ASISA GUIDELINE FOR ASSESSING DISABILITY DUE TO SPINAL IMPAIRMENT

Date of first publication: 3 April 2024

Date of last update: N/A

INDEX

1. INTRODUCTION

1.1. This Guideline for Assessing Disability due to Spinal Impairment ("**Guideline**") has been prepared on the basis of publicly available research conducted in relation to best practices in respect of spinal impairment disabilities and are being shared with our members and the public at large for their further consideration and education.

1.2. Whilst the Guideline may serve as a useful background to the industry as to how spinal impairment disabilities are ordinarily assessed, the Guideline is non-binding and each ASISA member and member of the public ought to take their own independent views and decisions as to how they wish to operate in the market.

1.3. By way of background, spinal impairments comprise one of the leading causes of disability claims in the South African insurance industry.

1.4. These claims can be complex for the following reasons:

1.4.1. complexity and subjectivity of measuring pain;

1.4.2. age-related degenerative changes are expected;

1.4.3. disparity between the investigation results and the claimant's physical symptoms;

1.4.4. BMI and sedentary lifestyle could play a role in neck and back pain;

1.4.5. the spine is involved in both physical and sedentary duties (i.e., for most occupations);

1.4.6. inadequate treatment – claimants are often only managed medically and are not referred to allied health professionals like physiotherapists or occupational

therapists who can assist with lifestyle modification, managing pain etc.;

1.4.7. inadequate funding for vocational or other rehabilitation;

1.4.8. inconsistency in the quality of medical reports;

1.4.9. inconsistency in treatment regimens (some doctors will recommend permanent boarding while others will attempt rehabilitation first).

1.5. There are also several non-medical reasons that contribute to the complexity of a disability claim, such as:

1.5.1. Pre-existing spinal impairments: In some instances, particularly under group arrangements, some employees have a pre-existing spinal impairment. They may be able to work with this impairment, sometimes with ongoing medical management. When this spinal impairment begins to affect their productivity or results in an increase in sick leave it sometimes results in the submission of a claim. The assessor would have to determine if the claim event has occurred within the pre-existing period as defined in the policy, or not. For individual business, clients who disclosed a pre-existing spinal condition may have a spinal exclusion on their policy. The assessor should determine whether the current claim is related to the pre-existing condition or not and whether the exclusion is applicable.

1.5.2. Lack of job availability/downturn in economy: A tough economic climate often drives the increase in submission of disability claims, or the pressure to pay income disability claims for a longer period. It is often difficult to motivate someone to return to work if the business is not doing well and their income may not be guaranteed.

1.5.3. Certain industries: Certain industries (for example mining) require people to be

physically and mentally fit and healthy to perform their occupation. There are stringent health and safety standards that must be adhered to, to allow someone to work. These standards often do not completely align to the insurance definitions in the contract. In addition, the responsibility to approve someone as fit to work lies with the occupational health practitioner at that specific employer, and not with the insurer. Certain industries with their own standards and codes may prove challenging for disability assessments.

1.5.4. Unfavourable working conditions: It is well known that the number of disability claims can be increased with job dissatisfaction, unpleasant working conditions, or menial job tasks.

2. BACKGROUND TO THE GUIDELINE

2.1. The need for a guideline for assessing disability claims for patients with back pain was initially addressed by the previous association for life insurers, the Life Offices Association ("**LOA**"). The LOA guideline was utilised in preparing this Guideline. It encompasses spinal pain (back and neck) and takes account of developments in the management and therefore outcomes of patients experiencing spinal pain. It includes references to new diagnostic tools and management techniques.

2.2. This Guideline was prepared by members of the ASISA Medical & Underwriting Standing Committee with assistance from the Claims Standing Committee.

3. PURPOSE OF THIS DOCUMENT

3.1. To provide a useful guideline for clients, doctors, and insurers on the various approaches to disability assessment for claims resulting from spinal impairments.

3.2. To assist in clarifying the potential roles and responsibilities of the parties involved.

3.3. To remind all relevant parties that insurance claims should be dealt with in accordance with the principles of Treating Customers Fairly.

