



WorkCover WA Guides for the Evaluation of Permanent Impairment

Second Edition Changes, November 2007

Location in WorkCover WA Guides	Description
	Paragraphs numbered to allow better referencing of particular parts of the WorkCover WA Guides
	Inserts information/clarification/instructions on:
Page 7 para 3.24	<ul style="list-style-type: none"> • Conditions which are not covered by the WorkCover/AMA5 Guides-Equivalent or Analogous Conditions;
Page 8 para 3.25	<ul style="list-style-type: none"> • Inconsistent Presentation;
Page 8 para 3.26	<ul style="list-style-type: none"> • Activities of Daily Living; and
Page 8 para 3.27	<ul style="list-style-type: none"> • Rounding.
Page 9 paras 3.31 and 3.32	Inserts two new headings: <ul style="list-style-type: none"> • Refusal of Treatment; and • Future Deterioration of a Condition.
Page 19 – 20 para 4.14	Insert: Conditions affecting the shoulder region. All shoulder assessments must have the following 'inclusion criteria': <ol style="list-style-type: none"> 1. A clear history of a shoulder injury 2. Symptoms consistent with a shoulder disorder (to be distinguished from symptoms due to referred pain from the neck). <ol style="list-style-type: none"> (i) Most shoulder disorders with an abnormal range of movement are assessed according to AMA5 Section 16.4-Evaluating Abnormal Motion. (ii) Rare cases of rotator cuff injury, where the loss of shoulder motion does not reflect the severity of the tear, and there is no associated pain, may be assessed according to AMA5 Section 16.8c – Strength Evaluation. (iii) Other specific shoulder disorders, where the loss of shoulder motion does not reflect the severity of the disorder, associated with pain, should be assessed by comparison with other impairments that have similar effect(s) on upper limb function.

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Page 20 para 4.15	Insert: 4.15 Ruptured long head of biceps shall be assessed as an upper extremity impairment (UEI) of 3%UEI or 2% WPI where it exists in isolation from other rotator cuff pathology. Impairment for ruptured long head of biceps cannot be combined with any other rotator cuff impairment.
Page 20 para 4.16	Insert: 4.16 Impingement. Diagnosis of impingement is made on the basis of positive findings on appropriate provocative testing and is only to apply where there is no loss of range of motion. Symptoms must have been present for at least 12 months. An impairment rating of 3% UEI or 2% WPI shall apply.
Page 20 para 4.17	Insert: Fractures Involving Joints. 4.17 Displaced fractures involving joint surfaces are generally to be rated by range of motion. If, however, this loss of range is not sufficient to give an impairment and movement is accompanied by pain and there is 2mm or more of displacement, allow 2% UEI (1%WPI).
Page 21 para 5.7	Insert: 'Regional impairments of the same limb (eg several lower extremity impairments) should be combined before converting to %WPI.'
Pages 27-28	Delete: Table 5.3 Lower extremity impairment flowchart
Page 29 para 6.11	Insert: Approved medical specialists should state the method they have used to measure the percentage compression of a vertebral body from relevant X-rays. The loss of vertebral height should be measured at the most compressed part and must be documented in the impairment evaluation report. The estimated normal height of the compressed vertebra should be determined where possible by averaging the heights of the two adjacent (unaffected and normal) vertebra.
Page 29 para 6.13	Insert: '(including Table 15-7, p404, AMA5). '
Page 30	Delete Table 6.1 Assessing spinal impairment.
Page 30	Delete Table 6.2 History of spinal complaint
Page 30 para 6.21	Delete: 'Impotence' and insert: 'Loss of sexual function' and insert after 'objective evidence of' the word 'relevant' before 'spinal cord'.

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Page 30 para 6.22	<p>Delete:</p> <ul style="list-style-type: none"> dermatomal distribution of pain or numbness or paraesthesia; positive root tension sign; concordant finding on an imaging study (Box 15-1, AMA5 p 382); loss or asymmetry of reflexes; muscle weakness that is anatomically localised to an appropriate spinal nerve root distribution; and reproducible sensory loss that is anatomically localised to an appropriate spinal nerve root distribution.
Page 30 para 6.22	<p>Insert:</p> <ul style="list-style-type: none"> Positive root tension sign (some examples are given at p375, AMA5); Loss or asymmetry of reflexes; Muscle wasting/atrophy (Box 15-1, p382, AMA5) Muscle weakness that is anatomically localised to an appropriate spinal nerve root distribution; Reproducible impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution. Findings on an imaging study consistent with the clinical signs (AMA5, p382).
Page 31 para 6.27	<p>Insert:</p> <p>'Displaced' before 'fractures of transverse or spinous processes are assessed as DRE Category II because the fracture does not disrupt the spinal canal (AMA5, p 385) and they do not cause multilevel structural compromise.'</p>
Page 31 para 6.28	<p>Insert:</p> <p>Within a spinal region separate spinal impairments are not combined. The highest value impairment within the region is chosen. Impairments in different spinal regions are combined using the combination tables.</p>
Page 31 para 6.29	<p>Insert:</p> <p>Impact of ADL's. Tables 15-3, 15-4 and 15-5 of AMA5 give an impairment range for DRE's II-V. The bottom of the range is chosen initially, and a percentage of from 0-3% may be added for the impact of the injury on the worker's ADL's. Hence, for example, for an injury which is rated DRE Category II, the impairment is 5%, to which may be added an amount of up to 3% for the impact of the injury on the worker's ADL's.</p>

