Guidelines to the Tables for the Assessment of Work-related Impairment for DSP

1 January 2012 – 31 March 2023

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List of Acronyms and Abbreviations

ACL	Assessment of care load
CA	Carer Allowance
CDP	Community Development Program
CITW	Continuing inability to work
CP	Carer Payment
DMA	Disability medical assessment
DSP	Disability Support Pension
DVA	Department of Veterans' Affairs
EPP	Employment pathway plan
GCD	Government-contracted doctor
GP	General practitioner
HPAU	Health Professional Advisory Unit
JCA	Job capacity assessment
JSP	Jobseeker payment
POS	Program of Support
RJCP	Remote Jobs and Communities Programme
SSAct	*Social Security Act 1991*
THP	Treating health professional

3.6.3 Guidelines to the Tables for the Assessment of Work-related Impairment for DSP

Introduction

The Impairment Tables (1.1.I.10) were last reviewed in 2011 to bring them up to date with contemporary medical and rehabilitation practice. The current Impairment Tables, which came into force on 1 January 2012, are used for the assessment of new DSP claims lodged on or after that date, and for reviews commencing on or after that date, regardless of a recipient's start date on DSP.

These Guidelines provide further explanation of the Impairment Tables and include background information as well as case studies.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011

Impairment Tables used prior to 01/01/2012

Links to the pre-January 2012 Impairment Tables and to the Guide to those Tables are included below for reference purposes only, as in practice they are no longer used.

- A Guide to the Tables for the Assessment of Work-Related Impairment for DSP (prior to 1 January 2012) PDF [489.06 KB]

Act reference: SSAct pre-1 January 2012 Schedule 1B Tables for the assessment of work-related impairment for DSP

The objective & intended use of these Guidelines

The objective of these Guidelines is to assist in the application of Tables for the Assessment of Work-related Impairment for Disability Support Pension (the Tables).

The Tables and the rules to be complied with in applying them, are contained in the Social Security (Tables for the Assessment of Work-related Impairment for Disability Support

Pension) Determination 2011 (the Determination) made by the Minister under the applicable provisions of the SSAct.

These Guidelines do not in any way alter or substitute the contents of the Tables and the rules for their application contained in the Determination. They are intended to provide assistance in interpreting these rules and the Tables' contents, consistent with their intent.

It should be emphasised that the Determination is the primary instrument to be used when applying the Tables while these Guidelines are a supporting source. As such, the Determination is always to be used when assessing impairments with the Guidelines to be used if further assistance in applying the provisions of the Determination is required.

Note: The Determination must always be used when assessing impairment. The Guidelines alone must never be used in applying the Tables.

To reflect these dependencies, the structure of the Guidelines corresponds with the structure of the Determination.

Although examples have been included in the Guidelines to assist in applying the Tables, it is emphasised that these examples are not intended to be strictly prescriptive for the purpose of assessing functional impact of impairment caused by medical conditions. Functional impact of each person's impairment must be assessed on an individual basis to account for the varying levels of impact a particular medical condition and its resulting impairment may have on different people.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011

3.6.3.01 Purpose & design of the Impairment Tables

Summary

This topic provides guidance on Part 2 of the Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 (the Determination), which sets out rules that are to be complied with in applying the Impairment Tables. This topic has headings emphasising significant principles and concepts underpinning provisions contained in that part of the Determination. It also provides guidance on the concepts and practical application of the DSP eligibility criteria contained in the SSAct.

This topic does not restate the definitions contained in Part 1 of the Determination. These definitions are to be accessed directly from the Determination.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Part 1 - Preliminary, Part 2 - Rules for applying the Impairment Tables.

Purpose & design of the Impairment Tables

Unless otherwise authorised by law, the Impairment Tables are used to determine whether a person whose qualification for DSP is being considered, meets a qualifying impairment threshold stipulated in the SSAct. This determination is made by assessing the level of functional impact of a person's impairment and assigning an impairment rating corresponding to the identified level of impact.

To qualify for DSP, a person must have, among other things, a physical, intellectual or psychiatric impairment assessed as attracting an impairment rating of 20 points or more under the Impairment Tables. A person is considered to have a severe impairment if they have 20 points or more under a single Impairment Table.

A person must also have a CITW - that is they must be unable, because of the impairment, to do any work of at least 15 hours per week independently of a POS in the next 2 years, or be re-skilled for such work within the next 2 years. To meet the CITW requirements, a

person whose impairment is not assessed as severe, must have also actively participated in a POS.

Impairment & continuing inability to work

The determination of an impairment rating and the assessment of CITW are 2 distinct assessments based on 2 different DSP qualification criteria. When assessing qualification for DSP, the requirement for a person to have a minimum qualifying impairment rating of 20 points or more and the requirement for a person to have a CITW, must both be met and are of equal importance.

Being assigned an impairment rating of 20 points or more does not mean a person qualifies for DSP but merely indicates the impairment-related qualification criterion has been satisfied.

Being assigned this rating does not mean a person will be unable to do any work of at least 15 hours per week in the next 2 years. What it does mean is a person's impairment may have a significant functional impact in many work situations. However, depending on their individual circumstances, coping mechanisms and reasonable adjustments by an employer, that person may still be able to work.

Example 1: A person is assessed as having an impairment rating of 20 points under Table 14 - Functions of the Skin, because they have severe difficulties performing tasks involving exposure to sunlight due to heightened sensitivity resulting from extensive skin grafts to their upper limbs. Also, this person is not able to wear clothing required in their workplace, such as protective gloves, because of sensitivity of their hands. While this person must avoid exposure to sunlight and cannot wear gloves or other protective equipment on their hands, they may be able to do work that does not involve such exposure or protective equipment. For instance, they may be able to perform clerical tasks and have their desk placed away from windows.

Example 2: A person has sustained brain and spinal injuries in a motor vehicle accident. Their impairments are assessed at:

- 10 points under Table 4 - Spinal Function (as they can drive a car for at least 30 minutes, but they are unable to bend forward to pick up light objects placed at knee height), and

- 10 points under Table 7 - Brain Function (as they have moderate difficulty solving some day to day problems and may need help from another person occasionally, but less than once per day.

This person therefore meets the minimum impairment threshold of 20 points and is clearly unable to do work that requires lifting objects and solving certain problems on their own. However, they may be able to undertake work that does not involve lifting, but involves routine repetitive tasks such as processing simple forms or data entry.

Figure 1: Summary of key medical & work capacity qualification requirements for DSP

Summary of key medical & work capacity qualification requirements for DSP (as per SSAct section 94 (1)(a)(b) & (c)(i) & (ii))
A person has a physical, intellectual or psychiatric impairment, and their impairment is rated at 20 points or more under the Impairment Tables, and they have a CITW, or they are participating in the supported wage system. CITW criteria are met when: 1. in cases where a. a person's impairment is NOT a severe impairment, or b. a person is a reviewed 2008-2011 DSP starter who has had an opportunity to participate in a POS c. they have actively participated in a POS and the POS was wholly or partly funded by the Commonwealth, and in cases where 2. in all cases, the impairment is sufficient to prevent a person from doing any work independently of a POS within the next 2 years, and 3. in all cases, either a. the impairment is sufficient to prevent a person from undertaking a training activity during the next 2 years, or b. if the impairment does not prevent a person from undertaking a training activity - such activity is unlikely to enable a person to do any work independently of a POS within the next 2 years. Severe impairment Severe impairment means a person has an assessed impairment of 20 points or more under the Impairment Tables, of which 20 points or more are assigned under a single

Summary of key medical & work capacity qualification requirements for DSP (as per SSAct section 94 (1)(a)(b) & (c)(i) & (ii))

Table. To have a CITW, DSP claimants with a severe impairment are not required to have actively participated in a POS but still need to meet the remaining CITW criteria listed above in dot points 2 and 3.

A person who does not have 20 points assigned under a single Table is not considered as having a severe impairment, even if their total impairment rating is 20 points or more from multiple Impairment Tables.

They are therefore required to have actively participated in a POS as part of the CITW requirements. If a person does not meet the POS criterion, they do not have a CITW and their claim must be rejected. If a person meets the POS requirement, to be considered to have a CITW, they must also meet the remaining CITW criteria in dot points 2 and 3 above.

Reviewed 2008-2011 DSP starter

A reviewed 2008-2011 DSP starter means a person who meets all the following conditions:

- the person made a claim for DSP before 3 September 2011 and was granted the payment on or after 1 January 2008
- on or after 1 July 2014 the person was legally notified their DSP qualifications would be reviewed
- at the time of being so notified the person was under age 35
- before the person was notified of the review, they had an assessed and recorded work capacity to work for at least 8 hours per week or they had no recorded work capacity at all
- as a result of the review it is determined the person
    - does not have a severe impairment
    - has a capacity to work for at least 8 hours per week, and
- the person does not have a dependent child under 6 years of age.

POS

Active participation in a POS is assessed under provisions of the Social Security (Requirements and Guidelines - Active Participation for Disability Support Pension) Determination 2014.

Independently of a POS means a person:

- is unlikely to need a POS

Summary of key medical & work capacity qualification requirements for DSP (as per SSAct section 94 (1)(a)(b) & (c)(i) & (ii))
• is likely to need a POS provided occasionally, or • is likely to need a POS that is not ongoing. POS means a program designed to assist persons to prepare for, find or maintain work and is funded (wholly or partly) by the Commonwealth or is of a type similar to such a program. Work means work that is for at least 15 hours per week, at or above the relevant minimum wage and exists (anywhere) in Australia, even if not within the person's locally accessible labour market, regardless of whether vacancies exist.

Conceptual design model of the Impairment Tables

The Impairment Tables are function-based rather than condition or diagnosis-based. They assess the functional impact of medical conditions on activities related to work performance, and assign an impairment rating consistent with the identified level of impact.

The basis for understanding the concept and design of the Impairment Tables as being function-based rather than condition or diagnosis-based, lies in a distinction between the concepts of medical conditions and impairments. The distinction between a medical condition and an impairment is therefore necessary.

Note 1: A medical condition is a disease, injury or abnormality of a body system or structure as diagnosed by an appropriately qualified medical practitioner.
Note 2: Impairment can be described as a sum of the effects or impacts of a person's medical condition on the person's ability to function in relation to work.

If an assessor does not appreciate the difference between a condition and a diagnosis or selects an inappropriate Table for assessment of a person’s condition, this can result in the assessor double counting one impairment. Assessors need to be able to identify when a single condition may result in a number of functional impairments assessable under more than one Table and conversely, when a number of conditions may cause a combined functional impairment appropriately assessable under a single Table. See 3.6.3.06. Also, see section rating multiple conditions with common impairments and double counting on 3.6.3.06.

Impairments can vary between individuals. Inappropriate assessments may result from assuming that all individuals with the same condition or diagnosis will have the same level of impairment.

Example: Two individuals with the same condition, 'below knee amputation of the left leg' may not necessarily have the same impairment rating assigned under Table 3 - Lower Limb Function, even though they share the same diagnosis. This is because it is their functional ability rather than their condition that is assessed.

Consistent with the function-based approach, the Impairment Tables describe functional activities, abilities, symptoms and limitations that must be taken into consideration when assessing the level of impact of impairments.

Each individual Table contains a set of instructions that must be followed when applying that specific Table. Typically, these instructions are set out in the introduction to each Impairment Table and:

- specify body functions to which that Table are to be applied
- specify which type of practitioner can diagnose medical conditions for that Impairment Table
- instruct that self-report of symptoms (by a person who is being assessed) must be supported by corroborating evidence of their impairment in order to assign an impairment rating
- provide examples of corroborating evidence that can be taken into account when applying that Table and examples of who can provide it, and
- where appropriate, an indication of conditions commonly associated with an impairment assessable under that Table.

Scaling system & descriptors

The Impairment Tables have been designed to be consistent where possible with the World Health Organization International Classification of Functioning, Disability and Health (WHO ICF), 2001.

Each Table contains descriptors which describe the level of functional impact of the impairment assessable under that Table. The first line of each descriptor (formatted in italics) describes the level of impact of the impairment (no, mild, moderate, severe or extreme impact). The level of impact is identified by referring to specific examples of functional activities, abilities, symptoms and limitations in the descriptor’s numbered paragraphs (descriptor points).

While the Impairment Tables are designed to assess the level of a person's impairment in relation to their capacity to perform work-related tasks and activities, the Impairment Tables

acknowledge some people being assessed for DSP purposes may have no work history and experience. This is addressed by including references to general activities of daily living in the descriptors.

Each individual descriptor specifies how it is to be met. For example, a descriptor may specify at least one, two or most of the descriptor points must be met.

Note: For the purpose of applying the Impairment Tables, 'most' means more than 50%. For instance: if there are 3 points in the descriptor, most means 2; if there are 4, most means 3; if there are 6, most means 4 etc.

Additionally, individual activities, abilities, symptoms and limitations specified in the descriptor points may contain terms such as 'occasionally', 'frequently', 'often', 'sometimes', and, 'regularly'. In some Tables, these terms may be further defined by references to the corresponding periods of sustained effort.

Example: Table 15 - Functions of Consciousness:

- under 5 points, rare episodes are defined as occurring no more than twice per year, and
- under 30 points, frequent episodes are defined as occurring at least once each week.

Note: Unless specifically defined in individual Impairment Tables (for example, Table 15), terms such as occasionally, frequently, often, sometimes, regularly etc., have their ordinary meaning. Please refer to 3.6.3.08 Assigning an impairment rating for more explanation on the significance of these terms in the context of the hierarchy of descriptors.

In all Tables, each level of functional impact has a corresponding rating expressed in points in accordance with a consistent, generic scale that has been adapted from the WHO ICF.

This generic scale is as follows:

- no functional impact - 0 points
- mild functional impact - 5 points
- moderate functional impact - 10 points
- severe functional impact - 20 points, and
- extreme functional impact - 30 points.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 section 5 Purpose and design of the

Tables, Table 1 - Functions requiring Physical Exertion and Stamina, Table 3 - Lower Limb Function, Table 4 - Spinal Function, Table 7 - Brain Function, Table 14 - Functions of the Skin, Table 15 - Functions of Consciousness

3.6.3.02 Applying the Impairment Tables

Summary

This topic provides guidance on Part 2 of the Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 (the Determination), which sets out rules that are to be complied with in applying the Impairment Tables. This topic has headings emphasising significant principles and concepts when applying the Impairment Tables to assess a person's functional capacity, which underpin provisions contained in that part of the Determination. It also provides guidance on the concepts and practical application of the DSP eligibility criteria contained in the SSAct.

This topic does not restate the definitions contained in Part 1 of the Determination. These definitions are to be accessed directly from the Determination.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Part 1 - Preliminary, Part 2 - Rules for applying the Impairment Tables

Assessing functional capacity

A person's impairment must be assessed according to their actual functional abilities, not what they choose to do or what others do for them - refer to 3.6.3.08.

Example: The fact a person's partner is typically responsible for certain household activities does not mean a person is unable to perform them. It is inappropriate to determine a person cannot perform certain tasks or activities solely on the basis of self-report of the situation in their household. This is because that specific situation may be a result of the domestic arrangements or reflect other factors such as family or cultural tradition.

Note: A determination that a person cannot perform certain activities must always be based on an objective assessment of a person's potential capability to do those things.

The Impairment Tables mandate that self-reported symptoms alone are insufficient. Accordingly, an impairment rating must always be supported by corroborating evidence of the functional impact of a person's condition.

Explanation: When assessing functional impairment, rather than asking 'Does this person vacuum floors or mow the lawns at their place?' One should consider 'if a person were to perform the task, what level of functional limitation, if any, would they experience?'

Permanency of conditions & impairments

The Impairment Tables can only be applied when a person has a medical condition which is permanent for DSP purposes; and which results in an impact on the person's ability to function (including zero impact) which is expected to persist for more than 2 years without significant improvement.

In deciding whether the Impairment Tables can be applied, the following are to be considered:

- whether a person has a medical condition and if so, whether the condition is permanent for DSP purposes
- whether this permanent condition has an impact on a person's ability to function, that is, whether the condition causes an impairment, and
- how long that impairment is likely to last.

The information to enable these considerations can be obtained from corroborating evidence provided by a person (see 3.6.3.03).

Explanation: For DSP purposes, a permanent medical condition does not mean a condition is lifelong or incurable. The condition can only be considered permanent, the Impairment Tables applied and an impairment rating allocated, if, in light of the available corroborating evidence, it is determined that:

- a person's medical condition is permanent for DSP purposes, that is, it is fully diagnosed by an appropriately qualified medical practitioner (this includes an appropriate specialist), fully treated and fully stabilised, and the impact of the impairment is expected to persist for more than 2 years, and
- this condition results in an impact on a person's ability to function (impairment).

The above criteria, in particular the criteria related to treatment and stability of medical conditions, are interrelated and are not to be considered in isolation from one another.

Explanation: In considering whether a condition is fully stabilised, it must be established whether the condition has been fully treated or not. An impairment that results from a specific permanent medical condition can only be assigned an impairment rating under the

Impairment Tables if that impairment is more likely than not, in light of the available evidence, to persist for more than 2 years.

Note: Impairments unlikely to persist for more than 2 years are not to be assessed under the Impairment Tables and an impairment rating cannot be assigned.

Example: A person is diagnosed with a fractured tibia, which impairs their ability to use their leg. This condition has been diagnosed by an appropriately qualified medical practitioner and they have had internal fixation of the fracture. It is assessed at claim as a temporary condition that is likely to improve and is therefore not expected to persist for more than 2 years. Therefore, the condition cannot be considered permanent for DSP and, consequently, a rating under the Impairment Tables cannot be assigned to any impairment caused by this condition.

Note: Impairments that are unlikely to persist for more than 2 years are not to be assessed under the Impairment Tables and an impairment rating cannot be assigned. It should also be kept in mind that it is possible for a medical condition causing impairment to last for more than 2 years but the resulting impairment can improve or even cease within 2 years.

Example: A person's osteoarthritis has been assessed as permanent and is likely to deteriorate with age. It will certainly persist for at least 2 years. However, it would be incorrect to assume that the impairment caused by this condition will always persist for more than the next 2 years. For instance, if it is assessed that the impairment will significantly improve or cease (for example, through medication, lifestyle changes or surgical intervention) within the next 2 years, an impairment rating cannot be applied to this impairment.

Fully diagnosed & fully treated

In determining whether a medical condition has been fully diagnosed, consideration of diagnostic information is required. The relevant diagnostic information is normally available in corroborating evidence.

To be valid for DSP purposes, diagnosis of a medical condition must usually be made by an appropriately qualified medical practitioner, however, for the purpose of Table 9 - Intellectual Function, an assessment of the condition must be made by an appropriately qualified psychologist.

Note: Appropriately qualified medical practitioner means a medical practitioner whose qualifications and practice are relevant to diagnosing a particular condition.

Example: A medical practitioner who solely practices psychiatry would not be regarded as an appropriately qualified medical practitioner to diagnose conditions resulting in impairments assessed under Table 2 - Upper Limb Function.

The introduction to some Tables instructs that the diagnosis made by an appropriately qualified medical practitioner must be supported by evidence from another appropriately qualified health professional.

The reason for this is to ensure a person has received the necessary diagnostic input and associated treatment considerations. The information should be contained within the medical records provided by the claimant or, where necessary, if this is not the case, the assessor may obtain verbal confirmation of the diagnosis from the medical practitioner at follow up. This verbal confirmation must be clearly documented by the assessor.

This is a summary of common types of medical evidence that may be used to confirm that a condition is fully diagnosed, for the purposes of applying Tables 5, 11 or 12. These Tables have particular diagnosis requirements, in addition to the standard requirement for conditions to be diagnosed by an appropriately qualified medical practitioner. Please note that this list is not exhaustive.

Figure 2: Examples of acceptable medical evidence

Table	Table requirement	Examples of acceptable medical evidence
Table 5 – Mental Health Function	The diagnosis of the condition must be made by an appropriately qualified medical practitioner (this includes a psychiatrist) with evidence from a clinical psychologist (if the diagnosis has not been made by a psychiatrist) or in limited circumstances, a paediatrician (see 3.6.3.50).	• Registered psychiatrist confirms diagnosis through written or verbal evidence • GP and clinical psychologist both confirm diagnosis through written or verbal evidence • GP confirms verbally or in writing that their diagnosis is confirmed by a psychiatrist or clinical psychologist, and provides details (including name) • Diagnosis was made by a psychiatric registrar supervised by a consultant psychiatrist

Table	Table requirement	Examples of acceptable medical evidence
		• GP's diagnosis is confirmed by a registered psychologist supervised by a registered clinical psychologist • Applicant is between 16 and 18 years at time of DSP claim and diagnosis of a childhood onset mental health condition was made by a paediatrician, for example attention deficit hyperactivity disorder (ADHD). This does not include conditions such as severe depression, psychotic disorders, or severe eating disorders.
Table 11 – Hearing and other Functions of the Ear	There must also be supporting evidence of the diagnosis from an audiologist or an ear, nose and throat (ENT) specialist, with evidence from an audiologist (if the diagnosis has not been made by an ENT specialist).	• ENT specialist confirms diagnosis through written or verbal evidence • GP confirms verbally or in writing that the diagnosis is confirmed by an audiologist or ENT specialist, and provides details (including name) • GP and audiologist both confirm diagnosis through written or verbal evidence • Diagnosis was made by an ENT registrar supervised by a consultant ENT specialist.
Table 12 – Visual Function	There must also be supporting evidence from an ophthalmologist.	• Ophthalmologist confirms diagnosis through written or verbal evidence • GP confirms verbally or in writing that the diagnosis was confirmed by an ophthalmologist, and provides details (including name) • Diagnosis was made by an ophthalmology registrar supervised by a consultant ophthalmologist.

The introduction to each Table also contains examples of the types of valid corroborating evidence and the types of health professionals who can provide it.

In determining whether a condition has been fully treated, the following factors are to be considered:

- the nature and effectiveness of past treatment
- the expected outcome of current treatment
- any plans for further treatment, and
- whether past, current or future treatment can be considered reasonable, giving consideration to the individual and overall medical status and circumstances of a person.

A condition is considered fully treated if, based on the above considerations, it is determined a person has received reasonable treatment or rehabilitation for the condition. Treatment includes medical treatment and other appropriate therapy (for example, physiotherapy) involving rehabilitation aimed at restoring mental or physical function, but does not extend to rehabilitation involving specific vocational programs. It should also be considered whether treatment is still continuing or is planned in the next 2 years. This is because the stability of a condition may depend on whether reasonable treatment has been undertaken, is being undertaken, or is planned to be undertaken, and the likely effect of such treatment on functional improvement within the next 2 years.

Note: Refer to section below for definition of 'reasonable treatment'.

Example: A person's non-terminal cancer which is still being treated with chemotherapy, and for which the prognosis is uncertain would not generally be considered fully treated.

Example: A person has been diagnosed with degenerative joint disease with symptoms of knee pain but has not yet received any treatment as they are on a waiting list for a knee replacement. The condition causes functional impairment and treatment is anticipated to significantly improve the impairment. The condition normally would not be considered fully treated. However, if the waiting list or the waiting list plus rehabilitation is 2 years or longer their condition may be considered fully treated.

Example: A person with severe osteoarthritis in the knee is scheduled to undergo joint replacement surgery within the next 2 years, which, together with a post-surgery rehabilitation program, is expected to result in a significant improvement of their level of mobility and overall function within the next 2 years. The condition is not considered fully treated.

Note: In some circumstances, however, a condition may be considered as fully treated even if the treatment is ongoing or is planned.

This may apply where it is clear a person's functional capacity is unlikely to significantly improve within the next 2 years even if a person continues to receive appropriate reasonable treatment.

Example: A person with severe burns may need to undertake a series of skin grafts and other treatment spread over more than 2 years but due to the severity of the burns, no significant functional improvement is expected within the next 2 years. This condition can be considered as fully treated.

Note: If a person has a diagnosed condition caused or exacerbated by a fully diagnosed substance use disorder, the former condition cannot be considered to be permanent until such time as the substance use disorder has been fully treated and fully stabilised.

Example: Where a person has a diagnosed but untreated methamphetamine-use disorder and a mental health condition with symptoms of psychosis, their mental health condition cannot be said to be fully treated and stabilised until their methamphetamine-use disorder has been fully diagnosed, treated and stabilised.

Explanation: The AAT (General Division) applied this approach in its decision in *Psomiadis; Secretary, DSS* (2017) AATA 1428.

Fully stabilised

For a condition to be considered fully stabilised, it must be established whether a person has undertaken reasonable treatment for the condition, and what the prospects are for significant functional improvement in the next 2 years.

The condition can be regarded as fully stabilised if:

- a person has undertaken reasonable treatment for the condition and
- it is considered any further reasonable treatment is unlikely to result in significant functional improvement in the next 2 years.

Note: In this context, significant improvement is improvement that will enable a person to undertake work in open, unsupported employment in the next 2 years.

The condition can also be considered fully stabilised even if a person has not undertaken reasonable treatment where either:

- significant functional improvement to a level enabling a person to undertake work in the next 2 years is not expected to result, even if a person undertakes reasonable treatment, or
- there is a medical or other compelling reason for a person not to undertake reasonable treatment.

In assessing stability of medical conditions, prognosis for significant functional improvement within the next 2 years must be considered in light of factors such as the history of the condition, response to treatment and the expected rate of recovery. The information necessary to establish prognosis and stability of conditions can be obtained from corroborating evidence provided by the claimant, or where relevant, directly from the treating health professional/s. Specific corroborating evidence as stipulated in the introduction to each Table must be considered.

Explanation: If corroborating evidence indicates the medical condition is likely to persist for more than 2 years, but significant functional improvement within the next 2 years is likely, the condition is not to be considered fully stabilised.

Where the available medical evidence indicates the condition is likely to fluctuate, deteriorate or remain unchanged, it should be considered whether reasonable treatment has been undertaken before determining whether the condition is fully stabilised.

Explanation: A fluctuating condition with intermittent episodes of exacerbation (for example, bipolar affective disorder) may be considered fully stabilised if a person is receiving reasonable medical treatment and their overall functional impact is unlikely to improve significantly within the next 2 years.

Explanation: An intermittent condition (for example, epilepsy) would not be considered fully stabilised if further reasonable treatment is likely, or expected to significantly improve a person's control of the condition and reduce the frequency of episodes, for instance by improving treatment adherence, adjusting dosage or type of medication to reduce side-effects or improve therapeutic effect.

Where treatment of a diagnosed substance use disorder can lead to improvement of another diagnosed condition, the latter condition cannot be considered fully stabilised or permanent, until the substance use disorder has been fully treated and stabilised.

Example: A person was diagnosed with depression, the onset of which followed a lengthy period of alcohol dependence. The person continues to be treated for depression but their alcohol dependence, while properly diagnosed, is not fully treated or stabilised. Corroborating evidence indicates the depression cannot be effectively treated while they continue drinking, but is expected to improve once the alcohol dependence is fully treated. In the circumstances, the depression cannot be considered to be fully stabilised until their alcohol use disorder has been fully treated and stabilised.

Explanation: The AAT (General Division) applied this approach in its decision in Psomiadis; Secretary, DSS (2017) AATA 1428.

However, where treatment of a substance use disorder is not expected to lead to any significant improvement of another condition, the latter condition can be considered stabilised.

Example: Advanced stage cirrhosis of the liver will not be improved by treating a person's substance use disorder. The term 'stability' as used for DSP purposes has a specific meaning. In this context, 'stabilised' does not mean 'stable' in the ordinary meaning of the word.

A condition may still be considered fully stabilised for DSP purposes when, even with incomplete or ongoing treatment:

- no functional improvement and/or
- no functional improvement is expected within the next two years and/or
- the prognosis is poor and/or
- treatment is no longer effective, is no longer indicated, is aimed at preventing further deterioration, or is palliative, and/or
- the level of impairment resulting from that condition is anticipated to worsen over the next 2 years.

Note: In some situations, functional improvement may appear theoretically possible, for example, where a change of treatment is proposed. However, it may be inappropriate to consider a condition as 'not fully stabilised' based solely on this fact. A thorough examination of the clinical history of the condition, response to previous treatment and prognosis for improvement or otherwise with a new medication must be undertaken.

Example: A person has a major depressive disorder, which remains poorly controlled after long-term treatment with various types of antidepressant or other appropriate medications and other appropriate treatment such as psychiatry review and input and/or engagement

with a psychologist or clinical psychologist. While alternative medications may be available, the clinical history of poor response to previous treatment suggests a poor prognosis with further reasonable treatment. Significant functional improvement within the next 2 years is unlikely. In this situation, it would be reasonable to consider the condition fully stabilised. This approach can also apply to other conditions and their impairments.

In other situations, even though significant improvement in functional ability with treatment is expected to occur over time, a condition may be considered fully stabilised if such improvement is unlikely to occur within the next 2 years. This may apply to conditions where corroborating evidence indicates slow, gradual improvement, or with very severe injuries where recovery is expected to be quite prolonged.

Example: A person with severe burns is being treated with a series of skin grafts. Corroborating evidence indicates that significant functional improvement to a level enabling the person to undertake work in the next 2 years is not expected, because planned treatment and recovery times will span more than 2 years. In this case, the condition may be regarded as fully stabilised for DSP purposes.

Example: When significant functional improvement takes longer than 2 years because a surgical procedure has to be delayed for some time, the condition may be considered as fully stabilised.

Note: Refer to section below for definition of reasonable treatment.

Reasonable treatment & compelling reasons for not undertaking reasonable treatment

To be considered 'reasonable', treatments must be evidence-based preferably adhering to treatment guidelines issued by appropriate authorities, such as the Royal Australian and New Zealand College of Psychiatrists, unless the medical evidence indicates there are pertinent reasons for not doing so. Alternative or complementary treatments without such evidence are not considered reasonable treatment for DSP purposes. A referral to the HPAU should be made if clarification is required. For DSP purposes, reasonable treatment means treatment:

- that is available at a location reasonably accessible to the person at a reasonable cost

    - **Explanation:** It would not be reasonable to expect a person to undergo prohibitively expensive treatment, or travel long distances to seek treatment, in order to satisfy the permanence criteria.
- or procedure that is of a type regularly undertaken or performed
    - **Explanation:** Treatments that are experimental in nature or not yet widely accepted or performed by the general medical community would not be considered reasonable.
- that has a high success rate and where substantial improvement can be reliably expected
    - **Explanation:** It would be inappropriate to consider impairment as being temporary solely because a person has not undertaken a treatment that has a poor success rate or is likely to result in only marginal functional improvement.
- that is of a low risk nature.
    - **Explanation:** A person may decide against having electroconvulsive therapy (ECT) for severe depression, even though ECT is usually very successful in the treatment of depression, as ECT procedures have the risk of subsequent memory loss and entails having frequent general anaesthetics.

If a person has not received or is not able to receive treatment within reasonable timeframes due to issues such as extended waiting lists, evidence is to be obtained, for example, a document from the relevant hospital or other relevant authority, setting out waiting times for the treatment or the date of the treatment. In cases of long waiting lists, it may be appropriate to consider a condition as stabilised.

Example: A person may be advised by their treating orthopaedic specialist they require a hip replacement which will significantly improve their level of mobility. However, they are advised by their hospital the waiting list for the surgery is between 18 to 24 months. Taking into account the recovery and rehabilitation period that may be required after such a surgical procedure, it may be reasonable in this circumstance to consider the condition to be stabilised.

It is assumed a person would generally wish to pursue any reasonable treatment that will improve or alleviate their condition. However, people cannot be expected to undergo treatment that is unreasonable.

There may be medical or other compelling and acceptable reasons for not proceeding with reasonable treatment, including where a person:

- has religious or recognised cultural beliefs prohibiting treatment (for example, blood transfusions)
- lacks insight or the ability to make appropriate judgements due to their medical condition and are unlikely to comply with treatment (for example, a person with a severe psychotic illness or dementia).

In those cases where significant functional improvement is not expected or where there is a medical or other compelling reason for a person not to pursue further treatment, it may be reasonable to consider the condition stabilised. A person's views (the subjective test) and all available information on treatment options, risks etc. (the objective test) must be considered in such situations.

If a person has not had reasonable treatment due to factors not of a compelling nature (for example, lack of personal motivation not due to their medical condition), then their condition would not be considered permanent for DSP purposes, as it is not fully treated and stabilised. Consequently, the Impairment Tables must not be applied and an impairment rating must not be applied to any impairment arising from this condition. In such situations, the following needs to be evaluated and documented:

- what reasonable treatment is feasible and what the probable outcome of treatment is
- what the risks and side effects of the treatment are
- why the treatment is considered reasonable, and
- what the person's reasons for choosing not to undertake this treatment are.

Assessing impairments with no or negligible functional impact

Subsection 6(8) of the Determination states the presence of a diagnosed condition does not necessarily mean there will be an impairment resulting in a functional impact. Where a condition is considered permanent (that is, fully diagnosed, fully treated and fully stabilised, and is more likely than not to persist for more than 2 years) and results in no or negligible functional impairment, a zero rating should be assigned under the relevant Impairment Table for the area of function it most commonly affected.

Example: Medical records provided by a person list hypertension as one of the diagnosed conditions. On assessment, it is determined they have undertaken reasonable treatment over the last 5 years and the condition is fully stabilised. While the condition will persist for more than 2 years, it is expected to remain stable with ongoing treatment. It would be

reasonable to consider this condition is permanent for DSP purposes, therefore the Impairment Tables must be applied. However, as the condition causes no restriction on activities that is, there is no impact on their functioning. An impairment rating of zero is assigned under Table 1 - Functions requiring Physical Exertion and Stamina.

Note: When it is determined a person meets all the required descriptors for a certain impairment rating level that rating will be applied. A person cannot be assigned an impairment rating level if they do not meet all required descriptors. The allocation of zero points does not always mean there is no functional impact at all. It may also mean the person does not meet all required descriptors for 5-points.