4. DISTINGUISHING BETWEEN DISABLITY AND IMPAIRMENT

For anyone dealing with claims on a medical basis, it is important to distinguish between "impairment" and "disability."

4.1. Impairment

The World Health Organisation ("**WHO**") defines "***impairment***" as "*any loss or abnormality of psychological, physiological or anatomical structure or function*."[1] In essence, this is a medical concept describing an alteration in an individual's health status. Impairment is assessed by medical means after a diagnosis has been made and appropriate treatment given. It is important to note which activities of daily living a person can perform and those which are not possible. It is also important to recognise that "normal" is not a fine point or absolute. Normality is often within a range, e.g. with vision or hearing and can vary with age, gender, and other factors. Interpretations of normal that are too strict can result in over or underestimation of the degree of impairment.

4.2. Disability

4.2.1. The WHO defines "***disability***" as "*any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being*".[1]

4.2.2. The American Medical Association defines "***disability***" as "*an alteration in the individual's capacity to meet personal, social or occupational demands or statutory or regulatory requirements because of an impairment*."[4]

4.2.3. Whereas impairment evaluation is a medical concept, disability assessment is a legal one. Disability represents the gap between what a person can do and what he or she wants or needs to do. It is clear that an impairment per se is not necessarily a disability.

4.2.4. In assessing disability, the extent of a person's impairment needs to be judged in the context of their job function, the definition of disability in the policy being considered and personal factors such as education, experience etc. These issues will be discussed in more detail in section 5.

4.2.5. It is therefore clear that, on their own and absent any additional input and/or advice a medical practitioner will not be in a position to unilaterally express an opinion on disability. The practitioner will be fully informed regarding the medical condition and its effects on the activities of daily living, but she/he usually has no information on:

- the patient's working history, previous occupations, qualifications, experience etc;
- the relevant job description; and
- the policy terms, conditions, and definitions.

4.2.6. The doctor's medical advice and views based on the patient's detailed medical information and functional impairment due to the disease will greatly assist the patient's insurer and/or employer in assessing the insured's claim.

4.2.7. It would be advisable for the patient to be informed that the ultimate decision regarding the disability claim will be made after the insurer's doctors, legal advisors, claims assessors and other relevant persons inputs and advice have been considered.

5. ASSESSING DISABILITY

As has already been stated above, disability assessments are, in the main, a legal assessment as opposed to a purely medical concept.

Based on the research conducted, insurers usually take the following into consideration when assessing disability claims:

- the claimant;
- job description, including work environment;
- policy contract which includes the disability definition;
- the medical impairment.

Factors regarding claimants that are likely to be considered include age, qualifications, experience, and previous occupational history.

Whilst occupations can generally be classified into several categories, they are most often split into manual, travel, supervisory or administrative functions. It will, therefore, become important to have a full description of the claimant's functional capacity and the effect that the impairment has on activities of daily living.

5.1. MOST READILY UNDERSTOOD DISABILITY CLAUSE DEFINITIONS

Clearly, clause wordings will differ from one company to another, and each insurer must

unilaterally determine their own contract wording, but for ease of reference, the three most common types of cover that are readily available include, own occupation; own or similar occupation and any occupation. These concepts are explored in further detail below.

5.1.1. Own Occupation

Where a claim is considered when the claimant can no longer perform his own specific occupation as was described and stated at the time of issue of the contract, or for group business, as defined by their job description.

5.1.2. Own or Similar Occupation

Where a claim under the contract is considered when the claimant is unable to perform his or her own occupation and is also incapable of performing a similar occupation that he or she may be expected to follow considering education, training, and experience.

It is often this definition that leads to misunderstandings and unhappiness on the part of the claimant, especially in circumstances where a medical practitioner has declared someone unfit to perform their own occupation but has not simultaneously had any regard to the terms and conditions of the claimant's insurance policy or contract.

5.1.3. Any Occupation

This is an extremely wide definition, where a claim is likely to be considered only when the claimant is unable to perform even the most menial of tasks.

5.2. TOTAL AND PERMANENT DISABILITY

5.2.1. **Permanence**

The concept of permanence is of crucial importance to assessments of disability.

