ReturnToWorkSA

Impairment Assessment Guidelines

Guide to changes from the first to second edition

September 2021

Foreword

Guide to changes in the Return to Work scheme's Impairment Assessment Guidelines Second Edition

This summary provides a reference to specific changes from the first edition of the Impairment Assessment Guidelines to the second edition, published in the South Australian Government Gazette by the Minister on 24 August 2021.

This document details the changes between the first and second editions. A number of other small changes were made to clarify and confirm messages and intention. While every endeavor has been made to ensure consistency between the first and second editions of the Guidelines and this document, in the event of any discrepancy, the Guidelines prevail.

The first edition of the South Australian Impairment Assessment Guidelines were published in 2015 to coincide with the establishment of the *Return to Work Act 2014*, which came into effect on 1 July 2015, to support the assessment of whole person impairment. They were based on the SA WorkCover Guidelines for the Evaluation of Permanent Impairment which had been established in 2008, and were themselves modified from the third edition of the WorkCover NSW Guidelines.

The second edition was a revision of the first edition of the Impairment Assessment Guidelines and not a complete redraft. Much of the first edition remains. The revision was a culmination of feedback from stakeholders, accredited assessors and observations of ReturnToWorkSA.

ReturntoWorkSA also sought advice with regard to specific aspects from the following contributors:

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ReturnToWorkSA extends its thanks everyone who contributed to the second edition of the Impairment Assessment Guidelines. It was a culmination of many years of work.

Contents

Glossary / Definitions

The Explanatory Notes in Appendix 2 and the Glossary in Appendix 3 were combined, moved to the front of the Guidelines and renamed 'Glossary/Definitions', as these definitions had been overlooked in the first edition. The number of definitions was also expanded to clarify interpretations made contrary to the original intention of the Guidelines.

Foreword

The foreword was updated to reflect experience in the scheme and provide further context regarding its application.

Chapter 1 – Introduction

Numbering was changed due to re-ordering and additional points. Changed text is underlined.

Clause	Change
1.6	The text was altered to read '*These Guidelines only apply to assessments for injuries sustained on or after 24 August 2021 as mandated by Section 22(6) of the Act.'*
1.9 (separated out from prev. 1.7)	Rewording of previous 1.7: '*If an assessor identifies an additional injury or condition that is not identified in the assessment request letter, the assessor must make reasonable efforts to contact the requestor to advise of the new condition/injury and to ascertain if the assessment should proceed or be deferred to a later date. In the event that the assessor is unable to contact the requestor, the assessor is to describe the history of the onset of the newly identified injury/condition in the report but not proceed with the %WPI calculation for any of the injuries/conditions until they have approval from the requestor (i.e. both the requested injuries and newly identified injuries are not to be assessed).'*
1.10 (was 1.8)	Sentence added: '*The Lead Assessor is not required to review compliance of the other assessors' reports and should refrain from providing comments in this regard.'*
1.12 (was 1.11)	Sentence added: '*The impairment ratings in the relevant chapters of AMA5 make allowance for any expected accompanying pain (refer 2.5e, p20, AMA5 and Errata)*.'
1.13 (was 1.12)	Sentence added: '*It should be noted that the Guidelines are subordinate legislation and must be adhered to.'*
1.14 (was 1.13)	Change made to the definition of MMI to: '*MMI occurs when the worker's condition has well stabilised and is unlikely to change substantially in the next year with or without medical treatment and further recovery or deterioration is not anticipated, but can include temporary fluctuations*.' A further sentence is added '*The report must address how specific findings relate to the conclusion of MMI status.*

	For example, if the assessor identifies that the worker's condition has changed substantially (either improved or deteriorated) but they consider that the worker is still at MMI, the report must provide a detailed explanation as to why.'
1.15 (was 1.14)	Text altered to read: '*If, in the assessor's opinion, MMI has not been reached, the assessment must be deferred, an explanation provided as to why MMI has not been reached and, if possible, an indication provided as to when the assessor considers it is likely to be reached.'*
1.16 (new)	New clause added: *'In the case of an accepted work injury for a terminal condition, a WPI assessment may be undertaken where the treating physician considers current treatment, as accepted by the worker, to be optimal and the condition to be stable in the short to medium term. An assessment under this section is not subject to the requirements of 1.14.'*
1.24 (was 1.28)	New text added to clause: '*Impairment ratings within the same body system are combined before combining with those from another body system*.'
1.26 (was 1.23)	*'Part of the body'* was changed to *'body part'* and examples are provided. Further explanation is provided in another sentence: '*The same part of the body, as above, is not divisible for the purpose of assessing unrelated injuries. For example, the knee is treated as a whole and is not divisible into its three compartments.'* '*Both'* injuries has been changed to '*each injury'* in case of multiple injuries.
1.27 (was 1.24)	Requires a rating of unrelated impairment regardless of whether it was asymptomatic – additional text added: *'Regardless of whether the unrelated injury or condition was asymptomatic, where there is objective evidence for an assessment of an unrelated condition it must be assessed and deducted.'*
1.30 (prev.)	Section removed. In terms of meeting the 5% threshold for entitlement to lump sum compensation provided for in section 58(2) (and economic loss lump sum in section 56(2)), the interpretation of chapter 1.30 inequitably favoured workers who had suffered an aggravation, acceleration, exacerbation, deterioration or recurrence of a previous work injury where they had received a lump sum payment for that previous work injury. The combined effect of the current and prior work injuries was used to satisfy sections 58(2) and 56(2). As a result workers who have suffered an injury that results from a prescribed event where it relates to a prior work injury where they have had a prior lump sum payment are placed in a more favourable position than those who have suffered a prescribed event where it relates to a non-work related injury or pre-existing condition or primary injury. The interpretation of chapter 1.30 presented an additional problem where an assessor is required to provide a % WPI for the combined effect of the current and prior work injuries for the purpose of determining a worker's entitlement to lump sum compensation for economic loss under section 56 of the Act. If the combined effect of a worker's permanent impairment exceeds the 29% maximum provided for in schedule 7, contrary to the requirements of chapter 1.30, there is no starting point specified for the compensation deduction and so the necessary calculation cannot be made.
1.33	Information required for assessments: New passage added to reflect changes in availability of imaging: *'The exception to this is radiological imaging. Due to reducing availability of imaging in hard copy and on portable storage devices,*