Example: A person was diagnosed with hypertension 5 years ago. The condition has been treated with medication and lifestyle changes and response to treatment has been generally good. A long-term consequence of the medication is mild fatigue. Therefore, the condition and its treatment have some impact on physical exertion and stamina. However, this is negligible and does not meet the 5-point descriptor under Table 1 - Functions requiring Physical Exertion and Stamina. In this case, an impairment rating of zero points is assigned under this Impairment Table.

Note: Table 1 does not assess 'general ability to function'.

Assessing functional impact of chronic pain

There is no longer an Impairment Table specifically dealing with chronic pain.

Chronic pain may be a stand-alone diagnosis and/or a symptom of another medical condition. The nature of a person's chronic pain is to be determined from corroborating evidence.

There are chronic pain medical conditions, for example, chronic pain syndrome, where the condition has been fully diagnosed, fully treated and fully stabilised, and is more likely than not to persist for more than 2 years (that is, permanent) any impairment is to be assessed using the Impairment Table most relevant to the function affected.

Chronic pain can also be a symptom of a medical condition, for example, where a person experiences constant pain from rheumatoid arthritis. Where the medical condition causing the chronic pain is fully diagnosed, fully treated and fully stabilised, and likely to persist for more than 2 years (that is, permanent), any resulting impairment from chronic pain

symptoms is to be assessed using the Impairment Table most relevant to the function affected.

It should be noted people may have multiple conditions causing pain, for example, osteoarthritis and fibromyalgia. In such cases, where these conditions are 'permanent', any resulting functional impairment from these conditions should be assessed on the relevant Impairment Tables.

To assign an impairment rating for chronic pain that is a stand-alone diagnosis, or the symptom of a permanent medical condition, the first step is to consider the functional impact as outlined in the medical evidence. For example, does it impact spinal function, upper or lower limb function, concentration and memory or physical exertion and stamina, for example, fatigue?

The next step is to determine which Impairment Table/s apply to the functional impact while avoiding double-counting of the impairment. When selecting Impairment Tables, the following should be taken into account:

- where chronic pain does not impact physical exertion and stamina, it would not be appropriate to select Impairment Table 1 - Functions requiring Physical Exertion and Stamina
- where chronic pain impacts physical exertion and stamina and is adequately assessed by another Impairment Table, there is no need to consider Impairment Table 1 - Functions requiring Physical Exertion and Stamina, and
- where chronic pain impacts physical exertion and stamina (for example, results in fatigue symptoms) and this is not adequately assessed by another Impairment Table, Impairment Table 1- Functions requiring Physical Exertion and Stamina should be considered, while ensuring the level of impairment is not overstated and all criteria are met.

Note: If a person experiences chronic pain as a result of a permanent condition and this pain impacts a particular function, the most relevant Impairment Table is to be used to assess the impact of the condition. For example, Impairment Table 2 - Upper Limb Function is to be used if pain affects the functioning of their upper limbs.

Note: If a person experiences chronic pain as a result of a permanent condition and this pain impacts multiple functions, more than one Impairment Table may be used to assess the resulting impairments. For example, Table 2 - Upper Limb Function, Table 3 - Lower Limb Function and/or Table 4 - Spinal Function can be used if these functions are affected, as long as the overall level of impairment is not overstated/double- counted.

Note: For systemic conditions that result in chronic pain, the impact on activities requiring physical exertion and stamina should be assessed under Table 1 - Functions requiring Physical Exertion and Stamina.

Note: Where a person's concentration and/or memory is also impacted by chronic pain and/or is associated with the side effects of treatment, consideration should be given to whether an additional rating under Table 7 - Brain Function is required.

Note: Where a person's chronic pain results in functional impairments which are adequately assessed by another Table, a rating should only be given on that Table, and no rating given on Table 1. For example, where Table 10 - Digestive and Reproductive Function adequately assesses the impacts from chronic pain, a rating should only be assigned on Table 10, without an additional rating being assigned on Table 1.

The following scenarios show how the Impairment Tables are to be applied when assessing chronic pain to avoid double-counting and includes consideration of the impact of pain and fatigue on a person's ability to undertake activities within the descriptors:

Example: A person with a permanent condition such as osteoarthritis resulting in chronic lower back pain is to be assessed using Table 4 - Spinal Function in accordance with the descriptors in that Table.

Example: A person with Chronic Pain Syndrome which only impairs their ability to use their arms and legs is to be assessed using Table 2 - Upper Limb Function and Table 3 - Lower Limb Function in accordance with the descriptors in these Tables.

Example: A 55 year-old woman has severe deteriorating rheumatoid arthritis. Corroborating evidence confirms that treatment has limited effectiveness and the impacts of the condition are systemic. She experiences marked fatigue, chronic inflammation of her joints with swelling, heat and pain, as well as muscle weakness and difficulty sleeping. The evidence also states that due to fatigue and pain the woman is unable to perform any light day-to-day household activities and would not be able to perform clerical or sedentary work tasks for a shift of 3 hours. She has difficulties with manual dexterity, especially with handling very small objects and doing up buttons. She sometimes uses a walking stick, particularly when she is fatigued. She has some difficulty managing stairs and has to hold onto the rail.

Rheumatoid arthritis is a systemic (that is, affecting the whole body) inflammatory illness with multiple associated functional impacts, including fatigue, weakness, and pain, swelling and stiffness in multiple joints. Some medications for this condition may also have side-effects such as fatigue. In this case the medical evidence clearly states that she has

widespread symptoms with the most significant being marked fatigue and weakness, rather than pain in specific joints, so it is considered that Table 1 is the most appropriate Table to use in rating her functional impairment.

The condition is considered permanent for DSP purposes and under Table 1 - Functions requiring Physical Exertion and Stamina, the woman would receive an impairment rating of 20 points as the impact on her ability to function meets criteria (1) (a) (iv) and (1) (b) for severe impact. To avoid double counting, no ratings are made under Table 2 - Upper Limb Function and Table 3 - Lower Limb Function, as the descriptors applied from Table 1 include assessment of mobility and capacity to undertake daily activities.

Example: A 45 year-old man has permanent inflammatory bowel disease. Medical evidence indicates that as a result of this condition he experiences chronic digestive pain resulting in persistent and debilitating fatigue. He has difficulty concentrating on tasks due to the pain and fatigue and his concentration is interrupted each hour as a result. He has to take three or four days leave from work each month as a result of the condition.

Under Table 10 - Digestive and Reproductive Function, the man would receive an impairment rating of 20 points as the impact on his ability to undertake work related activities is severely impacted by the symptoms of the digestive condition. Under the 20-point descriptor he would meet (1) (a) and (d). As the descriptors under Table 10 capture the impact of pain on fatigue and on the person's ability to concentrate, additional ratings greater than zero under Table 1 and/or Table 7 would usually not be applied as this may constitute double-counting in this case.

These examples are not exhaustive - it should be remembered chronic pain may affect a number of different body functions. If a person experiences chronic pain that falls outside these scenarios and it is unclear how this is to be rated to avoid double-counting, the case is to be referred to the HPAU.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Part 2 - Rules for applying the Impairment Tables, section 6 Applying the Tables, Table 1 – Functions requiring Physical Exertion and Stamina, Table 2 - Upper Limb Function, Table 3 - Lower Limb Function, Table 4 - Spinal Function, Table 5 - Mental Health Function, Table 7 – Brain Function, Table 9 - Intellectual Function, Table 11 - Hearing and other Functions of the Ear, Table 12 - Visual Function, Table 14 – Functions of the Skin.

3.6.3.03 Information that must be taken into account in applying the Tables

Summary

This topic provides guidance on Part 2 of the Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 (the Determination), which sets out rules that are to be complied with in applying the Impairment Tables. This topic has headings emphasising significant principles, concepts and information that MUST be taken into account when applying the Impairment Tables to assess a person's functional capacity, which underpin provisions contained in that part of the Determination. It also provides guidance on the concepts and practical application of the DSP eligibility criteria contained in the SSAct.

This topic does not restate the definitions contained in Part 1 of the Determination. These definitions are to be accessed directly from the Determination.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Part 1 - Preliminary, Part 2 - Rules for applying the Impairment Tables

Corroborating evidence

Medical evidence is the primary source of corroborating evidence used in determining whether a person's medical condition is permanent for DSP purposes and, if so, what impairment rating any impairment is assigned under the Impairment Tables.

Corroborating evidence may include, but is not limited to:

- information such as reports or letters provided by medical or other health/allied health professionals (for example, psychologists, registered nurses, physiotherapists, exercise physiologists or optometrists)
- reports from other sources such as, social workers, mental health workers or counsellors
- results of diagnostic tests (for example, medical imaging reports)
- any additional work capacity information that may be available, reports from previous examinations or assessments (for example, JCA), or

- any information that is required to be taken into account under individual Tables, including as specified in the introduction to each Table.

A person claiming DSP is responsible for obtaining corroborating evidence in support of their claim or payment continuation, usually medical documentation from their treating doctor and other health professionals. (Refer to 3.6.2.10 Medical evidence & diagnosis for vulnerable people). Where a person indicates they have a medical condition not included in their medical evidence, they should be requested to provide medical evidence detailing the diagnosis, treatment, prognosis and functional impact of the condition. This may involve requesting the person to obtain further information from their treating doctor or other relevant appropriately qualified medical and/or allied health practitioners.

If medical evidence has insufficient detail, consideration should be given to contacting the treating health professionals and/or referring to the HPAU. Medical evidence should include sufficient information including:

- the diagnosis of a person's medical condition, including date of onset and whether the diagnosis is confirmed
- clinical features including history and symptoms
- past, present and future/planned treatment, including periods of hospitalisation
- adherence with recommended treatment
- impact of the condition on a person's ability to function, including whether this impact is long term or temporary and the expected effect of the condition on a person's ability to function in the next 2 years
- any impact on life expectancy as a result of the medical condition, and
- supporting information such as medical imaging reports specialist reports, allied health reports, hospital records, or pathology test results.

All relevant medical evidence should be taken into consideration. Generally this should be recent medical evidence (for example, from the previous 2 years), however, if the medical evidence is not recent, it may still be useful depending on the nature of a person's condition, and whether the information is representative of their current level of impairment.

More detailed information on corroborating evidence, including examples of medical evidence that could be taken into account in assessing impairment is contained in 3.6.2.10.

Explanation: Medical evidence that is older than 2 years may still be of value if the condition remains unchanged since the time the evidence was issued - for instance, a condition present from birth or early childhood, or which is never likely to change (for example, amputation of a limb).

While such older evidence may be useful for the purposes of confirming diagnoses of medical conditions, it may not fully reflect the current level of impact of such conditions on a person's ability to function or more recently available treatments likely to significantly improve function.

Example: Since the time the evidence was issued, an amputee may have acquired a prosthesis and learned how to use it, which results in improved functional abilities.

Example: A person with an above knee amputation may have had difficulty tolerating their old prosthesis and more recently had their prosthesis replaced, (for example, an osseointegration prosthesis, with significant functional improvement).

Where the nature or severity of a condition is unclear, further information should be sought to clarify the condition and its impact on a person’s functioning. This could include a person providing further information, or their treating health/allied health professional being contacted for clarification.

At an assessment, a person may be asked to demonstrate abilities specified in the relevant Tables. This can only be done where:

- the assessor is qualified and competent to assess abilities of this nature (for example, a physiotherapist assessing movement)
- the requested task/function/ability is unlikely to cause a person pain, discomfort or undue emotional distress
- there are no medical or psychological contraindications (for example, acute pain), and
- the ability can be demonstrated in the assessment setting.

People living in remote areas

Assessments for DSP purposes must be based on the best available medical evidence. In the case of people from remote areas who may have limited access to medical services and doctors, and may find it difficult to obtain medical evidence in relation to their condition/s. In these cases, a community nurse can assist in collating their medical evidence, which is generally based on clinical notes from an appropriately qualified medical, health or allied health practitioner and must meet the diagnostic requirements of the relevant Table.

In these cases, it may be possible for the JCA or GCD to form an opinion regarding a person's medical qualification on the basis of the best available medical evidence. This will

only apply if the medical condition has been diagnosed, treated and stabilised to the extent that an impairment rating can be assigned. In all cases, any diagnosis must have been made by an appropriately qualified medical practitioner with evidence from a clinical psychologist, as appropriate.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 section 7 Information that must be taken into account in applying the Tables

Policy reference: SS Guide 3.6.2.10 Medical & other evidence for DSP

3.6.3.04 Information that must not be taken into account in applying the Impairment Tables

Summary

This topic provides guidance on Part 2 of the Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 (the Determination), which sets out rules that are to be complied with in applying the Impairment Tables. This topic has headings emphasising significant principles, concepts and information which MUST NOT be taken into consideration when applying the Impairment Tables to assess a person's functional capacity, which underpin provisions contained in that part of the Determination. It also provides guidance on the concepts and practical application of the DSP eligibility criteria contained in the SSAct.

This topic does not restate the definitions contained in Part 1 of the Determination. These definitions are to be accessed directly from the Determination.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Part 1 - Preliminary, Part 2 - Rules for applying the Impairment Tables

Self-reported symptoms

The introduction to each Table states that in assessing impairments, self-report of symptoms is insufficient and there must be corroborating evidence of a person's impairment before symptoms reported by a person can be taken into account. As the Impairment Tables are contained in a legal instrument (Determination), the requirement for corroborating evidence is a legal requirement. Examples of the corroborating evidence that may be taken into account and who can provide it, are set out in the introduction to each Table.

There are some self-reported symptoms for which objective medical measurement is difficult or impossible, such as pain, tinnitus, or hallucinations. In such cases, an appropriately qualified treating health practitioner will consider the self-reported symptoms in the context of objective findings from examination and investigations where necessary,

and review this against accepted diagnostic criteria and the scientifically documented course of the underling disease, to determine the veracity of the self-reported symptoms.

For example, an appropriately qualified medical practitioner diagnoses fibromyalgia in someone with a history of chronic widespread pain, when they meet the appropriate diagnostic criteria and other conditions have been excluded.

Non-medical factors

Impairment ratings are intended to reflect the level of work-related impairment due to permanent medical conditions.

For this reason, unless specifically required under the Impairment Tables, the impact of non-medical factors are not to be taken into account when assigning an impairment rating.

If a specific Table does not include considerations of non-medical factors, then such factors must be disregarded, that is, an impairment rating must not be influenced or adjusted because of these factors. Unless specified by a Table, the following must NOT be taken into account in assessing impairment:

- the availability of suitable work in the person's local community
- English language proficiency
- age
- gender
- level of education
- literacy and numeracy skills
- work skills and experience
- social or domestic situation
- level of motivation not associated with a medical condition
- religious or cultural factors.

Note: There may be medical or other compelling and acceptable reasons for not proceeding with reasonable treatment, including where a person has religious or recognised cultural beliefs prohibiting treatment. See 3.6.3.02.

Example: A non-English speaking person who is fluent in another language and does not have a medical condition affecting their communication function should not receive a rating under Table 8 - Communication Function just because they have difficulties communicating

in English. Table 8 measures impacts on communication in the language a person most commonly uses.

Example: Medical factors are not to be disregarded where they impact on function. For example, a person who is poorly motivated for work may have a medical basis to their lack of motivation, where it is an effect of an underlying medical condition such as depression. However, if the lack of motivation was not due to a medical condition, it should be disregarded.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 section 8 Information that must not be taken into account in applying the Tables, Table 1 - Functions requiring Physical Exertion and Stamina, Table 8 - Communication Function

3.6.3.05 Use of aids, equipment & assistive technology

Summary

This topic provides guidance on Part 2 of the Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 (the Determination), which sets out rules that are to be complied with in applying the Impairment Tables. This topic has headings emphasising significant principles and concepts relating to the use of aids, equipment and assistive technology when applying the Impairment Tables to assess a person's functional capacity, which underpin provisions contained in that part of the Determination. It also provides guidance on the concepts and practical application of the DSP eligibility criteria contained in the SSAct.

This topic does not restate the definitions contained in Part 1 of the Determination. These definitions are to be accessed directly from the Determination.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Part 1 - Preliminary, Part 2 - Rules for applying the Impairment Tables

Use of aids, equipment & assistive technology

The Impairment Tables consistently require a person's impairment to be assessed when they are using or wearing any aids, equipment or assistive technology they have (in their possession) and would normally use.

In cases where a person may need a certain aid, equipment or assistive technology but states they are unable to access it, do not have it or do not usually use it, this should be considered in line with reasonable treatment as defined in Part 2 of the Determination.

Some of the Impairment Tables specify a particular impairment rating when such items are used.

Example: A person's impairment attracts 20 points under Table 8 - Communication Function, where the person:

- uses an electronic communication device to produce electronic speech
- needs to use this technology to communicate with others in places such as shops, workplace, education or training facilities and
- is unable to be understood without this device.

Where the descriptors in some Tables (for example, Tables 1, 3 and 4) refer to moving around in or using a wheelchair, and transferring to and from a wheelchair, this includes both manually-propelled wheelchairs and powered mobility aids (such as power assist wheelchair, power wheelchair or mobility scooter).

Note: When assessing a person under Table 1, of relevance is the description of the activity involved. The objective is to measure a person's level of ability having regard to the severity of a person's symptoms (for example, shortness of breath, fatigue or cardiac pain) when performing certain tasks requiring physical exertion or stamina and consideration should be given to the type of mobility aid used.

Where descriptors in some Tables (for example, Table 1 and Table 3) refer to 'public transport', this means any mode of transport that runs to a timetable such as buses, trains, trams and ferries (it excludes taxis or hire cars). A person who is able to use any one of these modes of transport, having regard only to the level of impairment to their lower limbs, is considered able to use public transport, even if they are precluded from using the other modes of public transport. When assessing a person's ability to use public transport, it is irrelevant whether the person actually uses public transport, whether public transport is available and whether a person actually receives assistance from another person.

Similarly, where a specific Table refers to activities such as walking around a shopping mall, shopping centre or supermarket, it is irrelevant whether these types of businesses, buildings or structures actually exist in a person's locality. The objective is to measure a person's ability or inability to mobilise in these circumstances or settings.

Explanation: The AAT (General Division) applied this approach in its decision in *Wilson and Secretary, DSS* (2015) AATA 497.

Use of the term 'assistance' within the Impairment Tables

The term assistance is used in numerous descriptors within various Impairment Tables. In all cases assistance means assistance from another person, not assistance from any aids, equipment or assistive technology.

Explanation: This interpretation of the term assistance has been consistently adopted in a number of decisions by the AAT (General Division), including in *Summers and Secretary, DSS* (2014) AATA 165.

Example: Table 1 - Functions requiring Physical Exertion and Stamina uses the term assistance in the 20-point and 30-point descriptors. To meet these descriptors a person would require assistance from another person to undertake the activities listed in the descriptors, even while using a wheelchair or other mobility device they have and usually use.

Example: Table 2 - Upper Limb Function uses the term assistance in the 20-point descriptor at (1) (e) 'the person has severe difficulty turning the pages of a book without assistance'. To meet this point, a person would have severe difficulty turning the pages of a book without assistance from another person, even with any assistive technology they have and usually use.

Note: The person may not read or have access to books, in which case, an alternative example may be an inability to use the touchscreen of an electronic device such as a mobile phone without assistance.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 section 9 Use of aids, equipment and assistive technology, Table 1 - Functions requiring Physical Exertion and Stamina, Table 2 - Upper Limb Function, Table 8 - Communication Function

3.6.3.06 Selecting the applicable Impairment Table and assessing impairments

Summary

This topic provides guidance on Part 2 of the Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 (the Determination), which sets out rules that are to be complied with in applying the Impairment Tables. This topic has headings emphasising significant principles and concepts when selecting the applicable Impairment Table to assess a person's impairments, which underpin provisions contained in that part of the Determination. It also provides guidance on the concepts and practical application of the DSP eligibility criteria contained in the SSAct.

This topic does not restate the definitions contained in Part 1 of the Determination. These definitions are to be accessed directly from the Determination.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Part 1 - Preliminary, Part 2 - Rules for applying the Impairment Tables

Selection steps

Once it has been determined a person has a permanent physical, intellectual or psychiatric impairment, the appropriate Table/s can be selected.

Table selection is made as follows:

- identify the function affected or loss of function, and
- refer to the appropriate Table related to that area of function.

When identifying the loss of function, consideration is to be given to the ongoing side effects from treatment where treatment is required to be used for more than 2 years, (for example, there is no alternative reasonable treatment) and the impact from side effects will more than likely not persist for more than 2 years and not significantly improve within 2 years.

Example: Epilepsy that is largely, but not fully, controlled on medication may result in episodes of loss of consciousness once or twice a year. Additionally, persisting side effects

of long-term epilepsy medication may moderately impact memory causing a person to often forget to complete regular daily tasks or misplacing items necessitating assistance less than once a day from another person with daily activities. In this case, Table 15 - Functions of Consciousness and Table 7 - Brain Function are both considered.

The Table specific to the loss of function must always be used unless the instructions in that Table specify otherwise.

Example: The introduction to Table 8 - Communication Function specifically instructs that if a person uses recognised sign language or other non-verbal communication method as a result of hearing loss only, the person's communication function is to be assessed using Table 11 - Hearing and other Functions of the Ear.

Rating multiple impairments resulting from a single condition

The number of conditions does not always correspond to the number of impairments.

A single medical condition may result in multiple functional impairments, for which ratings can be assigned from more than one Table.

Note: Where a single medical condition causes multiple impairments, these impairments are to be assessed on all relevant Tables.

Example: A person who has had a stroke (cerebrovascular accident or CVA) may be assessed on a number of different Tables depending on the permanent effects of the stroke. For example, if they have permanent impacts on their upper and lower limbs, ratings from Tables 2 and 3 will be appropriate.

Example: End-stage renal failure can be assessed under a number of Tables depending on the functional impairment. Table 10 is to be used if there are gastrointestinal symptoms, Table 1 is to be used if there are problems with performing activities requiring physical exertion or stamina and Table 14 is to be used if there are skin symptoms like pruritus.

When using more than one Table to assess multiple functional impairments resulting from a single medical condition, to avoid the risk of double-counting, care must be taken to ensure different Tables are used to assess distinct functional impairments, and are not used to rate the same functional impairment more than once.

Below are examples of multiple Table use. Please refer to 3.6.3.07 for more details under these examples.

Example: Multiple Sclerosis - A person who has multiple sclerosis may have functional impairments in a number of areas depending on which part/s of the nervous system are affected, for example, cognitive difficulty, blind spots, constipation and muscle spasms.

Example: Diabetes - A person with treatment-resistant diabetes mellitus may experience a range of functional impairments, for example, fatigue, urinary frequency, numbness of hands and fingers, and episodes of confusion.

Example: Cirrhosis of the liver - A person with cirrhosis of the liver may experience a range of functional impairments including fatigue, nausea, fluid retention in the abdomen and legs, and cognitive difficulty.

Rating multiple conditions with common impairments, and double-counting

Only ONE impairment rating can be assigned from the same Table, even if multiple permanent medical conditions are assessed on that Table. To assign more than one rating would amount to double counting.

Where 2 or more medical conditions have common functional impact/s, the overall impact/s of the conditions must be combined under a single Table relevant to that function. A single impairment rating reflecting the overall impact on the affected function must be assigned on that Impairment Table.

Example: A person has heart disease and chronic lung disease, with symptoms of heart palpitations, low blood pressure and shortness of breath. All these symptoms impact on the person’s physical endurance and ability to undertake routine activities of daily living and to move around their home and community. The overall impact of these 2 conditions (their common and combined effect) is therefore on function requiring physical exertion and stamina, which is rated on Table 1 - Functions requiring Physical Exertion and Stamina. To avoid double counting, a combined impairment rating for both conditions must be assigned on Table 1.

Example: A person has spondylosis affecting the cervical spine, and also suffers chronic lower back pain. Both conditions are permanent with an overall impact on spinal function; therefore a single, combined impairment rating must be assigned from Table 4.

Example: A person has 3 medical conditions, all considered permanent for DSP purposes. They experience pain in the right calf when walking (intermittent claudication), due to permanent peripheral vascular disease, significant right knee symptoms due to permanent osteoarthritis, and an impairment due to chronic ligamentous instability affecting the left ankle. While the person suffers from 3 distinct medical conditions affecting both legs, the overall functional impact is on function of lower limbs. Therefore, only a single, combined rating must be assigned under Table 3 - Lower Limb Function.

Other situations where double-counting may occur

Double counting can also occur when more than one Table is applied to assess a single functional impairment resulting from a single medical condition, or a common functional impairment resulting from more than one condition.

This situation tends to occur when a single medical condition is inappropriately assessed as causing an additional functional impairment.

Example: A permanent mental health condition, which has been rated 10 points on Table 5 – Mental Health Function due to a moderate functional impact on mental health function, including moderate difficulties with concentration, task completion and decision-making, would not additionally be rated on Table 7 – Brain Function for those same impairments.

Note: Double-counting can also occur when there is an 'either-or' choice between Tables under which a particular impairment could potentially be assessed but a rating is inappropriately applied instead from both Tables.

Example: A person with inflammatory bowel disease has well-controlled abdominal symptoms, but continues to experience severe fatigue. They have difficulty sustaining sedentary work activities, are absent from work several times a month, and may struggle with heavier activities of daily living. Ratings could be made on either Table 1 – Functions requiring Physical Exertion and Stamina, or Table 10 – Digestive and Reproductive Function. In this case, a rating may be applied from either Table, but must not be applied from both Tables.

To minimise the risk of double counting in such situations, certain Tables contain instructions on how to avoid it.

Example: Table 4 - Spinal Function instructs that this Table's descriptors are to be met only from spinal conditions, and that restrictions on overhead activities resulting from shoulder conditions are to be rated under Table 2 - Upper Limb Function.

Example: Table 7 - Brain Function instructs that:

- a person with autism spectrum disorder who does not have a low IQ is to be assessed under this Table, and
- Table 7 is not to be used when a person has an impairment of intellectual function already assessed under Table 9 - Intellectual Function, unless they have an additional medical condition affecting neurological or cognitive function.

Table 9 instructs that a person with either autism spectrum disorder, fragile X syndrome or foetal alcohol spectrum disorder who also has a low IQ should be assessed under this Table.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 section 10 Selecting the applicable Table and assessing impairments, Table 1 - Functions requiring Physical Exertion and Stamina, Table 2 – Upper Limb Function, Table 3 – Lower Limb Function, Table 4 - Spinal Function, Table 7 - Brain Function, Table 8 - Communication Function, Table 9 - Intellectual Function

3.6.3.07 Case examples for assessing impairment from permanent conditions

Figure 3: Examples of Impairment Table use by condition/diagnosis

Condition/diagnosis	Example of Impairment Table use
Autism Spectrum Disorder	Autism Spectrum Disorder is a developmental disorder often characterised by problems with social interaction and communication, as well as restricted, repetitive patterns of behaviour, interests or activities. The magnitude and severity of the symptoms can vary widely for individuals. A person with a functional impairment caused by this condition would be assessed under the table/s relevant to the impacted function. For example: • Table 5 - Mental Health Function can be used to assess the functional impact of cognitive, social interaction and behavioural difficulties in circumstances where the level and nature of functional impairment as a result of Autism Spectrum Disorder (without an interpretable intelligence quotient between 70 and 85) is not adequately covered by Table 7, as the descriptors for each level of impairment rating on Table 5 are much broader and are sensitive to novel and social situations. • Table 7 - Brain Function can be used to assess the functional impact of cognitive, social interaction and behavioural difficulties if a person has Autism Spectrum Disorder impacting on day-to-day activities but does not have an interpretable intelligence quotient between 70 and 85. • Table 9 - Intellectual Function can be used to assess the functional impact of cognitive, social interaction and behavioural difficulties if a person has Autism Spectrum Disorder and an interpretable intelligence quotient between 70 and 85. To avoid double counting, it is important not to rate the same functional impairment more than once. This means a person

Condition/diagnosis	Example of Impairment Table use
	therefore should not be assessed under Table 5, Table 7 and Table 9, but under one of either Table 5 or Table 7 or Table 9.
Chronic fatigue	A person with chronic fatigue syndrome (also known as myalgic encephalomyelitis) may experience a range of symptoms including persistent fatigue, impaired short-term memory or concentration, muscle or joint pain, and unrefreshing sleep. A person with this condition may have functional impairments in a number of areas, depending on their presenting symptoms. In such cases all relevant tables should be used. For example: • Table 1 - Functions Requiring Physical Exertion and Stamina can be used if a person experiences limitation in exertion. • Table 7 - Brain Function can be used if a person presents with issues with concentration, memory difficulties or other neurological symptoms. • Table 10 - Digestive and Reproductive Function can be used if a person experiences gastrointestinal symptoms such as nausea, bloating, constipation or diarrhoea. The need to avoid double-counting must be considered, for example, if lower limb muscle weakness and limited mobility is due to fatigue, then a separate rating under Table 3 for lower limb conditions is not appropriate. Refer to the Irritable Bowel Syndrome (IBS) case study below for more detail on assessing conditions that have been stabilised as episodic or fluctuating. If assistance is required to determine the functional impairments caused by this condition, clarification and advice can be sought from a person's treating doctor and/or the HPAU.
Chronic pain	Acute pain is a symptom which may result in short term loss of functional capacity in one or more areas of the body but should resolve within a few months. Chronic pain can be a primary chronic pain syndrome, e.g. fibromyalgia or chronic regional pain syndrome and where it has been fully diagnosed, treated and stabilised, the assessor should assess any loss of functional

Condition/diagnosis	Example of Impairment Table use
	capacity using the table relevant to the area of function affected. Chronic pain can also be a symptom and when it stems from a permanent condition the functional impact of the pain should be rated using the relevant table/s to capture the appropriate level of impairment while ensuring the level of impairment is not overstated or double counted. For example: • Table 1 - Functions Requiring Physical Exertion and Stamina can be used if chronic pain impacts a person's physical exertion and stamina (e.g. fatigue symptoms) and is not adequately assessed by another table. Systemic conditions that are causing widespread pain with associated fatigue may be more appropriately assessed on Table 1. • Either Table 2 - Upper Limb Function, Table 3 - Lower Limb Function or Table 4 - Spinal Function can be used if the pain impacts a person in one of these areas of functioning. These tables can also be used in combination if the pain impacts the person in multiple areas. • Table 7 - Brain Function can be used if a person has chronic pain which impacts their memory, attention or concentration. Table 7 can be used in conjunction with other tables, as required. • Table 10 - Digestive and Reproductive Function can be used if a person has chronic pelvic pain that impairs their ability to concentrate on or sustain tasks or work activities. • Table 14 - Functions of the Skin can be used if a person has chronic pain related to a disorder of, or injury to, the skin. If it is unclear how chronic pain should be rated to avoid double counting, the claim should be referred to the HPAU.
Diabetes mellitus	A person with diabetes mellitus that is fully treated and fully stabilised may experience a range of functional impairments. In such cases, all relevant tables should be used. For example:

Condition/diagnosis	Example of Impairment Table use
	• Table 1 - Functions Requiring Physical Exertion and Stamina can be used if diabetes impairs a person's ability to perform and sustain physical activities • Table 3 - Lower Limb Function can be used if a person has peripheral neuropathy or vascular disease that affects their lower limb function. • Table 12 - Visual Function can be used if a person's vision is affected. • Table 15 - Functions of Consciousness can be used if a person has frequent hypoglycaemic episodes. However, if the person is experiencing frequent hypoglycaemic episodes, it must first be established whether the diabetes is fully treated and fully stabilised.
End-stage renal failure	A person with end-stage renal failure may experience a range of impairments and a number of tables can be used to assess this. For example: • Table 1 - Functions requiring physical exertion and stamina can be used where there is functional impairment when performing activities requiring physical exertion and stamina. • Table 10 - Digestive and reproductive function can be used where there is a functional impairment of the digestive system. • Table 14 - Functions of the skin can be used where there is functional impairment relating to the skin e.g. pruritus.
Epilepsy	A person with epilepsy may experience seizures where they have involuntary loss or altered state of consciousness. This condition is primarily rated on Table 15 Functions of Consciousness if it is fully diagnosed, fully treated and fully stabilised. The tables have severity and frequency built into the rating descriptors. For example, the descriptor for 20 points on Table 15 includes: • a person has episodes of involuntary loss of consciousness due to a diagnosed medical condition at least once each month which require first aid measures

Condition/diagnosis	Example of Impairment Table use
	and may require emergency medication and/or hospitalisation, OR • a person has episodes of altered state of consciousness that occur at least once per week during which the person's functional abilities are affected (e.g. the person remains standing or sitting but is unaware of their surroundings or actions during the episode). Impairment points could also be applied on Table 7 - Brain Function for cognitive issues relating to epilepsy and antiepileptic medication.
Fluctuating mental health conditions	If a person's mental health condition has been stabilised as episodic or fluctuating (as may be the case with conditions such as bipolar affective disorder), the rating that reflects the overall functional impact of the condition, taking into account the severity, duration and frequency of the episodes should be applied. Refer to the irritable bowel syndrome case study below for more detail on assessing conditions that have been stabilised as episodic or fluctuating. People with mental health conditions may not have good self-awareness of their impairment and may not be able to accurately describe its effects. In determining the functional impact of mental health conditions, Table 5 - Mental Health Function instructs assessors to consider information from a wide range of sources and a person's presentation on the day of the assessment should not be solely relied upon.
HIV/AIDS	A person living with HIV (PLHIV) may present with a range of co-morbidities and functional impairments, even where their condition is fully diagnosed, treated and stabilised. The magnitude and severity of symptoms and side effects from treatment can vary widely for individuals. In the assessment of a person living with HIV, all relevant tables should be applied. For example: • Table 1 - Functions Requiring Physical Exertion and Stamina can be used if there is functional impairment

Condition/diagnosis	Example of Impairment Table use
	when performing activities requiring physical exertion and stamina. • Table 2 - Upper Limb Function and/or Table 3 - Lower Limb Function can be used if a person has peripheral neuropathy such as numbness or tingling of fingertips and/or toes. • Table 5 - Mental Health Function can be used if a person has a functional impairment due to a psychological disorder, such as clinical depression or bipolar disorder. • Table 7 - Brain Function can be used if a person has a functional impairment of cognitive function, for example, from neurological conditions such as HIV dementia or HIV encephalopathy. • Table 10 - Digestive and Reproductive Function can be used if, for example, a person experiences diarrhoea. • Table 12 - Visual Function can be used if a person has functional impairment when performing activities involving visual function, such as from mycobacterium avium complex (MAC) which causes visual impairment or blindness. • Table 14 - Functions of the Skin can be used if there is functional impairment related to the skin. • Various tables may be used if the person has diabetes mellitus (refer to the diabetes mellitus case study above).
Hypertension	Fully treated hypertension usually does not result in functional impairment. Where hypertension results in no or minimal functional impact, a rating of zero under Table 1 should be assigned. If severe and treatment resistant hypertension has resulted in other fully diagnosed, treated and stabilised secondary conditions, such as damage to the eyes, kidneys or heart, the functional impacts of these conditions should be rated under the relevant tables. For example: • Table 1 - Functions requiring Physical Exertion and Stamina, and

Condition/diagnosis	Example of Impairment Table use
	• Table 12 - Visual Function.
Irritable Bowel Syndrome (IBS)	IBS is a chronic functional gastrointestinal disorder (i.e. no biochemical or structural abnormalities on investigation) which is rated under Table 10 (Digestive and Reproductive Function). It can be managed with diet, increasing soluble fibre intake, antidepressant medications and psychological therapies. However, whether or not there is impact on day-to-day functioning, the condition can be deemed fully diagnosed, treated and stabilised. IBS is characterised by recurrent abdominal pain or bloating related to defaecation and is associated with a change in stool frequency or appearance. IBS can be associated with considerable distress and patients may even be reluctant to leave the house and attend work, due to concerns that they may not be able to access a toilet in a timely fashion if they have an episode of diarrhoea. Symptoms often fluctuate in intensity, varying from week to week or even day to day. The person may also alternate between having constipation and diarrhoea. If a person's condition is episodic or fluctuating, a rating should be applied that reflects the overall functional impact of the condition, taking into account the severity, duration and frequency of the episodes. In determining the functional impact of fluctuating conditions, their impact on a person's ability to reliably perform work over the next 2 years without excessive leave or work absences should be considered. For example: • Approximately 2 weeks sick leave in a 26-week period due to episodic or fluctuating IBS is within what is considered reasonable leave. • Sick leave of a month or more in a 26-week period due to episodic or fluctuating IBS is considered excessive leave.
Malignancy (cancer)	The functional impact of permanent malignancy is variable depending on the body parts or systems involved the nature and effectiveness of treatment, and the extent or stage of the disease.

