WorkCoverWA

WorkCover WA Guidelines for the Evaluation of Permanent Impairment

Summary of changes from third to fourth edition

December 2016

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This summary provides technical information regarding specific changes from the third edition of the *WorkCover WA Guides for the Evaluation of Permanent Impairment* to the fourth edition of the *WorkCover WA Guidelines for the Evaluation of Permanent Impairment* (the WorkCover WA Guidelines).

To understand the specific information in this document you will need to read it in conjunction with the fourth edition of the WorkCover WA Guidelines. The numbering in this document refers to clauses in the fourth edition.

Overall changes to WorkCover WA Guidelines

In 2015 Safe Work Australia endorsed the template National Guidelines for the Evaluation of Permanent Impairment. The National Guidelines were based on the fourth edition of the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment.*

The WorkCover WA Guidelines have historically mirrored the NSW Guidelines. Accordingly, the changes in the fourth edition of the WorkCover WA Guidelines are not extensive when compared to earlier iterations of the Guidelines.

WorkCover WA has endeavoured to adopt the content of the National Guidelines wherever possible, to adhere to the aim of national consistency in the evaluation of permanent impairment.

Key modifications include the sequencing and content of the introduction, minor adjustment to some impairment figures, wording changes, relocation of the definitions and new methodology for the assessment of complex regional pain syndrome.

It should be noted this document identifies the material changes from the third edition of the Guidelines. It does not identify each and every change. For example, the deletion of redundant or outdated information is not identified (e.g. deletion of clause 3.8 of the third edition which relates to repealed legislation), nor are single word changes.

From Guides to Guidelines

The title of the document has changed from *WorkCover WA Guides for the Evaluation of Permanent Impairment* to *WorkCover WA Guidelines for the Evaluation of Permanent Impairment*. The change from 'guide' to 'guidelines' maintains consistency with the template National Guidelines.

A preface for each chapter

Each chapter now has a preface. This addition to the WorkCover WA Guidelines will provide readers with a snapshot of the chapter, outlining the references used and reading required before proceeding through the chapter.

1. Introduction

The structure of the introduction has altered to group similar paragraphs and content in a logical format, being:

- Intent and legislative basis for the WorkCover WA Guidelines
- Principles of assessment
- Administrative process

Clause	Change
1.9	**Principles of assessment** Revised summary of some of the key principles of permanent impairment assessment.
1.15	**Body systems covered by the WorkCover WA Guidelines** Refers to the introduction of revised Chapter 17 of the WorkCover WA Guidelines relating to the assessment of complex regional pain syndrome.
1.29	**Conditions that are not covered in the WorkCover WA Guidelines – equivalent or analogous conditions** Added new sentence to the end of first paragraph: *The assessor must stay within the body part/region when using analogy.*
1.31	**Activities of daily living** New clause which provides when assessing the impact of an injury on activities of daily living, the assessment should be verified by reference to objective assessments where possible.
1.32	**Rounding** Changed wording from 'values of 0.4 or less are rounded down to the nearest whole number' to: 'values of less than 0.5 are rounded down to the nearest whole number'.
-	**Future deterioration of a condition** Deleted the following text from clause 3.34 of the third edition as it does not reflect the assessment of impairment and the manner in which compensation is payable under the Act: *If the worker's condition deteriorates at a later time, the worker may request a further evaluation of impairment, subject to any relevant provision in the Act that affects the ability of a worker to request or obtain a further evaluation.*
-	Clause 3.77 of the third edition is deleted following the 2011 legislative amendments removing the prohibition on certificates being used for more than one purpose.
1.79 1.80 1.81	**AMS reports and certificates** New content in these clauses more clearly outlines the minimum requirements that should be addressed in a report and certificate evaluating a worker's degree of impairment. See WorkCover WA Guidelines clauses 1.79-1.81 for content in full.

