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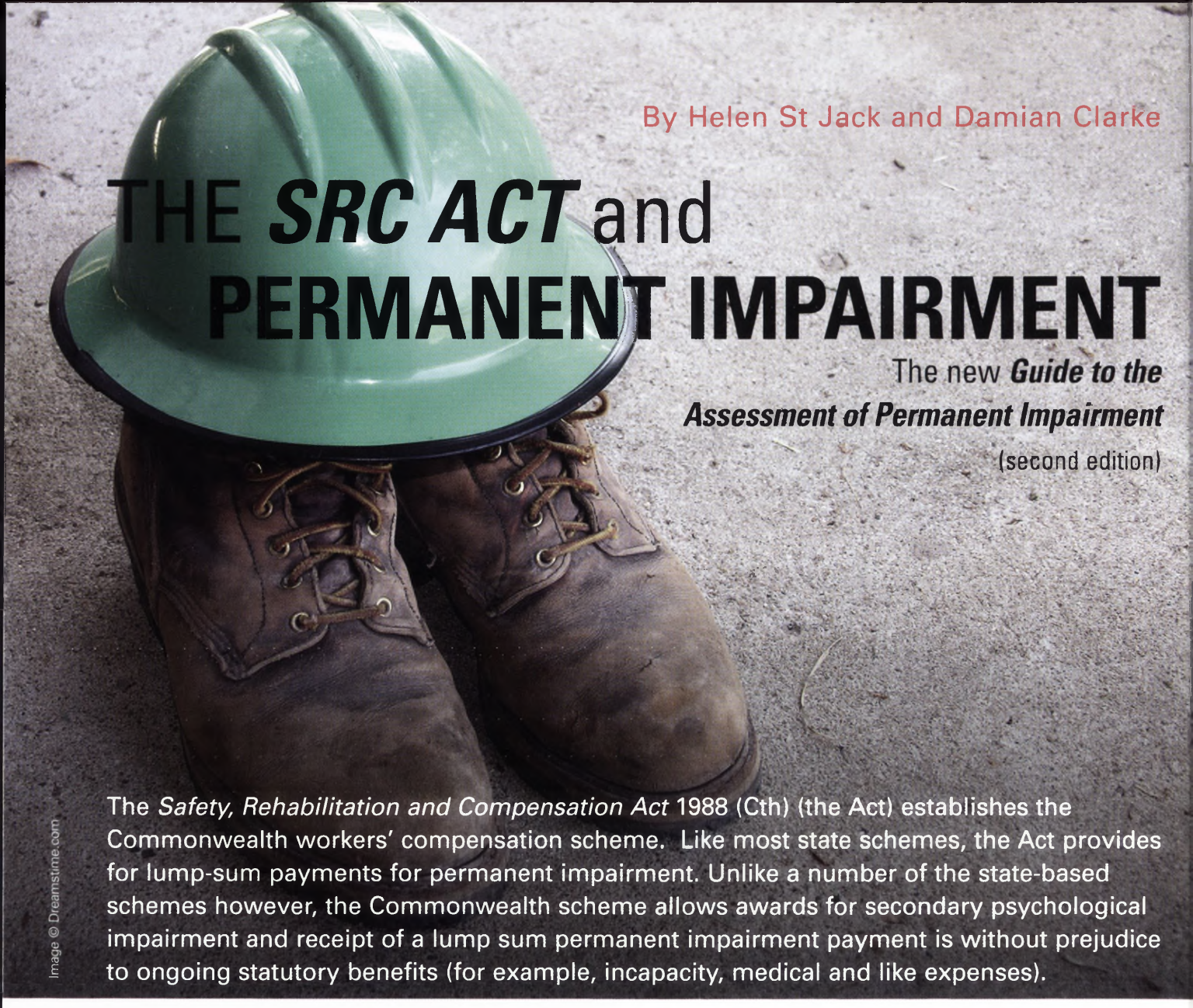
THE *SRC ACT* and PERMANENT IMPAIRMENT

The new *Guide to the Assessment of Permanent Impairment* (second edition)



The *Safety, Rehabilitation and Compensation Act* 1988 (Cth) (the Act) establishes the Commonwealth workers' compensation scheme. Like most state schemes, the Act provides for lump-sum payments for permanent impairment. Unlike a number of the state-based schemes however, the Commonwealth scheme allows awards for secondary psychological impairment and receipt of a lump sum permanent impairment payment is without prejudice to ongoing statutory benefits (for example, incapacity, medical and like expenses).

