NSW GOVERNMENT | State Insurance Regulatory Authority

NSW workers compensation guidelines for the evaluation of permanent impairment

Fourth edition – 1 April 2016

Foreword

The State Insurance Regulatory Authority has issued the 4th edition of the *NSW workers compensation guidelines for the evaluation of permanent impairment* (catalogue no. WC00970) (the Guidelines) for assessing the degree of permanent impairment arising from an injury or disease within the context of workers' compensation. When a person sustains a permanent impairment, trained medical assessors must use the Guidelines to ensure an objective, fair and consistent method of evaluating the degree of permanent impairment.

The Guidelines are based on a template that was developed through a national process facilitated by Safe Work Australia. They were initially developed for use in the NSW system and incorporate numerous improvements identified by the then WorkCover NSW Whole Person Impairment Coordinating Committee over 13 years of continuous use. Members of this committee and of the South Australia Permanent Impairment Committee (see list in Appendix 2) dedicated many hours to thoughtfully reviewing and improving the Guidelines. This work is acknowledged and greatly appreciated.

The methodology in the Guidelines is largely based on the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 5th Edition (AMA5). The AMA guides are the most authoritative and widely used in evaluating permanent impairment around the world. Australian medical specialists representing Australian medical associations and colleges have extensively reviewed AMA5 to ensure it aligns with clinical practice in Australia.

The Guidelines consist of an introductory chapter followed by chapters dedicated to each body system.

The Introduction is divided into three parts. The first outlines the background and development of the Guidelines, including reference to the relevant legislative instrument that gives effect to the Guidelines. The second covers general assessment principles for medical practitioners applying the Guidelines in assessing permanent impairment resulting from work-related injury or disease. The third addresses administrative issues relating to the use of the Guidelines.

As the template national guideline has been progressively adapted from the NSW Guideline and is to be adopted by other jurisdictions, some aspects have been necessarily modified and generalised. Some provisions may differ between different jurisdictions. For further information, please see the *Comparison of Workers' Compensation Arrangements in Australia and New Zealand report*, which is available on Safe Work Australia's website at safeworkaustralia.gov.au.

Publications such as this only remain useful to the extent that they meet the needs of users and those who sustain a permanent impairment. It is, therefore, important that the protocols set out in the Guidelines are applied consistently and methodically. Any difficulties or anomalies need to be addressed through modification of the publication and not by idiosyncratic reinterpretation of any part. All queries on the Guidelines or suggestions for improvement should be addressed to the State Insurance Regulatory Authority at contact@workcover.nsw.gov.au.

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1. Introduction

PART 1 – INTENT AND LEGISLATIVE BASIS FOR THESE GUIDELINES

1.1 For the purposes of the WorkCover Authority of NSW*, the 4th edition of the *NSW workers compensation guidelines for the evaluation of permanent impairment* (catalogue no. WC00970) (the Guidelines) are made under s376 of the *Workplace Injury Management and Workers Compensation Act 1998* (WIMWC Act). The Guidelines are to be used within the NSW workers compensation system to evaluate permanent impairment arising from work-related injuries and diseases.

The Guidelines adopt the 5th edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (AMA5) in most cases. Where there is any deviation, the difference is defined in the Guidelines and the procedures detailed in each section are to prevail.

Date of effect

1.2 The Guidelines replace the *WorkCover Guides for the evaluation of permanent impairment*, 3rd edition, which was issued in February 2009, and apply to assessments of permanent impairment conducted on or after 1 April 2016.

When conducting a permanent impairment assessment in accordance with the Guidelines, assessors are required to use the version current at the time of the assessment.

Development of the Guidelines

1.3 The Guidelines are based on a template that was developed through a national process facilitated by Safe Work Australia. The template national guideline is based on similar guidelines developed and used extensively in the NSW workers compensation system. Consequently, provisions in the Guidelines are the result of extensive and in-depth deliberations by groups of medical specialists convened to review AMA5 in the Australian workers compensation context. In NSW it is a requirement under s377(2) of the WIMWC Act that the guidelines are developed in consultation with relevant medical colleges. The groups that contributed to the development of the Guidelines is acknowledged and recorded at Appendix 2. The template national guideline has been adopted for use in multiple Australian jurisdictions.

1.4 Use of the Guidelines is monitored by the jurisdictions that have adopted it. The Guidelines may be reviewed if significant anomalies or insurmountable difficulties in their use become apparent.

1.5 The Guidelines are intended to assist a suitably qualified and experienced medical practitioner in assessing a claimant's degree of permanent impairment.

PART 2 – PRINCIPLES OF ASSESSMENT

1.6 The following is a basic summary of some key principles of permanent impairment assessments:

a. Assessing permanent impairment involves clinical assessment of the claimant as they present on the day of assessment taking account the claimant's relevant medical history and all available relevant medical information to determine:

- whether the condition has reached Maximum Medical Improvement (MMI)
- whether the claimant's compensable injury/condition has resulted in an impairment
- whether the resultant impairment is permanent
- the degree of permanent impairment that results from the injury
- the proportion of permanent impairment due to any previous injury, pre-existing condition or abnormality, if any, in accordance with diagnostic and other objective criteria as outlined in these Guidelines.

