OUR REF: GAP / 191877
YOUR REF:

30 July 2024

Return to Work SA Stakeholder Representative Consultation Group (SRCG)
c/- KPMG

BY EMAIL: IAGconsultation@KPMG.com.au

Dear Sir/Madam

Formal Consultation Feedback on draft IAG Third Edition

1. Thank you for the opportunity to provide feedback on the last consultation opportunity for your draft Impairment Assessment Guidelines, 3rd Edition (IAGs 3).

Background

2. As per your communication, the RTWSA Stakeholder Representative Consultation Group and Project Team, with the assistance of KPMG, is undertaking a formal consultation period for 6 weeks on the draft IAGs 3, with the opportunity for written feedback submissions concluding at 12 PM on Wednesday, 31 July 2024. You also convened two face-to-face workshops to facilitate discussion on select issues. Partners of the workers compensation team have attended and, voiced concern we have some issues of your draft IAGs 3, at your workshop.

3. As you may be aware, DBH Lawyers (formally Duncan Basheer Hannon Lawyers) have been providing legal services for injured workers and other misfortunate victims of personal injury in South Australia for over 50 years. We have a dedicated team of lawyers and support staff who specialise in work-related injury claims. We offer our clients a wide range of expertise and in-depth knowledge in this area of law, including where there is overlap in other areas of personal injury or civil law.

4. Our workers compensation team have experience in handling claims under the *Workers Rehabilitation & Compensation Act 1986 ("**WRC Act**")* (now repealed) and have continued to handle claims whilst they transitioned into the *Return to Work Act 2014 ("**the RTW Act**")*, the first iteration of the Impairment Assessment Guidelines (current), the

2nd edition (now repealed) and as such, our team of specialists are best placed to consider and provide feedback on some perceived issues with the proposed draft IAG 3.

5. The introduction of the RTW Act was touted as being a fundamental change to workers compensation claims in South Australia imposing "clear, unambiguous boundaries".[1] It was made clear that employer premiums were intended to result in a fully funded scheme. It also introduced the concept of a "seriously injured worker" which at the time, until more recent legislative amendments in August 2022, required a physically or psychiatrically injured worker to be assessed as suffering a whole person impairment ("WPI") of 30% or more. It is also important to note that injured workers could not have their physical impairment and any psychiatric impairment combined to achieve the 30% WPI threshold. The RTW Act was amended by Parliament on 14 July 2022, most significantly, by way of:-

   5.1. Embedding the principles for the combination of impairments set out in the *Summerfield* decision, while finding cost savings in other areas of the Return to Work scheme to help keep the average premium rate below 2.00%[2];

   5.2. increasing the threshold for seriously injured worker ("***SIW***") suffering physical injuries from 30% WPI up to 35% WPI.

6. A SIW is then entitled to income support until retirement age, lifetime care, support and medical and like expenses.

7. One of the unambiguous boundaries is a finite entitlement period to income support payments for injured workers other than those few assessed as SIW. Injured workers are entitled to a maximum of 104 weeks of income support entitlements, even if they are certified medically unfit to return to any kind of work after that two-year period. In our experience, this often places injured workers in the insidious position of resorting to total and permanent disablement claims, income protection claims, if either of which are available to them, otherwise they are forced to live off their savings, if they have any, or apply for Centrelink benefits. It is important to note that Centrelink benefits are not usually available to injured workers on working visas. In this context, an injured workers ability to access their workers compensation lump sum entitlement in a predictable and timely manner is critical, as the lump sum compensation is often relied on to

[1] The Hon. John Rau MP, Government Gazette, House of Assembly, 6 August 2014
[2] RTWSA website "News room" page: https://www.rtwsa.com/about-us/news-room/articles/significant-reforms-to-the-return-to-work-act-2014

"make ends meet" once an injured workers income support entitlements have ceased[3].

8. Section 58 of the RTW Act allows for modest noneconomic loss lump sum payments for those suffering permanent impairment on account of physical work injuries of between 5% WPI to 100% WPI (with the maximum lump sum payable from 50% WPI). Clauses 1.18 and 1.19 of draft IAG 3 make it clear that pain and suffering is not assessable.

9. There are no lump sum payments available for injured workers suffering 1% – 4% WPI. There is also no lump sum entitlement available for workers suffering permanent psychiatric impairment on account of work injuries.

10. It is important to note that the RTWSA Corporation appears to be financially quite healthy, maintaining their average premium rate for the 2024 – 25 financial year at 1.85% following strong return to work rates and "remain at and return to work performance".[4] Whilst it would appear that RTWSA's Annual Report for the financial year ending 2024 will not be published until late 2024 or early 2025, it appears to us there is no financial necessity for any amendment to the current Impairment Assessment Guidelines ("***IAG 1***").

11. We note in a recent actuarial report of Finity, the actual serious injury claims since 2015 have been 26 less than expected.[5] The increase in the WPI threshold from 30% WPI to 35% WPI will reduce the number of SIWs even further.