A permanent impairment is one that has become static or stabilised during a period of time sufficient to allow optimal recovery and healing and one that is unlikely to change despite further surgical or other medical treatment. This concept is similar to the American Medical Association's expression of maximal medical improvement. [4]

Reasonable treatment will depend on the risks attached to such treatment, the degree of success that can be expected undergoing such treatment and what the average reasonable patient with a similar condition would be prepared to undergo.

5.2.2. **Total Disability**

A person will only be considered totally disabled when they are unable to perform a substantial percentage of their occupational duties, despite optimal treatment. Each insurer should include in their policy wording what is considered "substantial."

5.3. OTHER COMMON / OFTEN USED CLAUSES IN THE POLICY CONTRACT

It is important to read the entire contract to determine if there are specific exclusions/conditions that may apply. There may be a specific spinal exclusion from the underwriting of the policy which needs to be taken into consideration. For example, in some contracts, claimants may be required to undergo or be compliant with treatment, to improve their condition. This is important to establish as it may be used in the case

management process.

5.4. AVAILABILITY OF EMPLOYMENT

Disability insurance usually only covers a person's ability to perform their occupation and not the availability of alternative employment or the ability to commute to work. The unavailability of another job within a company or in the open labour market is therefore often irrelevant in terms of disability insurance.

6. EVALUATING POTENTIAL CLAIMS

6.1. RECOGNIZED ROLES OF THE DIFFERENT PARTIES

The roles of the various people involved in the assessment are generally as follows:

6.1.1. Medical specialists

It is preferable for the treating doctor not to be involved in the assessment. The doctor may have been involved with his patient and the family for many years and it is possible that the treating doctor will be subjectively involved in the illness.

Whilst a full report from the treating doctor will most likely be required, the value of the report will most often be limited to obtaining a full history and cause of the illness of the claimant. The insurance companies do not underestimate the value of the information obtained from the treating doctor.

Notwithstanding the above usual practice, an independent medical specialist may still be used in the assessment process to provide an objective opinion on the medical impairment.

6.1.2. The Occupational Therapist

Occupational Therapists ("**OTs**") are often appointed by the Insurer to assist with a functional capacity evaluation, particularly for occupational disability claims. The OT should be carefully briefed on what is required of them and should provide the insurer with a detailed report of the claimant's abilities and limitations. This is done via standardized testing, interviewing and through obtaining collateral information. The OT usually provides feedback on the occupational match and whether any accommodations/adaptations would allow the claimant to continue working in a full or partial capacity but does not generally give an opinion on the outcome of the claim. Whilst not prescribed in any way, the cost of the OT evaluation is more often than not borne by the insurer.

6.1.3. Independent medical expert opinions (Specialists or Occupational Therapists)

Independent medical specialists and functional capacity examiners are usually requested when an objective opinion on the person's functional impairment is required. The Insurer will usually assess the claimant's disability by considering all the available information.

This usually relieves the pressure on the independent medical expert ("**IME**") and enables him/her to take a more objective decision.

The role of the IME is, therefore, generally limited to supplying the Insurer with a medical opinion about the degree of functional impairment.

Any decision by an employer to declare a person disabled for work does not necessarily mean that the patient will automatically qualify for a payment for

disability benefits under his/her insurance policy. The decision about disability will be taken by the relevant insurer, based on the terms and conditions of its policy conditions / contracts with the claimant.

6.1.4. The Employer or those who are self-employed

The employer will usually supply full details of the job description of the employee and consider the Labour Relations Act. This implies workplace adaption and the possibility of realignment within the company. For self-employed individuals it is important to understand the exact nature of their duties as well as how many people work for them, and whether any of them are able to assist with their job functions for a period of time.

6.1.5. The Life Insured

The life insured or claimant is the individual that supplies the insurer with complete and accurate details of their claim, usually on a standard form to give the insurer the necessary background information. All supporting evidence required by the insurer in question (e.g., medical reports, treatment history, current limitations etc.) are also provided.

6.1.6. The Insurer

In dealing with disability claims, communication with the claimant can solve many misperceptions. The insurer needs to be sensitive to the claimant's fears and concerns around the claim process. Any requirements should be explained to the claimant so that they become a willing participant in the process.