Claimants under the Act cannot receive both a lump sum for permanent impairment and damages against an employer. Both can be received in the case of non-employer damages claims/third-party claims, but there are implications for payback and loss of ongoing benefits.[1] The Act stipulates that an irrevocable election must be made between the two entitlements in the case of employer damages claims. If a claimant elects to pursue damages against an employer, that claim is restricted to non-economic loss damages alone and is capped at $110,000.[2]

PERMANENT IMPAIRMENT COMPENSATION UNDER THE ACT

Permanent impairment compensation comprises three elements:

(i) a s24 amount – being whole-person permanent impairment expressed as a percentage in accordance with the *Comcare*[3] *Guide* (a current maximum $141,351.15, indexed annually);

(ii) a further impairment component under s27 – based on the same permanent impairment percentage (to a current maximum $26,503.36 indexed annually); and

(iii) an additional non-economic loss component under s27 – based on the claimant's responses to a non-economic loss ratings questionnaire converted to a percentage (to a current maximum of $26,503.36, also indexed).

PERMANENT IMPAIRMENT ENTITLEMENTS AND DEFINITIONS (s24 OF THE ACT)

Section 24(1) of the Act provides that:

> 'Where an injury to an employee results in a permanent impairment, Comcare is liable to pay compensation to the employee in respect of the injury.'

The steps in the permanent impairment process were enunciated by the full court of the Federal Court (2005) in *Comcare v Canute*.[4] That decision has been the subject of a recent appeal to the High Court.[5] The High Court has essentially confirmed the reasoning of the full Federal Court in holding that each employment-related injury results in

a separate and discrete entitlement to compensation under the Act. It is irrelevant that a subsequent injury (that manifests later in time) is secondary to an earlier injury – that subsequent injury (provided it is an 'injury') must now be added to that earlier impairment (and not combined via Table 14.1). In addition, the decision in *Canute* clarifies the operation of s25(4) of the Act. Section 25(4) requires an increase in impairment of at least 10% in order for any subsequent additional impairment to be of a compensable level. We now know that if an injury that manifests later in time is a discrete injury, it will not attract the operation of s25(4) – the later injury will be compensable and should be added to any earlier impairment. The operation of s25(4) is essentially confined to a situation where the degree of impairment resulting from an 'injury' increases. What also appears to be clear is that the 10% impairment threshold for each 'injury' must be met in order for that injury to be compensable (that is, if none of the impairments reach 10% in and of themselves, the claim will fail).

The questions that should guide an impairment assessment are:

(a) Is the claimant an 'employee'? (ss4 and 5);
(b) Was an 'injury' suffered? (ss4 and 7);
(c) Did it result in an 'impairment'? (ss4 and 24);
(d) Is that impairment 'permanent'? (ss4 and 24).

'Injury' is defined in s4 (there are additional special provisions for disease in s7) to mean:

(a) A 'disease', being any ailment (meaning any physical or mental ailment, disorder, defect or morbid condition whether of sudden onset or of gradual development) or the aggravation (including acceleration or recurrence) of any such ailment being an ailment or aggravation that was contributed to in a material degree by employment;
(b) An 'injury' other than a disease, being a physical or mental injury arising out of or in the course of employment; or
(c) An 'aggravation' of a physical or mental injury other than a disease that arose out of or in the course of employment, regardless of whether the injury arose out of or in the course of employment.

'Impairment' is defined as 'the loss, the loss of the use, or the damage or malfunction, of any part of the body or of any bodily system or function or part of such system or function'.

'Permanent' is defined in s4 and means 'likely to continue indefinitely'. Section 24(2) lists the factors that must be taken into account when determining whether impairment is permanent.[6]

THE NEW GUIDES TO THE ASSESSMENT OF PERMANENT IMPAIRMENT

The Act provides that Comcare shall determine the degree of permanent impairment under the provisions of the 'Approved Guide'.[7] Until 1 March 2006, the first edition of the *Comcare Guides* governed the assessment of permanent impairment – the second edition of the *Comcare Guides* has now been released and will apply to all claims under s24 of the Act received on or after 1 March 2006. It will also apply to any 'top up' permanent impairment claims, including where the initial compensation was paid under the first edition.[8]

With the exception of psychiatric disorders, the second edition is generally based on the fifth edition of the *American Medical Association's Guides to the Evaluation of Permanent Impairment*. The assessment of psychiatric disorders in the second edition applies the same criteria laid down in the first edition (Chapter 5, Table 5.1 in both editions). The assessment of a non-economic loss component (s27 of the Act) also remains unchanged in the second edition.