12. Whilst the Finity actuarial review of 2023 makes no allowance for any potential changes that could emerge as a result of the present review of the Impairment Assessment Guidelines, it appears there is no financial need to amend the Impairment Assessment Guidelines.

13. Lastly, we note that there has been much Court litigation surrounding the current version of the Impairment Assessment Guidelines which came into effect for all whole person impairments conducted on or after 1 July 2015. The state of the workers compensation scheme could be described as reasonably certain as a consequence of the various Full Court and Court of Appeal decisions of South Australia's Supreme Court as well as the Full Bench and South Australian Employment Tribunal decisions which have followed those precedents. In our view, a change proposed to the IAGs will lead to a significant amount of re-litigation of many issues already decided,

[3] Which, for most injured workers, will be 104 weeks or 2 years after the date of injury.
[4] Ibid, https://www.rtwsa.com/about-us/news-room/articles/returntoworksa-maintains-average-premium-rate-for-2024-25
[5] Finity Consulting Pty Ltd, Scheme Actuarial Valuation as at 31 December 2023, p 28

merely due to slightly different wording or new clauses inserted into these draft IAG 3.[6]

14. Our feedback on the relevant chapters are as follows.

Chapter 1 – Introduction

15. The IAGs 3, clause 1.2, is drafted with the inference that will commence in 2024. It is now the end of July 2024. Further, we understand from the workshop that the complexity of the changes in IAG 3 compared to IAG 1, not to mention the increasing volume from 128 pages up to now 203 pages, will require a significant amount of time to train the current Accredited Assessors as well as any new Accredited Assessors to undertake the permanent impairment assessments in accordance with the new IAG 3.

16. There is a deviation from the current requirement of maximum medical improvement (MMI) to medical stability. We understand that will require the passage of a separate bill before Parliament, which proposes to amend, *inter alia*, section 22(7)(a) of the RTW Act and clause 2.3 of IAG one which presently requires maximum medical improvement or "MMI".[7]

17. Clause 1.15 of IAG 3 introduces a new concept of "effective communication" between all parties concerned with an assessment, to enable the "*fair, efficient and timely undertaking of assessments*". A review of the draft IAG 3 has revealed some correlation with chapter 17 entitled Assessor Selection Process, particularly clauses 17.1, 17.6 and 17.7. However, in our view the drafted clauses in this chapter and chapter 17 do not go far enough to ensure consistency and fairness in the worker and/or their legal representatives been provided with:-

    17.1. timely details of booking of their permanent impairment assessment/s;

    17.2. a draft of the report request, authored by the permanent impairment assessment requestor (claims agent or self-insured employer or their solicitors) in Microsoft Word format to enable the worker to meaningfully contribute to suggest amendments or additional relevant information or medical evidence

[6] C.f. - *Return to Work Corporation of South Australia v Opie & Anor* [2022] SASCA 12, *Paschalis v Return to Work Corporation of South Australia & Anor* [2021] SASCFC 44

[7] Ss 8 and s 5 of Schedule 1, Transitional Provisions, *Return to Work (Employment and Progressive Injuries) Amendment Bill 2024*

18. The current part of chapter 1 under the subheading Communication appears aspirational and serves no utility. It is reminiscent of the Service Standards under the RTW Act, which in our experience are often also contravened by the claims agent, without any ramification.

19. Clause 17.6 of Chapter 17 currently reads:-

"*The requestor must ensure the worker is provided with draft report request before it is sent to the assessor. The requestor must give the worker at least 10 business days to consider the request and provide them with an opportunity to raise any issues, errors or omissions*."

20. In our experience, the draft PIA report request is often sent to the worker or the representative only 10 days shy of the actual permanent impairment assessment, leaving no real opportunity for constructive feedback in the drafting of the report request or for identifying any outstanding relevant documentation required for the assessment.

21. Clause 17.7 gives the requestor options and excuses for delaying the booking of the permanent impairment assessment appointment or rebooking the appointment, even when the "time remaining is insufficient" is occasioned by the requestor's own delays.

22. Clause 17.4 seems to suggest that an injured worker or a claims agent will need to first obtain medical stability evidence prior to the scheduling of the worker's PIA appointment. In our view, that is inconsistent with the requirements of section 22(7)(a) of the RTW Act and under the current IAG, it is up to the Accredited Assessor on the day of the assessment to determine MMI or medical stability.[8] the responsibility in determining medical stability should be left as it presently is with the Accredited Assessor on the day of their assessment of the injured worker.

23. It is not clear how clause 1.38 of IAG 3 will be applied in practice. In our view, it is likely to lead to significant disputation, even more so where the worker or their representative is not provided the opportunity by the requestor to markup suggested amendments or "disagreements" with aspects of the draft PIA report request in Track Changes.

