



Independent  
Review Office

New South Wales Personal  
Injury Compensation

# A SYSTEM IN transformation

**IRO Annual Seminar** | Thursday 17 June 2021 | UTS Aerial conference space



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**Simon Cohen**  
**Independent Review Officer**

# Welcome



## COVID – QR Code

### Wi-Fi

- > Username is **UTS-FunctionCentre**
- > Password: **conference2020**

### IRO App

- > Download the *Ignite Event Launcher* from the Apple or Google Store
- > Enter the event code **IRO2021**
- > Enter Username (sent to registered email address)
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# **The Honourable Victor Dominello MP**

## **Minister for Customer Service and Digital**



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# **The Honourable Judge Gerard Phillips** **President, Personal Injury Commission**



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**Richard Harding**  
**CEO, icare**



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# **Dr Petrina Casey**

**Executive Director**

**Motor Accidents Insurance Regulation**

**State Insurance Regulatory Authority**

**Dr Petrina Casey**

**SIRA**

17 June 2021



State Insurance  
Regulatory Authority



# About SIRA

We have three functions in stewarding the schemes

- Designing and reforming the schemes
- Supervising performance and enforcing compliance
- Innovating and engaging others to improve outcomes

10 regulatory approach principles guide how we perform those functions

- Customer focus
- Responsiveness
- Stewardship
- Consultation
- Evidence
- Innovation
- Efficiency
- Fairness
- Information
- Accountability

First principle of SIRA's regulatory approach:

*Everything SIRA does is guided by protecting the interests of its customers – policyholders and people who make claims, now and in the future'*



# A system view of customer experience

## Customer service conduct principles for insurers

1. Be efficient and easy to engage
2. Act fairly, with empathy and respect
3. Resolve customer concerns quickly, respect customers' time and be proactive
4. Have systems in place to identify and address customer concerns
5. Be accountable for actions and honest in interactions with customers

# A system view of health outcomes

- Compensation factors can impact participant health (*Harris et al, 2008 and Grant et al, 2014*)
- Perceived injustice leads to amplified pain perception and is associated with poor recovery (*Sullivan, Yakobov, Scott & Tait, 2014*)
- Involvement in the process is stressful, including lengthy claims process, medico-legal assessments and poor claims information (*Grant et al, 2014*)
- Adversarial relationships with insurers lead to negative health outcomes (*Elbers et al, 2012*)
- People claiming compensation have a lower physical and mental health profile than the general population (*Littleton et al, 2011*)

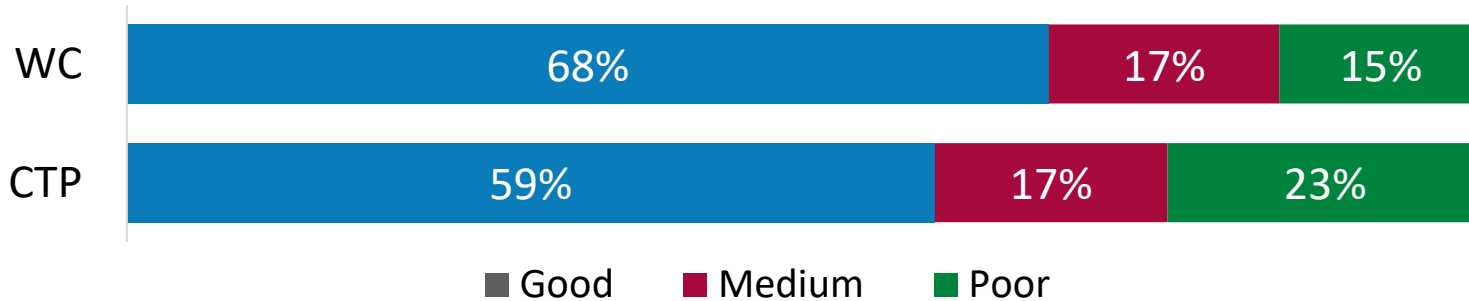
# An Australian first research project



- This research considered the experience of people who have claims in the workers compensation and CTP schemes across all the different insurer types.
- The participants were representative of the general population of people making claims in the schemes, based on age, gender, industry, language, locality and claim cost.
- Included those dealing with an insurer between 1 April 2019 and 31 March 2020.
- It measured customer experience with insurers, trust in the schemes, perceptions of justice, return to work and other activities, and health and social outcomes.

## Results on customer service

Customer Service Rating



Claimants had higher ratings for overall customer service experiences, such as being treated with dignity and respect by their insurer.

Ratings were lower for more practical principles, such as being efficient and resolving concerns quickly.

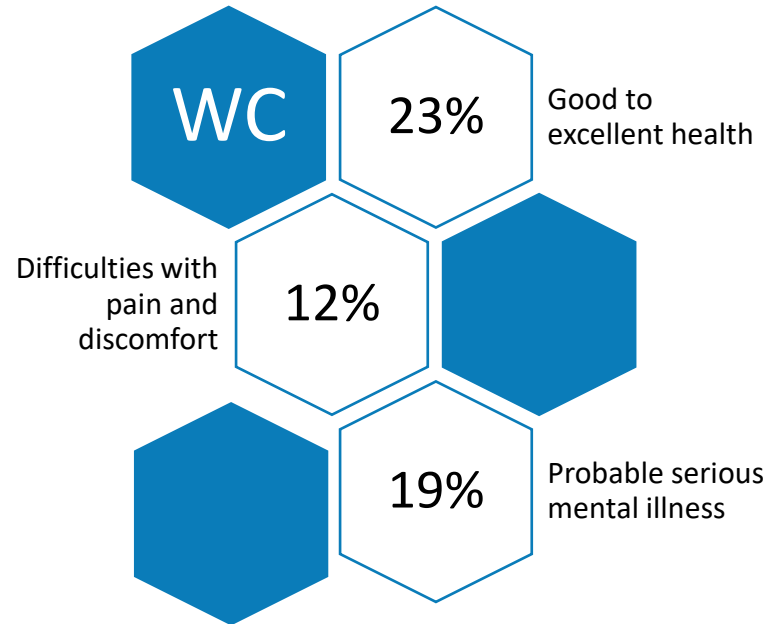
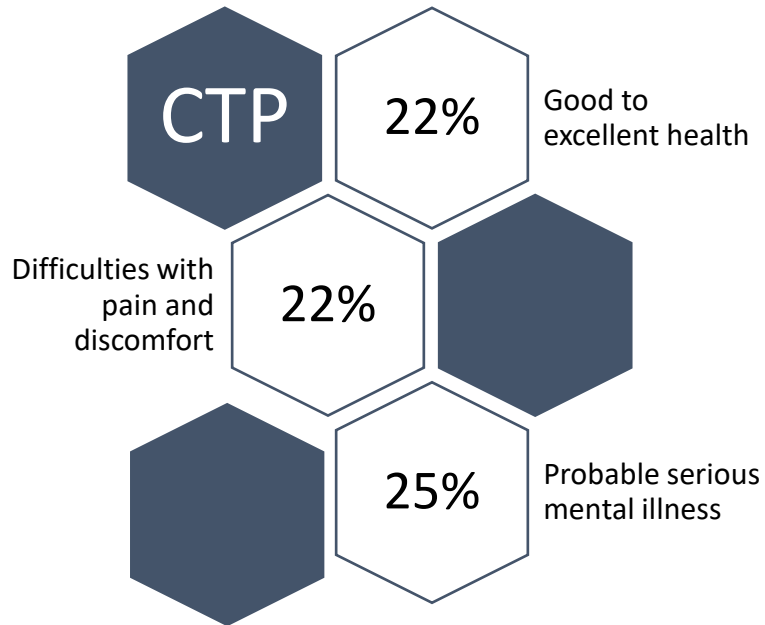
## Results on groups that reported poorer outcomes

SIRA's customer experience research has shown that certain groups of people tend to report poorer customer experience and health and social outcomes – regardless of injury severity or scheme.