* As of 1 September 2015, the workers compensation insurance regulatory functions of WorkCover NSW have been assumed by the State Insurance Regulatory Authority.

b. Assessors are required to exercise their clinical judgement in determining a diagnosis when assessing permanent impairment and making deductions for pre-existing injuries/conditions.

c. In calculating the final level of impairment, the assessor needs to clarify the degree of impairment that results from the compensable injury/condition. Any deductions for pre-existing injuries/conditions are to be clearly identified in the report and calculated. If, in an unusual situation, a related injury/condition has not previously been identified, an assessor should record the nature of any previously unidentified injury/condition in their report and specify the causal connection to the relevant compensable injury or medical condition.

d. The referral for an assessment of permanent impairment is to make clear to the assessor the injury or medical condition for which an assessment is sought – see also paragraphs 1.43 and 1.44 in the Guidelines.

1.7 Medical assessors are expected to be familiar with chapters 1 and 2 of AMA5, in addition to the information in this introduction.

1.8 The degree of permanent impairment that results from the injury/condition must be determined using the tables, graphs and methodology given in the Guidelines and the AMA5, where appropriate.

1.9 The Guidelines may specify more than one method that assessors can use to establish the degree of a claimant's permanent impairment. In that case, assessors should use the method that yields the highest degree of permanent impairment. (This does not apply to gait derangement – see paragraphs 3.5 and 3.10 in the Guidelines).

Body systems covered by the Guidelines

1.10 AMA5 is used for most body systems, with the exception of psychiatric and psychological disorders, chronic pain, and visual and hearing injuries.

1.11 AMA5 Chapter 14, on mental and behavioural disorders, has been omitted. The Guidelines contain a substitute chapter on the assessment of psychiatric and psychological disorders (Chapter 11) which was written by a group of Australian psychiatrists.

1.12 AMA5 Chapter 18, on pain, is excluded entirely at the present time. Conditions associated with chronic pain should be assessed on the basis of the underlying diagnosed condition, and not on the basis of the chronic pain. Where pain is commonly associated with a condition, an allowance is made in the degree of impairment assigned in the Guidelines. Complex regional pain syndrome should be assessed in accordance with Chapter 17 of the Guidelines.

1.13 On the advice of medical specialists (ophthalmologists), assessments of visual injuries are conducted according to the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th Edition (AMA4).

1.14 The methodology for evaluating permanent impairment due to hearing loss is in Chapter 9 of the Guidelines, with some reference to AMA5 Chapter 11 (pp 245–251) and also the tables in the National Acoustic Laboratories (NAL) Report No. 118, *Improved Procedure for Determining Percentage Loss of Hearing*, January 1988.

Maximum medical improvement

1.15 Assessments are only to be conducted when the medical assessor considers that the degree of permanent impairment of the claimant is unlikely to improve further and has attained maximum medical improvement. This is considered to occur when the worker's condition is well stabilised and is unlikely to change substantially in the next year with or without medical treatment.

1.16 If the medical assessor considers that the claimant's treatment has been inadequate and maximum medical improvement has not been achieved, the assessment should be deferred and comment made on the value of additional or different treatment and/or rehabilitation – subject to paragraph 1.34 in the Guidelines.

Multiple impairments

1.17 Impairments arising from the same injury are to be assessed together. Impairments resulting from more than one injury arising out of the same incident are to be assessed together to calculate the degree of permanent impairment of the claimant.

1.18 The Combined Values Chart in AMA5 (pp 604–06) is used to derive a percentage of whole person impairment (WPI) that arises from multiple impairments. An explanation of the chart's use is found on pp 9–10 of AMA5. When combining more than two impairments, the assessor should commence with the highest impairment and combine with the next highest and so on.

1.19 The exception to this rule is in the case of psychiatric or psychological injuries. Where applicable, impairments arising from primary psychological and psychiatric injuries are to be assessed separately from the degree of impairment that results from any physical injuries arising out of the same incident. The results of the two assessments cannot be combined.

1.20 In the case of a complex injury, where different medical assessors are required to assess different body systems, a 'lead assessor' should be nominated to coordinate and calculate the final degree of permanent impairment as a percentage of WPI resulting from the individual assessments.

Psychiatric and psychological injuries

1.21 Psychiatric and psychological injuries in the NSW workers compensation system are defined as primary psychological and psychiatric injuries in which work was found to be a substantial contributing factor.

1.22 A primary psychiatric condition is distinguished from a secondary psychiatric or psychological condition, which arises as a consequence of, or secondary to, another work related condition (eg depression associated with a back injury). No permanent impairment assessment is to be made of secondary psychiatric and psychological impairments. As referenced in paragraph 1.19, impairments arising from primary psychological and psychiatric injuries are to be assessed separately from the degree of impairment that results from physical injuries arising out of the same incident. The results of the two assessments cannot be combined.

Conditions that are not covered in the Guidelines – equivalent or analogous conditions

1.23 AMA5 (p 11) states: 'Given the range, evolution and discovery of new medical conditions, these Guidelines cannot provide an impairment rating for all impairments... In situations where impairment ratings are not provided, these Guidelines suggest that medical practitioners use clinical judgment, comparing measurable impairment resulting from the unlisted condition to measurable impairment resulting from similar conditions with similar impairment of function in performing activities of daily living.' The assessor must stay within the body part/region when using analogy.

'The assessor's judgment, based upon experience, training, skill, thoroughness in clinical evaluation, and ability to apply the Guidelines criteria as intended, will enable an appropriate and reproducible assessment to be made of clinical impairment.'

