

**A GUIDE TO THE TABLES  
FOR THE ASSESSMENT OF  
WORK-RELATED IMPAIRMENT  
FOR DISABILITY SUPPORT PENSION**

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# INTRODUCTORY NOTES ABOUT THE GUIDE

This Guide provides some enhancements to the presentation of the Tables for the Assessment of Work-Related Impairment for Disability Support Pension (1997) (referred to as the Tables) in order to improve its user-friendliness. The Guide has not altered the contents of the Tables themselves as they form Schedule 1B of the Social Security Act 1991, and such amendments can only be enacted through Parliament.

In order to improve ease of use in the application of the Tables, the Guide also provides clarification to assist in interpreting the Tables' contents. These explanations aim to clarify perceived ambiguities within the contents and to reflect the original intent of the Advisory Committee that developed the current version of the Tables. The Guide is not intended as a substitute for the explanatory notes within the Tables but should be read in conjunction with the Tables.

Although examples of specific medical conditions have been used to help illustrate these explanations, it should be emphasised that they are not intended to be generally prescriptive for the purpose of assessing impairment caused by such conditions. Each person's level of medical impairment must be assessed on an individual basis to account for the varying spectrum of severity and stability that can occur with a particular medical condition. Individualised assessments are also necessary to consider the effects of contributory non-medical factors on a person's work-related impairment.

# CHAPTER 1:

## GUIDE TO THE “INTRODUCTION” TO THE IMPAIRMENT TABLES

This chapter provides guidance and additional clarification relating to the thirteen paragraphs contained in the “Introduction” to the Tables for the Assessment of Work-Related Impairment for Disability Support Pension. This chapter is divided into subheadings emphasising significant concepts contained within the “Introduction”. The relevant paragraphs from the “Introduction” corresponding to each subheading are identified in parenthesis.

### (A) PURPOSE OF THE TABLES – (PARAGRAPH 1)

**Establishing whether medical impairment level reaches minimum qualifying threshold of 20 points for disability support pension purposes.**

The purpose of the Tables is to enable the assessment of medical impairment to be made in respect of persons whose qualification for disability support pension is being determined. The relevance of such an assessment is that qualification for disability support pension as set under section 94(1)(b) of the Social Security Act 1991, requires first establishing that the person has an **impairment level of at least 20 points** (previously, 20%). This **minimum qualifying threshold** is meant to be set at the level at or above which a person’s impairment has a significant adverse impact on their ability to work. (Refer also to Sections(B), (C),(D), (E).)

### (B) DEFINITION OF WORK – (PARAGRAPH 1)

**What is considered “work” for disability support pension purposes.**

Work is defined in section 94(5) of the *Social Security Act 1991*. For these purposes, work should be for **at least 15 hours per week** at or above the relevant minimum wage and should exist in Australia, even if not within the person’s locally accessible labour market.

The 15 hour work test applies to people whose start date on DSP is after 30 June 2006 and those whose start date on DSP is between 11 May 2005 and 30 June 2006 and have been reviewed after 30 June 2006 under the 15 hour rule.

For people whose start date on DSP is prior to 11 May 2005 and transitional DSP recipients work should be for at least 30 hours per week where wages are at or above the relevant minimum wage and should exist in Australia, even if not within the person’s locally accessible labour market.

In considering a person’s capacity for “work” as defined, it would be reasonable to expect that they must be capable of reliably performing such work on a sustainable basis, that is, for a reasonable period of time without requiring excessive leave or work absences. A reasonable period of time is taken to be 26 weeks. Further, it would be expected that such work is in open, unsupported employment and that the person does not require excessive support (ie more than what is usually considered reasonable adjustments and/or normal supervision) to perform the work. It is considered that the Tables refer to work in this context with regard to the assessment of work-related impairment. (Refer also to Sections (C), (D),(E).)

### (C) CONCEPTUAL MODEL OF THE TABLES – (PARAGRAPHS 1, 2, 3)

**Assessing work-related impairment and loss of functional capacity vs whole person impairment.**

The Tables are designed to assess the **loss of functional capacity** that affects a person’s ability to work rather than simply loss or abnormality of psychological, physiological or anatomical structure or function. This functional limitation of work-related tasks resulting from a medical condition or disability is referred to as **“work-related impairment”** and replaces the concept of “whole person impairment”.

Whole person impairment relates more generally to a person's overall health status and is a conceptual model used in previous versions of the Tables and in other types of impairment tables (eg Department of Veterans' Affairs GARP, American Medical Association's Guides...). Such assessment tools based on whole person impairment were developed mainly for compensation assessment purposes and as they do not focus particularly on the effects on a person's functional capacity for work, are of less relevance to the intended purpose of assessing disability support pension eligibility.

The current Tables however, represent an empirically agreed set of criteria for assessing the impact of impairment on normal functions as they relate to work performance and this is termed work-related impairment. They are scaled according to a point score system based around the minimum qualifying threshold set at 20 points. Unlike other models based on whole person impairment, the Tables do not measure exact percentage loss of function on a nil to 100% scale. (Refer also to Sections (F), (J).)

Although some of the descriptions of functional loss contained in the Tables would more appropriately be described as "disabilities" within the generally accepted meaning defined by the World Health Organisation, it was considered more accurate to describe the Tables as dealing primarily with the assessment of impairment rather than measuring disability. It is recognised that the terminology used in the Tables is not precise and at times, the term disability is used interchangeably with impairment. In this context, it should be noted again that the intended purpose of the Tables is to serve as an instrument of assessment for disability support pension purposes. (Refer also to Sections (A), (E).)

#### **(D) SIGNIFICANCE OF 20 POINTS IMPAIRMENT LEVEL – (PARAGRAPH 1)**

**Reaching the minimum qualifying threshold of 20 points does not automatically mean that the person is unable to work or that they qualify for disability support pension.**

In most cases it is expected that a person's work capacity should follow from and correlate reasonably with their level of impairment. It should be recognised however, that if a person has been rated under the Tables as having an impairment level of at least 20 points, it does not necessarily follow that they are incapable of working. It does mean that their medical impairment(s) are severe enough to cause significant difficulties in many work situations but depending on their individual circumstances, coping mechanisms and reasonable adjustments, they may still be able to sustain appropriate full-time employment. (Refer also to Sections (B), (C), (E).)

As an example, a person who has lost the use of their lower limbs (eg paraplegia) may be assessed as having 20 points impairment under Table 4 (Function of the Lower Limbs) but may still retain the capacity for sedentary type work. Another uncommon example is that of a young person who is profoundly deaf from birth but has adapted and learned to communicate sufficiently with the aid of a cochlear implant to enable employment. Such a person may still attract an impairment rating of 40 points under Table 12 (Hearing Function) as this table refers to unaided audiometric results. This is a somewhat exceptional circumstance as in most cases, an impairment rating significantly more than 20 points would suggest that the person is unable to sustain full-time open employment. (Refer also to Sections (F), (J), CHAPTER 5 – Table 4, CHAPTER 14 – Table 12.)

As demonstrating a **continuing inability to work** is the second medically-related criteria required for disability support pension, it follows that reaching the minimum impairment threshold of 20 points does not necessarily equate with eligibility for the disability support pension but merely indicates that the first qualifying criteria has been satisfied. (Refer also to Sections (A), (E).)

#### **(E) MEDICAL BASIS TO IMPAIRMENT – (PARAGRAPHS 1, 4)**

**Ratings applied from the Tables should reflect the level of work-related impairment due to the medical conditions and not due to non-medical factors.**

The Tables are intended to assess **work-related impairment due to a medical basis** and do not take into account the broader impact of functional impairment in a societal sense. For this reason, no specific adjustments are made for age and gender. It is recognised that there may be many non-medical factors (eg elderly age, gender, level of education, level of numeracy and literacy, level of work skills and experience, social or domestic situation, English language fluency, employment

market factors, level of personal motivation unrelated to a medical condition and religious or cultural factors) that contribute to why a person with a medical condition has difficulty working. Some of these non-medical factors may also adversely impact on a person's overall level of functional ability, affecting their coping abilities or interfering with optimal treatment of their medical conditions. (Refer also to Sections (C), (F), (K).)

However, under the existing disability support pension rules, the eligibility criteria are medically based and limitations have been placed on the relevance of non-medical factors. (Refer also to Sections (A), (D).) Accordingly, it is intended that in applying these Tables, the effects of such non-medical factors must not be taken into account when assessing a person's work-related impairment. For example, a non-English speaking person who is fluent in another language and does not have a medical condition affecting their communication or language competency should not receive a rating under Table 9 (Communication Function) just because they have difficulties communicating in English. (Refer also to CHAPTER 10 – Table 9.)

Work-related impairment of a medical nature may be attributed to physical, psychiatric and/or intellectual conditions. However, it is sometimes difficult to determine the degree of medical impairment in cases where contributory non-medical factors are considered relevant to the person's functional capacity. This is particularly so when the effects of the impairment are primarily subjective in nature or when motivational factors are considered significant.

For example, a person who is poorly motivated for work may or may not have a medical basis to their lack of motivation depending on whether it is an effect of an underlying medical condition such as a significant depressive disorder. Invariably this requires medical judgement with appropriate assessment and evaluation of the available medical evidence. (Refer also to Sections (I), (K).)

#### **(F) DESIGN OF THE TABLES – (PARAGRAPHS 2, 3)**

**Most tables relate to a particular body system and are function-based rather than diagnosis-based.**

The Tables consist of a number of **system-based** tables that contain specific sets of criteria (**descriptors**) classified into levels of impairment relating to that body system. These allow ratings to be assigned in proportion to the severity of the impact of medical impairments on functional work capacity. The impairment descriptors refer to defined functions and are generally scaled to reflect worsening levels of functional loss. In accordance with the underlying purpose of the Tables, the descriptor in each table corresponding to the level of impairment where there is significant impact on work ability (ie the minimum qualifying threshold) has been assigned a value of 20 points. (Refer also to Sections (A), (C), (D), (J).) Some tables (eg Tables 20, 21) are not specific to a particular body system and allow assessments of conditions that may cause multiple or global symptoms affecting more than one body system. (Refer also to Section (I), 22 – Table 20, CHAPTER 23– Table 21.)

In general, the tables are **function-based rather than diagnosis-based** reflecting their intended purpose of assessing work-related impairment. Ratings should only be assigned for diagnosed medical conditions if there is an associated current functional loss or where prolonged loss of function would be expected in most work situations. It is inappropriate to assign an impairment rating on the sole basis that a diagnosis has been listed in the explanatory notes for a particular table or mentioned in its descriptors. When assessing a particular medical condition, the assessor must have a clear understanding of how to select the most appropriate and relevant impairment table or tables. (Refer also to Sections (E), (G), (H), (L).)

#### **(G) APPROPRIATE SELECTION OF TABLES – (PARAGRAPHS 2, 7, 9, 12)**

**The choice of which tables to use depends on determining what functional losses have occurred. All relevant system-specific table(s) should be applied unless otherwise instructed.**

When assessing a person's level of work-related impairment, the selection of which tables to apply depends on what **functional losses** have occurred as a result of their medical condition(s). The approach should be to determine firstly which **body systems** have been affected and have a functional loss due to the medical condition(s). All relevant system-specific tables appropriate to the



functional impairments should then be applied unless qualifying instructions in the Tables specify otherwise. (Refer also to Sections (F), (I), (J).)

**1. Multiple tables selected to assess a single medical condition:**

A single medical condition may result in multiple functional impairments affecting different body systems and may therefore be assigned ratings from more than one table. For example, a person who has had a cerebrovascular accident (CVA or stroke) may be assessed as having no impairment rating or have impairment ratings from up to five different tables depending on what permanent residual effects they suffer. (Paragraphs 9 and 12 of the “Introduction”.) If they have recovered completely from their stroke and no longer experience any significant ongoing impairment, then no rating is applicable regardless of what effects they suffered initially.

Alternatively, permanent functional loss may have occurred in any or all of the following body systems as a result of the stroke. This would then require an assessment and rating to be applied from each of the relevant tables:

- Table 3 – Upper Limb Function – if damage to the motor centre of the brain caused weakness and loss of function in either arm (hemiparesis, hemiplegia).
- Table 4 – Function of the Lower Limbs – if damage to the motor centre of the brain caused weakness and loss of function in either leg.
- Table 8 – Neurological Function – if damage to the cerebral cortex caused cognitive impairment.
- Table 9 – Communication Function – if damage to the speech centre of the brain caused receptive and/or expressive communication impairment (aphasia, dysphasia).
- Table 15 – Visual Fields – if damage to the visual centre of the brain caused loss of visual fields.

The above example illustrates how one medical condition (diagnosis) can result in multiple impairments being rated under different tables. Another example of a medical condition that may cause multi-system effects is that of Diabetes Mellitus. As described in Paragraph 7 of the “Introduction”, this diagnosis may also require multiple impairment ratings depending on how long-term complications of the disease have affected the various body systems resulting in end organ damage. If all functional impairments are not identified and rated accordingly, then the overall work-related impairment due to the condition may be under-assessed. (Refer also to Section (L).)

**2. A single table selected to assess multiple medical conditions:**

Conversely, two or more medical conditions may result in a common impairment and if this is the case, then only one relevant table should be selected and a single rating assigned to reflect the combined functional loss. It would be inappropriate to assign a separate impairment rating for each medical condition as this would result in the same functional loss being assessed more than once. Examples of how such possible over-assessments may occur are described below. (Refer also to Sections (H), (L).)

**(H) DOUBLE COUNTING OF IMPAIRMENT – (PARAGRAPHS 7, 8, 12, 13)**

**Be wary of assessing a functional loss more than once. Rate the resulting functional impairments and not the individual medical conditions / diagnoses.**

As indicated above, inappropriate selection and/or application of the tables may result in double assessment of the same functional impairment (**double counting**) and this should be avoided when assessing work-related impairment. Double counting may occur in the following manner: (Refer also to Sections (G), (L).)

**1. The same functional loss is rated more than once using the same table:**

As a general rule, it is expected that regardless of the number of conditions affecting a person, only one rating may be applied from each system-specific table. There are some exceptions however, (eg with Table 3) and this does not always apply to non-system-specific tables (eg Tables 20 and 21). The instructions contained in the “Introduction” to the Tables and preceding each individual table should be considered before an appropriate rating is assigned. The following illustrates examples where a table may be inappropriately applied more than once

resulting in double counting of the same impairment. This situation is more likely to occur when multiple medical conditions or diagnoses result in the same functional loss. (Refer also to CHAPTER 4– Table 3, CHAPTER 22– Table 20, 23 – Table 21.)

- Paragraph 13 of the "Introduction" illustrates an example relating to cardiorespiratory impairment with a person suffering from both heart disease and chronic lung disease. Each condition may contribute to cause difficulties with breathing and reduce effort tolerance. The overall loss of function however, is a common and combined effect of the two conditions resulting in reduced exercise tolerance. Therefore, to avoid double counting, only one impairment rating should be assigned using Table 1 (Loss of Cardiovascular and/or Respiratory Function). (Refer also to CHAPTER 2 – Table 1.)
- A person diagnosed with peripheral vascular disease suffers from calf pain on walking a certain distance (intermittent claudication) and also suffers significant right knee symptoms due to osteoarthritis. There is also permanent impairment from chronic ligamentous instability affecting the left ankle. Although the person suffers from three distinct medical conditions affecting both legs, it would be inappropriate to apply three separate impairment ratings as the conditions all result in the same impairment (ie lower limbs functional loss). In this case, only one rating from Table 4 (Function of the Lower Limbs) is appropriate. (Refer also to CHAPTER 5 – Table 4.)
- A person with a psychiatric impairment may have been described as suffering from depression or anxiety. Alternatively, they may have been formally diagnosed with more specific conditions such as Post Traumatic Stress Disorder or Obsessive Compulsive Disorder. In general, regardless of the number of diagnoses or diagnostic labels used, the combined functional loss due to their psychiatric conditions should be assessed and a single rating assigned from Table 6 (Psychiatric Impairment) reflecting the overall psychiatric impairment. (Refer also to CHAPTER 7 – Table 6.)
- A person may have several conditions which are considered most appropriately assessed under Table 20 (Miscellaneous). However, care must be taken not to overassess the level of impairment when using this table, particularly if there is overlap in the symptoms attributed to the conditions. For example, if the person has several diagnosed conditions which all contribute to impairment from symptoms of chronic entrenched fatigue, it would be inappropriate to assign a separate rating for each condition as this would result in overassessment of the same functional impairment. Instead, a single rating should be assigned to reflect the overall (highest) level of impairment due to the fatigue symptoms. In a similar manner, if a person suffers from symptoms of chronic entrenched pain as well as fatigue (eg with fibromyalgia), it would be practical to assign a single rating from this table, reflecting the overall level of impairment due to both types of symptoms. This is discussed further in Chapter 22. (Refer also to Section(I), CHAPTER 22 – Table 20.)

**2. The same functional loss is rated more than once using different tables:**

Double counting can also occur when more than one table is being selected to assess a single medical condition. Care must be taken to ensure that the different tables are being used to assess separate functional losses and not the same functional impairment. The following illustrates examples where more than one table may be inappropriately applied resulting in double counting of the same impairment. This situation tends to occur when a single medical condition is inappropriately assessed as having additional functional losses. It can also occur when there is an "either-or" choice between tables under which a particular impairment may be assessed but a rating is inappropriately assigned instead from both tables. (Refer also to Section (I).)

- Paragraph 7 of the "Introduction" provides the example of an isolated lumbar spinal condition being rated inappropriately under more than one table. In most cases, the functional impairment resulting from this type of condition will be adequately assessed under Table 5.2 (Thoraco-lumbar-sacral Spine) alone. The descriptors in this table take into account the effects of back pain and referred leg pain on the ability to perform many physical activities including weight-bearing functions. It is therefore inappropriate in the majority of cases, to assign a further rating from Table 4 (Function of the Lower Limbs). An additional rating from

Table 4 should only be applied if there is a definite and permanent secondary neurological deficit in the lower limb(s) that has resulted in significant functional impairment. There should be objective evidence of functional loss in the lower limbs including clinically consistent signs of significant muscle wasting, loss of power, abnormal reflexes and anatomically appropriate sensory changes. In most cases, it is expected that such neurological deficits would have been confirmed with neurosurgical review and appropriate investigations (such as MRI scan). (Refer also to CHAPTER 5 – Table 4, CHAPTER 6 – Table 5.)

- Paragraph 12 of the “Introduction” describes a further example where the presence of mental confusion due to a cognitive impairment may suggest an additional impairment of communication function. However, if the speech centre of the brain is undamaged, then it is considered that the overall situation is due to a single impairment which should be rated under Table 8 (Neurological Function). Double counting would result if an additional rating is provided from Table 9 (Communication Function). (Refer also to CHAPTER 9 – Table 8, CHAPTER 10 – Table 9.)
- Paragraph 8 of the “Introduction” indicates that in certain circumstances, a medical condition such as a spinal condition may be rated under Table 20 (Miscellaneous) **instead of** the specific system-based table (ie Table 5 (Spinal Function) in this case). Double counting would result however, if a rating is assigned from both the specific table, Table 5, and from Table 20. Similarly, impairment from a respiratory condition may be rated under Table 2 (Loss of Respiratory Function) **instead of** Table 1 (Loss of Cardiovascular and/or Respiratory Function) if a reliable effort tolerance level cannot be established. However, double counting would occur if ratings are assigned from both tables. (Refer also to CHAPTER 2 – Table 1, CHAPTER 3 – Table 2, CHAPTER 6 – Table 5, CHAPTER 22 – Table 20.)

#### **(I) ASSESSING CHRONIC PAIN AND FATIGUE – (PARAGRAPH 8)**

**Table 20 may be used instead of the relevant system-specific tables to assess impairments due to a significant degree of chronic entrenched pain or fatigue.**

Paragraph 8 of the “Introduction” indicates that in general, pain and fatigue are assessed in terms of the underlying medical condition that causes it. In assessing the functional loss related to specific body systems, the descriptors of relevant system-based tables generally take into account the effects of symptoms such as pain and fatigue. However, if it is considered that the rating assigned under the system-specific table underestimates the level impairment due to effects of **chronic entrenched pain or fatigue**, then Table 20 (Miscellaneous) may be used instead to assign an alternative rating. It is emphasised again that to avoid double counting, only one rating should be assigned using either the system-specific table or Table 20 and not both tables concurrently. (Refer also to Section (H), CHAPTER 22 – Table 20.)

##### **1. Chronic Pain:**

This situation commonly occurs with painful orthopaedic conditions such as those causing low back pain. In many cases, the use of Table 20 will be considered when the degree of impairment from pain appears to be in excess of what is usually expected for the underlying pathology and a diagnosis of **chronic pain disorder or chronic pain syndrome** may be applicable. It may also be appropriate to consider using Table 20 instead of individual specific tables if the symptoms of chronic pain are generalised and widespread but somewhat variable in nature (eg some rheumatological conditions or other multi-system conditions). (Refer also to Section(J), CHAPTER 6 – Table 5, CHAPTER 22 – Table 20.)

##### **2. Chronic Fatigue:**

Symptoms of chronic fatigue may be caused by many medical conditions and is usually assessed under the specific system-based table associated with the causative medical condition. For example, fatigue as a symptom associated with established chronic liver disease is rated under Table 11.1 (Gastrointestinal: ...Liver...) whereas fatigue and lethargy as a manifestation of a psychiatric condition such as chronic depression would be rated under Table 6 (Psychiatric Impairment). However, if the functional loss is predominantly due to the presence of chronic entrenched fatigue, then the use of Table 20 may be appropriate. Diagnoses of exclusion such

as **chronic fatigue syndrome** or **fibromyalgia** where the specific cause is unknown and therefore a specific table cannot be applied would also be rated under table 20. (Refer also to Section (K), CHAPTER 7 – Table 6, CHAPTER 12 – Table 11.1, CHAPTER 22 – Table 20.)