	assessors are required to access imaging through online subscription where a written radiological report has been provided but not the images. Alternatively, or if online subscription is not available, assessors must seek information, measurements, etc. required for the purpose of rating impairment directly from the relevant Radiologist or radiology group. Radiological expenses incurred will be met by the compensating authority.'
1.41	Clarified what this section relates to: '*Where the effective long-term treatment of a work injury results in apparent substantial reduction or total elimination of the worker's whole person impairment, but the worker is likely to revert to a higher degree of impairment if treatment is withdrawn, the assessor may increase the percentage of whole person impairment by 1, 2 or 3% WPI for the impairment to which the treatment relates. This does not apply to the use of:'* First dot point changed to 'analgesic *and other medication for pain relief*, or…' Sentence added: '*The increase cannot be applied where the use of medication is a criterion for the assigned rating.*'; and '*Impairment due to side effects of pain medication, which are reversible upon ceasing, is not considered permanent or at MMI and therefore does not qualify for an impairment ratin*g'
1.42	Previous 1.42 under adjustment for the effects of treatment was removed as it was a duplication of information. New clause 1.42 inserted under assessment and reports: "*Impairment assessments and rationale must be thorough, medically accurate and evidence- based, to ensure the most appropriate impairment rating is determined."*
1.43	Amendments to add clarity and consistency: The word *'should*' was replaced with *'must'*. The word *'fair*' was removed and replaced with '*in accordance with the Guidelines, AMA5 section 2.6, pp21-22 and the applicable Court Rules*'. The words '*In general'* were removed. In the first dot point, wording was amended to read: '*current clinical status and diagnosis, including the basis and evidence used for determining the diagnosis and maximum medical improvement*'. A dot point was added: '*whether there is impairment arising from the work injury/condition*'. The words '*point value*' within a percentage range was added in the third dot point for clarity. The references to pre-existing condition or abnormality were replaced with '*unrelated injury/condition*' for consistency throughout.
1.44	*'Should'* changed to 'must' contain factual information. Additional information provided: '*The relevant history is obtained by a review of medical records reflecting past medical history and the worker's presentation of the current history. It is important to review the medical records before performing an impairment assessment, as this will enable the assessor, among other things, to:* *Clarify and document inconsistencies, if any, between the history provided by the worker and the history contained in the medical records.*

	Reconcile inconsistencies, if any, between the worker's history during the examination and other previous medical records. It is necessary to clarify historical inconsistencies because several issues are determined by the history. *Focus on the portions of the history pertinent to the impairment assessment.'*
1.45 (new)	*Clause added: 'Examination findings must be compared with those otherwise observed. Informal observation forms a part of the assessment and includes any behaviour and/or activities observed before, during and after the assessment. Observations must be documented in the report.'* *'If the assessor considers, on the basis of their informal observations of the worker, that the worker is not co-operating to the best of their ability during the formal assessment process, the worker should be reminded that, in order to obtain an accurate assessment, it is necessary for them to co-operate to the best of their ability.'*
1.48 (was 1.38)	Text altered to read: '*The Guidelines and AMA5 may allow for more than one equally valid and specific method that assessors can use to establish the degree of an injured person's permanent impairment. When choosing between these equally valid and specific methods (e.g. muscle strength or atrophy), assessors should use the method(s) that results in the highest degree of permanent impairment*.'
1.53 -1.55 (was 1.51 and 1.60-1.62)	The Quality Assurance section was replaced with the 'Compliance' section which incorporates the previous 1.60 to 1.62: *'Other than reports prepared by an IMA under Division 3, Part 8 of the Act, reports must be provided to ReturnToWorkSA or the self-insured employer requesting the report (as appropriate) for review of compliance. If, as part of the compliance process, it is not clear that the report has been completed in accordance with the Guidelines, clarification may be sought from the assessor who prepared the report by ReturnToWorkSA or the self-insured employer (as appropriate). ReturnToWorkSA or the self-insured employer may obtain independent medical advice as part of the compliance review process. However, the requestor must not direct an assessor to alter their medical opinion. If clarification is sought from an assessor, a response is required within 5 business days unless otherwise agreed. Any amended report should be marked as such with the amended date included.'* *'Where the impairment assessment has been requested by ReturnToWorkSA or its claims agents:* *• Workers and their representatives must promptly be provided with copies of correspondence between ReturnToWorkSA and the assessor in the course of ReturnToWorkSA's function of reviewing the assessor's assessment report for compliance with the Guidelines.* *• Arrangements for payment of an assessor's report fee must commence as soon as the assessor's initial report is received.* *Reports that have been compliance reviewed by ReturnToWorkSA will be forwarded to the requestor once this process is complete*.'
1.62 (was 1.57)	References updated and sentence added at the end *'Rationale must be documented as per clause 1.46.'*

Chapter 2 - Upper extremity

Clause	Change
Intro	Last sentence amended to read *'In the event of any inconsistency, the Guidelines take precedence over AMA5. Refer to paragraph 1.3.'*
2.10 (was 2.9)	First sentence clarified: '*If upper extremity impairment results solely from a peripheral nerve injury, clauses 16.5a to 16.5d of AMA5 are to be used.'*
2.11 (new)	For peripheral nerve assessment, normal two point discrimination has now been defined as ≤6mm.
2.12 (new)	New clause: *'Grade 4 Description of Table 16-10 is replaced with 'Distorted superficial tactile sensibility (diminished light touch OR two-point discrimination), with or without minimal abnormal sensations or pain, that is forgotten during activity.* *Accordingly, the text on page 483 referring to Grade 4 definition is replaced with 'Individuals in Grade 4 have diminished light touch OR two point discrimination (7 – 10mm), localisation of sensory stimuli, and good protective sensibility*.'
2.13 (new)	New clause: '*Decreased protective sensibility is defined as no ability to discern between the sharp and dull sensations in pin prick testing and two point discrimination >15mm*.'
2.15 (new) and Table 2.1	Carpal tunnel section replaced with: *'Table 2.1 is to be used in conjunction with section 16.5d, AMA5, and encompasses all types of nerve compression injuries, including median nerve (carpal tunnel syndrome). Where there is variation from AMA5, this table prevails. Where surgical decompression has occurred, only electromyography (EMG) and/or nerve conduction studies performed after an optimal recovery time will be valid.*'
2.16 (new)	New clause: '*Median nerve (below mid-forearm), Ulnar Nerve (below mid-forearm): In using Table 16-15 (AMA5, p492) for the sensory deficits, use only the digital branches that are involved as the multiplier. 39% UEI (median nerve) and 7% UEI (ulnar nerve) are only applied if all relevant digital branches are affected equally.'*
2.17 (was 2.12)	Text added to clause: *'If not all symptoms in the grade are present, a rating at the lower end of the grade should be selected and the ADL specifically affected by the peripheral nerve injury must be described*.'
2.20 (was 2.15)	Impairment due to other disorders of the upper extremity: The word *'should'* is replaced with the word *'must'*. Words added to sentence): '*i.e. decreased strength cannot be rated in the presence of decreased motion, painful conditions on clinical history and at the time of clinical examination, deformities and absence of parts...*'.
2.21 (was 2.16)	Conditions affecting the shoulder region: reference to *'shoulder disorder*' was replaced with '*diagnosed shoulder disorder*'. In the second dot point, a sentence was added: '*The caveats set out in paragraph 2.20 apply.*' New dot point added: '*Adhesive capsulitis cannot be rated until at least 18 months after an initial diagnosis by an appropriate musculoskeletal physician*.'