However, the second edition represents a marked departure from the relative simplicity of the first edition. Those practitioners familiar with the *AMA Guides* (fourth and fifth editions and, to a lesser extent, the second edition) will recognise the methodology, clinical criteria and combining principles now incorporated into the second edition *Comcare Guides*. In general, the second edition is substantially more detailed and comprehensive, with a significantly increased clinical focus. Compared with the first edition, the second edition is expected to provide a more comprehensive methodology for assessing impairment and should theoretically lead to more accurate assessments of permanent impairment entitlements. However it may also give rise to more disputation.

REVISED STRUCTURE OF THE SECOND EDITION

The second edition is divided into two parts: Part 1 concerns the assessment of claims other than defence-related claims, >>

which are dealt with in Part 2. Part 1 is in turn divided into three divisions: Division 1 deals with impairment assessment;[9] Division 2 is concerned with assessing an employee's non-economic loss resulting from impairment (unchanged from the first edition); and Division 3 contains the methodology used to calculate a total entitlement under ss24 and 27 of the Act. This article focuses on Part 1, Division 1, and in particular on significant changes to the assessment of permanent impairment.

Division 1 is organised according to body systems and, in essence, reflects the body systems covered by the first edition of the *Guides*, with the addition of a discrete chapter on haematopoietic disorders[10] – anaemia, leukocyte abnormalities and haemorrhagic, platelet and thrombotic disorders. Haematopoietic disorders had been included in the first edition but under a miscellaneous chapter (Chapter 13) that also dealt with malignancies and intermittent disorders (asthma, migraine, tension headache and epilepsy).

GENERAL CHANGES TO THE PRINCIPLES OF ASSESSMENT

The *Principles of Assessment* remain largely unchanged from the first edition. There are, however, some additions and changes.

Normal and efficient level of function benchmark

While the definition of impairment as laid down in subsection 4(1) of the SRC Act obviously still applies, the primary principle guiding the assessment of impairment itself has shifted somewhat. Whereas the first edition stipulated that impairment be 'measured against its effect on personal efficiency in the activities of daily living in comparison with a normal healthy person', the second edition lays down the following benchmark:

> '[Impairment] is assessed by reference to the impact of that loss on the normal efficient functioning of the whole person.'[11]

The concept of a 'normal and efficient level of function' is somewhat vague (as was the 'normal healthy person' in the first edition) and may be the subject of some judicial comment in the future. Similarly, the removal of the concepts of 'personal efficiency and activities of daily living' in favour of the more generalised notion of the impact of a loss of function on a particular individual may generate some debate.

Activities of daily living

The concept of activities of daily living (ADLs) as a guiding principle does not govern the second edition as it did the first. The definition of 'activities of daily living' no longer includes references to the types of activities that must be considered when assessing a claimant's capacity to perform ADLs (for example, standing, moving, feeding, sexual function, etc). The second edition instead includes relevant ADL indicators in each separate table of the *Guide* (where appropriate to do so).[12]

Approach to assessments under alternative tables

A more significant difference between the new and old *Guides* reflects the decision of the full Federal Court in *Whittaker v Comcare*,[13] which held that where two or more tables (or combinations of tables) apply, the degree of permanent impairment should be assessed under the table that yields the more favourable result to the employee. Assessors are now obligated to follow instructions to compare ratings under different tables to ensure that the higher result for the claimant is favoured. This principle has now been incorporated into the new *Principles of Assessment* (see 'Comparing Assessments under Alternative Tables').

As in the first edition, the principles of assessment reiterate that in the event that impairment cannot be assessed under the second edition, recourse should be had to the current *AMA Guides* (fifth edition) (with the exception of certain conditions).[14]

Combining methodology

The principles of assessment in the second edition also include reference to specific and binding instructions to decision-makers and assessors. These instructions relate to impermissible combinations of impairment ratings from different chapters (incompatible ratings), the correct method of combining within each chapter and whether to add or combine separate impairment ratings in particular circumstances.