Condition/diagnosis	Example of Impairment Table use
	In the assessment of a person with malignancy, all relevant tables should be applied, while avoiding double-counting. People who have terminal malignancy, where the average life expectancy of a patient is more likely than not to be 24 months or less and there is a significant reduction in work capacity within this period, are manifestly qualified for DSP.
Migraine	If a person experiences impairment to neurological or cognitive function, then Table 7 - Brain Function can be used. For example, severe pain may impair the person's abilities with regard to attention and concentration or comprehension. Table 1 - Functions Requiring Physical Exertion and Stamina may also be suitable in some circumstances. The usual approach to episodic or fluctuating conditions would also apply.
Miscellaneous ear/nose/throat conditions	Functional impairments resulting from ear, nose and throat conditions would be commonly assessed using Table 8 - Communication Function and Table 11 - Hearing and Other Functions of the Ear. For example: • Table 8 - Communication Function can be used if a person's speech production is impaired due to a laryngectomy (removal of larynx or voice box). • Table 11 - Hearing and Other Functions of the Ear can be used if a person's hearing is impaired due to otosclerosis (bone overgrowth in the middle ear) or if their balance is affected due to an inner ear (vestibular) disorder such as Meniere's disease.
Morbid obesity	Morbid obesity (class III obesity) in adults is defined as a body mass index (BMI) of equal to or greater than 40 kg/m2. A BMI of greater than or equal to 40 is generally considered to be incompatible with long term good health, however, does not necessarily correlate with significant functional impact. The functional impact of morbid obesity may range from minimal to very significant. In the assessment of a person with morbid

Condition/diagnosis	Example of Impairment Table use
	obesity, the tables relevant to the area of function affected should be applied. For example: • Table 1 - Functions Requiring Physical Exertion and Stamina can be used if the person experiences symptoms (shortness of breath, fatigue, cardiac pain) when performing physical activities. • Table 3 - Lower Limb Function can be used if the person has difficulty walking, using stairs, kneeling or squatting. Where morbid obesity results in no functional impact, a rating of zero under Table 1 should be assigned. If morbid obesity has resulted in other fully diagnosed, treated and stabilised secondary conditions, for example, osteoarthritis of the knee joints, the functional impacts of these conditions should be rated under the relevant tables. However, where 2 or more conditions cause a common or combined impairment, a single rating should be assigned in relation to that impairment under a single table. It is inappropriate to assign a separate impairment rating for each condition as this would result in the same impairment being assessed more than once.
Multiple Sclerosis (MS)	A person with MS may experience a range of symptoms and symptoms from MS can vary between people. In the assessment of a person with MS, all relevant tables should be applied. For example: • Table 1 - Functions Requiring Physical Exertion and Stamina can be used if a person has a functional impairment when performing activities requiring physical exertion and stamina. • Table 2 - Upper Limb Function and/or Table 3 - Lower Limb Function can be used if a person has muscle weakness or loss of coordination that results in impaired upper and/or lower limb function (e.g. lifting and manipulating objects or walking).

Condition/diagnosis	Example of Impairment Table use
	• Table 7 - Brain Function can be used if the person experiences functional impairment related to cognitive function, such as memory difficulties. • Table 13 - Continence Function can be used if a person has a functional impairment related to incontinence of the bladder or bowel.
Stroke (cerebro-vascular accident)	A person who has suffered a stroke (cerebro-vascular accident) may have functional impairments in a number of areas depending on the part/s of the brain that have been damaged. In such cases, assessors should use all of the relevant tables. For example: • Table 1 - Functions Requiring Physical Exertion and Stamina can be considered if fatigue is a feature (it often is with a stroke). • Table 2 - Upper Limb Function and Table 3 - Lower Limb Function can be used if a person has impaired upper and/or lower limb function. • Table 7 - Brain Function can be used if a person has impaired cognitive functions, such as difficulty with visuo-spatial functioning, attention or concentration. • Table 8 - Communication Function can be used if a person has difficulties understanding or producing speech.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Part 2 Rule for applying the Impairment Tables, Table 1 - Functions requiring Physical Exertion and Stamina, Table 2 - Upper Limb Function, Table 3 - Lower Limb Function, Table 4 - Spinal Function, Table 5 - Mental Health Function, Table 7 - Brain Function, Table 8 - Communication Function, Table 9 - Intellectual Function, Table 10 - Digestive and Reproductive Function, Table 11 - Hearing and other Functions of the Ear, Table 12 - Visual Function, Table 13 - Continence Function, Table 14 - Functions of the Skin, Table 15 - Functions of Consciousness

3.6.3.08 Assigning an impairment rating

Summary

This topic provides guidance on Part 2 of the Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 (the Determination), which sets out rules that are to be complied with in applying the Impairment Tables. This topic has headings emphasising significant principles and concepts when assigning an impairment rating to a person's functional capacity, which underpin provisions contained in that part of the Determination. It also provides guidance on the concepts and practical application of the DSP eligibility criteria contained in the SSAct.

This topic does not restate the definitions contained in Part 1 of the Determination. These definitions are to be accessed directly from the Determination.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Part 1 - Preliminary, Part 2 - Rules for applying the Impairment Tables.

Assigning an impairment rating

The following rules must be applied when assigning impairment ratings:

- ONLY ONE rating can be assigned from a single Table
- impairment ratings can only be assigned in accordance with the descriptors in each Table
- ratings cannot be assigned in excess of the maximum rating specified in each Table, and
- if an impairment rating is considered as falling between 2 ratings, the lower of the 2 ratings is to be assigned, and the higher rating must not be assigned unless all the descriptors required for that rating are fully met.

When determining which impairment rating applies to a person under a specific Table, the rating that best describes a person's abilities or difficulties must be applied. In doing so, the descriptor points under a specific impairment level must be considered and applied, as set out in the descriptor, that is:

- ALL the points in the descriptor must be considered

- NO descriptor points or their parts are to be disregarded.

While every descriptor point requires consideration, each Table provides instructions on the number of descriptor points to be met in order to assign an impairment rating. Determination of the descriptor that best fits a person's impairment level must be based on the corroborating evidence, including a person's medical history, investigation results and clinical findings. A person's self-reported symptoms MUST NOT SOLELY BE RELIED UPON. It is inappropriate to assign an impairment rating unless a person's self-reported functional impacts are consistent with, and supported by, corroborating evidence.

Example: A person with permanent osteoarthritis has functional impairment of their hands. On Table 2 – Upper Limb Function, they meet at least 4 of the 6-descriptor points for an impairment rating of 10 points (that is, 'most') of the descriptor points. They also satisfy a single 20-point descriptor point due to difficulty using a computer keyboard, despite appropriate adaptations. They do not satisfy any other required descriptor points for the 20-point rating and a rating of 10 points must be assigned. This is because the person does not meet at least 3 of the 5 (that is, most) of the descriptors at the 20 points rating. In this case, 10 points must be assigned and it is incorrect to assign 20 points.

When impairment ratings are applied from multiple Tables, the total work-related impairment is represented by the combined impairment rating.

Hierarchy of descriptors

The descriptors corresponding to the impairment rating level in each Table follow a consistent incremental hierarchy which is indicated by terms that describe increasing levels of difficulty in performing certain activities, for example:

- ‘without difficulty’
- ‘with some difficulty’
- ‘unable to’.

The hierarchy of descriptors in some Tables (for example, Table 3) take into account additional factors that reflect the severity of an impairment. These may include:

- a person's ability to perform certain activities unassisted or unaided and/or when using devices, or
- requirements for equipment or aids such as a lower limb prosthesis, a walking stick, crutches, a walking frame or wheelchair.

As the descriptors follow an incremental hierarchy, an assessment process should follow the same incremental path to establish the appropriate rating for a person's circumstances, that is, whether the impairment has no (0 points), mild (5 points), moderate (10 points), severe (20 points) or extreme (30 points) functional impact.

As a first step, all the descriptors for each impairment rating level in the Table under which a person is being assessed should be read as a whole so the descriptors, their relationship and hierarchy in that particular Table are understood.

The next step involves applying the descriptor for 0 points, and continuing to apply the descriptors for progressively higher impairment levels, until it is determined that:

- a person meets all the required descriptor points for a certain impairment rating level, and
- does not meet all the required descriptor points for the next level.

In determining whether the required descriptor points for a specific impairment level are met or not, ALL the descriptor points for that level must be considered and applied AS SET OUT IN THE DESCRIPTOR. No descriptor points or their parts are to be disregarded.

When it is determined a person meets all the required descriptors for a certain impairment rating level that rating will be applied. A person cannot be assigned an impairment rating level if they do not meet all required descriptors.

Note: Individual descriptors or their parts must not be applied in isolation from one another. For example, under Table 1 - Functions requiring Physical Exertion and Stamina, when reviewing a person at the 10 point rating, all points must be considered. In order for the 10-point rating to be applied, a person MUST meet points (1) (a) (i) OR (ii) as well as (1) (b) (i) AND (ii). If the person does not meet point (1) (a) (i), point (1) (a) (ii) must still be considered.

Explanation: Where a person meets the required descriptor points for 5 points but does not meet all the required descriptor points for 10 points, their impairment CANNOT be regarded as moderate, severe or extreme and neither 10, 20 nor 30 points can be allocated.

Example: A person’s impairment is being assessed under Table 2 – Upper Limb Function. An assessor first applies the descriptor for 0 points and is satisfied that the person can pick up, handle, manipulate and use MOST objects encountered on a daily basis without difficulty. Using descriptor for 5 points, the assessor also finds they have some difficulty doing up buttons but do not meet any other descriptor points for that rating. As such, the

appropriate impairment rating is 0 points and there is no need for the assessor to proceed any further. The person CANNOT be allocated 5, 10, 20 or 30 points.

Example: A person's impairment is being assessed under Table 4 – Spinal Function. In accordance with the incremental hierarchy principle, an assessor applies the descriptors in this Table sequentially, starting with the descriptor for 0 points and continues applying the higher-level descriptors. The assessor finds that the person meets the required descriptor points for a rating of 10 points, but does not meet any of the descriptor points for the 20-point rating. The person's impairment rating is 10 points and the assessor is not required to proceed any further. The person CANNOT be allocated 20 or 30 points.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 section 11 Assigning an impairment rating, Table 2 - Upper Limb Function, Table 4 – Spinal Function

Descriptors involving performing activities

When assessing whether a person can perform a certain activity listed in the descriptor, the activity cannot be taken as being able to be performed if it can only be performed once or rarely. A person needs to be able to perform this activity when they would normally be required to attempt it.

Example: If, under Table 4, a person is assessed as to whether they can bend down to pick a light object off the floor, they are taken as meeting this descriptor point only where a person is generally able to do that activity whenever they would normally attempt to perform it.

When a descriptor specifies a person's inability to perform an activity, it is considered to have been met if the person is unable to do the activity when they would normally be required to do so, unless otherwise specified in the Table.

Example: Under Table 3, a person is assessed as to whether they are unable to stand for more than 5 minutes as specified in descriptor 1(c) for 10 points. This descriptor is met where the person is unable to do this activity when they would normally be required to do so, for example as part of their day-to-day activities around the home and the community.

A person may perform a certain activity without assistance because they have no one to assist them. In these situations, a person may push themselves to perform the activity out of necessity. In assigning an impairment rating, consideration should be given to any

subsequent symptoms experienced by the person as a result of performing that activity, as an indicator of whether assistance is likely to be required.

Example: A person has difficulty walking around a supermarket, due to the impact of rheumatoid arthritis on their lower limbs. They do not have anyone available to assist them and so they do their shopping alone. Afterwards, they usually experience severe pain and fatigue and cannot walk any significant distance for the rest of the day. In this case, under Table 3, 20-point descriptor, the person should be considered unable to walk around a supermarket without assistance.

Assessing impairments caused by episodic or fluctuating medical conditions

Many medical conditions follow an episodic or fluctuating pattern. When assessing impairment caused by such conditions, the severity, duration and frequency of the episodes or fluctuations must be assessed. An impairment rating is then applied to reflect the overall functional impact that is present the majority of the time.

Example: A person has bronchiectasis which is permanent for DSP purposes. Over the past 2 years, they normally experience shortness of breath and have to rest frequently when doing the housework. They normally catch the bus to the supermarket and can do the shopping without assistance. They can perform tasks of a sedentary nature, such as working on a computer. They fulfil the descriptors for a 10 point impairment rating on Table 1 – Functions requiring Physical Exertion and Stamina.

Four to 5 times a year, they get a chest infection which substantially worsens their condition. During these exacerbations, they are short of breath when performing light physical activities, cannot perform any household activities, and cannot catch the bus without assistance from a friend. They are also unable to do any sedentary work for 3 hours at a time, due to increased fatigue. During these exacerbations, they fulfil the descriptors for a 20-point impairment rating on Table 1.

These chest infections usually last for 2 weeks and it takes a further 2 weeks for them to return to their previous functional capacity. At least once a year they have a severe chest infection, which requires hospital admission typically for a one-week period. During the hospital admission, they are unable to perform any activities requiring physical exertion and are prescribed oxygen treatment. It takes 6-8 weeks to recover from the severe chest infections. Therefore, they spend at least 26 weeks per year functioning at a 20-point or

worse level of impairment. As this is at least half of a typical year, a 20-point rating would be applied.

If their chest infections lasted 2 weeks, with one week to recover their normal level of functioning, they would be at a 20-point rating for 8 to 10 weeks per year. As they would spend the majority of the year at the 10-point rating, this is what would be applied.

The rules to applying the Impairment Tables deal with episodic and fluctuating conditions. Some Tables contain specific instructions that state impairments may vary over time, and a person's presentation on the day of assessment should not be solely relied upon.

Note: In order to ensure people with conditions resulting in impairments affecting mental health function and brain function are not disadvantaged, the introductions to Tables 5 and 7 contain specific instructions about how to assess such impairments, including how to deal with their episodic or fluctuating presentation.

3.6.3.10 Guidelines to Table 1 - Functions requiring Physical Exertion & Stamina

Summary

Table 1 is used where a person has a functional impairment when performing activities requiring physical exertion or stamina, which results from a condition commonly associated with cardiac or respiratory impairments, fatigue or exhaustion, or other conditions affecting physical exertion or stamina.

The diagnosis of the medical condition causing the impairment must be made by an appropriately qualified medical practitioner. This includes a general practitioner or other specialist such as a cardiology, respiratory, rheumatology or other specialist physician.

A PERSON'S SELF-REPORTED SYMPTOMS MUST NOT BE SOLELY RELIED UPON in determining functional impacts of the person's permanent condition (impairment). There must be corroborating medical evidence of the person's impairment.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 1 - Functions requiring Physical Exertion and Stamina

Interpretation & application of relevant terms

Where the descriptors in Table 1 refer to mobilising in a wheelchair, this includes both manually-propelled wheelchairs and powered mobility aids (such as power assist wheelchair, power wheelchair or mobility scooter).

'Public transport' means any mode of transport that runs to a timetable such as buses, trains, trams and ferries. It excludes taxis or hire cars. A person who is able to use at least one of these modes of transport, having regard only to the level of impairment assessable under Table 1, is considered to be able to use public transport for the purpose of this Table, even if they are precluded from using other modes of public transport. When assessing a person's ability to use public transport it is irrelevant whether the person actually uses public transport, whether public transport is available to the person in their local area and whether the person actually receives assistance.

Similarly, where Table 1 refers to activities such as walking (or mobilising in a wheelchair) to local facilities (e.g. a corner shop, around a shopping mall, a shopping centre or supermarket, larger workplace or education or training campus), it is irrelevant whether such establishments, businesses, buildings or structures actually exist in a person's locality or how they may be labelled. Of relevance is the description of the activity involved. The objective is to measure a person's level of ability having regard to the severity of a person's symptoms (e.g. shortness of breath, fatigue or cardiac pain) when performing certain tasks requiring physical exertion or stamina.

Explanation: The AAT (General Division) applied this approach in its decision in *Wilson and Secretary, Department of Social Services* (2015) AATA 497.

The 20 and 30-point descriptors in Table 1 use the term 'assistance'. Assistance means assistance from another person, rather than any aids or equipment the person has and usually uses (refer to 3.6.3.05 'Use of aids, equipment & assistive technology').

Explanation: This interpretation of the term 'assistance' has been adopted in a number of decisions by the AAT (General Division), including in *Summers and Secretary, Department of Social Services* (2014) AATA 165.

Determining the level of functional impact - general rules

As in the other Tables, the descriptors in Table 1 are interlinked in that they follow a consistent incremental hierarchy, which in this Table is expressed, among other things, by the use of terms indicating increasing levels of difficulty in performing certain activities (e.g. no difficulty, occasional difficulty, occasional symptoms, frequent symptoms, unable to, completely unable to).

Consequently, as is the case in applying any other Table, when establishing whether the impairment causes no (0 points), mild (5 points), moderate (10 points), severe (20 points) or extreme (30 points) functional impact, all the descriptors for each impairment rating level in Table 1 should be read as a whole and compared so the descriptors, and their relativity and hierarchy in this Table, are understood.

When determining a person's limitations in relation to conducting 'work tasks', this is taken to refer to any job available in Australia.

The structure of the Tables requires that, in assessing the level of functional impact, a comparison must be made of all the descriptors for each level of impairment. An assessment starts by considering the descriptors for 0 points, and if a person has more than 'no functional impact', the descriptors for 5 points are then considered, and so on for the descriptors for higher impairment levels. When it is determined that the person meets all the required descriptors for a certain impairment rating level, but does not meet all the required descriptors for the next impairment rating level, the appropriate impairment rating applicable to the person's circumstances will be the lower of those 2 impairment ratings (i.e. the rating at which all the required descriptors are met).

Note: Individual descriptors or their parts must not be applied in isolation from one another.

In determining whether the required descriptors for a specific impairment level are met or not, ALL the descriptors for that level must be considered and applied as set out in the descriptors. NO descriptors or their parts are to be disregarded. However, one of several descriptor points may be sufficient for that rating when the word 'or' links the descriptors.

For example, to be eligible for 20 points under Table 1 a person must have a SEVERE functional impairment on activities requiring physical exertion and stamina and must usually experience symptoms, such as shortness of breath, fatigue, cardiac pain or chronic pain, when performing light physical activity AND must be unable to do at least one of the activities listed under point (1)(a) AND must also satisfy point (1)(b).

Note: If the person's impairment does not meet sufficient required descriptors for a certain impairment level, the person's impairment cannot be rated at that level or at any higher level.

Explanation: Where a person meets the required descriptors for 5 points but does not meet sufficient required descriptors for 10 points, the correct impairment rating is 5 points. Their impairment CANNOT be assessed as moderate, severe or extreme and 10, 20 or 30 points cannot be allocated.

Determination of the descriptor that best fits the person's impairment level must be based on the available medical evidence including the person's medical history, investigation results and clinical findings. A person's self-reported symptoms must not be solely relied on. It would be inappropriate to apply an impairment rating based solely on a person's self-reported functional capacity if this level of functional impairment is not consistent with the medical evidence available.

In determining the level of functional impact, care should be taken to distinguish between activities that the person does not do as opposed to activities that they have difficulty performing because of their impairment.

An activity listed under a descriptor is not taken as being able to be performed if it can only be performed once or rarely - the person needs to be able to usually perform such activity whenever they would normally attempt it or be required to perform it. Where an activity is usually required to be performed repetitively, a person who can only perform such activity once and is then unable to perform the activity again when required will be taken to be unable to perform this activity. Conversely, where an activity is normally undertaken infrequently (e.g. only once per day or once per week), a person who can perform that activity once per day or once per week, as the case may be; is not unable to perform the activity merely because they are unable to perform the activity repetitively or with greater frequency than would normally be required.

When Table 1 refers to a person being unable to perform certain tasks, the term 'unable' is not intended to mean that the task is unable to be performed without some pain, shortness of breath or fatigue. When a person experiences some symptoms or pain when performing an activity this does not mean the person is 'unable' to perform the task. The assessment of the level of pain and symptoms experienced in performing the activity is relevant where the pain and symptoms are severe enough for the person to not be physically able to perform the activity on a repetitive or habitual basis and not once or rarely.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 section 11(2) In deciding whether an impairment has no, mild …, section 11(1)(c) If an impairment is considered as falling between …

0-point impairment rating level

The 0-point descriptor specifies the person is able to undertake exercise appropriate to their age for at least 30 minutes at a time (point (1)(a) AND has no difficulty completing physically active tasks in their home and community (point (1)(b).

To meet descriptor point (1)(a), it would not be expected that an older aged person is able to undertake the same level of intensity in exercise as someone aged in their 20's due to reduced stamina or loss of flexibility. Consideration should be given to the level of exercise a generally healthy person of the equivalent age would reasonably be expected to undertake.

5-point impairment rating level

For this rating to be assigned to a person, the person MUST meet at least one of the descriptor points (1)(a)(i) or (1)(a)(ii) AND also descriptor point (1)(b).

10-point impairment rating level

The 10-point descriptor requires that for this rating to be assigned to a person, the person MUST satisfy at least one of the descriptor points (1)(a)(i) or (1)(a)(ii) AND must also meet both descriptor points (1)(b)(i) and (1)(b)(ii).

20-point impairment rating level

The 20-point descriptor requires that any person considered for this rating must satisfy at least one of the requirements set out in (1)(a)(i), (1)(a)(ii), (1)(a)(iii) and (1)(a)(iv) AND must also meet the descriptor point (1)(b).

30-point impairment rating level

The 30-point descriptor includes people who require oxygen treatment (descriptor point 2). If a person requires oxygen treatment such as the use of an oxygen concentrator during the day or to move around, they should be assessed as meeting the 30-point descriptor, without the need to be assessed under descriptor point 1. Likewise if a person does not require oxygen treatment but meets points (1) (a) or (b) they would also meet the 30-point descriptor.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 1 - Functions requiring Physical Exertion and Stamina

Avoiding double counting

The descriptors in other Tables may also refer to certain activities relating to a person's ability to mobilise such as climbing steps etc., but those Tables measure the impact of impairment where that impairment is different to those assessed under Table 1. For example, some descriptors in Table 3 measure the level of difficulty in walking, climbing stairs or mobilising in a wheelchair due to symptoms affecting the use of lower limbs.

Table 1 may be used to assess the functional impact of chronic pain where there is corroborating medical evidence that chronic pain (affecting one or more body functions) also impacts physical exertion and stamina (e.g. results in fatigue symptoms). However, to avoid double counting, Table 1 should only be used if the level of impairment to a particular function is not adequately assessed by the Table relevant to that function. Therefore, if there is an impact on physical exertion and stamina and a rating has been allocated on other Tables (e.g. Tables 2, 3 and 10), it needs to be carefully considered whether the rating on the other Table already adequately captures the level of impairment. If the answer is NO, then use of Table 1 may be considered, while ensuring that the level of impairment is not overstated. If the answer is YES, there is no need to apply Table 1.

When assessing chronic pain under Table 1, refer to 3.6.3.02 'Assessing functional impact of chronic pain'. Please also refer to 3.6.3.06. More information about avoiding double counting and supporting examples are also contained in the below sections of this topic, titled: Some conditions causing impairment commonly assessed using Table 1 (Example 3) and Impairments that should not be assessed using Table 1.

If it is unclear how and when to use Table 1 while avoiding double counting, the case should be discussed with the HPAU.

Some conditions causing impairment commonly assessed using Table 1

These include but are not limited to:

- ischaemic heart disease or coronary artery disease with exercise induced angina
- cardiac disease which has resulted in chronic cardiac failure, such as cardiomyopathy or some cardiac valvular conditions
- cardiac arrhythmias that result in exercise induced restrictive symptoms
- chronic obstructive pulmonary disease (COPD)
- restrictive lung disorders
- exercise induced asthma
- autoimmune conditions such as systemic lupus erythematosus (SLE) and rheumatoid arthritis which impact a person's physical exertion or stamina and no other Table sufficiently captures the impairment
- chronic fatigue syndrome
- fibromyalgia
- chronic kidney disease known as stage 5 kidney disease when requiring dialysis

- diabetes mellitus.

Example 1: A 45 year old man is diagnosed with morbid obesity. The medical evidence states that this impacts on his ability to perform activities which require physical exertion and stamina. He finds it difficult to walk up stairs or complete lawn mowing without taking a break to rest due to shortness of breath. He is able to perform most work-related tasks, except work which would require heavy manual labour.

The condition is considered fully diagnosed, treated and stabilised and under Table 1, the man's impairment would be rated as 5 points, as the impact on his ability to perform tasks is only mildly affected. Under the 5-point descriptor the man would meet (1)(a)(ii) and (b).

Example 2: A 49 year old woman has been diagnosed with chronic obstructive pulmonary disease. Lung function tests indicate that the condition is causing low airflow to and from the lungs and impacts on the woman's ability to undertake physical activities. The woman experiences shortness of breath when undertaking day to day activities such as sweeping or walking very far outside her home. For example, she is not able to walk to her local shop and return home with a bag of shopping. She can perform light household tasks, such as cooking and doing dishes, and can read, pay bills and use a computer without experiencing shortness of breath.

The condition is considered fully diagnosed, treated and stabilised and under Table 1, the woman would receive an impairment rating of 10 points for the moderate impact the condition has on her ability to function. Under the 10-point descriptor the woman would meet (1)(a)(ii) and (b)(ii).

Example 3: A 55 year old woman has severe deteriorating rheumatoid arthritis. Medication provides limited relief and the doctor has stated she experiences associated chronic pain and fatigue. This condition is systemic in nature and the woman experiences persistent fatigue, chronic inflammation of her joints with swelling, heat and pain, as well as muscle weakness and difficulty sleeping. Medical evidence states that due to fatigue and pain the woman is unable to perform any light day to day household activities and would not be able to perform clerical or sedentary work tasks for a shift of 3 hours.

The condition is considered fully diagnosed, treated and stabilised and under Table 1-Functions requiring Physical Exertion and Stamina, the woman would receive an impairment rating of 20 points as the impact on her ability to function is severe. Under the 20-point descriptor the woman would meet (1) (a) (iv) and (1) (b). To avoid double counting ratings under Table 2-Upper Limb Function and Table 3-Lower Limb Function are not given as Table 1 includes assessment of mobility and capacity to undertake daily activities.

Example 4: A 50 year old man has longstanding type 2 diabetes mellitus and has developed stage 5 chronic kidney disease. He attends a haemodialysis clinic three to four times per week. Each episode of haemodialysis takes approximately 5 hours. After haemodialysis he typically goes home to sleep. His primary symptom is pronounced fatigue. During dialysis, the functional impact on physical exertion and stamina is extreme, as the nature of the treatment renders a person immobile. Before and immediately after dialysis fatigue is severe, and at other times it is moderately severe. Applying the medical evidence and the fluctuating nature of the symptomatology, a rating of 20 impairment points is allocated under Table 1.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 1 - Functions requiring Physical Exertion and Stamina

Impairments that should not be assessed using Table 1

Non-pathological causes such as lack of fitness that are not associated with a diagnosed medical condition, should not be assessed using Table 1.

Restriction of physical activity due to musculo-skeletal conditions, e.g. severe arthritis, spinal problems, unless the musculo-skeletal Tables 2, 3 or 4 do not sufficiently capture the impairment from any associated impact on physical exertion and stamina.

Assessors need to be mindful not to overstate the level and nature of impairment. Musculo-skeletal conditions can be expected to involve some level of ongoing pain and reduced stamina in addition to a loss of dexterity/flexibility which would all be factors in determining the level of severity of the impairment. This is more evident when assessing a person's ability to undertake the actions described on a repetitive basis rather than a one-off action.

Example 1: A 60 year old man has osteoarthritis in both knees which is fully diagnosed, treated and stabilised. The man experiences loss of flexibility in his knees and pain when bending to sit or on rising from a sitting position as well as when walking any distance. The man requires assistance from his carer within the home and a walking frame with assistance outside his home and is unable to walk far or stand up from a sitting position without assistance from another person.

The condition is considered fully diagnosed, treated and stabilised and under Table 3, the man's impairment would be rated as 20 points, as the impact is severe. Under the 20-point

descriptor the man would meet all points under (1)(a) and (1)(b). The descriptor also captures the level of pain resulting from the lower limb impairment.

Example 2: A 58 year old woman has chronic osteoarthritis in both her hands and wrists, which is fully diagnosed, treated and stabilised. She experiences lack of strength in her hands and ongoing chronic pain. This pain affects her ability to handle, move or carry most objects, use a computer keyboard or pen/pencil and turn the pages of a book.

The condition is considered fully diagnosed, treated and stabilised and under Table 2, the woman's impairment would be rated as 20 points due to the severe level of impairment. The woman is unable to perform any of the actions listed in the 20-point descriptor on a repetitive basis due to the loss of dexterity and chronic pain experienced when using her hands and arms. Under the 20-point descriptor the woman would meet all points under (1).

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011

3.6.3.20 Guidelines to Table 2 - Upper Limb Function

Summary

Table 2 is used to assess functional impairment when performing activities requiring the use of hands or arms.

Consistent with this purpose, the descriptors in Table 2 refer to a range of activities relevant to a person's ability to pick up, handle, manipulate and use objects encountered in everyday life, including but not limited to, coins, pencils, cartons of liquid, computer keyboards etc.

Table 2 specifies that the upper limbs extend from the shoulder to the fingers.

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. This includes a general practitioner or medical specialists such as a rheumatologist or rehabilitation physician.

A PERSON'S SELF-REPORTED SYMPTOMS MUST NOT BE SOLELY RELIED UPON in determining functional impacts of the person's permanent condition (impairment). There must be corroborating medical evidence of the person's impairment.

If the person has and usually uses an upper limb prosthesis or other assistive devices, the assessment under Table 2 must be undertaken considering what the person can do or has difficulty doing while using the prosthesis and/or assistive devices.

If a person has an amputation of an upper limb and does not use a prosthesis, consideration must be given to what the person can do or has difficulty doing with their remaining limb. In some cases the person may have made, or able to make adaptations in using their remaining limb and may be able to undertake activities with minimal difficulties.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 2 - Upper Limb Function

Interpretation & application of relevant terms

The 20-point descriptor in Table 2 uses the term 'assistance'. Assistance means assistance from another person, rather than any aids or equipment the person has and usually uses (refer to 3.6.3.05 'Use of aids, equipment & assistive technology').

Explanation: This interpretation of the term 'assistance' has been adopted in a number of decisions by the AAT (General Division), including in *Summers and Secretary, Department of Social Services* (2014) AATA 165.

Determining the level of functional impact - general rules

As in the other Tables, the descriptors in Table 2 are interlinked in that they follow a consistent incremental hierarchy, which in this Table is expressed, among other things, by the use of terms indicating increasing levels of difficulty in performing certain activities (e.g. without difficulty, some difficulty, difficulty, severe difficulty, unable to).

Consequently, as is the case in applying any other Table, in establishing whether the impairment causes no (0 points), mild (5 points), moderate (10 points), severe (20 points) or extreme (30 points) functional impact, all the descriptors for each impairment rating level in Table 2 should be read as a whole and compared so the descriptors, their relativity and hierarchy in this Table are understood.

When determining a person's limitations in relation to conducting 'work tasks', this is taken to refer to any job available in Australia.