2.25 - 2.28 (was 2.20)	The section Epicondylitis of the elbow was re-ordered and some new text added as follows: 2.26 *'This condition is rated as 2% UEI (1 % WPI) where there has been no surgery.'* 2.27 'Section 16.7d, AMA5 (p507) refers to tendon rupture or surgical procedures. *If there has been surgery then the procedure outlined on p507 can be used if there is no other rateable condition applicable to the elbow. The caveats set out in paragraph 2.20 apply. If there is an associated loss of ROM, these figures are not combined, but the method giving the highest rating is used. When strength is not a suitable method, and normal ROM is present, then the condition is rated as 2% UEI (1% WPI).'* 2.28 *'2% UEI can be applied for lateral and medial epicondylitis where they are both present in the same limb (i.e. 4% UEI) and the criteria in 2.25 are met.'*
2.30 (was 2.22)	Text altered as follows: *'Assessment for CRPS is not to proceed unless the following criteria have been met:* • *the diagnosis is to be confirmed by criteria in Table 2.2 below – each of the four boxes must be addressed* • *the initial diagnosis must have been present for at least 18 months immediately preceding the assessment (to ensure accuracy of the diagnosis and to permit adequate time to achieve MMI)* • *the diagnosis must have been made, prior to the assessment, by at least two examining specialists, with at least one of these being a Fellow of the Faculty of Pain Medicine or a Rheumatologist; and* • other possible diagnoses must have been excluded.' Additional note: '*The assessor must ensure that previous diagnoses confirmed have been for complex regional pain syndrome and not for chronic regional pain.'*
Table 2.2 (was Table 2.1)	In section 2: - *'Hypoaesthesia' changed to 'Hyperaesthesia (to include hyperalgesia)'* - Oedema changed to '*Diffuse oedema in the region affected by CRPS*' In section 3: '*Evidence of*' removed from headings. - '*Hypoaesthesia*' changed to '*Hyperaesthesia*' - '*to deep somatic pressure and/or joint movement*' removed from mechanical allodynia - *>2°* added to temperature asymmetry. - '*Oedema*' changed to diffuse oedema in the region affected by CRPS. Reference updated to table 2.2 due to insertion of new table 2.1.
2.31 (was 2.23)	CRPS: Altered to include assessment of CRPS I and II (CRPS II section removed). New methodology outlined in dot point 3, 4, and two new tables 2.3 and 2.4. Example added.

Chapter 3 - Lower extremity

Clause	Change
Intro	Last sentence amended to read 'In the event of any inconsistency, the Guidelines take precedence over AMA5. Refer to paragraph 1.3.'
3.3	Additional text: '*Assessment of the lower extremity involves clinical assessment and selection of a valid methodology. It is imperative that the most specific methods relating to the impairment are used and the reason for the chosen method is explained in the report.'*
3.4	'*Evaluation*' was changed to '*assessment*' for consistency. The word *'should'* was changed to '*The most specific method of impairment assessment must be used*.' and '*If several equally specific methods can be used…*'. Example added '*For example, where a DBE assessment is applicable this should be used rather than ROM. 1.48 does not apply to a less specific method. Reasons must be provided for this decision*.'
3.7	Text added: **'***To convert from FI to LEI, multiply the FI by 0.7, in accordance with Section 17.2a, AMA5 (p527)***'** Sentence added: 'W*hen assessing ankles/feet/toes, calculate and combine the impairment at the foot impairment level first, then convert to lower extremity impairment, then finally to WPI%*.'
3.8	Text added: *'each impairment should be rated and combined at the %WPI level.'* Sentence deleted: '*For example, if an injury to a knee manifests as assessable impairments of range of motion, diagnosis-based estimates and arthritis, then Table 17-2 is used to determine whether any combination of these impairments is allowable. If not, then the single, most appropriate impairment that gives the highest rating is chosen*.'
3.16	Manual muscle strength testing: Additional sentence added: '*The testing should be repeated with consistent results demonstrated on each occasion (17.2e, p531, AMA5), but it is not expected that the injured worker will require multiple examinations or assessments for this purpose. Where there is inconsistency, this method should not be used.*'
3.19	This clause was simplified to '*Varus and valgus deformities are to be measured in a weight-bearing position using a goniometer and must be combined with any range of motion for the knee or the ankle.'* In the second paragraph *'opposite'* was changed to *'contralateral'*
3.31 (new)	New clause: '*There is an error in AMA5 Table 17-32 (AMA5, p545). For syme (hindfoot) the figures should read 28% WPI (70% LEI) as 100% FI converts to these ratings*.'
3.35 (new)	New clause for Hip replacement: '*Table 17-34, rating hip replacement results (p548, AMA5) is replaced by the table below. Table 17-34 uses a point score system, and then the total of points calculated for the knee joint is converted to an*

	impairment rating from Table 17-33 (AMA5, pp546-547). Note that all the points are added in Table 17-34.'
Table 17-34 (new)	New table inserted for Hip Replacement which replaces AMA5 Table 17-34.
Table 17-35	Table 17-35 Rating knee replacement results was replaced.
3.48 (new)	New clause: *'When applying Tables 16-10 and 16-11, the assessor must use clinical judgement to estimate the appropriate percentage within the range of values shown for each severity grade. Rationale for the value selected must be provided in the report. The maximum value is not applied automatically. If all symptoms in the grade are not present, a rating at the lower end of the grade should be selected and the ADL specifically affected by the peripheral nerve injury must be described.'*
3.49 (was 3.44)	Text added: '*If a lower extremity impairment results solely from the peripheral nerve injury, the assessor must not evaluate impairment(s) of abnormal motion for that lower extremity when the abnormal ROM is caused by the peripheral nerve injury*'. Additionally, following the original text: *'There is an error in AMA5 Table 17-37. The motor rating for common peroneal nerve should read 17% WPI as this is the conversion from 42% LEI.*'
3.52 (was 3.47)	Text altered as per upper extremity 2.30
Table 3.3 CRPS	As per upper extremity Table 2.2
3.53 (was 3.48)	As per upper extremity 2.31