2. Upper extremity

Clause	Change
-	Clause 4.2 of the third edition has been deleted which stated: *"The most practical and useful approach to evaluating impairment of part of the upper extremity is to compare the current loss of function with the loss resulting from amputation."* The most useful approach to assessing impairment is to follow the procedure outlined in the WorkCover WA Guidelines, not by a direct comparison with amputation.
2.5	**The approach to assessment of the upper extremity and hand** Deleted paragraph 4.5 of the third edition. Replaced with: *Range of motion (ROM) is assessed as follows:* • *A goniometer or inclinometer must be used, where clinically indicated.* • *Passive ROM may form part of the clinical examination to ascertain clinical status of the joint, but impairment should only be calculated using active ROM measurements. Impairment values for degree measurements falling between those listed must be adjusted or interpolated.* • *If the AMS is not satisfied that the results of a measurement are reliable, repeated testing may be helpful in this situation.* • *If there is inconsistency in ROM then it should not be used as a valid parameter of impairment evaluation. Refer to paragraph 1.43 in the WorkCover WA Guidelines.* • *If ROM measurements at examination cannot be used as a valid parameter of impairment evaluation, the AMS should then use discretion in considering what weight to give other available evidence to determine if an impairment is present.*
2.8	**The approach to assessment of the upper extremity and hand** Added sentences to explain the combination of impairment before conversion of regional impairments to WPI: *When the Combined Values Chart is used, the AMS must ensure that all values combined are in the same category of impairment (that is WPI, upper extremity impairment percentage, hand impairment percentage and so on). Regional impairments of the same limb (eg. several upper extremity impairments), should be combined before converting to percentage WPI (Note that impairments relating to the joints of the thumb are added rather than combined – see AMA5, p 454, 16.4d thumb ray motion impairment.).*
2.9	**Peripheral nerve disorders** Added new sentence: *The assessment of carpal tunnel syndrome post-operatively is undertaken in the same way as assessment without operation.*

Clause	Change
2.12	**Impairment due to other disorders of the upper extremity** More detail provided about assessing the range of disorders: *In Section 16.7 (impairment of the upper extremities due to other disorders) AMA5 notes 'the severity of impairment due to these disorders is rated separately according to Table 16-19 through 16-30 and then multiplied by the relative maximum value of the unit involved as specified in Table 16-18'. This statement should not include tables 16-25 (carpal instability), 16-26 (shoulder instability) and 16-27 (arthroplasty), noting that these tables are already expressed in terms of upper extremity impairment.* Clause 4.12 of the third edition has been deleted, relating to carpal instability.
2.14	**Conditions affecting the shoulder region** New clause 2.14 replaces the 'inclusion criteria' from the third edition for assessing shoulder injury and replaces it with more explanatory guidance for assessment. Additionally, the impairment amounts attributable to resection arthoplasties have been modified. Impairment to the acromioclavicular joint has been decreased, while impairment to the sternoclavicular joint has been increased. The following three paragraphs have been added in relation to resection arthroplasty and impairment for the steroclavicular joint: *As noted in AMA5 16.7b 'Arthroplasty', "In the presence of decreased motion, motion impairments are derived separately and combined with the arthroplasty impairment". This includes those arthroplasties in Table 16-27 designated as "(isolated)".* *The following impairments in AMA5 are modified by the WorkCover WA Guidelines:* • *In Table 16-27 (p506 AMA5):* - *the figure for resection arthroplasty of the distal clavicle (isolated) is modified to be 5% upper extremity impairment,* - *the figure for resection arthroplasty of the proximal clavicle (isolated) is modified to be 8% upper extremity impairment.* • *In Table 16-18 (p499 AMA5) the figures for sternoclavicular joint are modified to be 25% upper extremity impairment and 15% whole person impairment.*
2.15	**Conditions affecting the shoulder region** Added words (underlined) *Ruptured long head of biceps shall be assessed as an upper extremity impairment (UEI) of three per cent UEI or two per cent 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 or with loss of range of movement.*

