# Guidelines to the Tables for the Assessment of Work-related Impairment for Disability Support Pension

# (the Tables)

**N.B for the Tables that come into effect from 1 January 2012**

# Table of content to the Guidelines

CHAPTER 1: THE OBJECTIVE AND INTENDED USE OF THESE GUIDELINES ..... 3

CHAPTER 2: GUIDELINES TO THE RULES FOR APPLYING THE IMPAIRMENT TABLES (PART 2 OF THE DETERMINATION)..... 4

(A) PURPOSE AND DESIGN OF THE TABLES – (SECTION 5 OF THE DETERMINATION) .... 4

(B) APPLYING THE TABLES – (SECTION 6 OF THE DETERMINATION)..... 8

(C) INFORMATION THAT MUST BE TAKEN INTO ACCOUNT IN APPLYING THE TABLES – (SECTION 7 OF THE DETERMINATION) ..... 16

(D) INFORMATION THAT MUST NOT BE TAKEN INTO ACCOUNT IN APPLYING THE TABLES – (SECTION 8 OF THE DETERMINATION)..... 17

(E) USE OF AIDS, EQUIPMENT AND ASSISTIVE TECHNOLOGY – (SECTION 9 OF THE DETERMINATION)..... 18

(F) SELECTING THE APPLICABLE TABLE AND ASSESSING IMPAIRMENTS –..... 19

(SECTION 10 OF THE DETERMINATION) ..... 19

(G) ASSIGNING AN IMPAIRMENT RATING - (SECTION 11 OF THE DETERMINATION)..... 21

CHAPTER 3: CASE EXAMPLES OF TABLE USE FOR PERMANENT CONDITIONS ..... 23

CHAPTER 4: GUIDELINES TO THE TABLES..... 27

## CHAPTER 1: THE OBJECTIVE AND INTENDED USE OF THESE GUIDELINES

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

The Tables and the rules to be complied with in applying them, are contained in the *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011* (the Determination) made by the Minister under the applicable provisions of the *Social Security Act 1991*.

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

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

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

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

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

## CHAPTER 2: GUIDELINES TO THE RULES FOR APPLYING THE IMPAIRMENT TABLES (PART 2 OF THE DETERMINATION)

This Chapter provides guidance on Part 2 of the Determination which sets out rules that are to be complied with in applying the Tables. This Chapter is divided into subheadings emphasising significant principles and concepts underpinning provisions contained in that part of the Determination. It also provides guidance on the concepts and practical application of the Disability Support Pension (DSP) eligibility criteria contained in the *Social Security Act 1991.*The relevant provisions of the Determination corresponding to each subheading are identified in parenthesis.

This Chapter does not restate the definitions contained in Part 1 of the Determination. These definitions should be accessed directly from the Determination.

### (A) PURPOSE AND DESIGN OF THE TABLES – (SECTION 5 OF THE DETERMINATION)

#### Purpose and design of the Tables

Unless otherwise authorised by law, the Tables are used to determine whether a person whose qualification for DSP is being considered, meets a qualifying impairment threshold stipulated in the *Social Security Act 1991*. This determination is made by assessing the level of functional impact of a person's impairment and assigning an impairment rating corresponding to the identified level of impact.

To qualify for DSP, a person must have, among other things, a physical, intellectual or psychiatric impairment assessed as attracting an **impairment rating of 20 points or more** under the Tables.

A person must also have a **continuing inability to work** – that is the person must be unable, because of the impairment, to do any work of at least 15 hours per week independently of a program of support in the next 2 years, or be re-skilled for such work within the next 2 years. To meet the continuing inability to work requirements, a person whose impairment is not severe, must have also participated in a program of support.

*Impairment and continuing inability to work*

The determination of an impairment rating and the assessment of continuing inability to work are two distinct assessments based on two different DSP qualification criteria. When assessing qualification for DSP, the requirement for the person to have an impairment rating of at least 20 points under the Tables and the requirement that the person has a continuing inability to work, are **of equal importance.**

For DSP qualification, both the minimum qualifying impairment threshold of 20 points **and** continuing inability to work criteria must be met and are of equal importance.

Achieving an impairment rating of least 20 points does not mean that the person qualifies for DSPbut merely indicates that the impairment-related qualification criterion has been satisfied.

Achieving this rating does not mean the person will be unable to do any work of at least 15 hours per week in the next 2 years, either. What it does mean is that the person's impairment may have a significant functional impact in many work situations but depending on the person's individual

circumstances, coping mechanisms and reasonable adjustments, that person may still be able to do work.

***Example 1: A person is assessed as having an impairment rating of 20 points under Table 14 – Functions of the Skin because they have severe difficulties performing daily activities due to scarring from burns which restricts movement of their arms. The person also has severe difficulties performing tasks involving exposure to sunlight due to heightened sensitivity resulting from extensive skin grafts. While this person is not able to perform certain work-related tasks such as lifting objects above their head height and must also avoid exposure to sunlight, they may be able to do work that does not involve such tasks or exposure. For instance, the person may be able to perform clerical tasks and have their desk placed away from the windows.***

***Example 2: A person has sustained brain and spinal injuries in a motor vehicle accident. The person's impairments are assessed at 10 points under Table 4 - Spinal Function (as they can drive a car for at least 30 minutes but are unable to bend forward to pick up light objects placed at knee height) and at 10 points under Table 7 – Brain Function (as they have difficulty solving some day to day problems and may need help on this from time to time). The person therefore meets the minimum impairment threshold of 20 points and is clearly unable to do work that requires lifting objects and solving certain problems on their own. However, the person may be able to undertake work that does not involve lifting and which requires routine, repetitive tasks such as processing simple forms or data entry.***

*Sustainability of work*

In assessing capacity for work, it is expected that a person will be capable of reliably performing work on a sustainable basis, that is, for a reasonable period of time without requiring excessive sick leave or work absences. In this context, a reasonable period of time generally means 26 weeks and work means work in open, unsupported employment. Sick leave or absences of one month or more (in total) taken in any given 26 week period are considered excessive.

It should be noted that a number of Tables (including but not limited to Table 1 – Functions requiring Physical Exertion and Stamina, Table 3 – Lower Limb Function or Table 7 – Brain Function) contain specific references to periods of sustained effort in relation to certain activities or tasks (e.g. sustaining appropriate exercise for 30 minutes, standing unaided for 10 minutes etc). These references **should not be confused** with the concept of the overall work sustainability mentioned above.

*Summary of key qualification requirements for DSP (as per Social Security Act 1991)*

The person has a physical, intellectual or psychiatric impairment; and

The person's impairment is 20 points or more under the Impairment Tables; and

The person has a **continuing inability to work**;or

The person is participating in the supported wage system.

***Continuing inability to work*** means that:

- In a case where the person's impairment is not a **severe impairment** - the person has **actively participated in a program of support**;and
- in all cases - the impairment is sufficient to prevent the person from doing any work **independently of a program of support** within the next 2 years; and
- in all cases, either:
    - the impairment is sufficient to prevent the person from undertaking a training activity during the next 2 years; or
    - if the impairment does not prevent the person from undertaking a training activity – such activity is unlikely to enable the person to do any work independently of a program of support within the next 2 years.

***Severe impairment*** means that the person has an assessed impairment of 20 points or more under the Impairment Tables, of which 20 points or more are assigned under a single Table.

***Active participation in a program of support***is assessed under provisions of the *Social Security (Requirements and Guidelines – Active Participation for Disability Support Pension) Determination 2011.*

***Independently of a program of support***means that the person:

- is unlikely to need a program of support; or
- is likely to need a program of support provided occasionally; or
- is likely to need a program of support that is not ongoing.

***Program of support*** means a program that is designed to assist persons to prepare for, find or maintain work and is funded (wholly or partly) by the Commonwealth or is of a type similar to such a program.

***Work*** means work that is for **at least 15 hours per week,** at or above the relevant minimum wage and that **exists (anywhere) in Australia**, even if not within the person's locally accessible labour market, regardless of whether vacancies exist.

*Conceptual design model of the Tables*

The Tables are function-based rather than diagnosis-based in that they focus on assessing impact of impairment on normal functions as they relate to work performance and assigning a rating consistent with the identified level of such an impact. As such, the Tables do not just assess a person's medical conditions, the person's overall health status or a loss or abnormality of psychological, physiological or anatomical structure.

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

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

If the difference between a condition and impairment is not appreciated, then inappropriate selection of Tables, double counting of impairment or assigning ratings to temporary impairments are more likely to occur.

The same condition **will not** always result in the same level of impairment. Inappropriate assessments may result from assuming that individuals with the same condition will have the same level of impairment.

***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 3 - Lower Limb Function, even though they share the same diagnosis. This is because it is their functional ability rather than their condition that is assessed.***

The Tables are function-based - they are used to assess functional impact of impairments resulting from medical conditions.

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

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

- specify body functions to which that Table should be applied;
- specify which practitioner can diagnose;
- instruct that self-report of symptoms (by the person who is being assessed) must be supported by corroborating evidence; and
- provide examples of corroborating evidence that can be taken into account when applying that Table, who can provide it and, where appropriate, an indication of conditions commonly associatedwith an impairment assessable under that Table.

*Scaling system and descriptors*

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

Each Table contains descriptors which describe the level of functional impact of the impairment assessed under that Table. The level of impact is described in the first line of each descriptor by reference to specific examples of functional activities, abilities, symptoms and limitations that are contained in the descriptor.

While the Tables are designed to assess the level of a person's impairment in relation to their capacity to perform work-related tasks and activities, the Tables acknowledge that some people being assessed for DSP purposes may have no work history and experience. This is addressed by including references to general activities of daily living in the descriptors.

Individual descriptors may require that for a descriptor to be met, at least one of the functional activities, abilities, symptoms or limitations must apply, or that at least two of them must apply, or that most of them must apply.

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

***Example: Table 15 – Functions of Consciousness under 5 points, defines rare episodes as occurring no more than twice per year, and under 30 points frequent episodes are defined as occurring at least once each week.***

For the purpose of applying the Tables "most" means more than 50 per cent. For instance: if there are 3 examples in the descriptor, "most" means 2; if there are 4 examples, most means 3; if there are 6, most means 4 etc.