Clear and precise reasons should be provided to the claimant in laymen terms if a claim is declined or there is a delay in the assessment process.

Where referrals are made to doctors and specialists the insurer must carefully brief them about their specific requirements.

6.2. MEDICAL ASPECTS

Introduction

6.2.1. Chronic pain is common, affecting around one in five patients in primary care. It may occur even more frequently in older individuals, whose presentation is often complicated by age-related physiological changes, or comorbidities. Chronic back pain patients are more likely to report anxiety or depression and significant activity limitations. Chronic pain may have a significant impact on health-related quality of life and may be difficult to manage. There may be multiple pathologies which can cause spinal pain, some with its own characteristics and others being non-specific, and this may require different management techniques. It may originate and present as radicular pain, facet joint pain, sacro-iliac pain, pain related to lumbar stenosis or discogenic pain.

Basic Anatomy and Pathophysiology

6.2.2. The spine has a complex anatomy. It consists of a supportive external skeletal structure made up of the vertebrae and the discs in between the vertebrae, as well as the internal structure consisting of the spinal cord and the nerve roots.

6.2.3. The anatomy of the spine allows it to be highly flexible, providing for mobility in many different planes while the intervertebral discs are compressible structures that can distribute compressive loads and allow rotational movement.

6.2.4. The vertebral structures include the vertebra, the intervertebral discs, the facet joints interlinking the vertebrae, the intervertebral foramen (opening) through

which the nerve roots exit the spine, and the spinal canal which contains the spinal cord.

6.2.5. Other soft tissue structures such as ligaments, tendons and muscles provide stability, protection, and movement to the spine.

6.2.6. The intervertebral disc comprises of an outer fibrous capsule (annulus fibrosus) and an inner gel-like substance called the nucleus pulposus. A capsular tear or traumatic injury can cause the inner gel-like substance to bulge and protrude causing a pressure effect on the surrounding structures such as the spinal cord and or nerve roots.

6.2.7. The spine is divided into in 5 areas, the cervical spine (C1 to C7), the thoracic spine (T1 to T12), the lumbar spine (L1 to L5), the sacral spine (S1 to S5) and the coccyx.

~~6.2.8.~~ The spinal cord extends from the medulla oblongata (bottom of the brain) and terminates at the level of T12 / L1 called the conus medullaris, whereafter it becomes a group of nerves (similar to the tail of a horse) and is called the cauda equina.

6.2.9. Spinal conditions are a consequence of a wide range of pathological causes, resulting in non-specific chronic spine pain, spondylosis, spinal stenosis, spondylolysis, spondylolisthesis, spondyloarthropathies and traumatic injuries such as fractures[4], and are defined as follows:

6.2.9.1. Spondylosis is a general term referring to the "wear and tear" of the vertebrae, spinal discs, and the facet joints between the vertebrae.

6.2.9.2. Spondylolysis is the breakdown of a portion of the vertebra called

the pars interarticularis. This defect predisposes to spondylolisthesis.

6.2.9.3. Spondylolisthesis is the forward or backward displacement of the body of one of the vertebrae.

6.2.9.4. Spondyloarthropathy refers to a group of inflammatory rheumatic diseases affecting the sacroiliac joint and includes ankylosing spondylitis and psoriatic arthritis.[4]

Radiculopathy

6.2.10. The American Medical Association Guides to the Evaluation of Permanent Impairment ("**AMA Guides**")[4] define radiculopathy as significant alteration in the function of a single or multiple nerve roots and is usually caused by a mechanical or chemical irritation of one or several nerves.

6.2.11. To satisfy the definition of a radiculopathy as per the AMA Guides, the following criteria must be met:

6.2.11.1. There must be a cause such as a mechanical irritation e.g., protrusion of a herniated disc.

6.2.11.2. It must result in significant alteration in the function of the nerve root.

6.2.11.3. The clinical signs can be objective i.e., you can test and quantify it, but it can also be subjective such as pain, numbness, and paraesthesia.