Chapter 4 - Spine

Clause	Change
Intro	Last sentence amended to read 'In the event of any inconsistency, the Guidelines take precedence over AMA5. Refer to paragraph 1.3.'
4.3 (new)	New clause: '*Impairments of different regions of the spine (e.g. cervical, thoracic, lumbar) must be combined before combining with other body part impairments (AMA5, p10, Fig 15-4, p380, Section 15.2a, Part 7, Table 15-20, p429, Errata).'*
4.9 (was 4.8)	New opening sentences: '*Cortico-spinal tract damage and cauda equina syndrome must have been diagnosed prior to the assessment by a Neurosurgeon, Neurologist, Rehabilitation Physician or Orthopaedic Surgeon. The assessor must be accredited in both the central and peripheral nervous system and the spine to undertake this assessment.'* New text added to last sentence: '*A cauda equina syndrome may occasionally <u>be a complication of</u> lumbar spine surgery. <u>In this situation</u>, a mass lesion <u>may not</u> be present in the spinal canal on radiological investigation <u>but neurological signs in the lower limbs and sacral region that are consistent with cauda equine syndrome need to be present</u>."*

4.17 (was 4.15)	New text added to sentence consistent with AMA5 '*Clinical features which are consistent with DRE II and which are present at the time of assessment include significant muscle guarding or spasm, asymmetric loss of range of movement or non-verifiable radicular complaints*'
4.18 (was 4.16)	Wording change: '*The reference to 'electrodiagnostic verification of radiculopathy' is not to be taken into account.'* (Rather than 'disregarded'.)
4.19 (was 4.17)	Added sentence: '*The selection within the range for a DRE category is determined by the impact on ADL, as per 4.25. Select the lowest value in the ranges given for the DRE category and then consider the impact on ADL*.'
Table 4.1	Added two new parts to procedure flow chart to account for assessment of ADLs and consideration of modifiers '*0, 1, 2 or 3% can be added to the bottom of the DRE category range based on the impact of the spinal condition on ADL*' and '*Consider modifiers and combine, if applicable, as per Table 4.2 of these Guidelines.*'
4.20 (was 4.19)	Removed words '*In general*' in first sentence. Words added to dot point one: '*marked and clinically significant*.' New sentence added to dot point two: '*Significant long standing weakness is usually accompanied by atrophy*.' Amended wording of dot point three: '*Reproducible impairment of sensation must be in a strict anatomic distribution localised to the appropriate spinal nerve root*.**'**
4.24 (was 4.23)	New text added to sentence '*The highest DRE category that includes any unrelated impairment (to be deducted as per paragraph 1.25 – 1.29) is chosen. Impairments in different spinal regions are combined using the Combined Values Chart (pp604-606, AMA5) in accordance with 4.3:*'
4.27 (was 4.26)	First dot point changed '*3%WPI if worker's capacity to undertake personal care activities such as dressing, washing, toileting and shaving has been restricted*' (rather than '*affected*').
4.28 (was 4.27)	Slight change to sentence: '*If, following the second injury, there is a worsening in the ability to perform ADL, the appropriate adjustments are made within the range.*' New sentence added: '*Where there are impairments to other body parts, only the portion of the activities of daily living resulting from the spine impairment are rateable, to avoid duplication of ratings, and this must be recorded*.'
4.29 (was 4.28)	A new dot point added: '*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.*' Text added to sentence: '*Table 4.2 indicates the additional ratings which should be combined with the rating determined under DRE III or DRE IV, using the DRE method where a further operation for an intervertebral disc prolapse, spinal canal stenosis or spinal fusion has been performed*.'

4.30 (was 4.29)	Second dot point '*determine the WPI value within the allowed range in*" changed to '*select the base WPI value from… and add the impact on the worker's ADL (1-3% WPI).*' Text added: '*The first row in the modifier table requires residual symptoms and radiculopathy to be present but the second, third and fourth rows do not require residual symptoms and radiculopathy to be present*.' This sentence was removed: '*Category V already takes into account residual neurological loss, whether cortico-spinal or radicular, so no modifier is necessary*.'
Table 4.2	Change of title and application of table to '*Modifiers for DREIII and IV following surgery*'. Reference added to 4.20 in the table.
4.33 (was 4.32)	Additional text added: *'The insertion of such devices, including any associated surgery e.g. laminectomy, does not warrant any addition to %WPI.*'
4.36 (new)	New clause: '*Rib fractures are not rateable. Only the impact, if any, on the respiratory or other systems can be rated.*'

Chapter 5 - Nervous system

Clause	Change
Intro	Last sentence amended to read 'In the event of any inconsistency, the Guidelines take precedence over AMA5. Refer to paragraph 1.3.'
5.9	Wording changed slightly: '*...the assessor ratings are based on clinical assessment and the results of neuropsychological testing, unless contra-indicated.'* *'Should'* amended to *'must'* with regard to neuropsychological testing. New sentence added: '*Where the injured worker is able to undertake neuropsychological testing, this should have been undertaken within the last 12 months.'*
5.10	Text altered to read: '*For traumatic brain injury (including post-concussion syndrome), there must be evidence of the mechanism of injury, such as a severe impact to the head or that the injury involved a high energy impact.'* *'In order to qualify for an assessment of brain injury, at least one of the following must be confirmed…'*
5.11 (new)	New section included for acquired brain injury.
5.12 (was 5.11)	Additional sentence '*For sleep apnoea, the cause needs to have been confirmed prior to assessment and a sleep study must have been conducted by a Respiratory Physician within the past two years*.'
5.16 (new)	New clause: '*Vestibulochochlear nerve assessment using AMA5 (p333): Tinnitus in the absence of hearing loss resulting from a traumatic brain injury, where it adversely affects activities of daily living, can be rated as 1% WPI.'*