Clause	Change
2.18	**Epicondylitis of the elbow** Added new clause: *This condition is rated as 2% UEI (1% WPI). In order to assess impairment in cases of epicondylitis, symptoms must have been present for at least 18 months. Localised tenderness at the epicondyle must be present and provocative tests must also be positive. If there is an associated loss of range of movement, these figures are not combined, but the method giving the highest rating is used.* Clauses 4.18-4.20 of the third edition have been deleted.
2.19	**Resurfacing procedures** Added new clause: *No additional impairment is to be awarded for resurfacing procedures used in the treatment of localised cartilage lesions and defects in major joints.*
2.20	**Calculating motion impairment** Added new clause: *When calculating impairment for loss of range of movement, it is important to always compare measurements of the relevant joint(s) in both extremities. If a contralateral 'normal/uninjured' joint has less than average mobility, the impairment value(s) corresponding to the uninvolved joint serves as a baseline and is subtracted from the calculated impairment for the involved joint. The rationale for this decision should be explained in the AMS report (AMA5, p 543, 16.4c).*
2.21	**Complex regional pain syndrome** New clauses: *Complex regional pain syndrome types 1 and 2 should be assessed using the method in Chapter 17 of the WorkCover WA Guidelines.* *For chronic pain assessment using AMA5 and the WorkCover WA Guidelines, Chapter 18 of AMA5 Pain (p 565-591) is excluded. Section 13.8 of AMA5 (p 343-344) is also excluded.*

3. Lower extremity

Clause	Change
3.7	**The approach to assessment of the lower extremity** Added sentences: *The assessed impairment of a part or region can never exceed the impairment due to amputation of that part or region. For the lower limb, therefore, the maximum evaluation is 40% WPI, the value for proximal above knee amputation.*
3.9	**Leg length discrepancy** The WorkCover WA Guidelines remove the element of choice in the range of impairment figures when using Table 17-4 of AMA5. The reproduced table has been amended to reflect the definitive impairment percentages.
3.14	**Muscle atrophy** The WorkCover WA Guidelines remove the element of choice in the range of impairment figures when using Table 17-6 of AMA5. The reproduced table has been amended to reflect the definitive impairment percentages.
3.16	**Range of motion** New sentence at the end of the first paragraph to address an anomaly in the table: *In Table 17-10 (knee impairment) (p537 AMA5) the sentence should read 'Deformity measured by femoral-tibial angle; 3° to 9° valgus is considered normal.* Added new paragraph after the first to address valgus/varus deformity: *Table 17-10 (p 537 AMA5) is misleading as it has valgus and varus deformity in the same table as restriction of movement, possibly suggesting that these impairments may be combined. This is not the case. Any valgus/ varus deformity present which is due to the underlying lateral or medial compartment arthritis, cannot be combined with loss of range of movement. Therefore, when faced with an assessment in which there is a rateable loss of range of movement as well as a rateable deformity, calculate both impairments and use the greater. Valgus and varus knee angulation are to be measured in a weight-bearing position using a goniometer. It is important to bear in mind that valgus and/or varus alignments of the knee may be constitutional. It is also important to always compare with the opposite knee.*