6.2.11.4. The objective signs include motor weakness, positive root tension sign and loss of reflexes.

6.2.11.5. Subjective signs are sensory signs such as pain, numbness, and paraesthesia.

*Objective findings are always given the greater weight of evidence over subjective complaints. Subjective signs are more difficult to assess and therefore these complaints should be consistent and supported by other findings of radiculopathy e.g., imaging and or objective evidence such as electrodiagnostic studies[4].

Risk factors

6.2.12. There are various known risk factors that increase the probability of an individual developing a spinal impairment.[3] The following factors are of significance:

- obesity;
- age;
- female sex;
- physically strenuous occupations or sporting activities;
- sedentary lifestyle;
- psychological stressors – anxiety, depression, somatization disorder;
- nutritional deficiencies e.g. calcium deficiency;
- smoking;
- autoimmune and musculoskeletal disorders – rheumatoid arthritis, osteoarthritis, osteoporosis, thyroid disease etc.;
- ergonomics;

- physical trauma.

6.2.13. Each insurer must ensure that they independently and unilaterally determine their own risk factors when setting their individual claims requirements.

Diagnosis and clinical screening

6.2.14. The diagnosis of spinal pathology involves a careful history of the symptoms and signs as well as functional impairment experienced by the patient, examination by a specialist such as a neurosurgeon or an orthopaedic surgeon as well as special investigations such as X-rays, MRI scanning, and electrodiagnostic testing (nerve conduction- and EMG studies).

6.2.15. An impairment caused by spinal pathology can be calculated according to the AMA Guides.[4] As per the AMA Guides, the diagnosis of spinal conditions is grouped as follows:

- non-specific chronic, or chronic recurrent spine pain;
- intervertebral disc and motion segment pathology (single and multiple levels);
- spinal stenosis;
- spine fractures and or dislocations.

Management of Spinal Conditions

6.2.16. In general, spinal pain is often the dominant sign or symptom of spinal impairment. Spinal pain is usually defined as acute when it persists for less than six weeks, subacute between six weeks and three months, chronic when it lasts longer than three months.

6.2.17. In clinical practice, triage is focused on identification and classification of pain into one of the 3 categories mentioned above, namely either acute, subacute or chronic. This categorization serves as an indicator of possible underlying pathology, including nerve root problems, which is usually established at diagnosis, based on physical examination and special investigations. This assessment also often drives the choice of treatment modalities employed.

6.2.18. Ideally the assessment and management of a pain related claim, as most Spinal impairments often present, should be done as soon as reasonably possible. Rehabilitation interventions involving the appropriate heath care professionals should occur without delay, as clinically required.

6.2.19. It is important to view each case on its own merits, taking into consideration the claimant's individual circumstances.

Treatment Modalities

6.2.19.1. A systematic review of the European Neck and Low Back Pain Clinical Practice Guidelines [5], which was borne out of a substantial evidence base, highlights the recommended treatment options for neck and back pain.

6.2.19.2. These guidelines encompass both nonpharmacological and pharmacological treatment modalities, as illustrated below:

- Nonpharmacological options
    - guidance to stay active and avoid bed rest;
    - exercise, manual therapy, or mobilization;

- psychological/behavioural therapy.

- Pharmacological options
  - paracetamol;
  - NSAIDs;
  - opioids;
  - muscle relaxant;
  - antidepressants.

* Please note the above should be prescribed by treating specialists and should be specific to the client's presentation, thus opioid prescription should not be standard practice.

- Surgical Intervention
  - laminectomy or spinal decompression;
  - discectomy;
  - foraminotomy;
  - spinal fusion;
  - artificial disk replacement;
  - vertebroplasty and kyphoplasty;
  - rhizotomy;
  - epidural injections with steroid and local anaesthetic.

6.2.19.3. Mounting evidence suggests that non-pharmacological treatment regimens can be as effective, and hypothesized to possibly be more

so, than the traditional approach of pharmacological therapy in isolation. A more holistic, multi-disciplinary approach is now advocated for by authorities in the field, which is supported by a rich evidence base.

