Training Manual

For Accredited Medical Practitioners Undertaking ISV Medical Assessments

Foreword by MAIAS Administrator

The South Australian Motor Accident Injury Accreditation Scheme (MAIAS) was established in February 2015 by the designated Minister (the South Australian Attorney-General) under section 76 (2) of the *Civil Liability Act 1936* (CLA).

This Scheme accredits medical practitioners to undertake ISV medical assessments that when required evaluate whole person impairment (WPI) and provide an opinion on the most appropriate injury Item Number from the "Ranges of Injury Scale Values" table in Schedule 1 of the CLA (ISV Table).

The key objective of the Accreditation Scheme is to create an independent system that provides consistent, objective and reliable ISV Medical Assessments to determine the ISV Item Number. The ISV Medical Assessment then assists in the claims settlement process where the ISV is determined.

The Training Manual provides guidance to Accredited Medical Practitioners through key features of the tools required to undertake an ISV Medical Assessments. These tools include the ISV Table, The Guide to the Evaluation of Psychiatric Impairment for Clinicians (GEPIC), The American Medical Association's Guide to the Evaluation of Permanent Impairment (AMA5) the prescribed ISV Medical Report templates and the MAIAS Rules.

The Attorney-General has approved the 2019 MAIAS Rules and approved the 2019 ISV Medical Assessment Report templates. The MAIAS Rules prescribe the regulatory and service standards required for medical practitioners to achieve and maintain accreditation under the MAIAS and give effect to MAIAS' key objective above.

The MAIAS Administrator has collaborated with the Return to Work Impairment Assessor Accreditation Scheme (RTW Scheme), administered by ReturntoWorkSA (RTWSA) to develop a joint process for applications, training and competency assessments.

Expert medical practitioners have been engaged to develop and present the content of all training materials and develop and conduct the competency bases assessments. For the first time, on line training has been introduced for the core modules.

The Attorney-General has appointed the CTP Regulator (established under the *Compulsory Third Party Insurance Regulation Act 2016*) as the MAIAS Administrator from 20 February 2019. I take this opportunity to acknowledge the foundation work of the MAIAS Panel chaired by Dr Andrew Sutherland in establishing the MAIAS.

Kim Birch
MAIAS Administrator
February 2019

Chapters

Chapter 1: Introduction

1A. Understanding Compulsory Third Party Insurance

The South Australian Compulsory Third Party Insurance Scheme

The SA CTP Scheme is a common law scheme modified by statute, principally by the *Civil Liability Act 1936* (CLA). CTP Insurance protects motor vehicle owners (and other people who use the vehicle, with or without consent) under a compulsory Policy of Insurance against financial impact of causing injury or death to other road users caused by or arising out of the use of the vehicle in any part of Australia.

Regardless of fault, CTP insurance covers children aged under 16 at the time of injury for ongoing treatment, care and support needs that are a direct result of their injury from the accident, provided it occurred in South Australia. A child under the age of 16 may also be eligible to lodge a CTP claim for compensation.

The Lifetime Support Scheme, administered by the Lifetime Support Authority provides treatment, care and support for people who have sustained very serious lifelong injuries as a result of a motor vehicle accident in South Australia, regardless of fault. An injured person may have a CTP claim as well as being a participant in the Lifetime Support Scheme.

From 1 July 2016, four government approved private insurers (CTP Insurers) commenced providing CTP insurance. Prior to 1 July 2016, the Motor Accident Commission (MAC) provided CTP insurance and the claims arising from these policies are managed for MAC, by its claims manager.