The structure of the Tables requires that, in assessing the level of functional impact, a comparison must be made of all of the descriptors in each level of impairment. An assessment starts by considering descriptors for 0 points and, if a person has more than 'no functional impact', the descriptors for 5 points are then considered, and so on for the descriptors for higher impairment levels. When it is determined that a person meets all the required descriptors for a certain impairment rating level, but does not meet all the required descriptors for the next impairment rating level, the appropriate impairment rating applicable to the person's circumstances will be the lower of those 2 impairment ratings (i.e. the rating at which all the required descriptors are met).

Note 1: Individual descriptors or their parts must not be applied in isolation from one another.

In determining whether the required descriptors for a specific impairment level are met or not, ALL the descriptors for that level must be considered and applied as set out in the descriptor. NO descriptors or their parts are to be disregarded.

For example, for a person to be assigned a 20 point rating under Table 2, at least 3 of the 5 descriptors must be satisfied.

Note 2: The descriptors must be applied sequentially to allocate an impairment rating - the incremental hierarchy of descriptors MUST NOT be ignored. As mentioned above, the assessment process involves applying the 0-point descriptors first and continuing to apply the descriptors for higher impairment levels, until all the required descriptor for a certain impairment rating level are met.

Note 3: If the person's impairment does not meet all the required descriptors for a certain impairment level, the person's impairment cannot be rated at that or any higher level.

Explanation: Where a person meets the required descriptors for 10 points but does not meet all the required descriptors for 20 points, the correct impairment rating is 10 points. Their impairment CANNOT be regarded as severe or extreme and neither 20 nor 30 points can be allocated.

Determination of the descriptor that best fits the person's impairment level must be based on the available medical evidence including the person's medical history, investigation results and clinical findings. A person's self-reported symptoms must not be solely relied on. It would be inappropriate to apply an impairment rating based solely on a person's self-reported functional history if this level of functional impairment is not consistent with the medical evidence available.

In determining the level of functional impact, care should be taken to distinguish between activities that the person does not do as opposed to activities that they have difficulty performing because of their impairment.

The descriptors are to be considered in relation to impairment to either hands or arms. The person may have one hand or one arm affected or both hands or both arms. In either circumstance, the descriptors are based on the activities the person can do or has difficulty doing with either of their hands or either arm. An activity listed under a descriptor is not taken as being able to be performed if it can only be done once or rarely - the person needs

to be able to perform such activity when they would normally attempt it or be required to perform it.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 section 11(2) In deciding whether an impairment has no, mild …, section 11(1)(c) if an impairment is considered as falling between …

0-point impairment rating level

The 0-point descriptor specifies the person has no functional impact on activities using hands or arms. The person can carry out all activities in descriptor (1).

5-point impairment rating level

The 5-point descriptor requires that for this impairment rating to be assigned to a person, the person must be able to manage most daily activities requiring the use of hands and arms but has SOME DIFFICULTY with most (i.e. at least 3) of the activities in the descriptor points (1)(a), (b), (c), and (d).

10-point impairment rating level

For this rating to be allocated to a person, they must have DIFFICULTY in performing most (i.e. at least 4) of the descriptor points (1)(a), (b), (c), (d), (e) and (f).

20-point impairment rating level

For a person to meet the 20-point descriptor, most (i.e. at least 3) of the descriptor points (1)(a), (b), (c), (d) and (e) must be met.

The 20-point descriptor (1)(a) requires that a person either has an amputation rendering one of their hands or arms non-functional, OR they have limited movement or coordination in both of their arms or both of their hands. Where a person does not have an amputation of 1 hand or arm, they may still satisfy descriptor (1)(a) if the severity of the condition is such that it renders 1 hand or arm completely non-functional, such as to be equivalent to an amputation.

A person cannot satisfy 3 or more descriptors to be assigned a 20 point rating under Table 2 where they have a condition affecting only one arm or one hand. Consideration must be

given to what the person can do, or could be retrained to do, with their unaffected arm or hand.

See *Sabeei and Secretary, Department of Social Services* (2014) AATA 815.

30-point impairment rating level

The policy intent of the 30-point descriptor is that a person is totally unable to perform any activities requiring the use of arms or hands.

Consistent with the principle of incremental hierarchy of descriptors, it would be expected that the level of impairment required for 30 points will be higher than that for 20 points. Given that the descriptor point (1)(a) for 20 points requires the person to have limited movement or coordination in both their arms or hands, or have an amputation rendering one of their arms or hands non-functional, in order to meet the 30-point descriptor, the person must have NO FUNCTION at all in either:

- both their hands, or
- both their arms.

Note: A person is considered to have no function in both their hands or both their arms, if the person has no movement or coordination in both their hands or both arms or has no hands or no arms. A person will not meet the 30 point descriptor if they have some movement or function in one of their hands or arms.

Example : A 35 year old woman has been diagnosed with cerebral palsy, which affects her upper limb function. This condition has a significant impact on the functioning of both hands and as a result she is unable to undertake any activities with either of her hands.

The condition is considered fully diagnosed, treated and stabilised and under Table 2, the woman would receive an impairment rating of 30 points due the extreme impact on her ability to function.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 1 - Functions requiring Physical Exertion and Stamina

Avoiding double counting

For bilateral conditions where both upper limbs are affected, a single impairment rating under Table 2 should be determined based on the resulting combined functional impairment.

Restrictions on overhead activities under Table 2 are only relevant in applying the 5 point descriptor. If the person has more severe restrictions on overhead activities arising from shoulder injury, they should still be assessed under Table 2 in relation to what they can/cannot do in accordance with the existing descriptors. People with shoulder or upper limb conditions are not to be assessed under Table 4, which is to be solely used to assess restrictions on overhead restrictions arising from spinal conditions. This avoids double-counting (3.6.3.06).

In determining the functional impact on activities using hands or arms, consideration should be given to the impact of pain on the person's ability to undertake these activities. For example, a person may have difficulty using their hands or arms on a repetitive basis due to the chronic pain they experience on doing so. This chronic pain could be either a symptom of a permanent condition impacting upper limbs or a permanent condition itself.

When assessing chronic pain under Table 2, refer to 3.6.3.02 'Assessing functional impact of chronic pain'.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 4 - Spinal Function, Table 2 - Upper Limb Function

Some conditions causing impairment commonly assessed using Table 2

These include but are not limited to:

- upper limb musculoskeletal conditions including specific degenerative joint disease (osteoarthritis)
- other permanent forms of arthritis or chronic rotator cuff lesions
- neurological conditions including cerebrovascular accident (CVA or stroke) or other brain or nerve injury causing paralysis or loss of strength or sensation
- cerebral palsy or other condition affecting upper limb coordination

- inflammation or injury of the muscles or tendons of the upper limbs
- upper limb amputations or absence of whole or part of upper limb
- chronic carpal tunnel syndrome
- ulnar nerve palsies.

Example 1: A 54 year old man has been diagnosed with arthritis in the elbow of each arm and in his right hand. He finds it difficult to pick up heavy objects due to pain in these areas. He also has some difficulty holding small objects and doing up buttons with his right hand, as he has lost some dexterity in his fingers. He is still able to complete his personal care routine, such as dressing without assistance and can undertake most household tasks (with the exception of heavy tasks like moving furniture).

The condition is considered fully diagnosed, treated and stabilised and under Table 2, the man would receive an impairment rating of 5 points due to the mild impact on his ability to function. Under the 5-point descriptor the man would meet (1)(a), (b) and (c).

Example 2: A 40 year old man has undergone an amputation of one of his arms. He does not use a prosthesis. Since the amputation, he has adapted to the way he uses his remaining arm and is able to undertake many daily activities involving upper limb function. He has adapted to type on a computer keyboard with his remaining hand and can use a pencil to write. He has difficulty picking up bulky objects and cannot pick up heavier objects such as a 1 litre carton of liquid. He has difficulty with tasks like tying shoelaces and unscrewing lids and needs assistance with these tasks.

The condition is considered fully diagnosed, treated and stabilised and under Table 2, the man would receive an impairment rating of 10 points due to the moderate difficulties he still has, despite the adaptations he has made since undergoing the amputation of his arm. Under the 10-point descriptor the man would meet (1)(a), (b), (d) and (f).

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 2 - Upper Limb Function

Impairments that should not be assessed using Table 2

Difficulties handling and manipulating objects due to severe visual impairment should not be assessed under Table 2 if there are no inherent medical conditions affecting the upper limbs. Such impairment should be assessed under Table 12 - Visual Function.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 2 - Upper Limb Function, Table 12 - Visual Function

3.6.3.30 Guidelines to Table 3 - Lower Limb Function

Summary

Table 3 is used where a person has a functional impairment when performing activities requiring the use of legs or feet in the context of a person's ability to move around in the environment (mobility).

Consistent with this purpose, the descriptors in Table 3 refer to a range of activities relevant to a person's ability to move around, including walking, kneeling, squatting, standing, standing up from a seated position, using stairs, using public transport or using a motor vehicle, and (where applicable) their ability to mobilise with the use of wheelchairs or walking aids.

The descriptors in other Tables may also refer to certain activities relating to a person's mobility but those Tables measure the impact of impairment where the function that is affected is different to those relevant to the application of Table 3. For example, some descriptors in Table 1 measure the level of difficulty in walking, climbing stairs or mobilising in a wheelchair due to symptoms arising from conditions affecting physical exertion or stamina. Table 3 is used to assess the level of difficulty in performing mobility-related activities arising from conditions affecting the use of lower limbs. When another Table is being considered, in addition to Table 3, care must be taken not to double count the impairment.

Table 3 specifies that the lower limbs extend from the hips to the toes.

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. This includes a general practitioner, an orthopaedic surgeon, a rheumatologist, a rehabilitation physician or other relevant specialist.

A PERSON'S SELF-REPORTED SYMPTOMS MUST NOT BE SOLELY RELIED UPON in determining functional impacts of the person's permanent condition (impairment). There must be corroborating medical evidence of the person's impairment.

If the person has and usually uses a lower limb prosthesis, the assessment under Table 3 must be undertaken considering what the person can do or has difficulty doing while using this prosthesis.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 3 - Lower Limb Function

Interpretation & application of relevant terms

Where the descriptors in Table 3 refer to moving around in or using a wheelchair and to transferring to and from a wheelchair, this includes both manually-propelled wheelchairs and powered mobility aids (such as power assist wheelchair, power wheelchair or mobility scooter).

For the purpose of the Impairment Tables, including Table 3, 'public transport' means any mode of transport that runs to a timetable such as buses, trains, trams and ferries. It excludes taxis or hire cars. A person who is able to use any one of these modes of transport, having regard only to the level of impairment to their lower limbs, is considered to be able to use public transport, even if they are precluded from using other modes of public transport. When assessing a person's ability to use public transport it is irrelevant whether the person actually uses public transport, whether public transport is available to the person and whether the person actually receives assistance.

Similarly, where Table 3 refers to activities such as walking around a shopping mall, a shopping centre or supermarket, or walking to local shops, it is irrelevant whether such businesses, buildings or structures actually exist in a person's locality or how they may be labelled. Of relevance is the description of activity involved. The objective is to measure a person's ability or otherwise to mobilise.

Explanation: The AAT (General Division) applied this approach in its decision in *Wilson and Secretary, Department of Social Services* [2015] AATA 497.

The 10- and 20-point ratings in Table 3 use the term 'assistance'. Assistance means assistance from another person, rather than any aids or equipment the person has and usually uses (refer to 3.6.3.05 'Use of aids, equipment & assistive technology').

Explanation: This interpretation of the term 'assistance' has been adopted in a number of decisions by the AAT (General Division), including in *Summers and Secretary, Department of Social Services* [2014] AATA 165.

Determining the level of functional impact - general rules

As in the other Tables, the descriptors in Table 3 are interlinked in that they follow a consistent incremental hierarchy which in this Table is expressed, among other things, by the use of terms indicating increasing levels of difficulty in performing certain activities (for example, without difficulty, with some difficulty, unable to). The hierarchy of descriptors in Table 3 also takes into account other factors. These include a person's ability to perform certain activities unassisted or unaided and/or when using devices, equipment or aids such as a lower limb prosthesis, a walking stick, other walking aids (for example, a quad stick, crutches, a walking frame) or a wheelchair.

Consequently, as is the case in applying any other Table, in establishing whether the impairment causes no (0 points), mild (5 points), moderate (10 points), severe (20 points) or extreme (30 points) functional impact, all the descriptors for each impairment rating level in Table 3 should be read as a whole and compared so the descriptors, their relativity and hierarchy in this Table are understood.

When determining a person's limitations in relation to conducting 'work tasks', this is taken to refer to any job available in Australia.

The structure of the Tables requires that, in assessing the level of functional impact, a comparison must be made of all of the descriptors for each level of impairment. An assessment starts by considering descriptors for 0 points and, if a person has more than 'no functional impact', the descriptors for 5 points are then considered, and so on for the descriptors for higher impairment levels. When it is determined that the person meets all the required descriptors for a certain impairment rating level, but does not meet all the required descriptors for the next impairment rating level, the appropriate impairment rating applicable to the person's circumstances will be the lower of those 2 impairment ratings (that is, the rating at which all the required descriptors are met).

Note 1: Individual descriptors or their parts must not be applied in isolation from one another.

In determining whether the required descriptors for a specific impairment level are met or not, ALL the descriptors for that level must be considered and applied as set out in the descriptor. NO descriptors or their parts are to be disregarded.

Note 2: The descriptors must be applied sequentially to allocate an impairment rating - the incremental hierarchy of descriptors MUST NOT be ignored. As mentioned above, the assessment process involves applying the 0-point descriptors first and continuing to apply the descriptors for higher impairment levels, until all the required descriptors for a certain impairment rating level are met.

Note 3: If the person's impairment does not meet all the required descriptors for a certain impairment level, the person's impairment cannot be rated at that or any higher level.

Explanation: Where a person meets the required descriptors for 10 points but does not meet all the required descriptors for 20 points, the correct impairment rating is 10 points. Their impairment CANNOT be regarded as severe or extreme and neither 20 nor 30 points can be allocated.

In establishing which descriptor in the hierarchy is appropriate in a person's circumstances, that is whether the impairment has no, mild, moderate, severe or extreme functional impact, all the descriptors for each impairment rating level in Table 3 should be read as a whole and compared before an appropriate impairment rating is assigned. Individual descriptors or their parts are not to be applied in isolation from one another.

As is the case in applying the other Impairment Tables, when determining which impairment rating applies to a person under Table 3, the rating that best describes the person's abilities or difficulties must be applied. In determining which impairment rating applies to a person, the descriptor points under a specific impairment level must be considered and applied as set out in the descriptor. ALL the points in the descriptor must be considered. NO descriptor points or their parts are to be disregarded.

An impairment rating can only be assigned if ALL the descriptors for a specific impairment rating are met. For example, if a person meets all the descriptors for 10 points and also meets some but not all descriptors for 20 points, an impairment rating of 20 points cannot be assigned and the correct impairment rating is 10 points.

Determination of the descriptor that best fits the person's impairment level must be based on the available medical evidence including the person's medical history, investigation results and clinical findings. A person's self-reported symptoms must not solely be relied on. It would be inappropriate to apply an impairment rating unless the person's self-reported functional impacts are consistent with and supported by the medical evidence available.

An activity listed under a descriptor is not taken as being able to be performed if it can only be performed once or rarely - the person needs to be able to usually perform such activity whenever they would normally attempt it.

For bilateral conditions where both lower limbs are affected, a single impairment rating under Table 3 should be determined based on the resulting combined functional impairment.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 section 11(2) In deciding whether an impairment has no, mild …, section 11(1)(c) if an impairment is considered as falling between …

Assessing impairment for persons using wheelchairs or walking aids

Where a person uses a wheelchair or certain walking aids (a quad stick, crutches or walking frame), the correct impairment rating depends, among other factors, upon the extent to which they are independent or dependent on other persons to mobilise while using a wheelchair or walking aids, and to transfer to and from a wheelchair. Within each of the 10- and 20-point impairment ratings, the descriptors state that this impairment rating level 'includes' a person who is either independent or who requires assistance to move around in or to transfer to and from a wheelchair (motorised or non-motorised), or to move around using walking aids.

For the purpose of Table 3, the term 'includes' means that a person who uses a wheelchair or certain walking aids may be included in a class or category of people who can be considered under the criteria for these impairment rating levels and MAY be eligible for either 10 or 20 points subject to their meeting ALL the requirements set out in the descriptors for these ratings. This term does not mean that a person who uses a wheelchair or walking aids automatically satisfies the overall requirements for 10 or 20 points solely because they meet the descriptor point (3) for a rating of 10 points or descriptor point (2) for a 20-point rating.

The use of wheelchairs or walking aids is not in itself an absolute indicator of the level of severity of a person's impairment when performing activities relating to their ability to move around. Individual circumstances do differ, including reasons for which people acquire such devices, frequency of use and the tasks for which they use them. A person may have a

number of devices or aids and use different devices or aids for different purposes or not used them at all for certain tasks. While the vast majority of people who use wheelchairs or walking aids do so upon recommendation by appropriate professionals, this equipment can nevertheless be purchased and used in Australia without prescription.

As outlined in 'Determining the level of functional impact - general rules' above, in deciding which impairment rating applies, ALL the descriptor points under a specific impairment rating level must be considered and NO descriptor points or their parts are to be disregarded. If the descriptors at point (3) in the 10-point rating and point (2) in the 20-point rating were read and applied in isolation, any person who uses a wheelchair or walking aids would qualify for at least 10 points under Table 3. This is not consistent with the policy intent.

The policy intent is that a person is not to be automatically allocated an impairment rating of 10 or 20 points solely on the basis that they use certain aids or equipment. The criteria in the descriptor point (3) for a rating of 10 points and in the descriptor point (2) for a 20-point rating are not stand alone and cannot be applied in isolation from the other requirements for these ratings. This intent is reflected in the assessment rule in the Impairment Tables discussed above which stipulates that a person can only be allocated a specific impairment rating if ALL the descriptors for that impairment level are met.

0-point impairment rating level

The 0-point descriptor specifies that there is no functional impact on activities requiring the use of the lower limbs. The person can carry out all activities in descriptor (1).

5-point impairment rating level

The 5-point descriptor requires that for this impairment rating to be assigned to a person, the person must have SOME DIFFICULTY with at least one of the activities in descriptor points (1)(a), (1)(b) or (1)(c) AND also at least one of the descriptor points (2)(a) or (2)(b).

If the person does not meet at least one descriptor point in one or both descriptor points (1) or (2), they cannot be allocated 5 points and the correct impairment rating is 0 points.

10-point impairment rating level

Consistent with the rules outlined above, in deciding whether an impairment of 10 points applies to a person, sufficient applicable descriptors under the 10-point impairment rating level must be considered and applied.

The 10-point descriptor requires that any person considered for this rating must be UNABLE to perform AT LEAST ONE of the activities in descriptor points (1) AND also satisfy descriptor point (2).

Example 1: A 45 year old man had a left below knee amputation 4 years ago as a result of injuries sustained in an industrial accident. The condition is fully diagnosed, fully treated and fully stabilised.

The man has been using a lower limb prosthesis. He has some difficulty climbing stairs but can otherwise mobilise effectively when using his prosthesis.

He needs to attend frequent and regular medical appointments. The man can walk to these appointments (when using his prosthesis) but usually develops some discomfort and low-grade pain after walking for some time. To avoid the discomfort and pain, he has decided to purchase a wheelchair and use it whenever he goes to the clinic. He moves around independently when using his wheelchair and can independently transfer to and from it.

As this man meets descriptor points (1)(c) and (2)(b) for 5 points under Table 3, the correct impairment rating is 5 points and no higher rating under this Table can be assigned. It would be inappropriate to allocate a rating of 10 points in such circumstances solely on the basis that this man 'meets' the requirements set out in descriptor point (3)(a) under the 10-point impairment rating level. This is consistent with the object of the Impairment Tables being to assess a person's impairment on the basis of what the person can, or could do, not on the basis of what the person chooses to do.

Example 2: A 50 year old woman has difficulties mobilising due to the effects of arthritis affecting joints in her lower limbs. The condition is fully diagnosed, fully treated and fully stabilised.

The woman uses a wheelchair. She usually uses a self-propelled wheelchair to move for short distances. She is able to transfer to and from this wheelchair and to mobilise independently using it. However, for long distances the woman uses a mobility scooter to avoid fatigue. She can independently transfer to and from her scooter and does not require assistance from another person to use a toilet.

As this woman does not require assistance from another person to transfer or to mobilise in a wheelchair, she does not qualify for 20 points under Table 3. She meets descriptor points (1)(a), (2) and (3)(a) for a 10-point rating. The correct impairment rating is therefore 10 points.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 section (6)(1) The impairment of a person must be assessed …

20-point impairment rating level

Consistent with the rules outlined above, in deciding whether an impairment rating of 20 points applies to a person, ALL the descriptor points under the 20-point impairment rating level must be considered and applied.

The 20-point descriptor requires that any person considered for this rating must be UNABLE to perform ALL of the activities set out in descriptor point 1(a) and 1(b).

Example: A 25 year old man had a car accident several years ago and sustained crush injuries to his legs. He uses a wheelchair to get around but finds it very difficult to go far without stopping to rest or getting assistance from another person. He also requires assistance from another person to use any form of public transport and to get in and out of his wheelchair and to perform some of his personal care needs, including using a toilet.

The condition is fully diagnosed, treated and stabilised and under Table 3, the man would receive an impairment rating of 20 points due to the severe impact his condition has on his ability to function. Under the 20-point descriptor the man would meet all points under (1)(a), (b) and (2)(a).

30-point impairment rating level

The 30-point descriptor states the person is unable to mobilise independently. To meet this descriptor the person would be completely unable to mobilise at all without assistance from another person. In comparison, someone who has some ability to mobilise very short distances without assistance (such as around the home) but is unable to do the activities listed in the 20-point descriptor points (1)(a)(i), (1)(a)(ii) or (1)(a)(iii) and requires assistance to use public transport (descriptor point (1)(b)) would meet the 20-point descriptor.

Impact of pain

In determining the functional impact on activities under Table 3, consideration should be given to the impact of pain on the person's ability to undertake these activities. For example, a person may have difficulty using their lower limbs other than for very short periods due to the pain they experience on doing so.

For more information about assessing pain, please refer to 3.6.3.02 'Assessing functional impact of chronic pain'.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 section 6(9) Assessing functional impact of pain

Some conditions causing impairment commonly assessed using Table 3

These include but are not limited to:

- lower limb musculoskeletal conditions including specific degenerative joint disease (osteoarthritis)
- other permanent forms of arthritis
- neurological conditions including peripheral neuropathy and strokes or cerebrovascular accidents (CVAs) causing paralysis or loss of strength or sensation
- cerebral palsy or other condition affecting lower limb coordination
- inflammation or injury of the muscles or tendons of the lower limbs
- lower limb amputations or absence of whole or part of lower limb
- long-term effects of musculoskeletal injuries
- some permanent vascular conditions (for example, peripheral vascular disease, varicose veins).

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 3 - Lower Limb Function

Impairments that should not be assessed using Table 3

Difficulties mobilising independently due to severe visual impairment should not be assessed under this Table if there are no inherent medical conditions affecting the lower limbs. Such impairment should be assessed under Table 12 - Visual Function.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 3 - Lower Limb Function, Table 4 - Spinal Function, Table 12 - Visual Function

3.6.3.40 Guidelines to Table 4 - Spinal Function

Summary

Table 4 is used where a person has a functional impairment when performing activities involving spinal function. Spinal function involves bending or turning the back, trunk or neck.

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. This includes a general practitioner, an orthopaedic surgeon, a rheumatologist, a rehabilitation physician, or other relevant specialist.

A PERSON'S SELF-REPORTED SYMPTOMS MUST NOT BE SOLELY RELIED UPON in determining functional impacts of the person's permanent condition (impairment). There must be corroborating medical evidence of the person's impairment.

Double-counting of impairments must be avoided (3.6.3.06). The Table 4 descriptors are to be met only from spinal conditions.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 4 - Spinal Function

Interpretation & application of relevant terms

The 10-point descriptor in Table 4 uses the term 'assistance'. Assistance means assistance from another person, rather than any aids or equipment the person has and usually uses (refer to 3.6.3.05 'Use of aids, equipment & assistive technology').

Explanation: This interpretation of the term 'assistance' has been adopted in a number of decisions by the AAT (General Division), including in *Summers and Secretary, Department of Social Services* (2014) AATA 165.

Determining the level of functional impact - general rules

As in the other Tables, the descriptors in Table 4 are interlinked in that they follow a consistent incremental hierarchy, which in this Table is expressed, among other things, by the use of terms indicating increasing levels of difficulty in performing certain activities (for example, without difficulty, some difficulty, difficulty, severe difficulty, unable to).

Consequently, as is the case in applying any other Table, in establishing which descriptor in Table 4 is appropriate to a person's circumstances, that is whether the impairment has no (0 points), mild (5 points), moderate (10 points), severe (20 points) or extreme (30 points) functional impact, an assessment process under this Table should follow the same incremental path.

The structure of the Tables requires that, in assessing the level of functional impact, a comparison must be made of all the descriptors for each level of impairment. An assessment starts by considering the descriptors for 0 points, and if a person has more than 'no functional impact', the descriptors for 5 points are then considered, and so on for the descriptors for higher impairment levels. When it is determined that the person meets all the required descriptors for a certain impairment rating level, but does not meet all the required descriptors for the next impairment rating level, the appropriate impairment rating applicable to the person's circumstances will be the lower of those 2 impairment ratings (that is, the rating at which all the required descriptors are met).

Note: Individual descriptors or their parts must not be applied in isolation from one another.

In determining whether the required descriptors for a specific impairment level are met or not, ALL the descriptors for that level must be considered and applied as set out in the descriptor. NO descriptors or their parts are to be disregarded however, one of several descriptor points may be sufficient for that rating when the word 'or' links the descriptors.

Note: If the person's impairment does not meet sufficient required descriptors for a certain impairment level, the person's impairment cannot be rated at that level or at any higher level.

Explanation: Where a person meets the required descriptors for 5 points but does not meet sufficient required descriptors for 10 points, the correct impairment rating is 5 points. Their impairment CANNOT be assessed as moderate, severe or extreme and therefore neither 10, 20 nor 30 points can be allocated.

Determination of the descriptor that best fits the person's impairment level must be based on the available medical evidence including the person's medical history, investigation results and clinical findings. A person's self-reported symptoms must not solely be relied on. It would be inappropriate to apply an impairment rating based solely on a person's self-reported functional capacity if this level of functional impairment is not consistent with the medical evidence available.

In determining the level of functional impact, care should be taken to distinguish between activities that the person does not do as opposed to activities that they have difficulty performing because of their impairment.

When determining whether the person is able to undertake the activities listed under the descriptors, consideration must be given to whether the person suffers pain on undertaking the activities. For example, under the 20-point descriptor, if a person is able to remain seated for 10 minutes but suffers significant pain on doing so, it should be considered that the person is therefore unable to remain seated for at least 10 minutes.

Chronic pain could be either a symptom of a permanent condition impacting spinal function or a permanent condition itself. When assessing chronic pain under Table 4, please refer to 3.6.3.02 'Assessing functional impact of chronic pain'.

Consideration must also be given to whether the person can undertake the activity on a repetitive or habitual basis (refer to 3.6.3.08 'Descriptors involving performing activities'). For example, under the 20-point descriptor, if a person is able to bend forward to pick up a light object from a desk or table but after doing this once has to rest their back and is unable to bend forward for the remainder of the day it should be considered that the person is therefore unable to do this activity.

An activity listed under a descriptor is not taken to have been performed if it can only be done once or rarely - the person needs to be able to usually perform such activity whenever they would normally attempt it.

0-point impairment rating level

The 0-point descriptor specifies the person has no functional impact on activities involving spinal function.

5-point impairment rating level

The 5-point descriptor requires that for this impairment rating to be assigned to a person, the person must meet at least one of the descriptor points (1)(a), (1)(b) or (1)(c).

If the person does not meet at least one descriptor point, they cannot be allocated 5 points and the correct impairment rating is 0 points.

10-point impairment rating level

The 10-point descriptor requires that for this impairment rating to be assigned to a person, The person is able to sit in or drive a car for at least 30 minutes and one of either (a), (b), (c) or (d) must apply.

In relation to descriptor (1) (a), the reference to 'sustain overhead activities' is intended to measure the level of difficulty the person has in looking up, NOT reaching up (for example, to carry out a task such as hanging out washing or counting items on an overhead shelf, which requires the person to look upwards for a period of time). That is, it is a measure of spinal function, NOT upper limb function.

20-point impairment rating level

The 20-point descriptor requires that for this impairment rating to be assigned to a person, the person must be unable to do at least one of the activities listed at (1)(a), (1)(b), (1)(c), or (1)(d). The person must not be able to perform the listed activity at all, rather than not be able to sustain the activity as required in the 10 point rating level.

In relation to descriptor (1) (b) the person must EITHER be unable to turn their head at all without moving their trunk OR be unable to bend their neck at all without moving their trunk.

In relation to descriptor (1) (c) a light object refers to any object that would weigh no more than 1 kg.

30-point impairment rating level

The 30-point descriptor requires that for this impairment rating to be assigned to a person, the person must meet at least one of the descriptor points (1)(a) or (1)(b).

The person must be completely unable to perform activities involving spinal function, to undertake the most basic of daily activities.

Some conditions causing impairment commonly assessed using Table 4

These include but are not limited to:

- spinal cord injury
- spinal stenosis
- cervical spondylosis and radiculopathy
- lumbar radiculopathy
- herniated or ruptured spinal disc
- spinal cord tumours
- arthritis or osteoporosis involving the spine.

Example: A 50 year old woman has been diagnosed with spondylosis and spinal cord tumour in her lumbar spine. Both these conditions result in functional impairment when the woman performs activities involving her spine. The woman takes regular medication to alleviate her symptoms but even with medication she continues to experience significant pain when undertaking daily activities. Her specialist has recommended spinal surgery but due to the high risks involved in this procedure the woman has decided not to undertake the surgery. This woman is unable to bend forward to pick up a light object such as a cup of coffee, placed at knee height without experiencing significant pain in her lower back. While she can remain seated for more than 30 minutes, she cannot sit for extended periods, such as a long car journey without a break to stand and move around to relieve the pressure on her lower spine.

The conditions are considered fully diagnosed, treated and stabilised. As both conditions cause the same functional impact a single impairment rating is given under Table 4, of 10 points, due to the moderate overall functional impact these conditions have on her ability to function. Under the 10-point descriptor the woman would meet (1)(c).

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 4 - Spinal Function

Impairments that should not be assessed using Table 4

Impairment, such as restrictions on overhead tasks, resulting from a shoulder or other upper limb condition should be rated under Table 2. Similarly, impairment, such as restrictions on bending tasks, resulting from a lower limb condition should be rated under Table 3.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 2 - Upper Limb Function, Table 3 - Lower Limb Function, Table 4 - Spinal Function

3.6.3.50 Guidelines to Table 5 - Mental Health Function

Summary

Table 5 is used where a person has a functional impairment due to a mental health condition. Recurring episodes of mental health impairment should also be assessed under Table 5.

The diagnosis of the medical condition causing the impairment must be made by an appropriately qualified medical practitioner, such as a psychiatrist.

Where this is not a psychiatrist, the diagnosis must be made by an appropriately qualified medical practitioner with evidence from a clinical psychologist. A PERSON'S SELF-REPORTED SYMPTOMS MUST NOT BE SOLELY RELIED UPON in determining functional impacts of the person's permanent condition (impairment). There must be corroborating medical evidence of the person's impairment.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 5 - Mental Health Function

Interpretation & application of relevant terms

A clinical psychologist is a psychologist registered with the Australian Health Practitioner Regulation Agency who holds an area of practice endorsement in clinical psychology as confirmed by the Psychology Board of Australia.

Corroborating evidence for the claim can include professional or clinical reports. It can also include advice from the treating practitioner that a clinical psychologist or a psychiatrist who made or confirmed the diagnosis or provided evidence in support of the diagnosis has seen the person. This advice either can be in writing or verbally provided to the assessor. The advice is required to include the name of the practitioner and must be documented and added to the person's Medical Information File.

In general, a psychiatry or clinical psychology registrar can be found to satisfy the requirements for diagnosis by an appropriately qualified medical practitioner, so long as

they are clinically supervised by a fully qualified psychiatrist or clinical psychologist, respectively.

Example: A 52-year-old woman has been treated by her GP for mild depression and anxiety for many years. 12 months before she applies for DSP, she experiences a significant life event. Her depression worsens over the next 6 months, and she is reluctant to leave the house, has lost 5 kg, wakes at 4 am each morning, feels hopeless about the future and cannot concentrate on the TV for more than ½ hour. Her GP commences an antidepressant medication, but there is no improvement within the following 6 weeks. Her GP is concerned that she is continuing to lose weight and is expressing thoughts that her family would be better off without her, and refers her to the local community mental health service. She is seen there by a psychiatric registrar who diagnoses major depressive disorder. The registrar writes a letter to the GP, which indicates this diagnosis and provides a treatment plan. All psychiatric registrars have regular supervision with a consultant psychiatrist and discuss their patients with the psychiatrist. As the psychiatric registrar is under supervision by a psychiatrist this condition can be rated as fully diagnosed.

Example: A 26-year-old woman has a long history of social anxiety, which commenced during adolescence. She left school at age 16 years, as she found social interactions there difficult and reported being bullied. She was seen by a registered psychologist from the ages of 16 to 18 years and had appropriate psychological therapy. She improved following this treatment and was able to complete a 2-year TAFE diploma course. She worked part-time for the next 12 months. However, she had a relapse of her social anxiety when her grandmother died, as her grandmother had been an important support for her. She ceased work at that point. She attended her GP for the next 4 years and was prescribed antidepressant medication. Even though psychological therapies had been helpful previously, she was reluctant to try this again, as it meant leaving her home. She avoided leaving the house unless someone else came with her; she avoided eating in public and had to be persuaded to answer the telephone. She lived with her parents who did her shopping and provided meals. Her GP encouraged her to reconsider psychological therapies and she eventually agreed to attend a psychologist. The GP referral letter indicated a diagnosis of severe social anxiety. A clinical psychology registrar who saw her confirmed the diagnosis. Clinical psychology registrars are registered psychologists who are in training to become clinical psychologists and are required to have regular supervision from a registered clinical psychologist. This clinical psychology registrar discussed this case with their supervisor who agreed with the diagnosis of severe social anxiety, as indicated by the patient's GP, so the condition of social anxiety can be rated as fully diagnosed for the purposes of Table 5.