6.2.19.4. Please refer to **Appendix 1** for further detailed information if required.

Specialist opinions and FCE

6.2.19.5. The management of backpain is usually handled by a multidisciplinary team, comprising the following medical professionals:

- The treating specialist(s):
  - neurosurgeon;
  - orthopaedic surgeon;
  - neurologist;
  - pain specialist, often an anaesthesiologist, when pain is chronic.
- Rehabilitation specialist/s
  - physiotherapist with a special interest in treating pain;
  - OT with a special interest in treating pain;
  - biokineticist;
  - acupuncturist;
  - chiropractor, etc.;

- psychologist – especially when pain is chronic and is affected by psychosocial factors or comorbid psychiatric diagnoses present.

6.2.19.6. The primary aim of management is to improve symptomatology and encourage return to function. In this regard, a comprehensive physical and biopsychosocial assessment is usually required to establish the diagnosis and to guide management decisions.

6.2.19.7. As mentioned, the objective of treatment in cases of Spinal Impairment is to either achieve complete resolution, or achieve optimal improvement in the condition, with the ultimate goal of maximal functionality and symptom control. In this light, the concept of maximal medical improvement or "**MMI**", as is it commonly referred to, is a measure of the point at which an individual has reached a state of their medical condition whereby the individual's medical condition and functioning cannot be improved any further. It is usually this milestone of MMI that triggers the consideration an impairment claim.

6.2.19.8. Once MMI had been attained, the treating specialist together with the multidisciplinary team, is to provide information pertaining to the clinical history, the functional impairment experienced as well as the findings on examination of the patient.

6.2.19.9. A functional capacity evaluation ("**FCE**") will add value in describing the impairments experienced by the patient in the context of his personal, social, and work life, and this evaluation will also provide recommendations on further rehabilitative measures that may be

necessary.

6.2.19.10. This information is invaluable during the claims assessment and claims management processes.

6.2.19.11. In some circumstances, an independent medical review may be necessary if the current medical management is not rendering any progress in functional status.

Source: AMA Guides 6th edition, The Spine and Pelvis, Chapter 17, p560 -592.[4]

Assessing Prognosis

6.2.20. The high prevalence of spinal impairments in South Africa and globally, has resulted in significant deterioration in quality of life for those afflicted by these heterogenous group of diagnoses. In terms of prognosis, this varies from person to person, and is often dependent on the severity of the underlying condition, and the efficacy of early and ongoing management or treatment strategies.

6.3. CASE MANAGEMENT

Regular reviews are performed on disability income claims to determine the claimant's response to treatment or rehabilitation and the likelihood of return to work. For spinal impairment claims it is imperative that the assessor has a clear understanding of the claimant's ongoing presentation and symptomatology, their response to treatment and whether rehabilitation is required or is being undertaken. It is also important to obtain regular medical feedback, including ongoing imaging and investigations to determine any change in the claimant's condition.

In practice, a clear, documented case management plan from the rehabilitation team is

usually required to plan for the claimant's successful return to work. This plan usually takes into account the claimant's functional abilities and limitations and clearly match these to their occupational duties. The assessor can potentially implement a graded return to work program, carefully increasing their exposure at work until full duties are possible. An OT can then potentially assist with this and manage the transition objectively.

It is noteworthy that, in most cases, case management will be at the direction of the claim assessor, after contact has been made with all role players. If external service providers or rehabilitation therapists are utilized for case management, it is recommended that a formal agreement be entered into between all parties. The employer, if applicable, should also be kept informed regarding the return-to-work plan to be prepared and able to monitor the claimant's progress.

In essence, where case management takes place, it should be proactive, frequent, accessible, and reasonable.

6.3.1. BRIEFING THE OCCUPATIONAL THERAPIST

6.3.1.1. When an OT FCE is required, the briefing of the OT is of the utmost importance. The assessor ought to provide clear direction regarding the requirements of the evaluation and should also provide all evidence including all medical reports, claim statements and job description. The OT should be advised whether they are assessing for own occupation/own duties or whether this extends to a reasonably suited occupation.

6.3.1.2. Best practice suggests that it is important that the OT evaluation includes:

- questionnaires and an interview with the claimant;
- collateral information from the spouse, a family member, the employer etc.;
- medical, social, and occupational history;
- standard tests a full assessment battery;
- clear understanding of the claimant's exact job duties and work set up;
- telephonic discussion with the treating specialist, if required.