The CTP Regulator was established from 1 July 2016 as an independent statutory authority under the *Compulsory Third Party Insurance Regulation Act 2016* (CTPIR Act). The key functions of the CTP Regulator are defined in section 5 of the CTPIR Act and include regulation of the CTP Insurers; monitoring and reviewing the operation and efficiency of the CTP Scheme; and providing, or facilitating, the provision of information to consumers about CTP insurance business and the CTP Insurers. The CTP Regulator is able to make Rules which complement existing legislation and with which the CTP Insurers must comply. The Regulator Rules are published on the Regulator's website: www.ctp.sa.gov.au

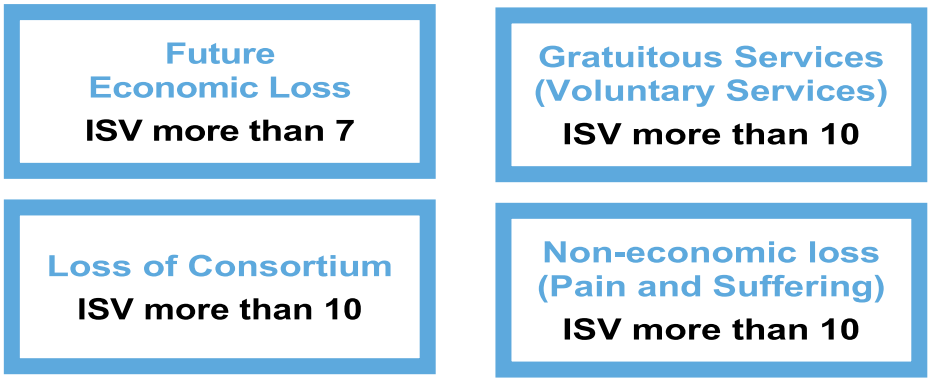
An injured person's entitlement to compensation is subject to eligibility requirements, including establishing fault, or partial fault, on the part of a South Australian registered motor vehicle or under the Nominal Defendant Scheme (if the vehicle was unregistered and therefore uninsured or cannot be identified); and meets the eligibility for compensation thresholds set out in Part 8 of the CLA.

When liability has been established, an injured person may access injury recovery supports during the life of the claim. The CTP Regulator, through the Injury Recovery and Early Intervention Framework aims to enhance outcomes for injured people and establish an efficient, repeatable and reliable system to facilitate the recovery of injured people that is consistent across the CTP Insurers. This Framework also facilitates communication between CTP insurers and medical and allied health providers to ensure reasonable and necessary treatment is funded that is goal-focused, evidence based and adopts a biopsychosocial model of recovery.

As it is modified common law scheme, compensation is paid as a lump sum usually through direct negotiation between the injured person and the CTP Insurer (or legal representatives for either party) at the finalization of the claim. Very few CTP claims are settled by the Courts.

Thresholds to Access Compensation

An injured person's entitlement to the following types of compensation is subject to a threshold based on the Injury Scale Value (ISV) for the injuries sustained. These types of compensation, or 'heads of damage" have the following thresholds:



Other types of compensation, or 'heads of damage' do not have a threshold:

1B. The Injury Scale Value (ISV) Medical Assessment

Injury Scale Value

In order to assess the injured person's entitlement to compensation, a numerical value on a scale from 0-100 (Injury Scale Value) is determined which reflects –

- the nature of the injury(ies) sustained;
- available medical evidence;
- the Item Number; and
- the impact or severity of the injury(ies) on the injured person.

The ISV for an injured person is primarily determined by reference to the ISV Table established under Schedule 1 of the *Civil Liability Regulations 2013* (CLR) (see next page). The ISV Table provides a list of Item Numbers for various types of injuries with headings, examples, comments and descriptors to assist in allocating the appropriate Item Number for each injury sustained in the motor vehicle accident.

Each Item Number provides a range of potential ISVs from which the final ISV for the injured person is determined by the parties or the court, NOT by the accredited medical practitioner.

When is an ISV Medical Assessment Required?

An ISV Medical Assessment is only required when requested by either party. Under Regulation 4(3) CLR, an ISV Medical Assessment may not be required where no qualified health professional has been accredited; or agreement is reached between the CTP Insurer and the injured person; or a court determines that such an assessment is not required.