This includes people:

- who are in the schemes for longer
- have symptoms of a probable serious mental illness
- experiencing pain

# Results on health outcomes



## Results on CTP vs WC claimants

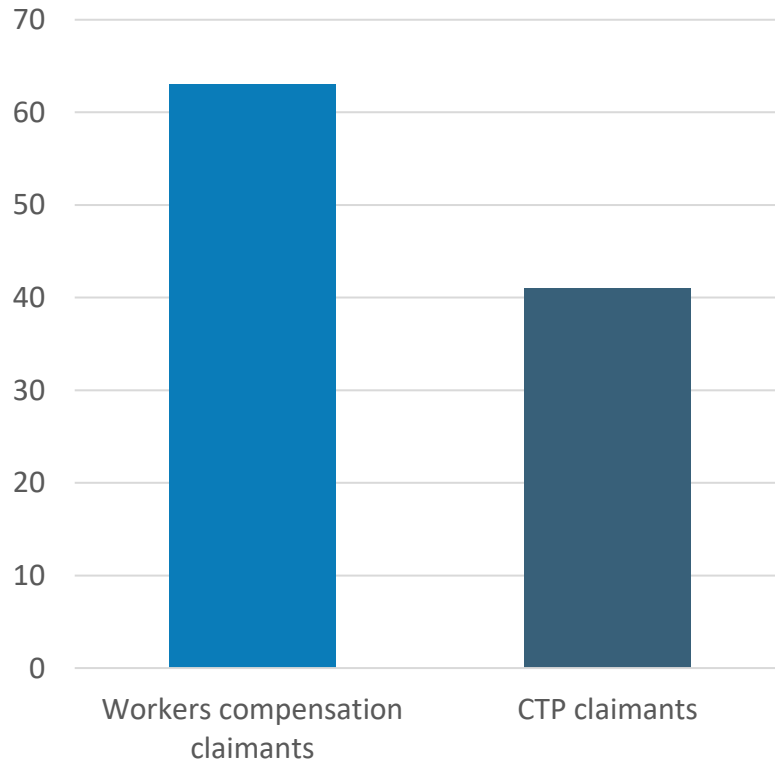
SIRA's customer experience research has shown that people with a CTP claim are more impacted by their injury. They self-report:

- a lesser sense of justice
- less trust that the scheme will help them get back to work and their usual activities
- more problems with their health



## Results on expectations of recovery

63% of workers compensation claimants expect to make a complete or nearly complete recovery

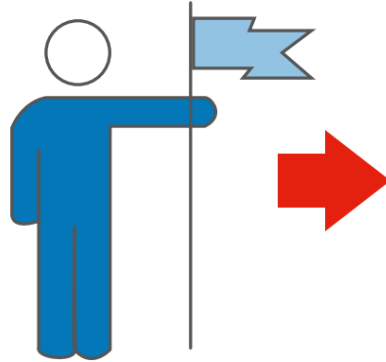


41% of CTP claimants expect to make a complete or nearly complete recovery

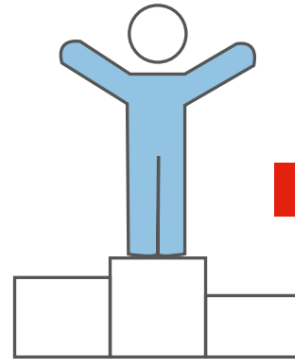
# Engaging with lived experience



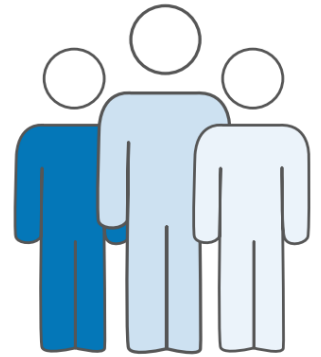
**Participation  
& engagement**



**Person-centred  
initiatives**



**Better  
outcomes**



**Greater  
impact**

# Suggestions for improvements



Improved information sharing and explanation of the claims process with a more proactive role played by insurer to explain the process, entitlements and decisions to claimant.



Clearer avenues for support and advocacy services to empower claimants to be able to maximise their outcomes in the claims process.



A more person-focused approach by insurer which prioritises the claimant's recovery journey and wellbeing.



Greater discretion given to treating doctors and health providers in process.



Improved language supports for LOTE claimants.

*“That’s how I’d improve the whole experience: let the doctor be the doctor and don’t try and deny everything that he says, and if you don’t trust that doctor then send me to a doctor you do trust and let him treat me.”*

(Male, CTP)

*“But for people who do get overwhelmed very easily, there should be some sort of—and I’m not saying insurance person; but there should be some sort of—a support thing there to help with forms and that when you’re not coping with them.”*

(Female, WC)

## Summary of learnings

- The longer people are in the compensation system, they report lower trust and poorer health
- Prevalence of mental health issues across both schemes, not represented in claims data
- Impact of pain as a complex component of recovery for many people
- Delayed decision-making and timeliness of information contribute to poorer experiences
- People with a CTP claim are more affected by their injury than people with a workers compensation claim.
- Continued focus on specific cohorts- through focus groups, those with English as a second language, Aboriginal and Torres strait islanders, people living in rural and remote areas
- Listening to the voice of the customer will help us to design and deliver services that best support people to recover and get their life back on track.



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# **Andrew Stone SC**

## **Sir James Martin Chambers**

# Improving the operation of the MAI Act



- > The 20 month damages claims barrier
- > Joint medico-legal examinations





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**David Shoebridge MLC**  
**Committee Member, Standing Committee**  
**on Law and Justice**



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**Independent Review Officer**





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# Lunch

**Afternoon session resumes at 1:00pm**



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**A/Professor Michael Fearnside**  
**Emeritus Neurological Surgeon**

# PAIN IN IMPAIRMENT ASSESSMENT

with reference to  
COMPLEX REGIONAL PAIN SYNDROME (CRPS)




A/Professor Michael Fearnside  
Emeritus Neurological Surgeon



# ASSESSMENT OF PAIN


“An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.”

International Association for the Study of Pain

- 
- Personal experience influenced by biological, psychological or social factors
  - Individuals learn the concept of pain through life experience
  - Pain has adaptive features but have adverse effects on function and well being
  - Different types, acute, chronic, burn, neuropathic, radicular




## “GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT” (AMERICAN MEDICAL ASSOCIATION)

- AMA<sub>4</sub> (Motor Vehicle NSW) was published in 1993
  - AMA<sub>5</sub> (Workers’ Compensation NSW) was published in 2000
  - AMA<sub>6</sub> was published in 2008. Not used in NSW
  - [Motor Accident Guidelines \(2019\)](#) amend AMA<sub>4</sub> (Part 6, medical)
  - [NSW WC Guidelines](#), most recent revision in 2016 (x<sub>4</sub>)
    - Modify AMA<sub>5</sub> to provide clarification and remove uncertainty or silence
    - They replace AMA<sub>5</sub> in these circumstances
    - Adopted by SafeWork Australia for those state jurisdictions which use AMA<sub>5</sub>
- 



# ASSESSMENT OF CHRONIC PAIN FOR MEDICOLEGAL PURPOSES

AMA 4 Ch 15 and AMA5 Ch18

- Chronic pain generally excluded as an entity in itself from impairment assessment because
    - Subjective experience and open to exaggeration
    - Depends on credibility of the person
    - Cannot be objectively measured
    - Tools to measure pain are largely self reports
    - Open to fabrication or falsification
  - Some WPI ratings can take pain into account
    - ADL in spine (AMA 5)
    - Sensory loss or pain in peripheral nerve injury
    - CRPS (Complex Regional Pain Syndrome)
- 