Chapter 6 – Ear, nose, throat and related structures

Clause	Change
Intro	Last sentence amended to read 'In the event of any inconsistency, the Guidelines take precedence over AMA5. Refer to paragraph 1.3.'
Table 6.1	Corrected reference from AMA5 to AMA4. Additional note added: '*Note 2: For cases of facial disfigurement (which can include scarring), the assessor may alternatively refer to the TEMSKI table, if that is considered more appropriate, given the nature of the disfigurement*.'
6.7 (new)	New clause: '*Assessments for obstructive sleep apnoea can only be undertaken by a Respiratory Physician or Ear, Nose and Throat Physician. The type of sleep apnoea must have been confirmed prior to rating*'.
6.8 (was 6.7)	Words added to this clause: '*Before impairment can be assessed for obstructive sleep apnoea (3rd paragraph, section 11.4a, AMA5, p259), the person must have had appropriate assessment and treatment by an Ear, Nose and Throat Physician and a sleep study by a Respiratory Physician undertaken within the past two years.'*
6.11 (was 6.10)	Introduction to new table for the assessment of mastication and deglutition added to the end of this clause: '*The selection within class 1 for mastication and deglutition is made in accordance with Table 6.3 below, which is an extension of Table 11-7 in AMA5 (p262). Table 6.3 divides class 1 of permanent impairment into 4 groupings of impairment.'*
Table 6.3 (new)	New table 6.3 inserted for rating mastication and deglutition within Class 1.
6.12 (new)	New clause: '*A treating Dentist or relevant specialist report confirming the diagnosis that impacts directly on mastication and deglutition is required*.'
6.19 (was 6.17)	Sentence added: '*A maximum of 5% WPI is allowable for total loss of each of these senses*.'
Table 6.4	This table number changed due to the insertion of the new Table 6.3.

Chapter 7 – Urinary and Reproductive systems

Clause	Change
Intro	Last sentence amended to read 'In the event of any inconsistency, the Guidelines take precedence over AMA5. Refer to paragraph 1.3.'
7.4	Word 'should' changed to 'must': 'For both male and female sexual dysfunction, identifiable pathology *must* be present for an impairment percentage to be given.'

7.5	New clause: '*For all assessments under this chapter, appropriate investigation, pathoanotomical diagnosis and treatment options must have been provided by a Urologist or Gynaecologist prior to the assessment.*'

Chapter 8 - Respiratory system

Clause	Change
Intro	Last sentence amended to read *'In the event of any inconsistency, the Guidelines take precedence over AMA5. Refer to paragraph 1.3.'*
8.7	Addition of wording in dot point one: • '*an appropriate diagnosis has been established by a Respiratory Physician based on clinical history, physical examination and spirometry with at least one appropriate lung function test performed to TSANZ standards by a pulmonary function laboratory within the last 12 months. In rare cases where the person is unable to undertake the test for medical reasons, an opinion from a second Respiratory Physician is required.'* Addition to wording of dot point three: • *'the worker has received optimal treatment, has an Asthma Plan in place, and is compliant with their medication regimen.'*
8.10 (new)	New clause: '*Assessments for obstructive sleep apnoea can only be undertaken by a Respiratory or Ear, Nose and Throat Physician. The cause must have been confirmed prior to rating*.'
8.12 (was 8.11)	Amendment to clause: '*Before permanent impairment can be assessed, the person must have had appropriate assessment and treatment by an Ear, Nose and Throat Physician and a sleep study by a Respiratory Physician undertaken within the past two years.'*
8.13 (was 8.12)	Words *'the'* and *'obstructive'* were added.
8.15 (was 8.14)	Additional text: '*Where surgery has occurred, assessment should not be undertaken until at least six months after the procedure.*'

Chapter 9 - Hearing

Clause	Change
Intro	Last sentence amended to read 'In the event of any inconsistency, the Guidelines take precedence over AMA5. Refer to paragraph 1.3.'
9.2 (new)	New clause: '*Cortical Evoked Response Audiometry (CERA) can be requested by the assessor in the event that standard audiology testing is inconsistent or there is a discrepancy between audiology test results and observed function. The rationale for requiring the test must be documented in the report*.'
9.5 (prev)	This passage was deleted and replaced with the new Noise Induced Hearing Loss section 9.18-9.21.

9.10	New sentence added 'Note" *Recent reprintings of this NAL guide have been corrected.'*
9.11	Additional text: 'T*he severity of tinnitus is determined by the assessor with consideration given as to the impact on ADL. The value assigned must be supported by clear rationale. Refer examples 9.1-9.5 in this chapter.'*
9.12(new)	New clause: '*Vestibulocochlear nerve assessment using AMA5 (p333): Tinnitus in the absence of hearing loss resulting from a traumatic brain injury, where it adversely affects ADL, can be rated as 1% WPI*.'
9.16 (was 9.15)	Sentence added: '*Notwithstanding section 22(7)(b) of the Act, regard must be had to any audiogram(s) undertaken post retirement and prior to the assessment in determining any non-work related component of the worker's current impairment.*' Sentence deleted '*The requestor is responsible for providing clear guidelines to an assessor regarding the assessment of impairment in such cases*.'
9.17 – 9.20 (new)	New heading of Noise Induced Hearing Loss above 9.16 (prev. 9.15) and clauses added: *'9.17 For the purpose of rating impairment, use the better of the air and bone conduction thresholds at 2000Hz and below. Above 2000Hz use the air conduction thresholds.* *9.18 Impairment due to noise induced hearing loss is to be calculated on the assessed hearing thresholds between 2000Hz and 4000Hz.* *9.19 If noise exposure has been prolonged, 1500Hz can be included in the impairment assessment, provided a detailed explanation is given as to frequency, duration and source of noise exposure, whether it was constant or intermittent and, if known, decibels.* *9.20 The following thresholds apply when rating for noise induced hearing loss. Any readings above these are to be rated as per the following limits:* *1500Hz – 45dB* *2000Hz – 65dB* *3000Hz – 90dB* *4000Hz – 90dB'*
Examples 9.1 - 9.7	The examples have been updated to more clearly articulate the process.

