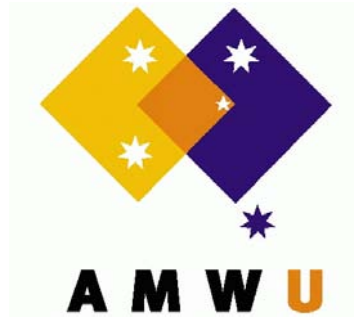


AUSTRALIAN MANUFACTURING WORKERS' UNION



Workers Compensation Amendment Bill

November 2010

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Chief Minister's Department
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INTRODUCTION

1. The Australian Manufacturing Workers' Union (AMWU) welcomes the opportunity to make a submission with relation to the current review of the ACT Workers Compensation System.
2. The full name of the AMWU is the Automotive, Food, Metals, Engineering, Printing and Kindred Industries Union. The AMWU has a membership of 120,000 members who work in every State and Territory of Australia. Our members are employed in the private and the public sectors, in blue collar and white collar positions, and in a diverse range of industries, vocations and locations.
3. Given the complexity of workers' compensation and the time constraints placed upon interested parties to make submissions, the AMWU submission will attempt to address issues raised in the issues paper and the legislation but reserves its right to make further submissions as it may see fit beyond the November deadline.
4. A fundamental objective of any workers compensation systems needs to be an equitable, fair and just system of income protection, access to medical treatment for workers with work related injuries or illnesses and a mechanism to aid injured workers back to work.
5. Workers compensation legislation is beneficial legislation targeted at injured workers. Any amendments to the legislation must be made with this in mind. The legislation was not established to benefit employers. Accordingly the statement as found in the explanatory statement that, *the ACT scheme must provide for reasonable balance...* is false and is openly rejected by this union.
6. The AMWU has a proud history of advocating on behalf of members to Governments across Australia of all political persuasions concerning the rights of working people. The premise upon which AMWU policy position and inline with that, this submission, is based, is that a worker who's quality of life is detrimentally altered as a result of their employment must have a right to redress and it be an expectation that all will be done to minimise the impact on their lives.

Question 1	Is it appropriate for compensation for permanent impairment to be payable in respect of psychological injuries?
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Yes. Workers compensation must be seen as payments to workers who sustain an injury arising from their employment. Injuries can be either physical or psychological. To distinguish between the two would amount to a form of discrimination. The disability related to a psychological injury is no less crippling than a physical injury and in many cases more severe, quite often resulting in an injured worker never been able to return to their pre-injury employment.

Question 2	Is it appropriate to replace the timeline requirements for making a
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	permanent impairment claim with a injury stabilized requirement?
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Yes. So long as a workers' naivety of the requirements of the scheme can not be used as an excuse to refuse a claim.

Question 3	Does the medical panel and its peer review requirements provide appropriate protection to the clinical integrity of permanent impairment assessments?
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No. This proposal for a medical panel is likely to establish an elitist club amongst those few doctors who are on the panel. With the scheme being their client and not the injured workers. This would lead to the interest of the scheme being put ahead of that of the injured worker leading to poor outcomes for injured workers.

The peer review would be appropriate if the reviewer was kept segregated from the panel i.e. could not receive referrals for assessments. Doctors have demonstrated over time a reluctance to critique their colleges for fear of reprisal, been ostracized or simply been proven wrong.

The AMWU recommends that all doctors who want to participate in the scheme and conduct permanent impairment assessments must have demonstrated an understanding of the guidelines and other tools which may be determined to be used. Following these doctors been certified as competent, workers would be free to self refer to certified doctors who's details would be found on the website.

Workers must always retain the right to select their own doctors regardless of the circumstances or the purpose.

Question 4	Will the imposition of timeframes around the determination of a worker's entitlement to compensation for permanent impairment assist workers to receive timely compensation?
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Yes. If strictly adhered to and policed by the regulator.

Question 5	Is the increase in statutory lumps from \$126,000 (single loss) to \$220,000 appropriate? If your answer is no, what would be appropriate?
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Yes

Question 6	Is the increase in the benefits payable for funeral costs from \$4,000 to \$9,000 appropriate? If your answer is no, what would be appropriate?
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Yes

Question 7	Is the increase in death benefits from \$189,000 to \$450,000 appropriate? If your answer is no, what would be appropriate?
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Yes. It is impossible for a statutory scheme to adequately compensate the family of a person killed in the workplace. This improvement in death benefits resembles a step in the right direction.

Question 8	Is the formula (WPI % x maximum lump sums) for the payment of the statutory lump sums appropriate? Under this formula workers with a WPI of 75% or more would receive the maximum lump sum available.
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No. WPI as assessed in accordance with the AMA guidelines is not a fit for purpose mechanism to calculate compensation. This is acknowledged within the *Guides to the Evaluation of Permanent Impairment fifth edition*. Chapter 1.2 page 5 states,

The medical judgment used to determine the original impairment percentages could not account for the diversity or complexity of work but could account for daily activities common to most people. Work is not included in the clinical judgment for impairment percentages for several reasons: (1) work involves many simple and complex activities; (2) work is highly individualized, making generalizations inaccurate; (3) impairment percentages are unchanged for stable conditions, but work and occupations change; and (4) impairments interact with such other factors as the worker's age, education, and prior work experience to determine the extent of work disability. For example, an individual who receives a 30% whole person impairment due to pericardial heart disease is considered from a clinical standpoint to have a 30% reduction in general functioning as represented by a decrease in the ability to perform activities of daily living. For individuals who work in sedentary jobs, there may be no decline in their work ability although their overall functioning is decreased. Thus, a 30% impairment rating does not correspond to a 30% reduction in work capacity. Similarly, a manual labourer with a 30% impairment rating due to pericardial disease may be completely unable to do his or her regular job and, thus, may have a 100% work disability.

As a result, impairment ratings are not intended for use as direct determinations for work disability. When a physician is asked to evaluate work-related disability, it is appropriate for a physician knowledgeable about the work activities of the patient to discuss the specific activities the worker can and cannot do, given the permanent impairment.

Chapter 1.2 page 8 states;

The Guides is not intended to be used for direct estimates of work disability. Impairment percentages derived accordingly to the Guides criteria do not measure work disability. Therefore, it is inappropriate to use the Guides' criteria or ratings to make direct estimates of work disability.

Chapter 1.8 page 13 states:

*Impairment percentages derived from the **Guides criteria should not be used as direct estimates of disability.** Impairment percentages estimate the extent of the impairment on the whole person functioning and account for basic activities of daily living, not including work. The complexity of work activities requires individual analysis...*

If the ACT is to move towards the full adoption of the AMA guideline, then it should be married with a formula that also recognises the disability an injured worker suffers. This recommendation has been supported in papers such as *Converting Impairment to Disability, Why It Matters* by Robert M. Aurbach, JD¹ and Alan Clayton, LLB².

Note: Converting Impairment to Disability, attached Appendix A.

The proposal to adopt the *NSW WorkCover Guidelines for the Evaluation of permanent Impairment (1st Edition)* as the only other document referred to is flawed. The NSW Guideline was formed as recognition of gaps within the *AMA Guides to the Evaluation of Permanent Impairment* and not as a formula to reflect the impact an injury has on a worker.

The threshold of 75% to receive the maximum statutory lump sum is unrealistic and harsh. Very few workers ever reach 75% WPI given the extent of the debilitation that this represents. Even at 50% WPI it is very unlikely that the injured worker will ever return to the workplace. This is a better level to set the maximum lump sum payment and would better reflect the impact on an injury on a worker.

Question 9	Do the thresholds of 15% (physical) and 20% (psychological) whole person impairment provide a reasonable balance between the accessibility of common law for seriously injured workers and the affordability of the Scheme for insurance policy holders? If not, what are the fair alternatives?
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No. The AMWU does not support the implementation of thresholds for access to common law. Particularly with the backdrop of this been done to reduce the premiums of employers. This linkage and the language (spin) of balance, is insulting to working people and their unions’.

Employer’s premiums should be reduced on the premise that the rate of injuries and fatalities is sustainably reducing, thus making and reduction affordable without affecting the beneficial nature of this legislation.

As earlier stated, it is discriminatory to treat physical injuries any differently to psychological injuries. Particularly when the level of disability from psychological injuries can be more crippling to the workers and their families.

If the ACT government is set on insulting working people and establishing thresholds, there should only be one threshold level. The

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threshold levels proposed are out of touch with the reality of the injuries and the effect on the workers and their families and need to be drastically reduced.

Common law for most injured workers is their only day in court, particularly with the appallingly low level of OHS prosecutions initiated by the ACT DPP. Injured workers seek some recognition of negligence from the employer for the permanent injury they have suffered. The proposed threshold levels would (by design) wipe out the vast majority of access to common law for injured workers and remove that sense of justice having been served.

Notwithstanding this there is also a deterrent effect with common law that forces employers to think twice about what they instruct workers to do or the environments workers are put in.

The ACT is not a scheme that is established around long term tail claims. Given this aspect of scheme design, to limit common law to injured workers serves as an injustice to any injured worker unable to meet the threshold levels. Given the relatively poor weekly benefits, long term injured workers are entitled to and a statutory WPI payment scheme that seeks to exclude some by virtue of the nature of their injury the proposal is set to create a sub-class of deprived (starving) injured workers.

Question 10	Will maintaining an unlimited common law damages environment for the Territory's seriously injured workers maintain the integrity of the Scheme?
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No. The financial integrity of the scheme has been effected by over servicing by ineffective service providers and unscrupulous lawyers. The key issue for the financial integrity is employers getting serious about stopping the carnage in the workplace. The figures relied upon by the ACT government are presumptive about other aspects of the proposed changes to the legislation. They fail to address the inefficiencies of the insurers who are administering the legislation which should have been the starting point.

