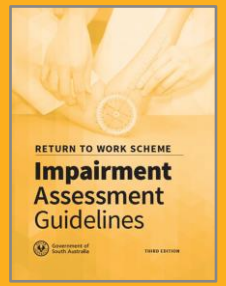
# Spine and Nervous System

## Changes to the Third Edition of Impairment Assessment Guidelines

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*We recognise that Aboriginal and Torres Strait Islander people are the First Peoples of Australia.*

*We acknowledge that we are meeting on the traditional lands of the Kaurna people and we pay our respects to the Kaurna people, and their Elders, past, present and emerging.*


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IAG3

# A new Third Edition of Impairment Assessment Guidelines will commence on 1 October 2025

- Stakeholder Consultation Group was established by Minister Kyam Maher MLC
- Representatives from Australian Medical Association SA, Law Society of SA, SA Unions, and ReturnToWorkSA
- Extensive multi- round consultation

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The Third Edition of the Impairment Assessment Guidelines has been developed with a strong focus on ensuring that workers receive fair, consistent, transparent and objective assessments.

The changes support the goal that workers with similar impairments will receive similar assessments.

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# Chapter 4 – Spine

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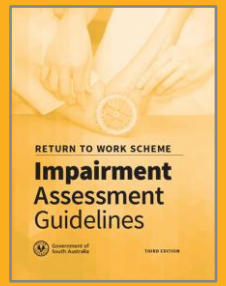


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# Learning Objectives

**Able to:**

- Understand the need for impairment assessment reports to include clear reasoning for the assessment method and impairment rating.
- Understand imaging required for assessments of the spine.
- Understand requirements for combining impairments of the spine first where there are other body part impairments to be considered.
- Understand the management of common developmental findings.
- Understand the diagnostic requirements of cauda-equina syndrome.

# Learning Objectives cont'd

**Able to:**

- Interpret motion segment integrity alteration from the AMA5.
- Understand changes to the interpretation of thoracic radiculopathy.
- Understand the methodology for assessment of spinal cord stimulators or similar devices.
- Understand the assessment method for assessment of sacral radiculopathy.
- Understand the management of rib fractures.

# Chapter 1:  Clauses 1.54, 1.55 and 1.60

- The assessor needs to provide the current clinical diagnosis including the basis and evidence used for determining the diagnosis.
- The assessor needs to consider any part of the impairment due to any previous or subsequent injury or cause (including developmental condition or abnormality), if any, relevant to the impairment being assessed.
- The report must provide a rationale consistent with the methodology of the IAG3 and include a comparison of the key findings with the criteria in the guidelines.
- The assessor should be aware that a technical review will be undertaken of the report, and if it is not clear that the report has been completed in accord with IAG3, clarification may be sought.

# SPINE

- The assessment report should set out the reasoning for the assessment of the work-related impairment and the relationship of the rating to the 'injury'.
- 4.1 - The assessment of impairment related to the spine is based exclusively on the DRE method of AMA5.
- 4.4 - Imaging findings used to support the impairment rating should be consistent with the symptoms and findings on examination.
- 4.8 - Clear understanding and description in the report of any developmental findings, noting that their presence does not in itself constitute an impairment due to injury.
- 1.37 - Where developmental findings are to the same region, and/or have relevance to the impairment being assessed, the requestor will ask that the assessor disregard or deduct the pre-existing/unrelated impairment due to the other injury or cause.

# New in IAG3

- 4.3 - The assessor should be aware that impairments affecting different regions of the spine must be combined prior to combining with other body part impairments (in keeping with AMA5).
- 4.4 - The assessor should review all available imaging (whether original film or online imaging). They should record in the report whether diagnostic tests and radiographs were viewed, or if they relied solely upon the reports, and advise if their opinion of the findings differs from the Radiologist's report.

# Cauda Equina Syndrome (CES) - 4.9

- Prior to the assessment, the diagnosis must have been made by a relevant medical specialist (Neurologist, Neurosurgeon, Orthopaedic Surgeon or Rehabilitation Physician) and a report obtained from that specialist.
- IAG1 required **bilateral** neurological signs, but neurological signs of CES may not include bilateral lower limbs deficit.
- For CES to be present, IAG3 requires neurological signs in the lower limbs and sacral region (except where studies identify a lesion at S2, S3 and/or S4).
- Requirement remains for a radiological study demonstrating mass effect on the cauda equina with compression of multiple nerve roots.
- Other tests may be considered in addition to MRI (Rectal Manometry, Urodynamics).