24. Clause 1.41 of IAG 3 provides *"… there is also no requirement that impairment from a pre-existing or subsequent injury or cause be symptomatic in order for it to need to be disregarded in the whole person impairment assessment* ". In our view, this unreasonably disadvantages workers and earmarks them for deduction on lump sum entitlements on account of asymptomatic conditions in the same body part/function as the work injury. Nothing is provided within this chapter

[8] see clause 1.13 1.14 of IAG 1

to ameliorate the harsh outcome where the extent of the deduction for pre-existing impairment does not accurately reflect the level, or lack thereof, of functional impairment.[9] In our view, a clause within this chapter should be amended to that effect.

25. In clause 1.45 under the subheading Information required for assessments, "*all relevant information*" should be limited to only directly relevant information. Clause 1.46 goes on to provide:-

"*The requestor is to use best endeavours to obtain all relevant medical and allied health information, including results of all clinical investigations related to the work injury that is to be assessed and is to provide that material to the assessor*"

26. In our view, this is a far-reaching clause and invites claims agent's or claims managers of a self-insured employer to make various requests for provision of treating doctors' notes, trawl through treating medical notes, physiotherapy or chiropractic notes in the pursuit of "*all clinical investigations*", many of which may not relate at all to the work injury because they are trying to satisfy themselves of compliance with section 22(8)(b) of the RTW Act. It also raises the question as to who pays for obtaining all the relevant medical information required for the permanent impairment assessment. In our view, it should be clearly mandated in the IAG 3 that irrespective of who obtained the medical information purportedly required under these IAG 3, the relevant claims agent or self-insured employer charged with arranging the permanent impairment assessment, will fund or reimburse the worker for the costs associated with the investigations all relevant medical information obtained.

Chapter 2 – Upper Extremity

27. We note 2.9 of IAG 3 requires "*symptoms to have persisted*" for peripheral nerve injuries for at least 12 months, otherwise they cannot be assessed. This puts injured workers with such injuries in a difficult predicament particularly so in cases where they have made a strident effort to return to work and are earning at or above their notional weekly earning entitlement to income support payments, such that they will only have 12 months of medical expense entitlements under the RTW Act[10].

[9] such as the case for a bilateral pars defect – c.f. *Perez v Return to Work Corporation of SA and WALGA Mining Services Pty Ltd* [2024] SAET 9, Rossi DPJ at [73], referring to the case of *Frkic* or asymptomatic congenital thoracic fusion *Belperio v Return to Work SA* [2018] SAET 210.

[10] As provided for at Section 30(22) of the RTW Act.

28. Similarly, clause 2.16 stipulates adhesive capsulitis cannot be rated (presumably assessed for permanent residual impairment purposes) until at least 18 months after an initial diagnosis.

29. Clause 2.18 of IAG 3 requires shoulder impingement to have been "*present for at least 12 months*".

30. We note the significant changes in respect of assessment of Complex Regional Pain Syndrome (CRPS) in IAG 3 from clauses 2.23 through 2.30 inclusive of examples at page 37.

31. Again, we hold concerns that 2.26 requires CRPS diagnosis to have "*been present for at least 18 months and has stabilised*". Furthermore, the diagnosis is to have been established by an appropriate medical specialist and the diagnosis confirmed by more than one medical specialist. Presumably, this is a pain specialist. In our experience, there are limited pain specialists in South Australia who are willing to provide treatment to workers compensation claimants. Furthermore, the majority of people who suffer CRPS develop the often debilitating condition following surgery for a work injury. Ordinarily, surgery does not occur on the day of the work injury or at the beginning of the workers income support entitlement period. For example, they may be 12 months or 18 months into their maximum 24-month entitlement period for weekly payments[11] and, by the time they are seen by the first pain specialist and diagnosed with CRPS, after excluding any other possible diagnosis that better explains the signs and symptoms, they may only have 12 months or less left of medical entitlements under the RTW Act.

32. We hold concerns many injured workers suffering CRPS which is later diagnosed in their work injury rehabilitation journey, will be locked out of medical treatment entitlements as a consequence of the presently drafted clause 2.26 of IAG 3, will also not be eligible to have their CRPS assessed for permanent residual impairment purposes.

33. Clause 2.29 Table 2.2 and clause 2.30 Table 2.3 introduces what appears to be an entirely new CRPS class rating score and rating table. This appears to limit the clinical judgment of the Accredited Assessor to the detriment of the injured worker. Table 2.4 introduces an ADL functioning assessment tool covering activities of daily living including self-care, cleaning, meal preparation, gardening, transport, shopping and social activity. Values are assigned independent (0), independent with difficulty (1), able to perform independently with aids (2), able to perform with assistance (3), able to perform with aids AND assistance (4), and unable to perform (5) with the values from lowest to highest and selecting the median (Middle value). This is similar to

[11] For injured workers other than seriously injured workers.

the psychiatric GEPIC assessment and in our view, is likely to result in a reduction in the injured worker's CRPS assessment and potential eligibility for SIW entitlements and/or lump sum compensation.

