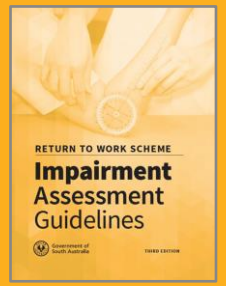
Chapter 6 – Ear, Nose & Throat
and
Chapter 9 – Hearing

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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IAAS - Impairment Assessor Accreditation Scheme
IAG3 Impairment Assessment Modules

IAG3

A new Third Edition of the 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 6 – ENT

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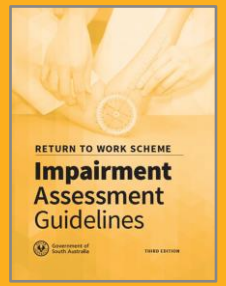

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Presenter

Tracey Kerrigan

After more than 30 years in practice, Tracey has developed an extensive practice in workers compensation, work health and safety and insurance litigation.

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Learning Objectives

Able to:

- understand the changes from the current IAGs in respect to the assessment of ear, nose and throat & related structures
- identify the body parts where changes have occurred.

Key changes to Chapter 6

- Use of TEMSKI Scale for disfigurement as alternative to Table 6.1.
- Expanded provisions in respect to sleep apnoea.
- New provisions for mastication and deglutition.
- Amendments re taste and limits on maximum assessment for olfaction and taste.

Chapter 6

Preamble – reiterates requirements in assessments

- requires method selection to be identified
- reiterates need for reasoning for assessment to be identified.

Clause 6.2

- The degree of impairment arising from unrelated injuries or causes (such as pre-existing conditions) must be assessed and considered when determining the degree of whole person impairment and then disregarded or deducted.

- The degree to which unrelated injuries or cause contribute to the degree of permanent impairment requires judgement on the part of the assessor undertaking the impairment assessment.

- Any deductions for these conditions need to be recorded and reasoning provided in the report.

Clause 6.3 - Ear

Hearing – assessed under Chapter 9

Deletes previous clause 6.4

Clauses 6.4 to 6.5 – Face

- Clause 6.4 of IAG3 replaces clauses 6.5 of IAG1– No changes.
- Table 6.1 provides the criteria for rating impairment due to facial disorders and/or disfigurement. Note 2 allows use of the TEMSKI if considered more appropriate.
- Clause 6.5 – Visual impairment related to eye disorders causing disfigurement must be assessed by an ophthalmologist.

Clause 6.6 – Respiration

- Was previously clause 6.7
- Provisions in respect to sleep apnoea now addressed separately in new clause 6.7
- Table 6.2 sets out criteria for assessment (no change).

Clauses 6.7 to 6.11 – Sleep apnoea

- Significantly expanded provisions.
- Assessments for sleep apnoea can only be undertaken by a respiratory and/or sleep physician or ENT specialist.
- Must still have sleep study and ENT examination.
- Must receive advice on available treatment options (raises issue of stabilisation if no treatment undertaken).
- Reports from the treating specialists are required.
- Clause 6.9 refers to obstructive sleep apnoea - assessed under Table 13-4 (AMA5 p317).
- Sleep and arousal disorders – assessed in reference to Table 13.4 AMA5 p317.

Clauses 6.12 & 6.13 – Mastication and deglutition

- New provisions
- Refers to Table 11-7 AMA5 p262.
- Adds Table 6.3, which is an extension of Table 11-7 (AMA5 p262)
- The first category in Table 11-7, which went from 0% to 19% WPI, has been broken down into five categories in Table 6.3 in IAG3 and various criteria have been set for each category.
- A treating dentist or relevant specialist report in relation to diagnosis and cause of any condition impacting directly on mastication and deglutition, and an orthopantomogram (with scans if available), are required in the 12 months prior to assessment.

Clauses 6.14 to 6.16 - Speech

- Slight amendment to clause 6.14 (previously clause 6.11).
- Amends examining procedure – clause 6.15. It deletes the sentence in the second paragraph under "Examining Procedure" in section 11.4d (AMA5 pp263-264). What this means is that, whilst it still requires reports pertaining to the worker's performance in everyday living situations, the reports do not need to be supplied by reliable observers who know the person well.
- Clause 6.16 in IAG3 - same as clause 6.13 in IAG1.

Clauses 6.17 – 6.18 – The voice

- No changes to clauses other than numbering

Clause 6.19 – ENT and related structures impairment evaluation summary

- Clause 6.19 of IAG3 replaces clause 6.16 of IAG1.

- Do not use Table 11-10, AMA 5 (pp 272-275), except for impairment of olfaction and/or the physiologic sense of taste, and hearing impairment as determined in the IAG3.

- Adds reference to “the physiologic sense of taste” vs “taste”.