Chapter 10 – Visual

Clause	Change
Intro	Last sentence amended to read 'In the event of any inconsistency, the Guidelines take precedence over AMA5. Refer to paragraph 1.3.'
10.8 (new)	New clause: '*If disfigurement is limited to the immediate periorbital area, being the orbital contents plus the eyelids, then it is to be assessed by the Ophthalmologist. However, if it extends to involve more of the face, it is to be undertaken in accordance with the Ear, Nose and Throat Chapter by an assessor accredited in that system*.'

10.9 (new)	New clause: '*For impairment assessment for monocular aphakia or monocular pseudophakia, AMA4 directs that the lower numbers are used in Table 3 (p212, AMA4). The separate scales are no longer required. Only the top numbers are to be used*.'
10.10 (new)	New clause: '*AMA4 allows an additional 5% to 10% visual impairment to be combined with the impaired visual function of the involved eye for abnormalities, such as media opacities, corneal or lens opacities and abnormalities resulting from such symptoms as epiphora, photophobia or metamorphopsia, if it interferes with the visual function and is not reflected in visual acuity, decreased visual fields or ocular mobility with diplopia (p209, AMA4). This impairment can be applied even where the visual function impairment is 0%*.'

Chapter 11 - Haematopoietic system

Clause	Change
Intro	Last sentence amended to read 'In the event of any inconsistency, the Guidelines take precedence over AMA5. Refer to paragraph 1.3.'
11.1	New sentence added: 'T*he diagnosis being rated must have been made by a Haematologist, Oncologist, Immunologist or other Specialist Internal Medicine Physician prior to the assessment.*'

Chapter 12 - Endocrine system

Clause	Change
Intro	Last sentence amended to read 'In the event of any inconsistency, the Guidelines take precedence over AMA5. Refer to paragraph 1.3.'
12.1	New sentence added: '*The diagnosis being rated must have been made by an Endocrinologist with supporting objective evidence prior to the assessmen*t.'
12.8 (new)	New clause regarding mammary glands: '*In AMA5 example 10-45 regarding current symptoms (p239), the last sentence is replaced with 'Routine use of bromocriptine and cabergoline is normal in Australia. It is rare that nausea precludes their use.'*

Chapter 13 - Skin

Clause	Change
Intro	Last sentence amended to read 'In the event of any inconsistency, the Guidelines take precedence over AMA5. Refer to paragraph 1.3.'
13.4	Text added: '*The skin is regarded as a single organ and all non-facial scarring, <u>including any compensable and non-compensable scarring</u>, is measured together as one overall impairment rather than assessing individual scars separately and*

	combining the results. If there is any unrelated component, then this is deducted from the total. As the skin is treated as a whole (except for the face), the location of the unrelated component does not need to be in the vicinity of the work injury to be deducted.'
13.5 (new)	New clause and example: '*If there are multiple claims being assessed at the same time, then the scars that relate to each claim must be assessed chronologically and any scarring resulting from the previous claim must be deducted as pre-existing e.g. assess scars from claim 1, as in 13.4, and then assess scarring from claim 1 and claim 2 together, then deduct the impairment as assessed from claim 1 as pre-existing (refer example).* ***Example: Claim 1 shoulder injury – Claim 2 knee injury*** *Assess pre-existing scar from abdomen1%* *Assess compensable shoulder scar plus abdomen 2%* *Assess compensable knee scar plus shoulder plus abdomen 3%* *Table 1 - Shoulder injury* *2%-1% = 1%* *Table 2 – Knee injury* *3% - 2% = 1%*'
13.8 (was 13.5)	Sentence extended: '*For cases of facial disfigurement (which can include scarring), refer to Table 6.1 in the Ear, Nose and Throat Related Structures chapter of the Guidelines or alternatively to the TEMSKI table (up to 4% unless accredited in skin), whichever is considered most appropriate given the nature of the disfigurement.'*
13.11 (was 13.9)	Sentence added: '*A scar may be present and rated as 0% WPI. For example, minimal uncomplicated scars for standard surgical procedures may not, of themselves, rate an impairment*'.
TEMSKI Table	Bracket added to heading in the final column: 5-9% WPI to ensure that it is clear that assessors not accredited in skin can only use the table up to 4%.
Example 13.2	Burns: Text altered in this example to change '*burns to forehead*' to '*burns to neck and chest*' and '*irritation caused by his shirt'* rather than his hat.

Chapter 14 – Cardiovascular system

Clause	Change
Intro	Last sentence amended to read 'In the event of any inconsistency, the Guidelines take precedence over AMA5. Refer to paragraph 1.3.'
14.2 (new)	New clause: '*The impairment being evaluated/rated must be diagnosed by a Cardiologist with evidence to support the diagnosis prior to the assessment. The exception is thoracic outlet syndrome (14.8).'*
14.10-14.11 (new)	New section on Pulmonary hypertension: '*14.10 In Table 4-6 of AMA5 'any degree of pulmonary hypertension' is defined as a PAP >40mmHg (p79).* *14.11 The classes (2, 3 and 4) referred to in the criteria in class 3 and 4 of Table 4-6, AMA5, relate to Table 3-1 – Functional Classification of Cardiac Disease (p26, AMA5) where these classes are written as Class II, III and IV.*'

14.13 (was 14.10)	'*Coronary disease*' changed to '*Coronary artery disease*'. *'Should'* was changed to *'must'* in this sentence to remove any ambiguity.

Chapter 15 – Digestive system

Clause	Change
Intro	Last sentence amended to read 'In the event of any inconsistency, the Guidelines take precedence over AMA5. Refer to paragraph 1.3.'
15.2 (new)	New clause: '*AMA5 Table 6-3 (p121) Class 1 is to be amended to read 'there are symptoms **and** objective evidence of upper digestive tract disease'*.
15.3 (new)	New clause: '*AMA5 Table 6-4 (p128) Class 1 is to be amended to read 'there are symptoms (infrequent and of brief duration) and objective evidence of either colonic and/or rectal disease.*'
15.4 -15.5 (new)	New section '*Effects of medication on the digestive tract*': '*15.4 Some medications may cause symptoms in the digestive tract:* • *In the absence of reproducible objective evidence of upper digestive tract disease, anatomic loss or alteration, a 0% WPI is to be assessed. Occasional minor dyspepsia, gas and belching are within the experience of all individuals (AMA5, p118).* • *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*.' *'15.5 For medication-related impairments to be assessed, the following must have occurred:* • *Appropriate investigation and tests have been undertaken, which may include but is not limited to, endoscopy or colonoscopy, confirming the disorder. All other possible causes for the condition have been excluded. Self-reporting of symptoms alone is insufficient.* • *Treatment options have been identified and discussed.* • *ADL have been impacted that are not elsewhere rated.'*
15.6 (was 15.5)	Title and text changed from '*Inguinal hernias*' to '*Herniae*' and language changed to reflect that assessors can now hold accreditation for the digestive system for herniae only, for the purposes of this assessment.