Chapter 3 – Lower Extremity

34. Total ankle replacements are assessed in accordance with clause 3.36 of both IAG 1 and IAG 3. It is noted that draft IAG 3 allows for the potential maximum 35% WPI for a class for "very poor" ankle replacement. It is also noted that a good result of an ankle replacement has been decreased from 12% WPI to 10% WPI, whereas a fair result and poor result have been increased from 16% to 18% WPI and 20% to 25% WPI, respectively. However, the "very poor" categorisation appears to require "*a poor result with catastrophic failure of an implant; and/or complicated by significant, chronic infection*". Furthermore, "*a report from the treating surgeon must be obtained to assess impairment in this class*".

35. We call for production on the actuaries' data on how many injured workers have or are likely to be assessed for a total ankle replacement. In our experience, a total ankle replacement is a very rare, almost unheard of, procedure for injured workers.

36. The consideration of Lisfranc fractures/dislocations at Table 3.3 of IAG 3 is welcomed, however, we note the requirement (again) for impairments "*not to be assessed before 18 months following the date of injury*". In any event, a non-displaced and symptomatic Lisfranc fracture would only result in 1% WPI, which in our experience, would be the vast majority of injured workers suffering Lisfranc fractures (if not "*healed, no objective deficits*").

37. We note clause 3.40 of IAG 3 proposes to limit and the replacement point score to lower extremity impairment (LEI) and WPI to a maximum of 25% WPI for a Class 3 "*poor*" and only injured workers with a "*poor result with catastrophic failure of an implant; and/or complicated by significant chronic infection*" along with a report from the treating surgeon, can they be considered for Class 4 "*very poor*" with a maximum 35% WPI. In our view, the proposed change is arbitrary and unfavourable for injured workers, particularly in respect of the directions for deduction for pre-existing conditions such as arthritis clauses 1.7, 3.24, and 3.25.

38. Furthermore that need for a treating surgeon to be required to provide an assessment of being a "very poor" outcome would be unlikely, potentially opening themselves up for alternative litigation. This requirement will not only reduce entitlements but significantly delay a worker's ability to access their entitlement and should be removed completely.

Chapter 4 – Spine

39. The direction to the Accredited Assessors at page 67 of IAG 3 wherein it says "*the impairment assessment report should set out the reasoning for the assessment of the work-related impairment and the relationship of the rating to the injury*" goes to the question of causation/compensability, which on the current state of the case law with regard to purpose and scope of the Section 22 Permanent Impairment Assessment process. It is an inappropriate exercise for Accredited Assessors to undertake, even more so where there is no requirement between the worker/their representative and the report requestor to agree the content or factual underpinning of the PIA report request.

40. It is our submission that this should be removed in full.

41. In Clause 4.16, the word "significant" is included before the words "muscle guarding or spasm". . We submit the addition of the word "significant" in this context is unnecessary and creates real potential for protracted litigation. Most injured workers who do not make a full recovery from a spine injury, and who are not candidates for surgical treatment, will fall withing the DRE Category 2 criteria. The degree of WPI assessable for a DRE Category 2 injury (between 5% and 8%) results in modest lump sum compensation[12]. Noting the same, the proposed changes will affect a substantial number of injured workers, who will likely bear some of the costs of litigation arising from the proposed change from a modest lump sum payment[13]. The current drafting creates ambiguity as to whether the word "significant" applies only to findings with regard to muscle guarding or spasm, or also applies to findings with regard to range of motion, radicular complaints, etc. Further, the current IAG 3 draft does not define the word "significant" or provide the Assessor with any direction or guidance as to the nature and/or extent of findings that could be regarded as significant (as compared to insignificant or not significant findings). Noting the same, we would propose removing the word "significant" from Clause 4.16 of the draft.

42. In clause 4.20, when assessing impairment caused by radiculopathy, the words "*clinically significant*" have been added before the words "loss of asymmetry of tendon reflexes anatomically related to the injury". . In line with our comments in the above paragraph 39, we

[12] In the range of approximately $18,000.00 to $55,000.00 total, assuming no discounts are applied to the Section 56 lump sum component on application of the Age Factor or Hours Worked Factor.

[13] Noting most law firms who act for injured workers will do so on a "conditional, pay on completion basis", where payment of legal fees is deferred until the lump sum is received.

submit the addition of the words “clinically significant” in this context is unnecessary and creates real potential for protracted litigation.

Chapter 5 – Nervous System

43. Clause 5.7 makes provision for the assessment of spinal cord injury, cauda equina, bilateral nerve root or lumbosacral plexus injury causing bladder, bowel or sexual dysfunction, to be done by an accredited assessor “*…and where relevant the assistance of a neurologist, gynecologist or colorectal surgeon”.*

44. In addition, Clause 5.11 provides that “*an assessor can make a request of the requestor that another accredited specialty be engaged to undertake part of the assessment with that opinion to be then used for the purpose of determining the impairment being assessed. If such a request is made, the requestor is to contact the person being assessed or their representative to advise of the request and the specialty nominated with the person being assessed given the option, in accordance with Chapter 17 and in particular paragraph 17.4 to choose an accredited assessor within that specialty*.”