Maximum values

Specific tables in the second edition now include maximum impairment ratings for the impairment of particular body parts. This maximum impairment value will apply even if the effect of combining ratings from different tables leads to a higher figure. For example, the maximum total impairment that can be attained for a lower limb impairment is 40%, for a shoulder is 35% and for a single upper limb is 60%. This is so even if the result of combining individual ratings from different tables yields a higher result (despite *Whittaker*).

INDIVIDUAL BODY SYSTEMS

The second edition includes a significantly increased number of impairment tables across most chapters of the *Guide*. This is particularly so in Chapters 9 and 12 (the musculoskeletal and neurological chapters respectively) but other chapters have been completely revised in terms of principles of assessment, methods of measurement and the breadth of conditions covered. Some examples are discussed below.

Chapter 2: Respiratory System

The first edition's respiratory system chapter,[15] for example, basically instructed the assessor to measure ventilatory function across three readings and derive an impairment rating from the best reading. The second edition proposes a number of different methods for assessing the severity of respiratory impairment (including spirometry, gas transfer and vO_2 max), and directs the assessor to select the most appropriate method under the circumstances. The respiratory chapter also now incorporates separate means

of assessing asthma,[16] lung cancer and mesothelioma,[17] and obstructive sleep apnoea.[18]

Chapter 4: Disfigurement and Skin Disorders

Similarly, the new Chapter 4 (Disfigurement and Skin Disorders) for the first time allows an assessment of bodily disfigurement,[19] and provides for separate assessment of scarring and disfigurement of the face,[20] as well as retaining assessment criteria for skin disorders generally. The concepts of intermittent, constant and complex treatment are also now usefully defined for the purposes of assessing skin disorders under Table 4.1.

Chapter 9: Musculoskeletal System

The musculoskeletal chapter incorporates the most numerous, comprehensive and complex changes to the *Guide*. Any practitioners who transitioned from the *AMA Guides* second edition to the fourth edition will recognise the basic shift from range of motion to diagnosis-related estimates (DRE) for assessing spinal impairment. Aside from that change however, we now have 18 tables overall (as compared with 6) and numerous impermissible ratings combinations within and between those tables (particularly relating to combining musculoskeletal and neurological ratings).

The new musculoskeletal chapter is divided into three parts: lower extremities, upper extremities and the spine. Maximum impairment values (as discussed above) apply across this chapter – for example, the maximum impairment value for multiple impairments of a hindfoot and ankle is 25%, while the maximum for multiple impairments of a knee is 40%. Calculating lower extremity impairment will involve both adding and combining impairments, but in general, impairments for each region of the lower extremity should be combined (the exceptions being that you must add impairments within a joint, and for each individual toe, and combine the resultant figure with any others obtained for the foot to derive the total impairment for that foot). Practitioners should also note that ratings involving spinal nerve root impairment (Table 9.6) cannot be combined with a DRE lumbar spine rating (Table 9.17) and should be aware of any similar prohibited combinations throughout Chapter 9.

The shift to DRE to assess the spine is perhaps the most significant change. Much of our work involves understanding the assessment of spinal function and pathology to some degree, and the new regime requires certain clinical criteria to be met in order to progress from one DRE category to the next. In general (and this pertains to the cervical, thoracic and lumbar spines), assessors will need to obtain a history and clinical findings compatible with the injury claimed in order to allocate an impairment rating. These clinical findings can include muscle guarding or spasm, an asymmetric loss of range of motion or non-verifiable radiculopathy (that is, pain in the nerve root without any objective findings as to the origin of that pain). Clinically significant radiculopathy, disc herniation or compression fractures of a vertebral body (less than 25%), healed posterior element fractures without dislocation or alteration of motion segment integrity and transverse process fractures with displacement (but without involvement of the spinal canal) will also attract an 8% rating.

Thereafter, the spine ratings increase according to (among other things) the severity of the fractures and resultant disruption to the spinal canal, the degree of loss of motion segment integrity and, in the case of the cervical spine, the degree of neurological loss. Practitioners should be aware that multi-level fractures of the spine will increase the DRE category of impairment by one or two levels (depending on the absence or presence of neurological compromise).[21]

Chapter 12: Neurological System

The methodology for assessing neurological impairment has also been radically overhauled. We now have 17 tables (where we previously had 5) and there are multiple impermissible combinations. By way of an overview, cerebral impairment is now assessed according to the following four categories:

- consciousness or awareness (Tables 12.1, 12.2 and 12.3);
- memory, learning, abstract reasoning and problem-solving ability (Table 12.2);
- communication (Tables 12.3.1 and 12.3.2); and
- emotional/behavioural (Table 12.4).