# Cauda Equina Syndrome (CES) - 4.9

- Whilst a CES may complicate lumbar spine surgery, in the absence of significant surgical complications such as post-operative haematoma or management of complex dural breach, it would be unlikely that a CES would be present following standard decompression or fusion surgery.

# Motion Segment Integrity – 4.13

- When AP Motion is present – Erect Films: Flexion/Extension
- Motion segment integrity alteration can be:

| | |
|---|---|
| Cervical Spine | ➢ 3.5 mm |
| Thoracic Spine | ➢ 2.5 mm |
| Lumbar Spine | ➢ 4.5mm |

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# Segmental Angulation – 4.13

| | |
|---|---|
| C1 – T1 | ➢ 11 degrees |
| L1 –L4 | ➢ 15 degrees |
| L4 – L5 | ➢ 20 degrees |
| L5 – S1 | ➢ 25 degrees |

Pre-Existing movement pattern, if relevant.

Clarification is required with reason if chosen by assessor and no records are available or any comments from relevant clinician on worker's previous spinal movement pattern.

# Criteria for Radiculopathy – 4.20

**New:**

- Loss or asymmetry of tendon reflexes are required to be ‘clinically significant’ – Consistent with diagnosis and imaging studies.
- Thoracic Spine radiculopathy – rare unless serious injury – fracture leading to surgery.
- For thoracic radiculopathy, criteria 3 + 6 must be present (anatomically appropriate sensory changes plus consistent imaging studies).
- Clinical justification must be provided by the assessor in the report.

# Activities of Daily Living (ADL) 4.27 - 4.28

**New**

- The assessor needs to consider only the ADL restricted or affected directly by the spine impairment and should exclude any impact on ADL caused by other body parts (knee, hip, ankle, foot, shoulder, etc.).
- 3%WPI is added if the worker's capacity to undertake personal care has been restricted (previously *'affected'* under IAG1).

# Table 4.2 - Modifiers for DRE III and IV where radiculopathy persists after surgery

- Additional line added to the table to allow for 1%WPI to be assessed for each additional level where 'Second/further levels injured'.
- Where the second and further level are operated on, the assessor is able to provide assessments for both the additional level injured and for the additional level operated on.

# Spinal cord stimulator or similar device – 4.33

- The insertion of such devices does not warrant any addition to WPI.
- Exception – where the device is inserted by performing a laminectomy, a DRE II rating can be assessed, but any such assessment must be incorporated into the DRE rating for the associated spinal region in line with the direction in 4.23 of the IAG3.
- Associated surgical scarring is also able to be assessed in accordance with Chapter 13 of IAG3.

# Pelvic fractures – 4.34 and Table 4.3

**New:**

- Sacral Radiculopathy following fracture assessed as 0 - 5%WPI.
- Assessor is to provide reasoning and apply the criteria for lumbar spinal assessment of cauda equina lesion (this is not to be assessed where the sacral injury is being assessed together and combined with a lumbar spine injury, also with radiculopathy).
- Fractures of the coccyx – healed (and truly) displaced fractures = 5%WPI (was 1% in IAG1).

# Rib fractures – 4.36

- Rib fractures are not ratable.  Only the impact, if any, on the respiratory or other body systems can be rated.
- ‘Intercostal Nerve Injury’ to be rated as per table for miscellaneous peripheral nerves in Nervous System, Chapter 5.

# Chapter 5 – Nervous

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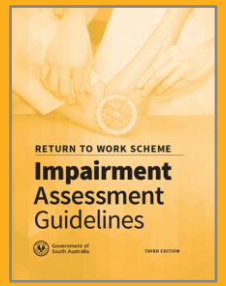


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# Learning Objectives

Able to understand:

- Modifications to AMA5 established by the Guidelines.
- Requirement for impairment assessment reports to include reasoning for the assessment method and impairment rating.
- Appropriate clinical testing and medical imaging to be undertaken prior to assessment and made available to the assessor.
- That when it is possible to obtain medical records, they must be provided to the assessor for their consideration.
- The new requirements which may impact assessments of spinal injury.