45. We would submit the wording of Clause 5.7 should be amended so it aligns with the wording of Clause 5.11, giving the injured worker the option to select the “…*neurologist, gynecologist or colorectal surgeon…”* involved in their assessment.

46. Further, clarification should be added to Clause 5.11 (and, by extension, Clause 5.7) about the manner in which the “secondary assessor” participates in the assessment, and in particular:

    46.1. Does the “secondary assessor” provide a written report to the selected assessor for the purposes of the final PIA report?

    46.2. If so, does the “secondary assessor” report need to comply with the IAG, and is the injured worker entitled to a copy of that report?

    46.3. If the “secondary assessor” does not need to provide a written report, what documentation is the secondary assessor required to retain and/or make available for the purposes of the PIA process (for reference in the event of a dispute regarding the PIA process/report)?

47. Clause 5.17 regarding the assessment of traumatic brain injury has been amended to allow assessment of brain injuries where there is “moderate impact or greater to the head” or an injury involving a “moderate to high energy impact”. This is welcomed, however, thankfully in our experience, traumatic brain injuries occurring at work are infrequent. Furthermore, we note the requirement of “*should be*

evidence" is replaced with the wording "*must be evidence*", which is a more difficult threshold to achieve.

48. Additionally, a new clause 5.18 mandates at least 18 months following the date of injury before an assessment of permanent impairment is undertaken. This is unlikely to be problematic for injured workers suffering a catastrophic traumatic brain injury, however, those suffering a mild or moderate brain injury who still fall short of the seriously injured worker threshold of 35% WPI, will be faced with an arduous race to gather all necessary medical evidence and reports prior to the end of their weekly payment entitlements within 24 months from the date of injury.

49. Clause 5.19 of IAG 3 amends the current 5.10 of IAG one and now proposes:-

In order to qualify for an assessment of traumatic brain injury at least one of the following must be confirmed:

(a) clinically documented abnormalities in initial post injury Glasgow Coma Scale with a score of 12 or below and requiring detailed information to the assessor as to the course of change in the Glasgow Coma Scale Score from the time of injury;

(b) significant duration of post traumatic amnesia of no less than 12 hours;

(c) significant intracranial pathology on specific testing being CT brain, MRI brain and where appropriate PEET scanning.

50. Whilst the changes are welcome, in our view, the proposed updated criteria required to be met for an injured worker to be assessed for a traumatic brain injury continues to create a situation in which the nature and quality of the initial medical treatment received by the injured worker dictates whether they can meet the criteria, resulting in situations where injured workers are unfairly and arbitrarily excluded.

In our experience, treating specialists will often be prepared to provide a diagnosis of traumatic brain injury where there is a clinical history of head trauma and consistent cognitive and behavioural symptoms in cases where the is no significant intracranial pathology. Sufficient observation and recording of GSC findings and PTA testing are often dependent on arbitrary factors like the timing of initial medical treatment, whether the injured worker was taken to a "major" hospital, the quality of the hospital triage, etc. Noting the same, we would propose expansion of the threshold criteria to include other criteria that are not dependent on the nature and quality of initial medical treatment, which could include:

50.1. A diagnosis of anosmia from a Neurologist or Neurosurgeon;

50.2. A diagnosis of traumatic brain injury from two appropriate specialists (Neurologist or Neurosurgeon);

50.3.

Chapter 6 – Ear, Nose, Throat and Related Structures

51. In respect of the requirements set out in clause 6.8 of IAG 3, it is our experience:

51.1. it is common for a Sleep Physicians to be involved in the treatment of sleep apnoea;

51.2. it is uncommon for Ear Nose and Throat Specialists to be involved in the treatment of sleep apnoea;

51.3. there is a current shortage of Ear Nose and Throat Specialists prepared to accept treating referrals for workers compensation matters involving sleep apnoea.

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52. As such, the proposed clause 6.8(a) appears to create an additional step that does not occur in the normal treating practice, and is occurring solely for the purpose of the PIA. Noting the same, we query;

52.1. what the purpose of the ENT review?

52.2. Whether the specialist review contemplated by the proposed clause 6.8(a) could be amended to include a Sleep Physician and/or an Ear Nose and Throat Specialists.

53. In respect of Table 6.3, in our experience, impairment ratings of between 0% WPI to 4% WPI are commonly assessed for injured workers suffering from impairment of mastication and deglutition due to dental deterioration. The addition of examples to this part of the IAG would assist the assessor (and other stakeholders) to identify whether an impairment should be the lower or higher end of the 1% WPI to 4% WPI range. Further, on the current wording of the proposed Table 6.3, an injured worker who reports that they have dry mouth and difficulty swallowing food requiring liquid chasers with meals will be assessed at 0% WPI. This outcome is inconsistent with the concept impairment arises from alteration to diet consequent on the work injury, and we would seek amendment to Table 6.3 to account for this circumstance (so that a WPI % is provided in the above situation).

