Perspectives on Telehealth IMEs
Dr Drew Dixon, AMLC President

Peter Berton has provided a very useful conceptual model regarding claimant triage prior to and during IME assessment including pre-appointment telephone triage, exclusion of patients with URTI and reducing traffic in waiting rooms and social personal distancing from staff. Hand sanitiser, surface wipes and personal hygiene are a given. Where the demographic is uncertain, video conferencing is a current option, particularly where assessment is urgent due to failing health, delay in necessary treatment, terminal patients trying to finalise claims and those whose changing circumstances such as isolation, quarantine, risk, excessive travel, regional border control and generalised immobility/incapacity precludes attendance or face to face assessment.

These are circumstances where if both parties and the claimant agrees, innovative telehealth measures such as video conferencing are safer for the claimant and Assessor.

Determinations on **causation** can be made on history taking, the mechanism of injury, accident documentation, ambulance and casualty, LMO, hospital discharge reports.

Diagnosis can be confirmed by telehealth examination and by supporting documents such as x-rays, CT, MRI, ultrasound, bone scans, nerve conduction studies etc.

Consistency can be enabled by pre-reading reports and conducting an audio-visual review with attendance to disability rating such as DASH and ADLs.

Treatment given and proposed has to be assessed as reasonable and necessary and causally related. Further treatment has to show:

1. It will improve the patient's condition;
2. Sustain wellbeing: physical and mental;
3. Promote return to function;
4. Assist the claimant with ADLs;
5. Facilitate return to work or domestic duties;
6. To be cost-effective, eg joint replacement, spinal fusion, cortisone injections;
7. Likely to produce sustained benefit.

Impairment The objective measure WPI may be reliant on interpretation of findings in the AMA Guides 4th and 5th Editions but a more realistic assessment should factor in impaction of activities of daily living and instrumental activities of daily living, eg creating a meal, assembling a construct, problem solving. Impairment assessment such as a successful anterior cervical decompression and fusion (ACDF) may be too high WPI assessment when the patient can subsequently be performing well and joint replacement may give a high WPI where the ADLs have substantially improved.

The AMA 6th Edition provides a paradigm shift from IMPAIRMENT >>>>> DISABILITY and is assisted by subjective questions such as AAOS lower limb rating scale and DASH (disability for shoulder and hand).

Work Capacity While this varies according to the type of industry involved, IMC plays a significant role as does the nominated treating doctor, occupational health physician and rehab consultant. The longer the claimant is away from work, the more accelerated is the deconditioning process and this requires physiotherapy and OT assessment as well as vocational guidance. Company MOs have an important role, eg Qantas Jet Base MOs, as do work site visits and return to work round table conferencing. It is a shame that occupation is not factored into WPI assessments as a low threshold WPI may impact on successful graduated return to work.

Domestic Assessment Ongoing assistance gratuitous or commercial, plus assistive devices such as hand rails, ramps, long handled tools are best assessed by home visits by OTs, particularly for future needs and costing of realistically necessary home modifications. OTs who do return to driving assessments are important in this context. Usually, domestic assistance has to be greater than 6 hours per week to have ongoing compensation.

The above remarks are a tentative preamble for the AMLC Webinar on causation, diagnoses, consistency, work capacity, domestic assistance.

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