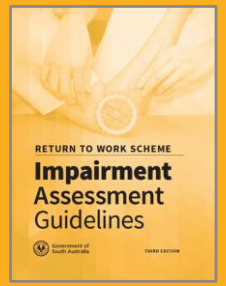
Clause 6.20 – Olfaction and taste

- New provision – can only assess maximum of 5% WPI each for loss of olfaction or loss of taste.

- Need to consider Table 11-10, AMA5 or refer to Table 6.4 (previously Table 6.3).

Chapter 9

Changes to the Third Edition of Impairment Assessment Guidelines



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Presenter

Natalie Stuart-Bell

I am a partner at MinterEllison in the Statutory Compensation Management team.

Prior to working in the law, I practiced as an audiologist in QLD, Vic & SA in both government and private practice

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Learning Objectives

Able to understand:

- The key changes to Chapter 9 when assessing Hearing.
- The requirement for reports to include reasoning for both the assessment method and impairment rating.
- The ability to request further testing prior to completing an assessment.

9

Key Changes

Key Changes

- Utilisation of Cortical Evoked Response Audiometry.
- Clearer identification of any non-work-related impairment.
- Removal of the use of the NAL monaural tables.
- Whether to utilise air and/or bone conduction thresholds.
- Assessment of tinnitus.
- Use of previous audiograms.
- Clear methodology for the inclusion of loss below 2000Hz in an assessment.
- Threshold limits at each frequency to be applied when rating noise induced hearing loss.

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General comments

- Chapter 9 to be read in conjunction with the requirements in Chapter 1 of IAG3

- An assessor **must** examine the worker in person (cl 9.1).

Cortical Evoked Response Audiometry (CERA) (cl 9.2)

- An assessor can request this test if standard audiology testing is inconsistent or there is a discrepancy between audiological test results and observed function

- The rationale for this test being required must be included in the assessment report.

Recording non-work-related impairment (Cl 9.3)

- The degree of hearing impairment or tinnitus not caused by exposure to noise **must** be assessed and considered when determining the degree of noise induced/work-related hearing impairment.

- Requires medical judgement however detailed reasons behind the identification of any non-work-related impairment **must** be set out in the assessment report.

Only hearing ear (Cl 9.4 & Cl 9.13)

- Tables RM 500 – 4000 from the NAL tables (the monaural tables) are no longer to be used.
- Clause 9.13 details how an assessment of an ‘only hearing ear’ is to be conducted. This clause is the same as cl 9.12 of the current IAGs but provides the following clarification:

  …There is no separate deduction to be applied on account of the previous loss to the “only hearing ear”.
- For an example of the method to use in the assessment of an only hearing ear, see Example F in IAG3.

Air conduction vs bone conduction (cl 9.9)

- New clause
- (a) If there is a significant gap between air and bone conduction thresholds at 2000Hz and below, then the assessor **must consider** :
  - (i) the worker's history and physical examination (including of the eardrum); and
  - (ii) whether to use tympanometry testing; and
  - (iii) whether any other conditions may exist; and

- **Must** include a detailed explanation of the application of subparagaphs (i) to (iii) in the report in determining whether to use air or bone conduction thresholds; and

- (b) Above 2000Hz, an assessor **is to use** the air conduction thresholds

Tinnitus (cl 9.12)

- Is to be classified as mild, moderate or severe
- Mild and moderate tinnitus is not ratable
- When considering the severity of tinnitus this is to be determined with consideration given to the impact of the tinnitus on Activities of Daily Living, which is to be documented in the report
- Table 1-2 in AMA5 p4 refers to the type of ADL to be considered
- The value assigned for tinnitus must be supported by clear rationale
- The IAGs provide for a BHI assessment of up to **5%** for severe tinnitus
- Examples for the assessment of tinnitus can be found at H, I & J in IAG3

S188 of the *Return to Work Act 2014* – Retirement & the use of prior audiograms (cl 9.16)

- If a worker has retired on account of age or ill-health, the assessor **must** consider any audiogram undertaken after ceasing work and prior to the assessment in determining any non-work-related component of the worker's current impairment.
- The requestor is to provide direction as to whether a worker has retired on account of age or ill-health in its letter of request

Use of frequencies outside 2000 to 4000Hz (cl 9.18)

If continuous noise exposure has been prolonged:

- (a) 1500Hz can be included in the impairment assessment, provided a detailed explanation is given as to frequency, duration and source of noise exposure, whether it was constant or intermittent and, if known, decibels; and

- (b) 500Hz and 1000Hz can be included in the impairment assessment, provided the criteria in (a) are met and the assessor demonstrates a detailed consideration and exclusion of all clinically plausible causes of hearing loss at those frequencies (other than noise induced hearing loss and presbycusis). This requires proper examination and report by the assessor.

Threshold Limits (cl 9.19)

The following thresholds apply when rating for noise induced hearing loss. Any readings above these are to be rated as per the following limits:

500Hz – 25dB

1000Hz – 35dB

1500Hz – 45dB

2000Hz – 65dB

3000Hz – 90dB

4000Hz – 90dB

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