Unless specifically defined in individual Tables (e.g. Table 15), terms, such as "occasionally, "frequently", "often", "sometimes", "regularly" etc, have their natural meaning. Please refer to Part G of this Chapter for more explanation on the significance of these terms in the context of the hierarchy of descriptors.

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

This generic scale is as follows:

- No functional impact - 0 points
- Mild functional impact - 5 points
- Moderate functional impact - 10 points
- Severe functional impact - 20 points
- Extreme functional impact - 30 points.

## (B) APPLYING THE TABLES – (SECTION 6 OF THE DETERMINATION)

### Assessing functional capacity

Consistent with the function-based design of the Tables, a person's impairment must be assessed on the basis of the person's abilities and not what the person chooses to do, or not to do, or what the person is accustomed to having another person do for them.

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

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

***Example: When assessing functional impairment, rather than asking "Does this person vacuum floors or mow the lawns at their place?" one should consider "Can this person perform these tasks and what level of functional limitation, if any, do they have when attempting these tasks?"***

**Applying the Tables and assigning impairment ratings**

*Permanency of conditions and impairments*

The Tables can only be applied after a person's medical history has been considered.

In deciding whether the Tables should be applied, the following should be considered:

- whether a person has a permanent medical condition;
- whether this condition has an impact on the person's ability to function (impairment); and
- whether the condition and the impairment are both considered permanent.

The information to enable these considerations can be obtained from a report prepared by a person's treating doctor (see Part C of this Chapter).

***Example: The medical condition and the resulting impairment can both be regarded as permanent and the Tables should be applied, if in light of the information in a report from the person's treating doctor, it is determined that:***

- ***the person's medical condition is fully diagnosed, treated and stabilised (permanent); and***
- ***this condition has an impact on the person's ability to function (impairment); and***
- ***the impact of this impairment is expected to persist for more than 2 years without functional improvement***

The Tables can only be applied if the medical condition**and**the resulting impairment are **both consideredpermanent** for DSP purposes.

For DSP purposes, 'permanent' medical condition does not mean condition that is 'indefinite' or 'incurable'. For DSP, **a condition is permanent**if it has been:

- fully diagnosed by an appropriately qualified medical practitioner (this includes an appropriate specialist); and
- fully treated; and
- fully stabilised; and
- is more likely than not, in light of available evidence to persist for more than two years.

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

***Example: Whether a condition has been fully treated or not, must be considered when determining whether the condition is fully stabilised. Therefore, some of the examples of conditions that may be considered as fully treated (provided under "Fully diagnosed and fully treated" below) are also reasonable indications of the condition's stability.***

An impairment that results from a specific condition can only be considered **permanent** if it is more likely than not, in light of the available evidence, to persist for more than 2 years.

Impairments that are not permanent are not to be assessed under the Tables and cannot be assigned an impairment rating. It is possible for a medical condition causing impairment to last for more than two years but the impact of the resulting impairment to improve or even cease within two years.

***Example: In the case of a person who has been diagnosed with osteoarthritis or degenerative joint disease of the knee, the condition is considered permanent and is likely to deteriorate with age. It will certainly persist for at least two years. However, its corresponding impairment may not necessarily be considered "permanent" for DSP purposes as this depends on whether, and if so how, the person's level of function is expected to changewithin the next two years. For instance, if it is assessed that the impairment will significantly improve or cease (e.g. through medication, lifestyle changes or surgical intervention) within the next 2 years, this impairment is not considered permanent for DSP purposes and the Tables are not to be applied.***

*Fully diagnosed and fully treated*

In determining whether a medical condition has been fully diagnosed, an examination and analysis of diagnostic information is required. The relevant diagnostic information is normally available in a report from the person's treating doctor and from other corroborating evidence.

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

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

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

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

The reason for this is to ensure that the person has received the necessary diagnostic input and associated treatment considerations. In these instances it is sufficient to consider clear indications that this has occurred as reported by the GP in the Medical Report or, where necessary, verbal confirmation of this by the GP at follow up, which must be clearly documented by the Assessor.

***Example 1: Table 5 - Mental Health Function requires that the diagnosis must be made by an appropriately qualified medical practitioner (including a psychiatrist) with evidence from a clinical psychologist (if the diagnosis has not been made by a psychiatrist).***

***Example 2: Table 11 - Hearing and other Functions of the Ear requires that the diagnosis must be supported by evidence from an audiologist or Ear, Nose and Throat (ENT) specialist.***

***Example 3: Table 12 - Visual Function requires that the diagnosis must be supported by evidence from an ophthalmologist.***

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

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

- the nature and effectiveness of past treatment;

- the expected outcome of current treatment;
- any plans for further treatment; and
- whether past, current or future treatment can be considered reasonable.

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

***Example 1: A person's non-terminal cancerthat is still being treated by chemotherapy and for which prognosis is uncertain, would not normally be regarded as fully treated.***

***Example 2: A person has been diagnosed with early degenerative joint disease with symptoms of knee pain but has not yet received any treatment. The condition should not be considered fully treated.***

***Example 3: A person with severe osteoarthritis in the knee is scheduled to undergo joint replacement surgery within the next two years which could result in significant improvement of their level of mobility and overall function. The condition should not be regarded as fully treated.***

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

This may apply where it is clear that a person's functional capacity will not improve within the next 2 years even if the person continues to receive appropriate reasonable treatment.

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

*Fully stabilised*

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

The condition can be regarded as fully stabilised if the person has undertaken reasonable treatment for the condition and it is considered that any further reasonable treatment is unlikely to result in significant functional improvement in the next 2 years. In this context, significant improvement is improvement that will enable the person to undertake work in the next 2 years.

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

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

In assessing stability of medical conditions, it is therefore required to consider the prognosis for improvement within the next 2 years in light of factors such as the history of the condition, response to treatment and the expected rate of recovery. The information necessary to establish prognosis and stability of conditions can be obtained from medical reports provided by a person's treating doctor. Any valid corroborating evidence as stipulated in the introduction to each Table should also be consulted.

***Example: If the available evidence indicates that the medical condition is likely to persist for more than 2 years but the prognostic information indicates that significant functional improvement within the next 2 years is likely, the condition is not to be considered as fully stabilised.***

Where the available evidence indicates that the condition is likely to fluctuate, deteriorate or remain unchanged, it needs to be considered whether all reasonable treatment has been undertaken before it can be concluded that the condition is not fully stabilised.

***Example 1: A fluctuating condition with intermittent episodes of exacerbation (e.g. Bipolar Affective Disorder) may be considered fully stabilised if it is receiving reasonable medical treatment and its overall functional impact is unlikely to improve significantly within the next 2 years.***

***Example 2:An intermittent condition (e.g. epilepsy) would not be considered fully stabilised if further medical treatment can significantly improve its control and reduce the frequency of its episodes, for instance by improving treatment compliance, adjusting dosage or type of medication to reduce side-effects or improve therapeutic effect.***

The term "stability" as used for DSP purposes has a specific meaning. In this context "stabilised" does not mean "stable" in the usual sense of the word.

While a condition may not be stable in the usual sense of the word because the level of impairment resulting from that condition is continuing to change (deteriorate), it may still be considered fully stabilised for DSP purposes.

***Example: This may occur where the prognosis is poor and no functional improvement is expected within the next 2 years. This situation may apply to a condition where active treatment is no longer effective or is no longer indicated.***

In some situations, a condition may be considered fully stabilised even though it could be argued that the condition has not been fully treated and therefore functional improvement would, theoretically, be possible. This is particularly so in relation to conditions resulting in impairments affecting mental health function.

***Example: A person has a major depressive disorder which remains poorly controlled after 5 years of treatment with various types of antidepressant medications and other appropriate treatment. There is evidence that the person's response to the medications and other treatment they tried has been poor. There are a few medications the person has not yet tried. Therefore functional improvement is, theoretically, possible with a change of medication. However, given the history of poor response to previous treatment, prognosis for a positive response to the untried medications is poor. In this situation it may be reasonable to consider the condition as fully stabilised. This example can also apply to other conditions and their impairments affecting mental health function.***

It may be inappropriate to consider a mental health condition as "not fully stabilised" based solely on the fact that a change of medication is possible. A thorough examination of the clinical history of the condition, response to previous treatment and prognosis for improvement or otherwise with a new medication must be undertaken.

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

***Example 1: A person with severe burns is willing to receive reasonable treatment by agreeing to undergo a series of skin grafts but it is clear that significant functional improvement to a level enabling the person to undertake work in the next 2 years is not expected to result because the planned treatment and recovery times will span more that 2 years. In this case, the conditionmay be regarded as fully stabilised for DSP purposes.***

***Example 2: When significant improvement takes longer than 2 years because a treatment procedure has to be delayed for some time (see also "Reasonable treatment and compelling reasons for not undertaking it" for information about waiting lists), the condition may be considered as fully stabilised.***

*Reasonable treatment and compelling reasons for not undertaking it*

To be considered reasonable, treatments must be evidence-based with scientific, peer-reviewed research findings to support the use of the treatment for specified medical conditions (i.e. alternative or complementary medicine or treatments without such research evidence are not considered to be reasonable treatment for DSP purposes). Off-label use of medications (i.e. medications used without a prescription or not in accordance with a prescription from a qualified medical practitioner) is also not considered to be reasonable treatment for DSP purposes. The Health Professional Advisory Unit (HPAU) should be consulted where clarification is required.

For DSP purposes, **reasonable treatment**means:

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

  ***Example: It would not be reasonable to expect a person to undergo prohibitively expensive treatment, or treatment that is only available in another country in order to satisfy the permanence criteria.***

- treatment or procedure that is of a type regularly undertaken or performed.

  ***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 that has a high success rate and where substantial improvement can be reliably expected.

  ***Example: It would be inappropriate to consider 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.

  ***Example: A person may decide against undertaking a certain treatment because it has serious associated risks, for instance major surgical procedure or unavoidable and significant side effects, such as chemotherapy.***

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

***Example: A person may be advised by their treating orthopaedic specialist that they require a hip replacement which will significantly improve their level of mobility. However, they are advised by their hospital that the waiting list for the surgery is between 18 to 24 months. Taking into account the recovery and rehabilitation period that may be required***

***after such a surgical procedure, it may be reasonable in this circumstance to consider the person's condition to be stabilised.***

Waiting list should be considered when assessing whether a medical condition is stabilised.