# ASSESSMENT OF PAIN

## AMA5

- WorkCover Guides prohibit the use of the specific pain (Ch 18)
- Pain assessment in AMA5 includes
  - Self report (T 18.4), 26 questions in 3 sections
  - Examiner rates pain behaviour (T18.5)
  - Clinical judgement rating (-10 to + 10)
  - Global Pain Score
  - Up to 3% WPI if the pain “increases the burden of illness slightly”

**Table 18-4** Ratings Determining Impairment Associated With Pain

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**I. Pain (Self-report of Severity)**

A. Rate how severe your pain is **right now, at this moment** (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 No pain Most severe pain can imagine

B. Rate how severe your pain is **at its worst** (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 None Excruciating

C. Rate how severe your pain is **on the average** (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 None Excruciating

D. Rate how much your pain is **aggravated by activity** (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 Activity does not aggravate pain Excruciating following any activity

Sum score of Section I: A-D = Total pain severity/4 = \_\_\_\_\_

E. Rate how **frequently** you experience pain (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 Rarely All of the time

Add total pain severity score (items A-D/4) to score for item E = \_\_\_\_\_  
 Total pain severity score (range from 0 to 20) = \_\_\_\_\_

**II. Activity Limitation or Interference**

A. How much does your pain interfere with your ability to **walk 1 block?** (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 Does not restrict ability to walk Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of groceries)? (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 Does not prevent from lifting 10 pounds Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for 1/2 hour?** (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 Does not restrict ability to sit for 1/2 hour Impossible to sit for 1/2 hour

D. How much does your pain interfere with your ability to **stand for 1/2 hour?** (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 Pain does not interfere with ability to stand at all Unable to stand at all

E. How much does your pain interfere with your ability to **get enough sleep?** (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 Does not prevent me from sleeping Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities?** (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere with social activities Completely interferes with social activities

G. How much does your pain interfere with your ability to **travel up to 1 hour by car?** (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere with ability to travel 1 hour by car Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your **daily activities?** (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere with my daily activities Completely interferes with my daily activities

I. How much do you **limit your activities to prevent your pain from getting worse?** (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 Does not limit activities Completely limits activities

J. How much does your pain interfere with your **relationship with your family/partner/significant others?** (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere with relationships Completely interferes with relationships

K. How much does your pain interfere with your ability to do **jobs around your home?** (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere Completely unable to do any job around home

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else?** (circle a number):  
 0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere at all My pain makes it impossible to shower or bathe without help



# ASSESSMENT OF PAIN

- Some WPI assessments allow for the effects of pain
  - Spinal Injury: Diagnosis Related Estimates
  - Sensory loss in peripheral nerve injury
    - Peripheral nerves contain both motor (movement) and sensory (feeling) fibres
  - CRPS

## Diagnosis Related Estimates in AMA 5

Note the WPI ranges for the effect on activities of daily living

**Table 15-3** Criteria for Rating Impairment Due to Lumbar Spine Injury

DRE Lumbar Category I 0% Impairment of the Whole Person	DRE Lumbar Category II 5%- 8% Impairment of the Whole Person	DRE Lumbar Category III 10%-13% Impairment of the Whole Person	DRE Lumbar Category IV 20%-23% Impairment of the Whole Person	DRE Lumbar Category V 25%-28% Impairment of the Whole Person
<p>No significant clinical findings, no observed muscle guarding or spasm, no documentable neurologic impairment, no documented alteration in structural integrity, and no other indication of impairment related to injury or illness; no fractures</p>	<p>Clinical history and examination findings are compatible with a specific injury; findings may include significant muscle guarding or spasm observed at the time of the examination, asymmetric loss of range of motion, or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity and no significant radiculopathy</p> <p><b>or</b></p> <p>individual had a clinically significant radiculopathy and has an imaging study that demonstrates a herniated disk at the level and on the side that would be expected based on the previous radiculopathy, but no longer has the radiculopathy following conservative treatment</p> <p><b>or</b></p> <p>fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation (not developmental spondylosis) that has healed without alteration of motion segment integrity; (3) a spinous or transverse process fracture with displacement without a vertebral body fracture, which does not disrupt the spinal canal</p>	<p>Significant signs of radiculopathy, such as dermatomal pain and/or in a dermatomal distribution, sensory loss, loss of relevant reflex(es), loss of muscle strength or measured unilateral atrophy above or below the knee compared to measurements on the contralateral side at the same location; impairment may be verified by electrodiagnostic findings</p> <p><b>or</b></p> <p>history of a herniated disk at the level and on the side that would be expected from objective clinical findings, associated with radiculopathy, or individuals who had surgery for radiculopathy but are now asymptomatic</p> <p><b>or</b></p> <p>fractures: (1) 25% to 50% compression of one vertebral body; (2) posterior element fracture with displacement disrupting the spinal canal; in both cases, the fracture has healed without alteration of structural integrity</p>	<p>Loss of motion segment integrity defined from flexion and extension radiographs as at least 4.5 mm of translation of one vertebra on another or angular motion greater than 15° at L1-2, L2-3, and L3-4, greater than 20° at L4-5, and greater than 25° at L5-S1 (Figure 15-3); may have complete or near complete loss of motion of a motion segment due to developmental fusion, or successful or unsuccessful attempt at surgical arthrodesis</p> <p><b>or</b></p> <p>fractures: (1) greater than 50% compression of one vertebral body without residual neurologic compromise</p>	<p>Meets the criteria of DRE lumbosacral categories III and IV; that is, both radiculopathy and alteration of motion segment integrity are present; significant lower extremity impairment is present as indicated by atrophy or loss of reflex(es), pain, and/or sensory changes within an anatomic distribution (dermatomal), or electromyographic findings as stated in lumbosacral category III and alteration of spine motion segment integrity as defined in lumbosacral category IV</p> <p><b>or</b></p> <p>fractures: (1) greater than 50% compression of one vertebral body with unilateral neurologic compromise</p>

# ACTIVITIES OF DAILY LIVING SCORES FOR INJURY TO THE SPINE



Pain might affect ADL and the final WPI rating

# PERIPHERAL NERVE INJURY: SENSORY ASSESSMENT

## where pain is rateable

**Table 16-10** Determining Impairment of the Upper Extremity Due to Sensory Deficits or Pain Resulting From Peripheral Nerve Disorders

a. Classification		
Grade	Description of Sensory Deficit or Pain	% Sensory Deficit
5	No loss of sensibility, abnormal sensation, or pain	0
4	Distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations or pain, that is forgotten during activity	1-25
3	Distorted superficial tactile sensibility (diminished light touch and two-point discrimination), with some abnormal sensations or slight pain, that interferes with some activities	26-60
2	Decreased superficial cutaneous pain and tactile sensibility (decreased protective sensibility), with abnormal sensations or moderate pain, that may prevent some activities	61-80
1	Deep cutaneous pain sensibility present; absent superficial pain and tactile sensibility (absent protective sensibility), with abnormal sensations or severe pain, that prevents most activity	81-99
0	Absent sensibility, abnormal sensations, or severe pain that prevents all activity	100


  

b. Procedure	
1	Identify the area of involvement using the cutaneous innervation chart (Figure 16-48) or the dermatome chart (Figure 16-49).
2	Identify the nerve structure(s) that innervate the area(s) (Table 16-12 and Figures 16-48, 16-49, and 16-50).
3	Grade the severity of the sensory deficit or pain according to the classification given above (a). Use clinical judgment to select the appropriate percentage from the range of values shown for each severity grade.
4	Find the maximum upper extremity impairment value due to sensory deficit or pain for each nerve structure involved: spinal nerves (Table 16-13), brachial plexus (Table 16-14), and major peripheral nerves (Table 16-15).
5	Multiply the severity of the sensory deficit by the maximum upper extremity impairment value to obtain the upper extremity impairment for each nerve structure involved.