Similar supervisory arrangements may also apply to other non-psychiatrist medical practitioners, for example visiting medical officers and overseas-trained practitioners. Complex decisions may be referred to the Health Professional Advisory Unit (HPAU).

For young people applying for DSP between the ages of 16 and 18 years with a mental health condition having onset in childhood, diagnosis from a paediatrician may be regarded as satisfying these requirements in some instances. This would generally apply to conditions such as Attention Deficit Hyperactivity Disorder (ADHD). Conditions such as severe depression, psychotic disorders, or severe eating disorders would usually be diagnosed (and treated) by a child psychiatrist or clinical psychologist.

The diagnosis made by a paediatrician must be relevant at the time of the DSP claim for this to apply. Where the diagnosis of a paediatrician continues to be relevant for young people over the age of 18 years at the time of applying for DSP, these requirements may be satisfied. This is to be determined on a case-by-case basis and a referral made to the HPAU.

Example: A man applies for DSP at the age of 20 years. He was diagnosed with ADHD by a paediatrician when he was 8 years old when he was prescribed appropriate stimulant medication. His paediatrician last saw him at age 17 years. The man has corroborating evidence of this diagnosis from the paediatrician. The available medical evidence indicates he has a long-standing presentation of predominantly behavioural difficulties including some difficulties with task completion, hyperactive behaviour, irritability and associated anxiety. The evidence also outlines a history of appropriate past, present and future treatment details. The case was referred to the HPAU, and although the diagnosis was made more than 2 years ago and the person is now over age 18 years, this condition continues to impact the person so the diagnosis from the paediatrician was still considered relevant.

The HPAU confirmed that the diagnosis requirements were met and the condition was considered fully diagnosed, treated and stabilised. Under Table 5-Mental Health Function an impairment rating of 5 points from the mental health impairment ONLY (avoiding double counting on Table 7) was allocated, due to the mild impact the condition has on his ability to function. Under the 5-point descriptor, the man would meet (1) (c), (d), (e) and (f).

Vulnerable people

There are some rare instances where it may not be possible for diagnosis of a mental health condition to be made as outlined above. Where the person lacks sufficient insight into their mental health condition or the person lives in a remote community with little or no access to

health services, a Services Australia psychologist may make a provisional diagnosis of a mental health condition.

However, in all cases where the above applies, the evidence/case history should be referred to the HPAU so consideration can be given to other medical factors that may be impacting on the person.

Note: This policy applies only to vulnerable people with mental health conditions, as assessed under Table 5. People who present with an acquired brain injury or substance use related impairment need to be assessed under the appropriate tables with the diagnosis provided by an appropriately qualified medical practitioner.

This policy is not designed to be used for people who can readily access health services and for whom a clinical psychological or psychiatric assessment has simply not occurred. In these instances, other avenues for obtaining this assessment exist.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 5 - Mental Health Function, Table 6 - Functioning relating to Alcohol, Drug, and Other Substance Use, Table 7 - Brain Function

Use of specialist assessments

In very limited circumstances, an external specialist assessment by a clinical psychologist or psychiatrist may need to be considered where a person is unable to access an assessment via other means. Where a specialist assessment occurs, consideration should be given by the clinical psychologist or psychiatrist to the diagnosis, reasonable treatment options, likely response to treatment, functional impact and the likelihood of significant improvement within 2 years.

Where a specialist assessment is being undertaken and the formal diagnosis is being made for the first time, consideration should be given as to whether the condition is also fully diagnosed, treated and stabilised.

Example: Joe lives in an isolated community and has experienced severe depression with suicidal ideation for a number of years. He has been treated by his GP with medication for several years and has seen a psychologist for cognitive behavioural therapy. The diagnosis has not been made by a psychiatrist or with the assistance of a clinical psychologist. As Joe lives in an isolated community, a specialist assessment was undertaken, which concurred with the GP diagnosis of major depressive disorder. Joe's condition of major depressive

disorder was regarded as unlikely to significantly improve with further treatment due to the limited response to prolonged and reasonable treatment undertaken to date. As such, he was found to be fully diagnosed, treated and stabilised.

Regardless of the number of mental health diagnoses a person may have, only one rating is to be applied under Table 5 to reflect the overall impairment to mental health function.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 5 - Mental Health Function

Determining the level of functional impact - general rules

When determining which impairment rating applies to a person the rating that best describes the person's abilities or difficulties must be applied.

Each descriptor in Table 5 contains the same domains of mental health impairment:

- self-care and independent living
- social/recreational activities and travel
- interpersonal relationships
- concentration and task completion
- behaviour, planning and decision-making, and
- work/training capacity.

Table 5 has 6 descriptor points at each impairment level. Where the descriptor refers to 'most of the following', most is taken to be at least 4.

As in the other tables, the descriptors in Table 5 are interlinked in that they follow a consistent incremental hierarchy, which in this Table is expressed, among other things, by the use of terms indicating increasing levels of difficulty in performing certain activities (i.e. no, mild, moderate, severe, or extreme difficulties). Consequently, as is the case in applying any other table, in establishing whether the impairment causes no (0 points), mild (5 points), moderate (10 points), severe (20 points) or extreme (30 points) functional impact, all the descriptors for each impairment rating level in Table 5 should be read as a whole and compared so the descriptors, their relativity and hierarchy in this Table are understood.

The structure of the tables requires that, in assessing the level of functional impact, a comparison must be made of all the descriptors for each level of impairment. An

assessment starts by considering the descriptors for 0 points, and if a person has more than 'no functional impact', the descriptors for 5 points are then considered, and so on for the descriptors for higher impairment levels. When it is determined that the person meets all the required descriptors for a certain impairment rating level, but does not meet all the required descriptors for the next impairment rating level, the appropriate impairment rating applicable to the person's circumstances will be the lower of those 2 impairment ratings (i.e. the rating at which all the required descriptors are met).

Note 1: Individual descriptors or their parts must not be applied in isolation from one another.

In determining whether the required descriptors for a specific impairment level are met or not, ALL the descriptors for that level must be considered and applied as set out in the descriptor. NO descriptors or their parts are to be disregarded.

Note 2: It is inappropriate to allocate an impairment rating without applying the descriptors sequentially - the incremental hierarchy of descriptors must not be ignored. As mentioned above, the assessment process involves applying the 0-point descriptors first and continuing to apply the descriptors for higher impairment levels, until all the required descriptors for a certain impairment rating level are met.

Note 3: If a person's impairment does not meet sufficient required descriptors for a certain impairment level, the person's impairment cannot be rated at that level or at any higher level.

Explanation: Where a person meets the required descriptors for 10 points but does not meet all the required descriptors for 20 points or 30 points, the correct impairment rating is 10 points. Their impairment CANNOT be regarded as severe or extreme and neither 20 nor 30 points can be allocated.

Each descriptor contains examples of mental health impairment for each domain. The examples reflect a person's expected level of severity of impairment at each rating level. If a similar example applies to a person but is not specifically listed in the descriptor, the person must have an equivalent level of severity of impairment in order for the descriptor to be met.

The examples referred to in Table 5 are not prescriptive or exhaustive. The examples are not to be treated as a further descriptor. Rather, examples are suggesting one possible impact from a set of possible impacts, which indicate the level of impairment required to meet the descriptor. A person may have impairment in undertaking other activities not listed in examples, to an equivalent degree.

Determination of the descriptor that best fits a person's impairment level must be based on the available medical evidence including the person's medical history, investigation results and clinical findings. It would be inappropriate to apply an impairment rating based solely on a person's self-reported functional capacity if this level of functional impairment is not consistent with the medical evidence available.

A person with a mental health condition may not have sufficient self-awareness of their mental health impairment and may not be able to accurately describe its effects. This should be kept in mind when discussing issues with the person and reading the supporting evidence. If required, interviews with those providing care or support to the person may be considered as corroborating evidence.

It is particularly important in the assessment of people with mental health conditions that a person's presentation on the day of the assessment should not solely be relied upon. In some mental health conditions, the person may have insufficient insight into their condition and minimise its impacts.

For mental health conditions which are episodic in nature and fluctuate in severity over time (e.g. bipolar disorder), the severity, duration and frequency of the episodes or fluctuations must be taken into account when determining the rating that best reflects the person's overall functional ability (refer to 3.6.3.08 'Descriptors involving performing activities').

In determining the work-related impairment for such fluctuating conditions, consideration should be given to the impact on a person's ability to reliably sustain work over a period of 26 weeks without excessive leave or work absences. Sick leave or absences of one month or more taken in any 6-month period are considered excessive.

In determining whether the mental health disorder has been fully treated and stabilised, one should consider whether a person has received reasonable treatment and whether with or without such treatment, the person's level of function will improve within 2 years. If for example, specialist advice is that a person would benefit from treatment with long-term psychotherapy but that significant functional improvement is not expected to occur within the next 2 years, then the mental health impairment may be considered fully treated and stabilised and rated accordingly.

If reasonable treatment has not been undertaken, it should be determined whether a person has a medical or other compelling reason for not doing so. For example, a person may have a psychotic illness that impairs their insight and ability to make sound judgements and this may affect their compliance with treatment. As such, the person's mental health impairment could then be considered stable and permanent for DSP purposes if it is unlikely that any

significant improvement will occur within 2 years. However, if they retain sufficient insight and judgement and their decision to not undertake reasonable treatment is not due to a medical or other compelling reason, the condition cannot be regarded as fully treated and stabilised (refer to 3.6.3.02 'Assessing functional impact of chronic pain').

0-point impairment rating level

The 0-point descriptor requires that for this impairment rating to be applied, a person has NO functional impact on activities involving a mental health function, i.e. they can carry out 4 or more activities in descriptor (1).

5-point impairment rating level

The 5-point descriptor requires that for this impairment rating to be applied to a person, they must have MILD DIFFICULTY in performing MOST of the functions in descriptors 1(a), (b), (c), (d), (e) and (f).

10-point impairment rating level

The 10-point descriptor requires that for this impairment rating to be assigned to a person, there is a moderate functional impact on activities involving mental health function.

For this rating to be allocated to a person, they must have MODERATE DIFFICULTY in performing MOST of the descriptor points (1) (a), (b), (c), (d), (e) and (f).

20-point impairment rating level

The 20-point descriptor requires that for this impairment rating to be assigned to a person, there is a severe functional impact on activities involving mental health function.

For this rating to be allocated to a person, they must have SEVERE DIFFICULTY in performing MOST of the descriptor points (1) (a), (b), (c), (d), (e) and (f).

30-point impairment rating level

The 30-point descriptor requires that for this impairment rating to be assigned to a person, there is an extreme functional impact on activities involving mental health function.

For this rating to be allocated to a person, they must have EXTREME DIFFICULTY in performing MOST of the descriptor points (1) (a), (b), (c), (d), (e) and (f).

Some conditions causing impairment commonly assessed using Table 5

These include but are not limited to:

- chronic depressive/anxiety disorders
- schizophrenia
- bipolar disorder
- feeding and eating disorders
- somatic symptom disorders
- personality disorders
- post-traumatic stress disorder
- attention deficit hyperactivity disorder (ADHD) manifesting with predominantly behavioural problems.

Example: A 39-year-old woman has a diagnosed condition of bipolar disorder. The condition was diagnosed by a clinical psychologist. She has undergone various treatment options for this condition, under the guidance of her treating psychiatrist. She regularly experiences fluctuations in her condition. Despite these fluctuations, the corroborating evidence provided by the treating psychiatrist indicates that her condition can be considered stabilised, due to the nature of this condition. She experiences periods of mania followed by periods of deep, prolonged and profound depression. Between these episodes, she is often symptom free. On average, she experiences periods of depressed mood every 3 months and is affected for roughly 1 month. Her periods of mania last a few days.

During the assessment for DSP, the woman presented as highly functioning and confident when communicating. However, the medical evidence outlines that she experiences regular periods of depression where she withdraws from social situations and has very limited contact with family or friends. During these times, her mother visits her every day, as she is often unable to take care of her personal hygiene or cook and clean for herself. During these depressive periods, she is unable to drive as she experiences slowed reaction times. When she is experiencing mania symptoms, she has increased energy and over activity and is often unable to sleep. She is unable to sustain a job for a prolonged period due to her mental health condition, as she has frequent fluctuations in her mood.

The condition is considered fully diagnosed, treated and stabilised and under Table 5, this woman would receive an impairment rating of 20 points due to the severe impact this condition has on her ability to function. The rating has taken into consideration the severity,

duration and frequency of fluctuating impairments to arrive at a rating that reflects the overall functional impact of those impairments. Under the 20-point descriptor the woman would meet (1) (a), (c), (d) and (f).

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 5 - Mental Health Function

Policy reference: SS Guide 3.6.1.67 Sustainability of Work & DSP

Impairments that should not be assessed using Table 5

Lack of personal motivation or apathy that is not considered to be due to a mental health condition.

Not all conditions listed in *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* should be rated under Table 5. For example, narcolepsy and dementia are listed in DSM-5 as mental disorders, however, they are better rated under Table 7 - Brain Function.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 5 - Mental Health Function

3.6.3.60 Guidelines to Table 6 - Functioning related to Alcohol, Drug & Other Substance Use

Summary

Table 6 is used where a person has a functional impairment due to excessive use of alcohol, drugs or other harmful substances or the misuse of prescription drugs.

Excessive use means problematic use that results in damage to a person's mental or physical health.

Harmful substances are those which on taking them result in damage to a person's mental or physical health for example, glue or petrol sniffing.

The problematic use of prescription drugs in a manner other than prescribed by a medical practitioner, and the problematic use has resulted in a permanent functional impairment.

The essential feature of a substance use disorder is a cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.

An appropriately qualified medical practitioner must make the diagnosis of the condition. This includes a GP or medical specialist such as an addiction medicine specialist or psychiatrist with experience in diagnosis of substance use disorders.

Table 6 applies only to people who have current, continuing alcohol, drug or other harmful substance use disorders and those in active treatment.

People who suffer from long-term impairment that has resulted from previous alcohol, drug or other substance use but who no longer have an active substance use disorder and are no longer receiving active treatment must be assessed under the other relevant tables and not Table 6. For example, if the person has a resulting brain injury, they should be assessed under Table 7 - Brain Function. Similarly, if a person had resulting chronic liver disease they should be assessed using Table 10 - Digestive and Reproductive Function.

A PERSON'S SELF-REPORTED SYMPTOMS MUST NOT BE SOLELY RELIED UPON in determining functional impacts of the person's permanent condition (impairment). There must be corroborating medical evidence of the person's impairment.

Regardless of the number of substances the person is dependent on only one rating is to be assigned under Table 6 to reflect the overall functional impairment.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 6 - Functioning related to Alcohol, Drug and Other Substance Use, Table 7 - Brain Function, Table 10 - Digestive and Reproductive Function

Determining the level of functional impact

When determining which impairment rating applies to a person the rating that best describes the person's abilities or difficulties must be applied. In applying the descriptors in Table 6, each descriptor sets out how the points within it are to apply.

For example, the 5-point descriptor states 'at least one of' the following descriptor points applies. The 10-point descriptor states 'most of' the following apply. It also applies to people receiving treatment who are in sustained remission and are able to complete most activities of daily living. Under the 20 and 30-point descriptors, 'most of' the descriptors must apply.

Where the descriptor refers to most of the following, most is taken to be more than half of the number of descriptor points for that impairment rating. For example, at the 10-point level, 'most' would be taken as at least 3 out of 5 descriptors applying and so on for the 20 and 30-point descriptors.

The structure of the tables requires that, in assessing the level of functional impact, a comparison must be made of all the descriptors for each level of impairment. An assessment starts by considering the descriptors for 0 points, and if a person has more than 'no functional impact', the descriptors for 5 points are then considered, and so on for the descriptors for higher impairment levels. When it is determined that the person meets all the required descriptors for a certain impairment rating level, but does not meet all the required descriptors for the next impairment rating level, the appropriate impairment rating applicable to the person's circumstances will be the lower of those 2 impairment ratings (i.e. the rating at which all the required descriptors are met).

Note: Individual descriptors or their parts must not be applied in isolation from one another.

In determining whether the required descriptors for a specific impairment level are met or not, ALL the descriptors for that level must be considered and applied as set out in the descriptor. NO descriptors or their parts are to be disregarded. One of several descriptor points may be sufficient for that rating when the word 'or' links the descriptors.

Explanation: Where a person meets the required descriptors for 5 points but does not meet sufficient required descriptors for 10 points or higher, the correct impairment rating is 5 points. Their impairment CANNOT be assessed as moderate, severe or extreme and 10, 20 or 30 points cannot be allocated.

Determination of the descriptor that best fits the person's impairment level must be based on the available medical evidence including the person's medical history, investigation results and clinical findings. A person's self-reported symptoms MUST NOT SOLELY BE RELIED ON. It would be inappropriate to apply an impairment rating based solely on a person's self-reported functional capacity if the level of functional impairment is not consistent with the medical evidence available.

High levels of intake will increase health risks but the use of alcohol, drugs or other harmful substances in itself does not necessarily indicate significant and permanent functional impairment. For example, a person with a high level of alcohol intake may not have developed any medical complications or experienced significant problems in how they function. Each person should be assessed on an individual basis, as the level of impairment cannot be predicted from the reported level of drug or alcohol use alone. It should not be assumed, for example, that a person on a methadone program is severely functionally impaired and has no work capacity.

If reasonable treatment has not been undertaken, it should be considered whether the person has a medical or other compelling reason for not doing so. For example, due to their condition, the person may have insufficient insight and ability to make sound judgements and this may therefore affect their compliance with recommended treatment. As such a person's impairment could then be considered fully stabilised and permanent for DSP purposes if it is unlikely to improve significantly within 2 years.

However, in cases where the person is considered to retain sufficient insight and judgement and their decision not to undertake reasonable treatment is not due to a medical or other compelling reason, the condition cannot be regarded as fully treated and stabilised even if significant improvement could be expected to occur with reasonable treatment.

When determining a person's limitations in relation to conducting 'work tasks', this is taken to refer to any job available in Australia.

0-point impairment rating level

The 0-point descriptor specifies that the person has NO functional impact from alcohol, drugs or other harmful substance use. The person can carry out all activities in descriptor (1).

5-point impairment rating level

The 5-point descriptor specifies that there is a MILD functional impact from alcohol, drugs or other harmful substance use.

For this rating to be assigned to a person, AT LEAST ONE of the descriptors (1)(a), (b) and (c) must apply. Additionally, if point (c) were to apply, a person would be expected to be able to sustain employment or training activities without excessive absences (i.e. no more than approximately 30 days total absence across a 6-month period.)

10-point impairment rating level

The 10-point descriptor specifies that there is a MODERATE functional impact from alcohol, drugs or other harmful substance use.

For this rating to be assigned to a person, MOST of the descriptors (1)(a), (b), (c), (d) and (e) must apply.

The 10-point descriptor also states that this rating level includes a person in receipt of treatment and in sustained remission who is able to complete most activities of daily living. To meet the 10-point descriptor, if a person meets (2) there would also need to be a moderate functional impact from harmful substance use or from the side effects of opiate replacement therapy treatment such as methadone and the person would also need to meet descriptor (1).

20-point impairment rating level

The 20-point descriptor specifies that there is a SEVERE functional impact from alcohol, drugs or other harmful substance use. For this rating to be assigned to a person, most of the descriptors (1) (a), (b), (c), (d), and (e) must apply.

30-point impairment rating level

The 30-point descriptor specifies that there is an EXTREME functional impact from alcohol, drugs or other harmful substance use. For this rating to be assigned to a person, MOST of the descriptors (1) (a), (b), (c), and (d) must apply.

Some conditions causing impairment commonly assessed using Table 6

These include but are not limited to:

- alcohol use disorder
- various illicit drug use disorders and
- various inhalant use disorders
- various prescription drug use disorders.

Example: A 35 year old man is diagnosed with alcohol use disorder. The medical evidence shows he has participated in rehabilitation treatments over the last 5 years but continues to be alcohol dependent. He uses alcohol every day and is often unable to complete his daily activities such as preparing meals or showering due to the effects of alcohol. His relationships with family members are often strained and at times family members are not on speaking terms with him. His work attendance records show that he often does not attend work for 1 or 2 days within a fortnight, but this varies. In addition, he has undergone liver function tests that identified significantly impaired liver function. Under Table 6, this man would receive an impairment rating of 10 points due to the moderate impact his condition of alcohol dependence has on his ability to function. In this case, consideration should also be given to whether his liver condition is permanent and fully diagnosed, treated and stabilised and, if so, whether it receives an impairment rating under Table 10 - Digestive and Reproductive Function.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 6 - Functioning related to Alcohol, Drug and Other Substance Use, Table 10 - Digestive and Reproductive Function

Impairments that should not be assessed using Table 6

Long term impairments that result from alcohol, drug or other substance use, can include neurological or cognitive impairment, cirrhosis or other chronic liver disease, pancreatitis or other complications of end organ damage. To avoid double counting, these resulting conditions should be assessed under the appropriate table according to the area of function affected.

3.6.3.70 Guidelines to Table 7 - Brain Function

Summary

Table 7 is used to assess functional impairment related to neurological or cognitive function.

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. This includes a GP or medical specialists such as a neurologist, rehabilitation physician, or psychiatrist.

People with an Autism Spectrum Disorder (ASD), Foetal Alcohol Syndrome (FAS), or Foetal Alcohol Spectrum Disorder (FASD) can be assessed using Table 7. However, if they have a low intelligence quotient (IQ) of between 70 and 85 the person should be assessed under Table 9.

A person with cognitive impairment whose IQ is not most meaningfully summarised by a full scale IQ (for example, this could be due to a significant variation in their cognitive profile) may be assessed using Table 7.

The assessment of IQ can be complex. Assistance may be required in interpreting test results that are included in psychological, neuropsychological or educational reports. In such instances, consultation with a Services Australia psychologist, or the HPAU should be undertaken.

A PERSON'S SELF-REPORTED SYMPTOMS MUST NOT BE SOLELY RELIED UPON in determining functional impacts of the person's permanent condition (impairment). There must be corroborating medical evidence of the person's impairment.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 7 - Brain Function

Determining the level of functional impact - general rules

When determining which impairment rating applies to a person the rating that best describes the person's abilities or difficulties must be applied.

Each descriptor in Table 7 contains various domains of neurological or cognitive impairment including: memory, attention and concentration, problem solving, planning, decision making, comprehension, visuo-spatial function, behavioural regulation and self awareness.

In determining which descriptor applies to the person, at least one of the domains must apply to the person in line with the level of severity stated under (1) (i.e. no, mild, moderate, severe, extreme difficulties). Additionally, as stated under (1) the level of assistance and supervision a person requires must also be considered. Each descriptor contains examples of brain function for each domain. These examples are not prescriptive or exhaustive. The examples are not to be treated as a further descriptor. Rather, examples are suggesting one possible impact from a set of possible impacts, which indicate the level of impairment required to meet the descriptor. A person may have impairment in undertaking other activities not listed in examples, to an equivalent degree. The examples reflect a person's severity of impairment at each rating level. If a similar example applies to a person but is not specifically listed in the descriptor, the person must have an equivalent level of severity of impairment in order for the descriptor to be met.

The descriptors in Table 7 use the term 'assistance'. Assistance means assistance from another person, rather than any aids or equipment the person has and usually uses (refer to 3.6.3.05 'Use of aids, equipment & assistive technology').

A person's concentration, memory, or other aspects of cognitive function may be impacted by chronic pain or its treatment. Medications taken for chronic pain or other conditions can impact cognitive function. Where these impacts arise from a fully diagnosed, treated and stabilised condition or these impacts are due to side effects of treatment and are likely to persist for more than 2 years, consideration should be given to a rating under Table 7. Double-counting must be avoided.

When assessing the impact of chronic pain on cognitive function under Table 7, please refer to 3.6.3.02 'Assessing functional impact of chronic pain'.

The structure of the tables requires that, in assessing the level of functional impact, a comparison must be made of all the descriptors for each level of impairment. An assessment starts by considering the descriptors for 0 points, and if a person has more than 'no functional impact', the descriptors for 5 points are then considered, and so on for the descriptors for higher impairment levels. When it is determined that a person meets all the required descriptors for a certain impairment rating level, but does not meet all the required descriptors for the next impairment rating level, the appropriate impairment rating applicable

to a person's circumstances will be the lower of those 2 impairment ratings (i.e. the rating at which all the required descriptors are met).

Note: Individual descriptors or their parts must not be applied in isolation from one another.

In determining whether the required descriptors for a specific impairment level are met or not, ALL the descriptors for that level must be considered and applied as set out in the descriptor. NO descriptors or their parts are to be disregarded. One of several descriptor points may be sufficient for that rating when the word 'or' links the descriptors.

Note: If the person's impairment does not meet sufficient required descriptors for a certain impairment level, the person's impairment cannot be rated at that level or at any higher level.

Explanation: Where a person meets the required descriptors for 5 points but does not meet sufficient required descriptors for 10 points, the correct impairment rating is 5 points. Their impairment CANNOT be assessed as moderate, severe or extreme and neither 10, 20 nor 30 points can be allocated.

Determination of the descriptor that best fits the person's impairment level must be based on the available medical evidence including the person's medical history, investigation results and clinical findings. A person's self-reported symptoms MUST NOT BE SOLELY RELIED UPON. It would be inappropriate to apply an impairment rating based solely on a person's self-reported functional history if this level of functional impairment is not consistent with the medical evidence available.

It is particularly important in the assessment of people with neurological or cognitive conditions that the person's presentation on the day of the assessment SHOULD NOT BE SOLELY RELIED UPON. This is because with some conditions such as dementia, the person may have insufficient insight and minimise the condition's impacts. Impacts of conditions can fluctuate over time and the severity, duration and frequency of the episodes or fluctuations must be taken into account when determining the rating that best reflects the person's overall functional ability (refer to 3.6.3.08 'Descriptors involving performing activities'). In determining the work-related impairment for such fluctuating conditions, consideration should be given to the impact on the person's ability to reliably sustain work over 2 years without significant absences.

When determining a person's limitations in relation to conducting 'work tasks', this is taken to refer to any job available in Australia.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 7 - Brain Function

0-point impairment rating level

The 0-point descriptor specifies the person has no functional impact on activities resulting from a neurological or cognitive function.

5-point impairment rating level

The 5-point descriptor specifies that the person must be able to complete most of the day-to-day activities without assistance and has MILD difficulties with at least one of the following descriptor points (1) (a), (b), (c), (d), (e), (f).

10-point impairment rating level

The 10-point descriptor specifies that the person needs occasional (less than once a day) assistance with day to day activities and has MODERATE difficulties in at least one of following descriptor points (1) (a), (b), (c), (d), (e), (f), (g), (h), (j).

20-point impairment rating level

The 20-point descriptor specifies that the person needs frequent (at least once per day) assistance and supervision and has SEVERE difficulties in at least one of the following descriptor points (1) (a), (b), (c), (d), (e), (f), (g), (h), (j).

30-point impairment rating level

The 30-point descriptor specifies that the person needs continual assistance and supervision and has EXTREME difficulties in at least one of the following descriptor points (1) (a), (b), (c), (d), (e), (f), (g), (h), (j).

Some conditions causing impairment commonly assessed using Table 7

These include but are not limited to:

- chronic pain affecting cognitive function
- acquired brain injury (ABI)

- stroke (cerebrovascular accident (CVA))
- conditions resulting in dementia
- brain tumours
- some neurodegenerative disorders
- ASD with no low IQ
- FAS or FASD without an interpretable full-scale IQ 85 or below
- migraine that results in impairment to neurological or cognitive function (but not loss of consciousness or altered states of consciousness)
- attention deficit hyperactivity disorder manifesting with predominantly attention and concentration problems.

Example 1: A 58 year old woman was diagnosed with post-herpetic neuralgia following an episode of shingles 2 years ago. She suffers from frequent burning pain in the affected dermatome which covers part of the back of the right forearm and hand. Symptoms persist despite extensive treatment from her neurologist and the chronic pain clinic. Sleep may be affected and her medical records state there is a moderate impact on attention and concentration as a result of chronic pain. She continues long-term treatment with gabapentin and nortriptyline and takes oxycodone as required. Non-narcotic analgesics had no beneficial effect on pain. She has difficulty using a pen, doing up buttons, unscrewing the lid on a bottle and picking up 1L of liquid. She requires occasional assistance from her partner to complete some daily tasks due to impaired concentration. The condition is considered fully diagnosed, treated and stabilised. This person would receive an impairment rating of 10 points under Table 7, due to the moderate impact her condition of chronic neuropathic pain and its treatment has on her cognitive function and the resulting assistance required. Under the 10-point descriptor she meets (1)(b). The difficulties with using the affected upper limb led to a rating of 10 impairment points under Table 2, meeting descriptors (1)(a), (c), (d) and (f).

Example 2: A 20 year old male has a diagnosed permanent condition of ASD. The medical evidence outlines that as a result of his condition he has occasional difficulty controlling his behaviour in routine situations. For example, when grocery shopping, he can lose his temper for minor reasons including a shop assistant misunderstanding him. He has difficulties engaging in social interactions, often missing nonverbal cues, talking over others, taking things literally and struggling to empathise with others. He lacks self-awareness of the extent of his difficulties in these circumstances. This person has undergone an assessment of intellectual functioning and has above average intelligence. He is particularly skilled in the area of computer programming and can become entrenched in such activity at the expense of other tasks. While he lives alone, his mother needs to visit a couple of times per week to ensure he attends to his household duties, providing assistance with household

shopping, cleaning and bill paying. The condition is considered fully diagnosed, treated and stabilised. This person would receive an impairment rating of 10 points under Table 7, due to the moderate impact his condition of ASD has on his ability to function and his resultant need for occasional assistance. Under the 10-point descriptor he would meet both (1)(h) and (j). He would not be rated under Table 9 as he does not present with low intellectual function.

Example 3: A 27 year old woman suffers from regular migraines. She was first diagnosed with this condition at around 8 years of age and her migraines have significantly impacted her functioning for almost 20 years. The condition has responded poorly to the past preventative and acute episode treatments recommended by her neurologist, and is not expected to significantly improve within the next 2 years. This woman experiences unpredictable severe migraines approximately once or twice a fortnight. These migraines leave her bedridden for periods of between 6- 24 hours. She prefers to live with her parents, as she needs occasional assistance from her parents, especially when she is having an acute episode. She is unable to reliably plan to attend future events, due to the unpredictable nature of her migraines. When she is having an acute migraine, she is unable to concentrate and is unable to tolerate bright light or loud noises. In between migraine episodes she is able to concentrate and problem solve without any functional impairment. Past attempts at working full-time have been short lived due to absences as a result of her symptoms.

The condition is considered fully diagnosed, treated and stabilised. This is an episodic condition and she is severely impaired during the acute episode and recovery period, but at other times she can function normally. This person would receive an impairment rating of 10 points under Table 7 due to the overall moderate functional impact of the migraines and her need for occasional assistance and supervision. Under the 10 point descriptor she would meet (1)(b) and (d).

Example 4: A 62-year-old male had a right cerebral infarct and they presented with a left sided hemiplegia. He spent 2 weeks in an acute stroke unit where it was observed that he would often forget to put his left arm into a sleeve, ignore visitors seated to his left, only ate the food on the right hand side of his plate and would bump into walls on his left when the physiotherapist was performing mobility rehabilitation. The neurologist asked him to draw a clock and he only drew the right side, so a left sided spatial neglect was diagnosed. He was transferred to a stroke rehabilitation unit where he spent the next 2 months. With appropriate rehabilitation, the left sided neglect improved, although he still had to be reminded about looking to the left.

Six months after the stroke the neurologist reported that there had been some improvement in the left sided neglect and further significant improvement was unlikely within the next 2 years. When he was asked to draw a clock they drew the entire clock, but with more detail on the right side. The man tended to walk close to the wall on the left, as he was fearful of bumping into objects or people on that side that he had failed to notice and his partner usually accompanied him when he left the house. His partner had to frequently remind him to comb his hair and brush his teeth on his left side. He was unable to have a driving licence, as the neurologist considered that he would not be safe when making turns to the left and using roundabouts. He also had trouble following directions. His partner received a carer payment, as he required frequent assistance and supervision. He made a claim for a DSP several weeks after the 6-month review by the neurologist.

The spatial neglect is considered to be fully diagnosed, treated and stabilised, as the neurologist said that no significant functional improvement was expected within the next 2 years. This person would receive a 20 point rating under Table 7 due to the severe functional impact of the spatial neglect. He needs daily assistance and supervision, and met the descriptor (g) for visuo-spatial function at the 20-point impairment level.

Example 5: A 32-year-old man fell off a stepladder and hit his head on a concrete driveway. He was unconscious when the ambulance arrived and spent the following 24 hours in a coma. He had sustained an extensive frontal lobe intracerebral haematoma. He spent 4 weeks in an acute neurosurgical unit and was then transferred to a brain injury rehabilitation unit. He had a further 3 months of inpatient rehabilitation and was then discharged to his parents' home. The rehabilitation medicine discharge summary stated that he had had a severe traumatic brain injury (TBI). He continued with appropriate outpatient rehabilitation. Six months after the accident, he made an application for a DSP. His rehabilitation medicine specialist reported that there may be a slight improvement over the next 2 years, but any improvement was unlikely to be significant. This was consistent with the initial severe injury. He continued to live with his parents and would be unable to live independently. He needed frequent assistance and supervision on a daily basis:

- He needed to be reminded verbally about appointments, even though he kept a diary and appointments were listed on a calendar.
- He could not be trusted to cook their own meals, as they forgot to turn off the gas burners and used metal bowls in the microwave.
- His parents had to assist with his financial management and were his Centrelink nominees.
- He was unable to plan a visit to a friend or what to buy them for a birthday present.