Activities of daily living

1.24 Many tables in AMA5 (eg in the spine section) give class values for particular impairments, with a range of possible impairment values in each class. Commonly, the tables require the assessor to consider the impact of the injury or illness on activities of daily living (ADL) in determining the precise impairment value. The ADL which should be considered, if relevant, are listed in AMA5 Table 1–2 (p 4). The impact of the injury on ADL is not considered in assessments of the upper or lower extremities.

1.25 The assessment of the impact of the injury or condition on ADL should be verified, wherever possible, by reference to objective assessments – for example, physiotherapist or occupational therapist functional assessments and other medical reports.

Rounding

1.26 Occasionally the methods of the Guidelines will result in an impairment value which is not a whole number (eg an assessment of peripheral nerve impairment in the upper extremity). All such values must be rounded to the nearest whole number before moving from one degree of impairment to the next (eg from finger impairment to hand impairment, or from hand impairment to upper extremity impairment) or from a regional impairment to a WPI. Figures should also be rounded before using the combination tables. This will ensure that the final WPI will always be a whole number. The usual mathematical convention is followed where rounding occurs – values less than 0.5 are rounded down to the nearest whole number and values of 0.5 and above are rounded up to the next whole number. The method of calculating levels of binaural hearing loss is shown in Chapter 9, paragraph 9.15, in the Guidelines.

Deductions for pre-existing condition or injuries

1.27 The degree of permanent impairment resulting from pre-existing impairments should not be included in the final calculation of permanent impairment if those impairments are not related to the compensable injury. The assessor needs to take account of all available evidence to calculate the degree of permanent impairment that pre-existed the injury.

1.28 In assessing the degree of permanent impairment resulting from the compensable injury/condition, the assessor is to indicate the degree of impairment due to any previous injury, pre-existing condition or abnormality. This proportion is known as 'the deductible proportion' and should be deducted from the degree of permanent impairment determined by the assessor. For the injury being assessed, the deduction is 1/10th of the assessed impairment, unless that is at odds with the available evidence.

Adjustment for the effects of orthoses and prostheses

1.29 Assessments of permanent impairment are to be conducted without assistive devices, except where these cannot be removed. The assessor will need to make an estimate as to what is the degree of impairment without such a device, if it cannot be removed for examination purposes. Further details may be obtained in the relevant chapters of the Guidelines.

1.30 Impairment of vision should be measured with the claimant wearing their prescribed corrective spectacles and/or contact lenses, if this was usual for them before the injury. If, as a result of the injury, the claimant has been prescribed corrective spectacles and/or contact lenses for the first time, or different spectacles and/or contact lenses than those prescribed pre-injury, the difference should be accounted for in the assessment of permanent impairment.

Adjustment for the effects of treatment

1.31 In circumstances where the treatment of a condition leads to a further, secondary impairment, other than a secondary psychological impairment, the assessor should use the appropriate parts of the Guidelines to evaluate the effects of treatment, and use the Combined Values Chart (AMA5, pp 604–06) to arrive at a final percentage of WPI.

1.32 Where the effective long-term treatment of an illness or injury results in apparent substantial or total elimination of the claimant's permanent impairment, but the claimant is likely to revert to the original degree of impairment if treatment is withdrawn, the assessor may increase the percentage of WPI by 1%, 2% or 3%. This percentage should be combined with any other impairment percentage, using the Combined Values Chart. This paragraph does not apply to the use of analgesics or anti-inflammatory medication for pain relief.

1.33 Where a claimant has declined treatment which the assessor believes would be beneficial, the impairment rating should be neither increased nor decreased – see paragraph 1.35 for further details.

Refusal of treatment

1.34 If the claimant has been offered, but has refused, additional or alternative medical treatment that the assessor considers likely to improve the claimant's condition, the medical assessor should evaluate the current condition without consideration of potential changes associated with the proposed treatment. The assessor may note the potential for improvement in the claimant's condition in the evaluation report, and the reasons for refusal by the claimant, but should not adjust the level of impairment on the basis of the claimant's decision.

Future deterioration of a condition

1.35 Similarly, if a medical assessor forms the opinion that the claimant's condition is stable for the next year, but that it may deteriorate in the long term, the assessor should make no allowance for this deterioration.

Inconsistent presentation

1.36 AMA5 (p 19) states: 'Consistency tests are designed to ensure reproducibility and greater accuracy. These measurements, such as one that checks the individual's range of motion are good but imperfect indicators of people's efforts. The assessor must use their entire range of clinical skill and judgment when assessing whether or not the measurements or test results are plausible and consistent with the impairment being evaluated. If, in spite of an observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the assessor may modify the impairment rating accordingly and then describe and explain the reason for the modification in writing.' This paragraph applies to inconsistent presentation only.

Ordering of additional investigations

1.37 As a general principle, the assessor should not order additional radiographic or other investigations purely for the purpose of conducting an assessment of permanent impairment.

1.38 However, if the investigations previously undertaken are not as required by the Guidelines, or are inadequate for a proper assessment to be made, the medical assessor should consider the value of proceeding with the evaluation of permanent impairment without adequate investigations.

1.39 In circumstances where the assessor considers that further investigation is essential for a comprehensive evaluation to be undertaken, and deferral of the evaluation would considerably inconvenience the claimant (eg when the claimant has travelled from a country region specifically for the assessment), the assessor may proceed to order the appropriate investigations provided that there is no undue risk to the claimant. The approval of the referring body for the additional investigation will be required to ensure that the costs of the test are met promptly.

