***	***67%***
Ankle	***15%***	***37%***	***53%***
Triple	***6%***	***15%***	***21%***
Subtalar	***4%***	***10%***	***14%***

Changes – *Lower extremity*

- Diagnosis Based Estimates

- There are some changes/additions to Table 17-33 (p546-7 AMA5):

- Pelvic fractures are assessed using Table 4.3 in the Spine chapter of IAG and not 17-33.
- Para. 3.34 Femoral Osteotomy DBE
- Para. 3.35 Patello-femoral joint replacement

Changes – *Lower extremity*

Diagnosis Based Estimates (cont.)

Para 3.36 Total ankle replacement – a new method, similar to that for total hip or knee replacement

Para 3.37 Hindfoot/ intra-articular fractures. The rating methodology is clarified

Para. 3.38 Plantar fasciitis. A rating of 2%LEI (1%WPI) is given

Para. 3.39 No additional rating is given for resurfacing procedures used in treatment of cartilage lesions/ major joint defects

Changes – *Lower extremity*

- Para 3.41 Table 17-35, Rating knee replacement results

- Clarification & expansion on deductions
  - Extension lag
  - Knee alignment varus/valgus (compare with unaffected limb to take into account constitutional changes)

Changes - *spine*

Old para. 4.7 *"If an assessor is unable to distinguish between two DRE categories, then the higher of these two categories should apply".*

- This paragraph has been deleted
- Clinicians should assign a correct DRE category
- Mostly applies to DRE I vs DRE II

Change - *spine*

IAG 4.8 page 40

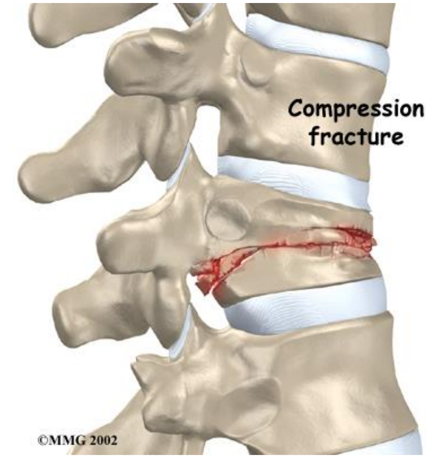
Cauda equina syndrome

- The definition in old para 4.19 is expanded:
  - For a cauda equina syndrome to be present, there must be bilateral neurological signs in the lower limbs and sacral region. Additionally, there must be a radiological study which demonstrates a lesion in the spinal canal…..etc.
  - Assessment is still using AMA5 Table 15.6 page 396 Rating Corticospinal Tract Impairment

Change - *spine*

IAG 4.11 page 40

Vertebral body fractures



Addition to old para 4.12

- "The assessment of a vertebral fracture is to be based upon a report of trauma resulting in an acquired injury, and not on developmental or degenerative changes. Justification must be provided in the report".

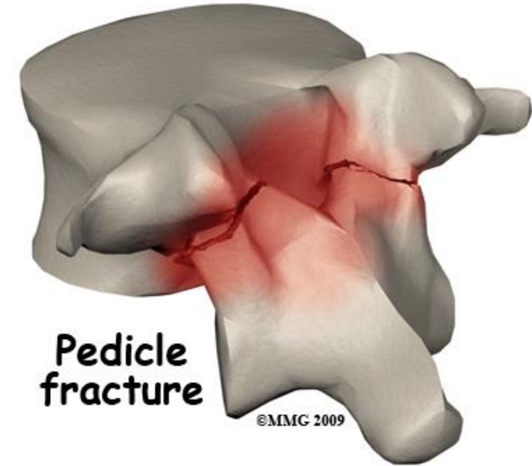
Change - *spine*

IAG 4.22 page 43

Posterior element fractures

i.e. lamina, pars and pedicle fractures

- at a single level DRE II (clarified)
- at multiple levels DRE III.



Change - *spine*

IAG 4.28 page 45

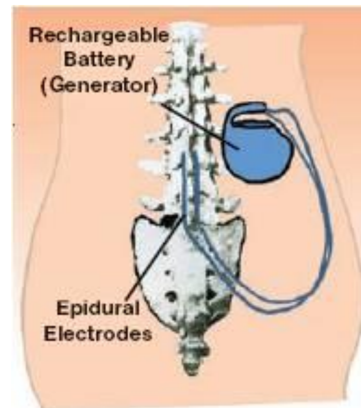
Effect of Spinal Surgery

- Persistent radiculopathy after surgery not accounted for in DRE III (or DRE IV in C Spine)
- IAG Table 4.2 p 45 provides additional ratings for persistent radiculopathy after surgery in DRE III (or DRE IV in C spine)
- DRE V already takes into account persistent radiculopathy – no additional modifier necessary

Change - *spine*

IAG 4.32 page 46

Spinal cord stimulator or similar device: The insertion of such devices does not warrant any addition to WPI.