- He was unable to follow basic instructions on using a computer and could not complete even basic tasks such as reading emails. He was also easily distracted after more than about 10 minutes.
- If he got frustrated he often responded with verbal abuse.
- He could not understand why he was no longer able to drive the family car and could become very irritable about this.

The TBI is considered to be fully diagnosed, treated and stabilised, as the rehabilitation medicine specialist said that no significant functional improvement was expected within the next 2 years. This person would receive a 20-point rating under Table 7 due to the severe functional impact of their TBI. He needs daily assistance and supervision, and while only one descriptor needs to be met, the following descriptors (a), (b), (c), (d), (e), (f), (h) and (j) were met at the 20-impairment point level.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 7 - Brain Function

Impairments that should not be assessed using Table 7

People with an ASD, FAS or FASD who also have an interpretable full scale IQ ranging from 70-85 are more appropriately assessed under Table 9 - Intellectual Function, as their condition results in an intellectual impairment originating before they turned 18 years of age.

Table 7 must not be used for people who have an impairment of intellectual function unless the person has an additional condition affecting neurological or cognitive function. These people are more appropriately assessed under Table 9 - Intellectual Function.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 7 - Brain Function, Table 9 - Intellectual Function

3.6.3.80 Guidelines to Table 8 - Communication Function

Summary

Table 8 is used where a person has a functional impairment affecting communication functions.

The diagnosis of the medical condition causing the impairment must be made by an appropriately qualified medical practitioner. This includes a general practitioner, a neurologist, a rehabilitation physician, an ear nose and throat surgeon or other relevant specialist.

If a person uses any aids or equipment to assist with their communication function, they must be assessed on their ability to undertake activities listed in Table 8 while using any aids or equipment that they have and usually use without physical assistance from a support person.

Table 8 refers to communication in a person's main language. This is the language a person most commonly uses. This may be the language the person uses at home or their first language and should be their most fluent language.

Table 8 covers both receptive communication, which is understanding language, as well as expressive communication, which is producing speech. Table 8 also covers the use of alternative or augmentative communication such as sign language, technology that produces electronic speech or the use of symbols or a note taker to assist in communication.

A person's self-reported symptoms MUST NOT BE SOLELY RELIED UPON in determining functional impacts of the person's permanent condition (impairment). There must be corroborating medical evidence of the person's impairment, which can include speech pathologist reports.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 8 - Communication Function

Determining the level of functional impact - general rules

When determining which impairment rating applies to a person the rating that best describes the person's abilities or difficulties must be applied. In applying the descriptors in Table 8, each descriptor sets out how the points within it are to apply.

For example, to meet the 10-point descriptor either (1)(a), (1)(b) or (1)(c) must apply. If (1)(a) applies then either (1)(a)(i) or (1)(a)(ii) must apply. To meet the 20-point descriptor in Table 8 either (1)(a), (1)(b) or (2) must apply. If (1)(b) applies then at least one of either (1)(b)(i), (1)(b)(ii), (1)(b)(iii) or (1)(b)(iv) must apply. If (2) applies, at least one of (2)(a), (2)(b), (2)(c) or (2)(d) must also apply.

The structure of the Tables requires that, in assessing the level of functional impact, a comparison must be made of all the descriptors for each level of impairment. An assessment starts by considering the descriptors for 0 points and, if a person has more than 'no functional impact', the descriptors for 5 points are then considered, and so on for the descriptors for higher impairment levels. When it is determined that a person meets all the required descriptors for a certain impairment rating level, but does not meet all the required descriptors for the next impairment rating level, the appropriate impairment rating applicable to the person's circumstances will be the lower of those 2 impairment ratings (i.e. the rating at which all the required descriptors are met).

Explanation: Where a person meets the required descriptors for 10 points but does not meet all the required descriptors for 20 points, the correct impairment rating is 10 points. The person's impairment CANNOT be regarded as severe or extreme for the purposes of DSP and neither 20 nor 30 points can be allocated.

Note: Individual descriptors or their parts must not be applied in isolation from one another.

In determining whether the required descriptors for a specific impairment level are met or not, ALL the descriptors for that level must be considered and applied as set out in the descriptor. NO descriptors or their parts are to be disregarded. One of several descriptor points may be sufficient for that rating when the word 'or' links the descriptors.

Determination of the descriptor that best fits a person's impairment level must be based on the available medical evidence including the person's medical history, investigation results and clinical findings and observations made during the assessment process.

Only one rating should be assigned from Table 8 even if the communication or language impairment is both receptive and expressive in nature.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 8 - Communication Function

0-point impairment rating level

The 0-point descriptor requires that a person has NO functional impact on communication in the person's main language.

5-point impairment rating level

The 5-point descriptor requires there must be a MILD functional impact on communication in the person's main language and at least one of the descriptors (1)(a) or (1)(b) applies.

10-point impairment rating level

The 10-point descriptor requires there must be a MODERATE functional impact on communication in the person's main language and either (1)(a), (1)(b) or (1)(c) must apply. If (1)(a) applies then either (1)(a)(i) or (1)(a)(ii) must apply.

20-point impairment rating level

The 20-point descriptor requires that there must be a SEVERE functional impact on communication in the person's main language. Either (1)(a), (1)(b) or (2) must apply. If (1)(b) applies, then at least one of either (1)(b)(i), (1)(b)(ii), (1)(b)(iii) or (1)(b)(iv) must apply. If (2) applies, then at least one of (2)(a), (2)(b), (2)(c) or (2)(d) must also apply.

30-point impairment rating level

The 30-point descriptor requires there must be an EXTREME functional impact on communication in the person's main language. Either (1)(a), (1)(b) or (2) must apply. If (1)(a) applies, then at least one of either (1)(i), (ii), or (iii) must apply. If (1)(b) applies, then at least one of either (1)(b)(i), (1)(b)(ii), (1)(b)(iii), or (1)(b)(iv) must apply. If (2) applies, then at least one of either (2)(a), (2)(b), or (2)(c) must apply.

Some conditions causing impairment commonly assessed using Table 8

There are a range of conditions a person may have which cause impairment affecting communication that can be appropriately assessed using Table 8. These include but are not limited to:

- stroke (cerebrovascular accident (CVA))
- other acquired brain injury that has damaged the speech/language centre of the brain, for example, dysphasia, aphasia
- cerebral palsy
- neurodegenerative conditions
- damage to the speech-related structures of the mouth, vocal cords or larynx.

Example 1: An 18-year-old woman has a diagnosed permanent condition of cerebral palsy, which she has had since birth. The medical evidence states that as a result of this condition the woman's speech is slurred. Sometimes she has difficulty being understood in certain situations so she uses an electronic voice output device at these times.

The condition is considered fully diagnosed, treated and stabilised, and under Table 8, this person would receive an impairment rating of 10-points due to the moderate impact this condition has on her communication function. Under the 10-point descriptor, this would meet (1)(c).

Due to her condition of cerebral palsy, the woman also has impairment in functioning of her lower and upper limbs. Consideration should be given to whether she would also receive an impairment rating for these impairments under Table 2 - Upper Limb Function and Table 3 - Lower Limb Function.

Example 2: A 55-year-old man was treated for laryngeal carcinoma 6 months before applying for DSP. Treatment included a total laryngectomy, primary tracheo-oesophageal puncture (TEP) and insertion of an indwelling voice prosthesis. The man had no post-operative complications and is generally well, with no evidence of recurrence or metastatic spread of the carcinoma. His cancer prognosis has been assessed as good.

The man's post-laryngectomy speech quality, achieved with the guidance of a speech pathologist, is intelligible and closely resembles laryngeal speech. He needs to manually cover the tracheal stoma while speaking, and has good hand dexterity. He has pre-existing well-managed chronic obstructive pulmonary disease (COPD), including mild emphysema,

due to a long-term smoking history. He has occasional problems with speech volume and production due to shortness of breath, particularly during COPD exacerbations. Due to post-laryngectomy nasopharyngeal airway dysfunction, he has decreased olfactory acuity (sense of smell).

Due to the post-laryngectomy condition this person would receive a rating of 5-points under Table 8 due to the mild impact on communication function. Under the 5-point descriptor this person would meet (1)(b).

Due to his condition of well-controlled COPD, this person also has impaired functioning under Table 1 - Functions requiring Physical Exertion and Stamina. His condition of partial anosmia is not assessable under the Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011.

Example 3: A 60-year-old man experienced a stroke one year ago, which has had a range of impacts, including on his speech clarity. Despite intensive rehabilitation including speech therapy, strangers are unable to understand his speech and he is unable to effectively converse with people. Due to this, he relies upon his partner or children to speak on his behalf at appointments, shops and so forth. He meets (1)(b)(ii) 20-point descriptor.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 2 - Upper Limb Function, Table 3 - Lower Limb Function, Table 8 - Communication Function

Impairments that should not be assessed using Table 8

There are a range of conditions a person may have which cause impairment affecting communication but should not be assessed using Table 8. These include but are not limited to:

- impairment affecting communication function as a result of hearing loss only
- impairment affecting communication function as a result of impairment in intellectual function only
- fluency or competency difficulties in using the spoken English language.

People who use recognised sign language or other non-verbal communication as a result of hearing loss only are more appropriately assessed under Table 11 - Hearing and Other Functions of the Ear. If a person's impairment affecting communication function is due to

impairment in intellectual function, it is more appropriately assessed under Table 9 - Intellectual Function.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 8 - Communication Function, Table 9 - Intellectual Function, Table 11 - Hearing and other Functions of the Ear

3.6.3.90 Guidelines to Table 9 - Intellectual Function

Summary

Table 9 is used where a person has a meaningful intelligence quotient (IQ) between 70 and 85 resulting in functional impairment. A meaningful IQ is one which best represents the person's general intellectual function. To use Table 9, this impairment in intellectual function must have originated before the person turned 18 years of age.

People with an autism spectrum disorder (ASD), fetal alcohol syndrome (FAS) or fetal alcohol spectrum disorder (FASD) who also have a meaningful IQ between 70 to 85 resulting in function impairment should be assessed under Table 9, as their condition presented with an intellectual impairment originating before they turned 18. However, in cases of ASD which do not have a meaningful IQ between 70 and 85 resulting in functional impairment, Table 7 or Table 5 may be applied.

For people with a meaningful IQ score of less than 70, the manifest eligibility criteria should be applied. The manifest eligibility criteria should also be applied for people whose intellectual impairment is so severe they are unable to undertake an IQ test. When another table is being considered in addition to Table 9, care must be taken not to double-count the impairment.

The assessment of IQ can be complex, for example if there are significant discrepancies in indices. In some instances, a variable cognitive profile may not make a full scale IQ score the most meaningful summary of a person's intellectual function. In some instances, the General Ability Index (GAI) or other suitable index score may be used, if appropriate. However, if these scores are not meaningful, Table 7 may be a more appropriate table.

Assistance may be required in interpreting test results that are reported in psychological, neuropsychological, or educational reports. In such instances, consultation with a Services Australia psychologist or a referral to the HPAU should be undertaken.

Consideration must be given to whether recognised assessments of intellectual function should be adapted for use with Aboriginal and Torres Strait Islander peoples. The Kimberley Indigenous Cognitive Assessment (KICA) may be appropriate for Aboriginal and Torres Strait Islander people.

For culturally and linguistically diverse (CALD) people, the Tests of Nonverbal Intelligence - Fourth Edition (TONI-4), or other equivalent tests of intelligence validated for CALD populations, may be considered.

The assessment of a person's condition must be made by an appropriately qualified psychologist who is able to administer an assessment of intellectual function and an assessment of adaptive behaviour.

A PERSON'S SELF-REPORTED SYMPTOMS MUST NOT BE SOLELY RELIED UPON in determining the functional impacts of the person's permanent condition (impairment). There must be corroborating medical evidence of the person's impairment.

Under Table 9, both an assessment of intellectual function and an assessment of adaptive behaviour must be undertaken.

An assessment of intellectual function is to be undertaken using an appropriate assessment tool that was current and valid at the time of testing intellectual function, such as the Wechsler Adult Intelligence Scale IV (WAIS IV) or equivalent contemporary assessment tool. This assessment should be conducted after a person turns 16 years of age. A Wechsler Intelligence Scale for Children (WISC) assessment completed when the person was between the age of 12 years and the age of 16 years and 11 months is also acceptable for people aged 18 years or under at the time of assessment. If the assessment tool used is not appropriate or there are any concerns that existing scores do not reflect the person's current circumstances, re-testing should be considered following consultation with a Services Australia psychologist.

Depending on the cause of the intellectual impairment, the impaired functioning measured before a child turns 12 years of age may not remain constant into adulthood. Therefore, any additional evidence should be reviewed to determine if further assessment is required after the age of 12 years.

Example 1: If a person had their intellectual function assessed before they turned 12 years of age and had only one assessment completed before that time, or if assessments prior to the age of 12 are borderline, then an additional assessment of intellectual function may be requested to ensure the accuracy of intellectual function.

Example 2: If a person had their intellectual function assessed before they turned 12 years of age but it was assessed more than once at different ages, and the results of these assessments remained consistent and supported a manifest grant, this may be considered sufficient evidence of intellectual function in this situation.

An assessment of adaptive behaviour is to be undertaken using an appropriate standardised assessment tool that was current and valid at the time of testing adaptive behaviour, such as the Adaptive Behaviour Assessment System (ABAS-II), the Scales for Independent Behaviour - Revised (SIB-R) or the Vineland Adaptive Behaviour Scales (Vineland-II). As these measures are based on responses from carers, teachers or self-report, consideration should be given to the capacity of the person reporting on the adaptive behaviour, for example, insight, observations in various settings, and social and cultural expectations. Consideration should be given to the validity of the assessments of adaptive function and whether the results are consistent with other corroborative evidence such as developmental history, formal assessment, school or work records and/or direct observation. If the measure of adaptive function is inconsistent with this, clinical judgement should be used to determine the level of adaptive behaviour that is consistent with the scores of adaptive behaviour found in the Table 9 descriptors.

Consideration must be given to the adaptation of recognised assessments of adaptive behaviour for use with Aboriginal and Torres Strait Islander peoples, as required.

If a valid and current assessment of adaptive behaviour is not available, referral for specialist assessment may be necessary.

Other contemporary standardised assessments of adaptive behaviour may be undertaken as long as they:

- provide robust standardised scores across the 3 domains of adaptive behaviour (conceptual, social and practical adaptive skills)
- have current norms developed on a representative sample of the general population
- demonstrate test validity and reliability
- provide a percentile ranking
- are a measure of stable adaptive deficit, rather than a temporary reduction in adaptive behaviour, and
- are indicative of the person's adaptive behaviour due to their intellectual function at the time of DSP assessment.

The following table describes how adaptive behaviour tools align with impairment ratings under Table 9.

Figure 4: Adaptive behaviour tools and table 9 impairment ratings

Points	Impact	SIB-R service level score	Vineland-II standard score	ABAS-II general adaptive composite scaled score	Percentile rank on a current standardised assessment of adaptive behaviour
0	**No impact.** Infrequent or no support required.	90-100	90-100	90-130+	24+
5	**Mild impact.** Intermittent or periodic support and supervision required.	80-89	80-89	80-89	9-23
10	**Moderate impact.** Limited but consistent support and supervision required.	71-79	71-79	71-79	3-8
20	**Severe impact.** Frequent or close support and supervision required.	51-70	51-70	51-70	0.1-2
30	**Extreme impact.** Highly intense and continuous levels of support and supervision required.	50 or less	50 or less	50 or less	<0.1 percentile rank

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 9 - Intellectual Function

Policy reference: SS Guide 3.6.2.50 Assessment of people with intellectual impairment for DSP, 3.6.2.20 Manifest grants & rejections for DSP

Determining the level of functional impact - general rules

When determining which impairment rating applies to a person the rating that best describes the person's abilities or difficulties must be applied.

The descriptors in Table 9 outline how a score of adaptive behaviour aligns with an impairment rating. For example, to meet the 20-point descriptor a person must have either a score of adaptive behaviour between 50 and 70 or be assessed within the percentile rank of 0.1 to 2.

The structure of the Tables requires that, in assessing the level of functional impact, a comparison must be made of all the descriptors for each level of impairment. An assessment starts by considering the descriptors for 0 points, and, if a person has more than 'no functional impact', the descriptors for 5 points are then considered, and so on for the descriptors for higher impairment levels. When it is determined that a person meets all the required descriptors for a certain impairment rating level, but does not meet all the required descriptors for the next impairment rating level, the appropriate impairment rating applicable to the person's circumstances will be the lower of those 2 impairment ratings (i.e. the rating at which all the required descriptors are met).

Note: Individual descriptors or their parts must not be applied in isolation from one another.

In determining whether the required descriptors for a specific impairment level are met or not, ALL the descriptors for that level must be considered and applied as set out in the descriptor. NO descriptors or their parts are to be disregarded. One of several descriptor points may be sufficient for that rating when the word 'or' links the descriptors.

Explanation: Where a person meets the required descriptors for 10 points but does not meet sufficient required descriptors for 20 points, the correct impairment rating is 10 points. The person's impairment CANNOT be regarded as severe or extreme for the purposes of DSP and neither 20 nor 30 points can be allocated.

Determination of the descriptor that best fits a person's impairment level must be based on the available medical evidence including the person's medical history, investigation results and clinical findings. A person's self-reported adaptive functioning must not solely be relied on. It would be inappropriate to apply an impairment rating based solely on a person's self-reported functional capacity if the self-reported level of functional impairment is not consistent with the evidence available.

Professional judgement is required regarding the best source of intellectual function and adaptive functioning information as in some instances it will be appropriate to obtain input from a parent, caregiver or teacher. A person's IQ and adaptive functioning test results should not be considered in isolation as they may also have insufficient insight into their condition.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 9 - Intellectual Function

0-point impairment rating level

The 0-point descriptor specifies that the person has NO functional impact on intellectual function. At least one of the descriptors (1)(a), or (1)(b) applies.

5-point impairment rating level

The 5-point descriptor requires that there is a MILD impact on intellectual function and at least (1)(a) or (1)(b) applies.

10-point impairment rating level

The 10-point descriptor requires that there is a MODERATE impact on intellectual function and at least (1)(a) or (1)(b) applies.

20-point impairment rating level

The 20-point descriptor requires that there is a SEVERE impact on intellectual function and at least (1)(a) or (1)(b) applies.

30-point impairment rating level

The 30-point descriptor requires that there is an EXTREME impact on intellectual function and at least (1)(a) or (1)(b) applies.

Some conditions causing impairment commonly assessed using Table 9

There are a range of conditions a person may have which cause impairment affecting intellectual function that can be appropriately assessed using Table 9. These include intellectual impairment resulting from:

- Down syndrome
- congenital/perinatal or early childhood infections (eg rubella, cytomegalovirus (CMV), bacterial meningitis, encephalitis)
- extreme prematurity or birth trauma
- a person with either autism spectrum disorder, fragile X sydnrome or foetal alcohol spectrum disorder who also has a meaningful IQ between 70 and 85 resulting in function impairment
- childhood developmental or congenital disorders.

Example: A 16-year-old male, on finishing formal schooling, lodged an application for DSP. He has been diagnosed with impaired intellectual functioning, which resulted from severe bacterial meningitis he contracted in early childhood. He has undergone an assessment of intellectual functioning and has an IQ score of 80.

A psychologist has conducted an assessment of adaptive behaviour with him, using the Adaptive Behaviour Assessment System (ABAS-II). He was assessed as having a score of adaptive behaviour of 71. This score was consistent with other corroborative evidence in relation to the young man's adaptive behaviour (school reports, previous assessments, information provided by his parents, direct observation, etc.).

The report from his psychologist outlines that he has some behavioural issues.

The condition is considered fully diagnosed, treated and stabilised and under Table 9, he would receive an impairment rating of 10 points, given the moderate impact his condition has on his ability to function. Under the 10-point descriptor the young man would meet (1)(a). As his IQ score is above 69, he is not manifestly eligible (3.6.2.20) for DSP.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 9 - Intellectual Function

Impairments that should not be assessed using Table 9

Behavioural problems unrelated to intellectual impairment may be assessed using Table 5 - Mental Health Function, if there is a permanent mental health condition.

For people with an autism spectrum disorder (ASD) or fetal alcohol syndrome (FAS) or fetal alcohol spectrum disorder (FASD) who do not have a meaningful IQ between 70 and 85 resulting in function impairment, Table 7 or Table 5 may be applied.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 5 - Mental Health Function, Table 9 - Intellectual Function

3.6.3.100 Guidelines to Table 10 - Digestive and Reproductive Function

Summary

Table 10 is used where a person has a functional impairment related to digestive or reproductive system functions. The diagnosis of the condition must be made by an appropriately qualified medical practitioner. This includes a general practitioner, a gastroenterologist, gynecologist, or other relevant specialist.

If a person has impairment related to both digestive and reproductive system functions a single rating under Table 10 should be assigned that reflects the overall functional impairment.

A person who has a permanent condition impacting digestive or reproductive system functions may be assessed under Table 10. This includes conditions of the digestive and reproductive systems (e.g. conditions of the stomach, bowel and liver), but also includes conditions of internal organs outside these systems, which may impact on digestive or reproductive systems. Examples may include chronic kidney disease and some autoimmune disorders. This is consistent with the Tables being function-based rather than diagnosis-based. Further examples of conditions causing impairments that may be rated under Table 10 are listed at the end of these Guidelines.

A PERSON'S SELF-REPORTED SYMPTOMS MUST NOT BE SOLELY RELIED UPON in determining functional impacts of the person's permanent condition. There must be corroborating medical evidence of the person's impairment.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 10 - Digestive and Reproductive Function

Determining the level of functional impact - general rules

Table 10 is different to most of the other Tables used to assess impairment for DSP purposes in that Table 10 specifically recognises the impact of impairments and their treatment on a person's attention and concentration.

When determining which impairment rating applies to a person the rating that best describes the person's abilities or difficulties must be applied. In applying the descriptors, each descriptor sets out how the points within it are to apply.

For example, the 5-point descriptor in Table 10 states that 'at least one of the following applies'. The 10-point, 20-point and 30-point descriptors state that 'at least 2 of the following apply'.

The structure of the Tables requires that, in assessing the level of functional impact, a comparison must be made of all the descriptors for each level of impairment. An assessment starts by considering the descriptors for 0 points and, if a person has more than 'no functional impact', the descriptors for 5 points are then considered, and so on for the descriptors for higher impairment levels. When it is determined that the person meets all the required descriptors for a certain impairment rating level, but does not meet all the required descriptors for the next impairment rating level, the appropriate impairment rating applicable to the person's circumstances will be the lower of those 2 impairment ratings (i.e. the rating at which all the required descriptors are met).

Note: Individual descriptors or their parts must not be applied in isolation from one another.

In determining whether the required descriptors for a specific impairment level are met or not, ALL the descriptors for that level must be considered and applied as set out in the descriptor. NO descriptors or their parts are to be disregarded however, one of several descriptor points may be sufficient for that rating when the word 'or' links the descriptors.

Note: If a person's impairment does not meet sufficient required descriptors for a certain impairment level, the person's impairment cannot be rated at that level or at any higher level.

Explanation: Where a person meets the required descriptors for 5 points but does not meet sufficient required descriptors for 10 points, the correct impairment rating is 5 points. The

person's impairment CANNOT be assessed as moderate, severe or extreme for the purposes of DSP and neither 10, 20 nor 30 points can be allocated.

Determination of the descriptor that best fits a person's impairment level must be based on the available medical evidence including the person's medical history, investigation results and clinical findings. A person's self-reported symptoms must not solely be relied on. It would be inappropriate to apply an impairment rating based solely on a person's self-reported functional history if this level of functional impairment is not consistent with the medical evidence available.

The 10-point and 20-point descriptors refer to the amount of absences a person may have. The 10-point descriptor states the person is often (once per month) absent and the 20-point descriptor states the person is frequently (twice or more per month) absent. One absence is taken to be one day and so where the person has frequent absences of 2 or more days, even where these are consecutive days, this would equate to absences of twice or more per month.

Where the descriptors make reference to symptoms or personal care needs associated with the digestive or reproductive system functional impact, the following information may be of assistance.

For digestive system functional impacts:

- associated symptoms include, but are not limited to, pain, discomfort, nausea, vomiting, diarrhoea, constipation, reflux, heartburn, indigestion or fatigue
- associated personal care needs include, but are not limited to, the need to take medications when symptoms occur, care of special feeding equipment (e.g. Percutaneous Endoscopic Gastrostomy (PEG) button or special feeding tube), special diets or feeding solutions, strategies to relieve pain, additional toileting and personal hygiene needs.

For reproductive system functional impacts:

- associated symptoms include, but are not limited to, pain, fatigue, menorrhagia or dysmenorrhea,
- associated personal care needs include, but are not limited to, strategies to relieve pain or more frequent menstrual care.

0-point impairment rating level

The 0-point descriptor specifies that a person has NO functional impact on work-related or daily activities due to symptoms or personal care needs associated with a digestive or reproductive system functions.

5-point impairment rating level

The 5-point descriptor requires that there is a MILD functional impact on work-related or daily activities due to symptoms or personal care needs associated with digestive or reproductive system functions and at least (1)(a) or (1)(b) applies.

10-point impairment rating level

The 10-point descriptor requires that there is a MODERATE functional impact on work-related or daily activities due to symptoms or personal care needs associated with digestive or reproductive functions and at least two of (1)(a), (1)(b), or (1)(c) apply.

20-point impairment rating level

The 20-point descriptor requires that there is a SEVERE functional impact on work-related or daily activities due to symptoms or personal care needs associated with digestive or reproductive system functions. At least two of (1)(a), (1)(b), (1)(c) or (1)(d) apply.

30-point impairment rating level

The 30-point descriptor requires that there is an EXTREME functional impact on work-related or daily activities due to symptoms or personal care needs associated with digestive or reproductive functions and at least two of (1)(a), (1)(b), (1)(c) or (1)(d) apply.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 10 - Digestive and Reproductive Function

Some conditions causing impairment commonly assessed using Table 10

A permanent condition resulting in functional impairment related to digestive system functions may include diseases in or remote from the digestive tract, which have significant impacts on digestive function such as:

- reflux oesophagitis
- refractory peptic ulcer disease
- established chronic liver disease
- chronic nausea and poor appetite from kidney disease
- irritable bowel syndrome
- inflammatory bowel disease (Crohn's disease, Ulcerative Colitis)
- established chronic pancreatic disease, abdominal hernias.

As the impact of digestive and reproductive functions on attention and concentration is specfically considered under the descriptors for a rating under Table 10, no further rating can be applied under Table 7. Likewise, the impact of digestive and reproductive functions on pain and stamina is specifically taken into account under the descriptors for a rating under Table 10, so no further rating can be applied under Table 1. Double-counting is to be avoided and multiple Tables would not be used unless other conditions causing functional impacts specific to Table 1 or Table 7 are present.

Reproductive system conditions may include gynecological disease as well as conditions of the male reproductive system including but not limited to:

- severe and intractable endometriosis
- pelvic inflammatory disease
- ovarian cancer
- testicular cancer.

Example 1: A 45-year-old man suffers from Crohn's disease. He was diagnosed with this condition several years ago and the medical evidence indicates he has undergone surgery in relation to this condition, due to suffering a blockage of the intestine. His current treatment consists of medication to alleviate the symptoms and sometimes a course of short term steroids during periods of active symptoms. He experiences intermittent periods of aggravation of his symptoms in between periods of remission. A report from his treating specialist outlines that he experiences these periods of active symptoms on an average of

once a month. During this time he is unable to attend work due to the severity of active symptoms, for at least one day. During periods of remission he is able to attend work reliably but his attention and concentration are interrupted by symptoms of abdominal pain and discomfort on a daily basis. During the periods of active symptoms, he experiences symptoms of severe abdominal pain and diarrhoea along with fatigue, nausea and loss of appetite. His attention and concentration are often reduced by the symptoms and he often loses weight during these times.

The condition is considered fully diagnosed, treated and stabilised and under Table 10, this man would receive an impairment rating of 10 points due to the moderate impact his condition has on his ability to function. Under the 10-point descriptor he would meet (1)(a) and (c).

Example 2: A 25-year-old woman has a diagnosis of endometriosis. She has undergone hormone therapy and currently takes medication to alleviate the symptoms. In the past, she has undergone a pelvic laparoscopy but her symptoms came back following this operation. Her symptoms include constant chronic pelvic pain which increases in severity once a month with menstruation. During this time she is unable to attend work for about 1 week and she usually needs to take another day or 2 off work at other times each month. Daily pain is intermittently severe and and briefly interrupts her attention and concentration at least once per hour during working hours. It occurs on both sides of the pelvis, radiating to the lower back. Her specialist has recommended she undergo a hysterectomy due to the severity of her symptoms but the woman has chosen not to undertake this form of treatment, due to the fact that she wants to try to have children in the near future. Also, there is still a risk that her symptoms can come back even after undergoing this procedure.

The condition is considered fully diagnosed, treated and stabilised and under Table 10, this woman would receive 20 points, due to the fact that her attention and concentration are frequently reduced by her pain symptoms and she is frequently absent from work due to her condition. Under the 20-point descriptor this woman would meet (1)(a) and (d).

Example 3: A 50-year-old person has longstanding type 1 diabetes mellitus and, as a result has developed gastroparesis. Gastroparesis causes slowed emptying of the stomach, in this case due to diabetic autonomic neuropathy. A gastroenterologist confirmed the diagnosis 2 years ago. The person has appropriately managed this condition including through optimising blood glucose control and the use of medications to accelerate gastric emptying, hence the condition is fully diagnosed, treated and stabilised. Gastroparesis makes this person feel nauseous with vomiting after meals several times per week. They also have acid reflux and abdominal bloating after most meals. As a result of this they have lost

weight. The symptoms of nausea, acid reflux and bloating affect the person at least once a day, but not every hour, reducing their ability to focus and concentrate on tasks. About once a month, the nausea and vomiting are worse than usual and the person cannot leave home on those days.

The person suffers from nausea, vomiting, acid reflux and bloating due to diabetic gastroparesis. As there is an impact on the digestive system from their diabetes, a 10-point rating can be applied under Table 10. Under the 10-point descriptor, descriptors (1)(a) and (1)(c) apply to the person.

Example 4: A 45-year-old person lives in a rural area and has had chronic kidney disease for 5 years. They have had stage 5 (previously known as end-stage) kidney disease for the last 2 years and have required dialysis for the last 18 months. A renal specialist and a dialysis nurse monitor the person's kidney condition. The person's home water supply is not suitable for peritoneal or haemodialysis and they therefore have to make a 100km return-trip from their home to the nearest dialysis centre and back 3 times per week. The person does not have a driving licence and relies on lifts from friends to make the return journey each time. The person is unable to arrange lifts about 1-2 times per month, which means they regularly miss 1-2 dialysis sessions each month. This means that the results of their dialysis are inconsistent leading to increased episodes of nausea, vomiting and poor appetite. This condition is fully diagnosed, treated and stabilised as the person's irregular attendance for dialysis sessions is due to factors outside their control. After a missed dialysis session, the person has constant nausea and vomits 1-2 times on that day and the next day until their next dialysis session. On other days they are nauseous at least once per day, but not every hour and the nausea interferes with their attention and concentration on tasks. The nausea and vomiting is due to their chronic kidney disease and as there is an impact on the digestive system from their kidney disease, a rating can be considered under Table 10. 10 points can be assigned as descriptors (1)(a) and (1)(c) apply to the person.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 10 - Digestive and Reproductive Function

Rating multiple impairments resulting from a single condition

A single medical condition may result in multiple functional impairments which can be assigned ratings from more than one table.

Explanation: A person with renal impairment may experience a range of symptoms and symptoms vary between people. In the assessment of a person with renal impairment assessors should apply all of the relevant Tables, taking care to avoid double counting, that is, when using more than one Table to assess multiple impairments resulting from a single condition, impairment ratings for the same impairment must not be assigned under more than one Table.

Impairments that should not be assessed using Table 10

If a person requires continence or ostomy care and has an ileostomy or colostomy they should be assessed under Table 13 - Continence Function.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 10 - Digestive and Reproductive Function, Table 13 - Continence Function

3.6.3.110 Guidelines to Table 11 - Hearing and Other Functions of the Ear

Summary

Table 11 is used where a person has a functional impairment when performing activities involving hearing function or other functions of the ear. Other functions of the ear include balance.

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. There must also be supporting evidence from an audiologist or an ear, nose and throat (ENT) specialist.

If the person uses a prescribed hearing aid, cochlear implant or other assistive listening device, they must be assessed on their ability to undertake activities listed in Table 11 while using any device that they have and usually use.

In determining whether a person has received reasonable treatment for their impairment, consideration should be given to the aids and equipment or other assistive devices they have and usually use. For example, if a person would benefit significantly from an assistive listening device but chooses not to use one, consideration should be given to whether they have received reasonable treatment and if their impairment can be considered fully treated and fully stabilised.

A PERSON'S SELF-REPORTED SYMPTOMS MUST NOT BE SOLELY RELIED UPON in determining the functional impacts of a person's permanent condition (impairment). There must be corroborating medical evidence of the person's impairment.

If the person uses a recognised sign language (e.g. Auslan) or other non-verbal communication method as a result of hearing loss, Table 11 should be used.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 11 - Hearing and other Functions of the Ear

Determining the level of functional impact - general rules

When determining which impairment rating applies to a person the rating that best describes the person's abilities or difficulties must be applied. In applying the descriptors, each descriptor sets out how the points within it are to apply.

In order to meet the applicable descriptors for the 5, 10 and 20 impairment point ratings, a person must satisfy either (1) or (2). All the descriptor points at (1) must be met for the applicable impairment point rating.