It is emphasised in Paragraph 8 of the “Introduction” that in choosing to apply a higher impairment rating using Table 20 rather than a system-specific table, the medical assessor must be convinced that pain or fatigue is a significant factor contributing towards the person’s overall functional impairment. Clinical judgement is required to assess that the severity of the impairment is consistent with the available medical evidence. It is recognised that this is often difficult to determine in view of the subjective nature of the symptoms. It is expected that the person’s history, medical reports and overall clinical presentation should consistently indicate the presence of chronic entrenched pain or fatigue. (Refer also to Section (E).)

#### **(J) SCORING SYSTEM OF THE TABLES – (PARAGRAPHS 10, 11)**

**Impairment ratings should only be assigned in accordance with the instructions in the Tables and are added together to provide a total work-related impairment.**

The scaling system for the Tables is based on points allocation, grading the impact of functional impairments on a person’s work ability. The points have significance only in relation to the minimum qualifying threshold set at 20 points rather than being exact measures of percentage loss of function of the whole person. (Refer also to Section (C).)

Ratings generally appear alongside the impairment descriptors in each table and represent the number of points allocated for that level of impairment. It should be noted that ratings between tables are not always comparable although the ratings have been allocated on the basis of likely impact of an impairment on work ability. The grading of scale points between rating levels in each table does not always occur in even increments as the proportionate impact on work-related impairment may vary depending on the particular type of functional loss. As mentioned before, the descriptor in each table corresponding to the level of impairment where there is significant impact on work ability has been assigned a value of 20 points. (Refer also to Sections (D), (F).)

#### **1. No idiosyncratic assessment systems are allowed:**

- Ratings can only be assigned in accordance with the rating scores in each table.
- Ratings cannot be assigned in excess of the maximum rating specified by each table (eg if the maximum rating in a table is 30 points, a rating greater than this figure cannot be assigned).
- Ratings cannot be assigned between consecutive rating levels (eg if the table specifies rating levels of only 10 or 20 points, an in-between rating of 15 points cannot be assigned).

#### **2. Choice of ratings between tables:**

If there is a choice **between** tables under which a particular impairment may be assessed, then the general approach unless specified otherwise is to choose the table that enables a **higher** rating to be assigned.

For example, if it is considered that a person has significant functional impairment from chronic severe back pain but retains normal or only minor loss of range of spinal movement, then Table 20 (Miscellaneous) should be selected in preference to Table 5.2 (Spinal Function – Thoracolumbar-sacral Spine) to assign a rating that more appropriately reflects the overall level of impairment. (Refer also to Sections (G), (H), (I), paragraph 8 of the “Introduction”, CHAPTER 6 – Table 5, CHAPTER 22 – Table 20.)

#### **3. Choice of ratings within a particular table:**

If an impairment level appears to fall between two rating levels described within a table, the general approach is to choose the **lower** of the two ratings. The higher rating level should not be assigned unless the entire impairment descriptor at that level has been fully satisfied.

For example, a person with a cervical spine condition may have some restriction of neck movement such that there is loss of a little more than a quarter normal range of movement with infrequent symptoms of neck pain. Using Table 5.1 (Spinal Function – Cervical Spine), a rating of

5 points should be assigned rather than 10 points as the full descriptor at the 10 points level has not been fully met. This approach will help avoid the situation where the minimum qualifying threshold is inappropriately met because of the cumulative assessments of minor impairments that neither individually nor in combination have a significant effect on work capacity. (Refer also to CHAPTER 6 – Table 5.)

**4. Obtaining the total work-related impairment rating:**

When more than one functional impairment is present, separate ratings are assigned from the appropriate tables relevant to each functional loss and the values are **added together** to obtain the total work-related impairment.

**5. Significance of nil impairment rating:**

It should be noted that a nil rating applied from a particular table does not necessarily indicate that the person suffers no symptoms or effects from a condition but only that the degree of functional loss experienced is not of sufficient severity to enable the next rating level to be assigned.

Additionally, a nil total impairment rating does not necessarily indicate that a person is currently fit for work as this only reflects the assessment of permanent impairment. The person may still be disabled due to temporary impairments that prevents them from working. (Refer also to Section (K).)

**(K) DETERMINING PERMANENT IMPAIRMENT – (PARAGRAPHS 4, 5, 6)**

**A rating can only be assigned if the impairment resulting from the condition is permanent (lasting for more than two years). This means that the condition has been fully diagnosed, treated and stabilised and it is unlikely there will be any significant functional improvement, with or without reasonable treatment within the next two years.**

**Note:** The concept of **permanent vs temporary impairment** appears to cause the most confusion in the application of the Tables. Some of the difficulties may be related to perceived ambiguities regarding the terminology used in Paragraphs 4, 5 and 6 of the "Introduction". It is emphasised that the definition of "permanent" as used in assessments for disability support pension purposes is not the same as its generally accepted meaning in common usage (ie taken to last indefinitely) but is rather taken to mean, "lasting for at least two years without significant functional improvement".

Additionally, difficulties arise in applying this particular definition of "permanent" when describing a "condition" as this is sometimes confused with the resulting "impairment" that the condition causes. When the Tables refer to a condition, it is usually implied that it is the resulting impairment that is being considered. As the Tables are function-based rather than diagnosis-based, they are designed to assess separate impairments rather than conditions. It may therefore be less confusing if the term "impairment" is substituted whenever "condition" is used in Paragraphs 4, 5 and 6 of the "Introduction". (Refer also to Section (L).) The criteria for permanence are qualified and explained in greater detail in this section.

**1. Permanence criteria = "fully diagnosed, treated, stabilised & won't improve significantly within the next two years":**

A permanent impairment rating can only be assigned if it is considered that the condition and its resulting level of impairment will persist for at least two years. Further, it should be considered unlikely that significant functional improvement will occur within that period. This requires that the condition causing the impairment has been fully diagnosed, treated and stabilised. Impairments that do not satisfy such criteria are by definition considered temporary and should not be rated under the Tables.

Medical judgement is usually required to evaluate the available medical evidence and determine if the permanence criteria have been satisfied. The question that needs to be answered generally is whether anything (eg further time or therapeutic intervention) is likely to result in significant functional improvement within the next two years. It is expected that this will usually require a comprehensive history and examination.

In general, if a medical condition were of sufficient severity to prevent a person from working in any capacity, it would be reasonable to expect that it has received optimal medical management. This should include appropriate investigations and/or specialist review and treatment as indicated. Impairments resulting from conditions that have not been fully diagnosed, treated and stabilised, should not be assigned a permanent rating but should be considered temporary until appropriate medical management and stabilisation has occurred. (Refer also to Section (J).)

## 2. **Fully Diagnosed – impact on prognosis and stability:**

Confirmation of a medical condition's exact diagnosis is usually only an issue if the prognosis of the condition's impairment lasting for at least two years is likely to be affected depending on the actual diagnostic cause.

For example, if a person is significantly impaired by symptoms of chronic fatigue, it is important to identify the cause as the prognosis may change depending on what the diagnosis is. It would be inappropriate to assign an impairment rating under Table 20 (Miscellaneous) for a person who has been prematurely labelled with Chronic Fatigue Syndrome before appropriate investigations and assessments have excluded other treatable diagnoses. If the person's fatigue symptoms are due to a treatable condition such as hypothyroidism or depression, then with appropriate treatment, their level of impairment may potentially improve within the next two years and therefore should not be considered permanent until fully treated and stabilised. (Refer also to Section (I).)

In many cases, medical evaluation of the available evidence will indicate the likely prognosis of the impairment and a presumptive working diagnosis may be sufficient. In cases where the level of impairment and prognosis is unlikely to change, referral for investigations or specialist review merely to confirm the diagnosis is unnecessary and inappropriate, as this will not change the impairment assessment. However, for poorly defined conditions (particularly psychiatric or intellectual disorders) where the nature or severity is unclear, referral for further investigations and assessment would be warranted.

## 3. **Fully Treated – impact of “reasonable treatment” on stability:**

In determining the permanence of a person's medical condition and its resulting impairment(s), one must consider whether the person has received optimal medical management and all reasonable treatment for the condition. This can be taken to include therapy (eg physiotherapy) involving the primary and secondary stages of rehabilitation aimed at restoring mental or physical functional stability but usually does not extend to tertiary rehabilitation involving specific vocational programs. The stability of a condition and the permanence of its impairment may depend on whether reasonable treatment has been undertaken.

In this context, **reasonable treatment** is taken to be:

- treatment that is **feasible and accessible** (ie available locally at a reasonable cost) – For example, it would not be appropriate to expect that a person undergo prohibitively expensive treatment, or treatment that is only available in another state or country in order to satisfy the permanence criteria.
- treatment or procedure that is **of a type regularly undertaken or performed** – For example, treatments that are experimental in nature or not yet widely accepted or performed by the general medical community would not be considered reasonable. Treatment is taken to refer to conventional western medical therapy and does not refer to alternative therapies.
- treatment that has a **high success rate** and where **substantial improvement can be reliably expected** – It would be inappropriate to consider an impairment as being temporary solely because the person has not undertaken a treatment that has a poor success rate or that is likely to result in only marginal functional improvement.
- treatment that is of a **low risk** nature – A person may decide against undertaking a certain treatment because it has serious associated risks (eg a major surgical procedure) or unavoidable and significant side effects (eg chemotherapy) even though their treating specialist has indicated that the treatment may have a good chance of a successful outcome. The risk assessment of whether to proceed with a treatment should be a fully informed decision that is medically appropriate.

It is assumed that a person will generally wish to pursue any reasonable treatment that will improve or alleviate an impairment. However, if the person has decided against proceeding with reasonable treatment that is likely to result in significant improvement, the impairment would not be considered stabilised unless there is a **medical or other compelling reason** for not undertaking treatment.

A permanent impairment rating is not assigned if compelling grounds do not exist but the following should be documented: what reasonable treatment is feasible that will result in significant improvement, the risks and side effects of the treatment, why the treatment is considered medically reasonable and the person's reasons for choosing not to undertake this treatment. Some reasons that may be considered compelling grounds for not proceeding with treatment are described below.

#### 4. **Fully Stabilised – no improvement over next two years:**

For a condition's impairment to be fully stabilised, it must be considered that with or without treatment, significant functional improvement is unlikely to occur within the next two years. Medical evaluation is required to assess the prognosis for further improvement within the next two years and factors such as the natural history of the condition, response to treatment and expected rate of recovery will need to be considered. It should be noted that "stability" as used in this context has a more specific meaning than that in common usage. The following examples illustrate further the restricted meaning of "fully stabilised".

- As indicated above, a medical condition and its resulting impairment is not considered fully stabilised if available treatment that may result in significant improvement within the next two years has not been undertaken. However, if the person has a **medical or other compelling reason** for not proceeding with such treatment, then it may be reasonable to consider the condition stabilised if no further improvement is expected. Such compelling reasons may include:
  - The treatment is not considered "reasonable" as defined above (eg high-risk procedure, poor chance of significant improvement etc.)
  - The person has religious or cultural beliefs prohibiting treatment (eg blood transfusions)
  - The person lacks insight or the ability to make appropriate judgements due to their medical condition and are unlikely to comply with treatment (eg a person with a severe psychotic illness or dementia).
  - The person has significant morbid fear of a treatment procedure (eg even minor surgery).

If a person has not had reasonable treatment due to factors that are not of a compelling nature, (eg lack of personal motivation that is not related to a medical basis), then their condition and impairment would not be considered fully treated and stabilised. (Refer also to Section (E).)

- A condition which is fluctuating and has a variable course with intermittent episodes of exacerbation (eg Bipolar Affective Disorder) may still be considered stable if it is being optimally managed and its current overall impact on work ability is unlikely to improve significantly within the next two years. However, an intermittent condition (eg epilepsy) would not be considered fully stabilised if further medical management can significantly improve its control and reduce the frequency of its episodes (eg by improving treatment compliance, adjusting dosage or type of anti-convulsant medication to reduce side-effects or improve therapeutic effect). (Refer also to CHAPTER 7 – Table 6, CHAPTER 23 – Table 21.)
- A condition may not be stable in the usual sense of the word if the degree of functional impairment is continuing to deteriorate but if the prognosis is poor and no significant functional improvement is expected within the next two years, it may be considered stabilised for the purpose of assigning an impairment rating. This may apply to a terminal illness for which no further active treatment is indicated other than palliative care. However, in situations where a person is undergoing or recovering from treatment for a malignant condition (cancer), stability cannot be established nor a permanent rating assigned until the prognosis and expected functional ability over the next two years can be reasonably

predicted. This often requires advice from the treating specialist in individual cases. (Refer also to CHAPTER 22 – Table 20.)

- In some situations, even though significant improvement in functional ability and work capacity will occur in time, a condition may be considered fully stabilised if such improvement is unlikely to occur within the next two year period. This may occur with conditions' whose natural history suggest slow, gradual improvement or with very severe injuries where recovery is expected to be quite prolonged. Another example is when significant improvement takes longer than two years to occur because a treatment procedure has to be delayed for some time. For example, a person may be advised by their treating orthopaedic specialist that they require a total hip replacement which will significantly reduce their pain symptoms and improve their level of mobility. However, in view of a long waiting list at the relevant hospital, they are advised that the surgery will not occur for at least 18 - 24 months. Taking into account the recovery and rehabilitation period that may be required after such a major surgical procedure, it may be reasonable in this circumstance to consider their current impairment stabilised. A permanent impairment rating can therefore be assigned and a further review in two years may be appropriate to assess the level of residual function once they have optimally recovered from definitive treatment.

#### **(L) CONDITION VS IMPAIRMENT – (PARAGRAPHS 2, 3, 4, 5, 6, 7, 8, 9, 12, 13)**

**A single medical condition may result in multiple functional impairments and conversely, multiple medical conditions may result in a single functional impairment. The Tables are designed to be impairment (function)-based and not condition (diagnosis)-based. A condition may last more than two years but the resulting impairment level may not last for a corresponding period.**

Although the definition of a “condition” vs an “impairment” is not explicitly addressed in the Tables, clarification is being provided as confusion has arisen because these terms are often perceived as being interchangeable. A medical condition refers to the disease or injury to which a medical diagnostic label has been applied. However, for the purpose of using the Tables, an impairment may be considered as the functional effects resulting from the condition, that is, how the changes (symptoms and signs) caused by the condition affect a person’s ability to function.

This is the basis for understanding the design of the Tables, which are impairment (function)-based rather than condition (diagnosis)-based. (Refer also to Section (F).) If the difference between a condition and its resulting impairment(s) is not appreciated, then inappropriate selection of tables, double counting of an impairment or inappropriate rating of temporary impairments are more likely to occur. Inappropriate assessments may also result from assuming that individuals with the same condition or diagnosis will have the same level of impairment.

##### **1. Underassessment due to inappropriate selection of tables:**

The number of conditions does not always correspond to the number of impairments. Inappropriate selection of tables resulting in underassessment is likely to occur if it is not understood that a single medical condition may result in multiple functional impairments. For example, (as in Paragraph 7 of the “Introduction”) if Diabetes Mellitus has resulted in secondary, end organ complications with multiple functional effects but is only rated as a single condition under Table 19 (Endocrine Disorders), then the person’s level of impairment may be significantly underassessed. (Refer also to Section, CHAPTER 21 – Table 19.)

##### **2. Overassessment due to double counting of a single impairment:**

Similarly, double counting of a single functional impairment may occur if it is not recognised that multiple medical conditions may result in a common functional impairment. For example (as in Paragraph 13 of the “Introduction”) if Table 1 (Loss of Cardiovascular and/or Respiratory Function) is used twice to rate heart disease and lung disease as separate conditions, then double counting of a single functional impairment (reduced cardiorespiratory effort tolerance) would occur. (Refer also to Section (H), CHAPTER 2 – Table 1.)



### 3. **Inappropriate rating of temporary impairments:**

Inappropriate rating of temporary impairments may occur if it is not recognised that a functional impairment may not persist for the same period of time as the condition that causes it. A medical condition may last indefinitely and be considered permanent in the common meaning of the word but the resulting level of impairment may fluctuate, improve or even cease within the next two years depending on multiple factors (eg natural history of the condition, response to treatment, improvement in the person's coping ability and adaptive function). The impairment may therefore be considered temporary for the purpose of assigning an impairment rating even though it is caused by a "permanent" condition.

For example, a person may have been diagnosed with osteoarthritis or degenerative joint disease of the knee. The condition is considered permanent in the general sense of the word and is likely to deteriorate with age as evidenced by radiological changes. It will certainly persist for at least two years. However, its corresponding level of impairment, may not necessarily be considered "permanent" for assessment purposes as this depends on how the person's level of function improves within the next two years. (It should also be noted that radiological findings do not always correlate well with the degree of functional ability.)

If, at the time of assessment, the person has evidence of early degenerative joint disease with symptoms of knee pain but has not received any significant treatment, the resulting level of impairment may be considered temporary if it has not yet been optimally managed. It may be considered that with adequate treatment, (eg appropriate use of anti-inflammatory medication, physiotherapy, exercises), they are likely to experience significant improvement in their pain symptoms and overall level of function. Alternatively, a person with severe osteoarthritis in the knee may undergo joint replacement surgery within the two years which could also result in significant improvement of their level of mobility and overall function.

It is therefore possible for a condition that is considered permanent in the general sense of the word to have a lower impairment rating or even a temporary impairment assigned on review some years later. (Refer also to Section (K).)

### 4. **Inappropriate assessment based on diagnoses:**

Inappropriate ratings may result from assuming that individuals with the same conditions / diagnoses will have the same level of impairment. For example, two individuals with the same condition, "below knee amputation of the left leg" may not necessarily be assigned the same impairment ratings under Table 4 (Function of the Lower Limbs) even though they may share the same diagnosis. This reflects assessment of their functional ability rather than their anatomical loss. Another example referring to the effect of an amputation on upper limb function is described in Chapter 4. (Refer also to Sections (C), (F), CHAPTER 4 – Table 3, CHAPTER 5 – Table 4.)

## **INTRODUCTION**

1. These Tables are designed to assess whether persons whose qualification or otherwise for disability support pension is being considered meet an empirically agreed threshold in relation to the effect of their impairments, if any, on their ability to work. Work is defined in section 94(5) of the Social Security Act 1991. The Tables represent an empirically agreed set of criteria for assessing the severity of functional limitations for work related tasks and do not take into account the broader impact of a functional impairment in a societal sense. For this reason, no specific adjustments are made for age and gender. The outcome of the application of these Tables following a medical assessment is termed work-related impairment and this term is used throughout this document.

2. These Tables are designed to assess impairment in relation to work and consist of system based tables that assign ratings in proportion to the severity of the impact of the medical conditions on normal function as they relate to work performance. These Tables are function based rather than diagnosis based. The Medical Officer should not approach the Tables hoping to find various conditions listed for which he or she can read off a rating. One of the skills which needs to be developed in order to assess impairment in this context is the ability to select the appropriate tables. The question which must be asked in each and every case is "which body systems have a functional impairment due to this condition?"

3. These Tables give particular emphasis to the loss of functional capacity that a person experiences in relation to work. This is measured by reference to an individual's efficiency in performing a set of defined functions in comparison with a fully able person. In using these tables ratings can only be assigned for conditions where there is an associated current loss of function or where prolonged loss of function would be expected in most work situations.

4. A rating is only to be assigned after a comprehensive history and examination. For a rating to be assigned the condition must be a fully documented, diagnosed condition which has been investigated, treated and stabilised. The first step is thus to establish a working diagnosis based on the best available evidence. Arrangements should be made for investigation of poorly defined conditions before considering assigning an impairment rating. In particular where the nature or severity of a psychiatric (or intellectual) disorder is unclear appropriate investigation should be arranged.

5. The condition must be considered to be permanent. Once a condition has been diagnosed, treated and stabilised, it is accepted as being permanent if in the light of available evidence it is more likely than not that it will persist for the foreseeable future. This will be taken as lasting for more than two years. A condition may be considered fully stabilised if it is unlikely that there will be any significant functional improvement, with or without reasonable treatment, within the next 2 years.

6. In order to assess whether a condition is fully diagnosed, treated and stabilised, one must consider:

- what treatment or rehabilitation has occurred;
- whether treatment is still continuing or is planned in the near future;
- whether any further reasonable medical treatment is likely to lead to significant functional improvement within the next 2 years.

In this context, reasonable treatment is taken to be:

- treatment that is feasible and accessible ie, available locally at a reasonable cost;
- where a substantial improvement can reliably be expected and where the treatment or procedure is of a type regularly undertaken or performed, with a high success rate and low risk to the patient.

It is assumed that a person will generally wish to pursue any reasonable treatment that will improve or alleviate an impairment, unless that treatment has associated risks or side effects which are unacceptable to the person. In those cases where significant functional improvement is not expected or where there is a medical or other compelling reason for a person not undertaking further treatment, it may be reasonable to consider the condition stabilised.

In exceptional circumstances, where a condition was considered not stabilised and a permanent impairment rating not assigned because reasonable treatment for a specific condition has not been undertaken, the medical officer should:

- evaluate and document the probable outcome of treatment and the main risks and or side effects of the treatment; and
- indicate why this treatment is reasonable; and
- note the reasons why the person has chosen not to have treatment.

