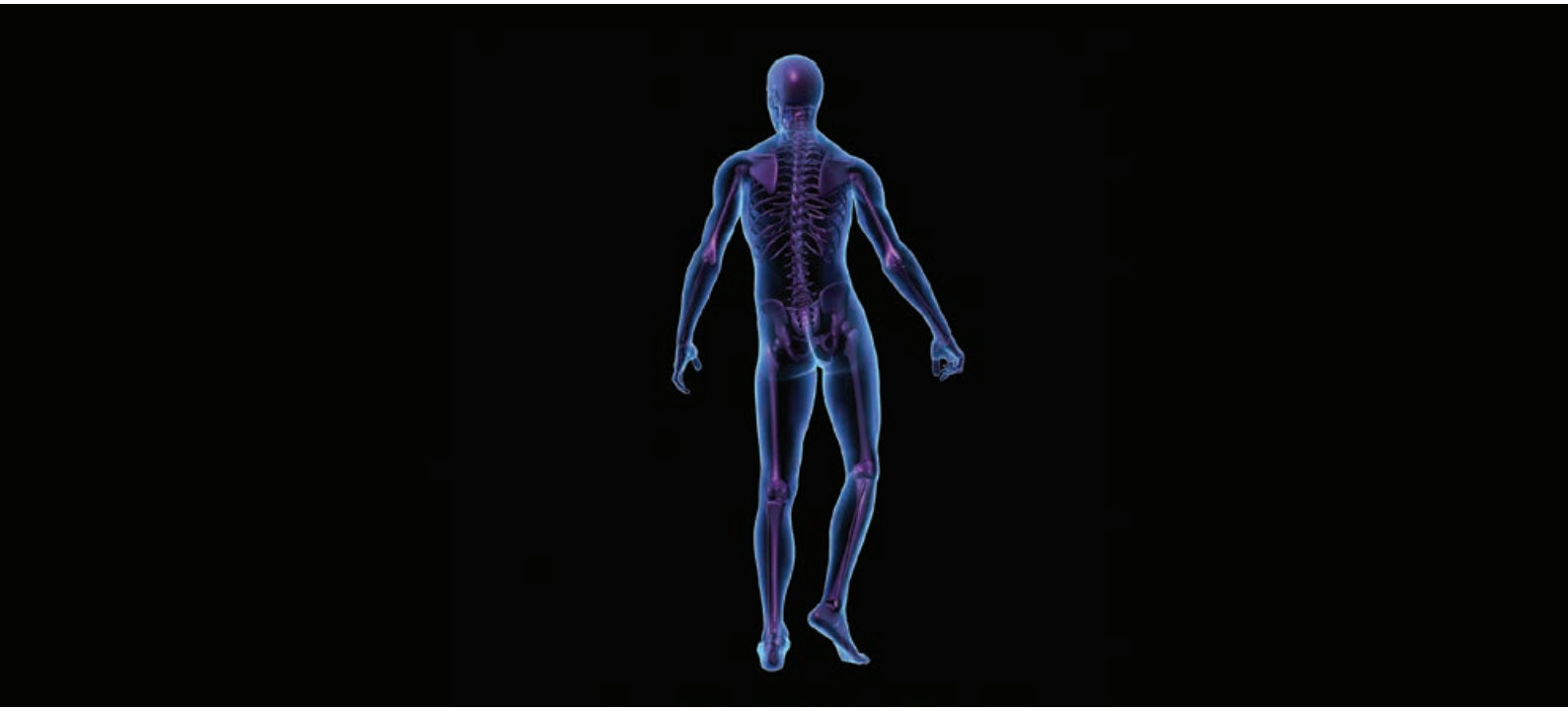
NSW GOVERNMENT | State Insurance Regulatory Authority



NSW workers compensation guidelines for the evaluation of permanent impairment

Summary of changes from third to fourth edition

Contents

This summary provides technical information regarding specific changes from the 3rd edition of the *WorkCover Guides for the evaluation of permanent impairment* (catalogue no. WC00970) to the 4th edition of the *NSW workers compensation guidelines for the evaluation of permanent impairment* (the Guidelines).