54. In our submission, the timings of required timeframes for obtaining reports or that they be obtained within any specified timeframe prior to

the assessment, should be removed from IAG 3 or, alternatively, Regulations should be passed by this Government confirming an injured worker's medical expenses entitlements continue until such time as they have undergone the section 22 Whole Person Impairment assessment so they are not disadvantaged by the requirements for investigations, medical records or the obtaining of reports.

Chapter 7 – Urinary

55. We note clause 7.4 of IAG 3 is new and confirms a urologist should assess neurologically based clinical problems and where there are pelvic and sexual dysfunction issues, either a urologist or gynaecologist should assess that function. Whilst not a controversial clause, we note there is a very limited number of available assessors to undertake assessment of the urinary system. The added complexity and technicality of IAG 3 may dissuade current Accredited Assessors or deter new Accredited Assessors and, where there is a shortage or lack of availability in Accredited Assessors, such only stands to disadvantage injured workers.

56. We note clause 7.5 of IAG 3 now requires "*long term case histories from treating general practitioners and, where issues relating to pharmacology and drugs associated with sexual dysfunction, there should be information sought as to the effect of the medication from a relevant specialist such as a clinical pharmacologist*". This unnecessarily adds delays in complexity prior to the worker undergoing their Permanent Impairment Assessment. If the effect of the clause is absolutely necessary, we submit it should be worded such that the Accredited Assessor can request that information if they consider it will be of benefit to them.

57. Clause 7.9 tends to suggest that treatment options must have been provided to the injured worker by a urologist or gynaecologist before the assessment. In our view, it is not clear what happens to the status of the injured worker's Permanent Impairment Assessment in situations where treatment options have not been advised. This should be clarified, noting the potential conflict with clause 1.43.

Chapter 9 – Hearing

58. We note clause 9.2 of IAG 3 introduces Cortical Evoked Response Audiometry (CERA) into the IAGs. In our view, CERA is likely to significantly delay the injured worker's permanent impairment assessment given that there is only one provider in South Australia (ONDC) that can undertake this test. If there is a waiting list for CERA testing at ONDC, workers will be disadvantaged by the application of presbycusis i.e. age-related loss which commences for males at age 56 and females at age 69.

59. The CERA test is approximately 3 hours in duration. Given the prolonged duration of the test, there has been incidences of workers demonstrating fatigue during the testing which an Audiologist (ONDC) has expressed that fatigue may affect the reliability of the results.

60. Whilst CERA testing is generally accepted as an objective and reliable testing, it should not become a regular practice for the purpose of a PIA. Further, it should ultimately be the assessor's discretion to accept or reject the results of the CERA testing as conclusive evidence.

61. Clause 9.2 needs to incorporate the Assessor's ability to exercise their clinical judgment as to whether to accept the CERA testing as conclusive evidence or not.

62. What if a worker who has undergone various Pure Tone Audiometry ('PTA') which all appear to be uniform whereas the CERA result appears to be an outlier (real case scenario). The Assessor should not be limited to basing their assessment of permanent impairment on the CERA testing alone.

63. We note clause 9.12 of IAG 3 amends clause 9.11 of IAG 1 consideration given to attendances as to its impact on ADLs. Whilst examples have been included to assist Assessors assigning the most appropriate loading for tinnitus, the assessor should be required to record in their assessment what the worker *actually* reported during the assessment and what questions were specifically asked or put to the worker.

64. In our experience, there has been several scenarios where the Assessor has inserted a blanket sentence stating "*worker reports constant tinnitus with no effect on his ADL. Accordingly, I do not believe a loading is warranted*". This has resulted in disputation as the loading for tinnitus can sometimes be the benchmark of whether a worker meets the 8.8%BHI or not.

65. We note clause 9.15 of IAG 3 includes a new requirement for an audiogram being undertaken after ceasing work and prior to the assessment in determining a non-work-related component of the workers current impairment.

66. Whilst the inclusion of section 188(2) and (3) of the *RTW Act* is consistent with the objectives of determining noise induced hearing loss for a worker not being a person who has retired from employment or a worker who has retired from employment on account of age or ill-health, the inclusion of considering audiogram undertaken after ceasing work and prior to the assessment in determining any non-work related component is an impossible task because:

66.1. the assessor would not have information surrounding the testing condition when the audiogram was conducted i.e. whether performed in a sound-proof booth/room, whether the worker was exposed to noise before the test was conducted;

66.2. the assessor would not have information as to what equipment was used or its calibration;

66.3. there is always a variation in audiograms and results may or may not be within the test/retest variation;

66.4. the worker will be disadvantaged not only by the application of presbycusis i.e. age-related loss, but also if the assessor considers that there should be further deduction for non-work-related components

67. This will result in assessors speculating non-work-related impairment and deducting in addition to the deduction for presbycusis, thereby resulting in a double deduction.