An ISV Medical Assessment is to be undertaken only when the injury has stabilised (Regulation 4(2) CLR). Stability is not defined in either the CLA or CLR because the question of stability is a medical opinion. Mosby's Medical, Nursing and Allied Health Dictionary (6th edition) defines 'stable' as 'remaining unchanged' and 'stable condition' as 'a state of health or disease from which little if any immediate change is expected'.

Under Regulation 3 CLR, permanent impairment is defined, "in relation to an injury, means the impairment an injured person has, or is likely, to have after maximal medical improvement (MMI) within the meaning of AMA 5."

Under AMA 5, impairment can only be rated when MMI has been reached. AMA 5 at page 2 states, "Impairment is considered permanent when it has reached maximum medical improvement, meaning that it is well stabilised and unlikely to change substantially in the next year with or without medical treatment."

In practice, before the CTP Insurer or the injured person (or legal representative for either party) arranges an ISV medical assessment, consideration will be given to available medical evidence as to whether stability has been reached.

If the AMP is not satisfied that MMI has been reached, under Regulation 5 CLR, the AMP is not to proceed to determine an Item Number and must provide a report to the party who arranged the assessment to that effect. In these circumstances, the CTP Insurer is liable for any costs associated with the assessment and report but only where the insurer has requested or pre-approved the assessment to the injured party or legal representative.

The ISV Table

The "Ranges of Injury Scale Value" (ISV Table) are prescribed in Schedule 1 of the CLR.

The ISV Table comprises 157 Item Numbers. Injuries are collated into Parts relating to the body system in which the injury falls. For example Part 6 relates to orthopaedic injuries and is further divided into Divisions and Subdivisions, such as Division 14 Foot Injuries, Subdivision 2 – Other foot injuries. Each injury has its own Item Number, for example Item Number 142 Injury Extreme Foot injury and a description/example or comment about the injury.

While each ISV Item Number includes an injury description, and a range of potential ISVs for each injury, as illustrated below, an AMP's medical assessment is only concerned with the providing the ***appropriate Item Number and reasoning for the selection of the Item Number*** and NOT the ISV (value) within the range:

1. An Item Number
2. Injury Title
3. A description of injuries that may be allocated to this ISV Item No (may include an example and/or comment)
4. An ISV Range

Foot 142-145

Item No	Injury	Range	
142	**Extreme foot injury**		
	Comment There will be permanent and severe pain or very serious permanent disability. EXAMPLE OF THE INJURY An unusually severe foot injury causing whole person impairment of 15% or more, for example, a heel fusion or loss of the tibia-calcaneum angle. **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is subtalar fibrous ankylosis in a severely malaligned position, ongoing pain and whole person impairment for the injury of 24%.	13	25

Most injury types are categorised as either:

- Extreme
- Serious
- Moderate or
- Minor

The ISV Table includes categories of physical injuries as well as psychiatric impairment (Pure Mental Harm Item Numbers 10-13).

Each category of injury has a separate Item Number. For example:

ISV Item No 142	**Extreme Foot Injury**
ISV Item No 143	**Serious Foot Injury**
ISV Item No 144	**Moderate Foot Injury**
ISV Item No 145	**Minor Foot Injury**

Item Number Descriptors

Descriptors of injury are provided within each Item Number. These descriptors provide additional information to assist the AMP to determine the appropriate Item Number for each injury which is assessed.

A WPI percentage may be contained in the descriptor and is often just one of a number of descriptors included in the ISV table for an injury that supports the allocation an Item Number.

Who Can Perform an ISV Medical Assessment?

Only a medical practitioner who has been accredited by the MAIAS can provide an opinion for physical ha to satisfy the requirements of Regulation 4 and 23 of the CLR.

An Accredited Medical Practitioner is a “Health Professional” defined in section 76(16) of the CLA.