To understand the specific information in this document you will need to read it in conjunction with the 4th edition Guidelines.

Overall changes to document

In December 2014 and with some modifications, Safe Work Australia endorsed the draft *NSW workers compensation guidelines for the evaluation of permanent impairment 4th edition* as the template national guideline for the evaluation of permanent impairment. Key modifications include the sequencing of the introduction, inclusion of a foreword and an appendix of definitions.

Foreword

A foreword has been added to explain that the 4th edition of the Guidelines is based on the template national guideline for the evaluation of permanent impairment. The foreword also outlines how the template national guideline was developed.

From Guides to Guidelines

The title of the document has changed from *WorkCover Guides for the evaluation of permanent impairment* (catalogue no. WC00970) to *NSW workers compensation guidelines for the evaluation of permanent impairment*. This will clarify the purpose of the document as a statutory guideline made under section 379 of the *Workplace Injury Management and Workers Compensation Act 1998*.

WorkCover to State Insurance Regulatory Authority

The reference to WorkCover throughout the document has been amended to the State Insurance Regulatory Authority (SIRA), following the structural reform of WorkCover on 1 September 2015.

Formatting

The following formatting changes have been made to improve legibility:

- larger font
- slightly more spacing between lines
- all headings in bold
- some points in bold such as 2.15 ruptured long head of biceps and 4.26, 4.27, 4.33
- all percentages written as numerical values rather than words, for example: Section 4.25: change ‘seven per cent’ to ‘7%’ and ‘30 per cent’ to ‘30%’.

A preface for each chapter

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

Here is an example:

Upper extremity

AMA5 Chapter 16 (p. 433) applies to the assessment of permanent impairment of the upper extremities, subject to the modifications set out below. Before undertaking an impairment assessment, users of the Guidelines must be familiar with:

- *the Introduction in the Guidelines*
- *chapters 1 and 2 of AMA5*
- *the appropriate chapter(s) of the Guidelines for the body system they are assessing*
- *the appropriate chapter(s) of AMA5 for the body system they are assessing.*

The Guidelines take precedence over AMA5.

1. Introduction

The introduction sequencing was significantly altered by the Safe Work Australia Permanent Impairment Temporary Advisory Group. This change groups similar paragraphs and allows for jurisdictionally specific content to be introduced in a logical format.

The other changes to content below were primarily determined by the NSW Permanent Impairment Coordinating Committee. Many existing clauses have been renumbered as well as the changes noted below:

Clause	Change
1.6 Part (a)	Principles of assessment **Reworded** paragraph to include a clinical assessment of the claimant. It now reads: *Assessing permanent impairment involves clinical assessment of the claimant as they present on the day of assessment taking into account the claimant's relevant medical history and all available relevant medical information to determine.*
1.6 Part (b)	Principles of assessment 'Medical specialists' changed to 'Assessors'.
1.6 Part (d)	Principles of assessment **Added** words to end of paragraph: 'see also paragraphs 1.43 and 1.44 in the Guidelines'.
1.9 Second sentence	Principles of assessment **Replaced** the word 'produces' with 'yields', and **added** a sentence after the second sentence. It now reads: *In that case, assessors should use the method that yields the highest degree of permanent impairment. (This does not apply to gait derangement – see paragraphs 3.5 and 3.10 in the Guidelines).*
1.10 1.11 1.12 1.13 1.14	Body systems covered by the Guidelines Separation of previous paragraph into separate paragraphs for detail about each body system, where assessment is not based on AMA5 (or not primarily AMA5): • psychiatric/psychological • pain • vision • hearing.
1.15	Maximum medical improvement Definition of maximum medical improvement has been amended to remove the reference to the condition being medically stable for the previous three months (as some conditions require more than three months), to the definition in line with AMA5: *This is considered to occur when the worker's condition is well stabilised and unlikely to change substantially in the next year with or without medical treatment.* This change has been made at the request of the NSW Coordinating Committee.