Adapted from Klein DK, Hulsbos AR. *Operative Results for Major Nerve Injuries, Zosteriform, and Tumor*. Philadelphia, Pa: WB Saunders Co; 1993:10. Minkoff JL. *Sensibility in reconstructive limb surgery*. In: Finkelstein N, Beach GS, eds. *Progress in the Neurological Aspects of Plastic Surgery*. St Louis, Mo: CV Mosby Co; 1976:16-35. Ober CE Jr, Beck-Krassnik J. Evaluation of clinical results following peripheral nerve anastomosis. In: Ober CE, Spiller RL, eds. *Beck AL, ed. Management of Peripheral Nerve Problems*. Philadelphia, Pa: WB Saunders Co; 1998:340-349. Seddon HJ. *Surgical Disorders of the Peripheral Nerves*. 2nd ed. Edinburgh, Scotland: Churchill Livingstone; 1975. Swanson AB. Evaluation of impairment of function in the hand. *Surg Clin North Am*. 1964;44:525-540. Swanson AB, de Coudre-Prevaux G. Evaluation of permanent impairment in the hand and upper extremity. In: Dwyer TG, ed. *Guides to the Evaluation of Permanent Impairment*. Fourth ed. Chicago, Ill: American Medical Association; 1993.



# ASSESSMENT OF PAIN AMA6

- No concordance of authors as to inclusion
  - Effect of pain on impairment (v disability) unclear
  - 15 self report questions
  - Scored and 0-3% WPI combined
- 



# ASSESSMENT OF PAIN

There remains no means of objectively measuring or validating pain in the clinical or medicolegal domains

## COMPLEX REGIONAL PAIN SYNDROMES (1 and 2)

- Characteristics of CRPS 1 (was reflex sympathetic dystrophy)
  - Continuous burning pain
  - Present without stimulation or movement
  - Occurs beyond the territory of a single peripheral nerve
  - Disproportionate to the inciting event
- Characteristics of CRPS 2 (was major causalgia)
  - As above but follows an injury to a mixed peripheral nerve
  - Clinical features more confined to the territory of the injured nerve (e.g. ulnar, median, sciatic or common peroneal)



## CHARACTERISTICS OF COMPLEX REGIONAL PAIN SYNDROME (IASP)

- Presence of a generally minor noxious (traumatic) event or cause (immobilisation)
- A limb(s) is(are) affected
- Continuous pain, allodynia or hyperalgesia where there is disproportionate to the stimulus e.g. touch, wind which would not normally cause pain
- At some time, oedema (swelling), changes in skin blood flow (colour change) or sudomotor (sweating) activity (sign or symptom)
- No other condition explains the pain and dysfunction



# ACUTE, CHRONIC and DYSTROPHIC CRPS

Marinus J, Mosley G et al

Clinical Features and Pathophysiology of Complex Regional Pain Syndrome

Lancet Neurology. 2011 10:637-648



**Figure 1: Acute CRPS, chronic CRPS, and CRPS dystonia**

(A) Acute CRPS with hyperaemia, swelling, and glossy skin. (B) Chronic, cold-type CRPS with blue discoloration of the fingers, glossy skin, and increased hair and nail growth. (C) CRPS-related dystonia of the left ankle and foot with plantar flexion and inversion of the ankle, and flexion of the toes; oedema and increased hair growth are also visible. CRPS=complex regional pain syndrome.

# SEQUENTIAL OR SUBTYPE CLINICAL STAGES (UNTREATED)

- **Stage 1, (Early acute), < 3 months**
  - Pain / sensory
  - Vasomotor, sudomotor, oedema prominent
- **Stage 2, (Dystrophic) 3-6 months**
  - Pain and sensory dysfunction worse
  - Motor / trophic changes develop
- **Stage 3, (Atrophic), >6 months**
  - Decrease in pain and sensory disturbance
  - Continued vasomotor
  - Increased motor / dystrophic

The signs change with time

Bonica J, *Causalgia and other reflex sympathetic dystrophies*. In: *Management of Pain* 1990, p 243

Maybe not sequential, rather **3 subtypes**:

1. Limited syndrome with vasomotor signs predominant
2. Limited syndrome with neuropathic pain / sensory features predominant
3. Florid CRPS similar to "classic CRPS" with motor and trophic changes

Harden R, Bruhl S

*Diagnosis of Complex Regional Pain Syndrome. Signs, symptoms and new empirically derived diagnostic criteria*  
Clin J Pain 2006. 22 (5): 415-419

Overall, a mixture of positive and negative noxious signs and symptoms which may confound medicolegal diagnosis and assessment because the signs change with time

# CRPS EPIDEMIOLOGY

## Medicolegal context

- Allen G et al (1999) n=134
  - Pain Clinic, Univ Washington, Seattle
  - Medicolegal
    - 54% had WC claim
    - 17% had an active lawsuit
    - 23% had undergone an independent medical examination (IME) at presentation
    - Similar findings Ochoa et al (1994)
      - 44% had WC claim
      - 18% had an active lawsuit
  - Occupations
    - Services – restaurant workers, police
    - Manual workers

Allen G et al  
*Epidemiology of complex regional pain syndrome: a retrospective chart review of 134 patients*  
Pain. 1999. 80: 539-544

# EPIDEMIOLOGY

## Medicolegal context

- Mean time to presentation at the Pain Clinic was 34 months
- Had seen an average of 4.8 doctors
- Had average of 5 treatments
  - Nerve blocks 88%
  - Physical therapy 70%
  - Meds: Analgesics 78%, opiates 70%, anti-epileptic medications 60%
  - Psychological 50%
  - Immobilisation 47% (mean 3 weeks, range 1-24 weeks)

Allen G et al  
*Epidemiology of complex regional pain syndrome: a retrospective chart review of 134 patients*  
Pain. 1999. 80: 539-544

# AETIOLOGY

- Is complex and incompletely understood
- Abnormal pathways:
  - Aberrant inflammatory mechanisms
  - Vasomotor (blood vessel) dysfunction
  - Maladaptive neuroplasticity (spinal cord and brain)
- Variability of responses results in clinical heterogeneity

## Clinical features and pathophysiology of complex regional pain syndrome

*Johan Marinus, G Lorimer Moseley, Frank Birklein, Ralf Baron, Christian Mailhöfner, Wade S Kingery, Jacobus J van Hilten*

Lancet Neurology 2011. 10:637-648

# AETIOLOGY

- Disorders of inflammation
  - Is aberrant and excessive
  - Inflammatory mediators cause peripheral neuronal sensitisation
  - Changes in nerve conduction causes release of neuropeptides, causing vasodilatation and fluid extravasation into tissues (oedema, tissue swelling)
  - Inflammatory substances probably act locally and on spinal cord
  - Levels of these mediators are elevated in tissue and blood in CRPS

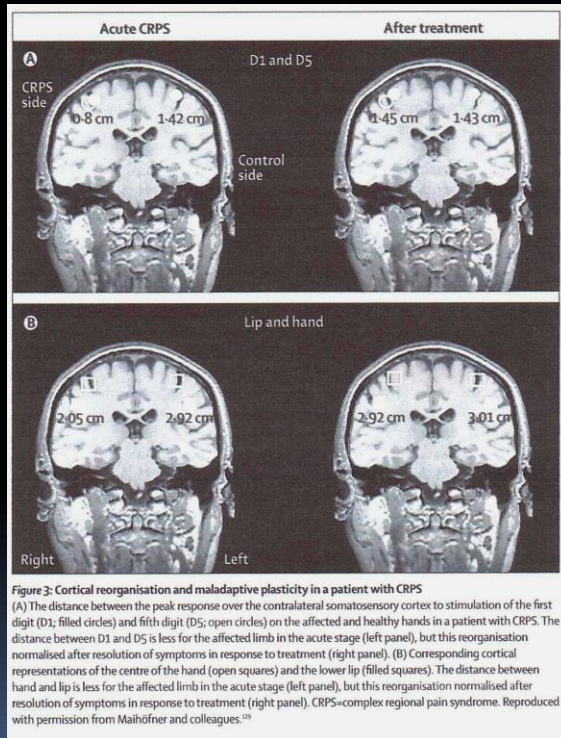
# AETIOLOGY

- Disorders of vasomotor (blood vessel) function
  - Limb is usually warmer early and colder later
  - Inhibition of vasoconstrictor neurons in acute phase, warm limb
    - Changes are probably central, spinal cord, brainstem or brain
  - Chronic phase, increased sensitivity to catechol amines causes vasoconstriction