PART 3 – ADMINISTRATIVE PROCESS

Medical assessors

1.40 An assessor will be a registered medical practitioner recognised as a medical specialist.

- 'Medical practitioner' means a person registered in the medical profession under the *Health Practitioner Regulation National Law (NSW)* No. 86a, or equivalent Health Practitioner Regulation National Law in their jurisdiction with the Australian Health Practitioner Regulation Agency.
- 'Medical specialist' means a medical practitioner recognised as a specialist in accordance with the *Health Insurance Regulations 1975*, Schedule 4, Part 1, who is remunerated at specialist rates under Medicare.

The assessor will have qualifications, training and experience relevant to the body system being assessed. The assessor will have successfully completed requisite training in using the Guidelines for each body system they intend on assessing. They will be listed as a trained assessor of permanent impairment for each relevant body system(s) on the State Insurance Regulatory Authority website at sira.nsw.gov.au.

1.41 An assessor may be one of the claimant's treating practitioners or an assessor engaged to conduct an assessment for the purposes of determining the degree of permanent impairment.

Information required for assessments

1.42 Information for claimants regarding independent medical examinations and assessments of permanent impairment should be supplied by the referring body when advising of the appointment details.

1.43 On referral, the medical assessor should be provided with all relevant medical and allied health information, including results of all clinical investigations related to the injury/condition in question.

1.44 Most importantly, assessors must have available to them all information about the onset, subsequent treatment, relevant diagnostic tests, and functional assessments of the person claiming a permanent impairment. The absence of required information could result in an assessment being discontinued or deferred. AMA5 Chapter 1, Section 1.5 (p 10) applies to the conduct of assessments and expands on this concept.

1.45 The Guidelines and AMA5 indicate the information and investigations required to arrive at a diagnosis and to measure permanent impairment. Assessors must apply the approach outlined in the Guidelines.

Referrers must consult this publication to gain an understanding of the information that should be provided to the assessor in order to conduct a comprehensive evaluation of impairment.

Reports

1.46 A report of the evaluation of permanent impairment should be accurate, comprehensive and fair. It should clearly address the question(s) being asked of the assessor. In general, the assessor will be requested to address issues of:

- current clinical status, including the basis for determining maximum medical improvement
- the degree of permanent impairment that results from the injury/condition, and
- the proportion of permanent impairment due to any previous injury, pre-existing condition or abnormality, if applicable.

1.47 The report should contain factual information based on all available medical information and results of investigations, the assessor's own history-taking and clinical examination. The other reports or investigations that are relied upon in arriving at an opinion should be appropriately referenced in the assessor's report.

1.48 As the Guidelines are to be used to assess permanent impairment, the report of the evaluation should provide a rationale consistent with the methodology and content of the Guidelines. It should include a comparison of the key findings of the evaluation with the impairment criteria in the Guidelines. If the evaluation was conducted in the absence of any pertinent data or information, the assessor should indicate how the impairment rating was determined with limited data.

1.49 The assessed degree of impairment is to be expressed as a percentage of WPI.

1.50 The report should include a conclusion of the assessor, including the final percentage of WPI. This is to be included as the final paragraph in the body of the report, and not as a separate report or appendix. The report must include a copy of all calculations and a summary table. A template reporting format is provided in the *WorkCover Guidelines on independent medical examinations and reports* at sira.nsw.gov.au.

1.51 Reports are to be provided within 10 working days of the assessment being completed, or as agreed between the referrer and the assessor.

Quality assurance

1.52 The degree of permanent impairment that results from the injury must be determined using the tables, graphs and methodology given in the Guidelines, as presented in the training in the use of the Guidelines and the applicable legislation. If it is not clear that a report has been completed in accordance with the Guidelines, clarification may be sought from the assessor who prepared the report.

1.53 An assessor who is identified as frequently providing reports that are not in accord with the Guidelines, or not complying with other service standards as set by the State Insurance Regulatory Authority, may be subject to State Insurance Regulatory Authority performance monitoring procedures and be asked to show cause as to why their name should not be removed from the list of trained assessors on the State Insurance Regulatory Authority website.

Code of conduct

1.54 Assessors are referred to the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia, 8.7 Medico-legal, insurance and other assessments*.

1.55 Assessors are reminded that they have an obligation to act in an ethical, professional and considerate manner when examining a claimant for the determination of permanent impairment.

1.56 Effective communication is vital to ensure that the claimant is well informed and able to maximally cooperate in the process. Assessors should:

- ensure that the claimant understands who the assessor is and the assessor's role in the evaluation
- ensure that the claimant understands how the evaluation will proceed
- take reasonable steps to preserve the privacy and modesty of the claimant during the evaluation
- not provide any opinion to the claimant about their claim.

1.57 Complaints received in relation to the behaviour of an assessor during an evaluation will be managed in accordance with the process outlined in the *WorkCover Guidelines on independent medical examinations and reports* at sira.nsw.gov.au and State Insurance Regulatory Authority performance monitoring procedures.

Disputes over the assessed degree of permanent impairment

1.58 Where there is a discrepancy or inconsistency between medical reports that cannot be resolved between the parties, the Workers Compensation Commission has the jurisdiction to determine disputes about assessed degree of permanent impairment.