Clause	Change
1.16	Maximum medical improvement **Added** words to the end of the paragraph: '– subject to 1.34 in the Guidelines', to provide clarification to assessors in relation to refusal of treatment by the claimant.
1.21	Psychiatric and psychological injuries **Minor rewording** in definition to highlight that this definition is NSW-specific and if assessing under another jurisdiction it may be different: *Psychiatric and psychological injuries in the New South Wales workers compensation system are defined as primary psychological and psychiatric injuries in which work was found to be a substantial contributing factor.* **Removed** reference to section 67 pain and suffering. The reference to section 67 (pain and suffering) in this clause does not affect an exempt worker's entitlement to this type of compensation. The reference to section 67 in this clause was a case management tool which is now considered inappropriate in a medical guideline.
1.22	Psychiatric psychological injuries Specific reference under the heading psychiatric and psychological injuries that impairment arising from primary psychological and psychiatric injuries cannot be combined with impairment resulting from physical injuries arising from the same incident. In the 3rd edition this was only referenced under multiple impairments in the introduction.
1.23	Conditions that are not covered in the 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.*
1.26	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'.
1.28	Deductions for pre-existing condition or injuries **Combined** the last two paragraphs under deductions for pre-existing impairment. This change was proposed by Safe Work Australia for the template national guideline as the 1/10th rule does not apply in all jurisdictions. By combining paragraphs 1.28 and 1.29 the numbering for the remainder of the Introduction remains consistent across the jurisdictions that adopt the template national guideline. **Added** 'that is' to the last sentence of the combined paragraph to improve clarity: *For the injury being assessed, the deduction is 1/10th of the assessed impairment, unless that is at odds with the available evidence.*
1.35	Future deterioration of a condition **Changed** wording from 'in the foreseeable future' to 'for the next year' to align with changed definition of maximum medical improvement at 1.17. It now reads: *Similarly, if a medical assessor forms the opinion that the claimant's condition is stable for the next year, but that it may deteriorate in the long term, the assessor should make no allowance for this deterioration.* **Removed** the following sentence: *If the claimant's condition deteriorates at a later time, the claimant may re-apply for further evaluation of the condition.* Removing this reference to deterioration in this clause does not affect an exempt worker's entitlement to claim for a deterioration of permanent impairment. The reference to deterioration in this clause was a case management tool which is now considered inappropriate in a medical guideline.

Clause	Change
1.40	**Medical Assessors** **Expanded** to clarify the requirements to undertake the role of assessor of permanent impairment in the NSW workers compensation system and the definitions of medical practitioner and specialist medical practitioner. It now reads: *An assessor will be a registered medical practitioner recognised as a medical specialist.* • *'Medical practitioner' means a person registered in the medical profession under the Health Practitioner Regulation National Law (NSW) No. 86a, or equivalent Health Practitioner Regulation National Law in their jurisdiction with the Australian Health Practitioner Regulation Agency.* • *'Medical specialist' means a medical practitioner recognised as a specialist in accordance with the Health Insurance Regulations 1975, Schedule 4, Part 1, who is remunerated at specialist rates under Medicare.* *The assessor will have qualifications, training and experience relevant to the body system being assessed. The assessor will have successfully completed requisite training in using the Guidelines for each body system they intend on assessing. They will be listed as a trained assessor of permanent impairment for each relevant body system(s) on the State Insurance regulatory Authority website at sira.nsw.gov.au.*
1.42	**Information required for assessments** **Added** new paragraph: *Information for claimants regarding independent medical examinations and assessments of permanent impairment should be supplied by the referring body when advising the appointment details.*
1.44	**Information required for assessments** **Changed** due to the reordering of paragraphs in the introduction. **Added** new paragraph to ensure the most relevant information is provided to assessors: *Most importantly, assessors must have available to them all information about the onset, subsequent treatment, relevant diagnostic tests, and functional assessments of the person claiming a permanent impairment. The absence of required information could result in an assessment being discontinued or deferred. AMA5 Chapter 1, Section 1.5 (p 10) applies to the conduct of assessments and expands on this concept.*
1.50	**Reports** **Added** the following words to the end of the paragraph: *The report must include a copy of all calculations and a summary table. A template reporting format is provided in the WorkCover guidelines on independent medical examinations and reports* at sira.nsw.gov.au.
1.53	**Quality Assurance** **Changed** paragraph in order to relate specifically to NSW workers compensation system. It now reads: *An assessor who is identified as frequently providing reports that are not in accord with the Guidelines, or not complying with other service standards as set by the State Insurance Regulatory Authority, may be subject to State Insurance Regulatory Authority performance monitoring procedures and be asked to show cause as to why their name should not be removed from the list of trained assessors on the State Insurance Regulatory Authority website.*
1.57	**Code of Conduct** **Changed** wording. It now reads: *Complaints received in relation to the behaviour of an assessor during an evaluation will be managed in accordance with the process outlined in the WorkCover guidelines on independent medical examinations and reports at sira.nsw.gov.au and State Insurance Regulatory Authority performance monitoring procedures.*