It is assumed that a person will generally wish to pursue any reasonable treatment that will improve or alleviate their condition. However, people cannot be expected to undergo treatment that is not reasonable. Treatment will not be considered reasonable if it is not based on the best medical information available.

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

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

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

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

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

*Assessing impairments with no or negligible functional impact*

Subsection 6(8) of the Determination states that the presence of a diagnosed condition does not necessarily mean that there will be an impairment to which an impairment rating may be assigned. The Explanatory Statement to the Determination clarifies that, consistent with the function-based (rather than condition-based) design of the Tables, this provision is intended to reinforce the distinction between a condition and any resulting functional impairment, with only the latter capable of being assigned a rating under the Tables. See *Conceptual design model of the Tables* in Part A of this Chapter.

It would be generally expected that if a condition is listed in a report from the person's treating doctor, such a condition would have **some** functional impact (impairment). There may be, however, situations where a diagnosed condition is present in the treating doctor's report or other appropriate medical evidence but the condition is considered as not resulting in permanent impairment. Subsection 6(8) of the Determination reinforces the rule that an impairment rating should not be assigned in such situations given there is no resulting permanent impairment.

***Example: A report from the person's treating doctor lists hypertension as one of the diagnosed conditions. On assessment, it is determined that this condition has been successfully treated with medication over the last five years, is stable and the prognosis for ongoing positive response to treatment is good. The person checks their blood pressure on a daily basis and, when measured, their blood pressure is within a healthy range. The person experiences no side-effects of medication and is able to undertake physical activities appropriate to their age. The person's doctor advises no restriction on activities. In this case, it would be reasonable to consider that this condition does not result in permanent impairment. Therefore the Tables should not be applied and no impairment rating is to be assigned.***

However, where the person's permanent medical condition is considered to result in any functional impact (even minimal), such impairment cannot be disregarded for DSP assessment purposes. As a rule, a medical condition and its resulting impairment that are both considered **permanent for DSP purposes** must be assessed by applying the relevant Table. The Table should be selected in accordance with the rules specified in Section 10 of the Determination (see also *"Selection steps"* in Part F of this Chapter).

In accordance with these rules, the permanent impairment resulting from the permanent condition should first be identified. The impact of the permanent impairment on the person's functional ability in relation to work must then be assessed.

Where it is concluded that the condition and the resulting impairment result in negligible functional loss, then the impairment is to be assessed as having no functional impact and assigned zero points under the Table relevant to the area of function most commonly affected by the condition under consideration. The allocation of zero points does not necessarily mean that there is no functional impact whatsoever – it may mean that the level of impact is such that the impairment rating of 5 points is not met.

***Example: A DSP claimant was diagnosed with hypertension 5 years ago. The condition has been treated with appropriate medication and the person's response to the medication has been generally good, however, from time to time the person suffers from side-effects of medication. For example, when they get up to a standing position too quickly, they experience dizziness. In addition, their doctor recommends restriction on certain activities such as lifting heavy weights in the gym. The condition and its treatment have, therefore, some impact on the person's general ability to function but the overall functional impact in relation to work can be considered as negligible or none. In this case, zero impairment points should be allocated under Table 1 – Functions requiring Physical Exertion or Stamina.***

*Assessing functional impact of pain*

There is no Table specifically dealing with pain.

Acute pain is a symptom that may result in a short-term loss of functional capacity in more than one area of the body.

Chronic pain is a medical condition and where it has been fully diagnosed, fully treated and fully stabilised, any resulting impairment should be assessed using the Table that is relevant to the function affected.

***Example 1: A person with fully diagnosed, fully treated and fully stabilised chronic lower back pain should be assessed using Table 4 – Spinal Function. The functional impact of the person's impairment on the person's ability to bend, move their trunk and remain seated would be assessed in accordance with the descriptors in that Table.***

***Example 2: If the person's chronic pain affects their ability to use their upper limbs, for example the person has a limited ability to lift objects, then Table 2 – Upper Limb Function should be used.***

***Example 3: If the person's ability to walk, climb stairs, rising from a kneel or squat or an ability to sustain a standing position is or are affected, then Table 3 – Lower Limb Function should be used.***

These examples are not exhaustive - it should be remembered that chronic pain may affect a number of different body functions.

## (C) INFORMATION THAT MUST BE TAKEN INTO ACCOUNT IN APPLYING THE TABLES – (SECTION 7 OF THE DETERMINATION)

The following information must be taken into account in applying the Tables:

- the information provided by health professionals specified in the relevant Table;
- any additional medical or work capacity information that may be available; and
- any information that is required to be taken into account under the Tables, including as specified in the introduction to each Table.

Generally, people claiming DSP must provide a report from their treating doctor in support of their claim**.** This report provides details of:

- the diagnosis of the person's medical condition, including date of onset and whether the diagnosis is confirmed;
- clinical features including history and symptoms;
- past, present and future/planned treatment;
- compliance with recommended treatment;
- impact of the condition on the person's ability to function, including whether this impact is long term or temporary, and the expected effect of the condition on the person's ability to function in the next 2 years (prognosis);
- any supporting information or reports that are available to the doctor, such as X-Rays, specialist reports or pathology test results; and
- periods of hospitalisation.

This report is the primary source of evidence used in determining whether the person's medical condition and its resulting impairment are permanent for DSP purposes and, consequently, whether the impairment arising from this condition can be assigned a rating under the Tables.

The person claiming DSP is responsible for obtaining all relevant medical evidence in support of their claim. Where the person indicates that they have a medical condition that is not listed in the report from the person's treating doctor, they should be asked to provide medical evidence detailing the diagnosis, treatment and prognosis of the condition. This may involve requesting the person to obtain further information from the person's treating doctor or another doctor or specialist.

Generally, medical evidence from the previous two years should be used, however, if the medical evidence is not recent, it may still be useful depending on the person's condition and whether the information is representative of the person's current level of impairment.

***Example: A report that is older than 2 years may still be of value if the condition remains unchanged since the time the report was completed – for instance a condition has been present from birth or early childhood, or is never likely to change (e.g. amputation of a limb).***

While such older evidence may be useful for the purposes of confirming diagnoses of medical conditions, it may not fully reflect the current level of impact of such conditions on the person's ability to function.

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

Where the nature or the severity of a condition is unclear, arrangements should be made for further investigation of the condition before undertaking an assessment of the functional impact of the condition on the person's capacity to work. In the first instance, the treating doctor should be contacted for clarification.

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

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

*People living in remote areas*

JCAs and related decisions must be based on the best available medical evidence. In the case of people from remote areas who may have limited access to doctors, the medical report may need to be completed by a community nurse, generally based on clinical notes from a GP (the diagnosis must have been made by an appropriately qualified medical practitioner). In these cases it may be possible for the job capacity assessor to form an opinion regarding the person's medical qualification on the basis of available evidence. This will only apply if the medical condition has been diagnosed, treated and stabilised to the extent that an impairment rating can be assigned.

## (D) INFORMATION THAT MUST NOT BE TAKEN INTO ACCOUNT IN APPLYING THE TABLES – (SECTION 8 OF THE DETERMINATION)

*Self-reported symptoms*

In assessing impairment, self-report of symptoms alone cannot be taken into account unless there is corroborating evidence of the person's impairment. Examples of the corroborating evidence that may be taken into account and who can validly provide it, are set out in the introduction to each Table.

Corroborating evidence may include, but is not limited to additional reports or letters from the person's treating doctor(s) or specialists, reports from previous examinations or assessments (e.g. job capacity assessment), results of diagnostic tests (e.g. X-Rays), reports from other health professionals (e.g. psychologists, physiotherapists, exercise physiologists or social workers) or reports from other sources such as mental health workers or drug and alcohol counsellors.

*Non-medical factors*

Impairment ratings should reflect the level of work-related impairment due to the medical conditions and not due to non-medical factors.

For this reason, **unless specifically required under the Tables**, the impact of non-medical factors should not generally be taken into account when assessing a person's impairment.

Individual Tables may contain descriptors that may take account of certain non-medical factors but they represent an exception rather than the rule.

***For example Table 1 – Functions requiring Physical Exertion or Stamina, contains a reference to an ability to undertake exercise appropriate to the person's age e.g. reduced stamina or loss of flexibility.***

Some Tables provide for certain non-medical factors to be taken into account.

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

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

***Example: A non-English speaking person who is fluent in another language and does not have a medical condition affecting their communication function should not receive a rating under Table 8 - Communication Function just because they have difficulties communicating in English. Table 8 measures impacts on communication in the language that the person most commonly uses.***

Medically-related factors should not be disregarded. 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 depression.

## (E) USE OF AIDS, EQUIPMENT AND ASSISTIVE TECHNOLOGY – (SECTION 9 OF THE DETERMINATION)

The Tables have a consistent requirement that a person's impairment is to be assessed when the person is using or wearing any aids, equipment or assistive technology that the person has (in their possession) and usually uses.

Some of the Tables specify a particular impairment rating when such assistance is used.

***Example: A person's impairment attracts 20 points under Table 8 – Communication Function, where the person uses an electronic communication device (which produces electronic speech) and needs to use this technology to communicate with others in places such as shops, workplace, education or training facilities and is unable to be understood without this device.***

## (F) SELECTING THE APPLICABLE TABLE AND ASSESSING IMPAIRMENTS – (SECTION 10 OF THE DETERMINATION)

*Selection steps*

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

Table selection depends on the function affected and is made as follows:

- identify the function affected / identify the loss of function;
- refer to the appropriate Table related to the area of function;
- identify the correct rating.

The Table specific to the impairment being rated must always be applied to that impairment unless the instructions in that Table specify otherwise.

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

*Rating multiple impairments resulting from a single condition*

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

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

Where a single medical condition causes multiple impairments, these impairments should be assessed on all relevant Tables.

***Example: A person who has had a cerebrovascular accident (CVA or stroke) may be assigned no impairment rating or have an impairment rating assigned from a number of different Tables depending on what permanent residual effects of stroke they suffer. If they have recovered completely from their stroke and no longer experience any significant impairment, then no rating is applicable regardless of what effects they suffered initially.***

When using more than one Table to assess multiple impairments resulting from a single medical condition, care must be taken to ensure that the different Tables are being used to assess separate functional impairments and not the same functional impairment.

The same impairment must not be assigned an impairment rating under more than one Table.

Below are some examples of multiple Table use. Please refer to Chapter 3 – Case Studies for more details under these examples.