2. Psychiatric and psychological disorders

AMA5 Chapter 14 is excluded and replaced by this chapter. Before undertaking an impairment assessment, users of the Guidelines must be familiar with (in this order):

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

The Guidelines replace the psychiatric and psychological chapter in AMA5.

Introduction

2.1 This chapter lays out the method for assessing psychiatric impairment. The evaluation of impairment requires a medical examination.

2.2 Evaluation of psychiatric impairment is conducted by a psychiatrist who has undergone appropriate training in this assessment method.

2.3 Permanent impairment assessments for psychiatric and psychological disorders are only required where the primary injury is a psychological one. The psychiatrist needs to confirm that the psychiatric diagnosis is the injured worker's primary diagnosis.

Diagnosis

2.4 The impairment rating must be based upon a psychiatric diagnosis (according to a recognised diagnostic system) and the report must specify the diagnostic criteria upon which the diagnosis is based. Impairment arising from any of the somatoform disorders (DSM IV TR, pp 485–511) are excluded from this chapter.

2.5 If pain is present as the result of an organic impairment, it should be assessed as part of the organic condition under the relevant table. This does not constitute part of the assessment of impairment relating to the psychiatric condition. The impairment ratings in the body organ system chapters in AMA5 make allowance for any accompanying pain.

2.6 It is expected that the psychiatrist will provide a rationale for the rating based on the injured worker's psychiatric symptoms. The diagnosis is among the factors to be considered in assessing the severity and possible duration of the impairment, but is not the sole criterion to be used. Clinical assessment of the person may include information from the injured worker's own description of his or her functioning and limitations, and from family members and others who may have knowledge of the person. Medical reports, feedback from treating professionals and the results of standardised tests – including appropriate psychometric testing performed by a qualified clinical psychologist and work evaluations – may provide useful information to assist with the assessment. Evaluation of impairment will need to take into account variations in the level of functioning over time. Percentage impairment refers to whole person impairment (WPI).

Permanent impairment

2.7 A psychiatric disorder is permanent if, in your clinical opinion, it is likely to continue indefinitely. Regard should be given to:

- the duration of impairment
- the likelihood of improvement in the injured worker's condition
- whether the injured worker has undertaken reasonable rehabilitative treatment
- any other relevant matters.

Effects of treatment

2.8 Consider the effects of medication, treatment and rehabilitation to date. Is the condition stable? Is treatment likely to change? Are symptoms likely to improve? If the injured worker declines treatment, this should not affect the estimate of permanent impairment. The psychiatrist may make a comment in the report about the likely effect of treatment or the reasons for refusal of treatment.

Co-morbidity

2.9 Consider comorbid features (eg bi-polar disorder, personality disorder, substance abuse) and determine whether they are directly linked to the work-related injury, or whether they were pre-existing or unrelated conditions.

Pre-existing impairment

2.10 To measure the impairment caused by a work-related injury or incident, the psychiatrist must measure the proportion of WPI due to a pre-existing condition. Pre-existing impairment is calculated using the same method for calculating current impairment level. The assessing psychiatrist uses all available information to rate the injured worker's pre-injury level of functioning in each of the areas of function. The percentage impairment is calculated using the aggregate score and median class score using the conversion table below. The injured worker's current level of WPI% is then assessed, and the pre-existing WPI% is subtracted from their current level, to obtain the percentage of permanent impairment directly attributable to the work-related injury. If the percentage of pre-existing impairment cannot be assessed, the deduction is 1/10th of the assessed WPI.

Psychiatric impairment rating scale (PIRS)

2.11 Behavioural consequences of psychiatric disorder are assessed on six scales, each of which evaluates an area of functional impairment:

1. Self care and personal hygiene (Table 11.1)
2. Social and recreational activities (Table 11.2)
3. Travel (Table 11.3)
4. Social functioning (relationships) (Table 11.4)
5. Concentration, persistence and pace (Table 11.5)
6. Employability (Table 11.6).

} Activities of daily living (items 2–4)

2.12 Impairment in each area is rated using class descriptors. Classes range from 1 to 5, in accordance with severity. The standard form must be used when scoring the PIRS. The examples of activities are examples only. The assessing psychiatrist should take account of the person's cultural background. Consider activities that are usual for the person's age, sex and cultural norms.

Table 11.1: Psychiatric impairment rating scale – self care and personal hygiene

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population
Class 2	Mild impairment: able to live independently; looks after self adequately, although may look unkempt occasionally; sometimes misses a meal or relies on take-away food.
Class 3	Moderate impairment: Can't live independently without regular support. Needs prompting to shower daily and wear clean clothes. Does not prepare own meals, frequently misses meals. Family member or community nurse visits (or should visit) 2–3 times per week to ensure minimum level of hygiene and nutrition.
Class 4	Severe impairment: Needs supervised residential care. If unsupervised, may accidentally or purposefully hurt self.
Class 5	Totally impaired: Needs assistance with basic functions, such as feeding and toileting.

Table 11.2: Psychiatric impairment rating scale – social and recreational activities

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: regularly participates in social activities that are age, sex and culturally appropriate. May belong to clubs or associations and is actively involved with these.
Class 2	Mild impairment: occasionally goes out to such events eg without needing a support person, but does not become actively involved (eg dancing, cheering favourite team).
Class 3	Moderate impairment: rarely goes out to such events, and mostly when prompted by family or close friend. Will not go out without a support person. Not actively involved, remains quiet and withdrawn.
Class 4	Severe impairment: never leaves place of residence. Tolerates the company of family member or close friend, but will go to a different room or garden when others come to visit family or flat mate.
Class 5	Totally impaired: Cannot tolerate living with anybody, extremely uncomfortable when visited by close family member.