For any common law damages environment to maintain its integrity then there must be unfettered access to it by those who would have a legitimate claim.

Question 11	Will the use of compulsory pre-hearing settlement conference reduce unnecessary litigation and provide greater certainty for injured workers?
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Yes. Whilst it may not provide for greater certainty, it will for many injured workers lead to certainty earlier on in proceedings. It would also reduce the amount of cases that need to go to a hearing.

Question 12	Should parties be able to conduct compulsory pre-hearing settlement conferences without an independent conciliator?
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No. If the independent conciliator is not present there is greater scope for the parties not to comply with their obligations under the Act in relation to

the proceeding or not provide information that is required.

The presence of a well trained conciliator would reduce the amount of cases that need to go to hearing reducing costs.

Question 13	Are additional dispute resolution mechanisms required to assist in the timely resolution of disputes and reduction of unnecessary litigation?
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Yes. The trade union movement in the ACT has advocated over an extended period of time for the formation of an industrial magistrates court to hear such matters. Unions are of a view that industry deserves consistency in the decisions that are made and expertise from those that are asked to make determinations. This can only be achieved by the creation of a specialist court.

Whilst it would be appropriate for a magistrate to arbitrate on any matter in dispute. If the ACT had an industrial magistrate's court the registrar could hear conciliations freeing up the courts and expediting the resolution of most issues.

It is also recommended that where disputes exist in relation to a claim the status quo should remain until the dispute is resolved. Meaning:

- A) Weekly benefits would continue to be paid to the worker, and
- B) Medical Treatment and Injury Management would continue as though the Claim had been accepted.

Following the resolution of a dispute, should the matter be found in favour of the insurer/employer then costs associated in relation to a) and b) above should not be recoverable from the injured worker.

Question 14	Is the maintenance of workers' ability to redeem their compensation benefits appropriate and in line with the return to work goals of the Scheme?
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Redemption of workers compensation benefits is only appropriate where a worker suffers a permanent injury. To be defined as having suffered a permanent injury a workers injury must have stabilised and reached expected full medical recovery.

It is a reasonable expectation that all return to work avenues have been exhausted prior to this occurring. The long term goal is often known well before a final certificate is issued. Where injured workers are unlikely to return to pre-injury duties, retraining should have already commenced along with job seeking activities.

The fact that this is often not the case is a failure of the administration of this scheme.

Injured workers should not be trapped to the mercy of the insurers/employers who often turn their lives into a living hell with ongoing unreasonable demands and jumping through hoops.

Redemption provides an escape for these workers.

Question 15	What measures should be introduced to ensure reasonable legal costs in connection with workers' compensation claims/disputes and related action for damages?
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It is recommended that the ACT government establish a legal fees schedule panel (this could be the advisory council) for the purpose of setting and reviewing a legal fees schedule which would set the maximum amounts claimable by lawyers for specific actions taken on behalf of clients.

Any such schedule would be gazetted under the Act and updated as determined necessary by the panel.

It is also important to introduce legislation that will deliver a reduction in disputes. Whilst the AMWU recognised the right of parties to seek second medical opinions, the outcomes of these opinions are often used as justification to support decisions by insurers/employer in denying liability for claims or disputing reasonable medical treatment. Historically where these decisions result in a dispute the decision by the insurer/employer are found unwarranted or not supported. This leads to both unnecessary medical and legal expenses.

It is important that the legislation minimises the capacity of employer/insurers to send workers to third parties. This in part has been achieved in NSW with the Independent Medical Examinations and Reports Guideline 2009 and the about to be gazetted Independent Medical Consultants Guideline 2010. The scheme also needs to reign in the use of (so called) factual investigations. These private investigators in the vast majority of cases provide little to no information that the case manager would not have already had at hand or would have been able to obtain making their own enquiries.

Note: WorkCover Guidelines on Independent Medical Examinations and Reports attached Appendix B.

It is recommended that gazetted guidelines be developed on the use of private investigators, not only dealing with when they are used, but the methodology used during these investigations and the professional qualifications required by the investigators.

Question 16	Is a 5% discount rate reasonable? If no, what rate would be reasonable?
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No. This legislative abnormality should be removed. Damages for future economic loss should not be discounted, they should be capitalised. Most schemes have a capitalisation rate which is commonly 5%. This is added to the amount not reduced. The capitalisation rate is to account for future inflationary and other pressures which would act to otherwise depreciate the value of the lump sum.

Premium Rates

7. The union regards the pressure currently being applied on workers compensation schemes as misleading and unproductive with the focus on entitlements an injured worker receives as the key reason behind the level of workers compensation premiums.
8. The key contributor to the cost of workers compensation schemes is the continuing high level of injuries and fatalities that plagues our industries in the 21st century. Since 2001-02 the ACT has seen a consistent rise in the level of compensated claims resulting in 1 week or more of compensation. The ACT is unfortunately not set to meet the national targets set for the reduction of injuries and fatalities by 2012.
9. The AMWU notes that its submission "*ACT Workers Compensation – How do we make it work better?*" *Review of ACT Workers Compensation System March 2007*, went unacknowledged and none of the recommendations submitted were enacted or considered. It is hoped that the ACT government is prepared to consider this submission more favourably.

Changes to Scheme designed likely to improve scheme performance

10. The union believes that early notification has been dealt with through the 2002 amendments but needs to be policed more vigorously particularly in light of what some employers have been doing with their company doctors. Another area that costs could be reduced in is with relation to dispute resolution. The Union submits that when an insurer rejects a claim by a worker under section 129 that the insurer should be mandated to accompany the notice with all relevant information used to make the decision. This frontloading of relevant information would minimise unwarranted or reckless claims rejection leading to less disputation. If the insurer failed to frontload the information then the insurer would not be able to rely on that information should the worker than dispute that decision.
11. The Union submits that there be an increase in the number of WorkSafeACT premium audits of employers and ensure that the audits include a complete check of workplace classifications.
12. The Union recommends that claims performance data for each insurer be made publicly available. WorkSafeACT should work with insurers to initiate and sponsor the development of scheme wide courses for claims management skills training and certification. The Union also recommends on this front that maximum ratios be established of claims managers to client.
13. The AMWU recommends that payments to injured workers who have been injured for a period of more than 26 weeks should be reviewed. The Union notes the slight improvements that were made in the 2002 Legislation, however the current payments still leave workers vulnerable to a life in poverty. Workers should not be disadvantaged as a result of being injured whilst engaged in their employment irrespective of time. This is now particularly vital if the ACT government decides to proceed with thresholds for access to common law.

14. Regarding Section 73 of the Workers Compensation Act *Payments for Medical Treatments Received From a Hospital* the Union submits that the employer should be liable for all costs as the current Section acts as a barrier to workers seeking immediate treatment. This is then counter productive to the timely and durable return to work of those workers adding further burden to the scheme.
15. Under Section 105 of the Act an employer must provide suitable work for full time, part time and casual workers. The Union would submit that the penalty currently in place needs to be drastically increased in an effort to influence the behaviour of Employers. This influence would then deliver higher return to work which would ultimately reduce the liability currently experienced by the Scheme.

Education and Training

16. It is imperative that regardless of the outcome following this consultative process that the ACT government set aside funding for education of workers and workplaces. Unions' have a rightful role in providing this training and ensuring workers are properly informed of changes to laws which have an effect or potential effect on their lives.

Conclusion

17. The AMWU supports the submission of Unions' ACT.
18. Working families rely on progressive Labor Governments to deliver an equitable, fair and just system of income protection; access to medical treatment for workers with work related injuries or illnesses; and a mechanism to aid injured workers back to work. The AMWU is committed to working towards these ideals and will look with interest at the deliberation of the ACT Government with relation to their workers compensation scheme.

End.

APPENDIX A

Converting Impairment to Disability

Why It Matters

Robert M. Aurbach, JD³
Alan Clayton, LLB⁴

Four Workers

Tom and Jerry each independently suffers very similar back injuries in the course and scope of their work. Each go home, sore but unaware of the severity of their injuries, and find that they “aren’t able to get out of bed” the next morning. Each is diagnosed with damaged disks at the L-4-L5 and L5-S1 levels. Unfortunately Tom and Jerry have very different consequences from their injuries. Tom is a claims adjuster. His adjusting company encourages him to come back to work, on a part time basis and he immediately receives assistance in modifying his workspace and expectations so that he can vary his working conditions and respond to the fact that he is uncomfortable sitting in a fixed position for extended periods of time. He receives competent care and consistent encouragement from the employer and his work team. As his condition improves, he needs less and less accommodation, and he returns to full time employment without restriction. As a result of competent care, he reaches maximum medical improvement within the expected period for routine recovery. He has a small impairment rating, based on the AMA Guides, but does not have significant functional impairment. He is able to return to his pre-injury job at his pre-injury wage and work without limitations after his period of care, and even his personal activities are not significantly impacted after a talented Pilates instructor helps him develop a tailored exercise routine.

Jerry is a manual labourer doing construction work. His employer will not make light duty work available and will not allow him back on the worksite unless he is fully released by a doctor. His employer also takes the position that he does not believe the injury occurred at work, and therefore causes the claim to be initially delayed for more investigation. As a result, Jerry does not receive initial care in a timely manner. He seeks other work, but has only an incomplete secondary education and no other relevant work experience. He is unable to get any work that pays remotely as well as the construction work, and ultimately quits trying. He seeks an attorney to help him, and the attorney, sensing a potential large

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payout in the case, sends him to a “friendly” physician, who counsels complete rest and inactivity. Ultimately, the inactivity combines with Jerry’s anxiety over the future, anger at his employer and stress over his growing unpaid bills to leave Jerry focused on his discomfort and disability. Jerry cannot sleep, and becomes increasingly dependent on prescription pain medications. Even if he was capable of finding other work at that point, his attorney discourages the idea, saying that it will adversely impact his case. His physician begins discussing back surgery for his unresolved pain complaints, despite the fact that he is a poor surgical candidate.