**Stroke.** A person who has suffered a stroke (cerebrovascular accident or CVA) may have functional impairments in a number of areas depending on which part(s) of the brain were damaged

**Diabetes.** A person with poorly controlled diabetes mellitus may experience a range of functional impairments

**HIV.** A person living with HIV (PLHIV) may present with a range of co-morbidities and a spectrum of functional impairments

When the impairment is assessed using more than one Table, the overall impact of the person's impairments is represented by a combined point score.

*Rating a common/combined impairment resulting from multiple conditions*

Two or more medical conditions may result in a common impairment. Because the Tables are function-based and not condition-based, where this occurs, only one relevant Table should be applied and a single impairment rating assigned to reflect the combined impairment. It would be inappropriate to assign a separate impairment rating for each medical condition as this would result in the same impairment being assessed more than once (double counting).

Double counting is not allowed and must be avoided.

***Example 1: The presence of both heart disease and chronic lung disease may each contribute to difficulties a person may have with breathing and to reduced effort tolerance. The overall loss of function however, is a common and combined effect of the two conditions that impact on function requiring physical exertion and stamina. Therefore, to avoid double counting, only one impairment rating should be assigned using Table 1 – Functions requiring Physical Exertion or Stamina.***

***Example 2: 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 affecting lower limb function. In this case, only one rating from Table 2 - Lower Limb Function should be applied.***

*Other situations where double counting may occur*

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

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

***Example: The presence of mental confusion due to 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 impairment is a single (cognitive) impairment which should be rated under Table 7 – Brain Function. Double counting would result if an additional rating is provided from Table 8 - Communication Function.***

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

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

***Example 1: Table 4 – Spinal Function instructs that this Table’s descriptors are to be met only from spinal conditions and that restrictions on overhead activities resulting from shoulder conditions should be rated under Table 2 – Upper Limb Function.***

***Example 2: Similarly, Table 7 – Brain Function instructs that a person with Autism Spectrum Disorder who does not have a low IQ should be assessed under this Table but it also instructs that Table 7 should not be used when a person has an impairment of intellectual function already assessed under Table 9 – Intellectual Function (unless the person has an additional medical condition affecting neurological or cognitive function). Conversely, Table 9 – Intellectual Function instructs that a person with Autism Spectrum Disorder, Fragile X Syndrome and Foetal Alcohol Spectrum disorder who also has a low IQ should be assessed under this Table.***

## (G) ASSIGNING AN IMPAIRMENT RATING - (SECTION 11 OF THE DETERMINATION)

The following rules must be applied in assigning impairment ratings:

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

***Example: Where a person with a permanent medical condition resulting in functional impairment due to excessive use of alcohol (Table 6 – Functioning related to Alcohol, Drug and Other Substance Use) meets most descriptors corresponding to an impairment rating of 10 points but also satisfies the 20-point descriptor of neglecting personal care, hygiene, nutrition and general health, a rating of 10 points must be assigned rather than 20 points as the person does not meet most of the descriptors at the 20 points rating.***

When more than one impairment rating is assigned, the point values of separate ratings are **added together** to obtain the total work-related impairment.

*Hierarchy of descriptors*

It should be emphasised that the descriptors in each Table are interlinked in that they follow a consistent, incremental hierarchy which is denoted, among other things, by the application of terms such as "occasionally, "frequently", "often", "sometimes", "regularly" etc.

Therefore, in deciding whether an impairment has no, mild, moderate, severe or extreme functional impact, all the descriptors in a specific Table should be read and compared before a decision is made to apply an appropriate impairment rating.

*Descriptors involving performing activities*

When assessing whether a person can perform a certain activity described in the descriptor, the descriptor will only apply if the person can do that activity on a repetitive or habitual basis and not only once or rarely.

***Example: If, under Table 2, a person is assessed as to whether they can unscrew a lid of a soft drink bottle, the relevant descriptor is met only where the person is generally able to do that activity whenever they attempt it.***

*Assessing impairments caused by episodic or fluctuating medical conditions*

Many medical conditions follow an episodic or fluctuating pattern. When assessing impairment caused by such conditions, a number of factors need to be taken into account. Consideration should be given to the severity, duration and frequency of the episodes or fluctuations and what is the **overall** functional impact the impairment(s). An impairment rating must then be assigned that reflects this overall functional impact.

A number of Tables that deal with functions that may be affected by conditions that often follow fluctuating or episodic patterns contain specific instructions that alert an assessor to the fact that the signs and symptoms of specific impairments may vary over time and that the person's presentation on the day of assessment should not solely be relied upon.

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

*No functional impairment resulting from a condition*

Please refer to the discussion in *Assessing impairments with no or negligible functional impact* in Part B of this Chapter.

## CHAPTER 3: CASE EXAMPLES OF TABLE USE FOR PERMANENT CONDITIONS

| Condition/diagnosis | Example of Impairment Table Use |
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| Autism spectrum disorder | Autism spectrum disorder is a developmental disorder often characterised by problems with social interaction and communication. The magnitude and severity of the symptoms can vary widely for individuals. A person with this condition would be assessed according to their presenting symptoms. For example:<br>• Table 8 (Communication) can be used if the person has difficulty with speech.<br>• Table 7 (Brain function) can be used to assess the functional impact of cognitive, social interaction and behavioural difficulties if the person has higher functioning autism (Aspergers) but does not have a low IQ.<br>• Table 9 (Intellectual Function) can be used to assess the functional impact of cognitive, social interaction and behavioural difficulties if the person has autism and a low IQ.<br>It is important not to rate the same functional impairment twice and a person therefore must not be assessed under both Table 7 and Table 9. |
| Cerebro-vascular accident (Stroke) | A person who has suffered a stroke (cerebro-vascular accident) may have functional impairments in a number of areas depending on the part(s) of the brain that have been damaged. In such cases, assessors should use all of the relevant tables. For example:<br>• Table 8 (Communication) can be used if the person has difficulties understanding or producing speech.<br>• Table 2 (Upper Limb Function) and Table 3 (Lower Limb Function) can be used if the person has paralysis.<br>• Table 7 (Brain Function) can be used if the person has impaired cognitive functions, such as difficulty with visuo-spatial functioning, attention or concentration. |
| Chronic Fatigue | A person with Chronic Fatigue Syndrome (Myalgic Encephalomyelitis) may experience a range of symptoms including exhaustion, persistent weakness, pain and neurological problems such as confusion. A person with this condition may have functional impairments in a number of areas, depending on their presenting symptoms. In such cases, assessors should use all of the relevant tables. For example:<br>• Table 1 (Functions requiring Physical Exertion and Stamina) can be used if the person experiences limitation in exertion.<br>• Table 7 (Brain function) can be used if the person presents with confusion, memory difficulties or other neurological symptoms.<br>• Table 10 (Digestive and Reproductive Function) can be used if the person experiences gastrointestinal symptoms such as nausea, bloating, constipation or diarrhoea.<br>If assistance is required to determine the functional impairments caused by this condition, assessors should seek clarification and advice from the person's treating doctor and/or the Health Professional Advisory Unit. |
| Chronic Pain | Acute pain is a symptom which may result in short term loss of functional capacity in more than one area of the body but should resolve itself within a few months.<br><br>However, chronic pain is a condition and where it has been diagnosed, fully treated and stabilised, the assessor should assess any loss of functional capacity using the Table relevant to the area of function affected. For example:<br>• Table 4 (Spinal Function) can be used if the person has chronic back pain that impairs their ability to bend and move their trunk and to remain seated.<br>• Table 3 (Lower Limb Function) can be used if the person has chronic pain in their lower limbs that impairs their ability to walk, climb stairs, or sustain a standing position.<br>• Table 2 (Upper Limb Function) can be used if the person has chronic pain in their upper limbs that impairs their ability to reach up or lift objects.<br>• Table 10 (Digestive and Reproductive Function) can be used if the person has chronic |

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| | pelvic pain that impairs their ability to concentrate on or sustain tasks or work activities.<br>• Table 1 (Functions Requiring Physical Exertion and Stamina) can be used if the person has chronic pain that impairs their ability to perform physical activities around the home and community.<br>• Table 7 (Brain Function) can be used if the person has chronic pain which is neuropathic and impairs their neurological or cognitive function, such as memory, attention and concentration. |
| Dementia | Dementia is rated under Table 7 (Brain Function) and is a progressive condition that causes a person's abilities to deteriorate over time. The progress of dementia varies between individuals. In some cases, a person's abilities will deteriorate rapidly over a few months, while in other cases a person's abilities will deteriorate more slowly over a number of years. The speed at which a person's abilities are deteriorating should be taken into account in assessing the functional impact of their condition.<br><br>The abilities of people with dementia may change from day to day, or even within the same day. If the person's condition is stabilised as episodic or fluctuating, the assessor should apply the rating that reflects the overall functional impact of the impairments, taking into account the severity, duration and frequency of the episodes.<br><br>In determining the functional impact of fluctuating conditions, assessors should consider their impact on the person's ability to reliably perform work over the next two years without excessive leave or work absences.<br>For example:<br>• Approximately two weeks sick leave in a 26 week period due to episodic or fluctuating dementia is within what is considered reasonable leave.<br>• Sick leave of a month or more in a 26 week period due to episodic or fluctuating dementia is considered excessive leave. |
| Diabetes Mellitus | A person with diabetes mellitus that is fully treated but poorly controlled may experience a range of functional impairments. In such cases, assessors should use all of the relevant tables. For example:<br>• Table 3 (Lower Limb Function) can be used if the person has peripheral neuropathy and vascular disease that affects their lower limb function.<br>• Table 12 (Visual Function) can be used if the person's vision is affected.<br>• Table 1 (Functions requiring Physical Exertion and Stamina) can be used if the person has cardiovascular disease that impairs their ability to perform and sustain physical activities.<br>• Table 15 (Functions of Consciousness) can be used if the person has frequent hypoglycaemic episodes. |
| Epilepsy | A person with epilepsy may experience seizures where they have involuntary loss or altered state of consciousness. This condition is rated under Table 15 (Functions of Consciousness). The Tables have severity and frequency built into the rating descriptors. For example the descriptor for 20 points on Table 15 includes:<br><br>The person has episodes of involuntary loss of consciousness due to a diagnosed medical condition at least once each month which require first aid measures and may require emergency medication and/or hospitalisation.<br>**OR**<br>The person has episodes of altered state of consciousness that occur at least once per week during which the person's functional abilities are affected (e.g. the person remains standing or sitting but is unaware of their surroundings or actions during the episode). |
| Fluctuating Mental Health Conditions | If a person's mental health condition has been stabilised as episodic or fluctuating (as may be the case with conditions such as Bipolar Affective Disorder), the assessor should apply the rating that reflects the overall functional impact of the impairments, taking into account the severity, duration and frequency of the episodes. Refer to dementia case study above for |