7. A single medical condition should be assessed on all relevant Tables when that medical condition is causing a separate loss of function in more than one body system. For example, Diabetes Mellitus may need to be assessed using the endocrine (19), exercise tolerance (1), lower limb function (4), renal function (17), skin disorders (18) and visual acuity (13) tables. When using more than one Table for a single medical condition the possibility of double assessment of a single loss of function must be guarded against. For example, it is

inappropriate to assess an isolated spinal condition under both the spine table (5) and the lower limb table (4) unless there is a definite secondary neurological deficit in a lower limb or limbs.

8. In general, pain or fatigue should be assessed in terms of the underlying medical condition which causes it. For example, Table 5 should be used for spinal pathology. However, where the medical officer is of the opinion that the Tables underestimate the level of disability because of the presence of chronic entrenched pain, Table 20 can be used to assign a rating **instead** of the Table(s) that otherwise would be used to assess the loss of function to which the pain relates. Medical officers must use their clinical judgement and be convinced that pain or fatigue is a significant factor contributing towards the person's overall functional impairment. Medical reports and the person's history should consistently indicate the presence of chronic entrenched pain or fatigue.

9. Always use a Table specific to the functional impairment being rated unless the instructions in a section specify otherwise. The system-specific Tables provide appropriate criteria with which to rate a disorder. The procedure is to identify the loss of function, refer to the appropriate system Table and identify the correct rating eg. a person with a CVA (stroke) could be assessed under five different Tables: upper and lower limbs (3 and 4), neurological (8 and 9) and visual field disorders (15). Table selection would depend on the functions affected.

10. Ratings can only be assigned in accordance with the rating scores in each Table. Ratings cannot be assigned between consecutive ratings (eg. a rating of fifteen cannot be assigned between ten and twenty). Nor can ratings be assigned in excess of the maximum rating specified by each Table (eg. if the maximum rating for a Table is 30, the medical officer cannot assign a greater rating than this figure). Ratings must be consistent with these Tables. No idiosyncratic assessment systems are allowed.

11. The scaling system for the Tables is based on points allocation with the number alongside each impairment descriptor representing the number of points to be allocated for that impairment. Ratings between Tables are not always comparable although the ratings have been allocated on the basis of the likely impact of an impairment on work ability. Where more than one impairment is present, separate scores are allotted for each and **the values are added together** giving a combined work-related impairment rating.

12. A medical condition such as Vascular disease (Stroke) may cause brain damage to different parts of the brain eg. damage to the cortex causing cognitive/comprehension impairments, damage to the speech centre causing aphasia (receptive or expressive communication impairments) and damage to the motor centre causing hemiparesis. Each separate or additional loss of function must be assessed under the relevant Table(s), in this case Tables 8, 9, 3 and 4. This is **not** double counting (also see para 7). Double counting is where one functional loss is counted twice. For instance, where a condition causes a cognitive impairment, the presence of mental confusion may suggest an extra communication impairment. However, if the speech centre of the brain is undamaged, the overall situation is regarded as a single impairment.

13. These Tables have been scaled so that where two conditions cause a common or a combined functional loss, a single rating should be assigned for both conditions and this should reflect the combined loss of function from each of the two conditions. For example, the presence of both heart disease and chronic lung disease may each cause difficulty with breathing and reduced effort tolerance. The overall loss of function is a combined or common effect with a contribution from each condition. In this case a single impairment rating is assigned based on overall reduction in effort tolerance using Table 1.

## CHAPTER 2:

### GUIDE TO TABLE 1. – LOSS OF CARDIOVASCULAR AND/OR RESPIRATORY FUNCTION: EXERCISE TOLERANCE

Table 1 is used to assess cardiorespiratory impairment resulting from conditions affecting the heart (cardiovascular function) or lungs (respiratory function). This impairment is measured by reference to **exercise (or effort) tolerance** which is quantified in terms of **METs**. One MET is defined as the energy expenditure at rest which is associated with the average oxygen consumption of 3.5 mL O<sub>2</sub>/kg of body weight/min.

The level of effort tolerance is assessed using Table 1.2 by determining the **lowest** level of activity (measured in METs) at which **restriction** occurs as a result of symptoms that are due to cardiac or respiratory conditions. An impairment rating is then assigned from Table 1 depending on this **symptomatic activity level** but **only one rating** may be applied regardless of the number of cardiac or respiratory conditions contributing to the restriction. (Refer also to Sections (H), (L)– Chapter 1, Paragraph 13 of the “Introduction”.)

#### **Exercise/Effort Tolerance:**

Effort tolerance is related to a person’s capacity to exercise from a **cardiorespiratory** point of view only and should not refer to overall exercise ability which may be restricted by other conditions. Reduced effort tolerance as a consequence of cardiorespiratory conditions is usually associated with symptoms such as angina (cardiac chest pain), dyspnoea (shortness of breath) or fatigue. An appropriate rating for reduced exercise ability cannot always be assigned from this table if the restriction is not due to cardiac or respiratory pathology (eg if mobility and limb function is restricted by musculoskeletal or neurological conditions, morbid obesity without cardiorespiratory complications, non-pathological reasons such as lack of fitness or deconditioning.)

#### **Symptomatic Activity Level (Restrictive METs Level):**

The symptomatic activity level is determined with reference to Table 1.2 – Metabolic cost of activities. It is the lowest METs level at which the majority of activities within the one category consistently give rise to cardiorespiratory symptoms that **restrict** the person from persisting with such activities. It is expected that a person should be unable to perform the activities listed at higher METs levels than their assessed restrictive METs level but that they remain capable of the activities listed at lower METs levels. In determining this level, less reliance is placed on sporadic activities which can be completed in less than a few minutes (eg playing one hole of golf) as it may take longer than this for symptoms to occur. Greater reliance is placed on activities that involve a steady expenditure of energy.

Although the instructions do not specifically indicate the length of time that each activity is performed when determining if symptoms occur, it is taken that they are performed for “more than a few minutes” but perhaps not for excessively prolonged periods. An example of 10 minutes has been provided for the activity of “walking steadily.” The instructions also do not specify any qualifications regarding the particular manner in which listed activities are performed even though this could affect their METs classification in circumstances. It is taken however, that activities described are performed in what would generally be considered to be the “usual” manner. Hence the activity of “driving a car” does not refer to situations such as racing cars for sport or engaging in a demolition derby but rather to personal driving in the manner encountered for usual day to day purposes.

Some of the activities listed in Table 1.2 refer to occupational activities (eg “clerical work...” at 2-3 METs level). It should not be assumed however, that if restrictive symptoms do not occur after performing the described work activity for a reasonable period of time (eg 10 minutes), the person is therefore capable of performing such work on a full-time basis. In some cases, the overall impairment resulting from a cardiac/respiratory condition may still be sufficient to prevent the person from sustaining such work over a full day or on a long-term term basis. Hence it is not necessarily inconsistent for a person with a cardiorespiratory restrictive level determined at 3-4 METs to be

considered unfit for full-time employment as a clerk even though this work activity is listed at a lower METs level.

**Determining a reliable level of effort tolerance impairment:**

Clinical judgement is required in assessing a reliable restrictive activity level that is consistent with the person's known cardiorespiratory pathology. This should be based on the available medical evidence including the person's medical history, investigation results and clinical findings. In determining a restrictive symptomatic level, care should be taken to distinguish between activities that the person does not do as opposed to activities that they are actually restricted from performing because of their cardiorespiratory condition. Exercise restrictions that are due to non-cardiorespiratory reasons should not be considered and this must be taken into account when determining if a valid impairment rating can be applied (see above).

Sometimes, a reliable exercise tolerance history is difficult to obtain despite discussions with the treating doctor. Significant inconsistencies may be apparent such as symptoms being inconsistently reported across varying activity levels or a reported level of function that does not correlate in severity with the known medical history, investigations results or clinical findings. In most cases, an appropriate and consistent restrictive level can be determined based on clinical judgement but for cases where this is not possible, the results of an Exercise ECG (stress test) or Respiratory Function Test may be obtained. Because of the higher level of objectivity, the results of exercise tests if available, are usually used in preference to assessments based on subjective self-reported symptoms.

If the impairment is due to a respiratory condition and a reliable lung function test result is available, then an assessment under Table 2 instead of Table 1 may be considered for situations where a valid level of effort tolerance is difficult to assess. (Refer also to CHAPTER 3 – Table 2.)

**Some conditions commonly assessed using this table:**

Ischaemic heart disease or coronary artery disease with exercise induced angina. Cardiac disease which has resulted in chronic cardiac failure such as severe cardiomyopathy or some cardiac valvular conditions. Cardiac arrhythmias that result in exercise induced restrictive symptoms. Chronic obstructive airways disease or chronic airways limitation (COAD/CAL), restrictive lung disorders, exercise induced asthma.

**Conditions that should not be assessed using this table:**

Cardiac or respiratory conditions that are asymptomatic and/or do not decrease effort tolerance (eg minor cardiac valvular lesions or pleural plaques) should not receive an impairment rating under this table. Hypertension should be rated under Table 20 and not Table 1 unless it has resulted in hypertensive heart failure causing restrictive symptoms. Peripheral vascular disease is usually rated under Table 4. Varicose veins may be rated under Table 4 or Table 18 depending on its effects. Asthma and cardiac arrhythmias that are not exercise induced but episodic or intermittent in nature should be rated under Table 21. (Refer also to CHAPTER 5 – Table 4, CHAPTER 22 – Table 20, CHAPTER 23 – Table 21.)

Restriction of physical activity due to musculoskeletal (eg severe arthritis, spinal problems) or neurological (eg paresis or paralysis) conditions should generally be rated under the relevant system-specific tables (usually Table 3, 4, 5) depending on the functional loss. Similarly, symptoms of fatigue that are not associated with a cardiorespiratory cause should be rated under the relevant table depending on their underlying cause. Non-pathological causes such as lack of fitness or excessive weight that is not associated with cardiorespiratory pathology should not be assessed as medical impairments under this table.

**Example of Cardiorespiratory Impairment Assessment using Table 1:**

A 58 year-old man diagnosed with chronic obstructive airways disease and angina has had to cease work as a manual labourer on his specialist physician's advice because he was becoming too short of breath performing work activities requiring heavy lifting and loading. He has moved from a third floor unit into a low set house because he was finding it too difficult to carry his groceries up three flights of stairs. He is still able to climb such stairs without stopping to rest if not carrying loads but he describes being "somewhat puffed" by the time he reaches the top.

He now lives alone and does not experience major difficulties with performing activities of daily living and most daily household chores. He is able to mow his small flat lawn at a slow steady pace. He still enjoys gardening but finds that he becomes short of breath if he does too much digging.

His angina is well controlled on medication and he does not have any regular symptoms of chest pain now as he no longer performs the heavy manual work activities that used to precipitate them.

Medical examination and assessment has determined that his conditions have been fully diagnosed, optimally treated and stabilised and that his cardiorespiratory impairment is unlikely to improve significantly within the next two years. His reported exercise tolerance level is also considered to be medically consistent with his known cardiorespiratory pathology. His cardiorespiratory impairment is therefore considered permanent and a reliable symptomatic activity level can be determined to assign a valid rating from Table 1.

Using Table 1.2, his symptomatic activity level is assessed at the 5-6 METs level as he is restricted by symptoms of shortness of breath related to his respiratory condition at this level. He is restricted from activities at a higher level but is still able to perform activities at a lower level without significant symptoms.

Using Table 1 – Assignment of rating, his symptomatic activity level at 5-6 METs corresponds to a rating of 15 points. His total cardiorespiratory impairment from his conditions of chronic obstructive airways disease and angina is therefore assessed at 15 impairment points for their combined effect on reduced effort tolerance.

**TABLE 1. LOSS OF CARDIOVASCULAR AND/OR RESPIRATORY FUNCTION: EXERCISE TOLERANCE**

Cardiovascular and Respiratory function is measured by reference to exercise tolerance. A rating is obtained from Table 1 by determining the lowest MET band which causes restriction in activity from a cardiac or respiratory condition. 1 MET is defined as average oxygen consumption at rest which is 3.5mL O<sub>2</sub>/kg/min.

The clinical judgement of medical officers based on history and examination is to be used but in cases where a reliable history is difficult to obtain despite discussions with the treating doctor or the history of exercise tolerance is inconsistent with clinical findings on examination, the results of an Exercise ECG or Respiratory Function Test may be obtained.

The appropriate MET level is calculated using the lists in Table 1.2.

Peripheral Vascular Disease is assessed under the lower limb Table 4. Varicose veins are assessed under either the Lower Limb or Skin Table. Hypertension is assessed under Table 20. Where exercise intolerance is caused by a combination of cardiac and respiratory conditions, Table 1 is to be used and used only once. Episodic conditions such as cardiac arrhythmias and episodic asthma should be assessed under Table 21 unless they are exercise induced.

**Assignment of rating**

<b>Rating</b>	<b>Symptomatic Activity Level (METs)</b>
NIL	7-8 or higher
FIVE	6-7
FIFTEEN	5-6
TWENTY	4-5
THIRTY	3-4
FORTY	2-3 or less

**TABLE 1.2 Metabolic cost of activities**

**INSTRUCTIONS**

Listed below is a more comprehensive set of activities, with their corresponding MET level. One MET represents the energy level expenditure associated with the consumption of 3.5ml O<sub>2</sub>/kg body weight/minute. Please use this list to assist you in determining an appropriate symptomatic MET level for the claimant.

In determining the symptomatic activity level, greater reliance is placed on activities which involve a steady expenditure of energy (eg. walking steadily for 10 minutes) as opposed to a sporadic expenditure of energy (eg. playing one hole of golf). The former activities are more reliable indicators of exercise tolerance. Less reliance is placed on activities which can be completed in less than a few minutes, as symptoms may take longer than this to occur.

**Metabolic Cost of Activities**

1-2 METs Energy expended at rest or minimal activity

Lying down	sitting and drinking tea	using sewing machine ( <i>electric</i> )
sitting down	sitting and talking on telephone	travelling in a car as passenger
strolling ( <i>slowly</i> )	standing	typing
sitting and knitting		

2-3 METs Energy expended to dress, wash and perform light household duties

Walking 3.5km/hr ( <i>slowly</i> )	playing piano/violin/organ	clerical work which involves moving around
setting table	playing billiards	
washing dishes	driving power boat	bench assembly work ( <i>sitting</i> )
dressing	light sweeping	using self-propelled mower
light tidying, dusting	horseback riding at walk	polishing silver
driving a car	lawn bowls	making bed
cooking, preparing meals		

3-4 METs Energy required for walking at average pace

Walking 5km/hr ( <i>average walking pace</i> )	vacuuming	machine assembly
	sedate cycling (10km/hr)	minor car repairs
shifting chairs	light gardening ( <i>weed/water</i> )	light carpentry ( <i>chiselling, hammering, sawing and planing with hand tools</i> )
hanging out washing	playing golf ( <i>with power buggy</i> )	
tidying house ( <i>includes carrying heavy objects</i> )	welding	

4-5 METs Moderate activities: encompasses more active daily activities with the exclusion of manual labour and vigorous exercise

Mopping floors	gentle swimming	stocking shelves with light objects
golf ( <i>pulling buggy, carrying bag</i> )	ballroom dancing	
beating carpets	stacking firewood	painting outside of house
polishing furniture	cleaning windows	wallpapering
hoeing ( <i>soft soil</i> )	pushing light power mower over flat suburban lawn at slow, steady pace	walking 6.5km/hr ( <i>sustained brisk walk, discomfort talking at the same time</i> )
showering		
cleaning car (excludes vigorous polishing)		

5-6 METs Heavy exercise: manual labour or vigorous sports

Shovelling dirt ( <i>12 throws/min.</i> )	digging in garden	walking slowly but steadily up stairs
tennis doubles ( <i>social non-competitive</i> )	scrubbing floors	pushing a full wheelbarrow (20kg)

6-7 METs

loading truck with bricks	pace walking	carrying load upstairs (10kg)

7-8 METs Very heavy exercise

Jogging (8km/hr)	sawing hardwood with hand tools	using pick & shovel to dig trenches
tennis (singles, non-competitive)	swimming laps (non-competitive)	

8-9 METs

Running (9km/hr)	chopping hardwood	

10 METs

Running quickly (10km/hr)	cycling quickly (25km/hr)	carrying loads (10kg) up a gradient



## CHAPTER 3:

### GUIDE TO TABLE 2. – LOSS OF RESPIRATORY FUNCTION: PHYSIOLOGICAL MEASUREMENTS

Table 2 is used to assess respiratory loss of function by reference to **physiological measurements**. In the majority of cases, respiratory impairment is assessed by reference to the impact on exercise tolerance and therefore, Table 1 is used to assign a rating. However, if a reliable and consistent level of exercise tolerance is difficult to determine, it may be considered more appropriate to assess the respiratory loss of function by using physiological measurements and Table 2 is used for this purpose. (Refer also to CHAPTER 2 – Table 1.)

Physiological loss of lung function is assessed by measuring the **FEV<sub>1</sub>** (Forced Expiratory Volume in one second) and the **FVC** (Forced Vital Capacity). The measured FEV<sub>1</sub> and FVC values are compared to predicted values obtained from the predictive nomograms in Tables 2.2/2.3 and the ratios are then expressed as percentages. An impairment rating is then determined from this **% predicted FEV<sub>1</sub> or FVC** but **only one rating** should be assigned from Table 2 regardless of whether the FEV<sub>1</sub> or FVC value is selected as being more appropriate. An additional rating should not be assigned from Table 1 as well as this will result in double counting of the same functional impairment. (Refer also to Section (H) – Chapter 1.)

#### **Determining a reliable measurement of physiological function:**

Measurements of FEV<sub>1</sub> and FVC should be performed with a vitalograph or equivalent instrument without the need for specific administration of a bronchodilator (“puffer” medication). The results obtained must be considered consistent and reliable so as to reflect optimal effort and provide a reasonably valid measure of lung function. Ideally, three readings should be taken and the best set of results (ie that indicating the greatest degree of health and the lowest level of impairment) selected to calculate a rating. Where available, results reported by a respiratory physician with lung function tests from a respiratory laboratory should be used in preference as these are likely to provide the greatest level of accuracy and reliability.

Testing pre- and post-bronchodilatation is unnecessary as this table is intended to assess only irreversible lung disease that should not respond to bronchodilator medication. Use of bronchodilatory medication is only beneficial to respiratory conditions with a reversible component (such as asthma) and these are usually not assessed under this table unless they are of such severity as to have resulted in persistent and irreversible airways limitation. In deciding whether to use the FEV<sub>1</sub> or FVC values for assigning a rating, it should be considered that the FEV<sub>1</sub> is usually selectively reduced in Chronic Airflow Limitation and the FVC in Restrictive Lung Disorders. The FEV<sub>1</sub> should therefore be used in preference to the FVC where there is a discrepancy between the two in Chronic Airflow Limitation.

#### **Calculating % Predicted FEV<sub>1</sub> or FVC:**

1. Obtain the measured FEV<sub>1</sub> and FVC values as above.
2. Determine the predicted FEV<sub>1</sub> and FVC values for the person depending on their gender, age and height by applying the nomograms in Table 2.2 (for males) or Table 2.3 (for females). This is done by ruling a straight line joining the appropriate point on the height column (in cm) to the corresponding point on the age column (in years). Where this line intersects the FEV<sub>1</sub> and FVC columns are the predicted values for FEV<sub>1</sub> and FVC.
3. Calculate the ratios of the measured FEV<sub>1</sub> and FVC values from 1. against the corresponding predicted FEV<sub>1</sub> and FVC values from 2. as percentages.  
(% predicted value = (actual measured value x 100) / predicted value)
4. Select the most appropriate % predicted value (either FEV<sub>1</sub> or FVC) and assign a corresponding rating from Table 2 – Assignment of a rating.

#### **Some conditions commonly assessed using this table:**

Irreversible lung disease such as chronic obstructive airways disease or chronic airflow limitation (COAD/CAL) and restrictive lung disorders.

**Conditions that should not be assessed using this table:**

Lung disease with a reversible component (such as asthma) should not be assessed under this table unless it has resulted in severe and persistent airflow limitation. Episodic asthma is usually rated using Table 21 for the intermittent impairment unless it is exercise induced in which case, Table 1 may be more appropriate. Cardiac conditions and other non-respiratory conditions that may result in feelings of breathlessness should not be assessed under this table. (Refer also to CHAPTER 2 – Table 1, CHAPTER 23 – Table 21.)

**Example of Respiratory Impairment Assessment using Table 2:**

A 50 year-old man diagnosed with mild chronic obstructive airways disease describes leading a very sedentary lifestyle and does not perform many physical activities. He describes inconsistent symptoms of shortness of breath at low levels of exertion such as walking at an average pace but also performs higher level activities including mowing his own lawn. It is suspected that he probably remains capable of sustaining activities at higher levels of exertion even though he does not undertake them. A reliable level of effort tolerance consistent with his expected level of respiratory pathology is difficult to establish and it is considered appropriate to assess his impairment by referring to physiological measurements using Table 2.

From Table 2.2, for his age of 50 years old and his height of 170 cm, his predicted FEV<sub>1</sub> is determined as 3.4 and his predicted FVC as 4.3. A recent review by a respiratory physician has established that his condition is fully diagnosed, treated and stabilised and reliable spirometry results indicate that his measured FEV<sub>1</sub> is 2.9 and his measured FVC is 4.1.

His % predicted FEV<sub>1</sub> is calculated as  $(2.9 \times 100) / 3.4 = 85.3\%$ .

His % predicted FVC is calculated as  $(4.1 \times 100) / 4.3 = 95.3\%$ .

As he has chronic airflow limitation, the FEV<sub>1</sub> value is used in preference to the FVC.

Using Table 2 – Assignment of a rating, his % predicted FEV<sub>1</sub> of 85.3% corresponds to a rating of nil points. His respiratory impairment from the condition of chronic obstructive airways disease is therefore assessed at nil impairment points based on physiological measurements of lung function.