Eve and Evelyn each suffer a ruptured ACL while at work. Eve is a college student, who was working part time during the school year. Although she has surgery to repair the rupture she recovers relatively routinely and ends up with a small residual impairment under the relevant edition of the AMA Guides. She was training for a career in the sciences, and the injury has little impact on her life, except that her intramural career as a fencer was cut short. He has moved on in her professional development without hindrance, and found other activities to substitute for fencing.

Evelyn is an older worker, in her late fifties. Her pre-injury assembly line work would be difficult for her to resume, due to requirements for continued movement while standing, during the entire working day. She was offered office work in the same business, but had no experience or natural aptitude for it, nor any real desire to work in that environment. She has tried to find gainful employment within her skill set, but is unable to manage the physical requirements. Employers seem uninterested in providing her opportunities for on the job training for other employment and she feels that her limited education and advanced age make it impossible for her to be retrained for other work. While her injury has resolved routinely, she is functionally unable to find any work.

Understanding the Importance of Assessment of “Disability”

Why it’s Important

Just Compensation

One of the major factors leading to the enactment of workers compensation legislation in the late nineteenth and early twentieth centuries was the highly restricted access to compensation under the fault based tort regime and the enormous variability in outcomes achieved by workers suffering similar injuries.

The statutorily based, no fault, workers compensation arrangements were seen to offer the prospect of providing just compensation to injured and ill workers, both in terms of certainty of payment and that there would be equality of treatment of workers suffering similar conditions. However, as the case examples of Tom and Jerry and Eve and Evelyn forcefully demonstrate, this second prospect has failed to materialize. There is a great need to fashion arrangements that will bring this goal closer to realization.

Social insurance “safety nets” do not function properly if they are designed in such a way as to benefit only one segment of the general population that they are designed to benefit. Failure to provide system participants with a sense of inter-participant justice can cost the program some of its support and therefore make it less stable. Moreover, if the general intention of having the various social insurance programs is that they interlock, such that people are looked after to the extent of their needs by the appropriate portion of the system. The failure to adequately cover some portions of the protected population may result in unanticipated cost shifting and general frustration of the intent of the larger system.

Non – injury Sources of Disability

It is also important to understand that a truly responsive approach to injury includes consideration of factors that are not limited to the nature of the injury, seen in a vacuum. Tom and Jerry’s injuries were of equivalent severity. The treatment Jerry received at the hands of his employer prevented his early return to work, when we know that length of time off work is an important predictive factor in eventual return to pre-injury employment.⁵ Jerry’s education and work

⁵ Fayad F, Lefevre-Colau MM, Poiraudau S , et al. Chronicity, recurrence, and return to work in low back pain: common prognostic factors. *Ann Readapt Med Phys.* 2004; 47: 179 –189. Jellema P, Van der Horst HE, Vlaeyen JW , et al. Predictors of outcome in patients with (sub) acute low back pain differ across treatment groups. *Spine.* 2006; 31: 1699 –1705. Main CJ, Sullivan MJ, Watson PJ, eds. *Pain Management: Practical Applications of the Biopsychosocial Perspective in Clinical and Occupational Settings.* 2nd ed. Edinburgh, Scotland: Churchill Livingstone; 2007. Van der Windt D, Hay E, Jellema P, et al. Psychosocial interventions for low back pain in primary care: Lessons learned from recent trials. *Spine.* 2008; 33: 81 – 89. Bruns, D. and Disorbio, J.M., Assessment of Biopsychosocial Risk Factors for Medical Treatment: A Collaborative Approach, *Journal of Clinical Psychology in Medical Settings*, DOI 10.1007/s10990-009-91-48-9, health: a review of the evidence. *Canadian Med Assoc J.* 1995;153(5):529-540; Johoda M. *Employment and Unemployment.* Cambridge: Cambridge University Press; 1983; Martikainen PT, Valkonen T. The effects of differential unemployment rate increases of occupation groups on changes in mortality. *Amer J Pub Health.* 1998;88;1859-1861; Mathers CD, Schofield DJ. The health consequences of unemployment: the evidence. *Med J Australia.* 1998;168;178-182; McGill CM. Industrial back problems: a control program. *J Occ Med.* 1968;10:174-8; Nachemson A. Work for all – for those with LBP as well. *Clin Orth Related Research.* 1983;179:77-85; Sander R, Meyers J. The relationship of disability to compensation status in railroad workers. *Spine.* 1986;11:141-143; Stewart JM. The impact of health status on the duration of unemployment spells and the implications for studies of the impact of unemployment on health status. *J Health Econ.* 2001;20:781-96; Strang JP, *The Chronic Disability Syndrome, Evaluation and Treatment of Chronic Pain*, ed. Aronoff GM (Baltimore, Maryland: Urban & Schwarzenberg, 1985):247-

experience act as limitations with regard to his ability to find other work, especially in conjunction with his need to replace his former income to maintain the lifestyle to which he was accustomed. By any reasonable standard Jerry is more “disabled” at the end of the process than was Tom, despite injuries that did not differ significantly.

Similarly, Eve and Evelyn were at different points of their working life when an injury impacted them both similarly in the physical sense. Eve had her entire range of career paths open to her, and was actively engaged in tertiary education at the time of injury. Evelyn had limited education and work experience, and was relatively close to the end of her expected working career. If disability is defined, even in part, as a limitation on the ability to find suitable employment, then Evelyn clearly had significant challenges only tangentially related to her injury that made her more disabled than Eve.

In addition, factors in the environment may contribute to the acquisition of disabled behaviours that have little to do with the injury, or personal characteristics of the worker. A discussion of disability would not be complete if it didn't recognize these sources of disability as well, although it is not suggested, at this time, that a proper mechanism for converting impairment to disability must include consideration of factors such as these.

In the workers' compensation arena, system –created (“iatrogenic”) disability occurs through common systemic structures. A claim is made and the worker often feels cut off from the employer and co-workers, as their claim is handed over to other professionals. The claims adjuster is often too burdened by caseload to be able to give the worker the individualized attention that he or she would like. The worker is often sent to a health care provider with whom they have no prior relationship, and in whom they may have reduced confidence. Income is often disrupted, and indemnity payments may be limited to a level that is inadequate to keep current with present obligations. Medical prognosis is often uncertain, and the worker may feel like their life has been permanently compromised. The stress and anxiety from these factors often impacts the ability to sleep, increases the perception of pain and causes or exacerbates co-morbid conditions, completing a nightmarish scenario.

The worker's most common remedy for this devil's brew of factors is recourse to the appropriate local system for workers' compensation. That system utilizes what most workers will find to be unfamiliar terminology and counterintuitive rules and procedures, leading to an exacerbation of their already considerable sensation of loss of control. This often leads workers to seek an advocate to lead them through the system. Unfortunately, the advocate often contributes, albeit inadvertently and unintentionally, to the disabling scenario.

58, McKee-Ryan, F, et al, Psychological and Physical Well-Being During Unemployment: A Meta-Analytic Study, *Journal of Applied Psychology*, 2005, Vol 90, No. 1, 53-76.

In the United States, the contingent fee arrangement usually utilized for the remuneration of worker's counsel creates perverse incentives in the system. The more disabled a worker is found to be, the larger the ultimate award of benefits the worker will ultimately obtain. Since contingent fees are based on the size of the award obtained, the larger the award, the larger the fee (within statutory constraints). While most attorneys are not guilty of excesses, persistent reports of workers reporting that their lawyers advise them against returning to work, because it "will hurt their case" are not uncommon. As noted above, a growing body of research also indicates that the longer a worker remains out of work, the greater the probability that the worker will never return to the pre-injury job. At the same time, the worker is conditioned by lawyer advertising and the advice of friends and co-workers that they are entitled to a cash "award" for their injury, creating a classic "zero sum game" where a "win" by the worker means a "loss" by the employer.

After accepting the case, the attorney for the injured worker will often attempt to manage their caseload through the use of settlements, which may not maximize the amount awarded, but increase case turnover rates and substitute fee volume and certainty for absolute fee magnitude. The worker may feel like they never get their "day in court" as a result of that process. That feeling is likely to be confirmed when the attorney ceases to provide support, guidance or an outlet for his or her complaints, at the end of the case. The worker is unceremoniously abandoned when the final check is delivered, without respect for his or her continuing needs for support, as provision of that support is not part of the remunerated services provided by the attorney.

There are a number of other mechanisms by which even the most scrupulous attorney may cause inadvertent harm. Workers are no more immune than school children from what we have learned to call "self-fulfilling prophecy" or the "Pygmalion effect". Thus when a lawyer talks, out of habits useful in court, about the worker's life being over, and no meaningful work being available to the worker, he or she may internalize the message. There may be encouragement for the modelling of claims supporting behaviour before the doctors, adjuster and in court, which eventually becomes habitual.

Similarly, the defence counsel is not immune from a role in the creation of needless disability. When the worker is challenged as to the credibility of their claim, the degree of their injuries, or the reasons for their failure to heal as anticipated, he or she will often experience both delay in claim resolution and financial hardship if benefits have been denied or delayed. During this period the worker is called upon to prove that he or she is disabled, giving the worker ample opportunity to practice the appropriate behaviour for their role. As they practice and emphasize the behaviour supporting their story, it becomes habitual.