68. The wording if the worker has "ceased working" is inconsistent with the objectives of section 188(2) and (3) of the *RTW Act*. If a worker has ceased working, it does not necessarily mean that their noise induced hearing loss has stabilised noting that the condition is a gradual onset condition. In our submission, "ceased working" should be replaced with "retired on account of age or ill-health" to ensure consistency with the objectives of s188(2) and (3) of the *RTW Act*.

69. In respect of clause 9.18 of IAG 3, whilst the inclusion of additional losses at 500 Hz, 1,000 Hz and 1,500 Hz provides a perceived benefit to the worker in their overall impairment assessment, there needs to be clarification that "*continuous noise exposure*" that has been "prolonged" does not necessarily mean with the one nominated employer but rather one or more than one employer over the course of the worker's working life, as is often the case in reality.

70. Workers have generally been disadvantaged by the compliance review process of self-insured employers who do not accept the inclusion of the 1,500 Hz despite the worker's 30 or 40 year history to industrial noise exposure.

Chapter 10 – Visual

71. As per clause 10.10 of IAG 3, we note Ophthalmologists are permitted to undertake relevant trigeminal nerve assessment in accordance with clause 5.24 in IAG 3.

72. We note there is a very limited number of available assessors (presently only one) to undertake assessment of the visual system.

The added complexity and technicality of IAG 3 may dissuade the current Accredited Assessor or deter new Accredited Assessors and, where there is a shortage or lack of availability in Accredited Assessors, such only stands to disadvantage injured workers.

Chapter 12 Endocrine

73. A further provision has been incorporated into the proposed guidelines in 12.4, namely that if the provision of medication would result in the substantial reduction or total elimination of a worker's WPI than the assessment must take place with the use of the medication, however an assessor can increase WPI by 1,2 or 3% if the withdrawal of medication would result in the worker reverting to the original WPI.

74. This is an unfair assessment term as a worker is limited by the time in which s/he can access paid medication in accordance with s33 of the Act and as such should only be incorporated should the worker be able to continue have paid medication as long as it is reasonably required.

75. Replacing table 10-8 from AMA-5 with Table 12.1, looks to be a fairer assessment for workers and we support that change.

Chapter 13 – Skin

76. The proposed wording of clause 13.4 appears to limit any deduction for pre-existing or unrelated scarring to pre-existing or unrelated scarring to the body part(s) affected by the work injury. Given this change would be a departure from the current status of the case law on this issue, we would recommend amending the wording of clause 13.4 to make the above clear and unambiguous by adding the following words to the end of the clause: "*…affecting the relevant body part or parts".*

Chapter 14 – Cardiovascular

77. We note under the subheading "testing" and clause 14.9 which stipulates:-

If investigations provided are inadequate for a proper assessment to be made, the assessor must consider the value of proceeding with the evaluation of whole person impairment without the adequate investigations and data (see Chapter 1 in these Guidelines, in relation to information required for assessment and ordering of additional investigations).

78. We agree that it is up to the Assessor to determine whether they have adequate investigations and data to proceed with their whole person impairment. The language in Chapter 1 and Appendix 1 should be consistent with the clause in this Chapter i.e. it should not be for a claims officer of a Compensating Authority to determine whether they have provided an Accredited Assessor with sufficient medical records or investigations.

Chapter 15 – Digestive System

79. Clause 15.2 requires "reproducible objective evidence of upper digestive tract disease, anatomic loss or alteration" however, in our submission this requires further clarification of examples of such objective evidence.

80. Clause 15.5, in respect of assessments of colorectal disease and anal disorders, require a full colonoscopy report. This is onerous for injured workers, especially those outside of their medical expenses' entitlement period. As submitted above, Regulations should be passed by this Government confirming an injured worker's medical expenses entitlements continue until such time as they have undergone their section 22 Whole Person Impairment assessment, so they are not disadvantaged by the requirements for undergoing such significant and costly medical investigations, obtaining medical records or the obtaining of reports only to appease these requirements in IAG 3.

81. With respect to submission 80 above, we also note that should this not be incorporated into the Act, it is likely that, injured workers will be forced to seek these procedures through the public health system, which is already at capacity. These are insured injuries, sustained at work, the costs of investigating and assessing same should not be borne by the State tax payer, but by the relevant insurer.

82. Clause 15.6 specifies "*ADL impact must not be elsewhere rated*". We query whether this contradicts the applicability of ADL impact in other Chapters of these draft IAG 3.

Chapter 16 – Psychiatric Disorders

83. It is our understanding that there are very few seriously injured workers, perhaps as little as 9 under the RTWSA Scheme, who have qualified under the current IAG 1 and the Guide to the Evaluation of Psychiatric Impairment for Clinicians (GEPIC). GEPIC assessments are limited to psychiatric injuries which is, defined under the *RTW Act* as mental harm other than sequential mental harm.