Only a Psychiatrist who is a MAIAS Accredited Medical Practitioner can provide an opinion for Pure Mental Harm (Psychiatric Impairment). The assessment must made using the GEPIC in accordance with Regulation 14 and 23 of the CLR.

The ISV Medical Assessment Report

The form of the ISV Medical Assessment Report is a prescribed template approved by the Attorney-General and published by the MAIAS Administrator. The current report templates for either Physical injury or Pure Mental Harm GEPIC are described and contained in the Training Manual at Chapter 3. They are also available, and can be downloaded from, the MAIAS website.

The Templates must be used as published and all the questions must be answered in full in accordance with MAIAS Rule 7. Failure to comply with completion of the published template and without alteration of the template will result in the requestor rejecting the report. The AMP will be required to resubmit a compliant report without additional charge to the requestor.

Repeated failure to comply may result in the MAIAS Administrator imposing requirements for remedial action in accordance with MAIAS Rule 14 or suspension or cancellation of accreditation in accordance with MAIAS Rule 12.

AMPs should be aware that provision is made in the ISV Medical Assessment Report (both Physical Injury and Pure Mental Harm) for the AMP to be requested to address additional questions in the opinion section of the template. However, the referring party can only include additional questions if agreed to by both parties. Generally, the additional questions should not exceed 3 questions. See Chapter 3 Training Manual for further details.

Whole Person Impairment (WPI) and the Item Number

When undertaking an ISV Medical Assessment, the AMP is required to assess a WPI percentage using AMA 5 or GEPIC or BHI% for Hearing loss. In providing an opinion as to the appropriate Item Number the AMP should:

- consider the diagnosis, nature and severity of the injury, and
- the Item Number descriptors relevant to the injury type, and
- the impairment evaluation of the injury, applying AMA 5 or GEPIC (or other source used).

AMPs should note that Regulation 10 of CLR states that the extent of a whole person impairment is an important consideration, but not the only consideration, affecting the final assessment of the injured person’s ISV. The specific ISV (value) is determined by the parties or the court; NOT the AMP.

The AMP must provide detailed and sound reasons for the appropriate Item Number only for each referred injury. AMPs DO NOT determine the ISV (value) within the range given in the ISV table.

Greater Weight to a Whole Person Impairment Provided Under AMA 5

Under Regulation 3 CLR, WPI is defined, in relation to a motor vehicle accident injury, as meaning "an estimate, expressed as a percentage, of the impact of a permanent impairment caused by the injury on the injured person's overall ability to perform activities of daily living, as described by AMA 5, other than employment."

Regulation 17 of CLR requires the Court (or CTP Insurer), in assessing an ISV, "the court must, unless it considers there is good reason for doing otherwise, give greater weight to a medical assessment for a whole person impairment based on the criteria for the assessment of whole person impairment provided under AMA 5 than to a medical assessment of a whole person impairment percentage not based on the criteria."

Exceptions to Regulation 17 CLR are the GEPIC assessment and medical assessment of scarring.

If an appropriate assessment method is not available in AMA 5 for the injury to be assessed, the AMP may choose an alternative method and must describe the reasons for the method used in the report, for example:

- an Ophthalmologist may not have the required equipment to complete an assessment using AMA 5, choosing to complete the assessment using AMA 4, or
- the assessment of binaural hearing loss as referred to in the ISV Table, NAL118 should be used. The Item number in this case is derived directly from the BHI%.

How is the Final ISV for the Injured Person Determined?

The AMP's opinion regarding the appropriate Item Number is one of a number of factors the Court takes into consideration when assessing the ISV. In addition to the ISV Medical Assessment Report, the Court or the parties may have regard to other matters to the extent they are relevant in a particular case. Regulation 9(3) CLR sets out some of these considerations, including but not limited to:

a) the injured person's age, life expectancy, pain, suffering and loss of amenities of life; and

b) the effects of a pre-existing condition for the injured person; and

c) difficulties in life likely to have emerged for the injured person whether or not the injury happened; and

d) with respect to assessing an ISV for multiple injuries, the range for an injury other than the dominant injury of multiple injuries; and

e) the extent to which the injured person has refused treatment that could lead to a significant improvement in the level of impairment caused by that injury or condition, reasons for any refusal of treatment, and any evidence provided by a health professional as to the likely effect of treatment.