The medical community is also a source of system-created disability. A common form of iatrogenic disability arises from the “medicalisation” of signs and symptoms. “Medicalisation” is a phenomenon associated with the fact that health care providers are generally compensated for the provision of services on the basis of reporting protocols that require the specification of a diagnosis. Where there are no objective findings to support an established diagnosis, the health care provider must, nonetheless name the ailment to provide treatment and be compensated for their services. Unfortunately, the worker is used to utterly relying on the opinions and services of physicians, and therefore the naming of the ailment, in a modern form of shamanism, creates the perception of its reality. Since there is no known cause or mechanism, there is also no cure, and the creation of iatrogenic disability is complete. The proliferation of new syndromes, which start as isolated reports and rapidly become common diagnoses proves the power of medicalisation to impact on people’s lives.

Nonetheless, most impairment ratings systems do not even attempt to take these highly personalized sources of disability into account. Rather, most systems start with some version of the American Medical Association

AMA GUIDES

Prevalence

Use of the some version of the *AMA Guides* is widespread in the United States. The 5th Edition is the most widely used, with sixteen states utilizing that edition.⁶ Ten States utilize the 6th Edition, which was adopted in December of 2007.⁷ Eight states utilize the 4th Edition for workers’ compensation,⁸ while Colorado and Oregon utilize the 3rd Edition, Revised. The remaining states either do not specify the version to be used, use some state-specific guide for rating impairment, or do not specify what guidance should be used for the determination of impairment.

In Australia all of the eleven major jurisdictions either designate the use of particular editions of the *AMA Guides* (usually with some specified modifications) or have developed their own Guides. However, these scheme Guides are essentially based on a particular edition of the *AMA Guides*.⁹ These Australian

⁶ California, Delaware, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Massachusetts, Nevada, New Hampshire, N. Dakota, Ohio, Rhode Island, Vermont and Washington.

⁷ Alaska, Arizona, Louisiana, Mississippi, Montana, New Mexico, Oklahoma, Pennsylvania, Tennessee, and Wyoming.

⁸ Alabama, Arkansas, Kansas, Maine, Maryland, S. Dakota, Texas and W. Virginia.

⁹ In Victoria, Queensland, Tasmania, the Northern Territory and the federal scheme covering the military the link is to the 4th edition while in New South Wales, Western Australia, South Australia, Comcare and Seacare, the link is to the 5th edition. In the Australian Capital Territory there is resort to both the 4th and 5th editions.

measures either designate or are based on the 4th and 5th editions of the AMA Guides. There is thus in Australia a patchwork of arrangements which are based on a particular edition of the AMA Guides but which typically modify their operation. For instance, in Victoria, which generally designates the 4th edition of the Guides, removes the chapter on pain (chapter 15) and substitutes a scheme derived measure in relation to hearing (chapter 9, section 9.1a)¹⁰ and mental and behavioural disorders (chapter 14).¹¹

Disclaimer in the Guides Themselves

Every version of the AMA *Guides* has specifically disclaimed the use of the document as a direct estimation of the degree to which an individual is disadvantaged with respect to his or her ability to perform specific job functions. Prior to the 6th Edition, the *Guides* contained specific warnings against using them for the making of direct financial awards or direct estimates of disability. The current version of the document contains a warning against using the *Guides* for making direct estimations of work participation restrictions. It is not known if the change in language with respect to the utilization of the Guides was intended to signal a change in philosophy.

Lack of Expertise to determine disability

One difficulty with the use of the Guides as a mechanism for the determination of disability is the relative lack of expertise and lack of necessary information for the determination of disability by most doctors.

If disability is a measure of the loss of the functional ability to do a particular job, or more broadly the loss of the functional ability to do any meaningful work, then doctors are not well qualified to assess disability. The disconnect comes from the fact that physicians are the ones most often utilized to assess impairments under the *Guides*.

Physicians are not routinely trained to assess ergonomics, the requirements of a particular job or the stresses that the body is put under when performing various physical activities. Moreover, they are not, as a group taught to do objective assessments of the behavioural factors that may significantly impact the outcome of a particular case. Even if the doctor had such expertise, it is highly unlikely that he or she would have the time and opportunity to go to the worksite, assess the job in question and formulate a reasoned opinion concerning the ability of the worker in front of them to perform the essential functions of the job. Relying therefore on the subjective reports of the worker, and the inconsistent quality of reports from employers, the physician is in the unenviable position of making an important assessment of workplace demands, ability, and restrictions with next to no reliable and objective evidence upon which to base the decision. It is

¹⁰ Replacing it a document titled *Improved Procedures for Determination of Percentage Loss of Hearing* (1988 edition or later prescribed edition).

¹¹ Replacing it with *The Guide to the Evaluation of Psychiatric Impairment for Physicians*.

therefore no surprise that every edition of the *Guides* contains a warning against using them as a determinant of disability.¹²

Inter rater reliability

When doctors attempt to assess impairment ratings they are utilizing judgment and expertise. Since these factors differ significantly for doctor to doctor, it is not surprising that different doctors will look at an injury differently. Additionally, doctors often get a reputation for getting most of their referrals from the plaintiff's or defence side of the equation. While the extent of influence from the referring party is generally unknown, it would be naïve to think that it doesn't happen. The high degree of variation between different raters was cited as a major reason for the adoption of the rating protocol utilized in the 6th Edition of the *Guides*.¹³ There is some evidence that the most recent edition of the *Guides* has diminished this phenomenon, at least temporarily.

Approaches that have been utilized

1989-1992 Victoria:

Under the former WorkCare scheme in Victoria amending legislation in 1989 provided for the reduction of weekly payments of compensation from 80 percent to 60 percent of pre-injury earnings, where a worker had been on benefits for twelve months, if the worker had a level of impairment of less than 15 percent "assessed according to the methods prescribed". The Government established a Tripartite Committee (with government, employer and union representatives) to develop the 'prescribed methods' for the operation of this provision.

The technical work was undertaken by a special Working Group which was directed to arrive at a test that took account of both:

- the nature and extent of the work-related condition; and
- the extent to which the impairment affects capability to work given the worker's personal circumstances (such as age, gender, ethnicity, disability, work history, education and training).

The Working Group sought, in the international experience, approaches that could operate as modifiers to the AMA Guides in order to fulfil the second of their mandated tasks. The Working Group developed a 'Disability Severity Scale' based on a comprehensive and mutually exclusive set of descriptors drawn from the World Health Organization's 'International Classification of Impairment,

¹² "The Guides is not intended to be used for direct estimates of work participation restrictions".
AMA Guides, supra. 6th Edition, p. 6.

¹³ AMA *Guides*, 6th Ed., p2.

Disabilities and Handicaps' (ICIDH) and the British Disability Survey. The latter was a project of the British Office of Population Census, led by Jean Martin, which utilized the ICIDH to create a disability severity scale for use in a national survey of the prevalence of disability in Britain. As well, the Working Group developed a measure of relative severity of handicaps in the labour market by focusing on personal characteristics which were believed likely to have a significant impact on whether a person with a medical impairment and a disability could re-enter the workforce.

The Working Group had no real precedents to guide them in terms of a measure for the severity of work-related handicap. However, after an examination of the literature and statistics related to labour market disadvantage, mobility and long-term unemployment, a number of determining characteristics were recognized. These were:

- age;
- years since last employed;
- previous occupation(s) and accompanying skill levels;
- language skills;
- place of residence;
- level of schooling;
- gender.

The results of these endeavours were brought together in a booklet, *Disability and Handicap Severity*

Scales, which by regulation were required to be used in establishing the disability/ handicap rating of a worker. This came into operation in 1990. However, in late 1992, there was a change of government which led to a radical recasting of the Victorian workers compensation legislation. This included repealing the legislative provisions underpinning the disability and handicap scales. There was thus a reversion to the previous situation of relying on a clinical measure of whole person impairment.

1990 New Mexico

The approach currently utilized in New Mexico was developed in 1990 and formally adopted in 1991¹⁴. It starts with the premise that a worker should be more highly compensated if their physical condition leaves them less likely to be able to find employment, after he or she has recovered to the extent they will be able to do so. Accordingly, the algorithm utilized has factors for the age of the worker (on the premise that older workers will be unable to find work) education (assuming that more educated workers will have more job opportunities) specific

¹⁴ Section 52-1- 26, NMSA, 1978, and each of the lettered subsections under that designation

vocational preparation (assuming that the development of skills for one job is likely to be transferable to another). These factors are added together and then multiplied by a matrix developed to express the residual physical capacity of the worker in comparison to the demands of the pre-injury job. The residual physical capacity is heavily weighted to measure the lifting capacity needed in the work, giving the model a distinctly physical work bias. The resulting number is a “modification factor” which is added to the impairment rating from the most recent edition of the *AMA Guides*.¹⁵

There were difficulties with the formula from the start. A young, college educated person with job specific experience who had a sedate job before the injury, and had only sedate residual physical capacity thereafter, literally was granted no modification factor to be added to impairment whatsoever. This resulted in various scenarios that were less than fully acceptable. A 25 year old Ph.D. scientist with a closed head injury that left him or her unable to do the intellectual work for which he or she had been college trained could, depending on the version of the *Guides* utilized, end up with a final modified impairment rating of 0-5 percent, despite the fact that the injury left him or her totally unable to do any work similar to that for which he or she had been trained. Similar results were obtained for other skilled professions. Moreover, the significance of the residual physical capacity component of the formula was sufficient to make it the focus of a great deal of concern about behaviour changes during the testing of that capacity.

Unintended consequences of Disability Algorithms Models of work.

