Impairment Assessment Guidelines

Third Edition

ReturntoWorkSA

Government of South Australia

Frequently Asked Questions (FAQ)

Chapter 4 – Spine
Chapter 5 – Nervous System

Q. Are asymptomatic pars defects rateable as pre-existing impairment?

A. Clause 1.41 of IAG3 directs that a pre-existing/subsequent injury or cause does not need to be symptomatic to be rateable. Posterior element (i.e. lamina, pars and pedicle) fractures at a single level are assessed as DRE II, and at multiple levels are assessed as DRE III, as per Clause 4.24.

Q. Imaging demonstrates osteochondrosis or Scheuermann's Disease which the worker reports to be asymptomatic prior to the work injury. Are these rateable as pre-existing vertebral fractures?

A. A pre-existing/subsequent impairment does not need to be symptomatic to be rateable. Clause 4.24 specifically directs that care should be taken not to interpret pre-existing conditions such as Scheuermann's osteochondrosis as vertebral fractures. Clause 4.8 directs that the presence of common developmental findings on imaging does not in itself mean that the individual has an impairment due to injury, but that is not to say that there may, however, be a pre-existing impairment. Impairments due to other causes such as congenital or developmental conditions are not required to be assessed unless they are to the same body part or region, or have impact on, or relevance to, the impairment being assessed.

Q. Why does insertion of a spinal cord stimulator attract an impairment rating when it is a treatment?

A. Surgery is commonly rated as a specific impairment throughout AMA5 and IAGs. Clause 4.33 allows for an assessment of DRE II to be rated for insertion of a spinal cord stimulator if such device was inserted via a laminectomy.
The requestor should provide the assessor with information from the treating specialist regarding the method used for insertion of the device. Any such assessment must be incorporated into the DRE rating for the associated spinal region, in line with the direction in Clause 4.23 which requires that separate spinal impairments in the same region are not combined, but instead the highest DRE category is chosen for that region.
In the instance that the laminectomy for the spinal cord stimulator was performed in a different spinal region than that being assessed, the impairments for both spinal regions are to be combined. An assessment is also able to be provided for the associated surgical scarring.

Q. How are multiple impairment assessments combined if the assessor is required to provide assessments for various body parts, including assessments for more than one region of the spine?

A. When combining multiple impairments, the assessor starts with the highest impairment and combines with the next highest and so on, unless there is contrary direction in the relevant body system. Clause 4.3 directs that impairments of different regions of the spine are combined first before combining with other impairments from other body parts.

Q. Is a fracture at T1 assessed with reference to the cervical spine or thoracic spine?

A. Clause 4.23 provides direction on assessments in the transitional zones. Fractures at C7 and T1 are assessed in the cervical spine, and fractures at T12 and L1 are assessed in the thoracic spine.

Q. Why doesn't IAG3 refer to a specific scale for measurement of post traumatic amnesia (e.g. Westmead PTA scale)?

A. This suggestion was not raised for consideration by the SRCG during the consultation.. PTA of no less than 12 hours would need to have been measured at the time of the injury and evidenced in the medical information provided to the assessor e.g. hospital records/clinical notes/medical reports, in order to utilise this criterion to qualify for an assessment of traumatic brain injury. If the Westmead PTA scale was recorded at the time of injury and confirms the duration of PTA, then it would be appropriate for an assessor to use this information to determine if the criterion has been met.

Q. Who can assess an intercostal nerve injury?

A. An assessor accredited in the Nervous System, with reference to Table 5.1 of IAG3 which provides the method for assessment of miscellaneous peripheral nerves including intercostal nerves.

Q. How is damage to the olfactory nerve assessed?

A. Clause 5.22 allows for an assessment of up to 5% WPI each for total loss of sense of smell and taste. Therefore, up to 10% WPI can be assessed in total, with the impact on ADL considered and described in the report to support the selected value from the available range for each assessment.

Q. Who can assess cauda equina syndrome/corticospinal tract damage?

A. As outlined in Clause 5.8, an assessor must be accredited in both the Spine and Nervous System to undertake assessment of corticospinal tract damage.

Q. Should an assessor use DRE V or the Tables 15-6 in AMA5 for assessment of cortico-spinal tract damage? Is there potential for overlap of assessment if both are used?

A. Clauses 5.7 and 5.8 direct that an assessment of spinal cord or cauda equina injury is to be undertaken with reference to the method described in Section 15.7 of AMA5 using Table 15.6. The assessor selects the appropriate DRE category and combines that assessment with the assessments from Table 15.6. The assessor should provide detailed reasoning for each assessment given and ensure no overlap of assessment is provided.

Q. In assessing a brain injury, Clause 5.18 directs that ideally a neuropsychological assessment will be undertaken within 6 months of the WPI assessment.
What if the neuropsychological assessment provided was undertaken outside of that timeframe?

A. The direction in Clause 5.18 is a recommendation, and the same direction is also provided in Appendix 1, Notes for the Requestor, at the back of IAG3. With reference to Clause 1.21, if the neuropsychological assessment has been undertaken greater than 6 months prior to the WPI assessment, and the assessor considers that an updated report is required to enable a full and complete assessment, then the assessment should be deferred.