2. Upper extremity

Clause	Change
2.5	The approach to assessment of the upper extremity and hand **Deleted** paragraph. **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 assessor 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 1.36 in the Guidelines.* • *If ROM measurements at examination cannot be used as a valid parameter of impairment evaluation, the assessor 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 category combination of impairment **before** conversion of regional impairments to WPI: *When the Combined Values Chart is used, the assessor 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 – AMA5 Section 16.4d 'Thumb ray motion impairment', p 454).*
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.*
2.12	Impairment due to other disorders of the upper extremity **Added** more detail provided about assessing the range of disorders: *AMA5 Section 16.7 (impairment of the upper extremities due to other disorders) 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 the information in these tables is already expressed in terms of upper extremity impairment.*

Clause	Change
2.14	**Conditions affecting the shoulder region** **Removed** the first sentence: *All shoulder assessments must relate to an intrinsic shoulder disorder and be clearly distinguished from symptoms due to referred pain from the neck.* **Added** the following three paragraphs to 2.14, in relation to resection arthroplasty and impairment suggested for the sternoclavicular 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).* *Please note that in AMA5 Table 16-27 (p 506) the figure for resection arthroplasty of the distal clavicle (isolated) has been changed to 5% upper extremity impairment, and the figure for resection arthroplasty of the proximal clavicle (isolated) has been changed to 8% upper extremity impairment.* *Please note that in AMA5 Table 16-18 (p 499) the figures of impairment suggested for the sternoclavicular joint have been changed from 5% upper extremity impairment and 3% whole person impairment, to 25% upper extremity impairment and 15% whole person impairment.*
2.15	**Conditions affecting the shoulder region** **Added** words at end of paragraph: 'or with loss of range of movement'.
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.*
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 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 assessor's report (see AMA5 Section 16.4c, p 543).*
2.21	**Complex regional pain syndrome** **Added** new clause: *Complex regional pain syndrome types 1 and 2 should be assessed using the method in Chapter 17 of the Guidelines.*