Table 11.3: Psychiatric impairment rating scale – travel

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: Can travel to new environments without supervision.
Class 2	Mild impairment: can travel without support person, but only in a familiar area such as local shops, visiting a neighbour.
Class 3	Moderate impairment: cannot travel away from own residence without support person. Problems may be due to excessive anxiety or cognitive impairment.
Class 4	Severe impairment: finds it extremely uncomfortable to leave own residence even with trusted person.
Class 5	Totally impaired: may require two or more persons to supervise when travelling.

Table 11.4: Psychiatric impairment rating scale – social functioning

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: No difficulty in forming and sustaining relationships (eg a partner, close friendships lasting years).
Class 2	Mild impairment: existing relationships strained. Tension and arguments with partner or close family member, loss of some friendships.
Class 3	Moderate impairment: previously established relationships severely strained, evidenced by periods of separation or domestic violence. Spouse, relatives or community services looking after children.
Class 4	Severe impairment: unable to form or sustain long term relationships. Pre-existing relationships ended (eg lost partner, close friends). Unable to care for dependants (eg own children, elderly parent).
Class 5	Totally impaired: unable to function within society. Living away from populated areas, actively avoiding social contact.

Table 11.5: Psychiatric impairment rating scale – concentration, persistence and pace

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population. Able to pass a TAFE or university course within normal time frame.
Class 2	Mild impairment: can undertake a basic retraining course, or a standard course at a slower pace. Can focus on intellectually demanding tasks for periods of up to 30 minutes, then feels fatigued or develops headache.
Class 3	Moderate impairment: unable to read more than newspaper articles. Finds it difficult to follow complex instructions (eg operating manuals, building plans), make significant repairs to motor vehicle, type long documents, follow a pattern for making clothes, tapestry or knitting.
Class 4	Severe impairment: can only read a few lines before losing concentration. Difficulties following simple instructions. Concentration deficits obvious even during brief conversation. Unable to live alone, or needs regular assistance from relatives or community services.
Class 5	Totally impaired: needs constant supervision and assistance within institutional setting.

Table 11.6: Psychiatric impairment rating scale – employability

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population. Able to work full time. Duties and performance are consistent with the injured worker's education and training. The person is able to cope with the normal demands of the job.
Class 2	Mild impairment. Able to work full time but in a different environment from that of the pre-injury job. The duties require comparable skill and intellect as those of the pre-injury job. Can work in the same position, but no more than 20 hours per week (eg no longer happy to work with specific persons, or work in a specific location due to travel required).
Class 3	Moderate impairment: cannot work at all in same position. Can perform less than 20 hours per week in a different position, which requires less skill or is qualitatively different (eg less stressful).
Class 4	Severe impairment: cannot work more than one or two days at a time, less than 20 hours per fortnight. Pace is reduced, attendance is erratic.
Class 5	Totally impaired: Cannot work at all.

Using the PIRS to measure impairment

2.13 Rating psychiatric impairment using the PIRS is a two-step procedure:

1. Determine the median class score.
2. Calculate the aggregate score.

Determining the median class score

2.14 Each area of function described in the PIRS is given an impairment rating which ranges from Class 1 to 5. The six scores are arranged in ascending order, using the standard form. The median is then calculated by averaging the two middle scores eg:

Example A: 1, 2, 3, 3, 4, 5 Median Class = 3

Example B: 1, 2, 2, 3, 3, 4 Median Class = 2.5 = 3*

Example C: 1, 2, 3, 5, 5, 5 Median Class = 4

*If a score falls between two classes, it is rounded up to the next class. A median class score of 2.5 thus becomes 3.

2.15 The median class score method was chosen as it is not influenced by extremes. Each area of function is assessed separately. While impairment in one area is neither equivalent nor interchangeable with impairment in other areas, the median seems the fairest way to translate different impairments onto a linear scale.

Median class score and percentage impairment

2.16 Each median class score represents a range of impairment, as shown below:

Class 1 = 0–3%

Class 2 = 4–10%

Class 3 = 11–30%

Class 4 = 31–60%

Class 5 = 61–100%

Calculation of the aggregate score

2.17 The aggregate score is used to determine an exact percentage of impairment within a particular median class range. The six class scores are added to give the aggregate score.

Use of the conversion table to arrive at percentage impairment

2.18 The aggregate score is converted to a percentage score using the conversion Table 11.7, below.

2.19 The conversion table was developed to calculate the percentage impairment based on the aggregate and median scores.

2.20 The scores within the conversion table are spread in such a way to ensure that the final percentage rating is consistent with the measurement of permanent impairment percentages for other body systems.