Chapter 16 – Psychiatric disorders

Clause	Change
16.12	The word *'justify'* was changed to *'explain'*. The word *'disregarded'* changed to *'ignored'* to avoid confusion with the definition of disregard which is a term used in the Act and has case law associated with it.

16.15 point 4	Additional words added: '*Write an impairment formulation, explaining your rationale for your impairment scores with sufficient detail describing how the worker's presentation aligns with the class criteria.'*
16.15 point 9	This section was expanded as follows: '*The assessing psychiatrist must use all available information to rate the injured worker's pre-injury level of functioning in each area. The percentage impairment is calculated and subtracted from the current WPI to obtain the percentage of impairment attributable to the work-related injury.'*
16.15 point 10	The words '*exclude that*' were changed to '*and deduct*'.
16.16	On Page 142, 5th paragraph beginning '*An appropriate…*', the words '*except in unusual circumstances*' were removed. In the examples dot points: removed the ranges. At the very end of the clause, a sentence was added: '*When selecting a percentage within a class (except where the median is not a whole number), the assessor should consider the overall severity of impairment, not just the median functions.*'
16.17	The requirement for neuropsychological testing has changed from *'should'* to *'must'* and the word *'generally'* was removed. A sentence was added: '*In the absence of any evidence of brain injury, disability or disease, the rating for intelligence would be expected to be class 1*.'
Table 16.6	In the table for rating mood, '*some days off*' was changed to '*some time off work*'.

Chapter 17 – Assessor selection process

Clause	Change
17.2	Additional dot point: '*The 'requestor' is the claims agent, self-insured employer or ReturnToWorkSA.'*
17.3	The procedure was refined to ensure efficiency and better clarity of process including: - Requestor to identify and provide the worker with a list of all qualifying assessors - Only using multiple Assessors where there is no single assessor accredited in the required body systems to assess all injuries - Ensuring appointments are made within the six week timeframe required by the Impairment Assessor Accreditation Scheme. The Minister has included a further safeguard to ensure the requestor may not direct the worker to choose a particular assessor unless they are unwilling or unable to do so.
17.4	Wording added that if the worker does not wish to select the assessor, or does not make a selection within 15 business days of being provided the list of applicable assessors, or as otherwise agreed, then the requestor should select the assessor, in consultation with the worker, taking into consideration the

	factors outlined in 17.3 – informing the worker of the chosen assessor(s) as soon as practicable after the selection is made.
17.5 (new)	New clause: '*The requestor must ensure that workers are provided with the draft report request prior to it being sent to the assessor. The requestor must give the worker at least ten business days to consider the request and provide them with an opportunity to raise any issues, errors or omissions. Assessments must not be booked until this process is finalised and all supporting documents obtained. Subject to 17.3, the requestor may not delay the booking of the appointment unless agreed with the worker.'*

Appendix 1 – Notes for the requestor

Clause	Change
Introductory paragraph	Text removed: '*If a monetary reduction of the compensation payable is required in accordance with subsection 58(7) or subsection 56(6) of the Act, that monetary reduction will be made by the requestor, making use of the information contained in the whole person impairment assessment report*.' The word '*pre-existing*' was replaced by '*unrelated*' consistent with the other changes and the definitions.
New section after dot points	'**Assessor Selection Process** '*The process for the selection of the assessor is included in Chapter 17 of the Guidelines*.' Moved from below: '*The requestor must ensure workers are provided with the report request prior to it being sent to the assessor. The requestor must give the worker at least ten days to consider the request and have an opportunity to raise any issues, errors or omissions before the request is sent to the assessor.*'
Definitions deleted	Definitions of disregarded, assessed together etc. have been removed as they are contained in the Glossary and Definitions at the front of the Guidelines.
New heading and text reworded	'***Request letter*** *Clear instructions must be provided to the assessor before the assessment is undertaken. The assessor must be provided with all relevant medical and allied health information, including results of all clinical investigations and previous assessments related to the work injury or condition in question. Assessors should contact the requestor if they consider additional information is required*.'
Additional dot point	Requestor instructions now includes additional dot point '*Which injury impairment(s) should be included in the assessment*'
New heading	**'Additional information to be provided**' this includes what was the 12th paragraph and what was the 11th paragraph amended to read: '*Where there are unrelated injuries/conditions that are relevant to the work injury need to be considered, the requestor should request a whole person impairment assessment for the total impairment encompassing both the work injury and the unrelated injury/condition, and then ask the assessor to deduct the degree of impairment attributable to the unrelated injury/condition.'*

	Clarifying information added to last dot point about the purpose of the additional information requirements.
Bladder impairment	Section replaced with: '**Origin of impairment** *An impairment often involves more than one body system and the same condition may be covered in more than one chapter. Usually the system where the impairment presents is used for evaluating the impairment, however if an impairment is related to an injury to another area e.g. the brain or spinal cord, the assessment may need to be undertaken by an assessor accredited in the system where the impairment originates.*'
Appendix 1 – Notes for the Requestor	A number of paragraphs in Appendix 1 have been revised and moved to a new section titled '*Additional information to be provided.'*
	Paragraph removed: '*If any of the injuries are previous work injuries and a previous whole person impairment assessment needs to be deducted, the requestor should provide the assessment information to the assessor, so that the deduction can be applied to the whole person impairment in the report*.'
	Paragraph moved from the Introduction: '*Requests for an assessment of permanent impairment and %WPI in respect of noise induced hearing loss will consider, in addition to section 22 of the Act, the requirements of subsections 188(2) and 188(3) of the Act. The requestor will consider these requirements and include relevant instructions in the request*.'
	Paragraph removed: '*As a condition of their accreditation by the Minister, the assessor is unable to offer any opinion regarding the determination of a claim or any legal comment about the claim*.'
	Paragraph removed: '*Clear instructions must be provided to the assessor before the assessment is undertaken or it is expected that the assessor will come back to the requestor for additional information.*'
	Paragraph removed: '*The assessment of permanent impairment and %WPI in respect of noise induced hearing loss needs to be assessed consistently with the particular impact of subsections 188(2) and (3) of the Act*.'
	Paragraph removed: '*The requestor is responsible for providing clear guidelines to an assessor regarding the assessment of impairment in such cases*.'
	Paragraph moved: 'T*he requestor must ensure workers are provided with the report request prior to it being sent to the assessor. The requestor must give the worker at least ten days to consider the request and have an opportunity to raise any issues, errors or omissions before the request is sent to the assessor*.'
	Claims Agent changed to '*The requestor*'.
Noise Induced Hearing Loss (NIHL)	Words added '*The requestor will consider these requirements and include relevant instructions <u>and information (e.g. date of retirement, if relevant)</u> in the request.*'
Sleep apnoea	Text updated to: '*For sleep apnoea assessment, a sleep study must have been conducted <u>by a Respiratory Physician within the past two years.</u> For <u>obstructive</u> sleep apnoea assessment, the worker must also have been*