# AETIOLOGY

- Disorders of brain function
  - CNS undergoes **functional and structural changes** in chronic pain and CRPS
  - **Central sensitisation** by activating glutamate receptors which enhance nociceptor transmission, causing chronic pain, hyperalgesia, allodynia, pain spreading to non-injured areas ( NMDA antagonist ketamine)
  - **Movement disorders**
    - Dystonia (anormal limb postures)
    - Subacute and chronic, therefore not inflammatory
    - Probably spinal cord level because baclofen is effective (GABA receptor agonist, enhances inhibition)
  - **Perceptual disorders** – perceived as larger, distortions of shape, posture or temperature
  - **Cortical reorganisation** – somatic representation





- A
  - Interdigit distances are less in CRPS (left) than unaffected side and normalise with resolution of CRPS
- B
  - Distance between lip and palm of affected side is less than on unaffected side and normalises with resolution of CRPS
- The affected hand is represented as smaller and shifted toward the mouth

# SUMMARY OF AETIOLOGY OF CRPS

Marinus J, Mosley G et al

Clinical Features and Pathophysiology of Complex Regional Pain Syndrome  
Lancet Neurology. 2011 10:637-648

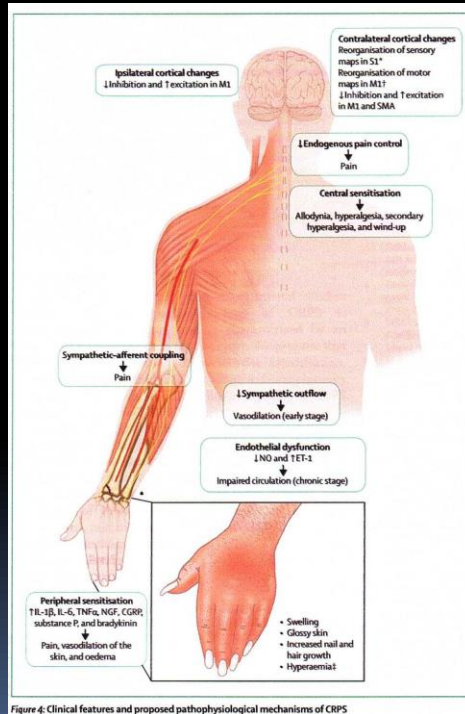


Figure 4: Clinical features and proposed pathophysiological mechanisms of CRPS

- All these mechanisms have been identified in CRPS
- May occur independently of each other
- Absence of fixed relations explains heterogeneity
- Multiplicity of mechanisms and clinical features confounds definition of CRPS

Review Article

## Potential Risk Factors for the Onset of Complex Regional Pain Syndrome Type 1: A Systematic Literature Review

Tracey Pons,<sup>1</sup> Edward A. Shipton,<sup>1</sup> Jonathan Williman,<sup>2</sup> and Roger T. Mulder<sup>3</sup>

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<sup>3</sup>Department of Psychological Medicine, University of Otago, Christchurch, Corner of Riccarton and Hagley Avenues, Christchurch 8042, New Zealand

Anaesthesiology Research and Practice. 2015, Article ID956539. <http://dx.doi.org/10.1155/2015/956539>

Meta-analysis of 16 articles 1996-2014

- RISK FACTORS
  - Female, especially postmenopausal
  - Distal fracture
  - Intra-articular fracture
  - Immobilisation \*
  - High pain levels in early post-traumatic phase
- OTHER STUDIES
  - ACE inhibitors
  - Asthma
  - Familial
    - Some evidence of inherited abnormalities in the inflammatory response to injury
  - ? Vitamin C early after limb fracture may be preventative
- NOT RISK FACTORS
  - Pre-injury psychological distress
  - Diagnostic bone scan
  - Psychological behaviour / predisposition, depression

\*Pepper A et al  
Complex Regional Pain Syndrome-Like Changes Following Hand Surgery  
J Pain. 2013. 14(5): 516-524

# THIS CAN CAUSE DIFFICULTY WITH WPI ASSESSMENTS

## Stage 1, (Early acute), < 3 months

Pain / sensory

Vasomotor , sudomotor, oedema prominent

## Stage 2, (Dystrophic) 3-6 months

Pain and sensory dysfunction worse

Motor / trophic changes develop

## Stage 3, (Atrophic), >6 months

Decrease in pain and sensory disturbance

Continued vasomotor

Increased motor / dystrophic

- When is maximum medical improvement (MMI) reached?
- **MMI**: condition is well stabilised and unlikely to change substantially in the next year with or without medical treatment.
- For CRPS the signs may change with time
- WPI assessment is to be made as the person presents “on the day”

# CHARACTERISTICS OF CRPS

- Constellation of symptoms and signs in 4 categories:
  - Altered pain signalling: disproportionate pain to the stimulus
  - Vasomotor (skin colour and temperature changes)
  - Sudomotor (sweating) and oedema (swelling)
  - Motor (joint stiffness) and trophic (deformity)
- Definition by expert consensus, requires external validation
- Pathophysiology not conclusive yet
- No “gold standard” for diagnosis
- These are confounding factors for medicolegal assessors.

# DIFFERENTIAL DIAGNOSIS

Definitions include the criterion that there must be no other explanation for the condition

- Neuropathic pain syndromes
  - Peripheral neuropathy (Diabetes)
  - Radiculopathy
  - Post-herpetic neuralgia
  - Post-surgical neuropathic pain
- Injury
  - Non-union
  - Immobilisation / disuse
- Infection
  - Osteomyelitis or cellulitis
- Vascular
  - Venous thrombosis

# MEDICOLEGAL ASSESSMENT OF CRPS

- The issue is the diagnosis of CRPS
- Methodology for WPI is complex but straightforward
- Orlando criteria

**Table 1** IASP diagnostic criteria for complex regional pain syndrome (CRPS)\* (adapted from [9])

1. The presence of an initiating noxious event, or a cause of immobilization<sup>†</sup>
2. Continuing pain, allodynia, or hyperalgesia in which the pain is disproportionate to any known inciting event
3. Evidence at some time of edema, changes in skin blood flow, or abnormal sudomotor activity in the region of pain (can be sign or symptom)
4. This diagnosis is excluded by the existence of other conditions that would otherwise account for the degree of pain and dysfunction

\* If seen without "major nerve damage" diagnose CRPS I; if seen in the presence of "major nerve damage" diagnose CRPS II.

<sup>†</sup> Not required for diagnosis; 5–10% of patients will not have this.