The difficulty with such algorithms is that they are virtually always blunt instruments in an environment where the ability to fine tune the result to the individual would be more conducive to individual justice. The New Mexico algorithm builds in a “heavy lifting” model of work, where the residual physical capacity of the worker, as measured by their ability to lift, is given great significance in the final disability calculation. Occupations that are based upon sedentary work are not able, due to the structure of the formula, to achieve high levels of disability, without regard to the impairment level determined.

Algorithms based upon objectively measurable factors have the virtue of being highly predictable with respect to overall outcomes. Claims adjusting personnel are able to predict the ultimate outcome of the case in terms of disability from objective factors and the impairment rating. While there may be some small variations in assessment under such a formula, they often are not sufficiently large in their impact upon the final compensation rate to justify the delay and cost of litigation over the difference. In this context, especially in the U.S. where contingent fees based upon the increment of award obtained by the services of the attorney representing the worker are common, counsel for both sides will often negotiate a resolution of any differences rather than expend a large amount of effort over a small amount of benefits in controversy. The resulting reduction in

¹⁵ [(Age factor + Education factor+ Specific Vocational preparation factor) X Residual Physical Capacity multiplier] + Impairment Rating = Disability.

systemic costs, both in terms of reductions in administrative costs of determining disability, and in terms of decreased uncertainty about the outcome and with it decreased dispute resolution costs, has sometimes been seen as a sufficient justification for the consequential de-emphasis on individual justice.

White collar bias

The examples of Tom and Jerry set out at the beginning of this article encapsulate one of the major problems with the treatment of disability within workers' compensation schemes. This is an entrenched bias against blue collar employment as against white collar occupations. This stems from the fact schemes use a measure of impairment as a proxy for *disability* or *incapacity*. The concepts are fundamentally different. Impairment is a clinical measure of an alteration of a person's health status or in the World Health Organization's definition "any loss or abnormality of psychological, physiological or anatomical structure or function".¹⁶ By contrast, incapacity/ disability relates to a change in a person's capacity to engage in a range of activities (personal, social and occupational). In relation to workers' compensation schemes, the occupational consequences of incapacity can be dramatically different. An individual in a range of white collar occupations can have a very significant impairment (for instance, quadriplegia) and still be able to engage in their pre-injury employment. Conversely, in a range of blue collar employments a relatively small level of impairment can preclude a return to pre-injury employment (for instance, a leg injury to a roof tiler).

Behaviour push

One additional consequence of any of the existing algorithms for transforming impairment based upon the AMA Guides to into disability is that it tends to reward behaviour that increases the ultimate disability rating. As noted above, the expectation that monetary awards are the outcome of workplace injury and the fee structure utilized for attorney remuneration, both create conditions where there is a conscious or unconscious encouragement of behaviour that is seen to be likely to result in a larger award.

The result of this phenomenon is the perceived, and sometimes explicit, requirement that physical testing (i.e. testing of physical effort in a lifting test) and subjective reporting (i.e. with regard to pain) utilized in the evaluation of

¹⁶ *International Classification of Impairments, Disabilities, and Handicaps*. Geneva, Switzerland: World Health Organization; 1980.

impairment be subject to some sort of empirical verification to be fully credited toward the derivation of impairment.¹⁷

Unfortunately these attempts to verify and objectify the behaviour are often perceived by the worker as an attempt to impugn his or her credibility, resulting in the continued focusing on and emphasis of the signs and symptoms that are being questioned. Habituation of the behaviour as an unintended consequence of questioning it is likely to follow, in much the same way that challenges based upon a charge of malingering by the defence attorney are likely to have similar unintended consequences.

Impairment Has a Role

Using Impairment as a Starting Place

Prior efforts

There are several US jurisdictions that do not use impairment as a determinant of disability at all. Approaches range from a measurement of wage loss¹⁸, to impairment rating utilized as a multiplier with respect to a statutorily adopted scale¹⁹, to impairment used as a multiplier with respect to standard or worker specific wages²⁰. The remaining 44 jurisdictions utilize some version of the *AMA Guides* as part of the disability calculation.

The *AMA Guides* have existed in one form or another since 1958.²¹ As noted above, the *AMA Guides to the Evaluation of Permanent Impairment* has never been intended as a determinant of disability. Nonetheless, many jurisdictions use the *Guides* in this fashion.

Those jurisdictions that have attempted to create some sort of conversion from impairment to disability have focused on factors that were related to the individual characteristics of the worker, analysed in broad categories. Age at the time of impairment rating, current level of education, and some measure of transferable skills are the most often utilized. Unfortunately, the systems utilized are not even consistent as to the direction in which each of these factors should be weighed. For instance, the State of Colorado utilizes a formula that gives greater credit in the determination of disability for youth, presumably on the basis

¹⁷ C. Brigham, E. Genovese and C. Uejo, *AMA Guides Sixth Edition: New Concepts, Challenges and Opportunities*, IAIABC Journal, Volume 45, No. 1, Spring 2008, Table 1, p12.

¹⁸ The state of Louisiana and the Federal Longshore and Harbor Workers' Compensation Programs use this approach. IAIABC – WCRI Workers Compensation Laws, 2d Edition, 2009, Table 6.

¹⁹ Indiana and Minnesota, IAIABC – WCRI, *ibid*.

²⁰ Alaska and Nevada, *ibid*.

²¹ C. Brigham, E. Genovese and C. Uejo, *AMA Guides Sixth Edition: New Concepts, Challenges and Opportunities*, IAIABC Journal, Volume 45, No. 1, Spring 2008, pp 13-59. The "First Edition of the Guides followed predecessor documents in 1971. Subsequent editions have been published approximately every 8 years thereafter.

of the greater impact on the worker over the period of their anticipated working life. The State of New Mexico weighs the age factor in the opposite direction, giving older workers a greater benefit in the disability calculation, reasoning that older workers will have greater difficulty in finding new work by virtue of their age.²² Unfortunately, the rationales behind the policy choices made are not often explicitly stated in statute or regulation, and are therefore not subject to scrutiny and review by those governed by them. Accordingly, disability calculation formulas based upon the AMA *Guides* that utilize some other algorithm for weighing in personal factors have been subject to question as to their consistency and understand ability on both inter-jurisdictional and intra-jurisdictional basis.

Nonetheless, there are some notably creative attempts to find substantive justice in a model that utilizes the AMA *Guides* as a starting ground. Wisconsin²³ separates out impairments by body part injured and assigns differing weeks of indemnity payments to the quantum of impairment for each body part. Thus, a 12.5 % impairment arising from an ankle injury will result in 31.25 weeks of disability at the rate prevailing at the time of injury, where the same percentage of impairment will result in 53.13 weeks of disability if the injury involves the knee. California has a highly developed formula to attempt to balance individual justice with reasonable predictability. The formula starts with the AMA impairment rating. The impairment rating is then adjusted by a factor that is based upon the observed tendency of some body parts to be over or under compensated relative to others based upon an empirical comparison between compensation rates and wage losses (see description of study, below). The adjusted impairment is then adjusted for worker age and occupation. Younger workers are given more compensation than older workers and sedentary jobs receive less compensation than more physically demanding jobs. The adjusted rating is converted by formula to the number of weeks for which permanent partial disability is paid, and the payment rate per week is applied.

FCEs

A recent volume published by the American Medical Association²⁴ discusses an entirely different approach towards the utilization of AMA *Guides* impairment ratings for the determination of disability. The *Guide to Evaluation of Functional Ability* looks at the current state of functional capacity examinations critically and

²² It is worth noting, however, that the State of New Mexico garnered the highest rate of wage replacement in a comparative study done by the Rand Corporation in 2002. The replacement rate differences observed are based upon more than just the age factor in the algorithm, to be sure, but they did result in higher wage replacement rates than California and all of the other states studied in R.Reville, J. Biddle, and L. Boden, *Comparing Compensation Adequacy: Workers' Compensation Permanent Disability Benefits in Five States* Rand Corporation, 2002.

²³ WKC 8486-P (Revised 5/10/2010)

²⁴ E. Genovese and J. Galper, *Guide to the Evaluation of Functional Ability: How to Request, Interpret and Apply Functional Capacity Evaluations*, American Medical Association, 2008.

suggests specific steps that are needed to restore faith in their accuracy and inter-rater consistency. The book goes on to theorize that the new paradigm for functional capacity examinations supports an entirely different approach to disability determination. Rather than having a legislatively determined set of factors that may increase predictability in the system and may approximate a just result for populations as a whole, the system proposed would allow an individual impairment rating and an individual rating of functional capacity to be combined for a highly personalized estimation of disability while retaining predictability in the system. Implementation of this model has not been attempted on a large scale, and the authors are clear that the current state of functional capacity examination quality would have to be significantly improved to support this function.

Cutting loose from the Paradigm

Psychosocial factors

A number of sources have attempted to identify factors that are associated with disability or failure to return to work, based upon the individual characteristics and circumstances of the worker. These factors are generally referred to as “psychosocial factors”²⁵ and include such things as lack of social support at work and low job satisfaction.²⁶ The popularization of the literature with respect to this set of factors has led to it being utilized as the basis of a set of “red flag” factors for prediction of disability. When utilized as the basis for assigning early intervention resources, these factors aren’t overly objectionable, even though they may lead to the allocation of early intervention resources in an un-egalitarian manner. One mistake that is commonly used with this line of research is to mistake correlation between the presence of psychosocial factors and the failure to thrive post injury with causation. Professionals are often seen to fall into the mistake of speaking about psychosocial factors “causing” failure to achieve early return to work, when we really don’t know what causes their obvious predictive value.