To satisfy 0-point or 30-point descriptors, all of the points listed in the descriptor must apply to the person.

The structure of the Tables requires that, in assessing the level of functional impact, a comparison must be made of all the descriptors for each level of impairment. An assessment starts by considering the descriptors for 0 points, and if a person has more than 'no functional impact', the descriptors for 5 points are then considered, and so on for the descriptors for higher impairment levels. When it is determined that the person meets all the required descriptors for a certain impairment rating level, but does not meet all the required descriptors for the next impairment rating level, the appropriate impairment rating applicable to the person's circumstances will be the lower of those 2 impairment ratings (i.e. the rating at which all the required descriptors are met).

Note: Individual descriptors or their parts must not be applied in isolation from one another.

In determining whether the required descriptors for a specific impairment level are met or not, ALL the descriptors for that level must be considered and applied as set out in the descriptor. NO descriptors or their parts are to be disregarded. One of several descriptor points may be sufficient for that rating when the word 'or' links the descriptors.

Explanation: Where a person meets the required descriptors for 5 points but does not meet sufficient required descriptors for 10 points, the correct impairment rating is 5 points. Their impairment CANNOT be assessed as moderate, severe or extreme, and neither 10, 20 nor 30 points can be allocated.

Determination of the descriptor that best fits a person's impairment level must be based on the available medical evidence including a person's medical history, investigation results and clinical findings. A person's self-reported symptoms must not solely be relied on. It

would be inappropriate to apply an impairment rating based solely on a person's self-reported functional capacity if this level of functional impairment is not consistent with the medical evidence available.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 11 - Hearing and other Functions of the Ear

0-point impairment rating level

The 0-point descriptor specifies that the person has NO or minimal functional impact on activities involving hearing function or other functions of the ear.

5-point impairment rating level

The 5-point descriptor requires that there is a MILD functional impact on activities involving hearing function. The person's impairment must meet descriptor points (1)(a), (b) and (c) or descriptor (2).

10-point impairment rating level

The 10-point descriptor requires that there is a MODERATE functional impact on activities involving hearing function even when using a hearing aid, cochlear implant or other assistive listening device; or sign language interpreting is required. A person's impairment must meet descriptor points (1)(a), (b) and (c) or descriptor (2).

20-point impairment rating level

The 20-point descriptor requires that there is a SEVERE functional impact on activities involving hearing function even when using a hearing aid, cochlear implant or other assistive hearing device or technology, or sign language interpreting is required. A person's impairment must meet descriptor points (1)(a), (b), (c), (d) and (e) or descriptor (2).

30-point impairment rating level

The 30-point descriptor requires that there is an extreme functional impact on activities involving hearing function even when using a hearing aid, cochlear implant or other assistive listening device. A person's impairment must meet both descriptor (1)(a) and (b).

Some conditions causing impairment commonly assessed using Table 11

These include but are not limited to:

- congenital deafness
- presbyacusis
- acoustic neuroma
- side-effects of medication
- Meniere's disease
- tinnitus, and
- noise-induced hearing loss.

Example: A 50-year-old man suffers from hearing difficulties due to many years working as a tradesman in the commercial building industry. Supporting evidence confirming the diagnosis of noise-induced hearing loss has been provided from an audiologist. This man has been fitted with hearing aids in both ears, which has significantly improved his hearing. He has been using these hearing aids for the past 5 years and without them, he finds communication more difficult, particularly at further distances. The medical evidence states that he use the hearing aids in most social environments.

Without his hearing aids, this man has severe difficulty hearing any conversation or sound. In situations with background noise and despite using hearing aids, he has some difficulty hearing a conversation at an average volume and has difficulty hearing a conversation when using a landline or mobile phone.

The condition is considered fully diagnosed, treated and stabilised. Under Table 11, this man would be assessed when using his prescribed hearing aid and would be assigned 5 points under Table 11 due to the mild functional impact his hearing has on his daily activities. Under the 5-point descriptor this man would meet (1)(a), (b) and (c).

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 11 - Hearing and other Functions of the Ear

Impairments that should not be assessed using Table 11

Impairment in communication function that is not due to hearing function or other functions of the ear would be more appropriately assessed under Table 8 - Communication Function.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 11 - Hearing and other Functions of the Ear

3.6.3.120 Guidelines to Table 12 - Visual Function

Summary

Table 12 is used where a person has functional impairment when performing activities involving visual function.

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. If the diagnosis has been made by an appropriately qualified practitioner, there must also be supporting evidence from an ophthalmologist. Corroborating evidence may be provided by an, optometrist or neurologist where the diagnosis has been made by another medical practitioner.

If a person uses any visual aids, such as spectacles or contact lenses, they must be assessed on their ability to undertake activities listed in Table 12 while using any aids that they have and usually use.

In determining whether the person has received reasonable treatment for their impairment, consideration is to be given to the aids and equipment or other assistive devices they have and usually use. For example, if a person would benefit significantly from spectacles or contact lenses but chooses not to use them, consideration is to be given to whether they have received reasonable treatment and if their impairment can be considered fully treated and fully stabilised.

Where severe or extreme loss of visual function is evident or suspected, it must be recommended to the person that they undergo an assessment by a qualified ophthalmologist to determine whether they meet the criteria for permanent blindness (3.6.2.20) as per SSAct section 95.

A PERSON'S SELF-REPORTED SYMPTOMS MUST NOT BE SOLELY RELIED UPON in determining functional impacts of the person's permanent condition (impairment). There must be corroborating medical evidence of a person's impairment.

Act reference: SSAct section 95 Qualification for DSP - permanent blindness

Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 12 - Visual Function

Determining the level of functional impact - general rules

When determining which impairment rating applies to a person the rating that best describes the person's abilities or difficulties must be assigned. In applying the descriptors, each descriptor sets out how the points within it are to apply.

For example, to meet the 20-point impairment rating in Table 12, a person must meet all the points of the descriptor (1)(a), (b), (c), and (e), and satisfy either (1)(d)(i) or (ii).

The 30-point impairment rating allows for assessment of people who are not considered permanently blind but have an extreme level of vision impairment which impacts their ability to mobilise and perform their daily activities.

The descriptors in Table 12 use the term 'assistance'. 'Assistance' means assistance from another person, rather than any aids or equipment the person has and usually uses (refer to 3.6.3.05 'Use of aids, equipment & assistive technology').

The structure of the Tables requires that, in assessing the level of functional impact, a comparison must be made of all the descriptors for each level of impairment. An assessment starts by considering the descriptors for 0 points, and if a person has more than 'no functional impact', the descriptors for 5 points are then considered, and so on for the descriptors for higher impairment levels. When it is determined that the person meets all the required descriptors for a certain impairment rating level, but does not meet all the required descriptors for the next impairment rating level, the appropriate impairment rating applicable to the person's circumstances will be the lower of those 2 impairment ratings (i.e. the rating at which all the required descriptors are met).

Note: Individual descriptors or their parts must not be applied in isolation from one another.

In determining whether the required descriptors for a specific impairment level are met or not, ALL the descriptors for that level must be considered and applied as set out in the descriptor. NO descriptors or their parts are to be disregarded. However, one of several descriptor points may be sufficient for that rating when the word 'or' links the descriptors.

Explanation: Where a person meets the required descriptors for 10 points but does not meet sufficient required descriptors for 20 points, the correct impairment rating is 10 points. Their impairment CANNOT be assessed as severe or extreme, and neither 20 nor 30 points can be assigned.

Determination of the descriptor that best fits the person's impairment level must be based on the available medical evidence including the person's medical history, investigation results and clinical findings. A person's self-reported symptoms must not solely be relied on. It would be inappropriate to apply an impairment rating based solely on a person's self-reported functional capacity if this level of functional impairment is not consistent with the medical evidence available.

Consideration should be given to the fact that 2 people with the same level of vision loss can have different levels of independence and skills. Assumptions must not be made based solely on the clinical level of visual loss the person has.

A single impairment rating under Table 12 is to be determined, regardless of whether one or both eyes suffer vision loss.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 12 - Visual Function

0-point impairment rating level

The 0-point descriptor specifies that the person has NO or minimal functional impact on activities involving vision.

5-point impairment rating level

The 5-point descriptor requires that there is a MILD functional impact on activities involving vision. The person can perform most day to day activities involving vision and has mild difficulties seeing things at a distance or close up when wearing glasses or contact lenses (if these are usually worn), and at least one of the following applies (1)(a), (b), (c), (d), or (e).

10-point impairment rating level

The 10-point descriptor requires that there is a MODERATE functional impact on activities involving vision. The person must meet (1)(a), (b) and (c), at least one of (1)(d)(i), (ii) or (iii), and (2)(a) and (b) must also apply.

20-point impairment rating level

The 20-point descriptor requires that there is a SEVERE functional impact on activities involving vision. The person must meet (1)(a), (b), (c), and (e), and at least one of (1)(d)(i) or (ii).

30-point impairment rating level

The 30-point descriptor requires that there is an EXTREME functional impact on activities involving vision. The person must meet both (1)(a) and (b).

Some conditions causing impairment commonly assessed using Table 12

These include but are not limited to:

- diabetic retinopathy
- glaucoma
- retinitis pigmentosa
- macular degeneration, and
- cataracts.

Example: A 50-year-old woman was diagnosed with glaucoma several years ago. She has undergone surgery for this condition which has slowed down the progression of the disease but medical evidence states that her current symptoms will not improve and will eventually get worse. This woman has lost much of her peripheral vision and has very limited vision to the sides when looking straight ahead. She has difficulty seeing bus route numbers and reading normal sized print. She is not able to drive but does regularly use public transport independently. She sometimes needs to ask someone to inform her of the numbers of approaching buses. She uses special computer software to magnify computer screen displays and read text on screen out loud.

The condition is considered fully diagnosed, treated and stabilised. Under Table 12, this woman would receive an impairment rating of 10 points due to the moderate functional impact the condition has on her ability to function. Under the 10-point descriptor this woman would meet (1)(a), (b), (c) and (d)(i) and (2)(a) and (b).

Impairments that should not be assessed using Table 4

Impairment in vision which is not due to functions of the eye or visual tracts. Cases of 'functional blindness', where there is no identified anatomical or physiological abnormality of the eyes, optic nerves, visual tracts or occipital lobes of the brain, would usually be given an impairment rating under Table 5 - Mental Health Function, if the condition is assessable as fully diagnosed, treated and stabilised. Functional blindness is considered to be a psychiatric disorder under the Diagnostic and Statistical Manual of Mental Disorders (DSM

5) classification-functional neurological symptom disorder, also known as conversion disorder.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 12 - Visual Function

3.6.3.130 Guidelines to Table 13 - Continence Function

Summary

Table 13 is used to assess functional impairment related to incontinence of the bladder or bowel.

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. This includes a general practitioner or medical specialists such as a urogynaecologist, gynaecologist, urologist or gastroenterologist.

A PERSON'S SELF-REPORTED SYMPTOMS MUST NOT BE SOLELY RELIED UPON in determining functional impacts of the person's permanent condition. There must be corroborating medical evidence of the person's impairment.

Table 13 should be used if a person has an ileostomy or colostomy and requires continence or ostomy care.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 13 - Continence Function

Determining the level of functional impact - general rules

When determining which impairment rating applies to a person the rating that best describes the person's abilities or difficulties must be assigned. In applying the descriptors, each descriptor sets out how the points within it are to apply.

The descriptors in Table 13 use the term 'assistance'. Assistance means assistance from another person, rather than any aids or equipment the person has and usually uses (refer to 3.6.3.05 'Use of aids, equipment & assistive technology').

Under the 5-point, 10-point, 20-point and 30-point descriptors in Table 13, the person must have impairment in either bladder or bowel continence function (or both) or they must use a continence aid. The points within each descriptor are applied differently within each descriptor.

For example, under the 5-point descriptor at least one of the points (a - f) must apply. Under the 10-point descriptor, one or more of (2), (3) or (4) must apply and within each of these, both (a) and (b) must apply. Under the 20-point descriptor, one or more of (2), (3) or (4) must apply and within each of these, one or more of (a), (b) or (c) must apply.

The structure of the Tables requires that, in assessing the level of functional impact, a comparison must be made of all the descriptors for each level of impairment. An assessment starts by considering the descriptors for 0 points, and if a person has more than 'no functional impact', the descriptors for 5 points are then considered, and so on for the descriptors for higher impairment levels. When it is determined that the person meets all the required descriptors for a certain impairment rating level, but does not meet all the required descriptors for the next impairment rating level, the appropriate impairment rating applicable to the person's circumstances will be the lower of those 2 impairment ratings (i.e. the rating at which all the required descriptors are met).

Note: Individual descriptors or their parts must not be applied in isolation from one another.

In determining whether the required descriptors for a specific impairment level are met or not, ALL the descriptors for that level must be considered and applied as set out in the descriptor. NO descriptors or their parts are to be disregarded however, one of several descriptor points may be sufficient for that rating when the word 'or' links the descriptors.

Note: If the person's impairment does not meet sufficient required descriptors for a certain impairment level, the person's impairment cannot be rated at that level or at any higher level.

Explanation: Where a person meets the required descriptors for 5 points but does not meet sufficient required descriptors for 10 points, the correct impairment rating is 5 points. Their impairment CANNOT be assessed as moderate, severe or extreme and neither 10, 20 nor 30 points can be allocated.

Determination of the descriptor that best fits the person's impairment level must be based on the available medical evidence including the person's medical history, investigation results and clinical findings. A person's self-reported symptoms must not solely be relied on. It would be inappropriate to apply an impairment rating based solely on a person's self-reported functional history if this level of functional impairment is not consistent with the medical evidence available.

Where the descriptors refer to the person's condition affecting the comfort and attention of co-workers, this can apply even if the person does not work. Consideration should be given to whether the descriptor would be more than likely to apply if the person did work.

Example: A 58-year-old woman has previously given vaginal birth to 5 full-term babies. As a result of birth canal trauma, she developed severe pelvic floor deficiency with both urinary and faecal incontinence symptoms. These problems eventually required a major surgical procedure, which was performed 5 years ago. The operation was of substantial benefit and she no longer suffers from urinary incontinence, however anal sphincter function remains deficient and further surgery within the next 2 years has been ruled out on gynaecological and proctologist advice. The woman wears a continence pad to prevent minor faecal soiling of her underwear. Episodes of minor faecal incontinence occur at least once per day, with significant associated offensive odour, including from excessive frequent flatus. In a workplace setting, odour and intermittent noises would be likely to affect the comfort or attention of co-workers and cause embarrassment to the woman herself.

The condition is considered fully diagnosed, treated and stabilised and under Table 13, this woman would receive an impairment rating of 20 points due to the severe impact this condition has on her work-related functioning. Under the 20-point descriptor this condition would meet descriptor points (3)(a) 'the person's condition may affect the comfort or attention of co-workers' and (b)' the person has minor leakage from the bowel … every day'.

If a person has impairment to both bladder and bowel function, only a single rating should be applied, having regard to the impairment that causes the most impact on function. For example, a person who has a mild impairment to bladder function (i.e. meets one of descriptors (1)(a), (b) or (c) in the 5 point rating, but does not meet both descriptors (2)(a) and (b) in the 10 point rating) and who has a moderate impairment to bowel function (meeting descriptors (3)(a) and (b) in the 10 point rating), should be assigned an impairment rating of 10 points under Table 13.

0-point impairment rating level

The 0-point descriptor specifies the person has NO functional impact on maintaining continence of the bladder and bowel.

5-point impairment rating level

The 5-point descriptor specifies that for this impairment rating to be assigned to a person the person has a MILD functional impact on maintaining continence of the bladder or bowel. At least one of the following (1)(a), (b), (c), (d), (e) or (f) applies.

10-point impairment rating level

The 10-point descriptor specifies that for this impairment rating to be assigned to a person the person has a MODERATE functional impact on maintaining continence of the bladder or bowel. At least (a) and (b) under either (2), (3) or (4) applies.

20-point impairment rating level

The 20-point descriptor specifies that for this impairment rating to be assigned to a person the person has a SEVERE functional impact on maintaining continence of the bladder or bowel. At least one of either (a), (b) or (c) under either (2), (3) or (4) applies.

30-point impairment rating level

The 30-point descriptor specifies that for this impairment rating to be assigned to a person the person has an EXTREME functional impact and is completely unable to maintain continence of the bladder or bowel. At least one of either (2), (3) or one of either (4)(a) or (b) applies.

Some conditions causing impairment commonly assessed using Table 13

These include but are not limited to:

- some gynaecological conditions
- prostate enlargement or malignancy
- gastrointestinal conditions
- incontinence resulting from spinal cord conditions
- spina bifida
- neurodegenerative conditions
- multiple sclerosis
- brain injuries, and
- severe intellectual disability.

Example: A 45-year-old woman has a 5 year history of stress urinary incontinence, which has gradually worsened over the years. Initially, she had frequent episodes of stress incontinence on standing up, and also with coughing or lifting, and needed to use continence pads and change them twice daily. Her GP thought her incontinence was related to her 2 previous vaginal deliveries and she was referred to a physiotherapist for pelvic floor

muscle training program. Six months later, her stress incontinence had only slightly improved and she was referred to a urogynaecologist. The urogynaecologist performed a mid-urethral sling procedure. Three months later her stress incontinence has significantly improved and now has minor leakage from the bladder with lifting. This occurs once a day and she needs to wear a panty liner to avoid staining her underwear.

This condition is considered to be fully diagnosed, treated and stabilised, and under Table 13, a 5 point impairment rating is assigned due to the mild functional impact of this condition. Descriptor (1)(a): 'minor leakage from the bladder (e.g. a small amount of urine when coughing or sneezing) at least once a day, but not every hour' is met at this level.

Example: A 62-year-old man developed urinary incontinence following a radical prostatectomy for prostate cancer 1 year ago. He had stress urinary incontinence with physical exertion or coughing, nocturnal incontinence and constant leakage of urine. He also had urge urinary incontinence 2 to 3 times weekly, when he was unable to access a toilet in a timely manner. Initially the urinary incontinence was severe and he needed to change full continence pads 3 to 4 times daily. He has had appropriate investigation and management, as recommended by his urologist. This included pelvic floor muscle training and bladder retraining programs, and medication. His urinary incontinence has improved and he now only has minor stress incontinence several times daily and he no longer has constant urine leakage or urge incontinence. He finds this condition embarrassing and worries that others may smell the odour of urine, so he changes continence pads once or twice during every day, as soon as possible after an episode of incontinence.

His urinary incontinence condition is considered fully diagnosed, treated and stabilised and under Table 13, an impairment rating of 10 points is assigned due to the moderate functional impact of this condition. Descriptors (2)(a): 'minor bladder leakage several times each day' and (2)(b): 'the bladder incontinence results in interruptions to work on most days' are met at this level.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 13 - Continence Function

Impairments that should not be assessed using Table 13

Conditions that relate to digestive function which do not result in continence difficulties must be rated on Table 10 - Digestive and Reproductive Function.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 13 - Continence Function, Table 10 - Digestive and Reproductive Function

3.6.3.140 Guidelines to Table 14 - Functions of the Skin

Summary

Table 14 is used to assess functional impairment when performing activities requiring healthy, undamaged skin.

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. This includes a general practitioner or medical specialists such as a dermatologist or burns specialist.

A PERSON'S SELF-REPORTED SYMPTOMS MUST NOT BE SOLELY RELIED UPON in determining the functional impacts of the person's permanent condition. There must be corroborating medical evidence of the person's impairment.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 14 - Functions of the Skin

Determining the level of functional impact - general rules

When determining which impairment rating applies to a person the rating that best describes the person's abilities or difficulties must be assigned. In applying the descriptors, each descriptor sets out how the points within it are to apply.

For example, the 10-point descriptor in Table 14 states that at least one of the following applies while the 20-point descriptor states that at least 2 of the following apply.

The structure of the Tables requires that, in assessing the level of functional impact, a comparison must be made of all the descriptors for each level of impairment. An assessment starts by considering the descriptors for 0 points, and if a person has more than 'no functional impact', the descriptors for 5 points are then considered, and so on for the descriptors for higher impairment levels. When it is determined that the person meets all the required descriptors for a certain impairment rating level, but does not meet all the required descriptors for the next impairment rating level, the appropriate impairment rating applicable

to the person's circumstances will be the lower of those 2 impairment ratings (i.e. the rating at which all the required descriptors are met).

Note: Individual descriptors or their parts must not be applied in isolation from one another.

In determining whether the required descriptors for a specific impairment level are met or not, ALL the descriptors for that level must be considered and applied as set out in the descriptor. NO descriptors or their parts are to be disregarded.

Note: If the person's impairment does not meet sufficient required descriptors for a certain impairment level, the person's impairment cannot be rated at that level or at any higher level.

Explanation: Where a person meets the required descriptors for 5 points but does not meet sufficient required descriptors for 10 points, the correct impairment rating is 5 points. Their impairment CANNOT be assessed as moderate, severe or extreme and neither 10, 20 nor 30 points can be allocated.

Determination of the descriptor that best fits the person's impairment level must be based on the available medical evidence including the person's medical history, investigation results and clinical findings. A person's self-reported symptoms must not solely be relied on. It would be inappropriate to apply an impairment rating based solely on a person's self-reported functional capacity if this level of functional impairment is not consistent with the medical evidence available.

Each of the descriptors must be considered in relation to the adaptations to daily activities that the person has to make as a result of their condition.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 14 - Functions of the Skin

0-point impairment rating level

The 0-point descriptor specifies the person has NO functional impact on activities requiring healthy, undamaged skin.

5-point impairment rating level

The 5-point descriptor specifies that for this impairment rating to be assigned to a person, the person has a MILD functional impact on activities requiring healthy, undamaged skin.

Minor adaptations to some daily activities are required and at least one of the following descriptor points (1)(a), (b) or (c) apply.

10-point impairment rating level

The 10-point descriptor specifies that for this impairment rating to be assigned to a person, the person has a MODERATE functional impact on activities requiring healthy, undamaged skin. The person has made adaptations to several daily activities and at least one of the following descriptor points (1)(a), (b), (c) or (d) applies. If the person can perform the listed activities in (1)(a), (b), (c) or (d) with the use of sun protection, then 10 points should not be assigned.

20-point impairment rating level

The 20-point descriptor specifies that for this impairment rating to be assigned to a person, the person has a SEVERE functional impact on activities requiring healthy, undamaged skin. Regarding the person's significant modifications to, or the inability to, perform daily activities, at least 2 of the following descriptor points apply (1)(a), (b), (c), (d) or (e).

30-point impairment rating level

The 30-point descriptor specifies that for this impairment rating to be assigned to a person the person has an EXTREME functional impact on activities requiring healthy, undamaged skin. The person has to make major modifications to most daily activities or is unable to perform most daily activities, requires repeated assistance throughout the day and could not attend work, education, or training for a continuous period of at least 3 hours as at least one of the following (1)(a), (b) or (c) must apply.

Some conditions causing impairment commonly assessed using Table 14

These include but are not limited to:

- burns
- severe eczema, psoriasis or dermatitis
- chronic pruritus
- allodynia
- ulceration or diabetic foot ulcers, and
- skin cancer, or long term effects of skin cancer treatment.

Example: A 57- year- old male has had varicose veins and swelling of his lower legs for several years. In the last 12 months, he has also developed chronic varicose eczema, with recurrent venous ulcerations and infections. These conditions have been appropriately diagnosed by his general practitioner. A vascular surgeon has confirmed that varicose vein surgery is contraindicated due to his other medical conditions (type 2 diabetes, obesity and a heart condition). He has had appropriate conservative management with compressive leg stockings, dressings, and antibiotics as needed. The dressings need to be changed several times per week and this frequency has not changed for the last 6 months. He needs help from his partner with dressing changes and he needs to allow 30 minutes for this. His partner also has to assist him daily with putting on the compressive stockings, and it usually takes 5-10 minutes to fit them each day. He is able to wear closed-in sneakers, but uses those with Velcro to make them easier to remove. He reported that he is unable to wear thongs because of his compression stockings, but has no other restrictions in clothing relating to dressings and compression stockings, and is able to wear long pants if they are loose fitting. His general practitioner has advised him to elevate his legs for several short periods each day to reduce the leg swelling and to avoid prolonged standing.

This condition is considered to be fully diagnosed, treated and stabilised. Under Table 14, the assigned impairment rating would be 10 points, as he has moderate difficulties performing daily activities due to lesions on the skin, which require creams or dressings, and limit movement or comfort. Under the 10-point descriptor, he would meet descriptor (1)(c).

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 14 - Functions of the Skin

3.6.3.150 Guidelines to Table 15 - Functions of Consciousness

Summary

Table 15 is used to assess functional impairment due to involuntary loss of consciousness or altered state of consciousness.

Altered state of consciousness includes instances where a person may not lose consciousness completely and may remain sitting or standing but becomes unaware of their surroundings or actions.

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. This includes a general practitioner or medical specialists such as a neurologist or endocrinologist. Assessments or reports from practitioners specialising in the treatment and management of these conditions (such as clinical nurse consultants or nurse practitioners specialising in diabetes management) can also be provided as supporting evidence of treatment and/or functional impairment. However, the diagnosis must be made by an appropriately qualified medical practitioner as described above.

A PERSON'S SELF-REPORTED SYMPTOMS MUST NOT BE SOLELY RELIED UPON in determining functional impacts of a person's permanent condition (impairment). There must be corroborating medical evidence of the person's impairment.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 15 - Functions of Consciousness

Determining the level of functional impact - general rules

When determining which impairment rating applies to a person the rating that best describes the person's abilities or difficulties must be assigned. In applying the descriptors, each descriptor sets out how the points within it are to apply.

Under the 5-point, 10-point, 20-point and 30-point descriptors in Table 15, the person must have either episodes of involuntary loss of consciousness or altered state of consciousness.

Under the 20-point descriptor all of (1)(a), (b), (c) and (d) must apply. Within descriptor (1)(a), the person must meet both of (A) and (B) in either (1)(a)(i) or (1)(a)(ii).

The structure of the Tables requires that, in assessing the level of functional impact, a comparison must be made of all the descriptors for each level of impairment. An assessment starts by considering the descriptors for 0 points, and if a person has more than 'no functional impact', the descriptors for 5 points are then considered, and so on for the descriptors for higher impairment levels. When it is determined the person meets all the required descriptors for a certain impairment rating level, but does not meet all the required descriptors for the next impairment rating level, the appropriate impairment rating applicable to the person's circumstances will be the lower of those 2 impairment ratings (i.e. the rating at which all the required descriptors are met).

Note: Individual descriptors or their parts must not be applied in isolation from one another.

In determining whether the required descriptors for a specific impairment level are met or not, ALL the descriptors for that level must be considered and applied as set out in the descriptor. NO descriptors or their parts are to be disregarded however, one of several descriptor points may be sufficient for that rating when the word 'or' links the descriptors.

Note: If the person's impairment does not meet sufficient required descriptors for a certain impairment level, the person's impairment cannot be rated at that level or at any higher level.

Explanation: Where a person meets the required descriptors for 5 points but does not meet sufficient required descriptors for 10 points, the correct impairment rating is 5 points. Their impairment CANNOT be assessed as moderate, severe or extreme and neither 10, 20 nor 30 points can be allocated.

Determination of the descriptor that best fits the person's impairment level must be based on the available medical evidence including the person's medical history, investigation results and clinical findings. A person's self-reported symptoms must not solely be relied on. It would be inappropriate to apply an impairment rating based solely on a person's self-reported functional history if this level of functional impairment is not consistent with the medical evidence available.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 15 - Functions of Consciousness

0-point impairment rating level

The 0-point descriptor specifies the person has NO functional impact from loss of consciousness or altered state of consciousness during waking hours when occupied with a task or activity.

5-point impairment rating level

The 5-point descriptor specifies that for this impairment rating to be assigned to a person the person has a MILD functional impact from loss of consciousness or altered state of consciousness during waking hours when occupied with a task or activity. The person must meet descriptors (1)(a), (b) and (c). Within the descriptor point (1)(a), they must meet both (A) and (B) in either (i) or (ii).

10-point impairment rating level

The 10-point descriptor specifies that for this impairment rating to be assigned to a person the person has a MODERATE functional impact from loss of consciousness or altered state of consciousness during waking hours when occupied with a task or activity. The person must meet descriptors (1)(a), (b), (c) and (d). Within the descriptor point (1)(a), they must meet both (A) and (B) in either (i) or (ii).

20-point impairment rating level

The 20-point descriptor specifies that for this impairment rating to be assigned to a person the person has a SEVERE functional impact from loss of consciousness or altered state of consciousness during waking hours when occupied with a task or activity. The person must meet descriptors (1)(a), (b), (c) and (d). Within the descriptor point (1)(a), they must meet both (A) and (B) in either (i) or (ii)

30-point impairment rating level

The 30-point descriptor specifies that for this impairment rating to be assigned to a person the person has an EXTREME functional impact from loss of consciousness or altered state of consciousness during waking hours when occupied with a task or activity. The person must meet descriptors (1)(a), (b), (c) and (d). Within the descriptor point (1)(a), they must meet both (A) and (B) in either (i) or (ii).

Some conditions causing impairment commonly assessed using Table 15

These include but are not limited to:

- epilepsy
- migraine that results in loss of consciousness or altered states of consciousness
- diabetes mellitus where due to hypoglycaemic events
- the person experiences loss of consciousness or altered states of consciousness, or are more rarely unconscious, and
- narcolepsy.

Example 1: A 27-year-old woman has been diagnosed with epilepsy. She has undergone treatment for this condition and her treating practitioner has outlined that her condition is now stabilised. She continues to experience seizures as a result of this condition, during which she loses consciousness. These seizures occur approximately 6 times per year. Following a seizure, she suffers extreme tiredness and headaches and is often unable to undertake her usual activities for a few days. In the past she has required hospitalisation as a result of a seizure. Between these seizures she is able to perform her regular daily activities but she is unable to obtain a driver's licence given the unpredictability of these seizures. She works part-time as a result of this condition and her employer makes allowances for her work absences when she has suffered a seizure. She is unable to work in a role where she could be at increased risk if she had a seizure, such as using machinery.

The condition is considered fully diagnosed, treated and stabilised. Under Table 15, this woman would receive an impairment rating of 10 points given the moderate impact this condition has on her ability to function. Under the 10-point descriptor this woman would meet (1)(a)(i)(A) and (B) and (1)(b), (c) and (d).

Example 2: A 58-year-old person has had type 2 diabetes for 25 years. They have adhered to dietary requirements and prescribed medications for many years. Their overall blood glucose control has improved over the years and they regularly see an endocrinologist and diabetic educator. Currently, they are prescribed a combination of oral medication and insulin injections. Letters from their endocrinologist over the last 2 to 3 years state that their blood glucose control is 'excellent'. However, despite this improvement they have developed a diabetic autonomic neuropathy with gastroparesis (delayed emptying of the stomach) and hypoglycaemic unawareness (i.e. they are not aware of their low glucose levels, even with

severe episodes). The gastroparesis has worsened their blood glucose control. Just before their claim for DSP, their endocrinologist was adjusting the dose of their insulin injections in an effort to reduce the number and severity of hypoglycaemic episodes, however they continued to have 1 to 2 episodes/week. During these episodes, they appeared to be confused and needed help from their partner. The episodes resolved within 20 minutes. They are not able to obtain a driver's licence because of these episodes.

Their type 2 diabetes condition is fully diagnosed, treated and stabilised, as it is a long standing condition and is being appropriately managed. They have developed the irreversible end organ complication of an autonomic neuropathy with frequent hypoglycaemic episodes. This has required adjustments to their medication, which is unavoidable in this situation and the endocrinologist has confirmed that even with further adjustments to the dose of their insulin injections, it is likely that the hypoglycaemic episodes will not reduce in frequency or severity. Under Table 15, an impairment rating of 10 points is appropriate, as descriptors (1)(a)(ii)(A), (B) and (C), and (1)(b), (c) and (d) are met.

Example 3: A 20- year- old person was diagnosed with narcolepsy (a chronic sleep disorder characterized by overwhelming daytime drowsiness and sudden attacks of sleep) following a sleep study 2 years ago. They had a 7 year history of daytime sleepiness, which was getting worse. When they attended high school, they had difficulty staying awake during classes or exams. After finishing high school, they worked in retail and they often dozed off while still standing up and were dismissed. They developed episodes of cataplexy (sudden loss of muscle tone triggered by intense emotions such as laughter or anger, which may result in facial drooping or falls to the ground) 3 years ago. After the diagnosis of narcolepsy was made, their sleep physician prescribed appropriate medications. This reduced their daytime sleepiness and cataplexy. They were usually able to stay alert, work on a computer and drive without sleep attacks, although they did require a brief nap after returning home from work. Sudden sleep attacks now occur once or twice a year in situations such as meetings and do not require hospitalisation. They have occasional episodes of cataplexy with drooping of the face or head. They were able to work and live alone without needing help from others. They had a conditional driver's licence which required them to maintain their treatment for narcolepsy.

Their narcolepsy condition is fully diagnosed, treated and stabilised. Under Table 15, an impairment rating of 5 points is appropriate, as descriptors (1)(a)(i)(A) and (B), and (1)(b) and (c) are met.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 15 - Functions of Consciousness

Impairments that should not be assessed using Table 15

Table 15 must not be used for migraines which do not result in loss or altered states of consciousness. These are more appropriately assessed under Table 7 – Brain Function.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 Table 7 - Brain Function

1.1.F.240 Fully diagnosed, fully treated & fully stabilised (FDTS) (DSP)

Fully diagnosed & fully treated

In determining whether a condition has been fully diagnosed by an appropriately qualified medical practitioner and whether it has been fully treated, the following is to be considered:

- whether there is corroborating evidence of the condition
- what treatment or rehabilitation has occurred in relation to the condition, and
- whether treatment is continuing or is planned in the next 2 years.