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| | more detail on assessing conditions that have been stabilised as episodic or fluctuating.<br><br>People with mental health conditions may not have good self-awareness of their impairment and may not be able to accurately describe its effects. In determining the functional impact of mental health conditions, Table 5 (Mental Health Function) instructs assessors to consider information from a wide range of sources and not to rely solely on a person's presentation on the day of the assessment. |
| HIV/AIDS | A person living with HIV (PLHIV) may present with a range of co-morbidities and functional impairments, even where their condition is fully diagnosed, treated and stabilised. The magnitude and severity of symptoms and side effects from treatment can vary widely for individuals. In the assessment of a person living with HIV, assessors should apply all of the relevant tables. For example:<br>• Table 1 (Functions requiring Physical Exertion and Stamina) can be used if the person experiences fatigue.<br>• Table 10 (Digestive and Reproductive Function) can be used if the person experiences diarrhoea.<br>• Table 14 (Functions of the Skin) can be used if the person has lipodystrophy (loss or accumulation of subcutaneous fat in various body parts due to HIV infection or side effects of medication).<br>• Table 2 (Upper Limb Function) and/or Table 3 (Lower Limb Function) can be used if the person has peripheral neuropathy such as numbness or tingling of fingertips and/or toes.<br>• Various tables may be used if the person has diabetes mellitus (refer to diabetes mellitus case study above).<br>• Table 12 (Visual Function) can be used if the person has Mycobacterium Avium Complex (MAC) which causes visual impairment or blindness.<br>• Table 5 (Mental Health Function) can be used if the person has a psychological disorder, such as clinical depression or bipolar disorder.<br>• Table 7 (Brain Function) can be used if the person has neurological conditions such as HIV dementia, HIV encephalopathy or Alzheimer's disease. |
| Hypertension | Fully treated hypertension usually does not result in functional impairment. Where hypertension results in no functional impact, a rating of zero under Table 1 should be assigned.<br><br>If severe and untreated hypertension has resulted in other fully diagnosed, treated and stabilised secondary conditions, such as damage to the eyes, kidneys or heart, the functional impacts of these conditions should be rated under the relevant tables (e.g. Table 12 – Visual Function and Table 1 – Functions requiring Physical Exertion and Stamina). |
| Malignancy (Cancer) | The functional impact of permanent malignancy is variable depending on the body parts or systems involved, the nature and effectiveness of treatment, and the extent or stage of the disease. In the assessment of a person with malignancy, assessors should apply all of the relevant tables.<br><br>People who have terminal malignancy, where the average life of a patient with the condition is 24 months or less, are manifestly qualified for DSP. |
| Miscellaneous Ear/Nose/ Throat conditions | Functional impairments resulting from ear, nose and throat conditions would be commonly assessed using Table 8 (Communication Function) and Table 11 (Hearing Function). For example:<br>• Table 8 can be used if a person's speech production is impaired due to a laryngectomy (removal of larynx or voice box).<br>• Table 11 can be used if a person's hearing is impaired due to otosclerosis (bone overgrowth in the middle ear) or if their balance is affected due to an inner ear (vestibular) disorder such as Meniere's Disease. |

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| Morbid Obesity | Morbid Obesity (class III obesity) in adults is defined as a Body Mass Index (BMI) of equal to or greater than 40 kg/$m^2$. A BMI of ≥ 40 is generally considered to be incompatible with long term good health, however, does not necessarily correlate with significant functional impact. The functional impact of morbid obesity may range from minimal to very significant. In the assessment of a person with morbid obesity, assessors should apply the tables relevant to the area of function affected. For example:<br>• Table 3 (Lower Limb Function) can be used if the person has difficulty walking, using stairs, kneeling or squatting.<br>• Table 1 (Functions requiring Physical Exertion and Stamina) can be used if the person experiences symptoms (shortness of breath, fatigue, cardiac pain) when performing physical activities.<br><br>Where morbid obesity results in no functional impact, a rating of zero under Table 1 should be assigned.<br><br>If morbid obesity has resulted in other fully diagnosed, treated and stabilised secondary conditions, for example osteoarthritis of the knee joints, the functional impacts of these conditions should be rated under the relevant Tables.<br><br>However, where two or more conditions cause a common or combined impairment, a single rating should be assigned in relation to that impairment under a single Table. It is inappropriate to assign a separate impairment rating for each condition as this would result in the same impairment being assessed more than once. |
| Multiple Sclerosis | A person with Multiple Sclerosis (MS) may experience a range of symptoms and symptoms from MS can vary between people. In the assessment of a person with MS, assessors should apply all of the relevant tables. For example:<br>• Table 1 (Functions requiring physical exertion and stamina) can be used if the person experiences fatigue.<br>• Table 2 (Upper Limb Function) and/or Table 3 (Lower Limb Function) can be used if the person has loss of muscle coordination that affects their ability to perform activities using their hands and arms (e.g. lifting and manipulating objects) or legs and feet (e.g. walking).<br>• Table 13 (Continence Function) can be used if the person's ability to control their bladder or bowel is affected.<br>• Table 7 (Brain Function) can be used if the person experiences memory loss.<br>• Table 11 (Hearing and Other Functions of the Ear) can be used if the person has loss of hearing. |

## CHAPTER 4:GUIDELINES TO THE TABLES

### Guidelines to Table 1 – Functions requiring Physical Exertion and Stamina

Table 1 is used to assess functional impairment when performing activities requiring physical exertion or stamina.

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

### Determining the level of functional impact

When determining which impairment rating applies to a person the rating that best describes the person's abilities or difficulties must be applied. To determine how the descriptor is to be applied, careful consideration must be given to each point within the descriptor.

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

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

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

The 0 point descriptor specifies the person is able to undertake exercise appropriate to their age. To meet this descriptor, it would not be expected that an older aged person is able to undertake the same level of intensity in exercise as someone aged in their 20's due to reduced stamina or loss of flexibility. Consideration should be given to the level of exercise a generally healthy person of the equivalent age would reasonably be expected to undertake.

Where descriptors refer to the activity of mobilising in a wheelchair, this includes either an electric or a manual wheelchair, depending on what the person has and usually uses.

Although the descriptors do not always 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 not for excessively prolonged periods. An activity listed under a descriptor is not taken to have been performed if it can only be done once or rarely.

If a person requires oxygen treatment such as the use of an oxygen concentrator during the day or to move around, consideration should be given as to whether this person meets the 30 point descriptor.

### Some conditions causing impairment 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
- diagnosed chronic pain which impacts a person's physical exertion or stamina
- chronic fatigue syndrome
- fibromyalgia

When assessing chronic pain under this Table, please refer within these Guidelines to Chapter 2, Part (B)*Assessing functional impact of pain*.

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

***Under Table 1, the man's impairment would be rated as 5 points, as the impact on his ability to perform tasks is only mildly affected.***

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

***Under Table 1, the woman would receive an impairment rating of 10 points for the moderate impact the condition has on her ability to function.***

**Impairments that should not be assessed using this Table**

Restriction of physical activity due to musculoskeletal (eg severe arthritis, spinal problems) or neurological (eg paresis, paralysis or neuropathic chronic pain) conditions should be rated under the relevant Tables (e.g. Table 2, 3, 4 or 7) depending on the functional loss.

Non-pathological causes such as lack of fitness that is not associated with a diagnosed medical condition.

## Guidelines to Table 2 – Upper Limb Function

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

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

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

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

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

### Determining the level of functional impact

When determining which impairment rating applies to a person the rating that best describes the person's abilities or difficulties must be applied. The descriptors for 5, 10 and 20 points state that most of the points must apply to the person. For 0 and 30 points, all aspects of the descriptor must apply.

Where the descriptor refers to 'most of the following' most is taken to be more than half.

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

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

Several of the points within the descriptors specify that either both hands or both arms need to be affected in order to satisfy the point. The descriptor for 20 points (1) (a) specifies that the person has limited movement or coordination in both arms or both hands. Also, the 30 points descriptor states the person is unable to perform any activities requiring the use of both hands or both arms.

To satisfy the 30 point descriptor the person would have incapacity in the use of either:

- both of their hands; or
- both of their arms.

(see example 2 below).

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

To avoid double-counting (see Chapter 2, Part (F)), upper limb impairment resulting from a spinal condition, which restricts overhead tasks, should be rated under Table 4 – Spinal Function only. Restrictions on overhead tasks which result from conditions of the shoulder should be rated under Table 2 only.

### Some conditions causing impairment commonly assessed using this Table

- upper limb musculoskeletal conditions including specific degenerative joint disease (osteoarthritis)
- other permanent forms of arthritis or chronic rotator cuff lesions
- neurological conditions including strokes (CVAs) or other brain or nerve injury causing paralysis or loss of strength or sensation
- cerebral palsy or other condition affecting upper limb coordination
- inflammation or injury of the muscles or tendons of the upper limbs
- upper limb amputations or absence of whole or part of upper limb, fractures, dislocations and long-term effects of musculoskeletal injuries
- chronic carpal tunnel syndrome
- ulnar nerve palsies

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

***Under Table 2, the man would receive an impairment rating of 5 points due to the mild impact on his ability to function.***

***Example 2: A 35 year old woman has been diagnosed with cerebral palsy, which affects her upper limb function. This condition has a significant impact on the functioning of both hands and as a result she is unable to undertake activities with either of her hands.***

***Under Table 2, the woman would receive an impairment rating of 30 points due the extreme impact on her ability to function.***

***Example 3: A 40 year old man has undergone an amputation of one of his arms. He does not use a prosthesis. Since the amputation he has adapted to the way he uses his remaining arm and is able to undertake many daily activities involving upper limb function. He has adapted to type on a computer keyboard with his remaining hand and can use a pencil to write. He is also able to handle and carry most objects but has difficulty picking up bulky objects. He has difficulty with tasks like tying shoelaces and unscrewing lids and needs assistance with these tasks.***

***Under Table 2, the man would receive an impairment rating of 10 points due to the moderate difficulties he still has, despite the adaptations he has made since undergoing the amputation of his arm.***

**Impairments 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 Table 12 – Visual Function.

## Guidelines to Table 3 – Lower Limb Function

Table 3 is used to assess functional impairment when performing activities requiring the use of legs or feet.