Table 11.7: Conversion table

% Impairment	Aggregate score																								
	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Class 1	0	0	1	1	2	2	2	3	3																
Class 2				4	5	5	6	7	7	8	9	9	10												
Class 3								11	13	15	17	19	22	24	26	28	30								
Class 4												31	34	37	41	44	47	50	54	57	60				
Class 5																66	65	70	74	78	83	87	91	96	100

Conversion table — explanatory notes

a. Distribution of aggregate scores

- The lowest aggregate score that can be obtained is: 1+1+1+1+1+1=6.
- The highest aggregate score is 5+5+5+5+5+5= 30.
- The table therefore has aggregate scores ranging from six to 30.
- Each median class score has an impairment range, and a range of possible aggregate scores (eg class 3 = 11-30 percent).
- The lowest aggregate score for class 3 is 13 (1 + 1 + 2 + 3 + 3 + 3 = 13).
- The highest aggregate score for class 3 is 22 (3 + 3 + 3 + 3 + 5 + 5 = 22).
- The conversion table distributes the impairment percentages across aggregate scores.

b. Same aggregate score in different classes

- The conversion table shows that the same aggregate score leads to different percentages of impairment in different median classes.
- For example, an aggregate score of 18 is equivalent to an impairment rating of
  - 10% in Class 2,
  - 22% in Class 3,
  - 34% in Class 4.
- This is due to the fact that an injured worker whose impairment is in median class 2 is likely to have a lower score across most areas of function. They may be significantly impaired in one aspect of their life, such as travel, yet have low impairment in social function, self-care or concentration.
- Someone whose impairment reaches median class 4 will experience significant impairment across most aspects of his or her life.

Examples: (Using the previous cases)

Example A

PIRS scores							Median class
1	2	3	3	4	5		= 3

Aggregate score						Total	% Impairment
1 +	2 +	3 +	3 +	4 +	5 =	18	22%

Example B

PIRS scores							Median class
1	2	2	3	3	4		= 3

Aggregate score						Total	% Impairment
1 +	2 +	2 +	3 +	3 +	4 =	15	15%

Example C

PIRS scores							Median class
1	2	3	5	5	5		= 4

Aggregate score						Total	% Impairment
1 +	2 +	3 +	5 +	5 +	5 =	21	44%

Table 11.8: PIRS rating form

Name		Claim reference number	
Date of birth		Age at time of injury	
Date of injury		Occupation before injury	
Date of assessment		Marital status before injury	

Psychiatric diagnoses	1.	2.
	3.	4.
Psychiatric treatment		
Is impairment permanent?	☐ Yes ☐ No (Tick one)	

PIRS category	Class	Reason for decision
Self care and personal hygiene		
Social and recreational activities		
Travel		
Social functioning		
Concentration, persistence and pace		
Employability		

Score class

Median

=

Aggregate score

+	+	+	+	+	+	=	Total %

Impairment (%WPI) from Table 11.7	
Less pre-existing impairment (if any)	
Final impairment (%WPI)	

15. Evaluation of permanent impairment arising from chronic pain

(exclude AMA5 Chapter 18)

15.1 The International Association for the Study of Pain (IASP) has defined pain as:

'An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage'.

15.2 For chronic pain assessment using AMA5 and the Guidelines, exclude AMA5 Chapter 18, on pain (p 565–91).

15.3 The reasons for excluding chronic pain, as a separate condition from the Guidelines are:

- It is a subjective experience and is, therefore, open to exaggeration or fabrication in the compensation setting. Assessment depends on the credibility of the subject being assessed. In order to provide reliability, applicants undergoing pain assessments require more than one examiner at different times, concordance with the established conditions, consistency over time, anatomical and physiological consistency, agreement between the examiners and exclusion of inappropriate illness behaviour.
- Pain cannot be measured and no objective assessment can be made.
- Tools to measure pain are based on self-reports and may be inherently unreliable.
- Some impairment ratings take symptoms into account and some of the ranges of impairment – eg whole person impairment (WPI) of the spine, may reflect the effect of the injury and pain on activities of daily living (ADL). This is not so for impairment assessment of the upper and lower limb, which is based on range of movement and diagnosis-based estimates, other than for peripheral nerve injury.

15.4 Where there is a peripheral nerve injury and there is sensory loss, some of the sensory nerve impairment categories permit pain to be included (AMA5 Table 16-10, categories 1-5, p 482).

15.5 AMA5 Section 17.2m, 'Causalgia and complex regional pain syndrome (reflex sympathetic dystrophy)' (p 553), should not be used. AMA5 Table 16-16 (p 496) has been replaced by Table 17.1 in the Guidelines. Table 17.1 is used to determine if complex regional pain syndrome (CRPS) is a rateable diagnosis. It is important to exclude diagnoses that may mimic CRPS, such as disuse atrophy, unrecognised general medical problems, somatoform disorders and factitious disorder. Once the diagnosis is established, assess impairment as in AMA5.

Complex Regional Pain Syndrome Type 1

For Complex Regional Pain Syndrome Type 1 (CRPS1) to be present for the purposes of assessment:

- the diagnosis is to be confirmed by criteria in Table 17.1
- the diagnosis has been present for at least one year (to ensure accuracy of the diagnosis and to permit adequate time to achieve maximum medical improvement)
- the diagnosis has been verified by more than one examining physician
- other possible diagnoses have been excluded.
- CRPS1 is to be assessed as follows:
  - Apply the diagnostic criteria for complex regional pain syndrome type 1 (Table 17.1).