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Page 31 para 6.30	<p>Insert:</p> <p>As a guide to determine whether 0, 1, 2, or 3%WPI should be added to the bottom of the appropriate impairment range the following should apply:</p> <ul style="list-style-type: none"> 0% where the activities of daily living has not been impaired, or only minimally impaired. 1% if the worker's capacity to undertake tasks related to sport, recreation, gardening, etc, has been impaired. 2% if the worker's capacity to undertake household tasks (eg. cooking, climbing stairs) has been affected. 3% if the worker's capacity to undertake personal care activities (eg dressing, washing) has been affected.
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Page 31 para 6.31	The maximum amount that the base impairment due to a spinal injury can be increased due to impact on ADL's is 3% WPI .
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Page 32 para 6.32	<p>Insert:</p> <p>'Therefore Table 6.2 was developed to rectify this anomaly.'</p> <p>Before 'Table 6.2 indicates the additional ratings to which...'</p>
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Page 32	<p>Insert in Table 6.2:</p> <table border="1"> <tr> <td>2nd and further levels, operated on, with medically documented pain and rigidity</td> <td>1% each additional level</td> <td>1% each additional level</td> <td>1% each additional level</td> </tr> <tr> <td>Second operation</td> <td>2%</td> <td>2%</td> <td>2%</td> </tr> <tr> <td>Third and subsequent operations</td> <td>1%</td> <td>1%</td> <td>1%</td> </tr> </table>	2nd and further levels, operated on, with medically documented pain and rigidity	1% each additional level	1% each additional level	1% each additional level	Second operation	2%	2%	2%	Third and subsequent operations	1%	1%	1%
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Page 32	<p>And insert after the Table:</p> <p>'In summary, to calculate whole person impairment (WPI) for persisting radiculopathy (as per definition) following surgery:</p> <ol style="list-style-type: none"> 1. Select the appropriate DRE category from Table 15-3, 15-4, or 15-5; 2. Determine a WPI value within the allowed range in Table 15-3, 15-4 or 15-5 according to the impact on the worker's activities of daily living; 3. Combine this value with the appropriate additional amount from Table 4.2 to determine the final WPI.
Page 32 para 6.33	<p>Insert:</p> <p>Disc Replacement Surgery. The impairment resulting from this procedure is to be equated to that from a spinal fusion.</p>
Page 35 para 7.16	<p>Delete:</p> <p>Assessment of sexual functioning (AMA5, Chapter 7, pp 143–171): Impotence is assessed as an impairment only if there is an associated neurological impairment.</p> <p>and insert:</p> <p>'Assessment of sexual functioning (AMA5, Chapter 7, pp 143–171): sexual function should only be assessed as an impairment where there is objective evidence of relevant spinal cord, cauda equina, or bilateral nerve root dysfunction, or lumbo-sacral plexopathy. There is no additional impairment rating for impotence in the absence of objective clinical findings.'</p>
Page 43	<p>Insert:</p> <p>9.14 Loss of sexual function related to spinal injury should only be assessed as an impairment where there is other objective evidence of relevant spinal cord, cauda equina or bilateral nerve root dysfunction. The ratings described in Table 13–21 on p342 of AMA5 are used in this instance. There is no additional impairment rating system for loss of sexual function in the absence of objective clinical findings.'</p>

Page 83

Insert:

- 18.2 **AMA5, p136: Section 6.6 Hernias.** Occasionally in regard to inguinal hernias there is damage to the ilio inguinal nerve following surgical repair. Where there is loss of sensation in the distribution of the ilio inguinal nerve involving the upper anterior medial aspect of the thigh, a 1%WPI should be assessed.
- 18.3 Where, following repair, there is severe dysesthesia in the distribution of the ilio inguinal nerve, a 2%WPI should be assessed.
- 18.4 Where, following repair of a hernia of the abdominal wall, there is residual persistent excessive induration at the site, which is associated with significant discomfort, this should be assessed as a Class 1 herniation (AMA5, Table 6-9, pp136).
- 18.5 Impairments due to nerve injury and induration can not be combined.
The higher impairment should be chosen.
- 18.6 A person who has suffered more than one work related hernia recurrence and who now has limitation of ADL's (eg lifting) should be assessed as herniation Class 1 (AMA5, Table 6-9, pp136).'