# Learning Objectives (continued)

- That an assessor may request another specialty be engaged to provide an opinion.
- There must be at least 18 months following the date of injury before an assessment of traumatic brain injury.
- The new requirements to be completed prior to the assessment of traumatic or acquired brain injury.
- The new requirements to be completed prior to the assessment of sleep apnoea. Assessments for sleep apnoea must be undertaken by a respiratory physician, sleep physician, or ENT specialist.

# Introduction (continued)

- Assessors should set out the reasoning for the assessment of work-related impairment and the relationship of the rating to the injury.
- Where method selection occurs, this should be reasoned with a description provided in terms of the method used and its relationship to the injury.
- Templates and proforma may be available.

# **Introduction** (continued)

## (5.1 - 5.4 IAG3)

- The assessor has appropriate clinical testing information available to them at the time of the assessment.
- The assessor has relevant medical imaging available to them.
- Where appropriate, neuropsychological testing results will be provided.
- Medical records will be provided to the assessor where available

# Spinal Cord Injury (5.7 IAG3)

- In a person with a spinal cord injury causing bowel, bladder and/or sexual dysfunction they should be assessed by the appropriate accredited Specialist and if relevant, may well require assessment by a Neurologist, Gynaecologist or Colorectal Surgeon.

# Spinal Cord Injury (continued)
## (5.11 IAG3)

One would envisage by the time of the assessment, the appropriate Specialists have already been involved:

- Neuro-urologist – urodynamics.
- Consultant in Rehabilitation Medicine – investigation and treatment of bladder, bowel, and sexual dysfunction.
- Also, that  investigations have been undertaken to exclude other causes for bladder, bowel, and sexual dysfunction (i.e., prostate, hormonal, etc.).
- The assessor can make a request to the requestor that another accredited specialty be engaged to undertake part of the assessment with that opinion then used for purpose of determining the impairment being assessed.

# Corticospinal Tract Injury (5.8 IAG3)

- The assessor must be accredited in the Central and Peripheral Nervous Systems and Spine to undertake this assessment.

# Traumatic Brain Injury (5.17 IAG3)

- There should be evidence of a severe impact to the head or the injury involved a high energy impact, has been replaced by:

*...there must be evidence of the mechanism of injury and that there is a moderate impact or greater to the head, or the injury involved a moderate to high energy impact*.

# Traumatic Brain Injury (continued) (5.18 IAG3)

There must be at least 18 months following the date of injury before an assessment of permanent impairment for a traumatic brain injury can be undertaken.

# Traumatic Brain Injury (continued) (5.19 IAG3)

- To qualify for an assessment of Traumatic Brain Injury at least one of the following must be confirmed:
  a) Clinically documented abnormalities in initial post injury Glasgow Coma Scale with a score of 12 or below.
  b) Significant duration of Post Traumatic Amnesia of no less than 12 hours
  c) Significant intracranial pathology on specific testing, that being CT Brain, MRI Brain and where appropriate PET Scanning

# Brain Injury/Neuropsychological testing

- Ideally, the neuropsychological assessment should be performed within 6 months of the date of the assessment.
- When possible, medical records should  be provided i.e.;
  - SA Ambulance records detailing initial Glasgow Coma Scale
  - Initial assessment in the hospital setting testing i.e., post traumatic amnesia testing.

# Acquired Brain Injury (5.20 IAG3)

- There must be evidence of the mechanism of injury such as disease, hypoxia or thrombus.
- To qualify for an assessment of Acquired Brain Injury at least one of the following must be confirmed:
    a) Appropriate clinical features as evidenced by suitable radiology, neuropsychological assessment and laboratory investigation indicating brain dysfunction.
    b) Significant intracranial pathology on MRI and appropriate other specific testing.

# Sleep Apnoea (5.21 IAG3)

Sleep apnoea assessments can only be undertaken by a Respiratory and/or Sleep Physician or ENT Specialist.

# Sleep Apnoea (5.21 IAG3)

Before impairment can be assessed:

a) the worker must have had a relevant review by an ENT Specialist;

b) undergone a sleep study by a Respiratory and/or Sleep Physician and undertaken within 12 months prior to the appointment request;

c) have been advised of available treatment options by an ENT Specialist or a Respiratory and/or Sleep Physician; and

d) reports must be obtained from those Specialists and provided to the assessor, including as to the diagnosis, cause and recommendations for treatment.