Impairment Assessment Guidelines

Third Edition

ReturntoWorkSA

Government of South Australia

Frequently Asked Questions (FAQ)

Chapter 2 – Upper Extremity
Chapter 3 – Lower Extremity
CRPS

Q. If an operation record indicates a resection arthroplasty of distal clavicle was performed, but radiologically and clinically there is no evidence of this, how do we approach rating the impairment?

A. Resection arthroplasty of the distal or proximal clavicle is defined as a **total** anatomical loss evidenced radiologically or by operative report from a surgeon. If there is any uncertainty as to whether there is total anatomical loss when considering the documentation supplied, the assessor should refer to the direction provided in paragraph 1.21 of IAG3 and contact the requestor about the matter.

Q. When providing an assessment of carpal tunnel, can I rate the injury using ROM?

A. As per paragraph 2.9 of IAG3, if upper extremity impairment results solely from a peripheral nerve injury, the assessor should not also evaluate impairment(s) of abnormal motion for that upper extremity when the abnormal range of motion is caused by the peripheral nerve injury.

Q. Paragraph 2.9 of IAG3 directs that peripheral nerves are not to be assessed until symptoms have persisted for at least 12 months. If there has been surgery, does the 12 months start again from the surgery date?

A. The minimum requirement is that symptoms have persisted for 12 months and that the condition is stable and unlikely to change in the next 12 months with or without further treatment. The assessor should consider the passage of time since the surgery, and be confident that the injury has stabilised prior to rating the impairment.

Q. If muscle atrophy is being considered as a method of assessment, would the injury be considered to have stabilised if the worker has not undergone a strengthening program?

A. Assessment on the day will determine whether the condition is unlikely to change substantially in the next 12 months with or without medical treatment. If the worker has had further treatment recommended and has yet to complete the further treatment, then the worker's condition may not be stable. If, however, the worker has been offered and has elected not to undergo further treatment that the assessor considers is likely to improve the worker's condition, the assessor must evaluate the current condition and treat it as "stable" without consideration of potential changes associated with the proposed treatment. The assessor must note the potential for improvement in their report, and the reasons for refusal by the worker, but must not adjust the degree of impairment on the basis of the worker's decision not to undergo treatment that may improve their condition.

Q. What is required to assess a 'very poor' outcome in a hip, knee, or ankle joint replacement (Class 4)?

A. A Class 4 assessment is defined as a poor result with catastrophic failure of an implant; and/or complicated by significant chronic infection. This should be rare.

A report from the treating Orthopaedic Surgeon should be obtained to assess impairment in this class, and detailed rationale must be included in the report to support the rating.

Q. For assessment of a 'very poor' outcome for a hip, knee, or ankle joint replacement (Class 4), a report from the treating Orthopaedic Surgeon is required. Whose responsibility is it to obtain the report, and will requestors wait to be asked by the assessor to obtain a report?

A. The treating Orthopaedic Surgeon's report should be provided by the requestor. If it is not provided, and the assessor considers there is evidence that indicates the worker may fulfill the criteria for an assessment of Class 4, the assessment should be deferred in line with paragraph 1.21 of IAG3 until such time that the report is provided.

Q. When measuring oedema using the figure 8 tape technique, how do we manage undertaking this on a worker with CRPS where the limb is hypersensitive and painful?

A. Some practical steps that may help:

1. Explain the specific need for the examination to the worker.
2. Conduct the assessment in an environment at a comfortable temperature for the worker – this may be warmer than normal in winter, or cooler than normal in summer.
3. Do not "tighten" the tape around the limb – this isn't necessary for an accurate measurement and may cause discomfort.

Contact allodynia is rarely severe unless there is significant pressure applied, or if there is movement of the tape against the skin of a scraping or brushing nature. This should be avoided.

If, despite this, the worker cannot tolerate the contact, this should be recorded, and subsequently oedema should not be included in the assessment.

Q. Is there a specific thermometer required for assessment of CRPS?

A. It must be a high accuracy infrared thermometer specified by the manufacturer to be accurate to 0.3 degrees Celsius (or better), and be regularly calibrated.

Q. How do I assess ADL for CRPS?

A. The impact of the condition on ADL is assessed using the ADL Functioning Assessment Tool (Table 2.4 for the upper extremity, and Table 3.7 for the lower extremity). Instructions on the application of Table 2.4 are included on pages 36-37 of IAG3, and on pages 62-63 for Table 3.7.

The determination of impact on ADL is not solely dependent on self-reporting, but is an assessment based on all clinical findings and other reports. The ADL tool is to be used in accordance with the principle of 'best fit'. The assessor must be satisfied that the ratings selected within an ADL category best reflect the category being assessed.

If, prior to the injury, the worker did not participate in one or more of the listed ADL, that activity is not rated and the median is obtained from the rated activities only. The highest of the 2 middle values applies.

Where there are impairments to other body parts, only those activities of daily living which are affected by CRPS should be rated, and this must be recorded in the report.

Q. If I am asked to provide an assessment of CRPS but I suspect there may be another diagnosis causing their symptoms, can I refer for further investigations?

A. In order for CRPS to be rateable for permanent impairment assessment, there must be no other diagnosis that better explains the signs and symptoms, as per paragraph 2.26(d) of IAG3 for the upper extremity and paragraph 3.51(d) of IAG3 for the lower extremity.

Where an assessor establishes that further diagnostic tests or medical investigations are required to enable a full and complete assessment to be undertaken, the assessor should refer to the direction provided in paragraph 1.21 of IAG3 and defer the assessment, ensuring that the reason for the deferral is recorded in the report, along with what needs

to occur in order for the assessment to be completed. The assessor must also explain the situation to the worker, and complete as much of the assessment as possible in the circumstances.

Q. Will there be any templates available to assist with rating CRPS?

A. Yes, templates for rating both upper and lower extremity CRPS will be available on the ReturnToWorkSA website in due course.