Clause	Change
3.17	**Range of motion** New sentence after second paragraph regarding ankle motion table: *Please note that in Table 17-11 (ankle motion) (p 537 AMA5) the range for mild flexion contracture should be one to 10 degrees, for moderate flexion contracture should be 11 to 19 degrees, and the figure for severe flexion contracture should be 20 degrees plus.* Added amended Table 17-11 AMA5. Added paragraph – must compare range of motion of injured limb to uninjured limb: *When calculating impairment for loss of range of movement it is most important to always compare measurements of the relevant joint(s) in both extremities. If a contralateral 'normal/uninjured' joint has less than average mobility, the impairment value(s) corresponding to the uninvolved joint serves as a baseline, and is subtracted from the calculated impairment for the involved joint. The rationale for this decision should be explained in the report (AMA5, p 454, 16.4c).*
3.18	**Ankylosis** Modified Table 3.1 to include pantalar and triple. Changed the wording of 'foot joint' to 'subtalar'.
3.20	**Arthritis** Rephrased with additional information: *The presence of osteoarthritis is defined as cartilage loss. Cartilage loss can be measured by properly aligned plain X-ray, or by direct vision (arthroscopy) but impairment can only be assessed according to the radiologically determined cartilage loss intervals shown in AMA5, Table 17-31 (p 544). When assessing impairment of the knee joint, which has three compartments, only the compartment with the major impairment is used in the assessment. That is, measured impairments in the different compartments cannot be added or combined.*
3.23	**Knee – Patello-femoral joint** Amended wording. It now reads: *Footnote to Table 17-31 (p 544 AMA5) regarding patello-femoral pain and crepitation:* *This item is only to be used if there is a history of direct injury to the front of the knee, or in cases of patellar translocation/dislocation without direct anterior trauma.* Added paragraph: *Note: Osteoarthritis of the patello-femoral joint cannot be used as an additional impairment when assessing arthritis of the knee joint itself, of which it forms a component.*

<table>
<tr><th>Clause</th><th>Change</th></tr>
<tr><td>3.28</td><td>Diagnosis-based estimates (lower extremity)

Significant and detailed additions to this clause for:

• pelvic fractures
• hip
• femoral osteotomy
• tibial plateau fractures
• patella-femoral joint replacement
• total ankle replacement
• hindfoot intra-articular fractures
• plantar fasciitis
• resurfacing procedures.

See WorkCover WA Guidelines clause 3.28 for clause in full.</td></tr>
<tr><td>3.30</td><td>Diagnosis-based estimates (lower extremity)

Reproduced Table 17-35: Rating knee impairment has been amended in section (f.) - Tibio-femoral alignment to include ranges of valgus alignment and any varus. Consequently the points awarded in this section have been altered.</td></tr>
<tr><td>3.34</td><td>Peripheral nerve injury (lower extremity)

New sentence:

Motor and sensory impairments given in Table 17-37 are for complete loss of function and AMS must still use Table 16-10 and 16-11 in association with Table 17-37.</td></tr>
<tr><td>3.35</td><td>Complex regional pain syndrome (lower extremity)

New clauses:

Complex regional pain syndrome types 1 and 2 are to be assessed using the method in Chapter 17 of the WorkCover WA Guidelines.

For chronic pain assessment using AMA5 and the WorkCover WA Guidelines, Chapter 18 of AMA5 Pain (p565-591) is excluded. Section 13.8 of AMA5 (p343-344) is also excluded.</td></tr>
<tr><td>3.37</td><td>Measurement of selected joint motion

Removed the following sentence as it is incorporated into 3.16:

Valgus and varus knee angulation are to be measured in a weight-bearing position using a goniometer.</td></tr>
</table>

4. The spine

Clause	Change
4.4	**Assessment of the spine** New clause: *The assessment should include a comprehensive, accurate history, a review of all pertinent records available at the assessment, a comprehensive description of the individual's current symptoms and their relationship to daily activities, a careful and thorough physical examination, and all findings of relevant laboratory, imaging, diagnostic and ancillary tests available at the assessment. Imaging findings that are used to support the impairment rating should be concordant with symptoms and findings on examination. The AMS should record whether diagnostic tests and radiographs were seen or whether they relied solely on reports.*
4.17	**DRE definitions of clinical findings** New clause: *The preferred method for recording ROM is as a fraction or percentage of the range or loss of the range. For example, either 'cervical movement was one half (or 50%) of the normal range of motion' or 'there was a loss of one half (or 50%) of the normal range of movement of the cervical spine'.*
4.18	**DRE definitions of clinical findings** Minor change to the second sentence (underlining is new text) It now reads: *Clinical features which are consistent with DRE II and which are present at the time of assessment include radicular symptoms in the absence of clinical signs (that is, non-verifiable radicular complaints), muscle guarding or spasm, or asymmetric loss of range of movement.*
-	**DRE definitions of clinical findings** The following sentence is deleted from clause 6.18 of the third edition: *If there is doubt about which of two DRE categories should be used, the higher should be chosen.*
4.19	**DRE definitions of clinical findings** New clause: *Asymmetric or non-uniform loss of range of motion may be present in any of the three planes of spinal movement. Asymmetry during motion caused by muscle guarding or spasm is included in the definition.* *Asymmetric loss of range of motion may be present for flexion and extension. For example, if cervical flexion is half the normal range (loss of half the normal range) and cervical extension is one third of the normal range (loss of two thirds of the range), asymmetric loss of range of motion may be considered to be present.*