3. Lower extremity

Clause	Change
3.7	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 **Removed** sentence reinforcing the numerical ratings as it was superfluous.
3.14	Muscle atrophy **Removed** sentence reinforcing the numerical ratings as it was superfluous.
3.16	Range of motion **Added** new paragraph after the first to address valgus/varus deformity: *AMA5 Table 17-10 (p 537) 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.*
3.17	Range of motion **Added** sentence after first paragraph regarding knee impairment table: *In AMA5 Table 17-10 (p 537), on knee impairment, the sentence should read: 'Deformity measured by femoral-tibial angle; 3° to 9° valgus is considered normal'.* **Added** sentence after second paragraph regarding ankle motion table: *In AMA5 Table 17-11 (ankle motion) the range for mild flexion contracture should be one to 10°, for moderate flexion contracture should be 11° to 19°, and for severe flexion contracture it should be 20° plus.* **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, Section 16.4c, p 454).*
3.18	Ankylosis **Modified** Table 3.1 to include pantalar and triple. **Changed** the wording of 'foot joint' to 'subtalar'. **Added** new Table 3.1(a) with explanation: *Table 3.1(a) is provided below as a guide to evaluate additional impairment owing to variation from the neutral position. The additional amounts at the top of each column are added to the figure for impairment in the neutral position. In keeping with the value given on page 541 of AMA5, the maximum impairment for ankylosis of the ankle remains at 25 (62) [88]% impairment.*
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.*

Clause	Change
3.23	Knee – Patello-femoral joint **Amended** wording. It now reads: *Footnote to AMA5 Table 17-31 (p 544) 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.*
3.28	**Significant and detailed additions to this paragraph for:** • pelvic fractures • hip • femoral osteotomy • tibial plateau fractures • patella-femoral joint replacement • total ankle replacement • hindfoot intra-articular fractures • plantar fasciitis • resurfacing procedures. Please refer to the sections of the Guidelines.
3.30	Rating knee replacement results **Amended** Table 17-35: Rating knee replacement - section f) from 'Alignment – valgus' to 'Tibio-femoral alignment*'. The alignment has been amended to include ranges of valgus alignment and any varus. Consequently the points awarded in this section have been altered and are as follows: *f. Tibio-femoral alignment* — Number of points* *>15° valgus — 20* *11–15° valgus — 3 points per degree* *5–10 ° valgus — 0* *0–4 ° valgus — 3 points per degree* *Any varus — 20*
3.34	Peripheral nerve injury (lower extremity) **Added** new sentence: *Motor and sensory impairments given in Table 17-37 are for complete loss of function and assessors must still use Table 16-10 and 16-11 in association with Table 17-37.*
3.35	Complex regional pain syndrome (lower extremity) **Changed** wording to: *Complex regional pain syndrome types 1 and 2 are to be assessed using the method in Chapter 17 of the Guidelines.*
3.37	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.*

4. Spine

The introduction of new paragraphs 4.17, 4.19, 4.22 and 4.42 has altered the numbering throughout the remainder of this chapter.

Clause	Change
4.2	Introduction **Added** 'DRE' to the first sentence to read: 'The DRE method…'
4.17	DRE definitions of clinical findings Numbering changes commence. Recording range of motion **Added** 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 in the second sentence beginning with 'Clinical features…' **Inserted** after 'include': *radicular symptoms in the absence of clinical signs (that is, non-verifiable radicular complaints)* 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.*
4.19	DRE definitions of clinical findings **Added** new clause: *Asymmetric or non-uniform loss of ROM 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 ROM 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 ROM may be considered to be present.*
4.22	DRE definitions of clinical findings **Added** new clause: *The cauda equina syndrome is defined in Box 15.1 in Chapter 15 of AMA5 (p 383) 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 **Added** 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 in the Guidelines is to be adopted. For fractures of C7 and T1, use the WPI ratings for the cervical spine (AMA5 Chapter 15, Table 15-5, p 392). For fractures of T12 and L1 use the WPI rating for the thoracic spine (AMA5 Chapter 15, Table 15-4, p 389).*