Change - *spine*

Pelvic Fractures

New Table 4.3 IAG p 46:

- internal fixation/ankylosis of pubic symphysis - 5%WPI
- internal fixation/ankylosis of sacro-iliac joint - 5%WPI
- two out of three joints internally fixed/ankylosed - 8%WPI
- all three joints are internally fixed/ankylosed -10%WPI

Change - *spine*

Pelvic Fractures (cont):

New footnote to Table 4.33:

- The rating of WPI is evaluated based on radiological appearance at maximum medical improvement, whether or not surgery has been performed. Multiple injuries of the pelvis should be assessed separately and combined.
- The maximum WPI for pelvic fractures is 20%.

Complex Regional Pain Syndrome (CRPS)

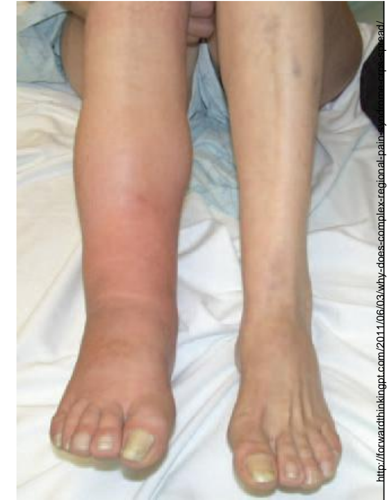
- The requirements for diagnosing Complex Regional Pain Syndrome Types I (Reflex Sympathetic Dystrophy) and II (Causalgia) for the purposes of assessing impairment have been changed.
- When the objective diagnostic criteria have been satisfied, the method of assessment has not altered.
- The methodology is given in AMA5 pp493- 497

CRPS – *Table 2.1, page 20*

Diagnostic criteria for CRPS types I and II in the upper extremity & lower extremity

Continuing pain as defined in Para 1, AMA5 (p495)

- spontaneous burning pain
- outside territory of single nerve,
- disproportionate to initiating event
- sudomotor & vasomotor dysfunction
- trophic changes all tissues; skin to bone


http://forwardthinkingpt.com/2011/06/03/why-does-complex-regional-pain-syndrome-crps-spread/

There is no other diagnosis that better explains the signs and symptoms.

Complex Regional Pain Syndrome

Must - *Minimum One symptom in each of the four categories*

Sensory (usually persistent) • Persistent hypoaesthesia • Mechanical allodynia	**Vasomotor** (often intermittent): • Temperature asymmetry • Skin colour changes • Skin colour asymmetry
Motor/trophic (usually persistent) • Decreased range of joint motion • Motor - weakness, wasting • Trophic changes - hair, nails, skin	**Sudomotor** (often intermittent): • Oedema • Sweating increase or decrease • Sweating asymmetry

At the time of evaluation *at least one **physical sign** must* be elicited in the affected part in *each of the following **four*** categories:

Sensory:	**Vasomotor***:*
• Hypoaesthesia • Mechanical allodynia to deep somatic pressure and/or joint movement	• Temperature asymmetry • Asymmetric skin colour changes
Motor/trophic:	**Sudomotor:**
• Joint stiffness & ↓ passive motion • Motor weakness • Wasting • Motor dysfunction – tremor, dystonia • Trophic changes – hair, nails, skin	• Oedema • Sweating asymmetry

Assessment issues

- Not using SA *Impairment Assessment Guidelines* as first reference point
- Addition (especially in Upper Limb) vs combined values chart (CVC)
- Using incorrect conversion tables
- Combining at WPI instead of extremity level
- Not assessing the opposite side for comparison purposes
- Rating arthritis using arthroscopy or clinical estimations
- Inappropriate use of analogy
- Not accredited in particular body system

Conclusion

From 1 July 2015 – IAG

Assessor selection process – Ch 17

Requestor – detailed instructions in Appendix 1

Check the relevant IAG chapter before AMA5

Where there is no statement in IAG follow AMA5

Consistency, reproducibility

Clarity of reporting & transparent reasoning

Compliance check

Worker entitlements/payment