Clause	Change
4.22	**DRE definitions of clinical findings** New clause: *The cauda equina syndrome is defined in AMA5 (Chapter 15, p 383, Box 15.1) as 'manifested by bowel or bladder dysfunction, saddle anaesthesia and variable loss of motor and sensory function in the lower limbs'. For a cauda equina syndrome to be present there must be bilateral neurological signs in the lower limbs and sacral region. Additionally, there must be a radiological study which demonstrates a lesion in the spinal canal causing a mass effect on the cauda equina with compression of multiple nerve roots. The mass effect would be expected to be large and significant. A lumbar MRI scan is the diagnostic investigation of choice for this condition. A cauda equina syndrome may occasionally complicate lumbar spine surgery when a mass lesion will not be present in the spinal canal on radiological examination.*
4.32	**Applying the DRE method** New paragraph to address adjacent vertebral fractures: *If there are adjacent vertebral fractures at the transition zones (C7/T1, T12/L1), the methodology in paragraph 4.30 is to be adopted. For fractures of C7 and T1, use the WPI ratings for the cervical spine (AMA5 chapter 15, page 392, Table 15.5). For fractures of T12 and L1 use the WPI rating for the thoracic spine (AMA5 chapter 15, page 389, Table 15.4).*
4.33	**Applying the DRE method** Changed wording: *Impact of ADL. Tables 15-3, 15-4 and 15-5 of AMA5 give an impairment range for DREs II to V. Within the range, 0%, 1%, 2% or 3 % WPI may be assessed using paragraphs 4.34 and 4.35 below. An assessment of the effect of the injury on ADL is not solely dependent on self-reporting, but is an assessment based on all clinical findings and other reports.*
4.36	**Applying the DRE method** New clause: *For a single injury, where there has been more than one spinal region injured, the effect of the injury on ADL is assessed once only.* *In the event of subsequent injury or injuries (whether to the same of different spinal regions), the maximum cumulative WPI is 3%. For example, if 1% WPI for ADL is assessed following the first injury and 3% after the second injury, then 2% WPI is the impact on ADL for the second injury.*
4.37	**Applying the DRE method** In the third dot point, the words 'with surgical ankylosis (fusion)' are deleted. Replaced with 'for spinal fusion (successful or unsuccessful)'.
4.37	**Applying the DRE method** The fourth dot point is new: *DRE Category V is not to be used following spinal fusion, where there is a persisting radiculopathy. Instead use Table 4.2 in the WorkCover WA Guidelines.*