**TABLE 2. LOSS OF RESPIRATORY FUNCTION: PHYSIOLOGICAL MEASUREMENTS**

Respiratory function is measured by reference to exercise tolerance in the majority of cases and so Table 1 is used. Spirometry can be used where the medical officer feels it is more appropriate for example, where a history of exercise tolerance is difficult to obtain and assess or the history of exercise tolerance is inconsistent with clinical findings on examination. A rating is then obtained using Table 2.

Predictive nomograms for the forced expiratory volume over one second (FEV<sub>1</sub>) and the forced vital capacity (FVC) are at Tables 2.2 and 2.3.

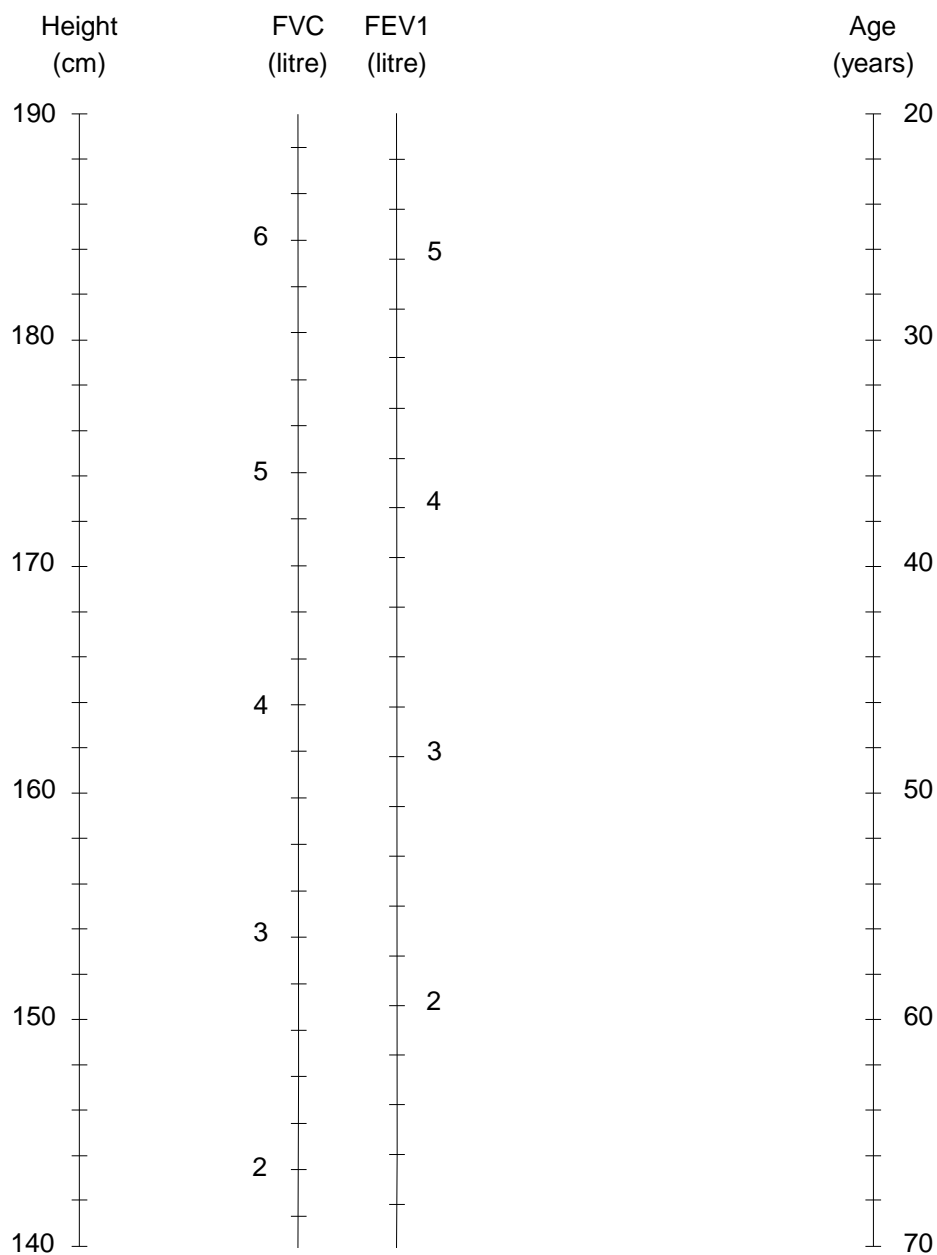
Measurements of Forced Expiratory Volume in one second and Forced Vital Capacity should be performed with a vitalograph or equivalent instrument. Ideally, three readings should be taken and the best of these used to calculate a rating. Calculate the ratio of FEV<sub>1</sub> and FVC against the predicted figures as a percent. Testing pre- and post-bronchodilatation is unnecessary as the aim of assessment under this Table is to assess people in their "normal" state. Furthermore, this Table is only to be used for people with irreversible lung disease. The FEV<sub>1</sub> is usually selectively reduced in Chronic Airflow Limitation and the FVC in Restrictive Lung Disorders. The FEV<sub>1</sub> should be used in preference to the FVC where there is a discrepancy between the two in Chronic Airflow Limitation.

**Assignment of a rating**

<b>Rating</b>	<b>% Predicted FEV<sub>1</sub> or FVC</b>
NIL	80+
TEN	75-79
FIFTEEN	70-74
TWENTY	65-69
TWENTY-FIVE	60-64
THIRTY	50-59
FORTY	49 or less

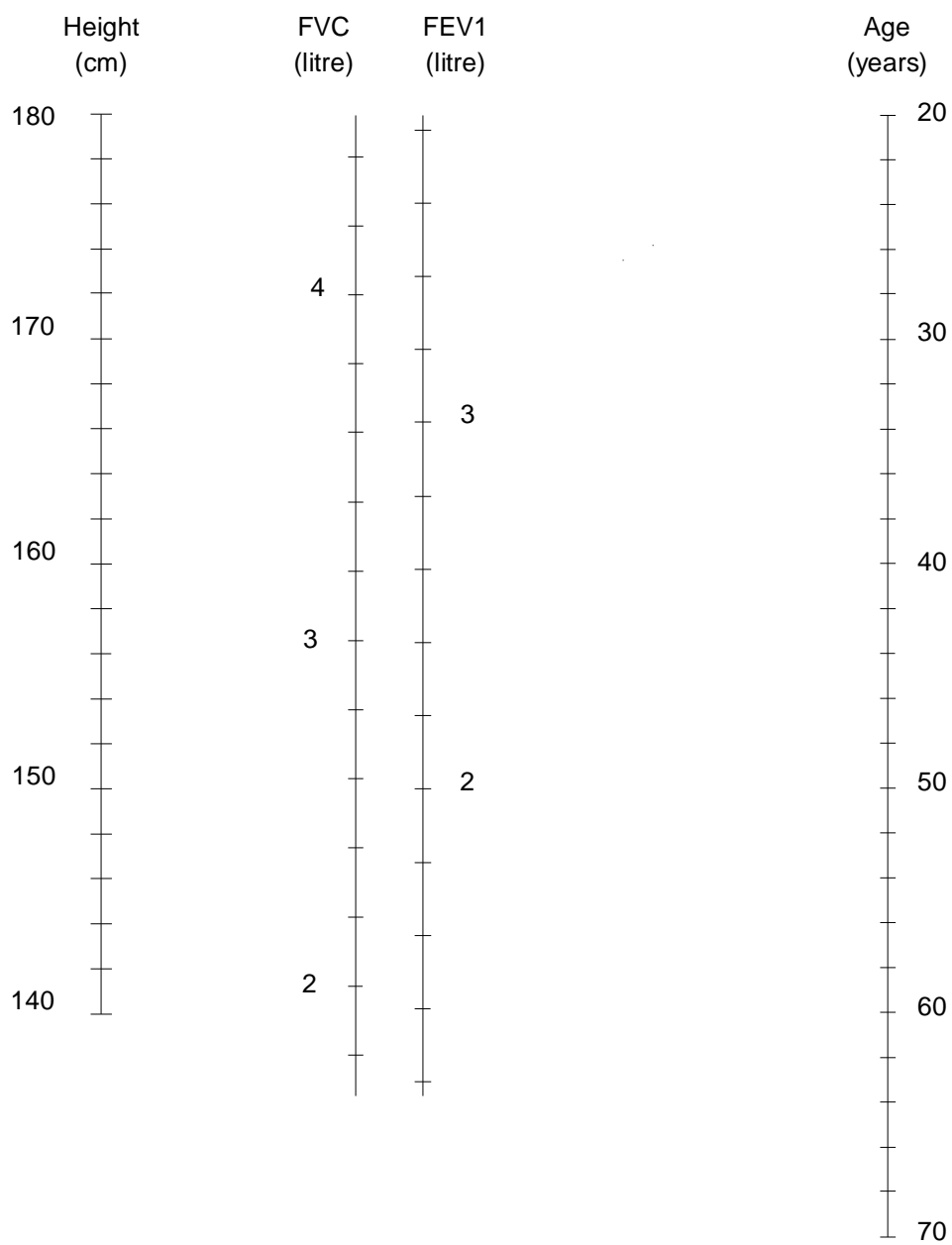
**TABLE 2.2 Prediction nomogram - males**

NOTES: From Kamburoff, Petia L., and Weitowitz, H.J. & R.H. (1972)



**TABLE 2.3 Prediction nomogram - females**

NOTES: From Kamburoff, Petia L., and Weitowitz, H.J. & R.H. (1972)



## CHAPTER 4:

### GUIDE TO TABLE 3. – UPPER LIMB FUNCTION

Table 3 is used to assess conditions that result in impairment of upper limb function. **Each arm is assessed separately** and therefore **more than one rating** may be assigned from this table if both arms are impaired. Hence, for bilateral conditions where both upper limbs are affected, a separate rating is applied for each arm and the two ratings are added to provide the total upper limb impairment rating. If only one arm is impaired, then only one rating is applied from this table. (Refer also to Section (H) – Chapter 1.)

#### **Determining a reliable level of upper limb impairment:**

Determination of the level of upper limb impairment must be based on a **demonstrable loss** of function. This means that there must be clinical evidence of functional impairment that is consistent with the reported level of functional loss. Clinical observations and findings on examination (such as muscle bulk or wasting, power, grip strength, tone, reflexes, sensory changes, coordination, range of joint movements, dexterity, presence of calluses etc.) should be correlated with the diagnosed medical pathology, functional history and reported symptom level. It would be inappropriate to apply a high impairment rating based solely on a person's self-reported functional history if this level of functional loss is not consistent with the clinically demonstrable evidence.

Upper limb impairment attributed to cervical spine pathology should only be rated under this table if there is a definite and permanent secondary neurological deficit in the upper limb that has resulted in significant functional impairment. There should be objective evidence of functional loss including clinically consistent signs (eg significant muscle wasting, loss of power, abnormal reflexes and anatomically appropriate sensory changes). In most cases, it is expected that such neurological deficits would have been confirmed with neurosurgical review and appropriate investigations (such as MRI scans). (Refer also to Section (H) – Chapter 1, CHAPTER 6 – Table 5.)

The descriptors in Table 3 are broadly separated into four levels of severity. The first three levels refer to “Demonstrable evidence of loss of strength, mobility, coordination, dexterity and/or sensation of upper limb which causes ... interference with hand function or manual handling”. These are categorised depending on whether there is “**mild**”, “**moderate**” or “**significant**” “interference...” The fourth and most severe level of impairment refers to being “**Unable to use ... upper limb at all.**” The last three levels are further categorised depending on whether it is the **dominant or non-dominant limb** affected as impairment of the dominant limb attracts an additional five points.

In terms of benchmarking the qualitative descriptors of “mild”, “moderate” or “significant” impairment, it should be remembered that in accordance with the underlying purpose of the Tables, the descriptors at 20 points correspond to the level of impairment where there is a significant impact on work ability. (Refer also to Sections (A), (C), (D), (F), (J) – Chapter 1.) Hence, on comparing the two descriptor alternatives at this level, it can be seen that for the functional loss in the “dominant” upper limb to be considered “significant”, it must be of equivalent severity to being “unable to use” the “non-dominant” upper limb at all (eg amputation at the shoulder).

As the Tables are intended to assess work-related impairment rather than whole person impairment, the person's usual level of upper limb function with or without assistive aids should be considered in determining their optimal capacity for “hand function or manual handling.” This is also consistent with the requirement that the condition and its resulting impairment has been fully treated and stabilised before a permanent rating can be assigned. It is expected that the impairment rating should reflect the person's optimal level of upper limb function and that no significant improvement in adaptive function will occur within the next two years. (Refer also to Sections (C), (K) – Chapter 1.)

The wording of the descriptors also reflects the design of the Tables as being function-based rather than diagnosis-based. Hence, it is possible for two individuals with the same diagnosis (eg amputation of the last three fingers of the right hand) to be assigned different upper limb impairment ratings from Table 3 depending on factors such as their limb dominance, presence of significant pain

and overall adaptive function. This reflects assessment of their functional loss rather than their anatomical loss. (Refer also to Sections (F), (L) – Chapter 1.)

**Some conditions commonly assessed using this table:**

Upper limb musculoskeletal conditions including specific degenerative joint disease (osteoarthritis), other permanent forms of arthritis, chronic rotator cuff lesions. Upper limb amputations, fractures, dislocations and long-term effects of musculoskeletal injuries. Neurological conditions including strokes (CVAs) causing hemiparesis, hemiplegia, dyspraxia. Chronic carpal tunnel syndrome, ulnar nerve palsies.

**Conditions that should not be assessed using this table:**

Difficulties handling and manipulating objects due to severe visual impairment should not be assessed under this table if there are no inherent medical conditions affecting the upper limbs. Such impairment should be assessed under the relevant visual impairment tables, Tables 13, 14 or 15. Intermittent conditions that do not cause chronic impairment but result in discrete episodes of impairment (eg gout causing intermittent joint pain) would be better assessed under Table 21. (Refer also to CHAPTER 23 – Table 21.)

**TABLE 3. UPPER LIMB FUNCTION**

All upper limb problems are assessed under the upper limb Table (Table 3). Each arm is assessed separately. Determination of upper limb impairments must be based on a demonstrable loss of function.

<b>Rating</b>	<b>Criteria</b>
NIL	Can use <b>dominant</b> limb effectively and/or  Demonstrable evidence of loss of strength, mobility, coordination, dexterity and/or sensation of upper limb which causes mild interference with hand function or manual handling.
FIVE	Demonstrable evidence of loss of strength, mobility, coordination, dexterity and/or sensation of <b>non-dominant</b> upper limb which causes moderate interference with hand function or manual handling.
TEN	Demonstrable evidence of loss of strength, mobility, coordination, dexterity and/or sensation of <b>dominant</b> upper limb which causes moderate interference with hand function or manual handling.
FIFTEEN	Demonstrable evidence of major loss of strength, mobility, coordination, dexterity and/or sensation of <b>non-dominant</b> upper limb which causes significant interference with hand function or manual handling.
TWENTY	Demonstrable evidence of major loss of strength, mobility, coordination, dexterity and/or sensation of <b>dominant</b> upper limb which causes significant interference with hand function or manual handling <u>or</u>  Unable to use <b>non-dominant</b> upper limb at all.
THIRTY	Unable to use <b>dominant</b> upper limb at all.

## CHAPTER 5:

### GUIDE TO TABLE 4. – FUNCTION OF THE LOWER LIMBS

Table 4 is used to assess conditions that result in impairment of lower limb function. It should not be used to assess impairment of lower spinal function. Because the two lower limbs act to constitute a single functional unit, **both legs are assessed together** and **only one rating** may be assigned from this table even when both legs are impaired. Hence, regardless of the number of conditions involved and whether one or both lower limbs are affected, a single rating is provided from this table for the total lower limb impairment rating. (Refer also to Section (H) – Chapter 1 and CHAPTER 6– Table 5.)

#### **Determining a reliable level of lower limb impairment:**

Determination of the level of lower limb impairment must be based on a **demonstrable loss** of function. This means that there must be clinical evidence of functional impairment that is consistent with the reported level of functional loss. Clinical observations and findings on examination (such as gait, mobility, muscle bulk or wasting, power, tone, reflexes, sensory changes, coordination, range of joint movements etc.) should be correlated with the diagnosed medical pathology, functional history and reported symptom level. It would be inappropriate to apply a high impairment rating based solely on a person's self-reported functional history if this level of functional loss is not consistent with the clinically demonstrable evidence.

This table should not be used to assess the effects of back pain which is usually rated under Table 5.2. Lower limb impairment attributed to lumbar spinal pathology should only be rated under this table if there is a definite and permanent secondary neurological deficit in the lower limb(s) that has resulted in significant functional impairment. There should be objective evidence of functional loss including clinically consistent signs (eg significant muscle wasting, loss of power, abnormal reflexes and anatomically appropriate sensory changes). In most cases, it is expected that such neurological deficits would have been confirmed with neurosurgical review and appropriate investigations (such as MRI scans). (Refer also to Section (H) – Chapter 1, Paragraph 7 of the "Introduction" and CHAPTER 6 – Table 5.)

The descriptors in Table 4 refer to "Demonstrable loss of strength, mobility, stability, balance, coordination and/or sensation such as to cause ... interference with walking and one or more of the following: climbing, squatting, sitting or kneeling." These are categorised depending on whether there is "**moderate**" or "**major**" "interference..." The alternative descriptors refer to restriction of **walking distance** due to "**pain or claudication**". In determining an accurate walking distance it is usually more reliable to establish a maximal duration for performing the activity rather than relying on self-reported perceptions of maximal distance achieved. This measure of impairment is usually more consistently reliable with conditions such as intermittent claudication.

In terms of benchmarking the qualitative descriptors of "moderate" or "major" impairment, it should be remembered that in accordance with the underlying purpose of the Tables, the descriptors at 20 points correspond to the level of impairment where there is a significant impact on work ability. (Refer also to Sections (A), (C), (D), (F), (J) – Chapter 1.) Hence, on comparing the descriptor alternatives at this level, it can be seen that for functional loss in the lower limbs to be considered "major", it must be of equivalent severity to being "unable to walk or stand but independently mobile using a self-propelled wheelchair" (eg paraplegia).

As the Tables are intended to assess work-related impairment rather than whole person impairment, the person's usual level of lower limb function with or without assistive aids should be considered in determining their optimal capacity for "walking..." and general mobility. This is also consistent with the requirement that the condition and its resulting impairment has been fully treated and stabilised before a permanent rating can be assigned. It is expected that the impairment rating should reflect the person's optimal level of lower limb function and that no significant improvement in adaptive function will occur within the next two years. (Refer also to Sections (C), (K) – Chapter 1.)

The wording of the descriptors also reflects the design of the Tables as being function-based rather than diagnosis-based. Hence, it is possible for two individuals with the same diagnosis (eg below



knee amputation of the left leg) to be assigned different lower limb impairment ratings from Table 4 depending on factors such as their overall adaptive function, presence of significant pain and the effects on walking and general mobility. This reflects assessment of their functional loss rather than their anatomical loss. (Refer also to Sections (F), (L) – Chapter 1.)

**Some conditions commonly assessed using this table:**

Lower limb musculoskeletal conditions including specific degenerative joint disease (osteoarthritis), other permanent forms of arthritis. Lower limb amputations, fractures, dislocations and long-term effects of musculoskeletal injuries. Neurological conditions including peripheral neuropathy and strokes (CVAs) causing paraplegia, ataxia, gait disturbance. Some permanent vascular conditions that have been optimally treated and stabilised (eg peripheral vascular disease, varicose veins).

**Conditions that should not be assessed using this table:**

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 the relevant visual impairment tables, Tables 13, 14 or 15. Intermittent conditions that do not cause chronic impairment but result in discrete episodes of impairment (eg gout causing intermittent joint pain) would be better assessed under Table 21. (Refer also to CHAPTER 23 – Table 21.)

**TABLE 4. FUNCTION OF THE LOWER LIMBS**

Table 4 is used to assess lower limb not spinal function (see Table 5). Assess both limbs together. Determination of lower limb impairments must be based on a demonstrable loss of functions.

<b>Rating</b>	<b>Criteria</b>
NIL	Walks without difficulty on a variety of different terrains and at varying speeds for distances of more than 500m.
TEN	Demonstrable loss of strength, mobility, stability, balance, coordination and/or sensation such as to cause <b>moderate</b> interference with walking and one or more of the following: climbing, squatting, sitting or kneeling <b>or</b>  Pain or claudication restricts walking to 250-500m or less, at a slow to moderate pace (4km/h). Can walk further after resting.
TWENTY	Demonstrable loss of strength, mobility, stability, balance, coordination and/or sensation such as to cause <b>major</b> interference with walking and one or more of the following: climbing, squatting, sitting or kneeling <b>or</b>  Pain or claudication restricts walking (4km/h) to 50-250m or less at a time. Can walk further after resting <b>or</b>  Unable to walk or stand but independently mobile using a self-propelled wheelchair.
THIRTY	Pain or claudication restricts walking (4km/h) to 50m or less at a time. Can walk further after resting or restricted to walking in and around home and: <ul style="list-style-type: none"> <li>• requires quad stick, crutches or similar walking aid, or</li> <li>• is unable to transfer without assistance.</li> </ul>
FORTY	Unable to walk or stand and mobile only in a motorised wheelchair or wheelchair with an attendant.

## CHAPTER 6: GUIDE TO TABLE 5. – SPINAL FUNCTION

Table 5 is used to assess conditions that result in impairment of spinal function. Table 5.1 is used to assess impairment of the cervical spine (neck) and Table 5.2 to assess thoraco-lumbar-sacral spine (upper and lower back) impairment. **A separate rating** may be assigned from **each table** depending on which parts of the spine have been affected.