It is a matter for the parties to determine the ISV for an injured person by negotiation but, failing agreement, the Court decides at trial.

The Dominant Injury

When a person has sustained multiple injuries, the final ISV determined by the parties will be based on the dominant injury only. The dominant injury is the injury that has the highest possible ISV score within the ranges provided in the ISV Table. For example:

Injury	ISV Item Number	ISV Range	Comment/Supporting Evidence
Dental Injury	18.3	0-2	Damage to single tooth
Cervical Spine Fractures	82	5-15	Wedge fracture. C4 vertebral body. Less than 25% loss of height, 8% WPI.
Thoracic Spine Fractures **DOMINANT INJURY**	86	16-35	Fracture with 50% loss of height at T4. 18% WPI.
Pelvis Fracture	123	0-10	Left inferior pubic ramus fracture, healed, no impairment. 0% WPI.

The determination of the dominant injury is for the parties or the court to determine.

In assessing multiple injuries, the AMP must ensure that each referred injury is assessed separately and an Item Number assigned to each injury. This will assist the parties to determine the dominant injury.

The impact of any non-dominant injury is considered by the parties when determining the ISV within the range of the Item Number for the dominant injury. If the parties or the court, consider that the adverse impact of multiple injuries is so severe that the maximum ISV for the dominant injury is inadequate, it can increase the ISV above the range for the dominant injury.

This is another reason why it is important that the AMP must ensure that the Item Number for each referred injury is assessed separately.

1C. Role of the Accredited Medical Practitioner as an Expert for the Court

In assessing and providing an ISV Medical Assessment report, the AMP is doing so as an expert of the Court regardless of which party retained the AMP and must comply with, and acknowledge in the report, compliance with those obligations. A copy of the Court Rules is located in the Training Manual under Other Resources.

The AMP's obligations as an expert include the paramount duty being to the Court and to assist on matters relevant to the AMP's area of expertise. The ISV Medical Assessment Report template incorporates the requirements of the Court Rules for experts, such as the expert's obligation to list all documents and information provided with the ISV Medical Assessment referral letter.

The ISV Medical Assessment Report must be signed by the AMP and not by any other person or colleague.

The report incorporates the statements required by the Court Rules at the beginning and end of the report template, including the declaration which must be made by the assessor, namely:

- an acknowledgement that the accredited assessor has been provided with copies of rule 160 of the Supreme Court Rules 2006 and Division 2 of Part 9 of the Supreme Court Civil Supplementary Rules 2014 before preparing the report and that the expert has read and understood them; and
- a declaration that the accredited assessor has made all inquiries that the expert believes are desirable and appropriate and no matters of significance that the expert regards as relevant have, to the expert's knowledge, been withheld from the Court.

Service Standards for Accredited Medical Practitioners

When undertaking an ISV Medical Assessment and completing the ISV Medical Assessment Report, an AMP must abide by the criteria for accreditation, terms and conditions of accreditation, service standards as prescribed by the RTW Scheme for Impairment Assessors, except when they are inconsistent with the express terms of the MAIAS.

The MAIAS Service Standards are outlined in MAIAS Rule 6. In addition to the RTW Scheme requirements, AMPs must:

- Provide medical assessment reports using the current ISV Medical Assessment Report templates prescribed by the Minister
- Comply with the timeframe for the provision of reports set out in Regulation 23(1) of the CLR
- Not provide comment to the media on ISV Medical Assessments that are, or have been before them
- Not identify themselves as an Accredited Medical Practitioner if providing comment to the media on matters unrelated to their assessment responsibilities
- Comply with the requirements of this Scheme where they differ from service standards prescribed by the RTW Scheme for Impairment Assessors
- Comply with the performance and review requirements set out in the MAIAS Rules
- Comply with the guidance material provided in this Training Manual.