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

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

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

### Determining the level of functional impact

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

For example, to meet the 20 point descriptor all the points below (1) (a) must apply (i, ii and iii) and the person must also require assistance to use public transport. (2) (a) and (b) outline the level of assistance required by a person who either uses a wheelchair or walking aid. If the person uses a wheelchair or walking aid either one of these points must also be met.

The 10 point descriptor includes a note. This note contains examples of impairments the person may have at this rating level. The person may have impairment in undertaking other activities not listed in this note, to an equivalent degree.

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

An activity listed under a descriptor is not taken to have been performed if it can only be done once or rarely.

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

### Some conditions causing impairment commonly assessed using this Table

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

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

***Under Table 3, the man would receive an impairment rating of 20 points due to the severe impact his condition has on his ability to function.***

**Impairments that should not be assessed using this Table**

To avoid double-counting (see Chapter 2, Part (F)),Table 3 should not be used to assess impairment to lower limbs resulting from a spinal condition. Table 4 – Spinal Function should be used where the impairment results from a spinal condition.

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

## Guidelines to Table 4 – Spinal Function

Table 4 is used to assess functional impairment when performing activities involving spinal function. Spinal function involves bending or turning the back, trunk or neck.

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

Double-counting of impairments must be avoided (see Chapter 2, Part (F)). The Table 4 descriptors are to be met only from spinal conditions.

### Determining the level of functional impact

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

For example, under the 20 point descriptor the 'or' which comes at the end of each point (a), (b) and (c) indicates that the person must be unable to do at least one of the activities listed to meet this descriptor. The 10 point descriptor differs in that the person must be able to sit in or drive a car for at least 30 minutes plus one of either (a), (b), (c) or (d) must apply.

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

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

Consideration must also be given to whether the person can undertake the activity on a repetitive or habitual basis (see Chapter 2, Part (G)*Descriptors involving performing activities*). For example, under the 20 point descriptor, if a person is able to bend forward to pick up a light object from a desk or table but after doing this once has to rest their back and is unable to bend forward for the remainder of the day it should be considered that the person is therefore unable to do this activity.

An activity listed under a descriptor is not taken to have been performed if it can only be done once or rarely.

### Some conditions causing impairment commonly assessed using this Table

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

***Example: A 50 year old woman has been diagnosed with osteoarthritis and disc degeneration in her lumbar spine. Both these conditions result in functional impairment when the woman performs activities involving her spine. The woman takes regular medication to alleviate her symptoms but even with medication she continues to experience significant pain when undertaking daily activities. Her specialist has recommended spinal***

***surgery but due to the high risks involved in this procedure the woman has decided not to undertake the surgery.This woman has difficulty bending forward to pick up something light, such as a piece of paper, placed at knee height without experiencing significant pain in her lower back. She also experiences significant pain after remaining seated for 15 minutes.***

***As both conditions cause the same functional impact a single impairment rating is given under Table 4, of 10 points, due to the moderate overall functional impact these conditions have on her ability to function.***

**Impairments that should not be assessed using this Table**

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

**Guidelines to Table 5 – Mental Health Function**

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

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. This includes a general practitioner or a psychiatrist. Where the appropriately qualified medical practitioner is not a psychiatrist, the diagnosis must be made by a general practitioner with evidencefrom a clinical psychologist.

Supporting evidence for the DSP claim can include professional or clinical reports but can also include advice from the general practitioner that the person has been seen by a clinical psychologist or a psychiatrist who made or confirmed the diagnosis or provided evidence in support of the diagnosis. This advice can be either in writing in the Medical Report or other document, or verbally to the Assessor. Verbal confirmation must be documented and added to the person's Medical Information File.

A clinical psychologist is taken to be a psychologist registered with the Australian Health Practitioner Regulation Authority with an area of practice endorsed as clinical psychology by the Psychology Board of Australia.

**Vulnerable Customers**

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

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

Please note, this policy applies only to vulnerable people with mental health conditions, as assessed under this Table. People who may have an acquired brain injury or substance use problem such as excessive use of alcohol or other drugs or petrol sniffing, need to be assessed under the appropriate Table (i.e. Table 7- Brain Function or Table 6 – Functioning related to Alcohol, Drug and Other Substance Use) with the diagnosis provided by an appropriately qualified medical practitioner.

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

**Use of Specialist Assessments**

In some instances a specialist assessment by a clinical psychologist or psychiatrist may need to be considered where the person is unable to access an assessment via another means. Where a specialist assessment occurs, consideration should be given by the clinical psychologist or psychiatrist to the diagnosis and the implications of this for further treatment and stability of the condition.

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

*Example: Joe has experienced severe depression with suicidal ideation for a number of years. He has been treated by his general practitioner with medication for several years and has seen a psychologist for cognitive behavioural therapy as well. The diagnosis had not been made by a psychiatrist or with the assistance of a clinical psychologist so a specialist assessment was*

*undertaken, which confirmed severe depression. Joe's condition of severe depression was found to be fully diagnosed, treated and stabilised.*

Regardless of the number of mental health diagnoses a person may have, only one ratingis to be assigned under this Table to reflect the overall mental health function.

**Determining the level of functional impact**

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

Each descriptor contains the same domains of mental health impairment: self care and independent living; social/recreational activities and travel; interpersonal relationships; concentration and task completion; behaviour, planning and decision-making; and work/training capacity. In determining which descriptor applies to the person, most of the domains must apply to the person in line with the level of severity stated in the first line (i.e. no, mild, moderate, severe, extreme difficulties).

Where the descriptor refers to 'most of the following' most is taken to be more than half.

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

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

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

It is particularly important in the assessment of people with mental health conditions that the person's presentation on the day of the assessment should not solely be relied upon. This is because with some mental health conditions the person may lack insight into their condition and believe they are fully functioning.

For mental health conditions which are episodic in nature and fluctuate in severity over time (e.g. Bipolar Affective Disorder),the severity, duration and frequency of the episodes or fluctuations must be taken into account when determining the rating that best reflects the person's overall functional ability(see Chapter 2, Part(G) *Assessing impairments caused by episodic or fluctuation medical conditions*).

In determining the work-related impairment for such fluctuating conditions, consideration should be given to the impact on the person's ability to reliably sustain work over two years without significant absences.

In determining whether the mental health disorder has been fully treated and stabilised, one should consider whether the person has received reasonable 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 mental health impairment may be considered permanent and rated accordingly.

If reasonable 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 mental health 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(see Chapter 2, Part (B) *Reasonable treatment and compelling reasons for not undertaking it*).

**Some conditions causing impairment commonly assessed using this Table**

- chronic depressive/anxiety disorders
- schizophrenia
- bipolar affective disorder
- eating disorders
- somatoform disorders
- pathological personality disorders
- post traumatic stress disorder
- attention deficit hyperactivity disorder manifesting with predominantly behavioural problems
- behavioural problems related to acquired brain injury/frontal lobe syndrome.

***Example: A 39 year old woman has a diagnosed condition of Bipolar Affective Disorder. She has undergone various treatment options for this condition, under the guidance of her treating psychologist. She regularly experiences fluctuations in her condition. Despite these fluctuations the corroborating evidence provided by the treating psychologist indicates that her condition can be considered stabilised, due to the nature of this condition. She experiences periods of deep, prolonged and profound depression which are followed by periods of excessively elevated mood. Between these episodes she is often symptom free.On average, she experiences periods of depressed mood every 3 months and is affected for roughly 1 month. A period of mania usually follows and lasts a few days.***

***During the assessment for DSP the woman presented as highly functioning and confident when communicating. However, the medical evidence outlined that she experiences regular periods of depression where she withdraws from social situations and has very limited contact with family or friends. During these times her mother visits her every day as she is often unable to take care of her personal hygiene or cook and clean for herself. During these depressive periods she is unable to drive as she experiences slowed reaction times. When she is experiencing mania symptoms she has increased energy and overactivity and is often unable to sleep.***

***Under Table 5, this woman would receive an impairment rating of 20 points due to the severe impact this condition has on her ability to function.***

**Impairments that should not be assessed using this Table**

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

**Guidelines to Table 6 – Functioning related to Alcohol, Drug and Other Substance Use**

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

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

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

The *misuse of prescription drugs* means using prescription drugs in a way outside that which has been prescribed by a medical practitioner.

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. This includes a general practitioner or medical specialists such as an addiction medicine specialist or psychiatrist with experience in diagnosis of substance use disorders.

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

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

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

**Determining the level of functional impact**

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

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

Where the descriptor refers to 'most of the following' most is taken to be more than half.

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

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

If reasonable treatment has not been undertaken, it should be considered whether the person has a 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 even if significant improvement could be expected to occur with reasonable treatment.

**Some conditions causing impairment commonly assessed using this Table**

- alcohol dependence
- dependence on illicit drugs (eg heroin)
- dependence on other harmful substances such as glue or petrol
- misuse of analgesic medications or prescription drugs

***Example: A 35 year old man is diagnosed with alcohol dependence. The medical evidence shows he has participated in rehabilitation treatments over the last 5 years but continues to be alcohol dependent. He uses alcohol every day and is often unable to complete his daily activities such as preparing meals or showering due to the effects of alcohol. His relationships with family members are often strained and at times family members are not on speaking terms with him. His work attendance records show that heoften does not attend work for one or two days within a fortnight, but this varies.***

***Also, he has undergone liver function tests which identified significantly impaired liver function.***

***Under Table 6, this man would receive an impairment rating of 10 points due to the moderate impact his condition of alcohol dependence has on his ability to function. In this case, consideration should also be given to whether his liver condition is permanent and fully diagnosed, treated and stabilised and, if so, whether it receives an impairment rating under Table 10 – Digestive and Reproduction Function.***

**Impairments that should not be assessed using this Table**

Long term impairments that result from the alcohol, drug and other substance use, for example, neurological of cognitive impairment, cirrhosis or chronic liver disease, pancreatitis or other complications of end organ damage. These resulting conditions should be assessed under the appropriate Table according to the area of function affected.