Clause	Change
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.*
4.34 Diagram	Applying the DRE method **Changed** font in the first sentence – the words 'as a guide' to be bold. It now reads: *The following diagram should be used* ***as a guide*** *to determine whether 0%, 1%, 2% or 3% WPI should be added to the bottom of the appropriate impairment range.*
4.36	Applying the DRE method **Added** 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.* *For injuries to one spinal region on different dates, the effect of the injury on ADL is assessed for the first injury. If, following the second injury, there is a worsening in the ability to perform ADL, the appropriate adjustments are made within the range. For example, if WPI for ADL is assessed as 1% following the first injury and 3% after the second injury, then WPI for ADL for the second injury is assessed as 2%.* *For injuries to different spinal regions on different dates, where there is a worsening of ability to perform ADL after the second injury, additional impairment may be assessed. For example, if ADL for a cervical spine injury is assessed as 1%, and an assessment of a subsequent lumbar spine injury determined 3% WPI for ADL, then WPI for impact on ADLs for the lumbar injury is assessed as 2% WPI.*
4.37 After first sentence	Applying the DRE method **Added** a short sentence as a lead into the dot points: *The assessor should note that:*
4.37 Third bullet point	Applying the DRE method **Removed** the words 'with surgical ankylosis (fusion)'. **Replaced** with 'for spinal fusion (successful or unsuccessful)'.
4.37 Add new dot point	Applying the DRE method **Inserted** new dot point after the third dot point: *DRE Category V is not to be used following spinal fusion, where there is a persisting radiculopathy. Instead use Table 4.2 in the Guidelines.*
4.37 Paragraph before Table 4.2	Applying the DRE method **Removed** the first sentence: *Therefore table 4.2 was developed to rectify this anomaly.* **Added** the words 'or spinal fusion' to the paragraph to indicate that this should be included when using Table 4.2. **Removed** the following words from the last sentence in the paragraph: *…and where there is a residual radiculopathy following surgery.* Entire 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 or spinal fusion has been performed.*

<table>
<tr><th>Clause</th><th>Change</th></tr>
<tr><td>4.37
Table 4.2</td><td>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 Guidelines)
Amended first column/second row under Procedures to state ‘Second and further levels’.
Table 4.2 now reads:
Table 4.2: Modifiers for DRE categories following surgery
<table>
<tr><th>Procedures</th><th>Cervical</th><th>Thoracic</th><th>Lumbar</th></tr>
<tr><td>Spinal surgery with residual symptoms and radiculopathy (refer to 4.27 in the Guidelines)</td><td>3%</td><td>2%</td><td>3%</td></tr>
<tr><td>Second and further levels</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% each</td><td>1% each</td><td>1% each</td></tr>
</table>
</td></tr>
<tr><td>4.41</td><td>Applying the DRE method
Added new clause:
Spinal cord stimulator or similar device: The insertion of such devices does not warrant any additional WPI.</td></tr>
<tr><td>4.42</td><td>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
Added 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 injuries of the pelvis should be assessed separately and combined, with the maximum WPI for pelvic fractures being 20%.</td></tr>
</table>

5. Nervous system

The introduction of a new paragraph, 5.6 has altered the numbering by one thereafter.

Clause	Change
5.2	Introduction **Added** sentences to paragraph: *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 II-V for cervical and lumbar impairment and categories II-IV for thoracic impairment to obtain an exact total value.*
5.3	Introduction **Rephrased** sentence: *Impairments of the peripheral nervous system are assessed by using the relevant parts of the upper extremity, lower extremity and spine sections of AMA5.*
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 point 5.6 below.
5.6	The approach to assessment of permanent neurological impairment **Added** 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 AMA5 Section 15.7 and Table 15-6 (a)-(g) (pp 395-398).*
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 Guidelines.*
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 (AMA5 sections 13.3a, 13.3c, 13.3d, 13.3e and 13.3f; pp 309–311 and 317–327), the assessor 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.*

Clause	Change
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 AMA5 Table 13-21 (p 342). 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.*
5.16 and Table 5.1	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 Table 6.1 Under column Class 3	The face **Removed** '(AMA5 chapter 12)' and **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

Clause	Change
7.5	Bladder **Added** words to end of sentence 'of the Guidelines'.
7.9	Penis **Added** 'AMA5' before Table 7-5.

8. Respiratory system

No changes except for preface to module.