6.3.1.3. If the OT report contains only self-reported information, the assessor will likely contact them to request that further work and functional tests be performed to support their conclusions and an addendum be added to the report. As one can imagine, it is vitally important that the assessor read and understand the full report and not just the conclusion. As in the case of the treating doctor, the OT's comments on the claimant's ability to perform their occupation will usually be considered as once of the factors to be taken into account when determining the claimant's disability and/or the outcome of the claim.

6.3.2. **EXAMPLES OF FUNCTIONAL QUESTIONS FOR THE CLAIMANT INCLUDE, BUT ARE NOT LIMITED TO**

- What is your current diagnosis/impairment?
- Please describe all your symptoms and their frequency.
- What tests were done to confirm your diagnosis?

- Which doctor is currently treating you and what is their speciality?
- How often are you attending this specialist?
- What treatment has your specialist prescribed for you? Please share details of your progress and any side effects.
- What is your current occupation? Please provide clear details of your specific work duties, including your work environment.
- What aspects of your occupation are you still able to perform/are you unable to perform?
- Is there any accommodation that can be made at work, to allow you to continue or return?
- What is your greatest difficulty at present?
- Comment on your ability to walk indoors and outdoors, as well as climb a flight of stairs.
- Comment on your ability to drive a car or utilise public transport.
- Which daily activities worsen your lower back pain?
- Which daily activities are you comfortably able to perform without pain?
- How long are you able to sit for, without significant pain?
- Comment on your ability to perform household chores such as sweeping, mopping, doing laundry, cleaning your car, making your bed, cleaning the swimming pool, fixing things etc.
- Comment on your ability to bend and pick something up off the floor.
- What weight are you able to lift within your pain threshold?

- What sport or leisure activities are you involved in?
- Comment on the quality of your sleep at night.

6.3.3. **EXAMPLES OF MEDICAL QUESTIONS FOR THE MEDICAL SPECIALIST INCLUDE BUT ARE NOT LIMITED TO**

- Please confirm the diagnosis/diagnoses and tests performed to verify this.
- What are the claimant's current symptoms, as well as the severity?
- Please describe the claimant's treatment regime, including any future intervention that can be tried.
- What rehabilitation would improve the claimant's symptoms and allow for an improvement in their functioning?
- Based on the imaging and test results, how is their condition likely to progress?
- What are the claimant's present limitations as a result of their back pain?
- In your opinion, what are the specific contra-indications for a return to their current occupation?
- Please comment on their ability to sit, stand, and mobilize currently.
- What other specialists has the claimant consulted to assist with their medical care?
- How are they able to manage their pain currently? Is there any other medical professional who should get involved to assist with this?
- Have they been referred to any mental health professional to help with managing their back pain? Please provide the details.

- Is their level of functioning aligned with their clinical picture? Please provide details.

7. REFERENCES

1. World Health Organisation. International Classification of Impairments, Disabilities, and Handicaps Geneva, Switzerland: World Health Organisation; 1980
2. World Health Organisation. International Classification of Impairments, Disabilities, and Handicaps Geneva, Switzerland: World Health Organisation; 1980
3. GBD 2021 Low Back Pain Collaborators. Global, regional, and national burden of low back pain, 1990-2020, its attributable risk factors, and projections to 2050: a systematic analysis of the Global Burden of Disease Study 2021. Lancet Rheumatol. 2023 May 22;5(6):e316-e329. doi: 10.1016/S2665-9913(23)00098-X. PMID: 37273833; PMCID: PMC10234592.
4. American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment. https://ama-guides.ama-assn.org/
5. Corp N, Mansell G, Stynes S, Wynne-Jones G, Morsø L, Hill JC, van der Windt DA. Evidence-based treatment recommendations for neck and low back pain across Europe: A systematic review of guidelines. Eur J Pain. 2021 Feb;25(2):275-295. doi: 10.1002/ejp.1679. Epub 2020 Nov 12. PMID: 33064878; PMCID: PMC7839780.