## Guidelines to Table 7 – Brain Function

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

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

People with an Autism Spectrum Disorder who do not have a low IQ should be assessed using this Table.

### Determining the level of functional impact

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

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

In determining which descriptor applies to the person, at least one of the domains must apply to the person in line with the level of severity stated under (1) (i.e. no, mild, moderate, severe, extreme difficulties). The person must also meet the description of ability to complete day to day activities or the level of assistance and supervision required, as stated under (1).

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

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

It is particularly important in the assessment of people with neurological or cognitive conditions that the person's presentation on the day of the assessment should not solely be relied upon. This is because with some conditions such as temporal lobe dementia, the person may lack insight into their condition and believe they are fully functioning.

For conditions which are episodic in nature and fluctuate in severity over time (e.g. dementia), the severity, duration and frequency of the episodes or fluctuations must be taken into account when determining the rating that best reflects the person's overall functional ability(see Chapter 2, Part (G) *Assessing impairments caused by episodic or fluctuating medical conditions*).

In determining the work-related impairment for such fluctuating conditions, consideration should be given to the impact on the person's ability to reliably sustain work over two years without significant absences.

### Some conditions causing impairment commonly assessed using this Table

- chronic pain which is neuropathic
- acquired brain injury (ABI)
- stroke (cerebrovascular accident CVA)
- conditions resulting in dementia
- brain tumours
- some neurodegenerative disorders
- Autism Spectrum Disorders with no low IQ

***Example 1: A 43 year old woman suffers from body wide chronic pain which developed after she contracted shingles roughly 5 years ago. The medical evidence outlines that her symptoms include shooting and burning pain as well as tingling and numbness in various parts of her body. She has been diagnosed with chronic neuropathic pain. The woman has attended a pain management clinic and uses some pain management techniques to manage her pain. She also uses medication treatment. Despite these treatments she continues to suffer impairment as a result of her condition.***

***Her attention and concentration is severely impacted by this condition. She is easily distracted from any task she is trying to focus on and is unable to concentrate on any task for more than about 5 minutes. Her memory is also impacted and she often does not remember to complete regular tasks such as attending to her personal hygiene. Her sister visits her home once a day to make sure she attends to her personal hygiene and cooks and cleans for her.***

***This woman would receive an impairment rating of 20 points under Table 7, due to the severe impact her condition of chronic neuropathic pain has on her ability to function. Under the 20 point descriptor she would meet both (1) (a) and (b).***

***Example 2: A 20 year old young male has a diagnosed permanent condition of Asperger's Syndrome. The medical evidence outlines that as a result of this condition he has difficulty with self awareness. He also has difficulty controlling his behaviour in routine situations, such as completing the shopping, and willlose his temper occasionallyfor minor reasons such as a shop assistant misunderstanding him. He has difficulties engaging in social routines, often has difficulty with small talk and empathising with others. This young male has undergone an assessment of intellectual functioning and has an above average intelligence. He is particularly skilled in the area of computer programming.***

***This young male would receive an impairment rating of 10 points under Table 7, due to the moderate impact his condition of Asperger's has on his ability to function. Under the 10 point descriptor he would meet both (1) (h) and (j).***

**Impairments that should not be assessed using this Table**

Memory or concentration problems unrelated to a neurological or cognitive condition.

People with an Autism Spectrum Disorder who also have a low IQ are more appropriately assessed under Table 9 – Intellectual Function.

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

## Guidelines to Table 8 – Communication Function

Table 8 is used to assess functional impairment affecting communication functions.

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

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

Table 8 refers to communication in the person's *main language*. This means the language the person most commonly uses. This may be the language they use at home or their first language and should be the language they are most fluent in.

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

### Determining the level of functional impact

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

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

To meet the 10 point descriptor either (1) (a), (b) or (c) must apply. If (a) applies then either (i) or (ii) must apply.

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

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

### Some conditions causing impairment commonly assessed using this Table

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

***Example: A 35 year old woman has a diagnosed permanent condition of cerebral palsy which she has had since birth. The medical evidence states that as a result of this condition her speech is slurred. Sometimes she has difficulty being understood in certain situations so she uses an electronic voice output device at these times.***

***Under Table 8, this woman would receive an impairment rating of 10 points due to the moderate impact this condition has on her communication function.***

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

**Impairments that should not be assessed using this Table**

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

This Table must not be used for people who use recognised sign language or other non-verbal communication as a result of hearing loss only. In these cases, Table 11 – Hearing and Other Functions of the Ear is the most appropriate Table to be used.

If a person's impairment affecting communication function is due to impairment in intellectual function, Table 9 – Intellectual Function must be used as it is the most appropriate in these cases.

## Guidelines to Table 9 – Intellectual Function

Table 9 is used to assess low intellectual function resulting in functional impairment. To use this Table the low intellectual function must have originated before the person turned 18 years of age.

Low intellectual function means the person has an Intelligence Quotient (IQ) score of 70 to 85. For people with an IQ score of less than 70, the manifest eligibility criteria should be applied.

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

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

An assessment of intellectual function is to be undertaken in the form of a Wechsler Adult Intelligence Scale IV (WAIS IV) or equivalent contemporary assessment. This assessment should be conducted after the person turns 16 years of age. A Wechsler Intelligence Scale for Children (WISC) assessment completed between the ages of 12 and 16 years is also acceptable for people aged 18 years or under at the time of assessment.

An assessment of adaptive behaviour is to be undertaken in the form of either the Adaptive Behaviour Assessment System (ABAS-II), the Scales for Independent Behaviour – Revised (SIB-R) or the Vineland Adaptive Behaviour Scales (Vineland-II).

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

- provide robust standardised scores across the three domains of adaptive behaviour (conceptual, social and practical adaptive skills);
- have current norms developed on a representative sample of the general population;
- demonstrate test validity and reliability; and
- provide a percentile ranking.

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

The following table describes how adaptive behaviour tools have been aligned with impairment ratings under Table 9.

| **Points** | **Impact** | **SIB-R Service Level score** | **Vineland-II Standard score** | **ABAS-II General Adaptive Composite Scaled Score** | **Percentile Rank on a current standardised assessment of Adaptive Behaviour** |
|---|---|---|---|---|---|
| 0 | **No impact**<br>Infrequent or no support required | 90-100 | 90-100 | 90-130+ | 24+ |
| 5 | **Mild impact**<br>Intermittent or periodic support and supervision required | 80-89 | 80-89 | 80-89 | 9-23 |
| 10 | **Moderate impact**<br>Limited but consistent support and supervision required | 71-79 | 71-79 | 71-79 | 3-8 |
| 20 | **Severe impact**<br>Frequent or close support and supervision required | 50-70 | 50-70 | 50-70 | 2 |

| | | | | | |
|---|---|---|---|---|---|
| 30 | **Extreme impact**<br>Highly intense and continuous levels of support and supervision required | <50 | <50 | <50 | <2.0 |

**Determining the level of functional impact**

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

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

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

Professional judgement is required regarding the best source of intellectual function and adaptive functioning information as in some instances it will be appropriate to obtain input from a parent, caregiver or teacher.

**Some conditions causing impairment commonly assessed using this Table**

Intellectual impairment resulting from:

- Down Syndrome
- congenital/perinatal or early childhood infections (eg rubella, cytomegalovirus (CMV), bacterial meningitis, encephalitis)
- extreme prematurity or birth trauma
- a person with either Autism Spectrum Disorder, Fragile X or Foetal Alcohol Spectrum Disorder who also has a low IQ
- childhood developmental or congenital disorders

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

***A psychologist has conducted an assessment of adaptive behaviour with him, using the Adaptive Behaviour Assessment System (ABAS-II). He was assessed as having a score of adaptive behaviour of 71.***

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

***Under Table 9, he would receive an impairment rating of 10 points, given the moderate impact his condition has on his ability to function. As his IQ score is above 69, he is not manifestly eligible for DSP.***

**Impairments that should not be assessed using this Table**

Behavioural problems unrelated to intellectual impairment may be assessed using Table 5 – Mental Health Function.

## Guidelines to Table 10 – Digestive and Reproductive Function

Table 10 is used to assess functional impairment related to digestive or reproductive system functions.

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. This includes a general practitioner or medical specialists such as a gastroenterologist, gynaecologist, urologist or oncologist.

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

### Determining the level of functional impact

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

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

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

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

For digestive conditions:

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

For reproductive system conditions:

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

### Some conditions causing impairment commonly assessed using this Table

Digestive conditions may include diseases that affect the mouth, salivary glands, oesophagus, stomach, small or large intestines, pancreas, liver, gall bladder, bile ducts, rectum or anus such as:

- reflux oesophagitis
- refractory peptic ulcer disease
- established chronic liver disease
- chronic symptoms from renal disease
- irritable bowel syndrome
- inflammatory bowel disease (Crohn's disease, Ulcerative Colitis)
- haemorrhoids
- established chronic pancreatic disease, abdominal hernias

Reproductive system conditions may include gynaecological disease and conditions of the male reproductive system such as:

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

***Example 1: A 45 year old man suffers from Crohn's disease. He was diagnosed with this condition several years ago and the medical evidence indicates he has undergone surgery in relation to this condition, due to suffering a blockage of the intestine. His current treatment consists of medication to alleviate the symptoms and sometimes a course of short term steroids during periods of active symptoms.***

***He experiences intermittent periods of aggravation of his symptoms in between periods of remission. A report from his treating specialist outlines that he experiences these periods of active symptoms on an average of once every 4 months. During this time he is unable to attend work due to the severity of active symptoms, for up toa week. During periods of remission he experiences relatively mild symptoms and is able to attend work reliably.***

***During the periods of active symptoms, he experiences symptoms of severe abdominal pain and diarrhoea along with fatigue, nausea and loss of appetite. He often loses weight during these times.***

***Under Table 10, this man would receive an impairment rating of 10 points due to the fact that his attention and concentration are often reduced by the symptoms of his condition and he is often absent from work due to the condition.***

***Example 2: A 25 year old woman has a diagnosis of endometriosis. She has undergone hormone therapy and currently takes medication to alleviate the symptoms. In the past she has undergone a pelvic laparoscopybut her symptoms came back following this operation. Her symptoms include constant chronic pelvic pain which increases in severity once a month with menstruation. During this time she is unable to attend work for about 1 week.The pain is severe and occurs on both sides of the pelvis, radiating to the lower back. Her specialist has recommended she undergo a hysterectomy due to the severity of her symptoms but the woman has chosen not to undertake this form of treatment, due to the fact that she wants to try to have children in the near future. Also, there is still a risk that her symptoms can come back even after undergoing this procedure.***

***Under Table 10, this woman would receive 20 points, due to the fact that her attention and concentration are frequently reduced by her pain symptoms and she is frequently absent from work due to her condition.***

**Impairments that should not be assessed using this Table**

If a person requires continence or ostomy care and has an ileostomy or colostomy they should be assessed under Table 13 – Continence Function.