In this context, it would be quite dangerous for a workers’ compensation scheme designer to attempt to integrate psychosocial factors into a system for converting disability into impairment. As we have seen above, the inclusion of factors into a disability system that can be adopted or encouraged often translates into patterns of behaviour where subtle influences push the increased prevalence of such behaviours in the environment. If we say that psychosocial factors

²⁵ R Gotchal and N. Kisimo, Clinical Effectiveness of Early Intervention for Musculoskeletal Pain Disorders, IAIABC Journal, Volume 7, No 1, Spring 2010.

²⁶ Hoogendoorn, W. E., van Poppel, M. N. M., Bongers, P. M., Koes, B. W., & Bouter, L. M. (2000). Systematic review of psychosocial factors at work and in the personal situation as risk factors for back pain. *Spine*, 25, 2114-2125, J. Turner, et. al., Early Predictors of Chronic Work Disability, A Prospective, Population-Based Study of Workers With Back Injuries, *Spine*, Vol. 33, No. 25, 2008

influence disability then the phenomenon of “self-fulfilling prophesy”²⁷ suggests that, as we intentionally or unintentionally communicate these factors to claimants, some of them will internalize the factors, and needless disability may be created.

Rand study

An interesting line of research, begun²⁸ by the Rand Corporation with the groundbreaking study, *Evaluation of California’s Permanent Disability Rating Schedule*²⁹ utilizes empirical data concerning the wage replacement rate obtained by injured workers as a measure of the effectiveness of the conversion of impairment ratings into disability. In the course of analysing a very large California data set, the researchers discovered that the body part injured was related to the adequacy of compensation as measured by wage replacement, and that there were significant differences between injured body parts in that regard. Thus, the study showed that, for example, knee injuries were associated with reduced adequacy of wage replacement based upon the *AMA Guides* than were shoulder injuries. The State of California, as noted above, has adjusted its disability determination algorithm to reflect this reality. It would be possible, at least in theory, for the same line of research to be utilized to correct what might be perceived, based upon that research, as deficiencies in the accuracy of the *AMA Guides*.

WHO ICF

The International Classification of Functioning, Disability and Health (ICF) represents an international, scientific tool for understanding human functioning and disability for clinical, research, policy development and a range of other public health uses. It is part of the World Health Organization (WHO) Family of International Classifications (WHO-FIC) covering a variety of classifications in a range of health settings.

²⁷ This is now properly understood in terms that neuroscience has defined for us as “neuroplasticity”. See, e.g., R. Aurbach, *Getting Justice: Unintended Consequences of the Dispute Resolution System*, in *Current Perspectives on Management and Treatment of Workers’ Compensation Claims*, C. Stout, editor, Bentham Scientific Publishing, pending publication.

²⁸ More recently see, Bhattacharya, Jayanta, Frank Neuhauser, Robert T. Reville, and Seth A Seabury, “Evaluating Permanent Disability Ratings Using Empirical Data on Earnings Losses.” *Journal of Risk and Insurance*, 2010, Vol. 77, No. 1. 231-260. and “Comparing Severity of Impairment for Different Permanent Upper Extremity Musculoskeletal Injuries,” *Journal of Occupational Rehabilitation*, Sept. 2002. With Robert T. Reville, Jayanta Bhattacharya and Craig Martin.

²⁹ R. Reville, S. Seabury and F. Neuhauser, Rand Corporation DB 443 ICJ, December 2003.

The ICF framework provides an understanding of disablement as an identifiable variation of human functioning seen through the prism of the three dimensions of impairments, activity limitations and participation restrictions. It is underpinned by the recognition that functioning and disability represent a complex interaction between the health condition of the individual, the nature of environment in which the individual operates, together with personal factors. It is a framework which is interactive and dynamic rather than linear or static.

The ICF framework regards functioning and disability as multi-dimensional concepts structured around three main elements:

- body functions and structures
 - body functions are the physiological functions of body systems (including psychological functioning)
 - body structures are anatomical parts of the body such as organs, limbs and their components
- the activities that people do and the areas of life in which they participate
 - an activity is the execution of a task or action by an individual
 - participation is involvement in a life situation
- the environmental factors that affect these experiences
 - environmental factors constitute the physical, social and attitudinal environment in which people live and conduct their lives – these can either be barriers to or facilitators of a person's functioning.

Potential of the ICF Framework

In Australia, the ICF framework has been used by a number of bodies, including the Australian Bureau of Statistics, for a number of purposes and in a number of settings.³⁰ In particular, the Australian Institute of Health and Welfare, which is

³⁰ These include:

- the use by the Australian Bureau of Statistics of the ICIDH and ICF concepts in its five major population Surveys of Disability, Ageing and Carers, in 1981, 1988, 1993, 1998 and 2003;
- the use of the ICF as a framework and classification in redeveloping the major national administrative data collection in the disability services sector, the Commonwealth/State Disability Agreement Minimum Data Set (CSDA MDS);
- the use of the framework and key concepts of the ICF in developing an Australian tool to measure therapy outcomes—the Australian Therapy Outcomes Measures (AusTOMs);
- the use by the Communication Disability in Ageing Research Unit at the University of Queensland of the ICF and its predecessors in the education of speech pathologists and audiologists, in clinical practice with older people with hearing impairment and aphasia; and

one the WHO collaborating centres, has identified a number of potential ways in which the ICF could be used to improve policy and information on disability and human functioning. These include:

- use of the broad ICF conceptual framework in advocacy, teaching, planning and education;
- use of the classification at various levels in information systems, for instance, national data on disability or rehabilitation services;
- reference to the classification in designing new assessment methods, or relating various methods to each other within a common framework; and
- use of the detailed codes in specific service, clinical or therapeutic settings.

For accident compensation systems the ICF framework offers the possibility of fashioning arrangements that can deal with the impact of an injury or illness upon a worker's activities and participation not simply in the work environment but more widely, including their domestic and social life.

Can the ICF be Operationalised?

It is important to remember that the ICF represents a framework and series of classifications and is not itself an assessment or measurement instrument or tool. However it does provide a rigorous structure within which assessment and measurement instruments and tools can be developed and against which they can be judged. The great challenge for accident compensation schemes in adopting the ICF framework in this area is how to operationalise its insights in terms of the development of classification and assessment instruments that can be used at the individual claimant level and that can provide scalable measures in respect of the ICF's three dimensions. It is this scalability and comprehensive application to impairment conditions, that probably primarily accounts for the ongoing influence of the *AMA Guides* as a proxy for assessing disability..

The *AMA Guides* in their latest manifestation - the sixth edition - have begun to engage with the conceptual framework of the ICF.³¹ In large part this reflects the criticism of previous editions that the impairment ratings did not adequately or accurately reflect loss of function. This is clearly a work in progress and we are

-
- the use of the ICF in a collaborative project between The University of Sydney, the Royal Rehabilitation Centre Sydney and the Centre for Developmental Disability Studies in developing a new system for classifying and assessing the support needs of people with disabilities.

³¹ See Christopher Brigham, Elizabeth Genovese and Craig Uejo, *AMA Guides Sixth Edition: New Concepts, Challenges and Opportunities* IAIABC Journal, Vol. 45, No. 1, pp. 13-59.

still at a preliminary stage. This is acknowledged by some of the architects of the sixth edition in terms that:

"[u]se of the ICF model does not indicate that the *Guides* will now be assessing disability rather than impairment. Rather, the incorporation of certain aspects of the ICF model into the impairment rating process reflects efforts to place the impairment rating into a structure that promotes integration with the ICF constructs for activity limitations and limitations in participation, ultimately enhancing its applicability to situations in which the impairment rating is one component of the "disability evaluation process".³²

Given the importance of sophisticated, but robust, measurement tools for a range of purposes in accident compensation schemes, particularly workers' compensation and motor accident compensation systems, it would be appropriate for the peak bodies in these areas to explore the feasibility of developing a measure of work-related capacity that could be used for the determination of entitlements and for other purposes within accident compensation schemes. One line of approach would be to build upon the move in the sixth edition of the AMA Guides of incorporating aspects of the ICF model into the impairment rating process. This is likely to be a difficult and fraught process and perhaps a more direct approach should be adopted. It is suggested that the approach developed in Victoria between 1989 and 1992 should be revisited. This was a very methodologically rigorous, evidence based exercise undertaken by a very technically competent Working Group. The Working Group recognized the innovatory nature of its work and saw the need for ongoing monitoring of the tools that it developed and for further refinement with the benefit of experience and further testing. As noted earlier this experiment was cut short by a change of government.

The question then is how such a project can be taken forward. It is suggested that in Australia such work should be initiated by bodies such as the Heads of Workers Compensation Authorities (HWCA) and the Heads of CTP Authorities (HCTP), in conjunction with State and Territory regulators in these fields. In the United States, the International Association of Industrial Accident Boards and Commissions (IAIABC) and in Canada, the Association of Workers' Compensation Boards of Canada (AWCBC) would be appropriate facilitators of such an approach. Better still, such a project could be undertaken as a trans-Pacific initiative.

³² Ibid, p17.

APPENDIX B

1756 OFFICIAL NOTICES 17 April 2009

WORKCOVER GUIDELINES ON INDEPENDENT

MEDICAL EXAMINATIONS AND REPORTS

I, John Watson, Acting Chief Executive Officer of the WorkCover Authority of New South Wales, under s119(4) and s376 of the Workplace Injury Management and Workers Compensation Act 1998, issue the following guidelines.

Dated, this 14th day of April 2009.

John Watson

A/ Chief Executive Officer

WorkCover Authority

WORKCOVER GUIDELINES ON INDEPENDENT

MEDICAL EXAMINATIONS AND REPORTS

Workplace Injury Management and Workers Compensation Act 1998

These guidelines are issued under s119 (4) and s376 of the Workplace Injury Management and Workers Compensation Act 1998. The guidelines set out WorkCover's policy in respect of independent medical examinations as well as the mandatory obligations for employers/insurers when referring a worker for a medical. They also provide guidance for all parties, including referrers, examining medical practitioners, and injured workers.