The MAIAS ISV Medical Assessment Report compliance requirements are set out in MAIAS Rule 7. The ISV Medical Assessment Reports completed by the AMP must:

- Use the current edition of the prescribed templates without amendment or deletion of any section, heading, or question (Regulation 23(2) of the CLR)
- Contain clear rationale for the AMP's opinion
- Not contain material or typographic errors such that correction of the alleged error may result in a materially different outcome of the assessment
- Provide a written report to the requestor within 30 days of the examination or assessment (Regulation 23(1) of the CLR)
- Accurately record all assessment findings based on due rigour and intellectual honesty
- Provide the information prescribed by Regulation 23 (1) of the CLR
- Conform with the guidance material provided in this Training Manual

AMPs must meet the service standards described in the MAIAS Rules.

If an AMP does not meet the service standards, they may be required to undertake further education as required by the MAIAS Administrator at the practitioner's cost or their accreditation may be suspended or cancelled as outlined in MAIAS Rules 10, 12 and 14.

1D. Performance Monitoring and Complaints

Performance Monitoring

The MAIAS Administrator is responsible for monitoring the performance of AMPs to ensure conformity with accreditation obligations as outlined in MAIAS Rule 8. In monitoring the performance of AMPs, the MAIAS Administrator will:

- monitor the performance of AMPs to ensure conformity with accreditation obligations
- monitor services provided by AMPs to ensure that the standards required by the MAIAS Rules, the CLA and the CLR are met
- monitor ISV Medical Assessment Reports to ensure:
  - compliance with the accreditation obligations and the CLA and CLR
  - accuracy in assessment methodology chosen and calculations
  - medical consistency and sound reasoning
  - assessment reports are delivered within required timeframes
  - assessments are completed on the prescribed template

Complaints

In accordance with MAIAS Rule 13, the MAIAS Administrator will:

- review all complaints received in writing
- investigate where required and make a formal finding

Following completion of a review and investigation of a complaint, the MAIAS Administrator may take no further action, require the AMP to undertake counselling or additional training, recommend to the Minister, suspension or cancellation of the AMP's accreditation.

AMPs must cooperate in any review and findings arising from performance monitoring and complaint investigations by:

- responding to MAIAS Administrator enquiries
- engaging with peer medical experts
- demonstrating willingness and/or ability to comply with the MAIAS Rules, CLA and CLR
- participating in any remedial action including retraining, performance monitoring or peer reviews
- accepting the AMP will be required to reimburse the MAIAS Administrator for costs arising from any remedial actions.

The past performance of AMPs compared with other AMPs may be taken into account during the renewal process.

Self-Review and Quality Assurance

It is expected that AMPs regularly review and evaluate their own performance and capacity and maintain the knowledge and skills necessary for the effective performance of their assessment responsibilities.

1E. Definitions

In this Training Manual document:

Accredited Medical Practitioner means a medical practitioner who is accredited as an Accredited Health Professional under the Motor Accident Injury Accreditation Scheme established by the designated Minister under the CLA and the CLR.

AMA 5 means the American Medical Association Guide to the Evaluation of Permanent Impairment, Fifth Edition.

CLA means the *Civil Liability Act 1936.*

CLR means the *Civil Liability Regulations 2013.*

CTP Regulator means the Regulator established under Part 2 Division 1, *Compulsory Third Party Insurance Regulation Act 2016.*

CTP Scheme means the Compulsory Third Party insurance required under Part 4 of the *Motor Vehicles Act 1959* and claimant entitlements under Part 8 of the CLA.

Consequential harm means mental harm that is a consequence of bodily injury to the person suffering the mental harm.