Fully stabilised

A condition is fully stabilised if:

- either the person has undertaken reasonable treatment for the condition and any further reasonable treatment is unlikely to result in significant functional improvement to a level enabling the person to undertake work in the next 2 years, or
- the person has not undertaken reasonable treatment for the condition and:
    - significant functional improvement to a level enabling the person to undertake work in the next 2 years is not expected to result, even if the person undertakes reasonable treatment, or
    - there is a medical or other compelling reason for the person not to undertake reasonable treatment.

1.1.I.10 Impairment Tables (DSP)

Definition

For the purposes of DSP, the Impairment Tables are tables designed to assess impairment in relation to work. They consist of a set of tables that assign ratings in proportion to the severity of impact of the impairment on function as it relates to work performance.

The Impairment Tables were last reviewed in 2011 to bring them into line with contemporary medical and rehabilitation practice. The current Impairment Tables are contained in the Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011. These Tables have been in force from 1 January 2012 and are used for the assessment of new DSP claims made on or after that date and reviews commenced on or after that date.

The Tables:

- are function based rather than diagnosis based
- describe functional activities, abilities, symptoms and limitations, and
- are designed to assign ratings to determine the level of functional impact of impairment and not to assess conditions.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011

SSAct pre-1 January 2012 Schedule 1B Tables for the assessment of work-related impairment for DSP

Policy reference: SS Guide 3.6.3 Guidelines to the Tables for the Assessment of Work-related Impairment for DSP

1.1.P.220 Permanent condition & permanent impairment (DSP)

Definition

For the purposes of DSP, both a person's medical condition and the resulting impairment must be permanent before an impairment rating can be assigned under the Impairment Tables (1.1.I.10).

A permanent condition is a medical condition which has been fully diagnosed, fully treated and fully stabilised (1.1.F.240) and is more likely than not, in light of available evidence, to persist for more than 2 years.

A permanent impairment is an impairment resulting from a permanent condition which is more likely than not, in light of available evidence, to persist for more than 2 years.

Example: A condition may last for more than 2 years, but the impairment resulting from that condition may be assessed as likely to improve or cease within 2 years. If this is the case an impairment rating cannot be assigned to the impairment.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011

Policy reference: SS Guide 3.6.2.100 DSP assessment of impairment ratings

3.6.1.67 Sustainability of work & DSP

Topic applies to

This topic applies to people who are subject to either the 15 hour work capacity rule or the 30 hour work capacity rule for DSP qualification.

Policy reference: SS Guide 3.6.1.12 Qualification for DSP - 15 hour rule, 3.6.1.10 Qualification for DSP - 30 hour rule

Overview

Capacity to work for 15 hours or more per week means the ability to reliably perform work of 15 hours or more per week for a period of 26 weeks without excessive leave or work absences.

Similarly, capacity to work for 30 hours or more per week means the ability to reliably perform work of 30 hours or more per week for a period of 26 weeks without excessive leave or work absences.

Explanation: Approximately 2 weeks sick leave in relation to a person's condition in a 26 week period is considered to be reasonable leave.

Explanation: Sick leave of a month or more in relation to a person's condition in 26 weeks is more than what is considered reasonable.

Increase to allowable hours of work for DSP recipients

From 1 July 2012 DSP recipients continue to receive DSP if they obtain paid work of at least 15 and less than 30 hours a week.

Act reference: SSAct section 96 Continuation of DSP

Policy reference: SS Guide 3.6.1.100 Continuation, variation or termination of DSP

Episodic, fluctuating, or intermittent conditions

In cases where a person's medical condition is variable, their ability to reliably perform work of 15 hours (or 30 hours, if subject to this rule) or more per week for a period of 26 weeks without excessive leave or work absences will be considered.

The following explanations and examples are given in relation to people subject to the 15 hour rule. The following also applies to people subject to the 30 hour rule.

Explanation: A person with a stable permanent condition characterised by infrequent or brief episodes who is able to work 15 hours (30 hours) or more per week for a period of 26 weeks would be ineligible for DSP, but may qualify for JSP or another appropriate payment.

Example: Rob has an anxiety disorder which is asymptomatic for long periods between discreet episodes of impaired functioning. Over a 26 week period, Rob's condition will prevent him from attending work for around 2 weeks. Rob can work 15 hours (30 hours) a week for a period of 26 weeks and is not eligible for DSP.

Explanation: A person with a permanent condition characterised by severe and frequent episodes who is unable to work 15 hours (30 hours) per week for a period of 26 weeks without significant work absences may be eligible for DSP.

Example: Jacqui has a psychiatric impairment which is likely to persist for the foreseeable future. Despite undergoing all reasonable treatment for her condition, Jacqui still experiences frequent psychotic episodes. Consideration of work capacity takes into account these fluctuations. Over a 26 week period, Jacqui takes an average of 6 weeks leave because of these episodes. She is unable to work 15 hours (30 hours) a week without requiring excessive leave or work absences for the purpose of DSP.

Policy reference: SS Guide 3.6.3 Guidelines to the Tables for the Assessment of Work-related Impairment for DSP, 6.2.5.03 DSP - Application of DSP Qualification Rules at Review

3.6.2.10 Medical & other evidence for DSP

Summary

Medical evidence (1.1.M.100) is required to determine whether a person meets the DSP impairment and CITW (1.1.C.330) qualification requirements. It is the person's responsibility to provide medical evidence in support of their DSP claims and payment continuations.

For DSP claims lodged on or after 3 September 2011 and certain DSP recipients aged under 35 years subject to review (6.2.5.03), other evidence is also required to determine whether a person who does not have a severe impairment (1.1.S.127) or is a reviewed 2008-11 DSP starter (1.1.R.285) has actively participated in a POS (1.1.A.30).

Medical and other evidence is used for the purposes of:

- conducting a JCA (1.1.J.10) and preparing reports to inform DSP decision making
- completing a DMA (1.1.D.180)
- making determinations about granting, rejecting, cancelling or continuing DSP, and
- reviewing decisions about DSP eligibility made under social security law (reviews and appeals).

Act reference: SSAct section 94 Qualification for DSP

Social Security (Active Participation for Disability Support Pension) Determination 2014

Policy reference: SS Guide 3.6.2 Assessment for DSP

Changes to medical evidence for DSP claims

From 1 July 2015, people claiming DSP are not required to submit a medical report from their treating doctor. Instead, they need to provide their medical records.

Prior to 1 January 2015, the primary source of medical evidence for DSP was a medical report from a person's treating doctor (1.1.T.160). From 1 January 2015, changes were made to the way medical evidence is sourced and provided in support of a claim for DSP.

Some people claiming DSP were no longer required to submit a medical report from their treating doctor, and instead needed to provide their medical records. Initially these changes applied to people aged under 35 and living in a capital city.

From 1 July 2015, medical reports from treating doctors are no longer required for any DSP claims. From that date, the primary source of medical evidence is a person's medical records provided by the person.

Medical report - DSP reviews

DSP recipients whose medical qualification is being reviewed, are still required to provide a medical report from their treating doctor. The person may also provide additional information about their medical conditions (1.1.M.90) and how these impact on their ability to work.

Primary medical evidence

DSP determinations are based on a range of considerations pertaining to the qualification criteria for the payment. These considerations include whether a person's condition is permanent, that is whether, in light of available evidence, the condition is fully diagnosed, fully treated and fully stabilised and more likely than not to persist for more than 2 years. Diagnosis of medical conditions for DSP purposes can only be provided by an appropriately qualified medical practitioner (exceptions are outlined below). Medical evidence should therefore contain sufficient information to enable DSP determinations to be made, including details of:

- the diagnosis of the person's medical condition/s, including date of onset and whether the diagnosis is confirmed, and the details of the medical professional who made the diagnosis
- clinical features including history, current symptoms and prognosis
- past, present and future/planned treatment
- impact of condition/s on ability to function, including whether this impact is long term or temporary and whether the effect of the condition on the person's ability to function is expected to remain unchanged, improve, or deteriorate
- any impact on life expectancy as a result of the medical condition/s, and
- any supporting information used by the doctor, such as x-rays, hospital records or pathology results.

Examples of medical evidence could include, but not be limited to:

- medical history reports
- specialist medical reports
- medical imaging reports

- compensation reports
- physical examination reports
- hospital/outpatient records
- operative reports
- rehabilitation reports, or
- details of any current or planned treatment from a treating doctor or specialist.

Types of evidence acceptable in certain circumstances

The above primary medical evidence requirements may not apply in certain circumstances where sufficient information to make a DSP determination is available from other sources, including for:

- People with an intellectual disability who have attended a school which provided tailored education for children with disability, or classes within a mainstream school which were tailored to meet their needs, and are able to provide a report from their school which indicates their IQ.
- People who are blind and are able to provide a report from an ophthalmologist, or a report from an optometrist, which is supported by a report from the treating or formerly treating ophthalmologist.
- A child assessed before 1 July 2009 as being a profoundly disabled child (1.1.C.146) whose carer was being paid CP up to the time the child turns 16.
- A person in receipt of a DVA disability pension at special rate (totally and permanently incapacitated (TPI)). The person must provide their special rate decision letter from DVA or give authority for Services Australia to obtain the relevant payment information from DVA.

In limited circumstances a claimant's eligibility for DSP may be based on the provisional diagnosis of a mental health condition provided solely by a Services Australia registered psychologist (see below).

Unclear evidence

If a person indicates that they have a medical condition that is not included in their medical evidence, they should be asked to provide additional medical evidence detailing the diagnosis and treatment of this medical condition. This may involve the person asking the

provider of the medical evidence for further information (if this doctor has treated them for the unlisted condition), or obtaining evidence from another doctor or specialist. It is generally the person's responsibility to provide all relevant medical evidence in support of their claim or payment continuation.

If a report, document or other material contains unclear terminology or lacks clarity, it should also be discussed with its author. If there is still a need for an expert medical opinion, the HPAU (1.1.H.60) can provide advice, clarification and interpretation of medical information to a job capacity assessor (1.1.J.20) and Services Australia staff for DSP claim, review and appeal purposes.

Any discussions to clarify unclear evidence must be recorded and form part of the evidence used to support the decision about qualification for DSP.

People living in remote areas

JCAs, DMAs and payment decisions informed by these assessments must be based on the best available medical evidence. In the case of people from remote areas who may have limited access to doctors, a community nurse can assist in collating their medical evidence, which should generally be based on clinical notes from a GP (the diagnosis must be made by a qualified medical practitioner). In these cases it may be possible for the job capacity assessor or the GCD to form an opinion regarding the person's medical qualification on the basis of available evidence. This will only apply if the medical condition has been fully diagnosed, treated and stabilised (1.1.F.240) to the extent that it is possible to assign an impairment rating.

Explanation: People living in remote areas may have limited access to medical services and may find it difficult to obtain current medical evidence in relation to their condition/s.

Medical evidence & diagnosis for vulnerable people

There are a small number of vulnerable people with suspected mental health conditions who are likely to be qualified for DSP or eligible for a significant reduction in their participation requirements but are unable to be effectively assessed through normal DSP assessment procedures. This may be because they are disengaged from the health system, or do not acknowledge the impacts of their condition on their capacity to work or comply with requirements. This may include people who:

- are living in remote communities with little or no access to health services, and/or
- have been identified by Services Australia staff based on the information (which may originate from within Services Australia or externally, for example from relevant state authorities or employment service providers) that is contained in the person's Services Australia records, as continually unable to comply with the relevant

requirements, and demonstrating behaviours consistent with a chronic mental health condition.

In these circumstances the provisional diagnosis of a mental health condition can be made by a Services Australia psychologist and this assessment may be considered sufficient medical evidence for DSP purposes.

In all these cases the evidence/case history should be discussed with the HPAU so that consideration can be given to other medical factors which may be impacting on the person.

In limited and specifically defined circumstances, a person's medical condition/s may be verified as fully diagnosed, treated and stabilised without written medical evidence. Diagnosis and other details relevant to assessment of DSP may be based solely on documented conversations with the person's treating doctor in the following limited circumstances:

- where the person is unlikely to provide written medical evidence because of a mental health or other serious condition, and/or
- where the person lives in a remote area and has limited access to medical services.

Medical information provided in these circumstances must contain the same level of details as that normally contained in the primary medical evidence outlined above.

Other medical evidence

The person may choose to provide other relevant medical evidence. This type of evidence may also be available from other sources such as Services Australia records. However, this type of evidence can only be used as supporting or complementary evidence and cannot be used in isolation from, or instead of, the primary evidence containing the required details (including diagnosis, treatment and prognosis) outlined above. This type of evidence may include but is not limited to:

- medical certificates from the person's treating doctor or specialist
- hospital/outpatient reports
- x-ray and other medical investigation reports
- psychometric test results
- prescriptions/sample medication
- medical information used by Services Australia to assess entitlement to other payments

    - **Example:** If a person has recently attracted payment of CP or CA, the delegate can refer to previous medical reports held on the CP/CA file for the person.

- reports from para-professionals, or
- reports from non-medical practitioners or community services.
    - **Example:** Psychologists, mental health workers, social workers, drug and alcohol counsellors, community medical health workers, physiotherapists and occupational therapists.

Explanation: This type of information may supplement but cannot be used in isolation from or instead of the primary medical evidence from appropriately qualified medical practitioners.

Non-medical evidence

The person may also choose to provide non-medical evidence in support of their DSP claim or continuation. This evidence may include but is not limited to:

- reports from alternative health practitioners (e.g. naturopaths, massage therapists)
- letters or references from various sources (e.g. carers, friends, community members), or
- reports from teachers (other than reports from teachers on behalf of special schools that contain IQ test results).

Explanation: Reports from special schools/teachers on behalf of special schools that contain IQ test results are treated as medical evidence.

Non-medical evidence alone cannot be used for determining DSP eligibility.

Evidence of active participation in a POS

Any material which is related to a person's participation in a POS can be used to determine whether that person has actively participated. This may include information from one or more designated providers (1.1.D.115). The information in relation to the POS must provide the following:

- details of the designated provider
- periods of participation in the program
- periods of non-participation in the program and associated reasons
- reasons for ceasing the program (if any)

- the terms of the program that were specifically tailored to address the person's level of impairment, individual needs, barriers to employment, and capacity to work
- the terms with which the person had to comply in order to satisfy the program requirements and the level of compliance with those terms
- details of vocational, rehabilitation or employment activities undertaken during the program, and
- the frequency of contact the person had with the designated provider.

Documents or other material that may assist in determining whether a person has actively participated in a POS include but is not limited to:

- EPPs (1.1.J.25), or
- DES, Workforce Australia, CDP (former RJCP) or Australian Disability Enterprise program progress, exit or closure reports.

A person cannot meet the requirements for active participation in a POS (1.1.A.30) unless they have commenced a POS. A person is generally required to have participated in a POS for at least 18 months during the relevant period applying to the person (generally 36 months). However, a person who has commenced their POS will not be required to have participated for the full 18 months, where:

- the POS was terminated before the end of the relevant period applying to the person because the person was unable, solely due to their impairment, to improve their work capacity, or
- at the end of the relevant period (e.g. at the date of claim), the person is participating in a POS but is prevented, solely because their impairment, from improving their work capacity through continued participation in the program.

Explanation: The above provisions are not exemptions from the POS requirements. They provide alternative avenues through which persons can meet the POS requirements in certain circumstances. In order for a person to meet the POS requirements under the above provisions, robust evidence must be provided which demonstrates the person commenced a POS but was or is unable to improve their work capacity by participating in a program solely due to their impairment. A report must be provided by the designated provider, which details the person's participation in a POS, why the program was terminated (if relevant) and why the person was or is unable to benefit from continuing in the program as a result of their impairment. This applies to new claimants and certain DSP recipients aged under 35 years who are subject to POS requirements on review (6.2.5.03), from 1 July 2014.

Currency of evidence

The 'best available' medical evidence must be used in the assessment. If the medical evidence is not recent, it may still be useful depending on:

- the person's condition, and
- whether the information is representative of the person's current degree of impairment.

Example: A report which is several years old may still be of value in forming an opinion if the condition remains unchanged since the time the report was completed.

The currency of evidence, used to determine whether a person has actively participated in a POS, will differ depending on people's circumstances (1.1.A.30).

Policy reference: SS Guide 3.6.1 DSP - qualification & payability

3.6.2.20 Manifest grants & rejections for DSP

Summary

Where sufficient information is contained in the evidence provided by the claimant, a claim can be determined without the need for further assessment in the following situations:

- manifest medical/work capacity grant
- manifest medical/work capacity rejection, and
- non-medical/non-work capacity rejection.

DSP claimants are considered to be manifestly (1.1.M.30) qualified, when they clearly and obviously meet all the qualification criteria in SSAct section 94. Only in very clear cut cases outlined below, can claims be granted without further assessment.

This provision also applies in reverse, in that a claim from a person who is clearly and obviously NOT qualified can be rejected without further assessment.

As with all other claims for DSP, documented medical evidence of the extent and severity of the condition/s is necessary to assess the impact on the claimant's CITW (1.1.C.330). All decisions must be fully documented.

To help decision makers identify and expedite manifest grants of DSP 2 lists of catastrophic, profound and/or terminal conditions can be found below. See 'List of conditions for determining manifest eligibility'.

Manifest grants

DSP may only be granted without the need for further assessment in the following LIMITED CIRCUMSTANCES.

Manifest grants may only be made where a person:

- has a terminal illness (life expectancy of less than 2 years with significantly reduced work capacity during this period)
- has permanent blindness (meets the test for permanent blindness for social security purposes)
- has an intellectual disability where medical evidence clearly indicates an IQ of less than 70
- has an assessment indicating that they require nursing home level care (see note below)

- has category 4 HIV/AIDS, or
- is in receipt of a DVA disability pension at special rate (totally and permanently incapacitated (TPI)).

Note: Care recipients may be accepted as requiring nursing home level care if they were assessed as a profoundly disabled child (1.1.C.146), and the person's carer must have:

- claimed CP in respect of the care receiver before 1 July 2009, and been receiving CP up to the time the care receiver turned 16, OR
- claimed CP in respect of the care receiver on or after 1 July 2009, and the child care receiver has a THP score of >= 4 and an ACL score of >= 300.

Act reference: SSAct section 94 Qualification for DSP

Policy reference: SS Guide 3.6.1.10 Qualification for DSP - 30 hour rule, 3.6.1.12 Qualification for DSP - 15 hour rule, 3.6.2.10 Medical & other evidence for DSP, 3.6.2.30 Manifest grants & continuing inability to work (DSP)

Terminal illness

Manifest qualification for DSP is accepted if medical evidence indicates the claimant's current medical condition (1.1.M.90) is chronic and debilitating with a prognosis (1.1.P.440) that the condition is terminal, and the average life expectancy of a patient with this condition is 24 months or less, and there is a significant reduction in work capacity within this period.

Permanent blindness

A claimant whose medical evidence clearly indicates that they have no vision is accepted as being manifestly qualified for DSP.

Example: A person who has been totally blind since birth or has lost both eyes due to cancer or an accident.

A claimant whose supporting report (SA013) completed by their treating ophthalmologist confirms that they meet the criteria for permanent blindness is accepted as being manifestly qualified for DSP.

Note: It is not acceptable to make a manifest grant if an optometrist completes the SA013, even if the details of a treating or formerly treating ophthalmologist are provided.

Act reference: SSAct section 95(1) Qualification for DSP-permanent blindness

Policy reference: SS Guide 3.6.2.40 Assessment of blindness for DSP

Intellectual disabilities

A claimant whose medical evidence clearly indicates that they have an IQ of less than 70 is accepted as manifestly qualified for DSP.

Policy reference: SS Guide 3.6.2.50 Assessment of people with intellectual impairments for DSP

Nursing home level care

A claimant who has evidence indicating they are a long term patient of a hospital or nursing home, or require nursing home level care because of illness or infirmity and are unlikely to be discharged in the foreseeable future, is accepted as manifestly qualified for DSP. The medical evidence needs to provide details of:

- the nature of the impairment and reason for long term hospitalisation
- the likelihood of discharge, and
- ability to perform activities of daily living.

Note: A person does not have to be in a nursing home to be manifestly granted DSP, it is sufficient that they require the same level of care (usually provided by carer/s).

Category 4 HIV/AIDS

A claimant who has category 4 HIV/AIDS is accepted as being manifestly qualified for DSP, subject to medical evidence (1.1.M.100) supporting the claim.

DVA disability pension at special rate (totally & permanently incapacitated (TPI))

Where the claimant is in receipt of a DVA disability pension at special rate (TPI) they are considered manifest for the purposes of DSP qualification. The claimant must provide their special rate decision letter from DVA or give authority for Centrelink to obtain the relevant payment information from DVA.

List of conditions for determining manifest eligibility

From 1 July 2010, 2 lists of conditions are available to help decision makers determine manifest eligibility for DSP on the grounds of terminal illness, nursing home level care requirements, and/or intellectual disability

The lists supplement, rather than replace existing manifest guidelines, therefore manifest grants can still be made for claimants with conditions not yet listed. Additionally, the lists are not designed to cover manifest grants on the grounds of permanent blindness nor category 4 HIV/AIDS.

About list 1

List 1 catalogues conditions which are accepted as manifest (clearly and obviously meet all the DSP qualification criteria) on diagnosis alone.

Decision makers will check whether the condition listed in the DSP claimant's medical evidence is on list 1, and if it is then they will establish eligibility without the need for a JCA.

List 1

Note: A manifest grant of DSP is able to be made when a claimant is diagnosed with one or more of the following conditions (on list 1).

Letter	Condition	Manifest category
A	Amyotrophic Lateral Sclerosis (ALS)	Nursing home level care
	Angelman Syndrome	Nursing home level care
C	Creutzfeldt-Jacob Disease (CJD) - Adult	Nursing home level care
G	Gallbladder cancer	Terminal illness
	Gioblastoma Multiforme (brain tumour)	Terminal illness
L	Lesch-Nyhan Syndrome (LNS)	Nursing home level care
	Liver cancer (primary cancer)	Terminal illness
M	Mantle cell lymphoma (MCL)	Terminal illness
	MPS III (San Filippo Syndrome)	Nursing home level care
	MPS VII (Sly Syndrome)	Nursing home level care

Letter	Condition	Manifest category
P	Patau Syndrome (Trisomy 13)	Nursing home level care
	Peritoneal Mesothelioma	Terminal illness
	Plural Mesothelioma	Terminal illness
	Prader-Willi Syndrome	Intellectual disability
S	Sjogren-Larsson Syndrome	Intellectual disability
	Small cell cancer of the large intestine	Terminal illness
	Small cell cancer of the ovary	Terminal illness
	Small cell cancer of the prostate	Terminal illness
	Small cell cancer of the uterus	Terminal illness
	Small cell lung cancer	Terminal illness

About list 2

The second list of conditions includes those which may upon some further investigation, be manifest on the grounds of terminal illness, nursing home level care requirements, or intellectual disability which would attract 20 or more points under the Impairment Tables and a CITW.

If the DSP claimant's medical evidence lists a condition from list 2, the Centrelink decision maker will obtain on the spot advice about the condition, treatment regime and likely prognosis by contacting the treating doctor and/or the HPAU.

The treating doctor, or the HPAU may be able to confirm the expected prognosis, including whether terminal, or would necessitate nursing home level care, or indicates a manifest intellectual disability, and thereby expedite the claim as manifest without a JCA.

For a number of conditions on list 2, it will be important to establish the date of onset and/or the level of care the claimant requires for decisions of manifest eligibility.

Example: Amyotrophic lateral sclerosis (ALS) is fatal within 3 to 5 years of onset.

For other conditions, the associated grade/stage/phase will be crucial for decision making about manifest eligibility. Examples include 'Grade III or IV', 'with distant metastases or inoperable or unresectable or recurrent', and 'stage 3 or 4' or 'Blast Phase'.

Where the medical evidence not only names the listed condition, but its associated grade/stage/phase are also indicated, then a manifest decision is able to be made from that evidence.

Example: Adrenal cancer with distant metastases or inoperable, unresectable or recurrent.

However, where the medical evidence lists the condition in name only, further investigation is required to determine the expected prognosis by calling the treating doctor or HPAU.

For some list 2 conditions, marked variation in prognosis appears more likely and it will be important for decision makers to clarify the expected prognosis by calling the treating doctor or the HPAU.

Example: Most people with Friedreich's Ataxia (FRDA) die in early adulthood if there is significant heart disease. Some people with less severe symptoms live much longer.

There are a number of list 2 conditions which cause intellectual impairment and have marked variation in their prognosis. Further investigation with the HPAU or the treating doctor is required to determine prognosis and whether there is an existing IQ score to support a manifest determination.

Example: CHARGE Syndrome, where physical impact can range from near normal to severe and intellect can range from normal to severely impaired.

List 2 includes conditions of the lungs where further investigation is required to confirm the claimant is receiving domiciliary oxygen therapy in order to make a manifest grant of DSP.

Example: If a claimant has Cystic Fibrosis AND requires domiciliary oxygen therapy a manifest grant is permissible.

List 2 includes a general listing for dementia rather than naming numerous conditions associated with it. The HPAU, or treating doctor, will therefore be required to confirm the prognosis before a manifest decision can be made.

Example: Metachromatic Leukodystrophy, though not named individually on list 2, is associated with and captured by the general listing for dementia.

List 2

Note: A manifest grant of DSP is able to be made when a claimant:

- is diagnosed with one or more of the following conditions on list 2, AND
- undertakes the additional action in the table, AND
- provides evidence that the claimant is clearly qualified for DSP.

In contrast, where that evidence does not support a manifest grant, the claimant must be referred for a JCA.

Letter	Condition	Additional action key (see table below)
A	Acute leukaemia	1
	Adrenal cancer	2
	Anaplastic adrenal cancer	2
	Astrocytoma Grade III	3
	Astrocytoma Grade IV	3
	Ataxia Telangiectasia	1
B	Bladder cancer	2
	Bone cancer	2
	Breast cancer	2
C	CHARGE Syndrome	4
	Chronic Myelogenous Leukaemia (CML) Blast Phase	5
	Chronic Obstructive Pulmonary Disease (COPD)	6
	Cockayne Syndrome (Types I, II, III)	1
	Coffin Lowry Syndrome	1
	Cornelia De Lange Syndrome	4
	Cri Du Chat Syndrome	4
	Cystic Fibrosis	6
D	Dementia	1
	Down Syndrome	4
	Duchenne Muscular Dystrophy	1
F	Fragile X Syndrome (Adult)	4
	Friedreich Ataxia (FRDA)	1
H	Head and neck cancers	2

Letter	Condition	Additional action key (see table below)
I	Idiopathic Pulmonary Fibrosis	6
	Inflammatory Breast Cancer (IBC)	1
K	Kabuki Syndrome	4
	Kidney cancer	2
L	Large intestine cancer	2
M	Machado-Joseph Disease (aka Spinocerebellar Ataxia Type 3)	1
	MPS I (Hurler Syndrome)	4
	MPS II (Hunter Syndrome)	4
	MPS IV (Morquio Syndrome, MPS I IVA)	1
	MPS VI (Maroteaux-Lamy Syndrome)	1
	Multiple System Atrophy	1
N	Neck and head cancers	2
	Non-small Cell Lung Cancer	2
O	Ornithine Transcarbamylase (OTC) Deficiency	1
	Ovarian cancer	2
P	Pancreatic cancer	1
	Pelizaeus-Merzbacher Disease	1
	Primary Lateral Sclerosis	1
	Primary Pulmonary Hypertension	6
R	Rett (RTT) Syndrome	1
S	Salivary tumours	1
	Seckel Syndrome	4
	Small intestine cancer	2

Letter	Condition	Additional action key (see table below)
	Smith-Magenis Syndrome	4
	Steele-Richardson-Olszewski diseases (aka progressive supranuclear palsy)	7
	Stomach cancer	2
T	Thyroid cancer	1
U	Ureter cancer	2

The table below is the additional action key.

The follow up action is to ascertain information on the prognosis or severity/progression of the condition so that a decision can be made whether a manifest grant is appropriate. For potentially terminal cancer type conditions, if the medical evidence indicates the condition has reached the grade or stage indicated in action 2, 3 or 5 in the table below, manifest grant for terminal illness may be made even if the evidence will not state that the condition is likely to be terminal within 2 years. For other conditions, information must be obtained indicating that nursing home level care is required or an intellectual disability attracting at least 20 points exists. If not a JCA should be booked.

Action	Explanation	Manifest grants category where follow-up action indicates that manifest grant is appropriate
1	Establish prognosis and/or level of care required as prognosis can vary and/or the condition is progressive.	Could be either: • Requires nursing home level care or terminal illness. • Cancer type conditions would be coded as terminal illnesses where prognosis indicates life expectancy of less than 2 years. For other conditions listed under this follow-up action reason, generally the follow-up is whether the condition has progressed to a stage where nursing home level care is required.
2	Confirm the associated grade/stage/phase is with distant	Terminal illness.

Action	Explanation	Manifest grants category where follow-up action indicates that manifest grant is appropriate
	metastases or inoperable, unresectable or recurrent.	
3	Confirm the associated grade is Grade III or Grade IV.	Terminal illness.
4	Establish prognosis and/or level of care required as prognosis can vary and investigate whether there is an existing IQ score.	Could be either: • Requires nursing home level care or intellectual disability. • It will depend on additional information obtained. • If IQ score indicates manifest eligibility, use this.
5	Confirm the associated phase is Blast Phase.	Terminal illness.
6	Confirm the claimant is receiving domiciliary oxygen therapy.	Requires nursing home level care.
7	Confirm the likely prognosis of the progressive condition including impact of dementia.	Requires nursing home level care.

Young people

All the guidelines about impairment ratings and inability to work apply equally to adults and young people applying for DSP.

Non-medical or work capacity rejections

A claim for DSP can be rejected without any further assessments where the claimant does not meet the basic qualifications for DSP (other than medical or work capacity), the person cannot make a proper claim for DSP or DSP is not payable.

Example: If any of the following preclude the person from DSP, residence, age, compensation preclusion and income and assets.

Manifest rejections (medical or work capacity)

A claim for DSP can be rejected without an assessment if there is substantial evidence to indicate that:

- the person's impairment would clearly score an impairment rating of less than 20 points on the Impairment Tables, and/or
- where the condition is not fully diagnosed, treated and stabilised i.e. a temporary condition, and/or
- the person has a clear ability to work 15 hours or more per week at relevant minimum wages (1.1.R.133).

Example: A person with a condition that is clearly temporary such as a simple fracture, where it is clearly evident that the impairment and corresponding inability to work would be expected to exist for less than 2 years. In this instance no impairment rating could be assigned, as the condition is not expected to exist for more than a few weeks. The person could not be seen to have a CITW, and a more appropriate form of income support such as JSP should be considered.

It is expected that the decision to reject a claim for DSP without a JCA would only be exercised where the presented information is unambiguous.

Example: Where the medical evidence indicates the medical condition is definitely short term or where the person is working 15 hours or more per week at the relevant minimum wage.

Where a claimant seeks a review of the decision to reject DSP on the grounds of being manifestly ineligible, the delegate must then refer the case for an appropriate assessment.

Act reference: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011

SSAct pre-1 January 2012 Schedule 1B Tables for the assessment of work-related impairment for DSP

Policy reference: SS Guide 3.6.2.30 Manifest grants & continuing inability to work (DSP), 3.6.2.100 DSP assessment of impairment ratings, 3.6.2.110 DSP assessment of continuing inability to work - 30 hour rule, 1.1.H.60 Health Professional Advisory Unit (HPAU)

3.6.2.50 Assessment of people with intellectual impairments for DSP

People with intellectual disability

A claimant with an intellectual disability may be manifestly granted (1.1.M.30) DSP where they have an IQ of less than 70.

Medical evidence

In order to make a manifest grant of DSP, the medical evidence in support of the claim must include a current assessment of intellectual function that clearly indicates an IQ of less than 70 using the WAIS IV or equivalent contemporary assessment.

Claimants with intellectual disabilities who are about to turn 16 years of age, and have been in a school which provided tailored education for children with disability, or classes within a mainstream school which were tailored to meet their needs, should be asked to provide a report from the school to support their claim including the latest result from IQ testing conducted by their school. In some cases a report from the school may indicate that the recipient has a very severe intellectual disability and is therefore not able to undergo an IQ test - these recipients may also be manifestly granted DSP.

Explanation: In these situations this type of testing is often done within the child's school and THPs may not have any record of IQ testing.

People with low intellectual function

People with low intellectual function, meaning an IQ score of 70 to 85, who are not manifestly eligible for DSP may be found eligible following assessment depending on their level of functional impairment (1.1.F.270). Impairment Table 9 - Intellectual Function should be used to assess the person.

To qualify for DSP the person's condition resulting in low intellectual function must have originated before the person turned 18 years of age.

Medical evidence

In order to complete an assessment under Impairment Table 9 an assessment of intellectual function must be undertaken in the form of a WAIS IV or equivalent contemporary assessment.

A standardised assessment of adaptive behaviour must also be undertaken in the form of either the Adaptive Behaviour Assessment System (ABAS-II), the Scales for Independent Behaviour - Revised (SIB-R), the Vineland Adaptive Behaviour Scales (Vineland - II) or any other standardised assessment of adaptive behaviour that:

- provides robust standardised scores across the 3 domains of adaptive behaviour (conceptual, social and practical adaptive skills),
- has current norms developed on a representative sample of the general population,
- demonstrates test validity and reliability, and
- provides a percentile ranking.

Note: Claimants with an intellectual disability must have an assessment of intellectual function in the form of a WAIS IV, or equivalent contemporary assessment. Where the WAIS IV is not the most appropriate test to use, the IQ test as determined by a psychologist as being the most appropriate given the person's circumstances may be used. The IQ test must be one recognised by the relevant professional body. Consideration should be given to the adaptation of recognised assessments of intellectual function for use with Aboriginal and Torres Strait Islander peoples as required.

Policy reference: SS Guide 3.6.3 Guidelines to the Tables for the Assessment of Work-related Impairment for DSP