9. Hearing

Clause	Change
9.5	Assessment of hearing impairment (hearing loss) **Added** sentence after dot points: *Where an assessor 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).*
9.9	Hearing impairment **Removed** the sentence: *The binaural tables RB 500-4000 (NAL publication, 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 publication, pp 11-16) are to be used. The extension tables EB 4000-8000 (NAL publication, pp28-30) may be used when the worker has a 'special requirement to hear at frequencies above 4000Hz' (NAL publication, p6). Where an assessor uses the extension tables, they must provide an explanation of the worker's special requirement to be able to hear at frequencies above 4000Hz.*
9.10	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 older than 81), use the formula shown in Appendix 6, line 160 of the 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, where the number 1.79509 is incorrectly used.*
Examples 9.1 and 9.4	Examples **Updated** to improve clarity and provide examples where the calculation of WPI for some is greater than 10%.

10. The visual system

No changes except for preface to module.

11. Psychiatric and psychological disorders

Paragraph 11.4 from the 3rd edition, on the development of the PIRS has been removed to align to the Safe Work Australia national template guideline. The numbering therefore changes from 11.4 onwards (in comparison to the 3rd edition).

Clause	Change
11.3	Introduction **Removed** 3rd and 4th sentences that referenced s67 pain and suffering. Removing the reference to s67 in this clause does not affect an exempt worker's entitlement to claim for pain and suffering compensation. The reference to s67 in this clause was a case management tool which is now considered inappropriate in a medical guideline.
11.9	Co-morbidity **Removed** the Alzheimer's disease example. **Replaced** with a bi-polar disorder example.
11.10	Pre-existing impairment Minor change to second half of the paragraph for improved clarity, and to align with the wording in 1.28 in the Guidelines: **Rephrased** to: *The injured worker's current level of WPI% is then assessed, and the pre-existing WPI% is subtracted from their current level, to obtain the percentage of permanent impairment directly attributable to the work-related injury. If the percentage of pre-existing impairment cannot be assessed, the deduction is 1/10th of the assessed WPI.*

12. Haematopoietic system

No changes except for preface to module.

13. The endocrine system

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

14. Skin system

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

Clause	Change
14.6	Introduction **Added** 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 assessor must provide detailed reasons as to why this category has been chosen over other categories.*

15. Cardiovascular system

Minor changes to align with changes to Introduction

Clause	Change
15.9	Refusal of treatment **Removed** entire paragraph. Duplication of paragraph 1.34.
15.10	Future deterioration **Removed** entire paragraph. Duplication of paragraph 1.35.

16. Digestive system

Major changes to this chapter as it has not had a review since the 1st edition of the Guides.

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 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 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.*

Clause	Change

16.9	Introduction
	Added new clause:
	Effects of analgesics on the digestive tract:
	• *AMA5 Table-6-3 (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.*
	• *Failure to provide such reports may result in a 0% WPI.*

16.10	Introduction Added new clause: ***Splenectomy:** Post-traumatic splenectomy or functional asplenia following abdominal trauma should be assessed as 3% WPI.*
16.11	Introduction Added new clause: ***Abdominal adhesions:** Intra-abdominal adhesions following trauma requiring further laparotomy should be assessed according to AMA5 Table 6-3 (p 121).*

17. Evaluation of permanent impairment arising from chronic pain

Replaces the previous note on p 91: Evaluation of permanent impairment arising from chronic pain (exclusion of AMA5, Chapter 18)

- The whole chapter is new
- Reasons given for excluding chronic pain as a separate condition
- The methodology for assessing complex regional pain syndrome is modified from the 3rd 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 Guideline
- Appendix 2 updated to reflect current membership of the Coordinating Committee and the working groups for the 4th edition
- Removal of previous Appendix *Guidelines for Medico-legal consultations and Examinations* – produced by NSW Medical Board 2005 – has been superseded by the Medical Council Code of Conduct which is referenced in the Introduction
- Removal of previous Appendix *Understanding Medico-legal Examinations* – produced by the NSW AMA and NSW Law Society. This is no longer current and cannot be easily obtained.

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