Merksey H, Bogduk N  
*Classification of Chronic Pain: Descriptions of Chronic Pain  
Syndromes and Definitions of Pain Terms*  
Seattle WA. IASP Press 1994.  
In: Harden R et al  
*Proposed new diagnostic criteria for complex regional pain  
syndrome*  
Pain Medicine. 2007; 8(4): 326-331

# MEDICOLEGAL ASSESSMENT OF CRPS

## AMA 4

- Major causalgia (specific nerve) and minor causalgia (RSD)
- Constant and intense burning pain
- 4 threshold characteristics are
  - Pain
  - Swelling
  - Stiffness
  - Discoloration
- Bone scan, stellate block, Bier block (intravenous infusion of local anaesthetic) may be “supportive”



# MEDICOLEGAL ASSESSMENT OF CRPS

AMA 5. Ch16 p495-6. Published 2002

- Describes
  - Burning pain disproportionate to cause
  - Present with minimal stimulation
  - Pain extends beyond the territory of single nerve or nerve root
  - Vasomotor, sudomotor, trophic changes
- Reflects the IASP criteria
- Signs must be present at the time of assessment

**Table 16-16** Objective Diagnostic Criteria for CRPS (RSD and causalgia)

Local clinical signs
Vasomotor changes: <ul style="list-style-type: none"><li>• Skin color: mottled or cyanotic</li><li>• Skin temperature: cool</li><li>• Edema</li></ul>
Sudomotor changes: <ul style="list-style-type: none"><li>• Skin dry or overly moist</li></ul>
Trophic changes: <ul style="list-style-type: none"><li>• Skin texture: smooth, nonelastic</li><li>• Soft tissue atrophy: especially in fingertips</li><li>• Joint stiffness and decreased passive motion</li><li>• Nail changes: blemished, curved, talonlike</li><li>• Hair growth changes: fall out, longer, finer</li></ul>
Radiographic signs
<ul style="list-style-type: none"><li>• Radiographs: trophic bone changes, osteoporosis</li><li>• Bone scan: findings consistent with CRPS</li></ul>
Interpretation:
≥ 8 Probable CRPS
< 8 No CRPS

Modified from Ensalada LH. Complex regional pain syndrome. In: Brigham CR, ed. *The Guides Casebook*. Chicago, Ill: American Medical Association; 1999:14.

# MEDICOLEGAL ASSESSMENT OF CRPS

AMA 5. Ch16 p495-6. Published 2002

- Signs not symptoms
- At least 8 signs must be concurrently present at the time of examination
- Restrictive objective criteria

**Table 16-16** Objective Diagnostic Criteria for CRPS (RSD and causalgia)

Local clinical signs
Vasomotor changes:
• Skin color: mottled or cyanotic
• Skin temperature: cool
• Edema
Sudomotor changes:
• Skin dry or overly moist
Trophic changes:
• Skin texture: smooth, nonelastic
• Soft tissue atrophy: especially in fingertips
• Joint stiffness and decreased passive motion
• Nail changes: blemished, curved, talonlike
• Hair growth changes: fall out, longer, finer
Radiographic signs
• Radiographs: trophic bone changes, osteoporosis
• Bone scan: findings consistent with CRPS
Interpretation:
≥ 8 Probable CRPS
< 8 No CRPS

Modified from Ensalada LH. Complex regional pain syndrome. In: Brigham CR, ed. *The Guides Casebook*. Chicago, Ill: American Medical Association; 1999:14.

# CRPS CRITERIA REVISED 2003

- Budapest criteria 2003. Consensus statement
- Identified 4 groupings:
  - Abnormal pain processing
  - Vasomotor/temperature
  - Sudomotor/oedema
  - Motor/trophic
- Analysis showed these subgroups did not overlap
- Reflected in AMA 6 diagnostic criteria

Washington State Dept L&I (2011)  
permits a characteristic bone scan to be substituted for 1  
sign

**Table 3** Proposed clinical diagnostic criteria for CRPS

**General definition of the syndrome:**

CRPS describes an array of painful conditions that are characterized by a continuing (spontaneous and/or evoked) regional pain that is seemingly disproportionate in time or degree to the usual course of any known trauma or other lesion. The pain is regional (not in a specific nerve territory or dermatome) and usually has a distal predominance of abnormal sensory, motor, sudomotor, vasomotor, and/or trophic findings. The syndrome shows variable progression over time

**To make the clinical diagnosis, the following criteria must be met:**

1. Continuing pain, which is disproportionate to any inciting event

2. Must report at least one symptom in *three of the four* following categories:

**Sensory:** Reports of hyperesthesia and/or allodynia

**Sudomotor/Edema:** Reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry

**Motor/Trophic:** Reports of edema and/or sweating changes and/or sweating asymmetry

**Motor/Trophic:** Reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin)

3. Must display at least one sign **at time of evaluation** in two or more of the following categories:

**Sensory:** Evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or temperature sensation and/or deep somatic pressure and/or joint movement)

**Vasomotor:** Evidence of temperature asymmetry ( $>1^{\circ}\text{C}$ ) and/or skin color changes and/or asymmetry

**Sudomotor/Edema:** Evidence of edema and/or sweating changes and/or sweating asymmetry

**Motor/Trophic:** Evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin)

4. There is no other diagnosis that better explains the signs and symptoms

**For research purposes,** diagnostic decision rule should be at least one symptom *in all four* symptom categories and at least one sign (observed at evaluation) in two or more sign categories.

Harden R et al  
*Proposed New Diagnostic Criteria for Complex Regional Pain  
Syndrome*  
Pain Medicine 2007. 8(4): 326-331

# DIAGNOSIS OF CRPS

NSW WorkCover Guides (Ed 4).

## 1. Continuing pain, disproportionate to causal event

### 2. Must report at least **1 symptom** in each of the **4 following categories**;

- Sensory: Hyperaesthesia and/or allodynia
- Vasomotor: Temperature asymmetry and/or skin colour changes or asymmetry
- Sudomotor/oedema: oedema and/or sweating increase/decrease or asymmetry
- Motor/trophic: decreased joint movement, and/or motor dysfunction (dystonia, tremor) and/or trophic (hair, nail, skin)

### 3. Must display at least **1 sign\*** at evaluation in each of the following **4 categories**:

- Sensory: allodynia and/or hyperalgesia (to touch, deep pressure or joint movement)
- Vasomotor: temperature asymmetry or asymmetric skin colour change
- Sudomotor/oedema: oedema and/or sweating asymmetry
- Motor/trophic: Decreased active joint ROM and/or motor dysfunction (dystonia, tremor) and/or trophic (hair, skin, nails)

### 4. There is no other diagnosis that better explains the signs and symptoms

\* A sign is included only if it is observed and documented at the time of the impairment evaluation

# WPI ASSESSMENT FOR CRPS 1

## AMA 4 and 5

- Once the diagnosis is made, assessment proceeds:
  - Loss of ROM of each **individual joint** in the affected limb and convert to extremity impairment (EI)
  - Grade the **sensory alteration/pain** which best describes the interference with ADL. The value selected is the EI
  - Combine EI for loss of joint movement and sensory/pain
  - Convert to WPI

**Table 16-10** Determining Impairment of the Upper Extremity Due to Sensory Deficits or Pain Resulting From Peripheral Nerve Disorders

a. Classification		
Grade	Description of Sensory Deficit or Pain	% Sensory Deficit
5	No loss of sensibility, abnormal sensation, or pain	0
4	Distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations or pain, that is forgotten during activity	1-25
3	Distorted superficial tactile sensibility (diminished light touch and two-point discrimination), with some abnormal sensations or slight pain, that interferes with some activities	26-60
2	Decreased superficial cutaneous pain and tactile sensibility (decreased protective sensibility), with abnormal sensations or moderate pain, that may prevent some activities	61-80
1	Deep cutaneous pain sensibility present; absent superficial pain and tactile sensibility (absent protective sensibility), with abnormal sensations or severe pain, that prevents most activity	81-99
0	Absent sensibility, abnormal sensations, or severe pain that prevents all activity	100

**b. Procedure**

- Identify the area of involvement using the cutaneous innervation chart (Figure 16-48) or the dermatome chart (Figure 16-49).
- Identify the nerve structure(s) that innervate the area(s) (Table 16-12 and Figures 16-48, 16-49, and 16-50).
- Grade the severity of the sensory deficit or pain according to the classification given above (a). Use clinical judgment to select the appropriate percentage from the range of values shown for each severity grade.
- Find the maximum upper extremity impairment value due to sensory deficit or pain for each nerve structure involved: spinal nerves (Table 16-13), brachial plexus (Table 16-14), and major peripheral nerves (Table 16-15).
- Multiply the severity of the sensory deficit by the maximum upper extremity impairment value to obtain the upper extremity impairment for each nerve structure involved.