Clause	Change
4.37	**Applying the DRE method** In the paragraph before Table 4.2 the following is deleted from the third edition: *Therefore table 4.2 was developed to rectify this anomaly.* *…and where there is a residual radiculopathy following surgery.* Paragraph now reads: *Table 4.2 indicates the additional ratings which should be combined with the rating determined using the DRE method where an operation for an intervertebral disc prolapse, spinal canal stenosis <u>or spinal fusion</u> has been performed.*
4.37 Table 4.2	**Applying the DRE method** Removed the words 'where radiculopathy persists after' from the name of table. Inserted the word 'following' into the name of table to read: *Table 4.2: Modifiers for DRE categories following surgery.* In the first column/first row of Table 4.2, removed: *Discectomy, or single level decompression with residual signs and symptoms.* Replaced with: *Spinal surgery with residual symptoms and radiculopathy (refer to 4.27 in the WorkCover WA Guidelines)* Amended first column/second row under Procedures to state *'Second and further levels'.*
4.41	**Applying the DRE method** New clause: *Spinal cord stimulator or similar device: The insertion of such devices does not warrant any additional WPI.*
4.42	**Applying the DRE method** Moved the entire pelvic fractures section to the end of this chapter. It now sits below: *4.39 Arthritis* *4.40 Posterior spacing or stabilisation devices* *4.41 Spinal cord stimulator or similar device* New points to Table 4.3: *3. Traumatic separation of the pubic symphysis* *iv. internal fixation/ankylosis* *4. Sacro-iliac joint dislocations or fracture dislocations* *iii. internal fixation/ankylosis* *5. If two out of three joints are internally fixed/ankylosed If all three joints are internally fixed/ankylosed* Altered wording to allow the combination of pelvic disorders and maximum WPI for pelvic fractures from 12 to 20%: *Multiple impairments of the pelvis should be assessed separately and combined, with the maximum WPI for pelvic fractures being 20%.*

5. Nervous system

Clause	Change
5.2	**Introduction** Spinal cord injuries are assessed in accordance with AMA5 Chapter 15, rather than Chapter 13 as stated in the third edition. New paragraph: *Spinal cord injuries are to be assessed using AMA5 chapter 15. Table 15.6 (pp 396-397) is to be used for evaluation of spinal cord injuries. These impairments, once selected, are then combined with the corresponding additional spinal impairment from DRE categories 11-V for cervical and lumbar impairment and categories II-IV for thoracic impairment to obtain an exact total value.*
5.5	**The approach to assessment of permanent neurological impairment** Rephrased paragraph: *AMA5 Sections 13.5-13.6 (pp 336-340) should be used for cerebral, basal ganglia, cerebellar or brain stem impairments. This section, therefore, covers hemiplegia, monoplegia (arm or leg), and upper or lower limb impairment due to incoordination, or movement disorder due to brain injury.* Reference to cauda equina made into new clause 5.6.
5.6	**The approach to assessment of permanent neurological impairment** New clause (separate from 5.5): *If a person has a spinal injury with spinal cord or cauda equina, bilateral nerve root or lumbosacral plexus injury causing bowel, bladder and/or sexual dysfunction, he or she is assessed according to the method described in section 15.7 and Table 15.6 (a)-(g), pp 395-398, AMA5.*
5.7	**The approach to assessment of permanent neurological impairment** Rephrased sentence: *Complex regional pain syndrome types 1 and 2 are to be assessed using the method in Chapter 17 of the WorkCover WA Guidelines.*

Clause	Change
5.9	**Specific interpretation of AMA5** Reworded paragraph: *In assessing disturbances of mental status and integrative functioning; and emotional or behavioural disturbances; disturbances in the level of consciousness and awareness; disturbances of sleep and arousal function; and disorders of communication (sections 13.3a, 13.3c, 13.3d, 13.3e, 13.3f, AMA5 pp 309-311, 317-327), the AMS should make ratings based on clinical assessment and the results of neuropsychometric testing, where available.* Added sentence: *For traumatic brain injury, there should be evidence of a severe impact to the head or that the injury involved a high energy impact.* Reworded: *Clinical assessment must include at least one of the following:* Added last sentence: *Neuropsychological test data is to be considered in the context of the overall clinical history, examination and radiological findings, and not in isolation.*
5.11	**Specific interpretation of AMA5** Added last sentence: *The effect on activities of daily living should be considered.* Deleted reference to table 11-10 AMA5 (p272-275).
5.13	**Specific interpretation of AMA5** Removed the following sentence from first paragraph: *Impairment percentages for the three divisions of the trigeminal nerve should be apportioned with extra weighting for the first division.* Replaced with this sentence: *Lesions of the ophthalmic division of the trigeminal nerve with impairment of corneal sensation should be apportioned with extra weighting.* Added last sentence: *For bilateral injury to the trigeminal nerves, assess each side separately and combine the assessed WPIs.*
5.15	**Specific interpretation of AMA5** Rephrased paragraph: *Impairment of sexual function caused by severe traumatic brain injury is to be assessed by using Table 13.21 (p 342 AMA5). For spinal cord, nerve root or more peripheral nerve injury, sexual impairment should only be assessed where there is appropriate objective evidence of spinal cord, cauda equina or bilateral nerve root dysfunction or lumbosacral plexopathy.*