	examined by an Ear, Nose and Throat Physician. *Central sleep apnoea is rated by an assessor accredited in the Nervous System.'*
Asthma	Clause altered to read: '*The requestor should ensure that a diagnosis has been made for asthma by a Respiratory Physician and the diagnosis has been confirmed over time with repeated testing, before requesting an assessment. At least one lung function test must have been performed to TSANZ standards by a pulmonary function laboratory and it would be expected that spirometry has been conducted within the previous six months. The requestor should provide details of ay available Asthma Plan(s), to assist in the impairment assessment process.'*
Other respiratory disorders	Text altered to read: '*The requestor is required to provide* an appropriate set of respiratory function tests *performed to TSANZ standards by a pulmonary function* laboratory.'
Traumatic head injury	Information moved to Brain injury section below.
Arthritis	Text amended: '*Arthritis, as measured by cartilage interval, can only be assessed with the appropriate x-rays. Due to reducing availability of imaging in hard copy, and on portable storage devices, requestors can direct assessors to access the relevant imaging via online subscription or direct from the Radiologist or radiology group (refer 1.33)*.'
Operation notes	Text amended: '*When surgery has occurred, it is important that the requestor obtains all relevant operation notes and imaging for provision to the assessor.'*
Adhesive capsulitis (frozen shoulder)(new)	New paragraph: '*Adhesive capsulitis can be rated 18 months after an initial diagnosis by an appropriate musculoskeletal physician. The requestor must ensure that this timeframe is met prior to the assessment*.'
Brain injury (new)	New paragraph: '*Neuropsychological testing for brain injury is required to be undertaken within the 12 month period before the assessment. If the injured worker is unable to undertake that testing, the requestor must explain this in the request*.'
Complex Regional Pain Syndrome	*'Examiners*' changed to *'examining specialists*' and text added as follows: '*The diagnosis of complex regional pain syndrome (CRPS) must have been present for at least 18 months immediately preceding the assessment to ensure accuracy of the diagnosis and to permit adequate time to achieve MMI. The diagnosis must have been made prior to the assessment by at least two examining specialists; with at least one being made by a Fellow of the Faculty of Pain Medicine or a Rheumatologist. Care should be taken to ensure that any previous diagnoses have been for Complex Regional Pain Syndrome as opposed to Chronic Regional Pain.'*
Cortico-spinal tract and cauda equina syndrome (new)	New paragraph: '*Cortico-spinal tract damage and cauda equina syndrome must have been diagnosed prior to the assessment by a Neurosurgeon, Neurologist, Rehabilitation Specialist or Orthopaedic Surgeon.* *The assessor must be accredited in both the Nervous System and the Spine*.' *If impairment is caused by an injury to the brain and/or spinal cord, such as bladder, bowel, sexual dysfunction, etc., the request should be made to an*

	assessor accredited in the relevant body system (e.g. spine or nervous system). A request to an assessor accredited in the affected body system would usually only be made where the impairment is due to an injury directly to the affected body system.'
Dental	Text added as follows: 'Assessment for dental injuries and conditions is conducted by an assessor accredited in the Ear, Nose and Throat system and is assessed in relation to the impact on mastication and deglutition. To assist the assessment process, the requestor should obtain and provide prior dental records.'
Epicondylitis	Text altered to '*The requestor must ensure that symptoms have been present for at least 18 months prior to arranging for assessment of epicondylitis*.'
Lung cancer (new)	'*Impairment due to lung cancer that has been treated surgically should be assessed at least six months after surgery*.'
Peripheral nerve injuries (new)	New paragraph: '*The requestor must ensure that symptoms have persisted for at least 12 months prior to arranging an assessment for a peripheral nerve injury.* *In the case of compression and entrapment nerve injuries (such as carpal tunnel syndrome and cubital tunnel syndrome), copies of nerve conduction study results must be provided to the assessor. Where surgery has been undertaken, and the worker continues to report ongoing symptoms, updated nerve conduction studies undertaken post-surgery (following an optimal recovery time) will need to be obtained prior to the assessment.* *Whilst still useful, nerve conduction studies are not a requirement for traumatic injuries to the peripheral nerves such as in the case of crush injuries and lacerations.*'
Plantar fasciitis	'*The requestor must ensure that symptoms have persisted for at least 18 months prior to arranging an assessment for plantar fasciitis*'.
Psychiatric disorders	Text changed from '*psychiatrist or psychologist*' to '*the treating Psychiatrist*'.
Terminal disease (new)	New paragraph: ''*In the case of an accepted work injury of a progressive nature such as silicosis and other terminal disease, a WPI assessment may be requested where a worker's treating physician considers the condition to be stable in the short to medium term and treatment is optimised, as outlined in paragraph 1.16. In these circumstances the assessor will be asked to assess the degree of impairment as if the worker's condition has reached MMI. MMI in diseases of long term progressive decline needs to be considered on a case by case basis*.'

Appendices 2-5

Appendix 2 and 3 – Explanatory notes and Glossary: The Explanatory notes have been combined with the Glossary, renamed 'Definitions' and moved to the front of the Guidelines.

Appendix 4 – Development of the Guidelines: This appendix was removed as it applies to the first edition of the Impairment Assessment Guidelines.

Appendix 2 – GEPIC worksheet – was Appendix 5: Correction to table labelling on page 2 – Worksheet 2.

OFFICIAL

RETURN TO WORK SCHEME

Enquiries: 13 18 55
400 King William Street, Adelaide
South Australia 5000
wpi@rtwsa.com
www.rtwsa.com

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