# WPI ASSESSMENT for CRPS 2

## AMA 4 and 5

- Once the diagnosis is made, assessment proceeds:
  - Loss of ROM of each **individual joint** in the affected limb and convert to extremity impairment (EI)
  - Grade the **sensory alteration/pain** which best describes the interference with ADL for the injured nerve. The value selected is the EI
  - Rate the EI for loss of **motor function**
  - Combine the EI for loss of joint ROM, sensory/pain deficits and motor deficit
  - Convert EI to WPI

# BONE SCAN

- Lee and Weeks (1995)
  - Meta analysis of 6 papers
  - 3 phase bone scan
    - Blood flow: Immediate = angiogram
    - Blood pool: 1- 5 mins = regional blood distribution
    - Delayed phase: 1.5- 5 hrs = bone uptake (most sensitive for diagnosis)
  - Abnormal in 55%
  - Not recommended as major diagnostic criterion for CRPS

Lee G and Weeks P  
*The Role of Bone Scintigraphy in Diagnosing Reflex Sympathetic Dystrophy*  
J Hand Surg 1995; 20A:458-463

# CONCLUSIONS

- CRPS is a constellation of symptoms and signs
- The aetiology is not yet conclusive, is complex with multiple inputs, but is an identifiable syndrome
- Diagnosis is by consensus (Budapest criteria) requiring external validation
- For impairment, diagnosis (threshold criteria) is the critical issue
- AMA methodology for WPI assessment is complex, but fairly straightforward
- Fortunately, not a common condition for WPI assessment





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**Jnana Gumbert**  
**Barrister, Jack Shand Chambers**

# **Judicial Review of Personal Injury Commission decisions**

Jnana Gumbert  
Jack Shand Chambers

# Some leading authorities

- *Wingfoot v Kocak* (2013) 252 CLR 480
- *Zahed v IAG Limited t/as NRMA* (2016) 75 MVR 1
- *Allianz v Cervantes* (2012) 61 MVR 443
- *Minister for Immigration & Ethnic Affairs v Wu Shan Liang* (1996) 185 CLR 259
- *Minister for Immigration and Citizenship v Li* (2013) 249 CLR 332
- *Hossain v Minister for Immigration and Border Protection and Another* [2018] HCA 34; (2018) 359 ALR 1

# MAIA Decisions

- *AAI Limited v Singh* [2019] NSWSC 1300 (Fagan J)
- *AAI Ltd trading as GIO v Moon* [2020] NSWSC 714 (Wright J)
- *Allianz Australia Insurance Ltd v Jenkins* [2020] NSWSC 412 (Adamson J)
- *Briggs v IAG Limited t/as NRMA Insurance* [2020] NSWSC 1318 (Harrison AsJ)
- *QBE v Abberton* [2021] NSWSC 588 (Cavanagh J)

# Workers Compensation

- *Kitanoski v JB Metropolitan Distributors Pty Limited* [2019] NSWSC 1802 (Adamson J)
- *Peachey v Bildom Pty Ltd (Quality Siesta Resort Pty Limited and Quality Hotel)* [2020] NSWSC 781 (Adamson J)
- *Ballas v Department of Education (State of NSW)* [2020] NSWCA 86
- *Specialist Diagnostic Services Pty Ltd t/as Laverty Pathology v Aisha Naqi* [2020] NSWSC 1791 (Schmidt AJ)



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# Key Issues Arising from IRO Complaints

**Jeffrey Gabriel**  
Director Solutions

# A NEW ERA – 1 MARCH 2021



- > Schedule 5 – Personal Injury Commission Act 2020
- > CTP Complaints (MACA and MAIA)



# A NEW ERA – 1 MARCH 2021



## Working with SIRA

- > Transition to CTP Complaints
- > Information Sharing





# A NEW ERA – 1 MARCH 2021



## New IRO Complaint Handling Protocol

- > Published on our website
- > Consultation with industry
- > What we need for complaints.
- > When we won't deal with complains
- > IRO Investigations



# BY THE NUMBERS – JULY TO MAY 2021



<b>Case Type</b>	<b>Received YTD</b>	<b>+/- Same Period 19-20</b>
WC Complaint	7,430	+ 3.9%
WC Enquiry	7,218	- 24.2%
CTP Complaint	229	N/A
CTP Enquiry	94	N/A



# TALKING POINTS IN 2020-21



- > Covid-19
- > Media coverage of workers compensation
- > PIAWE Remediation Program



# ENGAGEMENT WITH SIRA/icare



- > IRO has bilateral discussions with each
- > Tangible outcomes



# CASE STUDIES

- > IME Appointment with vulnerable worker.
  - > Engagement with insurer
  - > Use of Telehealth
- > Provision of Rehabilitation Where Workers Compensation Claim Disputed
- > Section 38A – Worker with Highest Needs

# INSIGHTS FROM IRO SOLUTIONS



## Insurers:

*A complaint is an "expression of dissatisfaction made to or about an organization, related to its products, services, staff or the handling of a complaint, where a response or resolution is explicitly or implicitly expected or legally required."*



# INSIGHTS FROM IRO SOLUTIONS



## Insurers (Continued):

- > Return phone calls
- > Put things in writing, including disputes
- > Provide timeframes (and stick to them)
- > Doing someone a favour can lead to false expectations



# INSIGHTS FROM IRO SOLUTIONS



## Solicitors:

- > Follow up with insurers. In the time it takes you take to call us, you could call them
- > Icare is the Nominal Insurer







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# **Workers Compensation in New South Wales Current issues and recent decisions of interest**

**Michelle Riordan**

Manager – Legal Education

# Part 1

Section 39 *WCA* & Clause 28C of Schedule 8  
of the *Regulation*

## 39 Cessation of weekly payments after 5 years

- (1) Despite any other provision of this Division, a worker has no entitlement to weekly payments of compensation under this Division in respect of an injury after an aggregate period of 260 weeks (whether or not consecutive) in respect of which a weekly payment has been paid or is payable to the worker in respect of the injury.
- (2) This section does not apply to an injured worker whose injury results in permanent impairment if the degree of permanent impairment resulting from the injury is more than 20%.

Note - For workers with more than 20% permanent impairment, entitlement to compensation may continue after 260 weeks but entitlement after 260 weeks is still subject to section 38.

- (3) For the purposes of this section, the degree of permanent impairment that results from an injury is to be assessed as provided by section 65 (for an assessment for the purposes of Division 4).

## 28C 5 year limit on weekly payments



Section 39 of the 1987 Act (as substituted by the 2012 amending Act) does not apply to an injured worker if the worker's injury has resulted in permanent impairment and—

- (a) an assessment of the degree of permanent impairment for the purposes of the Workers Compensation Acts is pending and has not been made because an approved medical specialist has declined to make the assessment on the basis that maximum medical improvement has not been reached and the degree of permanent impairment is not fully ascertainable, or
- (b) the insurer is satisfied that the degree of permanent impairment is likely to be more than 20% (whether or not the degree of permanent impairment has previously been assessed).



# The current state of the law



## **Section 39 WCA**

*Hochbaum v RSM Building Services Pty Ltd; Whitton v Technical and Further Education Commission t/as TAFE NSW (Hochbaum & Whitton)* [2020] NSWCA 113 (17/06/2020)

## **Clause 28C of the Regulation**

*Jansen v Colin Smith t/as Col's Clip Joint (Jansen)* [2021] NSWPIC 24 (15/03/2021)



# Hochbaum & Whitton

Court of Appeal set aside the Presidential decisions and reinstated the first-instance decisions in each matter.