DSM5 The Diagnostic and Statistical Manual of the American Psychiatric Association 5th Edition

GEPIC means the Guide to the Evaluation of Psychiatric Impairment for Clinicians prepared by MWN Epstein, G Mendelson and NHM Strauss as published in the Victorian Government Gazette on 8 May 2008.

GEPIC report means a report prepared by an accredited medical practitioner which complies with Regulations 14 and 23 of the CLR.

Health Professional means a registered health practitioner under the Health Practitioner Regulation National Law (other than a student); or a person who is within a class brought with the ambit of this, the CLA Section 76(16) definition by the CLR.

Injured person means a person who claims damages in respect of personal injury arising from a motor vehicle accident.

Injury Scale Value (ISV) means a numerical value on a scale running from 0 to 100 determined pursuant to Section 52 (3) of the CLA, with reference to Schedule 1 of the CLR.

ISV Table means Schedule 1 of the CLR.

Item Number means the number positioned to the left of every injury type listed in the ISV Table.

Item Number Descriptors means the injury title, comments, examples of injury, commentary on WPI and other information within an Item Number in the ISV Table.

ISV Range means the low and high numerical values in the final two columns of the ISV Table.

ISV Medical Assessment means a medical examination or assessment undertaken by an AMP.

ISV Medical Assessment Report means a report prepared by an AMP under Regulations 14 and 23 of the CLR.

MAIAS Administrator means the South Australian CTP Regulator, appointed by the Attorney-General to administer the Motor Accident Injury Accreditation Scheme.

MAIAS Rules means the regulatory and service standards for obtaining and maintaining accreditation determined by the Minister under Section 76 of the CLA.

Mental harm means impairment of a person's mental condition as defined in Section 3 of the CLA.

Motor Accident Injury Accreditation Scheme (MAIAS) means the Accreditation Scheme as established by the Minister under section 76(2) of the CLA.

Motor vehicle accident means an incident in which personal injury is caused by or arises out of the use of a motor vehicle as defined in the *Motor Vehicles Act 1959*.

Permanent impairment, in relation to an injury, means the impairment an injured person has, or is likely to have, after maximal medical improvement within the meaning of AMA 5.

Psychiatric impairment means Pure Mental Harm.

Pure Mental Harm means mental harm other than consequential mental harm.

Whole person impairment (WPI), in relation to an injury, means an estimate, expressed as a percentage, of the impact of a permanent impairment caused by the injury on the injured person's overall ability to perform activities of daily living, as described by AMA 5, not including work.

Chapter 2: The ISV Medical Assessment

2A. Referrals for ISV Medical Assessment

Who can Request an ISV Medical Assessment?

Requests for an ISV Medical Assessment may be made by either the injured party or the CTP Insurer or their legal representative.

Accepting ISV Medical Assessment Referrals

The AMP is reminded that the ISV Medical Assessment must not be undertaken until each of the injuries to be assessed has stabilised as outlined in Regulation 4 (2) of the CLR.

A referral to an AMP for a WPI or GEPIC will be considered to be a request for an ISV Medical Assessment and must be completed on an ISV Medical Assessment Report template.

The AMP may also receive referral from the same party for an Independent Medical Examination (IME) which is a separate assessment and report. IME assessment is NOT reported using the ISV Medical Assessment Report template.

If the AMP receives a referral for an IME and an ISV Medical Assessment Report, in some instances, for the convenience of the injured person, it may be appropriate for the AMP to undertake two assessments on the same day the injured party attends.

Under no circumstances is an ISV Medical Assessment report to be provided without an ISV Medical Assessment having been undertaken on the injured person specifically related to the injury(ies) requested.

If an AMP is uncertain of their obligations in these circumstances they should contact the referring party.

Accreditation, Body Systems & MAIAS Training Manual

AMPs may only accept referrals for injuries in the body systems for which they have been accredited. The Training Manual chapters sets out assessment requirements to align with each body system. When assessing injuries, the AMP should refer to the relevant Training Manual chapters, as aligned with the accredited body systems. The Training Manual may guide the AMP to other sections of the manual to complete the assessment.