## Guidelines to Table 11 – Hearing and other Functions of the Ear

Table 11 is used to assess functional impairment when performing activities involving hearing (communication) function or other functions of the ear. Other functions of the ear include balance.

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. There must also be supporting evidence of the diagnosis from an audiologist or an Ear, Nose and Throat (ENT) specialist.

If the person uses a prescribed hearing aid, cochlear implant or other assistive listening device the person must be assessed on their ability to undertake activities listed in this Table while using any device that they have and usually use.

If the person uses recognised sign language or other non-verbal communication method as a result of hearing loss, Table 11 should be used.

### Determining the level of functional impact

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

Under the 5, 10 and 20 point descriptors in order to meet the descriptor a person must satisfy either (1) or (2). To satisfy (1) all of the sub points (a), (b) and (c) must apply to the person. Point (1) relates to hearing function, while point (2) relates to difficulty with balance or ringing in the ears.

To satisfy the 0 or 30 point descriptors, all of the points listed in the descriptor must apply to the person.

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

### Some conditions causing impairment commonly assessed using this Table

- congenital deafness
- presbyacusis
- acoustic neuroma
- side-effects of medication
- Meniere's disease which affects the inner ear
- tinnitus
- neurological conditions which affect hearing function such as Multiple Sclerosis

***Example: A 50 year old male suffers from hearing difficulties due to many years working as a tradesman in the commercial building industry. Supporting evidence confirming his diagnosis has been provided from an audiologist.This man has been fitted with a hearing aid which has significantly improved his hearing. He has been using this hearing aid for the past 5 years and without it, he finds communication more difficult particularly at further distances. The medical evidence states that he uses his hearing aid in most social environments.***

***Without his hearing aid, this man has severe difficulty hearing any conversation or sound. With his hearing aid, he has some difficulty hearing a conversation at an average volume and has difficulty hearing a conversation when using a standard telephone.***

***Under Table 12, this man would be assessed when using his prescribed hearing aid so would receive 5 points under this Table due to the mild functional impact his hearing has on his daily activities.***

**Impairments that should not be assessed using this Table**

Impairment in communication function that is not due to hearing function or other functions of the ear.

## Guidelines to Table 12 – Visual Function

Table 12 is used to assess functional impairment when performing activities involving visual function.

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. There must also be supporting evidence from an ophthalmologist or ophthalmic surgeon.

If the person uses any visual aids, such as spectacles or contact lenses, they must be assessed on their ability to undertake activities listed in this Table while using any aids that they have and usually use.

Where severe or extreme loss of visual function is evident or suspected, it must be recommended to the person that they undergo an assessment by a qualified ophthalmologist to determine whether they meet the criteria for permanent blindness as per section 95 of the *Social Security Act 1991*.

### Determining the level of functional impact

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

For example, to meet the 20 point descriptor a person must meet all the points under (1). Under point (1) (d) they must satisfy either (i) or (ii).

The 30 point descriptor allows for assessment of people who are not considered permanently blind but have an extreme level of vision impairment which impacts their ability to mobilise and perform their daily activities.

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

Consideration should be given to the fact that two people with the same level of vision loss can have different levels of independence and skills. Assumptions must not be made based solely on the clinical level of blindness the person has.

A single impairment rating under this Table should be determined, regardless of whether one or both eyes suffer vision loss.

### Some conditions causing impairment commonly assessed using this Table

- diabetic retinopathy
- glaucoma
- retinitis pigmentosa
- macular degeneration
- cataracts

***Example: A 50 year old woman was diagnosed with glaucoma several years ago. She has undergone surgery for this condition which has slowed down the progression of the disease but medical evidence states that her current symptoms will not improve and will eventually get worse. This woman has lost much of her side vision and has very limited vision to the sides when looking straight ahead. She has difficulty seeing bus route numbers and reading normal sized print. She is not able to drive but does regularly use public transport independently. She sometimes needs to ask someone to inform her of the***

***numbers of approaching buses. She uses special computer software to magnify computer screen displays and read text on screen out loud.***

***Under Table 12, this woman would receive an impairment rating of 10 due to the moderate functional impact her condition has on her ability to function.***

**Impairments that should not be assessed using this Table**

## Guidelines to Table 13 – Continence Function

Table 13 is used to assess functional impairment related to incontinence of the bladder or bowel.

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. This includes a general practitioner or medical specialists such as anurogynaecologist, gynaecologist, urologist or gastroenterologist.

Table 13 should be used if a person has an ileostomy or colostomy and requires continence or ostomy care.

### Determining the level of functional impact

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

Under the 5, 10, 20 and 30 point descriptors, the person must have impairment in either bladder or bowel function (or both) or they must use a continence aid. The points within each descriptor are applied differently within each descriptor.

For example, under the 5 point descriptor at least one of the points (a – f) must apply.

Under the 10 point descriptor, either (2), (3) or (4) must apply. Also, both points under either 'bladder', 'bowel' or 'continence aids' must apply i.e. both (a) and (b).

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

Where the descriptors refer to the person's condition affecting the comfort and attention of co-workers, this can apply even if the person does not work. Consideration should be given to whether the descriptor would be more than likely to apply if the person did work.

If a person has impairment with both bladder and bowel function a single rating must be assigned which best reflects their overall functional impairment.

### Some conditions causing impairment commonly assessed using this Table

- some gynaecological conditions
- prostate enlargement or malignancy
- gastrointestinal conditions
- incontinence resulting from paraplegia
- spina bifida
- neurodegenerative conditions
- severe intellectual disability

***Example: A 48 year old woman suffers from bladder incontinence which she developed following the births of her four children. She has undergone numerous treatments for this condition which assisted in improving her symptoms, including pelvic floor muscle retraining, behavioural changes and medication, and her specialist urologist has indicated that this condition is now fully treated and stabilised. She continues to experience symptoms including involuntary loss of continence when coughing, sneezing and engaging in physical activity. She has to wear a continence pad on a regular basis and suffers minor leakage several times a day. She has to stop what she is doing regularly through the day to change her continence pad.***

***Under Table 13, this woman would receive an impairment rating of 10 points due to the moderate impact this condition has on her ability to function.***

**Impairments that should not be assessed using this Table**

Conditions that relate to digestive function which do not result in continence difficulties must be rated on Table 10 – Digestive and Reproductive Function.

## Guidelines to Table 14 – Functions of the Skin

Table 14 is used to assess functional impairment related to disorders of, or injury to, the skin.

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. This includes a general practitioner or medical specialists such as a dermatologist or burns specialist.

### Determining the level of functional impact

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

For example, the 10 point descriptor states that at least one of the following applies while the 20 point descriptor states that at least two of the following apply.

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

An activity listed under a descriptor is not taken to have been performed if it can only be done once or rarely.

Each of the descriptors must be considered in relation to the adaptations to daily activities that the person has to make as a result of their condition.

The descriptors give an example of allodynia as a condition that causes nerve pain. Allodynia is pain, generally on the skin, which is caused by something that would not normally cause pain, such as wearing clothing. Depending on severity, this condition may affect a person's ability to wear appropriate clothing likely to be required in a workplace.

### Some conditions causing impairment commonly assessed using this Table

- burns
- severe eczema, psoriasis or dermatitis
- allodynia
- severe cellulitis
- necrotising fasciitis

***Example: A 35 year old male suffered third-degree burns to his upper body as a result of a car accident 5 years ago. He underwent major skin graft surgery following the accident and continues to have impairment as a result, when performing his daily activities. The medical evidence states that the resulting scarring affects his ability to move both his arms and upper body. It also affects his ability to carry out fine motor skills using either of his hands. He needs assistance with daily activities including getting dressed, taking care of his personal hygiene and cooking and cleaning for himself. He has a carer who attends his home once a day to assist him with these tasks. He also has difficulty undertaking work tasks such as using a computer keyboard and uses assistive technology which converts his speech to text.***

***Under Table 14, this man would receive an impairment rating of 20 points due to the significant modifications he has to make to his daily activities and the severe impact this condition has on performing activities using his hands and upper body.***

**Impairments that should not be assessed using this Table**

## Guidelines to Table 15 – Functions of Consciousness

Table 15 is used to assess functional impairment due to involuntary loss of consciousness or altered state of consciousness.

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

### Determining the level of functional impact

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

Under the 5, 10, 20 and 30 point descriptors, the person must have either episodes of involuntary loss of consciousness or altered state of consciousness. Under the 20 point descriptor either (1) (a) (i) or (ii) must apply and the corresponding (A) and (B) points must also both apply. The person must also meet (b), (c) and (d).

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

Altered state of consciousness includes instances where a person may not lose consciousness completely and may remain sitting or standing but becomes unaware of their surroundings or actions.

### Some conditions causing impairment commonly assessed using this Table

- epilepsy
- some forms of migraine
- diabetes mellitus
- transient ischaemic attacks

***Example: A 27 year old woman has been diagnosed with epilepsy. She has undergone treatment for this condition and her treating practitioner has outlined that her condition is now stabilised. She continues to experience seizures as a result of this condition, during which she loses consciousness. These seizures occur roughly 6 times per year. Following a seizure she suffers extreme tiredness and headaches and is often unable to undertake her usual activities for a few days. Between these seizures she is able to perform her regular daily activities but she is unable to obtain a driver's licence given the unpredictability of these seizures. She works part-time as a result of this condition and her employer makes allowances for her work absences when she has suffered a seizure. She is unable to work in a role where she could be at increased risk if she had a seizure, such as using machinery.***

***Under Table 15, this woman would receive an impairment rating of 10 points given the moderate impact this condition has on her ability to function.***

### Impairments that should not be assessed using this Table