Table 17.1 Diagnostic Criteria for Complex Regional Pain Syndrome types 1 and 2

1. Continuing pain, which is disproportionate to any causal event.
2. Must report at least one symptom in each of the four following categories: • Sensory: Reports of hyperaesthesiae and/or allodynia. • Vasomotor: Reports of temperature asymmetry and/or skin colour changes and/or skin colour asymmetry. • Sudomotor/oedema: Reports of oedema and/or sweating increase or decrease and/or sweating asymmetry. • Motor/trophic: Reports of decreased range of joint motion and/or motor dysfunction (tremor, dystonia) and/or trophic changes (hair, nail, skin).
3. Must display at least one sign* at time of evaluation in all of the following four categories: • Sensory: Evidence of hyperalgesia (to pin prick) and/or allodynia (to light touch and/or deep somatic pressure and/or joint movement). • Vasomotor: Evidence of temperature asymmetry and/or asymmetric skin colour changes. • Sudomotor/oedema: Evidence of oedema and/or sweating asymmetry. • Motor/trophic: Evidence of decreased active joint range of motion and/or motor dysfunction (tremor, dystonia) and/or trophic changes (hair, nail, skin).
4. There is no other diagnosis that better explains the signs and symptoms. *A sign is included only if it is observed and documented at time of the impairment evaluation.

Then consider the following in assessing CRPS1:

- If the criteria in each of the sections 1, 2, 3 and 4 in Table 17.1, above, are satisfied, the diagnosis of CRPS1 may be made.
- Rate the extremity impairment resulting from loss of motion of each individual joint involved.
- Rate the extremity impairment resulting from sensory deficits and pain, according to the grade that best fits the degree or amount of interference with ADL, as described in AMA5 Table 16.10a (p 482). Use clinical judgement to select the appropriate severity grade and the appropriate percentage from within the range shown in each grade. The maximum value is not automatically applied. The value selected represents the extremity impairment. A nerve value multiplier is not used.
- Combine the extremity impairment for loss of joint motion with the impairment for pain or sensory deficit using the Combined Values Chart (AMA5, p 604) to obtain the final extremity impairment.
- Convert the final extremity impairment to WPI using AMA5 Table 16.3, (p 439) for the upper extremity and AMA5 Table 17.3 (p 527) for the lower extremity.

Complex Regional Pain Syndrome Type 2, causalgia

For Complex Regional Pain Syndrome Type 2 (CRPS2), the mechanism is an injury to a specific nerve. The methodology in AMA5 (pp 496–97) is to be followed:

- If the criteria in each of sections 1, 2, 3 and 4 in Table 17.1, above, are satisfied and there is objective evidence of an injury to a specific nerve, the diagnosis of CRPS2 may be made.
- Rate the extremity impairment due to loss of motion of each individual joint involved.
- Rate the extremity impairment resulting from sensory deficits and pain of the injured nerves according to the determination methods described in AMA5 Chapter 16, Section 16.5b and Table 16-10a. Use clinical judgement to select the appropriate severity grade and the appropriate percentage from within each range shown in the grade.
- Rate the extremity impairment resulting from motor deficits and the loss of power of the injured nerve according to the determination method in AMA5 Chapter 16, Section 16.5b and Table 16-11a.

- Combine the extremity impairment percentages for loss of range of motion of the joints involved, pain or sensory deficits, and motor deficits, if present, to determine the final extremity impairment, using the Combined Values Chart in AMA5 (p 604).
- Convert the final extremity impairment to WPI using AMA5 Table 16.3 (p 439) for the upper extremity and AMA5 Table 17.3 (p 527) for the lower extremity.

Appendix 1: Key definitions

AMA5

The 5th edition of the American Medical Association's (AMA) *Guides to the evaluation of permanent impairment* and any published errata.

AMA4

The 4th edition of the American Medical Association's (AMA) *Guides to the evaluation of permanent impairment*.

Approved Medical Specialist (AMS)

A senior practising specialist with a sound knowledge of the NSW workers compensation system and workplace-based injury management. They are appointed by the Workers Compensation Commission to assess disputes about medical issues for workers compensation claims lodged on or after 1 January 2002.

Assessor

An assessor will be a registered medical practitioner recognised as a medical specialist.

- 'Medical practitioner' means a person registered in the medical profession under the *Health Practitioner Regulation National Law (NSW)* No. 86a, or equivalent Health Practitioner Regulation National Law in their jurisdiction with the Australian Health Practitioner Regulation Agency.
- 'Medical specialist' means a medical practitioner recognised as a specialist in accordance with the *Health Insurance Regulations 1975*, Schedule 4, Part 1, who is remunerated at specialist rates under Medicare.

The assessor will have qualifications, training and experience relevant to the body system being assessed. The assessor will have successfully completed requisite training in using the Guidelines for each body system they intend on assessing. They will be listed as a trained assessor of permanent impairment for each relevant body system(s) on the State Insurance Regulatory Authority website at sira.nsw.gov.au.

Degree of impairment

The degree of permanent impairment as assessed according to section 65 of the *Workers Compensation Act 1987*.

Injury

A personal injury arising out of or in the course of employment and includes a disease injury.

Maximum medical improvement (MMI)

This is considered to occur when the worker's condition is well stabilised and is unlikely to change substantially in the next year, with or without medical treatment.

NSW Guidelines

The *NSW workers compensation guidelines for the evaluation of permanent impairment*.

Secondary injury

Means an injury to the extent that it arises as a consequence of, or secondary to, another injury.

The Act

The *Workers Compensation Act 1987*

The *Workplace Injury Management and Workers Compensation Act 1998*

The *Workers Compensation Regulation 2010*