### **Determining a reliable level of spinal impairment:**

Determination of the level of spinal impairment must be based on a **demonstrable loss** of function. This means that there must be clinical evidence of functional impairment that is consistent with the reported level functional loss. Clinical observations and findings on examination (such as physique, posture, gait, mobility, sitting and weight-bearing tolerances, straight leg raising, range of spinal movements etc.) should be correlated with the diagnosed medical pathology, functional history and reported symptom level. It would be inappropriate to apply a high impairment rating based solely on a person's self-reported functional history if this level of functional loss is not consistent with the clinically demonstrable evidence.

It should be emphasised that although the descriptors refer to **loss of normal range of spinal movement** as part of the criteria, this factor **alone** does not necessarily correlate well with a person's overall level of functional impairment. A person may be significantly impaired from symptoms of chronic spinal pain but still retain reasonable range of movement and conversely, a person with significant loss of spinal movement but minimal pain may retain a high level of functional ability. The spinal range of movement may also fluctuate over time if the restriction in movement is related to fluctuating levels of pain.

It is therefore important to assess the additional criteria in relation to **pain** when determining an appropriate impairment level. Table 5.1 includes the presence and frequency of neck pain as an additional factor and Table 5.2 considers further the impact of back pain on a person's usual **functional tolerances** (eg standing / sitting). Table 5.2 also takes into account the effects of back pain and referred leg pain on the ability to perform many physical activities including weight-bearing functions. It is inappropriate in the majority of cases, to assign a further impairment rating from Table 4 for the effects of back pain on walking and general mobility as this would result in double counting. In general, an additional rating would only be applied from Table 3 or 4 if there is a definite and permanent secondary neurological deficit caused by the spinal condition(s) resulting in demonstrable upper or lower limb impairment. (Refer also to Section (H) – Chapter 1, Paragraph 7 of the "Introduction" and CHAPTER 4 – Table 3, CHAPTER 5 – Table 4.)

Where it is considered that the rating assigned under Table 5.1 or 5.2 underestimates the level of impairment due to the effects of **chronic entrenched pain**, Table 20 may be used **instead** to assign an alternative rating. For example, if it is considered that a person has significant and permanent functional impairment from chronic severe back pain but retains normal or only minor loss of range of thoraco-lumbar-sacral spinal movement, Table 20 may be selected in preference to Table 5.2 to assign a rating that more appropriately reflects the overall level of impairment.

It is emphasised in Paragraph 8 of the "Introduction" that in choosing to apply a higher impairment rating using Table 20, the medical assessor must be convinced that pain is a significant factor contributing towards the person's overall functional impairment. Clinical judgement is required to assess that the severity of the impairment is consistent with the available medical evidence. It is recognised that this is often difficult to determine in view of the subjective nature of pain symptoms. It is expected that the person's history, medical reports and overall clinical presentation should consistently indicate the presence of chronic entrenched pain. (Refer also to Section (E) – Chapter 1.)

Table 20 is often considered when the degree of impairment from pain appears to be in excess of what is usually expected for the underlying spinal pathology and a diagnosis of chronic pain disorder or chronic pain syndrome may be applicable. It is emphasised again that to avoid double counting,

only one rating should be assigned using either Table 5 or Table 20 and not both tables concurrently. (Refer also to Sections (H), (I), (J) – Chapter 1, Paragraph 8 of the “Introduction” and CHAPTER 22 – Table 20.)

The full descriptor at a particular impairment level must be satisfied before the rating can be assigned. For example, when using Table 5.1, a person with loss of a little more than a quarter normal range of neck movement and with infrequent symptoms of pain should be assigned 5 points rather than 10 points as the full descriptor at the 10 points level has not been fully met. (Refer also to Section (J) – Chapter 1.)

It should be noted that an “**unstable joint**” as mentioned in the descriptor at the forty points level does not specifically refer to the diagnosis of spondylolisthesis as this condition can be an incidental radiological finding that is asymptomatic and stable. As the Tables are primarily function-based rather than diagnosis-based, it should be evident that a diagnosis of spondylolisthesis alone does not automatically equate to forty points impairment. This descriptor level is intended to reflect instead, the impairment caused by extreme cases of gross spinal instability or equivalent impairment caused by ankylosis in an unfavourable position. It is likely that with such severe cases of spinal instability, surgical intervention would be necessary because of a high probability of serious damage to the spinal cord. (Refer also to Section (F) – Chapter 1.)

It should also be noted that as spinal mobility is a **composite movement**, Table 5.2 measures the overall mobility of the trunk including hip movement and is not intended to measure the mobility of individual spinal segments.

**Some conditions commonly assessed using this table:**

Neck and low back pain attributed to various musculoskeletal/orthopaedic causes.

**TABLE 5. SPINAL FUNCTION**

Determination of spinal impairments must be based on a demonstrable loss of function.

**TABLE 5.1 Cervical spine**

<b>Rating</b>	<b>Criteria</b>
NIL	Normal or nearly normal range of movement.
FIVE	Loss of quarter of normal range of movement.
TEN	Loss of half of normal range of movement and frequent/constant neck pain <b>or</b> loss of three quarters of normal range of movement with infrequent neck pain.
TWENTY	Loss of three-quarters of normal range of movement and constant neck pain.
THIRTY	Loss of almost all movement, or complete ankylosis in position of function.
FORTY	Ankylosis in an unfavourable position, or unstable joint.

**TABLE 5.2 Thoraco - lumbar-sacral spine**

As spinal mobility is a composite movement, this Table measures overall mobility of the trunk including hip movement and is not intended to measure mobility of individual spinal segments.

<b>Rating</b>	<b>Criteria</b>
NIL	Normal or nearly normal range of movement.
FIVE	Loss of one-quarter of normal range of movement.
TEN	Loss of one-quarter of normal range of movement <b>as well as</b> back pain or referred pain: <ul style="list-style-type: none"><li>• with many physical activities and</li><li>• with standing for about 30 minutes and</li><li>• with sitting or driving for about 60 minutes.</li></ul> <p><b><u>or</u></b></p> Loss of half of normal range of movement.
TWENTY	Loss of half of normal range of movement as well as back pain or referred pain: <ul style="list-style-type: none"><li>• with most physical activities and</li><li>• with standing for about 15 minutes and</li><li>• with sitting or driving for about 30 minutes.</li></ul> <p><b><u>or</u></b></p> Loss of three-quarters of normal range of movement.
FORTY	Ankylosis in an unfavourable position, or unstable joint.

## CHAPTER 7: GUIDE TO TABLE 6. – PSYCHIATRIC IMPAIRMENT

Table 6 is used to assess permanent impairment resulting from psychiatric conditions. As clinical signs and investigation results are generally of limited benefit in the assessment of these conditions, medical judgement is required to establish a **detailed psychiatric and functional history** and to provide a mental state assessment. If there is insufficient clinical information available, it may be necessary to obtain a current or recent specialist report. This may be required to determine the severity of the psychiatric impairment and its prognosis over the next two years.

In general, regardless of the number of psychiatric diagnoses or diagnostic labels used, **only one rating** should be assigned from this table to reflect the overall psychiatric impairment. (Refer also to Section (H) – Chapter 1.)

### **Determining a reliable level of psychiatric impairment:**

It is important to distinguish between temporary and permanent psychiatric disorders as this table is only used for assessing psychiatric conditions that result in permanent impairment. A permanent rating can only be assigned if it is considered that the psychiatric condition and its resulting impairment will last for at least two years and significant functional improvement is unlikely to occur within that period. This requires that the condition causing the impairment has been fully diagnosed, treated and stabilised. (Refer also to Section (K) – Chapter 1.)

Establishing an exact psychiatric diagnosis however, is only important if this will determine the prognosis over the next two years. For example, the prognosis may vary depending on whether a depressed person is diagnosed with a severe chronic depressive disorder or an acute adjustment disorder with reactive depression due to a personal stressor (eg recent marital breakdown). The latter diagnosis is usually considered to be temporary in nature as it is likely to improve and hence an impairment rating should not be assigned initially. However, if it is apparent that regardless of what the exact psychiatric diagnosis is and regardless of what treatment is received, a person's impairment is not expected to improve significantly within two years, then it would be unnecessary to refer for specialist review solely to confirm a diagnosis. A permanent rating can be assigned accordingly in this case.

In determining whether the psychiatric disorder has been fully treated and stabilised, one should consider whether the person has received optimal and "reasonable" psychiatric treatment and whether with or without such treatment, the person's level of function will improve within two 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 for many years, then the psychiatric impairment may be considered permanent and rated accordingly.

If optimal treatment has not been undertaken, it should be determined whether the person has a reasonable medical or other compelling reason for not doing so. For example, the person may have a psychotic illness that impairs their insight and ability to make sound judgements and this may affect their compliance with treatment. Such a person's psychiatric impairment could then be considered stable and permanent if it is unlikely that any significant improvement will occur within two years. However, if they retain good insight and judgement and their decision to abstain from reasonable treatment is due to personal choice without medical or other compelling grounds, then the impairment should be considered temporary and not rated under this table.

Some established psychiatric conditions such as Bipolar Affective Disorder ("Manic Depression") may be highly variable in their clinical presentation with a fluctuating course. They may still be considered stable and rated accordingly if they are being optimally managed and their current overall impact on work ability is unlikely to improve significantly within the next two years. In determining the work-related impairment for such fluctuating conditions, one should consider their impact on the person's ability to reliably sustain full-time work over two years without significant absences. (Refer also to Section (B), (K)– Chapter 1.)

Some psychiatric disorders may be associated with somatic effects such as dyspepsia, irritable bowel symptoms and headaches. Symptoms of fatigue, lethargy and impaired memory and concentration are commonly described with depressive illnesses. If these symptoms are considered to be psychogenic in origin and due primarily to the underlying psychiatric condition rather than to separate organic diseases, then it may be appropriate to assess their combined effects as part of the psychiatric impairment. A single rating may then be assigned from Table 6 to reflect the overall impairment if the permanence criteria have been satisfied. (Refer also to Section (I) – Chapter 1, CHAPTER 9 – Table 8, CHAPTER 13 – Table 11.2, CHAPTER 22– Table 20.)

**Some conditions commonly assessed using this table:**

Chronic depressive/anxiety disorders, schizophrenia, bipolar affective disorder, eating disorders, somatoform disorders, pathological personality disorders, post traumatic stress disorder (PTSD). Attention deficit hyperactivity disorder (ADD/ADHD) manifesting with predominantly behavioural problems. Behavioural problems related to acquired brain injury/frontal lobe syndrome.

**Conditions that should not be assessed using this table:**

Acute, short-term psychiatric conditions such as adjustment disorders, reactive depression. Other psychiatric conditions that have not been fully diagnosed, treated and stabilised. “Difficult” personality traits which are not of sufficient severity to be diagnosed as personality disorders. Lack of personal motivation or apathy that is not considered to be due to a psychiatric condition.

**TABLE 6. PSYCHIATRIC IMPAIRMENT**

It is important to record a detailed psychiatric history, a mental state examination, and to distinguish between temporary and permanent psychiatric disorders. People with established psychiatric disorders (eg. Bipolar Disorder) may be highly variable in their clinical presentation and this factor must be taken into account in the assessment. The assessment of psychiatric impairment may benefit from investigating; reports from mental health case managers, compliance with and the effects of medication, support systems that people have in place, the degree of insight present and the presence of psychotic illness. Where a person has a short term problem, for example an adjustment disorder with depression following an illness or marital breakdown, initially this should usually be considered to be of a temporary nature. Table 6 is used for permanent psychiatric disorders only. If there is insufficient clinical information available, a current or recent specialist report should be obtained.

Rating	Criteria
NIL	Mild but regular symptoms which tend to cause subjective distress. On most occasions able to distract themselves from this distress. Minimal interference with function in everyday situations. Exacerbation of symptoms may cause occasional days off work. (eg. There may be some loss of interest in activities previously enjoyed. There may be occasional friction with family, colleagues or friends) Medical therapy or some supportive treatment from treating doctor may be required.
TEN	Moderate and regular symptoms and generally functioning with some difficulty. (eg. noticeable reduction in social contacts or recreational activities, or the beginnings of some interference with interpersonal or workplace relationships). May have received psychiatric treatment which has stabilised the condition. Minor effects on work attendance and/or ability to work but the impairment would not prevent full-time work. (eg. short periods of absence from work)
TWENTY	Psychiatric illness or disorder with either serious symptomatology OR impairment in functioning that requires treatment by a psychiatrist (eg. frequent suicidal ideation, severe obsessional rituals, frequent severe anxiety attacks, serious anti-social behaviour, diagnosed psychotic illness with continuing symptoms ). There is significant interference with interpersonal or workplace relationships with serious disruption of work attendance or ability to work.

- THIRTY Serious psychiatric illness with major impairments in several areas, such as work, interpersonal relations, judgement, thinking, or mood (eg. depressed person avoids friends, neglects family, unable to do housework), OR some impairment in reality testing or communication (eg. speech is at times obscure, illogical or irrelevant).
- FORTY Major chronic psychiatric illness which results in an inability to function in almost all areas, OR behaviour is considerably influenced by either delusions or hallucinations, OR serious impairment in communication (eg. sometimes incoherent or unresponsive) or judgement (eg. acts grossly inappropriately).

## CHAPTER 8: GUIDE TO TABLE 7. – ALCOHOL AND DRUG DEPENDENCE

Table 7 is used to assess impairment resulting from alcohol and drug dependence. **Only one rating** may be assigned from this table to reflect overall impairment regardless of the number of substances (alcohol or drugs) that the person is dependent on.

### **Determining a reliable level of impairment from alcohol and drug dependence:**

Before a rating other than nil is assigned from this table, it must be considered that the person's medical, functional history and clinical presentation consistently indicate chronic entrenched drug and/or alcohol dependence. The dependence should also be causing functional impairment (eg secondary medical problems, legal or forensic problems, impact on work performance/attendance, interference with social and interpersonal relationships.)

High levels of intake will increase health risks but the use of alcohol or drugs 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.

Before a permanent rating is assigned, it should be determined that the impairment has been optimally managed and stabilised and that no further treatment (eg medication, detoxification or rehabilitation programs, psychiatric or psychological counselling) will result in significant functional improvement within two years. If optimal treatment has not been undertaken, it should be considered whether the person has a reasonable medical or other compelling reason for not doing so. For example, due to their condition, the person may have lost their insight and ability to make sound judgements and this may therefore affect their compliance with recommended treatment. Such a person's impairment could then be considered stable and permanent if it is unlikely to improve significantly within two years.

However, in cases where the person is considered to retain good insight and judgement and their decision to abstain from reasonable treatment is due to a fully informed personal choice without medical or other compelling grounds, then the impairment should be considered temporary if significant improvement is expected to occur with reasonable treatment. (Refer also to Section (K) – Chapter 1.)

If complications of end organ damage are associated with the alcohol and drug dependence, then any resulting permanent impairments should be assessed under the appropriate tables (eg Table 4 for peripheral neuropathy, Table 8 for cognitive impairment, Table 11.1 for cirrhosis or chronic liver disease). The separate ratings are then added together to obtain the total work-related impairment. (Refer also to Sections (G), (J) – Chapter 1.)

### **Some conditions commonly assessed using this table:**

Alcohol dependence, dependence on illicit drugs (eg heroin) and other substances including analgesic medications and prescription drugs.



**TABLE 7. ALCOHOL AND DRUG DEPENDENCE**

Alcohol and drug dependence is assessed using Table 7. A rating other than **NIL** on this Table should only be assigned where the person's medical and other reports, history and presentation consistently indicate chronic entrenched drug and alcohol dependence. It should also be causing a functional impairment; the use of drugs or alcohol does not in itself constitute or necessarily indicate permanent impairment. Any associated neurological functions or end organ damage should also be assessed on the appropriate tables in addition to Table 7. The ratings are then added together to obtain a total work-related impairment rating.

When applying this Table, consideration should be given to the known biological and behavioural effects of particular substances.

<b>Rating</b>	<b>Criteria</b>
NIL	A pattern of alcohol or drug use with no or only minor effects on daily functioning or work capacity.
FIVE	A pattern of alcohol or drug use sufficient to cause intermittent or temporary absence from work.
TWENTY	Dependence on alcohol or other drugs, well established over time, which is sufficient to cause prolonged absences from work. Reversible end organ damage may be present.
THIRTY	Dependence on alcohol or other drugs, well entrenched over many years, with minimal residual work capacity. Irreversible end organ damage may be present.
FORTY	Pattern of heavy alcohol or other drug use with severe functional disability and irreversible end organ damage.

## CHAPTER 9:

### GUIDE TO TABLE 8. – NEUROLOGICAL FUNCTION: MEMORY, PROBLEM SOLVING, DECISION MAKING ABILITIES AND COMPREHENSION

Table 8 is used to assess conditions that result in impairment of higher neurological functions of memory, problem solving, decision making ability and comprehension. **Only one rating** should be assigned from this table to assess this loss of cognitive impairment. This type of impairment is usually the result of an **acquired brain injury** which may also be associated with other functional losses. Any such additional impairments should be rated using the relevant tables and the ratings added together to assess the overall work-related impairment.

For example, a person who has suffered a severe head injury may have associated upper and lower limb impairments as a consequence of the injury and these should be assessed under Tables 3 and 4 respectively. Associated problems with behaviour or loss of insight that have been diagnosed and are considered permanent may also attract an additional rating from Table 6. Care however, must be taken to avoid overassessment, particularly with double counting the same functional impairment with regards to the additional use of Tables 9 or 10. (Refer also to Sections (G), (H), (J) – Chapter 1, Paragraph 12 of the “Introduction”, CHAPTER 7 – Table 6, CHAPTER 10 – Table 9, CHAPTER 11 – Table 10.)

#### **Determining a reliable level of cognitive impairment:**

Before assigning a rating from this table, it is important to establish that the cognitive impairment from an acquired brain injury has stabilised and will not improve significantly over the next two years. Some severe brain injuries may take up to two years before optimal recovery and function is achieved. It may be necessary to obtain a current or recent specialist’s evaluation (usually a neuropsychological assessment) to quantify the person’s level of cognitive deficits and to provide a prognostic opinion regarding when optimal function is likely to be achieved (Refer also to Section (K) – Chapter 1.)

It is expected in most cases that there should be a history of a significant head injury or brain insult that is the likely cause of the cognitive impairment. This table is not intended for assessing memory and concentration problems that are temporary in nature and unrelated to acquired brain injuries. For example, it would be inappropriate to rate such symptoms under this table if they are the result of untreated depression. Referral for formal neuropsychological evaluation may also be inappropriate in the presence of mood disorders that have not been treated and stabilised as these may affect the validity and interpretation of the results. (Refer also to CHAPTER 7 – Table 6.)

#### **Some conditions commonly assessed using this table:**

Any type of acquired brain injury (ABI) that has caused cognitive impairment. This can be the result of traumatic injury, infections (eg meningitis/encephalitis), alcohol or drug abuse, strokes (cerebrovascular accidents), epilepsy or tumours. Dyslexia which is a specific reading disability can be rated under this table but should generally attract nil impairment. Attention deficit hyperactivity disorder (ADD/ADHD) may be assessed under this table if the manifestations of the condition relate mainly to learning difficulties; otherwise it may be assessed under Table 6 for associated behavioural problems.

#### **Conditions that should not be assessed using this table:**

Intellectual impairment should be rated under Table 10. Specific dysphasia/aphasia communication conditions are assessed under Table 9. Memory and concentration problems associated with psychiatric conditions should be assessed as part of the overall permanent psychiatric impairment under table 6. Illiteracy and innumeracy are not medical impairments as such and should not be rated under this table. (Refer also to CHAPTER 7 – Table 6, CHAPTER 10 – Table 9, CHAPTER 11 – Table 10.)

**TABLE 8. NEUROLOGICAL FUNCTION: MEMORY, PROBLEM SOLVING, DECISION MAKING ABILITIES & COMPREHENSION**

Table 8 is used to rate impairment of higher neurological functions of memory, problem solving, decision making ability and comprehension. Loss of function within this group is rated only once using this Table. If there are additional functional losses, these are also assessed using other relevant Tables.

People with acquired brain injury may have associated problems with behaviour and/or insight. These impairments may be rated using both Table 8 and Table 6.

If there is insufficient clinical information available on cognitive function, a current or recent specialist report should be obtained (eg. neurologist, specialist physician or neuropsychologist). The report should address functions of comprehension, memory, ability to concentrate, problem solving, loss of motivation, fatigue or any associated behavioural abnormalities or disorders.

<b>Rating</b>	<b>Criteria</b>
NIL	Comprehension, reasoning and memory are comparable with peers or only minor difficulties.
TEN	Can understand movies, radio programs or group discussions, but with some difficulty. Comprehension is good in most situations, but understanding is difficult in large groups, or when tired and upset. Has difficulty coping with rapid changes of topic <b>or</b>  Mild impairment of problem solving and ability to concentrate: appropriate use is made of accumulated knowledge, and reasonable judgement is shown in routine daily activities most of the time. Difficulties are apparent in new circumstances <b>or</b>  Mild impairment of memory. Can learn, although at a slower rate than previously. Impairment has little impact on everyday activity because of compensation through reliance on written notes, schedules, checklists and colleagues.
TWENTY	Can understand speech face-to-face, but confusion or fatigue occurs rapidly in any group. Is unable to cope with rapid change in topic, or with complex topics and is unable to understand a series of work instructions from a supervisor <b>or</b>  Moderate impairment of memory: has frequent difficulty in recalling details of recent experiences; frequently misplaces objects; fails to follow through with intentions or obligations; tends to get lost more easily in unfamiliar areas. Compensation through use of aids, eg, lists or diaries is normally adequate. If restricted to familiar schedules, activities, procedures and areas, is largely independent <b>or</b>  Moderate impairment of problem-solving ability and ability to concentrate: relies on accumulated knowledge. Suffers significant disadvantage in circumstances requiring complex decision-making or non-routine activities, ie, when past decision-making is not directly relevant. Has reduced initiative/spontaneity, reduced ability to concentrate and/or reduced capacity for abstract thinking <b>or</b>  Significant perceptual problems (visual, space or time) making learning and complying with work tasks very difficult.
THIRTY	Can understand only simple sentences, and follow simple sentences from context and gesture, although frequent repetition is needed.
FORTY	Can understand only single words. Shows some understanding of slowly-spoken simple sentences from context and gesture, although frequent repetition is needed <b>or</b>  Severe loss of problem solving ability. Is partially able to compensate, but unable to function with complete independence.