We must now take only the highest rating from these four categories, and ratings from each category cannot be combined. The highest rating may then be combined with >>

any other table in the chapter or the *Guide* overall.

There are tables for assessing each of the cranial nerves[22] and separate tables for assessing neurological impairment involving other body systems and function.[23]

Complex Regional Pain Syndrome (CRPS)

Finally, the second edition includes a methodology for assessing impairment as a result of CRPS. Figure 9-E lists objective diagnostic criteria (objective signs) for CRPS *of which at least eight must be present* in order to attract an impairment rating. The *Guide* proposes two methodologies for assessing CRPS should at least eight criteria be present – the first methodology is used to assess CRPS 1 (reflex sympathetic dystrophy) and the second CRPS 11 (causalgia). Only one of the two methodologies may be used, and ratings obtained under each methodology may not be combined.

SOME CONCLUSIONS

Overall, the second edition places a much greater emphasis on diagnosing specific disorders as well as functional outcomes. This in turn increases the need for medical examiners and report end-users to understand and identify the components that now lead to an impairment. Familiarisation with the second edition assessment criteria will be a high priority for ensuring accurate, appropriate and robust impairment-assessment outcomes.

The implementation of the second edition will also raise many questions and debates regarding interpretation and application. There will no doubt be instances where an entitlement for the same condition under the first edition appears to be reduced under the second edition and *vice versa*. Similarly, the shift away from concepts like 'pain', 'degree of difficulty' and 'range of motion' toward seemingly more objective clinical criteria are not regarded by all as a positive development. On the other hand, the increased range of conditions and pathologies now assessable under this second edition should arguably be viewed as a positive step for injured workers – both in terms of preserving their current rights and entitlements under the Act and expanding and clarifying the injuries and conditions that will attract an impairment rating. ■

Notes: **1** *Safety, Rehabilitation and Compensation Act* 1988 (Cth) (SRC Act) s48. **2** SRC Act s45. **3** Any reference to Comcare, unless the contrary intention appears, includes a licensed authority or corporation under the Act – s4(10) and (10A). **4** [2005] FCAFC 262. **5** *Canute v Comcare* [2006] HCA 47 (28 September 2006). **6** These factors are: the duration of the impairment; the likelihood of improvement in the employee's condition; whether the employee has undertaken all reasonable rehabilitative treatment for the impairment, and any other relevant matters. **7** SRC Act s24(5). **8** Note that Jurisdictional Policy Advice No. 2005/10, issued by Comcare in respect to the second edition *Guide*, provides: '[W]here the initial claim for compensation for permanent impairment was determined under the first edition of the *Guide*, in determining the degree of any subsequent increase, the degree of permanent impairment or non-economic loss shall not be less than the degree determined under the provisions of the first edition of the *Guide*, unless that determination would not have been made but for a false statement or misrepresentation of a person.' **9** Division 1 – Assessment of the Degree of an Employee's Permanent Impairment Resulting from an Injury. **10** Chapter 13 – The Haematopoietic System. **11** Comcare (2005) *Guide to the Assessment of the Degree of Permanent Impairment*, p11 (the second edition). **12** ADLs are now individually included in Chapters 1 (cardiovascular), 4 (disfigurement and skin disorders), 5 (psychiatric condition), 8 (digestive system), 9 (musculoskeletal) and 12 (neurological). **13** *Whittaker v Comcare* (1998) 28 AAR 55. **14** Those exceptions are psychiatric, visual system and hearing impairments and chronic pain conditions (except migraines and headaches). **15** Chapter 2 of the second edition. **16** Chapter 2 – Figure 2A and Table 2.2. **17** Chapter 2 – 2.3. **18** Chapter 2 – Figure 2-B and Table 2.4 (other sleep disorders to be assessed under Table 12.1.3). **19** Chapter 4 – Table 4.3. **20** Chapter 4 – Table 4.2. **21** Second edition, p113. **22** Tables 12.5.1 to 12.5.6. **23** Namely, the respiratory, urinary and anorectal system and sexual functioning.

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