DOCUMENT HISTORY

Date	Publication / amendment

RESPONSIBLE COMMITTEES AND SENIOR POLICY ADVISOR

Responsible Board Committee	ASISA Life and Risk Board Committee
Responsible Standing Committees	ASISA Medical & Underwriting Standing Committee
Responsible SPA	ASISA Point Person to the ASISA Life and Risk Board Committee

APPENDIX 1

Taken from Corp N, Mansell G, Stynes S, Wynne-Jones G, Morsø L, Hill JC, van der Windt DA (Reference 5).

TABLE 5 Consistency of recommendations across low back pain vs neck pain guidelines

Intervention	Low Back Pain		Neck Pain	
	No. guidelines (countries)	Overall strength of recommendation	No. guidelines (countries)	Overall strength of recommendation
Reassurance (advice)	4(4)	Weak FOR	3(3)	Weak FOR
Advice and Education (advice)	10(8)	Strong FOR	5(5)	Weak FOR
Remain active (advice)	9(6)	Strong FOR	2(2)	Weak FOR
Encourage physical exercise (advice)	7(6)	Weak FOR	3(3)	Weak FOR
Continue/return to work (advice)	2(2)	Weak FOR	1(1)	(For)
Bed rest (advice)	6(4)	Strong AGAINST WITH EXCEPTIONS	1(1)	(Against)
Analgesics incl. for neuropathic pain	1(1)	(For)	2(2)	Weak FOR
Paracetamol	8(6)	Moderate AGAINST	2(2)	Weak FOR
NSAIDs	9(7)	Inconsistent	4(3)	Weak FOR
Opioids (including tramadol) +/- paracetamol (or NSAIDs)	8(6)	Inconsistent	2(1)	Weak FOR
Antidepressants	6(5)	Strong AGAINST WITH EXCEPTIONS		
Anticonvulsants/Antiepileptics	5(5)	Strong AGAINST		
Muscle relaxants	5(4)	Strong AGAINST WITH EXCEPTIONS		
Topical medications incl. NSAIDS	3(3)	Inconclusive	2(2)	Moderate FOR
Spinal injections [for non-specific LBP]	6(5)	Strong AGAINST		
Spinal epidural steroid injection	5(5)	Inconsistent	1(1)	(For)
Other injections	2(2)	Inconclusive		
Thermotherapy	5(4)	Inconsistent	2(2)	Inconclusive
Manual therapy	8(6)	Inconsistent	5(4)	Inconsistent
Manual therapy combined with other treatment	4(3)	Moderate FOR	3(3)	Moderate FOR
Exercise programs/therapy	9(6)	Strong FOR	5(5)	Moderate FOR
Exercise therapy combined with other treatment			2(2)	Moderate FOR
Group exercise programmes/back schools	3(3)	Moderate FOR		
Postural therapies	3(3)	Inconclusive		
Traction	6(6)	Strong AGAINST	3(3)	Inconclusive
Electrotherapy	6(6)	Strong AGAINST	4(4)	Inconclusive
Orthoses	6(6)	Strong AGAINST	4(4)	Inconclusive
Acupuncture	5(4)	Inconsistent	4(3)	Inconsistent
Psychological therapies	4(3)	Strong FOR SPECIFIC SUBGROUPS	3(3)	Weak FOR SPECIFIC SUBGROUPS
Psychological therapies combined with other treatment	2(2)	Moderate FOR		
Multidisciplinary treatment	7(5)	Strong FOR SPECIFIC SUBGROUPS	2(2)	Weak FOR SPECIFIC SUBGROUPS

(Continues)

TABLE 5 (Continued)

Intervention	Low Back Pain		Neck Pain	
	No. guidelines (countries)	Overall strength of recommendation	No. guidelines (countries)	Overall strength of recommendation
Work-based interventions	3(3)	Moderate FOR		
Return to work programmes	3(3)	Strong FOR		
Imaging	9(6)	Strong AGAINST WITH EXCEPTIONS	2(2)	Inconclusive
To surgeon/surgery	8(6)	Strong FOR SPECIFIC SUBGROUPS		Appendix S1 Appendix S2 Appendix S3 Appendix S4 Appendix S5 Appendix S6 Appendix S7