## CHAPTER 10:

### GUIDE TO TABLE 9. – COMMUNICATION FUNCTION – RECEPTIVE AND EXPRESSIVE LANGUAGE COMPETENCY

Table 9 is used to assess conditions that result in impairment of communication function and language competency. **Only one rating** should be assigned from this table even if the communication or language impairment is both **receptive** (processing) and **expressive** in nature. This table is intended to assess medically based language difficulties and is not used to assess fluency or competency of the spoken English language. (Refer also to Section (E) – Chapter 1.)

Impairment of language and communication may be a consequence of cognitive loss in which case, a single rating should be assigned under Table 8. Care must be taken not to double count the same overall functional loss in this situation. However, where language impairment is a separate or additional loss to cognitive impairment (eg if damage to the specific speech centre of the brain has occurred), then a separate rating may be applied from this table. This is described in Paragraph 12 of the “Introduction” with reference to double counting. (Refer also to Sections (G), (H) – Chapter 1, Paragraph 12 of the “Introduction” and CHAPTER 9 – Table 8.)

Impaired language processing or expression may also occur with hearing loss particularly with congenital causes of profound deafness. In these cases, a rating may be assigned from this table as well as from Table 12 for the degree of hearing loss. However, if there is normal language competency (eg where hearing loss is acquired after language has developed), then it would be inappropriate to assign an additional score from this table and only Table 12 is applicable. (Refer also CHAPTER 14 – Table 12.)

#### **Determining a reliable level of communication or language impairment:**

In determining an appropriate impairment rating, one should consider the person’s optimal level of communication function. This should take into account the ability to utilise compensatory aids and strategies including the use of assistive devices (eg hearing aids), non-verbal language (eg reading, writing or signing) and environmental cues and resources to reduce the impact of the impairment. Where there is insufficient clinical information to determine the level of communication ability, a current or recent specialist assessment (eg from a speech pathologist or neuropsychologist) may be required.

#### **Some conditions commonly assessed using this table:**

Any trauma or injury that has damaged the speech/language centre of the brain – dysphasia, aphasia. Some cases of profound congenital deafness may also be associated with impaired language processing or expression.

#### **Conditions that should not be assessed using this table:**

Cognitive impairment without a separate loss of language impairment should only be rated under Table 8. Psychiatric conditions that may appear to cause communication impairment should be assessed under Table 6. Dyslexia is a specific reading disability that is usually rated under Table 8 and should generally attract nil impairment. Illiteracy and innumeracy are not medical impairments as such and should not be rated under this table. (Refer also to CHAPTER 7 – Table 6, CHAPTER 9 – Table 8.)

**TABLE 9. COMMUNICATION FUNCTION - RECEPTIVE AND EXPRESSIVE LANGUAGE COMPETENCY**

This Table measures communication and language competency and addresses both receptive (processing) and expressive language impairment. Hearing loss with impaired language processing or expression should be scored using this Table and Table 12. Hearing loss with normal language competency should only be scored on Table 12. Where language impairment is an effect of cognitive loss, a single rating should be assigned using Table 8 to reflect the combined loss of cognitive and language function. Where language impairment is separate or additional to a cognitive impairment, these losses may be rated using Table 8 and Table 9. The following factors should be considered in determining an impairment rating:

The ability to independently and successfully use appropriate assistive devices, aids or strategies to reduce the impact of the impairment;

The ability to make use of environmental cues and resources (including sign interpreters in the case of deaf people) to reduce the impact of the impairment;

Intactness of other channels of communication:  
reading, writing, non-verbal language;

The degree of effort required by the communication partner(s) in any particular communication setting;

Appropriateness and degree of success of communicative interactions.

If there is insufficient clinical information available on communication skills, a current or recent specialist report should be obtained (eg. speech pathologist, neurologist or neuropsychologist). The report should comment on functional communication status, including the capacity to utilise compensatory strategies/aids to reduce the impact of the impairment.

<b>Rating</b>	<b>Criteria</b>
NIL	Satisfactory or only minor difficulties with communication
FIFTEEN	Difficulty with unfamiliar, lengthy or complex verbal situations and unable to adapt or manage interruption but competent communication in favourable settings. Could work in a wide range of occupations but high public contact and high communication content jobs may be too demanding.
TWENTY	Communication is effortful and limited. A communication partner is required to assist in interpreting the information. Unable to cope with rapid change in topic or complex/abstract information but can understand simple sentences & follow information from context and gestures. Could work in open employment in a limited range of occupations but could not manage jobs which require high communication demands or public contact.
THIRTY	Communication is very limited. May be able to use context to convey message and may be able to comprehend material if it is repeated, rephrased or represented in another format. May convey information via a YES/NO response. Unlikely to cope with open employment unless work tasks had minimal communication requirements.
FORTY	There is little or no functional understanding of verbal language and communication relies entirely on someone else to interpret meaning. May have an augmentative/communication device or board but only able to use it effectively in familiar settings. Unlikely to cope with any open employment.

## CHAPTER 11: GUIDE TO TABLE 10. – INTELLECTUAL DISABILITY

Table 10 is used to assess conditions that have resulted in intellectual impairment. Intellectual disability indicates a significantly below average level of intelligence functioning (as measured by standardised Intelligence Quotient (IQ) scores) and associated problems in adaptive functioning which begins prior to the age of eighteen. **Only one rating** should be assigned from this table after assessment of the following three key criteria:

**IQ score** – full scale score - Revised Weschler Adult Intelligence Scale (WAIS-R)

**Adaptive Behaviour**

**Capacity for Independent Living**

A score is assigned for each criteria from the corresponding columns and the three scores are then added. The final score is then converted to an impairment rating using the Table for conversion to work-related impairment rating.

### **Determining a reliable level of intellectual disability:**

This table is not used to assess cognitive impairment as a consequence of a brain injury acquired at a later stage in life (which is assessed under Table 8) but is intended to measure intellectual disability. (Refer also to CHAPTER 9 – Table 8.) In assessing a person's capacity for independent living, one should not just consider whether they are currently performing the required daily activities but rather whether they are capable of doing so (with or without assistance).

A score can only be assigned for the second two (social functioning) criteria if a score has first been assigned for a **low IQ** (ie an IQ of less than 80). If the person is classed as being of low average intelligence, their IQ score remains within the "normal" range and therefore an impairment rating cannot be applied from this table. If such a person experiences significant behavioural problems and/or has difficulties with independent living, it needs to be established whether there is a medical basis for these difficulties that can then be assessed accordingly (eg a psychiatric impairment that can be rated under Table 6).

### **WAIS-R vs WAIS-III:**

Currently, Table 10 specifies the use of the WAIS-R for assessing an IQ score. It should be noted however, that this assessment scale has now been updated and the latest version (WAIS-III), reflects the phenomenon of IQ score inflation over time. This means that an IQ score obtained using the WAIS-R will in general differ by a few points from a score assessed under the WAIS-III. However, as the Tables are a legislative instrument, amendments to update their contents cannot be made without formal enactment through Parliament. Where a WAIS-R IQ assessment cannot be obtained, discussion with a psychologist may be beneficial to determine an appropriate score for rating purposes.

### **Some conditions commonly assessed using this table:**

There are many childhood developmental or congenital disorders that can result in intellectual impairment/disability. Some examples are chromosomal abnormalities such as Down syndrome (Trisomy 21), congenital/perinatal or early childhood infections (eg rubella, CMV, HIV, bacterial meningitis, encephalitis), extreme prematurity or birth trauma.

### **Conditions that should not be assessed using this table:**

Cognitive impairment due to acquired brain injury is usually assessed under Table 8. Diagnosed behavioural problems unrelated to intellectual impairment should be assessed under Table 6. Dyslexia is a specific reading disability that is usually rated under Table 8 and should generally attract nil impairment. Attention deficit hyperactivity disorder (ADD/ADHD) is usually assessed under either Table 6 or Table 8 depending on the manifestations of the condition. Illiteracy and innumeracy are not medical impairments as such and should not be rated under this table. (Refer also to CHAPTER 7 – Table 6, CHAPTER 9 – Table 8.)

**Example of Intellectual Disability Assessment using Table 10:**

A person with intellectual disability is assessed as having a full scale IQ score of 70 points. No significant behavioural problems are identified but it is noted that some supervision with routine financial transactions is required. Prompting and reminders are also required regarding performing some routine tasks.

IQ Score – a score of 3 points is assigned under the first criteria

Adaptive Behaviour – a score of 0 points is assigned for the second criteria

Capacity for Independent Living – a score of 3 points is assigned for the third criteria

The total score is: 3 + 0 + 3 = 6

Using the Table for conversion to work-related impairment rating, a score of 6 corresponds to a rating of 25 points. The total impairment from intellectual disability is therefore assessed at 25 impairment points using Table 10.

**TABLE 10. INTELLECTUAL DISABILITY**

This Table is only to be used for intellectual disability. Three key criteria are assessed, IQ using the Weschler Adult Intelligence Scale (Revised WAIS-R) and two areas of social functioning: adaptive behaviour and capacity for independent living. The claimant is given a score for each and the **three scores are then added**. The final figure is converted to a work-related impairment rating using the table below. A score can only be assigned for the two social functioning criteria if a score has been assigned for a low IQ. Where it is clear that the person is moderately to severely intellectually impaired, formal psychometric testing may not be necessary but in borderline and mild cases where no formal testing has been performed, this should be arranged.

<b>INTELLIGENCE (IQ)</b>	<b>SCORE</b>	<b>ADAPTIVE BEHAVIOUR</b>	<b>SCORE</b>
Normal	<b>0</b>	No or only mild behavioural problems	<b>0</b>
70 - 79	<b>3</b>	Moderate to severe behavioural problems	<b>3</b>
50 - 69	<b>5</b>		
30 - 49	<b>6</b>		
Below 30	<b>8</b>		

<b><u>CAPACITY FOR INDEPENDENT LIVING</u></b>	<b><u>SCORE</u></b>
Self-sufficient	<b>0</b>
Needs <b>supervision</b> of daily activities and routine financial transactions eg. needs to be reminded to perform routine tasks/personal care	<b>3</b>
Needs <b>regular</b> help with daily activities and routine financial transactions	<b>4</b>
Needs <b>major</b> help with daily activities and routine financial transactions	<b>5</b>
Totally dependent	<b>6</b>

(Conversion Table over page)

**Table for conversion to work-related impairment rating.**

<b><u>SCORE</u></b>	<b><u>RATING</u></b>
3	TEN
5	TWENTY
6	TWENTY FIVE
7	THIRTY
8	THIRTY FIVE
9 or above	FORTY



## CHAPTER 12:

### GUIDE TO TABLE 11.1 – GASTROINTESTINAL: STOMACH, DUODENUM, LIVER AND BILIARY TRACT

Table 11.1 is used to assess impairments resulting from conditions affecting the upper part of the gastrointestinal tract. This includes conditions affecting the oesophagus, stomach, duodenum, liver and biliary tract which tend to result in symptoms such as nausea, vomiting, epigastric or upper abdominal pain and sometimes fatigue. In general, **only one rating** reflecting the highest (most severe) level of gastrointestinal impairment should be applied from this table, regardless of the number of conditions affecting the person.

#### **Determining a reliable level of upper gastrointestinal impairment:**

Before a rating is assigned, it must be determined that the condition has been appropriately diagnosed, optimally managed and that significant functional improvement is unlikely to occur within the next two years. (Refer also to Section (K) – Chapter 1.)

The diagnosis of established chronic liver disease should not be based on (potentially reversible) elevated liver function tests alone. In many cases, the diagnosis may have been confirmed with the results of liver biopsy. Some liver conditions may remain asymptomatic (eg some people with positive Hepatitis C serology) and clinical judgement is required to assess if subjective symptoms such as fatigue and nausea are consistent with the known pathology and are permanently and significantly disabling before an appropriate rating is assigned. (Refer also to Sections (E), (I), – Chapter 1.)

#### **Some conditions commonly assessed using this table:**

Reflux oesophagitis, refractory peptic ulcer disease, established chronic liver disease. Chronic symptoms from renal disease such as persistent intractable vomiting despite optimal treatment may also be assessed under this table.

**TABLE 11.1 GASTROINTESTINAL: STOMACH, DUODENUM, LIVER AND BILIARY TRACT**

<b>Rating</b>	<b>Criteria</b>
NIL	Peptic ulcer/oesophagitis/liver disease: mild symptoms despite optimal treatment.
TEN	Nausea and vomiting: moderate symptoms despite optimal treatment Peptic ulcer/oesophagitis: continuing frequent symptoms despite optimal treatment Past gastric surgery with moderate dyspepsia and dumping syndrome Established chronic liver disease. Symptoms (eg fatigue, nausea) may cause minor loss of efficiency in daily activities but rarely prevent completion of any activity.

TWENTY      Constant dysphagia requiring regular dilatation

Vomiting: severe, not controlled despite optimal medication, and causing significant weight loss

Peptic ulcer refractory to all treatment including surgery or with complications eg bleeding or outlet obstruction

Established chronic liver disease. Symptoms (eg, more persistent fatigue, nausea, abdominal pain) may prevent or lead to avoidance of some daily tasks and simple tasks will usually aggravate symptoms of fatigue. Most daily activities can be completed but only with some difficulty.

THIRTY      Diet limited to liquid or to pureed food or long term total parenteral nutrition

Gastrostomy

Established chronic liver disease. Symptoms (eg, ascites, bleeding disorders, hepatic encephalopathy, more severe fatigue, nausea, vomiting) may cause substantial difficulty with most daily tasks.

## CHAPTER 13:

### GUIDE TO TABLE 11.2 – GASTROINTESTINAL: PANCREAS, SMALL AND LARGE BOWEL, RECTUM AND ANUS

Table 11.2 is used to assess impairments resulting from conditions affecting the lower part of the gastrointestinal tract. This includes conditions affecting the pancreas, small and large bowel, abdominal wall (hernias), rectum and anus which tend to result in symptoms such as lower abdominal pain, bowel dysfunction, diarrhoea, constipation or faecal soiling. In general, **only one rating** reflecting the highest (most severe) level of gastrointestinal impairment should be applied from this table regardless of the number of conditions affecting the person.

#### **Determining a reliable level of lower gastrointestinal impairment:**

Before a rating is assigned, it must be determined that the condition has been appropriately diagnosed, optimally managed and that significant functional improvement is unlikely to occur within the next two years. (Refer also to Section (K) – Chapter 1.)

The diagnosis of irritable bowel syndrome should be reasonably confirmed in that other treatable diagnoses have been excluded before a permanent impairment rating is assigned. If such symptoms are precipitated by “stress” and are exacerbated by or related to an untreated psychiatric condition, then the impairment may be considered temporary if it is determined that treatment of the psychiatric impairment will also result in significant improvement of the bowel symptoms within two years. (Refer also to CHAPTER 7 – Table 6.)

#### **Some conditions commonly assessed using this table:**

Irritable bowel syndrome, inflammatory bowel disease (Crohn’s disease, Ulcerative Colitis), haemorrhoids, established chronic pancreatic disease, abdominal hernias.

**TABLE 11.2 GASTROINTESTINAL: PANCREAS, SMALL AND LARGE BOWEL, RECTUM AND ANUS**

<b>Rating</b>	<b>Criteria</b>
NIL	Anal disorder: infrequent and minor symptoms, eg, haemorrhoids, anal fissures, controlled by medication  Bowel disorder, eg, irritable bowel, diverticulosis: infrequent and minor symptoms such as constipation, or bowel disorder which respond to dietary treatment alone.
TEN	Bowel disorder: frequent moderate symptoms despite optimal treatment  Occasional faecal soiling despite optimal treatment  Anal disorder: marked symptoms despite regular treatment  Colostomy, ileostomy - well controlled  Established chronic pancreatic disease with moderate symptoms (pain/steatorrhoea)  Large abdominal hernia not easily reduced and resulting in persistent moderate symptoms.

TWENTY	<p>Faecal soiling necessitating frequent changes of underwear and an incontinence pad despite optimal treatment</p> <p>Bowel disorder: marked symptoms, such as regular diarrhoea and frequent abdominal pain, only partially controlled by optimal treatment</p> <p>Colostomy, ileostomy - poorly controlled</p> <p>Large abdominal hernia and/or repeated unsatisfactory hernia repairs resulting in frequent and persistent severe symptoms</p> <p>Established chronic pancreatic disease with severe symptoms (pain/steatorrhoea).</p>
THIRTY	<p>Bowel disorder: diarrhoea and abdominal pain on most days, with poor response to treatment and considerable interference with daily routine</p> <p>Jejunostomy</p> <p>Established chronic pancreatic disease with severe symptoms (pain/steatorrhoea) and with intractable complications.</p>
FORTY	<p>Complete faecal incontinence.</p>

## CHAPTER 14: GUIDE TO TABLE 12. – HEARING FUNCTION

Table 12 is used to assess conditions that result in impairment of hearing function. This impairment is measured by reference to the hearing threshold results of **unaided audiometric testing** (ie conducted without hearing aids). A recent audiogram is usually required unless the level of hearing loss is unlikely to have changed significantly (eg profoundly deaf since birth). Although it is not specifically indicated, air conduction results alone are accepted as sufficient for rating purposes. The hearing thresholds (measured in decibels (dB)) for both ears are used to calculate the percentage loss of hearing across a range of frequencies (500Hz, 1000Hz, 1500Hz, 2000Hz, 3000Hz, 4000Hz) using Tables 12.2 – 12.7. These six percentages are added to obtain the total **Percentage Loss of Binaural Hearing** and a corresponding rating is then assigned using Table 12.

**Only one rating** may be assigned from this table regardless of whether the person has both conductive and sensorineural types of hearing loss. However, if there is an associated loss of communication function from impaired language processing or expression (eg in some people with congenital profound deafness) then an additional rating may be assigned from Table 9 as well. (Refer also to CHAPTER 10 – Table 9.)

In general, the ratings have been scaled to reflect the impact of the degree of hearing loss on functional work ability. If significant hearing loss is not apparent clinically and communication ability appears reasonable, then a nil impairment rating using this table is likely to result from audiometric evaluation. For example, a person who is totally deaf in one ear but still retains normal hearing thresholds in the other ear will attract nil points under table 12. The ratings from this table however, may not reflect the clinical impairment of a person who uses effective hearing aids or has a cochlear implant in place as the table refers to unaided audiometric results. (Refer also to Section (D) – Chapter 1.)

### Example of Hearing Impairment Assessment using Table 12:

A person has a degree of hearing impairment and the results of their audiometric testing are as follows:

	500Hz	1000Hz	1500Hz	2000Hz	3000Hz	4000Hz
RIGHT	35dB	30dB	45dB	45dB	55dB	60dB
LEFT	30dB	30dB	35dB	55dB	55dB	80dB

Using Tables 12.2 to 12.7, the percentage (%) loss of hearing corresponding to the hearing threshold levels in the better and worse ears are calculated for each frequency. The results are summarised in the following table:

Tables	12.2 500Hz	12.3 1000Hz	12.4 1500Hz	12.5 2000Hz	12.6 3000Hz	12.7 4000Hz
<b>BETTER EAR</b>	30dB (L)	30dB	35dB (L)	45dB (R)	55dB	60dB (R)
<b>WORSE EAR</b>	35dB (R)	30dB	45dB (R)	55dB (L)	55dB	80dB (L)
<b>% LOSS</b>	3.4	3.5	5.5	6.4	5.6	6.3

Adding the six figures of % loss of hearing for each frequency gives the total percentage loss of binaural hearing:

$$3.4 + 3.5 + 5.5 + 6.4 + 5.6 + 6.3 = 30.7\%$$

Using Table 12 – Assignment of work-related impairment rating, the Percentage Loss of Binaural Hearing of 30.7% corresponds to a rating of 5 points. The total impairment from hearing loss is therefore assessed at 5 impairment points using Table 12.

**TABLE 12. HEARING FUNCTION**

Testing to be carried out without a hearing aid.