Clause	Change
5.16	**Specific interpretation of AMA5** Only one of either the greater occipital, or lesser occipital or greater auricular nerves are to be assessed rather than all three. In Table 5.1 under Clinical features: Removed the word 'loss' and replaced it with the word 'alteration' for both columns of 2%–3% WPI and 4%–5% WPI. Columns now read: *Mild to moderate neurogenic pain and sensory alteration in an anatomic distribution.* and *Severe neurogenic pain and sensory alteration in an anatomic distribution.*

6. Ear, nose, throat and related structures

Clause	Change
6.4	**The face** In column 3 of Table 6.1 the reference to '(AMA5 chapter 12)' is replaced with '(AMA4 Chapter 8)'.
6.14	**The voice** Rephrased paragraph to state: *Example 11.25 (AMA5, p 269) 'Impairment rating', second sentence: add the words "including respiratory impairment" into the sentence to read 'Combine with appropriate ratings due to other impairments including respiratory impairment to determine whole person impairment'.*

7. Urinary and reproductive systems

No changes except for preface to chapter.

8. Respiratory system

No changes except for preface to chapter.

9. Hearing

Clause	Change
9.6	**Assessment of hearing impairment (hearing loss)** Added sentence after dot points: *Where an AMS uses the extension tables, they must provide an explanation of the worker's 'special requirement to hear at frequencies above 4000Hz.' (NAL Report No.118, p 6).*
9.10	**Hearing impairment** Removed the sentence: *The binaural tables RB 500-4000 (NAL no 118, pp 11-16) are to be used, except when it is not possible or unreasonable to do so.* Replaced with: *The binaural tables RB 500-4000 (NAL Report no. 118, pp 11-16) are to be used. The extension tables EB 4000-8000 (pp 28-30) may be used when the worker has a 'special requirement to hear at frequencies above 4000Hz' (NAL Report no.118, p 6). Where an AMS uses the extension tables, they must provide an explanation of the worker's special requirement to be able to hear at frequencies above 4000Hz.*
9.11	**Hearing impairment** Changed spelling from 'presbycusis' to 'presbyacusis'. Added the following sentences to the end of the paragraph: *Please note that when calculating by formula for presbyacusis correction (e.g. when the worker is above 81 years) use the formula at appendix 6 at line 160 (NAL publication, p 26) which uses the correct number of 1.79059. Note: there is a typographical error in Table P on p 25 of the NAL publication, with the number 1.79509 incorrectly used.*
9.16	New clause provides guidance for applying a deduction for previous assessment of hearing loss.

10. The visual system

No changes except for preface to chapter.

11. Psychiatric and psychological disorders

Clause	Change
11.4	**Diagnosis** The reference to DSM IV has been updated to reflect the most recent update - DSM IV TR, pp 485-511.
11.9	**Co-morbidity** Removed the Alzheimer's disease example. Replaced with a bi-polar disorder example.

12. Haematopoietic system

No changes except for preface to chapter.

13. The endocrine system

Clause	Change
13.2	**Introduction** Removed the words 'the visual system (Chapter 12)'. Inserted at the end of paragraph: '…and the visual system (Chapter 8 AMA4).'

14. The skin

Changes made to tighten the assessment of permanent impairment for surgical scars.

Clause	Change
14.6	**Introduction** New sentence: *Note that uncomplicated scars for standard surgical procedures do not, of themselves, rate an impairment.*
14.8	**Introduction** Reworded the instructions regarding use of the TEMSKI table as below: *If the skin disorder does not meet all of the criteria within the impairment category, the AMS must provide detailed reasons as to why this category has been chosen over other categories.*
Table 14.1	New row in Table 14.1 'Adherance to underlying structures'.