84. We further note that injured workers suffering psychiatric injuries are already disadvantaged in their eligibility for compensation under the

RTW Act, by the requirements of section 7(2)(b) in that employment must be "*the significant contributing cause*" of the psychiatric injury and there are a number of disqualifying factors including:

84.1. reasonable action taken in a reasonable manner by the employer to transfer, demote, discipline, counsel, retrench or dismiss the worker or a decision of the employer not to renew or extend a contract of service;

84.2. a decision of the employer, based on reasonable grounds, not to award or provide a promotion, transfer or benefit in connection with the worker's employment;

84.3. reasonable administrative action taken in a reasonable manner by the employer in connection with the worker's employment;

84.4. reasonable action taken in a reasonable manner under this Act affecting the worker.

85. In our submission, injured workers suffering residual Whole Person Impairment on account of pure mental harm injuries suffered out of or in the course of employment should be entitled to non-economic and economic loss lump sum entitlements, the same as physically injured workers.

Chapter 17 – Assessor selection process

86. We note the object and purpose of this chapter is expanded upon when compared with IAG 1 to now include:-

(a) expectations on the timeframes for completing a permanent impairment assessment;

(b) the matters that need to be taken into consideration when selecting an assessor;

(c) the process by which a worker is given a choice of who will assess their whole person impairment; and

(d) the process to be followed if the worker elects not to choose an assessor.

87. Further, clause 17.1 provides:

"*Every reasonable effort to be taken to minimise avoidable delays and facilitate the worker's permanent impairment assessment in a timely manner. On assessor selection by the worker under paragraph 17.4, or assistance election under paragraph 17.5, the requestor should act promptly to draft the report request and make the assessment*

appointment, noting that there may be a delay in some cases, such as when waiting for the receipt of further medical information"

88. It is our submission that the language here in clause 17.1 is too liberal in allowing delays in the process for 2 reasons:-

    1. the report requestor (claims agent or self-insured employer) will simply blame delays as being "unavoidable"; and/or

    2. the report requestor will assert medical evidence has not yet been obtained that a work injury or injuries have stabilised and that a permanent impairment assessment is required (in accordance with clause 17.4 of draft IAG 3)

89. Furthermore, somewhat contradictorily with draft clause 17.7, clause 17.1 tends to suggest the order of the PIA process is:-

    1. medical evidence of medical stability (per clause 17.4)

    2. worker selects assessor

    3. requestor drafts the report request

    4. request or makes the assessment appointment

90. There has been some confusion and litigation regarding the ordering of the PIA process under the current IAGs. The re-drafting of the IAGs and this draft IAG 3 is an opportunity to clarify the correct ordering of the PIA process. Some of that has been ameliorated by this government's amendments to section 115 (1) and the powers of the South Australian Employment Tribunal upon application for expedited decision under part 7 of the *RTW Act*, however, not entirely.[14]

91. We repeat what we said in respect of Chapter 1 about the issues as we see them with Chapter 17.

Appendix 1 – Notes for the requestor

92. We note there is a new subheading in this chapter '*Key matters to be identified*'. Clause 6 provides:-

    The requestor should provide an assessor with the information reasonably required by an assessor to initiate and undertake an assessment taking into account section 22(8) and related provisions. Chapter 1 of these Guidelines provides further guidance in this regard.

93. In our submission, when read in conjunction with clauses 7, 12 and 13, with wording such as "*reasonable steps should be taken to*

[14] C.f. *Sullivan v Return to Work Corporation of South Australia* [2023] SAET 109

identify", " *the requestor should ensure that , prior to requesting assessment , any relevant clinical studies*…" , …*the requestor send all relevant operation notes and imaging to the assessor* ", the clauses and their present wording are too liberal and allows, if not invites, claims agents or self-insured employers to go on fishing expeditions and trawl through any number of historical medical records of an injured worker, hoping to find relevant documents to forward to an assessor or at least, delay and frustrate the injured worker's permanent impairment assessment process.

94. There should be a clause or caveat in this chapter, as well as any other related chapters such as chapter 17 chapter 1 that it is the Accredited Assessor that determines whether further, apparently relevant, information is required for the assessment. At the moment, as the chapter is presently drafted, it is unclear and tends to suggest the requestor has the final say.

95. We repeat the concerns were raised earlier in Chapters 2, 3, 5 and 6 regarding the increased timeframe for the assessment of "some conditions" from clauses 15 through 46 inclusive of this chapter.

Conclusion

In conclusion, we are concerned that some of the changes suggested in the Draft IAG 3 will result in a more costly process for the scheme, delays for the injured workers and more pressure on an already at capacity public health system should all costs associated with the new requirements for a PIA not be sought during a worker's medical entitlement period.

Should you have any questions or queries or wish to discuss this submission please do not hesitate to contact us directly.

Yours faithfully
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Yours faithfully
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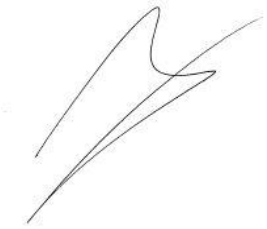

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