**Assignment of work-related impairment rating**

<b>Percentage Loss of Binaural Hearing</b>	<b>Rating</b>
0 - 24.9	NIL
25 - 34.9	FIVE
35 - 44.9	TEN
45 - 54.9	FIFTEEN
55 - 64.9	TWENTY
65 - 74.9	TWENTY FIVE
75 - 84.9	THIRTY
85 - 94.9	THIRTY FIVE
95 - 100	FORTY

**TABLE 12.2 500 Hz**

VALUES OF PERCENTAGE LOSS OF HEARING CORRESPONDING TO GIVEN HEARING THRESHOLD LEVELS IN THE BETTER AND WORSE EARS AT 500Hz

HTL - BETTER EAR

≤15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	≥95
-----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----

HTL - WORSE EAR

≤15	0.0																
20	0.4	0.6															
25	0.6	1.0	1.4														
30	1.0	1.4	2.0	2.8													
35	1.3	1.8	2.5	3.4	4.5												
40	1.7	2.2	3.0	3.9	5.1	6.4											
45	2.0	2.6	3.4	4.3	5.5	6.8	8.1										
50	2.3	2.9	3.7	4.7	5.8	7.1	8.4	9.7									
55	2.5	3.2	4.0	5.0	6.1	7.3	8.6	9.9	11.2								
60	2.7	3.4	4.2	5.2	6.3	7.5	8.8	10.0	11.3	12.6							
65	2.8	3.5	4.4	5.4	6.5	7.7	8.9	10.2	11.5	12.7	14.0						
70	2.9	3.7	4.5	5.5	6.6	7.8	9.1	10.3	11.6	12.9	14.2	15.5					
75	3.0	3.8	4.7	5.7	6.8	8.0	9.2	10.5	11.8	13.1	14.5	15.7	16.9				
80	3.1	3.9	4.8	5.8	6.9	8.1	9.3	10.6	12.0	13.3	14.7	16.0	17.2	18.2			
85	3.2	4.0	4.9	5.9	7.0	8.2	9.4	10.7	12.1	13.5	14.9	16.2	17.4	18.4	19.1		
90	3.4	4.1	5.0	6.0	7.1	8.1	9.5	10.8	12.2	13.6	15.0	16.3	17.6	18.5	19.2	19.7	
≥95	3.4	4.2	5.1	6.1	7.1	8.1	9.5	10.8	12.2	13.6	15.0	16.4	17.6	18.6	19.3	19.7	20.0

**TABLE 12.3 1000 Hz**

VALUES OF PERCENTAGE LOSS OF HEARING CORRESPONDING TO GIVEN HEARING THRESHOLD LEVELS IN THE BETTER AND WORSE EARS AT 1000Hz

HTL - BETTER EAR

≤15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	≥95
-----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----

HTL - WORSE EAR

≤15	0.0																
20	0.5	0.8															
25	0.8	1.2	1.8														
30	1.2	1.7	2.5	3.5													
35	1.7	2.3	3.1	4.3	5.7												
40	2.1	2.8	3.7	4.9	6.3	8.0											
45	2.5	3.3	4.2	5.4	6.9	8.5	10.2										
50	2.8	3.6	4.7	5.9	7.3	8.8	10.5	12.1									
55	3.1	3.9	5.0	6.2	7.6	9.1	10.7	12.4	14.0								
60	3.3	4.2	5.3	6.5	7.9	9.4	11.0	12.6	14.2	15.7							
65	3.5	4.4	5.5	6.7	8.1	9.6	11.2	12.8	14.4	15.9	17.5						
70	3.7	4.6	5.7	6.9	8.3	9.8	11.3	12.9	14.6	16.2	17.8	19.4					
75	3.8	4.7	5.8	7.1	8.5	10.0	11.5	13.1	14.8	16.4	18.1	19.7	21.1				
80	3.9	4.9	6.0	7.3	8.6	10.1	11.7	13.3	15.0	16.7	18.4	20.0	21.5	22.7			
85	4.1	5.0	6.2	7.4	8.8	10.3	11.8	13.4	15.1	16.9	18.6	20.3	21.7	23.0	23.9		
90	4.2	5.2	6.3	7.5	8.9	10.3	11.9	13.5	15.2	17.0	18.7	20.4	21.9	23.2	24.1	24.6	
≥95	4.3	5.3	6.4	7.6	8.9	10.3	11.9	13.5	15.2	17.0	18.7	20.5	22.0	23.3	24.2	24.7	25.0



**TABLE 12.4 1500 Hz**

VALUES OF PERCENTAGE LOSS OF HEARING CORRESPONDING TO GIVEN HEARING THRESHOLD LEVELS IN THE BETTER AND WORSE EARS AT 1500Hz

HTL - BETTER EAR

≤15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	≥95
-----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----

HTL - WORSE EAR

≤15	0.0																
20	0.4	0.6															
25	0.6	1.0	1.4														
30	1.0	1.4	2.0	2.8													
35	1.3	1.8	2.5	3.4	4.5												
40	1.7	2.2	3.0	3.9	5.1	6.4											
45	2.0	2.6	3.4	4.3	5.5	6.8	8.1										
50	2.3	2.9	3.7	4.7	5.8	7.1	8.4	9.7									
55	2.5	3.2	4.0	5.0	6.1	7.3	8.6	9.9	11.2								
60	2.7	3.4	4.2	5.2	6.3	7.5	8.8	10.0	11.3	12.6							
65	2.8	3.5	4.4	5.4	6.5	7.7	8.9	10.2	11.5	12.7	14.0						
70	2.9	3.7	4.5	5.5	6.6	7.8	9.1	10.3	11.6	12.9	14.2	15.5					
75	3.0	3.8	4.7	5.7	6.8	8.0	9.2	10.5	11.8	13.1	14.5	15.7	16.9				
80	3.1	3.9	4.8	5.8	6.9	8.1	9.3	10.6	12.0	13.3	14.7	16.0	17.2	18.2			
85	3.2	4.0	4.9	5.9	7.0	8.2	9.4	10.7	12.1	13.5	14.9	16.2	17.4	18.4	19.1		
90	3.4	4.1	5.0	6.0	7.1	8.3	9.5	10.8	12.2	13.6	15.0	16.3	17.6	18.5	19.2	19.7	
≥95	3.4	4.2	5.1	6.1	7.1	8.3	9.5	10.8	12.2	13.6	15.0	16.4	17.6	18.6	19.3	19.7	20.0

**TABLE 12.5 2000 Hz**

VALUES OF PERCENTAGE LOSS OF HEARING CORRESPONDING TO GIVEN HEARING THRESHOLD LEVELS IN THE BETTER AND WORSE EARS AT 2000Hz

HTL - BETTER EAR

≤15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	≥95
-----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----

HTL - WORSE EAR

≤15	0.0																
20	0.3	0.5															
25	0.5	0.7	1.1														
30	0.7	1.0	1.5	2.1													
35	1.0	1.4	1.9	2.5	3.4												
40	1.3	1.7	2.2	2.9	3.8	4.8											
45	1.5	1.9	2.5	3.3	4.1	5.1	6.1										
50	1.7	2.2	2.8	3.5	4.4	5.3	6.3	7.3									
55	1.9	2.4	3.0	3.7	4.6	5.5	6.4	7.4	8.4								
60	2.0	2.5	3.1	3.9	4.7	5.6	6.6	7.5	8.5	9.4							
65	2.1	2.6	3.3	4.0	4.9	5.7	6.7	7.6	8.6	9.6	10.5						
70	2.2	2.7	3.4	4.1	5.0	5.9	6.8	7.8	8.7	9.7	10.7	11.6					
75	2.3	2.8	3.5	4.3	5.1	6.0	6.9	7.9	8.9	9.9	10.8	11.8	12.7				
80	2.4	2.9	3.6	4.4	5.2	6.1	7.0	8.0	9.0	10.0	11.0	12.0	12.9	13.6			
85	2.4	3.0	3.7	4.4	5.3	6.1	7.1	8.1	9.1	10.1	11.1	12.1	13.0	13.8	14.3		
90	2.5	3.1	3.8	4.5	5.3	6.2	7.1	8.1	9.1	10.2	11.2	12.2	13.2	13.9	14.4	14.8	
≥95	2.6	3.2	3.8	4.6	5.4	6.2	7.1	8.1	9.1	10.2	11.3	12.3	13.2	14.0	14.5	14.8	15.0

**TABLE 12.6 3000 Hz**

VALUES OF PERCENTAGE LOSS OF HEARING CORRESPONDING TO GIVEN HEARING THRESHOLD LEVELS IN THE BETTER AND WORSE EARS AT 3000Hz

HTL - BETTER EAR

≤15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	≥95
-----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----

HTL - WORSE EAR

≤15	0.0																
20	0.2	0.3															
25	0.3	0.5	0.7														
30	0.5	0.7	1.0	1.4													
35	0.7	0.9	1.2	1.7	2.3												
40	0.8	1.1	1.5	2.0	2.5	3.2											
45	1.0	1.3	1.7	2.2	2.7	3.4	4.1										
50	1.1	1.4	1.9	2.3	2.9	3.5	4.2	4.8									
55	1.2	1.6	2.0	2.5	3.0	3.6	4.3	4.9	5.6								
60	1.3	1.7	2.1	2.6	3.1	3.7	4.4	5.0	5.6	6.3							
65	1.4	1.8	2.2	2.7	3.2	3.8	4.4	5.1	5.7	6.4	7.0						
70	1.5	1.8	2.3	2.8	3.3	3.9	4.5	5.2	5.8	6.5	7.1	7.7					
75	1.5	1.9	2.3	2.8	3.4	4.0	4.6	5.2	5.9	6.6	7.2	7.8	8.4				
80	1.6	2.0	2.4	2.9	3.4	4.0	4.7	5.3	6.0	6.6	7.3	8.0	8.6	9.1			
85	1.6	2.0	2.5	3.0	3.5	4.1	4.7	5.4	6.0	6.7	7.4	8.1	8.7	9.2	9.5		
90	1.7	2.1	2.5	3.0	3.5	4.1	4.7	5.4	6.1	6.8	7.5	8.2	8.8	9.2	9.6	9.8	
≥95	1.7	2.1	2.6	3.0	3.6	4.1	4.7	5.4	6.1	6.8	7.5	8.2	8.8	9.3	9.6	9.8	10.0

**TABLE 12.7 4000 Hz**

VALUES OF PERCENTAGE LOSS OF HEARING CORRESPONDING TO GIVEN HEARING THRESHOLD LEVELS IN THE BETTER AND WORSE EARS AT 4000Hz

HTL - BETTER EAR

≤20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	≥95
-----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----

HTL - WORSE EAR

≤20	0.0															
25	0.2	0.3														
30	0.3	0.5	0.8													
35	0.5	0.7	1.0	1.5												
40	0.6	0.9	1.3	1.8	2.5											
45	0.8	1.1	1.5	2.1	2.7	3.5										
50	0.9	1.3	1.7	2.3	2.9	3.6	4.4									
55	1.0	1.4	1.9	2.4	3.1	3.8	4.5	5.2								
60	1.2	1.5	2.0	2.6	3.2	3.9	4.6	5.3	6.0							
65	1.2	1.6	2.1	2.7	3.3	3.9	4.6	5.3	6.0	6.7						
70	1.3	1.7	2.2	2.7	3.4	4.0	4.7	5.4	6.1	6.8	7.5					
75	1.4	1.8	2.3	2.8	3.4	4.1	4.8	5.5	6.2	6.9	7.6	8.2				
80	1.4	1.9	2.3	2.9	3.5	4.2	4.9	5.6	6.3	7.0	7.7	8.4	8.9			
85	1.5	1.9	2.4	3.0	3.6	4.2	4.9	5.7	6.4	7.1	7.8	8.5	9.0	9.5		
90	1.6	2.0	2.5	3.0	3.6	4.3	5.0	5.7	6.5	7.2	7.9	8.6	9.1	9.5	9.8	
≥95	1.6	2.0	2.5	3.1	3.7	4.3	5.0	5.7	6.5	7.2	8.0	8.7	9.2	9.6	9.8	10.0

## CHAPTER 15: GUIDE TO TABLE 13. – VISUAL ACUITY IN THE BETTER EYE

Table 13 is used to assess conditions that result in impairment of visual acuity. This is assessed by reference to the **best corrected vision in the better eye** with the aid of corrective spectacles or contact lenses (if applicable). Referral for an optometrist or ophthalmologist assessment may be required if there is doubt as to whether best corrected vision has been achieved or with the accuracy of the Snellen's Chart assessment. **Only one rating** may be assigned from this table regardless of whether one or both eyes suffer loss of visual acuity.

(Note: Although the table's instructions includes the visual acuity criteria for permanent blindness, it should be noted that applicants for disability support pension on the basis of permanent blindness (Blind Pension) are not assessed by the use of this table.)

This table's formatting is somewhat confusing and requires some clarification. The first column refers to the levels of best corrected visual acuity in the better eye. The following four columns refer to the corresponding impairment ratings depending on a history of cataract operations. If there is no history of cataract surgery, the second column is used to assign a rating depending on the best level of vision.

However, if the person has undergone such a procedure, the impairment rating is then assigned from one of the three columns on the right depending on how their vision has been corrected: whether with lens implants, with contact lenses or with glasses. As the rating depends on the best corrected vision in the better eye, it should not differ regardless of whether one of both eyes have undergone such an operation. The following may help clarify the table's application.

BEST CORRECTED VISUAL ACUITY IN BETTER EYE	IMPAIRMENT RATING			
	NO CATARACT OPERATION	CATARACT OPERATION CORRECTED WITH:		
		IMPLANT	CONTACT LENSES	GLASSES
6/6	0	0	0	10
6/9	0	0	10	20
6/12	5	10	20	40
6/18	10	20	40	40
6/24 or worse	20	40	40	40

**TABLE 13. VISUAL ACUITY IN THE BETTER EYE**

Work-related impairment in relation to a loss of visual acuity is assessed by measuring visual acuity. This refers to best corrected vision in the better eye with spectacles or contact lenses (if applicable). Referral to an optometrist or ophthalmologist may be required if there is doubt as to whether best corrected vision has been achieved or with the accuracy of the Snellen's Chart assessment. A person meets the criteria for permanent blindness under section 95 of the Social Security Act if the corrected visual acuity is less than 6/60 on the Snellen Scale in both eyes or there is a combination of visual defects resulting in the same degree of permanent visual loss.

**Visual Acuity**

**Rating**

		<u>Cataract operation</u> (unilateral and bilateral aphakia not to receive a different rating)		
		Implant	Contact lenses	Glasses
6/6	0	0	0	10
6/9	0	0	10	20
6/12	5	10	20	40
6/18	10	20	40	40
6/24 or worse	20	40	40	40

## CHAPTER 16: GUIDE TO TABLE 14. – MISCELLANEOUS EYE CONDITIONS

Table 14 is used to assess impairment resulting from miscellaneous eye conditions. Specialist ophthalmological advice may be beneficial to evaluate the nature of heterotropia (squint) with diplopia (double vision).

A person who is permanently blind in one eye may be assigned a rating of five points from this table for the loss of stereoscopic (binocular) vision. However, if there is also a loss of visual acuity or loss of visual fields in the remaining sighted eye, then additional ratings may also be assigned under Tables 13 and 15 respectively. This is not double counting as these are separate types of functional losses. (Refer also to Section (G) – Chapter 1.)

**TABLE 14. MISCELLANEOUS EYE CONDITIONS**

<b>Visual Disturbance</b>	<b>Rating</b>
Squint (Heterophoria): Latent	0
Squint (Heterotropia): Without diplopia	0
Acquired Heterotropia (squint) with diplopia:	
one quadrant of upward gaze	5
all directions of upward gaze	10
one quadrant of downward gaze	10
one direction of sideways gaze	10
both directions of sideways gaze	10
all directions of gaze	20
all directions of downward gaze	20
all range of near vision	20
Constant irritation of eyes, photophobia, epiphora, ectropion or entropion	0
Gaze defects (vertical and/or horizontal)	10
Glaucoma without visual loss	0
Longstanding Blepharospasm	10
Loss of stereoscopic vision in absence of squint	
Permanent (eg. blind in one eye)	5
Intermittent (eg. ptosis or tarsorrhaphy)	10
Nystagmus without diplopia	Rate as for visual acuity
Retinal Dystrophy with night blindness	Rate as for visual acuity and visual fields

## CHAPTER 17: GUIDE TO TABLE 15. – VISUAL FIELDS

Table 15 is used to assess impairment resulting from the loss of visual fields. This may occur commonly from strokes (cerebrovascular accidents) and it is usually necessary to seek ophthalmological advice to determine an accurate assessment of the extent of visual field loss. Once the type/extent of the visual field defect has been established, it is relatively straightforward to assign an appropriate impairment rating from this table. **Only one rating** should be assigned from this table.

(Note: Although the table's instructions includes the loss of visual fields criteria for permanent blindness, it should be noted that applicants for disability support pension on the basis of permanent blindness are not assessed by the use of this table.)

**TABLE 15. VISUAL FIELDS**

It is usually necessary to seek ophthalmological advice for an accurate assessment under this Table. A person meets the criteria for permanent blindness under section 95 of the Social Security Act if their field of vision is constricted to ten degrees or less of arc from central fixation in the better eye irrespective of corrected visual acuity or there is a combination of visual defects resulting in the same degree of visual impairment.

Type of Defect	Rating	
	Only one eye affected	Both eyes affected (or there is only one eye and it is affected)
Temporal Hemianopia	10	20
Nasal Hemianopia	10	20
Upper half loss	10	20
Lower half loss	20	20
Upper quadrant loss	0	20
Lower quadrant loss	0	20
Constriction outside 30 degrees of fixation	0	0
Constriction to within 30 degrees of fixation	10	10
Constriction to within 20 degrees of fixation	20	20
Constriction to within 10 degrees of fixation	20	permanent blindness (see above)



## CHAPTER 18:

### GUIDE TO TABLE 16. – LOWER URINARY TRACT

Table 16 is used to assess impairment resulting from conditions affecting the lower urinary tract. This includes problems relating to urinary incontinence and other urethral and bladder outlet disorders. Specialist advice has indicated that the impact of urinary tract impairments on work ability has been greatly reduced over the years. Many previously disabling conditions are now better managed to the extent that the person can now self-administer the necessary treatment. Before an impairment rating is assigned from this table, it must be considered that the condition has been optimally managed and that significant functional improvement is not expected to occur within the next two years. **Only one rating** should be assigned from this table. (Refer also to Section (K) – Chapter 1.)

#### TABLE 16. LOWER URINARY TRACT

This Table is to be used for incontinence and other urethral and bladder outlet disorders.

Rating	Criteria
NIL	Minor stress incontinence. Bladder outlet or urethral obstruction with mild symptoms.
TEN	Loss of voluntary control of bladder, but satisfactory emptying achieved by triggering of reflex activity, suprapubic pressure or Valsalva manoeuvre. No incontinence aid needed
	<b><u>or</u></b>
	Ileal or Sigmoid conduit
	<b><u>or</u></b>
	Chronic Urinary Obstruction needing regular catheterisation.
TWENTY	Loss of voluntary control of bladder with dribbling incontinence needing frequent change of incontinence pads, or a collection device, eg, urodome catheter
	<b><u>or</u></b>
	Ureterosigmoidostomy.

## CHAPTER 19: GUIDE TO TABLE 17. – RENAL FUNCTION

Table 17 is used to assess the impairment relating to a person's level of functioning on **dialysis** for chronic renal disease. Additional work-related impairment from the **systemic effects** of renal disease however, is assessed depending on the nature of the resulting symptoms and loss of function. For example, persistent generalised symptoms of fatigue are assessed under Table 20 whilst persistent gastrointestinal symptoms (eg vomiting) despite optimal treatment are assessed using Table 11.1. Renal transplants are also assessed using Table 20. (Refer also to Sections (G), (I) – Chapter 1, CHAPTER 12 – Table 11.1, CHAPTER 22 – Table 20.)

Nephrologist's advice has indicated that a person on dialysis treatment is not necessarily precluded from working. This is based on improvements in self-management through the availability of home dialysis and improvements in medical therapy to better control the side-effects of dialysis treatment. Each person must be assessed on an individual basis and an appropriate rating assigned from this table to reflect their level of functioning. **Only one rating** for dialysis should be assigned from this table.

### TABLE 17. RENAL FUNCTION

As renal disease has systemic effects, assessment of renal impairment as it impacts on work capacity is based upon the loss of function resulting from these systemic effects. For example, for persistent generalised symptoms such as fatigue use Table 20, refractory anaemia is assessed using Table 20, persistent gastrointestinal symptoms (eg. vomiting) despite optimal treatment are assessed using Table 11 and persistent Central Nervous System symptoms using Table 8. Renal transplants are assessed using Table 20.

#### Dialysis is rated as follows:

FIFTEEN	All types of dialysis (except outpatient haemodialysis) which are functioning well. Some decreased ability to carry out everyday activities but independence is retained.
TWENTY	Outpatient haemodialysis and all types of dialysis which are functioning poorly. More severe symptoms with a decreased ability to carry out many everyday activities. Most daily activities can be completed with some difficulty. Symptoms may prevent or lead to avoidance of some daily tasks and simple tasks will usually aggravate symptoms of fatigue.
THIRTY	End stage renal disease with very severe symptoms which lead to substantial difficulties with most daily tasks.
FORTY	End stage renal disease leading to major restrictions in many everyday activities. Capacity for self-care is restricted leading to dependence on others.

## CHAPTER 20: GUIDE TO TABLE 18. – SKIN DISORDERS

Table 18 is used to assess impairment resulting from skin disorders. In determining the degree of impairment, the prime consideration relates to the level of **functional loss** which impacts on the ability to perform normal daily activities. However, where there is extensive cosmetic or cutaneous involvement, this should also be considered. Before an impairment rating is assigned from this table, it must be considered that the condition has been optimally managed and that significant functional improvement is not expected to occur within the next two years. **Only one rating** should be assigned from this table. (Refer also to Section (K) – Chapter 1.)

### TABLE 18. SKIN DISORDERS

In the evaluation of work-related impairment resulting from a skin disorder, the actual functional loss is the prime consideration. However, where there is extensive cosmetic or cutaneous involvement, this should also be considered.

Rating	Criteria
NIL	Signs and symptoms of skin disorder present and with treatment there is NO limitation in the performance of normal daily activities.
TEN	Signs and symptoms of skin disorder present despite optimal treatment and results in some interference with normal daily activities.
TWENTY	Signs and symptoms of skin disorder present despite optimal treatment and results in significant interference with normal daily activities.
FORTY	Very severe symptoms requiring continuous treatment which may include periodic confinement to home or hospital and needs considerable assistance with normal daily activities.