These guidelines replace guidelines dated 27 October 2006 and published in the Government Gazette No. 129.

These guidelines commence on 1 May 2009.

In this guideline, the Workers Compensation Act 1987 is referred to as the 1987 Act, and the Workplace Injury Management and Workers Compensation Act 1998, is referred to as the 1998 Act.

Definition of Insurer

Insurer is an insurer within the meaning of the Workers Compensation Act 1987 and the Workplace Injury Management and Workers Compensation Act 1998 and includes Scheme Agents, and self and specialised insurers.

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INTRODUCTION

Purpose and Scope of the Guidelines

Medical questions that arise in the context of managing a workers compensation claim should be directed to the treating medical practitioner(s) in the first instance. The nature of the relationship between the injured worker and the practitioner(s), and their knowledge of the worker's medical history, before and after the injury, make their input invaluable to the management of the worker's injury.

Referral for an independent medical examination is only appropriate when information from the treating medical practitioner(s) is inadequate, unavailable or inconsistent and where the referrer has been unable to resolve the problem directly with these practitioner(s).

Against this background, the purpose of these guidelines is to provide the basis for a shared understanding of the role of independent medical examinations in the management of compensable injuries in the NSW workers compensation system.

The guidelines outline mandatory [as per section 119(4) of the 1998 Act] and other obligations for the referral, conduct and reporting of independent medical examinations, and complaints management.

Mandatory obligations are set out in Part 1 of these guidelines. These are made in accordance with section 119(4) of the 1998 Act which states that an examination of a worker who has given notice of an injury must be in accordance with the WorkCover guidelines.

The other obligations set out in the Introduction and Part 2 of the guidelines applies to all independent medical examinations.

This document is intended for use by those who:

- refer injured workers for independent medical examinations
- undertake independent medical examinations and provide reports
- use independent medical examination reports in managing injuries, claims and disputes.

This document is also intended for use by injured workers and their representatives. A brochure is available from WorkCover for injured workers who are referred for independent medical examinations. The NSW Medical Board

policy *Medico-Legal Guidelines* provides useful information for workers and referrers (available from their website www.nswmb.org.au).

This document covers referrals by employers/insurers and lawyers involved in the workers compensation system, but not referrals to approved medical specialists by the Workers Compensation Commission of New South Wales.

Definition of Independent Medical Examination

Independent medical examination means an impartial assessment based on the best available evidence that is requested by a worker, a worker's solicitor or employer/insurer and undertaken by an appropriately qualified and experienced medical practitioner (who is not in a treating relationship with the worker) for the purposes of providing information to assist with workers compensation injury and claims management.

PART 1 MANDATORY OBLIGATIONS FOR EMPLOYERS/INSURERS

Part 1 sets out the mandatory obligations (pursuant to section 119(4) of the 1998 Act for employers/insurers when they require a worker to attend an independent medical examination.

Referral for an independent medical examination is only appropriate when information from the treating medical practitioner(s) is inadequate, unavailable or inconsistent and where the referrer has been unable to resolve the issues related to the problem directly with the practitioners.

All referrals for independent medical examinations are to be arranged at reasonable times and dates and with adequate notice provided to the worker, as outlined on page 7, 'Notification and explanation to the worker'.

Referrals for an independent medical examination are only to be made when answers to one or more of the questions outlined on page 5, 'Reasons for referral', cannot be obtained from the treating medical practitioner(s). If an injured worker submits a report from an assessor of permanent impairment regardless of whether they are the worker's treating medical practitioner or not and questions regarding that assessment arise, they are to be posed to the author in the first instance. If the response from the assessor is inadequate, unavailable, inconsistent or not received in 10 working days, a referral to an independent medical examiner may proceed.

All referrals to independent medical examiners are to be to appropriately qualified medical practitioners who have the expertise to adequately respond to the question(s) outlined in the referral. The independent medical examiner is to be a specialist medical practitioner with qualifications relevant to the treatment of the injured worker's injury. Care is to be taken when referring a worker with complex injuries. Referrers are to ensure that medical specialists with specific expertise are selected, e.g. a hand or plastic surgeon for hand injuries, a spinal surgeon for complex back injuries, a neurosurgeon or rehabilitation specialist for head injuries.

If the worker has not been treated by a medical specialist, the referral is to be arranged with a medical practitioner with qualifications and expertise in the treatment of the worker's injury.

The employer/insurer must meet any reasonable costs incurred by the worker, including wages, travel and accommodation. This may include pre-payment of travel and accommodation expenses. If the worker is not reasonably able to travel unescorted, this may include expenses for the worker's escort. Reference section 125 of the 1998 Act.

A worker receiving weekly compensation payments can be required to submit themselves for subsequent independent medical examinations only when information from the treating medical practitioners remains inadequate, unavailable or inconsistent and where the referrer cannot resolve the issues related to the problem directly with the treating practitioner(s) and:

- the subsequent independent medical examination is with a specialist medical practitioner with qualifications relevant to the treatment of the injured worker's injury; and
- the employer/insurer has evidence that the worker's medical condition as a result of the injury has changed; or

- the employer/insurer has evidence of a change in the worker's health not resulting from the injury which will affect the worker's participation in the labour market; or
- the employer/insurer has evidence of a material change, or need for material change, in the manner or type of treatment; or
- the worker makes a claim for section 66 lump sum compensation or work injury damages; or
- the worker requests a review pursuant to a notice issued under section 54 of the 1987 Act or section 74 of the 1998 Act and includes additional medical information that the employer/insurer is asked to consider; or
- there has been at least 6 months since the last independent medical examination required by the employer/insurer; or
- the last independent medical examination was unable to be completed.

Subsequent independent medical examinations must be with the same medical practitioner unless they have ceased to practise (permanently or temporarily) in the specialty concerned, or they no longer practise in a location convenient to the worker, or both parties agree that a different medical practitioner is required.

If the worker considers the requirement to attend an independent medical examination is unreasonable, the worker is to advise the referrer of the reasons for their objection. The referrer must take account of this objection and advise the worker of their decision following this consideration. Benefits are not to be affected prior to adequate written notice being received by the worker following this consideration (see WorkCover Guidelines for claiming compensation benefits, clause 9.3, Part 2). Any decision to suspend payment of weekly compensation can only be made after the worker has had an opportunity to comply with a reasonable request and must be made on the basis of sound

evidence and the worker advised in writing of the reasons for the suspension. The worker may contact WorkCover's Claims Assistance Service on 13 10 50 or their union for assistance in relation to such requests and decisions. The insurer is to respond to these requests.

PART 2 OBLIGATIONS FOR ALL INDEPENDENT MEDICAL EXAMINATIONS

Part 2 sets out the obligations for all independent medical examinations (in addition to the mandatory obligations set out in Part 1).

1. Referral for Independent Medical Examination

Reasons for referral

An independent medical examination is appropriate where the information required relates to:

- diagnosis of an injury reported by the worker and determining the contribution of work incidents, duties and/or practices to that injury
 - diagnosis of the worker's ongoing condition and whether it still results from the injury
 - recommendations and/or need for treatment
 - fitness for pre-injury duties and hours, and the likelihood of, and timeframe for recovery
 - fitness for other jobs/duties, including those in the worker's recent employment history (descriptions of such duties are to be provided to the independent medical examiner)
 - what past and/or ongoing incapacity results from the injury
 - physical capabilities and any activities that must be avoided
-
- an assessment of permanent loss (injuries pre 1 January 2002) or whole person impairment (injuries on and after 1 January 2002) resulting from the injury, including any proportion to be deducted that is due to a pre-existing injury, abnormality or condition.

Barriers in relation to return to work and difficulties in communicating with a treating doctor might best be resolved through use of an Injury Management Consultant (refer to WorkCover's Guidelines on the Appointment and Functions of Injury Management Consultants).

Responsibility of referrer

The referrer has a responsibility to ensure that:

- the referral is made to an appropriate medical practitioner
- an appointment can be made within a reasonable period of time (usually 4 weeks)
- all parties are informed of the appointment details of the examination
- the worker is provided with an explanation of the nature of the examination and the details of the appointment

- the worker's special needs are catered for, e.g. interpreter, disabled access
- the independent medical examiner is provided with details of the worker and the specific reason for the referral
- all the information relevant to the referral question(s) is provided to the independent medical examiner
- the independent medical examiner is paid promptly for providing the service at the rate set out in the Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order in force at the time of the examination (www.workcover.nsw.gov.au).
- there is no conflict of interest in relation to the worker and referrer. It is not acceptable to list standard questions that are not relevant to the specific aspect of the claim leading to this referral.

Selection of an appropriate medical practitioner for the examination

It is important that the independent medical examiner who is selected to provide the examination is appropriately qualified and has the expertise to competently provide an opinion on the question(s) in the referral. The independent medical examiner is to be a medical specialist with qualifications relevant to the treatment of the injured worker's injury. If the worker has not been treated by a medical specialist, an appointment is to be arranged with a medical practitioner in a specialty relevant to the treatment of the worker's injury. If the referral includes a question of causation or treatment, the independent medical examiner is to be in current clinical practice.

If the medical report relates to a claim for permanent impairment, it must be completed in accordance with the WorkCover Guides for the Evaluation of Permanent Impairment by a medical specialist with qualifications and training relevant to the body system being assessed who has been trained in the WorkCover Guides.

If there is more than one impairment that requires assessment by different medical specialists, one specialist must be nominated as the lead assessor and determine the final amount of whole person impairment.

A subsequent examination is to be with the same independent medical examiner who conducted the original examination, whenever practical.