## **Brereton JA (White JA agreeing):**

- > The date on which an impairment threshold is crossed is not a relevant consideration in any question arising under s 38A *WCA*.
- > Only relevant question is what degree of permanent impairment has resulted from the injury?
- > The final degree of permanent impairment is determinative of whether the worker is in the exempt class.

# Hochbaum & Whitton (continued)



## **Simpson AJA** held:

- > It is not necessary to go further than the text of s 39 *WCA* to resolve the dispute.
- > Nothing in any of the subsections states, explicitly or implicitly, provides that the removal of s 39 (1) bar is dependent upon the date of the assessment of the degree of permanent impairment as distinct from the existence of the degree of permanent impairment.
- > The foundation for the removal of the ss (1) bar lies in the existence of a degree of permanent impairment exceeding 20%.
- > Subsection (3) does no more than specify the mechanism for assessment and nothing in ss (3) suggests that an assessment may only be prospective.
- > If it were necessary to go beyond the text of s 39 *WCA*, resort to the principles of statutory interpretation would support the same approach.



# Jansen v Colin Smith t/as Col's Clip Joint (Jansen) [2021] NSWPIC 24 (15/03/2021)

**Member Burge** held that the respondent was not required to make weekly payments during the period from the end of the second entitlement period until the date of issue of a MAC that certified that the degree of permanent impairment is not yet fully ascertainable.

- > There is a temporal element in cl 28C of Sch 8 of *the Regulation*, which must be satisfied before *the Regulation* operates to vitiate the operation of s 39 *WCA*.
- > Matter distinguished from *Hochbaum & Whitton*.
- > The member applied the decision of Snell DP in *Strooisma v Coastwide Fabrication & Erections Pty Ltd* [2020] NSWCCPD 65.

**Held:** The worker could not satisfy the requirements of cl 28C until the assessment of permanent impairment was “*pending*” and this did not occur until the MAC issued. Therefore, the respondent was not required to resume weekly payments prior to that date.



# Part 2

Determination of work capacity  
disputes by the WCC and PIC

# Analysis

- > Both the WCC and PIC have applied a strict interpretation of the definition of “*suitable employment*” in s 32A WCA and adopted an evidence-based approach to the determination of work capacity disputes.
- > Delegates of the Registrar of the WCC declined to issue Interim Payment Directions (IPDs) where the evidence supported the work capacity decision and the worker did not produce evidence, including medical evidence, that contradicted the decision.
- > Where an NTD has certified that the positions identified in the work capacity decision are suitable, an application challenging that decision is unlikely to succeed unless there is evidence that there is not a safe climate for accepting the NTD’s evidence. For example – evidence that the NTD was not fully advised of the duties involved in the identified roles.

# Matters in which IPDs were declined

## Stefanac – Arbitrator Egan as Delegate of the Registrar

Worker's solicitor conceded that she had capacity to work in her substantive position but not at her pre-injury locations. Worker argued that she should be provided with a position closer to her home. Held that the WCC is not to have regard to the worker's place of residence. The worker's capacity to earn in suitable employment is equal to PIAWE and she was not entitled to weekly payments.

## Kochel- Delegate Gamble

NTD certified the worker fit for suitable duties for 16 hpw & in 2018, Dr Machart assessed him fit for full-time work that was "*predominantly sedentary*". NTD agreed that the roles identified in the work capacity decision are suitable. Evidence indicated that the worker had the computer skills required to undertake the identified roles and that average weekly earnings in those roles exceeded PIAWE.

## **Hall – Delegate McAdam**

NTD approved the identified roles (receptionist, concierge & call contact centre operator) as suitable employment and certified the worker has having current capacity to work for 24 hpw.

The worker argued that she lacked the required skills and could only earn \$250 pw.

### **Held:**

The worker's argument was contrary to the evidence and she failed to discharge her onus of proof.

## Cotterill - Delegate McAdam

- > The worker worked in the film and television industry in various roles, most-recently as a technical producer. In July 2019, he accepted a redundancy package and had not worked since then.
- > NTD certified the worker fit for suitable employment for 40 hpw with limits on lifting etc. No medical evidence contradicted this certification.
- > The insurer made a work capacity decision that the worker was fit for suitable duties as a technical producer for 40 hours per week. However, the worker raised issues regarding the availability of work and that certain roles may be seen as a downgrade in his career.

### Held:

- These factors are specifically excluded by s 32A WCA and the worker's extensive skills and work experience make him a competitive applicant within the industry.
- The role of floor manager is suitable employment.
- Work capacity decision was upheld.

# Matters in which IPDs were issued



## Hassett - Senior Arbitrator Capel as Delegate of the Registrar

**Held:** Given the worker's lack of experience as a Disability Services Officer, he would likely only secure an entry-level position, which would pay a lower hourly rate than that assessed by the insurer.

The position of Sales Assistant was more suitable and the worker would be able to earn \$440 per week in that work.

## Hoque - Arbitrator Harris as Delegate of the Registrar

- > COC certified capacity for some employment for 30 hpw with physical restrictions, but the evidence indicated that the worker lacked English language skills and readily transferrable skills for an unrelated industry/vocation.
- > *Wollongong Nursing Home Pty Ltd v Dewar* applied – “Suitable employment means employment in work for which the worker is currently suited”.

**Held:** Respondent provided the worker with “assistance” and not “retraining”. Worker has no current work capacity to undertake the roles identified in the work capacity decision.



## **Singh - Delegate McAdam**

Significant injury to left hand and a psychological injury (chronic PTSD associated with major depression).

Insurer decided that the worker had current work capacity for suitable employment as a general farm hand/machinery operator for 40 hpw and reduced weekly payments to \$109.72 per week.

Parties agreed that the worker was *"a worker with high needs"*.

NTD imposed significant physical restrictions.

### **Held:**

The suitable employment identified in the decision was not suitable having regard to the factors in s 32A WCA.

# Personal Injury Commission Decisions



## **Ali v Woolworths Group Limited [2021] NSWPIC 150 – Senior Member Bamber – 23/03/2021**

On 29/01/2020, the worker injured his back at work. He resumed some work on 8/06/2020 and full-time work on 26/08/2020.

On 31/03/2020, the insurer made a work capacity decision that the worker has capacity to work pre-injury hours and earn his PIAWE and that weekly payments would reduce to NIL from 7/04/2020. It relied upon a medico-legal report from Dr Wallace.

The worker sought a review and relied upon an opinion from Dr Assem, that he was fit for work for 3 to 4 hpd, 3 dpw until 4/07/2020. However, the insurer maintained its decision.

The Senior Member found the treating doctors' evidence "*compelling*" and noted that they considered the effect that the injury had on the worker's psychological state. Dr Wallace did not explain exactly what suitable duties he thought that the worker could perform and without that information, his views regarding work capacity could not be properly considered.

Accordingly, the Senior Member issued an IPD for weekly payments.





## **Saade v Sydney Night Patrol Inquiry Co Pty Ltd t/as SNP Security [2021] NSWPIC 53 – Senior Member Haddock – 30/03/2021**

The worker injured his left heel, both legs and lower back and alleged a secondary psychological injury. The respondent accepted the physical injuries but disputed the psychological injury and argued that the worker did not suffer a partial or total incapacity for work resulting from a work-related injury.

### **Held:**

- The evidence indicated that the worker could not resume PID's and could only perform sedentary work.
- The identified roles require cognitive skills - communication, organisation, analysis and decision-making.
- The NTD stated that the worker had capacity for 16 hpw in a job that did not require him to interact with unfamiliar people, make complex decisions or sustain intense concentration for long periods.
- The identified roles overlook the worker's significant psychological symptoms.
- No evidence of any recent RTW plans or occupational rehabilitation services that are to be considered in deciding whether the worker has current work capacity.
- The worker has no current work capacity.



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**Simon Cohen**  
**Independent Review Officer**