## CHAPTER 21: GUIDE TO TABLE 19. – ENDOCRINE DISORDERS

Table 19 is used to assess impairment resulting from endocrine disorders depending on their **level of control** and management. Endocrine disorders may cause multi-system effects with impairments affecting various body systems (eg Diabetes Mellitus causing visual and lower limbs impairment). These separate functional losses should be assessed under the relevant tables and the ratings added to the rating from this table to provide an overall assessment. (Refer also to Sections (G), (L) – Chapter 1 and Paragraph 7 of the “Introduction”).

Before assigning an appropriate rating from this table, it must be considered that the endocrine disorder has received optimal treatment and stabilisation for best control of the condition. It should be noted that the diagnoses, Diabetes Mellitus and Addison’s Disease do not appear in the descriptor at the ten points impairment level. This is not an oversight as specialist advice has indicated that improvements in treatment mean that these conditions are mostly well controlled or otherwise belong to a population where satisfactory control cannot be adequately achieved. Individuals whose level of impairment falls in between these two levels should probably be considered to suffer from a temporary impairment as it is likely that their condition will benefit from specialist management and respond to more vigorous therapy. (Refer also to Section (K) – Chapter 1.)

**TABLE 19. ENDOCRINE DISORDERS**

The effects of endocrine disorders eg. diabetes mellitus on other body systems eg. the vascular and visual systems should be assessed from the appropriate tables and added together with values from this table.

<b>Rating</b>	<b>Criteria</b>
NIL	Thyroid disease, Acromegaly, Cushing's disease, Prolactinoma, Diabetes Mellitus, Diabetes Insipidus, Parathyroid Disease, Paget's disease, Osteoporosis, Addison's Disease adequately controlled with hormone replacement and/or surgery and/or radiotherapy and/or therapeutic agents.
TEN	Thyroid disease, Acromegaly, Cushing's disease, Prolactinoma, Diabetes Insipidus, Parathyroid Disease, Paget's disease or Osteoporosis which is incompletely controlled or treated eg. symptomatic Paget's disease, osteoporosis or other bone disease with pain not completely controlled by continuous therapy.
TWENTY	Diabetes mellitus or Addison's Disease not satisfactorily controlled despite vigorous therapy as indicated by for example frequent hospital admissions, recurrent hypoglycaemic or hypotensive episodes and/or progressive end organ damage.

## CHAPTER 22:

### GUIDE TO TABLE 20. – MISCELLANEOUS – MALIGNANCY, HYPERTENSION, HIV INFECTION, MORBID OBESITY (ie BMI >40), HEART / LIVER/ KIDNEY TRANSPLANTS, MISCELLANEOUS EAR / NOSE / THROAT CONDITIONS & CHRONIC FATIGUE OR PAIN

Table 20 is used to assess impairments caused by miscellaneous conditions such as those addressed below. In general, the system-specific tables associated with the underlying medical conditions should be used to assess a person's impairments. However, there are situations where Table 20 may be considered more appropriate particularly when there are multiple or global effects of more than one body system causing functional impairment. (Refer also to Sections (F), (G) – Chapter 1.)

When applying this table, care must be taken to avoid double counting of the same functional loss, particularly if there is a choice of other tables that may be used to assign ratings or if there is overlap in the symptoms caused by multiple conditions. In general, if more than one condition (eg those causing chronic pain and/or fatigue) may be rated under this table, it would be practical to assign a single rating reflecting the overall (highest) level of impairment. However, in some cases, it may be appropriate to provide individual ratings for separate diagnoses if it is considered that the impairments resulting from these conditions are discrete and separate, corresponding to the descriptors in the table. (Refer also to Sections (H), (I), (J) – Chapter 1.)

#### **Malignancy:**

Assessment of malignant conditions under this table takes into account the functional effects of the condition as well as the prognosis of the condition. It is recognised that individuals diagnosed with a malignant condition may still retain a high level of functional ability. Before a rating can be assigned from this table, the impairment resulting from the malignant condition must be considered permanent and stabilised. This means that the prognosis and expected level of functional capacity over the next two years can be reasonably predicted and often requires advice from the treating oncologist. (Refer also to Section (K) – Chapter 1.)

#### **Hypertension:**

Hypertension does not usually cause significant functional effects unless it has resulted in end organ damage. Before a rating is assigned from this table, the condition must be considered optimally treated and stabilised. In most cases where the impairment is considered permanent and the condition has been difficult to control despite "intensive therapy", it would be reasonable to expect that the person has received specialist review and management. In general, hypertension should be rated under this table and not under Table 1 unless it has resulted in heart failure causing restriction of effort tolerance. (Refer also to CHAPTER 2 – Table 1.)

#### **HIV Infection:**

A rating is assigned for this condition based on the resulting functional effects and the prognosis. Assessments should be individualised as both the degree of functional impairment and prognosis may vary depending on the individual's circumstances. As with malignant conditions, advice from the treating specialist may be required.

#### **Morbid Obesity:**

Morbid Obesity is defined as having a Body Mass Index (BMI) of over 40. (BMI is calculated by the formula: Weight (kg) / Height (metres)<sup>2</sup>. A BMI > 40 is generally considered to be incompatible with long term good health but does not necessarily correlate with significant functional impairment. This table may be used to assign an overall rating reflecting the resulting functional effects but assessments should be individualised as the functional impairment may vary from minimal to very significant impairment. If long term morbid obesity has resulted in specific secondary effects (eg osteoarthritis of the knee joints), these may be rated under the relevant system-specific tables (eg Table 4) but care must be taken to avoid overassessing the same impairment.

**Heart / Liver / Kidney / Transplants:**

It is generally more appropriate to rate the effects resulting from organ transplants under this table rather than under the system-specific tables. For example, a person who has undergone a heart transplant for severe ischaemic heart disease should not be rated under Table 1, as their effort tolerance would no longer be restricted by symptoms of angina.

**Miscellaneous Ear / Nose / Throat Conditions:**

Conditions such as Meniere’s Disease, vertigo and tinnitus may have a rating assigned using this table if they are causing chronic, continuous effects. However, Table 21 should be used instead if they result in intermittent, discrete episodes. A rating should only be assigned in the presence of a fully diagnosed condition causing such symptoms. (Refer also to CHAPTER 23 – Table 21.)

**Chronic Fatigue or Pain:**

This table may be used to assign an alternative rating in situations where it is considered that assessment under relevant system-specific tables underestimates the level of impairment due to the effects of chronic entrenched pain or fatigue. This is explained in much greater detail in Section (I) of Chapter 1 relating to Paragraph 8 of the “Introduction”. (Refer also to Sections (H), (I), (J) – Chapter 1, Paragraph 8 of the “Introduction” and CHAPTER 6 – Table 5.)

**TABLE 20. MISCELLANEOUS - MALIGNANCY, HYPERTENSION, HIV INFECTION, MORBID OBESITY (ie BMI >40), HEART/LIVER/KIDNEY TRANSPLANTS, MISCELLANEOUS EAR/NOSE/THROAT CONDITIONS & CHRONIC FATIGUE OR PAIN.**

Table 20 can be used for miscellaneous conditions, for example, malignancy, HIV infection, morbid obesity, transplants, miscellaneous ear/nose/throat conditions, disorders with chronic fatigue (including Chronic Fatigue Syndrome) or pain and hypertension. Where there is a separate loss of function, in addition to the loss which can be rated using the system-specific Tables, Table 20 can be used. Double-counting of a particular loss of function, by the use of more than one Table, must be avoided.

Rating	Criteria
NIL	<p>Controlled hypertension</p> <p>Malignancy in remission with a good to fair prognosis</p> <p>Minor symptoms which are easily tolerated and have no appreciable effect on ability to work.</p>
TEN	<p>Mild to moderate symptoms which are irritating or unpleasant but which rarely prevent completion of any activity. Symptoms may cause loss of efficiency in daily activities but minimal interference performing or persisting with work-related tasks. There is minimal effect/impact on work attendance.</p> <p>Hypertension that is difficult to control despite intensive therapy but without end-organ damage</p> <p>Potentially life-threatening condition which is currently <b>not</b> interfering with daily activities eg. malignancy in remission with a poor prognosis</p> <p>Heart/Liver/Kidney transplants - well controlled (well functioning) with only mild systemic symptoms.</p>

- FIFTEEN Moderate to severe symptoms which are more distressing but prevent few everyday activities. Self-care is unaffected and independence is retained. Symptoms may have mild to moderate impact on ability to perform or persist with work-related tasks and/or attend work. Full-time work would still be possible.
- Potentially life-threatening condition which is currently interfering with daily activities but self-care is unaffected.
- TWENTY More severe symptoms with a decreased ability/efficiency to carry out many everyday activities. Most daily activities can be completed with some difficulty. Symptoms may prevent or lead to avoidance of some daily tasks and simple tasks will usually aggravate symptoms of fatigue. Symptoms cause significant interference with ability to perform or persist with work-related tasks. Symptoms may cause prolonged absences from work.
- THIRTY Very severe symptoms which lead to substantial difficulty with most daily tasks. Assistance with elements of self-care may be required. Symptoms cause severe interference with ability to work or attend work (ie. minimal residual work capacity).
- Heart/Liver/Kidney transplants - poorly controlled (poorly functioning) with fairly severe symptoms which lead to substantial difficulty with most daily tasks
- Malignant hypertension - severe, uncontrolled
- Inoperable, symptomatic and life-threatening aneurysm or malignancy. Very poor prognosis with only a very limited lifespan.
- FORTY Major restrictions in many everyday activities. Capacity for self-care is restricted, leading to dependence on others. No residual work capacity.

## CHAPTER 23:

### GUIDE TO TABLE 21. – INTERMITTENT CONDITIONS

Table 21 is used to assess conditions that result in intermittent impairment. These are conditions that usually cause minimal or no impairment in between discrete, recurrent episodes of impairment. Such intermittent impairments are assessed by reference to the severity, duration and frequency of the episodic attacks:

**Severity** – How severe the symptoms and resulting effects are during an episode is defined with reference to Table 21.1

**Duration** – How long the episodes last for is defined with reference to Table 21.2

**Frequency** – How often the episodes occur is defined according to the number of days affected per year as indicated in Table 21.4

A rating is determined from these three factors by first assigning a level of severity (0 to 6) and duration (transient/short/medium/prolonged) for the episodes using Tables 21.1 and 21.2 respectively. The results are then used to determine an intermittent grading code (A to J) using Table 21.3. This grading code is then correlated with the estimated frequency (affected days/year) of episodes to obtain the corresponding final impairment rating using Table 21.4.

#### **Determining a reliable level of intermittent impairment:**

Before a rating is assigned from this table, it must be considered that the condition causing the intermittent impairment has been adequately diagnosed and optimally treated and stabilised. For example, impairment caused by longstanding epilepsy may still be viewed as temporary and hence not rated if it is determined that further medical management would significantly improve its control within the next two years (eg by improving treatment compliance, adjusting dosage or type of anti-convulsant medication to reduce side-effects or improve therapeutic effect). (Refer also to Section (K) – Chapter 1.)

As episodes may vary in severity, duration and frequency, the general approach is to determine an **average estimate** for each factor. However, some intermittent conditions may have distinct and **separate phases** or components within each episode or alternatively may have **distinct types** of episodes that differ in severity, duration and/or frequency. In these cases, separate ratings may be assigned for each phase or type of episode and the ratings are then added together to provide an overall intermittent impairment rating. (Refer also to Section (H) [Hlk498259708](#) – Chapter 1.)

For example, for grand mal (generalised tonic-clonic) epilepsy, one rating may be provided taking into account the severity, duration and frequency of the ictal phase of a seizure and an additional rating can also be assigned based on the different level of severity and duration for the post-ictal phase. The frequency would usually remain the same for both phases of the same episode.

The effects of chronic disorders are usually rated under the system-specific tables relating to the underlying medical conditions. It is indicated that if a system-specific table is applicable for an intermittent disorder, then it is used in preference to this table. It is expected that this would generally result in a higher impairment rating (eg severe asthma resulting in persistent airways limitation can attract a higher rating using either Table 1 or Table 2 rather than Table 21.) (Refer also to Section (J) – Chapter 1.)

However, where the conditions also cause **acute exacerbations** that are considered significantly frequent and severe, an additional rating may also be provided from Table 21 for the impairment caused by these intermittent exacerbations. For example, Chronic Obstructive Airways Disease with frequent episodic attacks of severe Acute Bronchitis may be rated under Table 21 for the intermittent effects as well as under either Table 1 or Table 2 for the effects of chronic airways limitation. (Refer also to Sections (F), (G) – Chapter 1, CHAPTER 2 – Table 1, CHAPTER 3 – Table 2.)

In assessing the level of severity (Table 21.1), clinical judgement is required to determine a reliable level that is consistent with the person's known pathology. Consideration of an appropriate level should not be based on what activities the person does not do but rather on what they are unable to



do due to the symptoms experienced during an episode. Capacity for self-care should be carefully assessed in this regard. Episodes of some intermittent conditions may be of sufficient severity to necessitate hospital admission (levels 5 and 6) but it is expected that at such levels of severity, the person would be incapable of self-care. It should be noted that hospital admission for surgery is not to be used as a basis for ratings from this table.

When assessing the duration of an episode (Table 21.2), attacks which last more than a day should be rated as “prolonged”. In this case, the frequency of the episodes will be more than the number of episodes occurring in a year as it reflects the number of affected days per year.

**Some conditions commonly assessed using this table:**

Migraines and other types of severe headaches that have been fully diagnosed and optimally treated and stabilised. Epilepsy and transient ischaemic attacks that have been optimally controlled. Symptomatic cardiac arrhythmias and asthma that are intermittent in nature. Episodes of tinnitus or vertigo that are intermittent and not continuous. Gout and other arthropathies that cause recurrent and discrete episodes of symptoms despite optimal treatment.

**Conditions that should not be assessed using this table:**

Tinnitus or vertigo that is continuous rather than intermittent should be rated under Table 20. Asthma that is exercise induced should be rated under Table 1 and if it has resulted in severe chronic airways limitation, it may be rated under Table 1 or Table 2. Angina from coronary artery disease or ischaemic heart disease should be rated under Table 1. Gastrointestinal symptoms from conditions such as reflux oesophagitis, peptic ulcer disease, irritable bowel syndrome or inflammatory bowel disease should be rated under Table 11.1 or Table 11.2. Episodes of pain from endometriosis or other gynaecological conditions should be rated under Table 22. Spinal conditions should generally be rated under Table 5.1/5.2 or Table 20. (Refer also to CHAPTER 2 – Table 1, CHAPTER 3 – Table 2, CHAPTER 6 – Table 5, CHAPTER 22 Table 20, CHAPTER 24 – Table 22.)

**Example of Intermittent Impairment Assessment using Table 21:**

A 38 year-old woman suffers from recurrent headaches which have been fully investigated and following neurologist review of her medical management, her condition is considered to have been optimally treated and stabilised. She continues to suffer headaches on a monthly basis. When they occur, she has difficulties concentrating whilst performing household chores and often finds it necessary to take prescribed analgesic medication and lie down during the episode. She lives alone and is able to cope during these episodes without having to call on a relative or friend for assistance with self-care. She reports that on average, her headaches can last up to three or four hours.

Using Table 21.1, the severity of her headaches is estimated at level 3. Using Table 21.2, the duration of her headaches is estimated as medium. Using Table 21.3, an intermittent grading code of D is obtained by correlating the duration and severity level. Using Table 21.4, this code D is correlated with the estimated frequency of 10+ days affected a year to provide a rating of nil. The impairment from her condition of intermittent headaches is therefore assessed at nil impairment points.

**TABLE 21. INTERMITTENT CONDITIONS**

Intermittent but continuing disorders that remain asymptomatic between discrete episodes of impairment eg. gout, epilepsy, Meniere's Disease, vertigo & tinnitus (only to be scored in the presence of a diagnosed condition causing these symptoms but if the symptoms are continuous Table 20 should be used) are rated by reference to severity, duration and frequency of attacks:

**severity** during an attack is defined in the descriptions below;

**duration** is defined in the descriptions below;

**frequency** is determined by the number of affected days in a year.

A rating using the above three factors is made by first coding severity and duration into an intermittent grading. The code is then combined with frequency, using Table 21.4, to give the rating.

Some intermittent disorders may be rated using system-specific tables. The system-specific table is then used in preference eg. severe asthma where there is persistent airway limitation.

When episodes vary in severity, duration or frequency, an average for each factor should be estimated. More than one rating may be given for the same disorder. Thus for grand mal epilepsy one rating is given for the ictal phase and a second rating for the post-ictal stage. The two are then added together.

For acute exacerbations of chronic disorders, where the acute relapses are frequent and severe, the Intermittent Tables can be used in addition to the primary score derived for the underlying medical condition eg. frequent attacks of acute bronchitis can be scored using Table 21 in addition to Table 1 or 2 for Chronic Airways Limitation and the scores added together.

**TABLE 21.1 Intermittent attack - severity**

<b>Level</b>	<b>Criteria</b>
NIL	Minor symptoms which are easily tolerated.
ONE	Mild to moderate symptoms which are irritating or unpleasant but which rarely prevent completion of any activity. Symptoms may cause loss of efficiency in some activities.
TWO	More severe symptoms which are distressing, but prevent few everyday activities. Loss of efficiency is discernible elsewhere. Self-care is unaffected and independence is retained.
THREE	Loss of efficiency is discernible in many everyday activities. Some elements of self-care are restricted but in most respects, independence is retained. Bed-rest is often necessary during an attack.
FOUR	Major restrictions in many everyday activities. Capacity for self-care is increasingly restricted, leading to partial dependence on others.
FIVE	Most everyday activities are prevented. Dependent on others for many kinds of self-care. Able to be maintained at home only with considerable difficulty, or hospital admission is required.
SIX	Total incapacity. Unconscious or delirious. Self-care is impossible.

**TABLE 21.2 Intermittent attack - duration**

<b>Description</b>	<b>Duration</b>
Transient	Lasting up to and including five minutes.
Short	Lasting more than five minutes but less than 30 minutes.
Medium	Lasting from 30 minutes to four hours.
Prolonged	Lasting more than four hours.

**TABLE 21.3 Severity - grading code**

Description	Severity Level						
	0	1	2	3	4	5	6
Transient	A	A	A	B	C	C	F
Short	A	A	C	C	D	E	H
Medium	A	B	C	D	E	H	I
Prolonged	A	C	D	F	G	I	J

A rating is obtained using Table 21.3 and Table 21.4:

determine the intermittent grading code appropriate to the estimated severity and duration from Table 21.3; and

make the rating appropriate to the intermittent grading code and frequency from Table 21.4.

**TABLE 21.4 Assignment of a rating**

Intermittent Grading code	Frequency (Affected days/year)					
	2+	5+	10+	20+	40+	100+
	<b>Rating</b>					
A	-	-	-	-	-	-
B	-	-	-	-	-	5
C	-	-	-	-	5	10
D	-	-	-	5	10	20
E	-	-	-	5	10	30
F	-	-	5	5	10	30
G	-	-	5	10	20	30
H	-	-	5	10	30	40
I	-	5	10	30	40	40
J	5	10	20	40	40	40

## CHAPTER 24: GUIDE TO TABLE 22. – GYNAECOLOGICAL CONDITIONS

Table 22 is used to assess impairment resulting from gynaecological conditions. An impairment rating should only be assigned for significant conditions that have been properly diagnosed and are affecting normal daily functioning despite optimal treatment. The impairment must also be considered likely to continue for the foreseeable future (ie at least the next two years). **Only one rating** overall should be assigned from this table. (Refer also to Section (K) – Chapter 1.)

### Some conditions commonly assessed using this table:

Pelvic inflammatory disease, endometriosis.

### Conditions that should not be assessed using this table:

Malignancies such as cervical or uterine cancer should be assessed under Table 20. Mastectomy that has an associated loss of upper limb function would be rated under Table 3. Severe post-natal depression that is expected to persist for the next two years may be rated under Table 6. Pregnancy is a physiological state and not a pathological condition and should not be rated as an impairment particularly as it is a temporary condition. For males, genital disorders should be assessed under Table 16 or Table 17. (Refer also to CHAPTER 22– Table 20.)

### TABLE 22. GYNAECOLOGICAL CONDITIONS

Gynaecological conditions such as pelvic inflammatory disease and endometriosis should be assessed using Table 22. The Medical Officer should only use this Table for significant diagnosed conditions affecting normal daily functioning and which are likely to continue for the foreseeable future. Malignancy should be scored using Table 20. Disability due to mastectomy should only be scored where there is an associated loss of upper limb function and Table 3 should then be used. Post-natal depression may be scored using Table 6 if considered to be adversely affecting function for the next two years. For males, disorders of the genital system should be assessed under Tables 16 or 17.

Rating	Criteria
NIL	Minor symptoms which are easily tolerated. Minimal effect on daily functioning or work capacity.
TEN	Moderate and frequent symptoms present despite treatment due to a condition which has been properly diagnosed. Some decreased ability to carry out every day activities but independence is retained.
TWENTY	Moderate to severe symptoms frequently present despite optimal treatment due to a condition which has been properly diagnosed. Decreased ability to carry out everyday activities, requiring assistance with elements of self-care.
THIRTY	More severe symptoms frequently present despite optimal treatment due to a condition which has been properly diagnosed. This results in substantial difficulties with most daily tasks.
FORTY	Severe symptoms frequently present despite optimal treatment due to a condition which has been properly diagnosed and needs considerable assistance with many daily activities.

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