The location of the independent medical examiner's rooms should be as geographically close to the worker's home address as possible or accessible by direct transport routes. The rooms should contain appropriate facilities, including access for people with ambulatory difficulties, and accommodate the worker's specific physical needs.

Special requirements of the worker relating to gender, culture or language are to be accommodated.

If the worker wishes to have an accompanying person with them at the examination, the independent medical examiner's agreement to the presence of a companion is to be obtained.

The independent medical examiner should be able to provide an appointment within a reasonable time, usually 4 weeks, and a report of the examination within 10 working days, unless different arrangements are agreed by the parties.

Where it is the independent medical examiner's routine practice to record the examination on audio or video, the worker must be informed of this and be in agreement prior to the examination being scheduled. The recording of the examination is only to proceed if the worker consents.

Communication with the selected medical practitioner

The letter of referral to the independent medical examiner must provide clear direction about the question(s) to be addressed and the medical opinions sought.

Documents to be included

The independent medical examiner must be provided with all the information that is relevant to the questions to be addressed. Documents could include a claim form, medical certificates, witness reports, employer reports of injury, clinical notes/reports of treating doctors, medical reports, medical investigation reports, rehabilitation and functional assessment reports, job descriptions and duty statements, details of work with other employers and details of other settlements or awards.

Independent medical examiners are not able to order additional radiological or similar investigations so the results of all existing investigations are to be made available to the independent medical examiner.

Reports and/or electronic records of lay investigators are not to be provided with referrals for assessment of permanent impairment.

Documents are to be provided to the independent medical examiner at least 10 days prior to the arranged appointment. They should be provided in a manner that facilitates review/perusal by the independent medical examiner.

Notification and explanation to the worker

The worker is to be first advised in writing at least 10 working days before the appointment, unless a shorter time is required because of exceptional and unavoidable circumstances and agreed to by the parties, e.g. a need to consider an urgent request for treatment.

Advice about the appointment with the independent medical examiner must include:

- the specific reason for the examination
- an explanation of why the response from the treating practitioner or author of the assessment report to the insurer's enquiry was inadequate, inconsistent or unavailable
- the likely duration of the examination
- name, specialty and qualifications of the examiner
- date, time and location of the appointment and contact details of the examiner's offices and appropriate travel directions
- the need to be punctual
- what to take, e.g. x-rays, reports of investigations/tests, comfortable clothing to enable an appropriate examination to be conducted
- how costs are to be paid

- that a failure to attend the examination or an obstruction of the examination may lead to –
 - o a suspension of weekly compensation and/or
 - o the right to recover compensation under the 1987 Act
- that the worker may be accompanied by a person other than their legal representative with the agreement of the independent medical examiner, however, the accompanying person must not participate in the examination and may be required to withdraw from the examination if the examiner requests it
- that no one may be present during the actual physical/psychological examination of the injured worker, unless agreed by the worker and by the medical examiner
- whether the travel costs for an accompanying person will be met (this usually only applies if the worker requires an attendant as a result of the injury)
- how complaints are to be managed
- that the workers compensation legislation gives the worker or a nominee a right to a copy of any report relevant to a decision made by a referrer to dispute liability for, or reduce, compensation benefits.

A WorkCover brochure about independent medical examinations is to be provided to the worker with the written notice of the appointment.

2. Conduct of an Independent Medical Examination

The NSW Medical Board's policy Medico-Legal Guidelines provides principles for the independent medical examiner's conduct during the examination.

If the worker provides the independent medical examiner with any additional information at the time of the examination, this information is to be noted in the examiner's report.

If the injured worker fails to attend the examination, the independent medical examiner must notify the referrer as soon as possible.

3. Reporting an Independent Medical Examination The suggested format for the report is attached as Attachment A.

The report is to be written in plain English and use accepted medical terminology as the intended audience is insurer staff, workers and workers' representatives, e.g. unions, legal representatives.

The report is to answer the referrer's question(s) and include other information elicited during the examination that is relevant to those questions. The independent medical examiner's report will list the material reviewed, any facts relied upon, the relevant medical history, examination findings, and the medical reasons for their conclusions.

The report should be provided to the referrer within 10 working days of the examination, or within a different timeframe if agreed between the parties.

4. Corrections and Updating of Reports

Where a report contains an obvious error, the referrer may request the independent medical examiner to clarify and correct the report at no extra cost. Such requests are to be made in writing.

Where the referrer requests that the examiner review additional information and seeks a supplementary report, that report will attract an additional cost.

5. Complaints about Independent Medical Examinations If the worker has concerns about the conduct of the independent medical examiner during the examination, they should raise those issues with the examiner at the time of the examination. The examiner should record the complaint and forward this to the referrer with their report and advise the worker to do likewise.

If the worker does not feel confident enough to do this, the worker should raise their concerns with the referring party as soon as possible after the examination. All insurers have in place a complaints management process. Making such a complaint can be facilitated by a union.

If the complaint is unable to be satisfactorily resolved, the worker may forward their complaint to WorkCover. WorkCover will advise the independent medical examiner of the complaint and provide an opportunity for the examiner to respond to the complaint.

WorkCover may refer the matter to the Health Care Complaints Commission, if it meets the criteria for such referral, e.g. more than 5 complaints about one independent medical examiner are received within a 12 month period and found to be justified, or if professional misconduct or fraudulent action are alleged. The worker may at any time make a complaint to WorkCover, the insurer, the Health Care Complaints Commission, or the NSW Medical Board.

6. Complaints about Workers

Independent medical examiners should report any unreasonably late or nonattendance by the worker to the referring party. Similarly, any inappropriate behaviour or behaviour which impeded the examination should likewise be brought to the notice of the referrer within 2 days.

7. Fees and Payments for Properly Completed Reports The maximum fees to be charged and paid are those set out in the Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order in force at the time of the examination.

The referrer is to either:

- a. agree the category of report being requested with the independent medical examiner and confirm the request in writing indicating that payment will be made within 10 days of receipt of a properly completed report and invoice; or
- b. pay in accordance with a contractual arrangement between the medical practice and the referring body on receipt of a properly completed tax invoice. Either arrangement cannot agree to a fee above the maximum fee prescribed in the Workers Compensation (Medical Examinations and Reports) Order.

The referrer's liability to pay for a report will be contingent on the report containing the information listed in the standard format, or as agreed between the parties.

If it involves an assessment of permanent impairment for an injury on or after 1 January 2002, the assessment must be in accordance with the WorkCover Guides for the evaluation of permanent impairment.

In some instances, the referrer will require an assessment in accordance with the WorkCover Guides for the evaluation of permanent impairment, even though the injury is before 1 January 2002. The independent medical examiner must be advised if this is the case.

Use of an interpreter, multiple system injuries and more complex matters will attract a

surcharge in addition to the basic fees. These are listed in the Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order

current at the time of the examination.

The Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order classifies the problems to be addressed into standard, moderately complex and complex. Definitions of these are:

A. Standard Reports are reports relating solely to a single event or injury in relation to:

- causation; or
- fitness for work; or
- treatment; or
- simple permanent impairment assessment of one body system.

B. Moderately Complex Reports are:

- reports relating to issues involving a combination of two of the following:
 - o causation
 - o fitness for Work
 - o treatment
 - o simple permanent impairment assessment of one body system
- or

- reports of simple permanent impairment assessment of two body systems or more than one injury to a single body system.

C. Complex Reports are:

- reports relating to issues involving a combination of 3 or more of the following:
 - o causation
 - o fitness for Work
 - o treatment
 - o simple permanent impairment assessment of one body system.
- or

- A complex method of permanent impairment assessment on single body system or multiple injuries involving more than one body system. The referrer is to indicate the expected level of complexity on referral and the independent medical examiner should advise the reason for any difference from this level. *Fees for cancellations, non-attendance or late cancellation by the worker or another party, such as an interpreter, are included in the Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order current at the time of the examination.* Complaints about patterns of late or non-payment by insurers should be referred for investigation to the WorkCover doctors' hotline on 1800 661 111 or by email to provider.services@workcover.nsw.gov.au

ATTACHMENT A

Report format

- Worker's details including:
 - date of examination
 - worker's name
 - date of birth/age
 - details of who attended the examination (i.e. interpreter, family member or friend).
- General history including:
 - date of injuries
 - brief history of the circumstances of the injuries
 - job description/work tasks (when relevant).
- Clinical history including:
 - summary of injuries received and diagnoses made of the worker's condition.
 - summary of all treatment provided
 - details and dates of clinical investigations carried out
 - details of any previous or subsequent injuries, condition or abnormality.
- Examination findings including:
 - list of injuries assessed
 - your findings on comprehensive clinical examination, including negative findings
 - your comments on consistency of presentation and, where appropriate, how this compares to the medical reports and other material sighted.
- Conclusions
 - Your opinion in relation to the specific questions asked in the letter of referral (refer to page 5).
 - If the referral is about permanent loss of use as a result of injuries received before 1 January 2002 or for whole person impairment for injuries received on or after 1 January 2002, questions regarding maximum medical improvement, whether the condition has resulted in a permanent impairment, and whether there is any deduction for a pre-existing condition must be addressed. A summary table (see Table 1) and a copy of all calculations must be included.

Table 1– Whole Person Impairment (WPI)

Body part Date of Chapter, Chapter, page, % or system injury page and paragraph, figure
WPI paragraph and table numbers number in AMA5 Guides WorkCover Guides

- 1.
- 2.
- 3.

% WPI deductions pursuant to S323 for pre-existing injury, condition and abnormality
Sub-total/s % WPI in whole numbers (after any deductions in column 5)

Total % WPI (the Combined Table values of all sub-totals in whole numbers)