15. Cardiovascular system

Minor changes to align with changes to Introduction

Clause	Change
	Effect of medical treatment Removed entire clause 17.9 from the third edition. Duplication of paragraph 1.41.
	Future deterioration of a condition Removed entire clause 17.10 from the third edition. Duplication of paragraph 1.42.

16. Digestive system

Changes to impairment ratings and assessment methodology.

Clause	Change
16.2	**Introduction** In relation to the loss of sensation in the distribution of the ilio-inguinal nerve following surgical repair: Added a reference to Table 5.1 at end of sentence: '…as per Table 5.1 in the WorkCover WA Guidelines'. Added the following sentence: *This assessment should not be made unless the symptoms have persisted for 12 months.*
16.3	**Introduction** Severe dysaesthesia in the distribution of the ilio-inguinal nerve following repair may now rate up to 5% (previously 2%), using Table 5.1 in the WorkCover WA Guidelines: Added the following sentence at end of paragraph: *This assessment should not be made unless the symptoms have persisted for 12 months.*
16.4	**Introduction** Added the following sentence at the end of paragraph: *This assessment should not be made unless the symptoms have persisted for 12 months.*
16.7	**Introduction** Added new clause: *A diagnosis of hernia should not be made on the findings of an ultrasound examination alone. For the diagnosis of a hernia to be made there must be a palpable defect in the supporting structures of the abdominal wall and either a palpable lump or a history of a lump when straining.*
16.8	**Introduction** Added new clause: *A divarication of the rectus abdominus muscles in the upper abdomen is not a hernia, although the supporting structures have been weakened, they are still intact.*

<table>
<tr><th>Clause</th><th>Change</th></tr>
<tr><td>16.9</td><td>Introduction

New clause:

Effects of analgesics on the digestive tract:

• Table-6-3, AMA5 (p 121) Class 1 is to be amended to read ‘there are symptoms and signs of digestive tract disease’.

• Nonsteroidal anti-inflammatory agents, including Aspirin, taken for prolonged periods can cause symptoms in the upper digestive tract. In the absence of clinical signs or other objective evidence of upper digestive tract disease, anatomic loss or alteration a 0% WPI is to be assessed.

• Effects of analgesics on the lower digestive tract:

- Constipation is a symptom, not a sign and is generally reversible. A WPI assessment of 0% applies to constipation.

- Irritable bowel syndrome without objective evidence of colon or rectal disease is to be assessed at 0% WPI.

• Assessment of colorectal disease and anal disorders requires the report of a treating doctor or family doctor, which includes a proper physical examination with rectal examination if appropriate, and/or a full endoscopy report.</td></tr>
<tr><td>16.10</td><td>Introduction

New clause:

Splenectomy: Post-traumatic splenectomy or functional asplenia following abdominal trauma should be assessed as 3% WPI.</td></tr>
<tr><td>16.11</td><td>Introduction

New clause:

Abdominal adhesions: Intra-abdominal adhesions following trauma requiring further laparotomy should be assessed under Table 6-3, AMA5, p 121.</td></tr>
</table>

17. Evaluation of permanent impairment arising from chronic pain

Replaces the previous chapter 19: Evaluation of permanent impairment arising from chronic pain (exclusion of AMA5, Chapter 18)

- The whole chapter has been revised.
- Reasons given for excluding chronic pain as a separate condition.
- The methodology for assessing complex regional pain syndrome is modified from the third edition and includes Table 17.1 for the rating of Complex Regional Pain Syndrome Type 1 and Complex Regional Pain Syndrome Type 2.

Appendices

- Appendix 1 added to include definitions in WorkCover WA Guidelines. Relocated from Chapter 2 of the third edition.
- Appendix 2 briefly outlines the application of Schedule 2 of the Act and the conversion tables.
- Appendix 3 updates with 2013 permanent impairment co-ordinating committee list.

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