In the MAIAS Accreditation Scheme, all AMPs may provide an opinion regarding the appropriate Item Number for minor scars if requested in the referral letter (refer to Chapter 15, Skin and Scarring, Page 101).

All AMPs may use AMA 5 Pain Chapter (AMA 5 Chapter 18) where relevant with the exception of Psychiatrists undertaking assessments of Pure Mental Harm, who must use GEPIC.

Minor Chest Injuries (i.e. fractures or internal organ injury that resolve or substantially resolve may be assessed by AMPs accredited in

- The Spine
- Upper Extremities
- Lower Extremities
- Cardiovascular or
- Respiratory Systems

Who is Responsible for Payment of the ISV Medical Assessment Report?

The party requesting the report will be liable for payment of the assessment and the ISV Medical Assessment Report. In the case of a referral from the injured party or legal representative, the CTP Insurer is only liable to pay, if it has pre-approved the assessment and report (Regulation 25 CLR). Unless advised otherwise, the AMP should send their report and account to the requesting party.

If the injured person fails to attend the ISV assessment arranged by the injured party or legal representative, without reasonable cause, the CTP insurer is not required to pay the non-attendance fee unless it had pre-approved the ISV medical assessment. The injured party or legal representative (the referring party) would be required to pay the non-attendance fee.

Refusing an ISV Medical Assessment Referral

In accordance with MAIAS Rule 9, AMPs must not accept a request if:

- the AMP has been asked to provide an assessment in respect of a body system for which the Practitioner is not accredited.
- the AMP is unable to see the injured person within six weeks of the appointment being requested. The assessment should occur as soon as possible, generally within three weeks after the request for an appointment is made, unless agreed and documented between the requestor and AMP.
- the AMP determines there is an actual or potential conflict of interest in providing the requested service with respect to the injured person. Where such a perceived or actual conflict of interest exists, the Accredited Assessor should notify the requestor immediately.
- the AMP has provided or plans to provide any form of treatment, treatment advice or assessment in relation to the injured person unless there is no other assessor available to undertake the assessment.

Incomplete or Inappropriate ISV Medical Assessment Referrals

Regulation 22 of the CLR provides that a request for an examination or assessment made to an AMP for the purposes of an ISV Medical Assessment must be accompanied by a copy of each of the following:

a) any relevant medical history, records or notes provided by the injured person's medical practitioner (if available);

b) any relevant hospital notes;

c) any other medical information so far as it is relevant to the injured person's claim;

d) any documents required by rules of court or practice directions.

If an AMP believes a request for assessment is inappropriate or incomplete, the assessor must discuss their concerns with the referring party and refuse the request if their concerns are not resolved.

All Questions Contained Within the ISV Medical Assessment Referral Must be Answered

The ISV Medical Assessment Report templates contains a set of legislated questions that the AMP must answer as outlined in MAIAS Rule 7.

Each referral letter also includes an option for the referring parties to ask additional questions, as have been agreed between the parties.

If additional questions (as agreed by the parties) are included, the AMP must answer them. If the AMP believes the additional questions are complex and/or onerous, they may contact the referring party to discuss additional assessment time and the appropriate fee arrangement.

Guarantee of ISV Medical Assessments

There is no guarantee of a minimum number of requests an AMP might receive during the accreditation period.

Register of Accredited Medical Practitioners

A register of AMPs including relevant accreditation information (e.g. accredited per body systems, location of assessor, etc.) is published on the MAIAS website: www.maias.sa.gov.au

2B. The ISV Medical Assessment

AMPs evaluating injuries for the purpose of providing an ISV Medical Assessment and an opinion on the allocation of the Item Number MUST be accredited for this body system by the responsible Minister (the Attorney- General) before undertaking an ISV Medical Assessment.

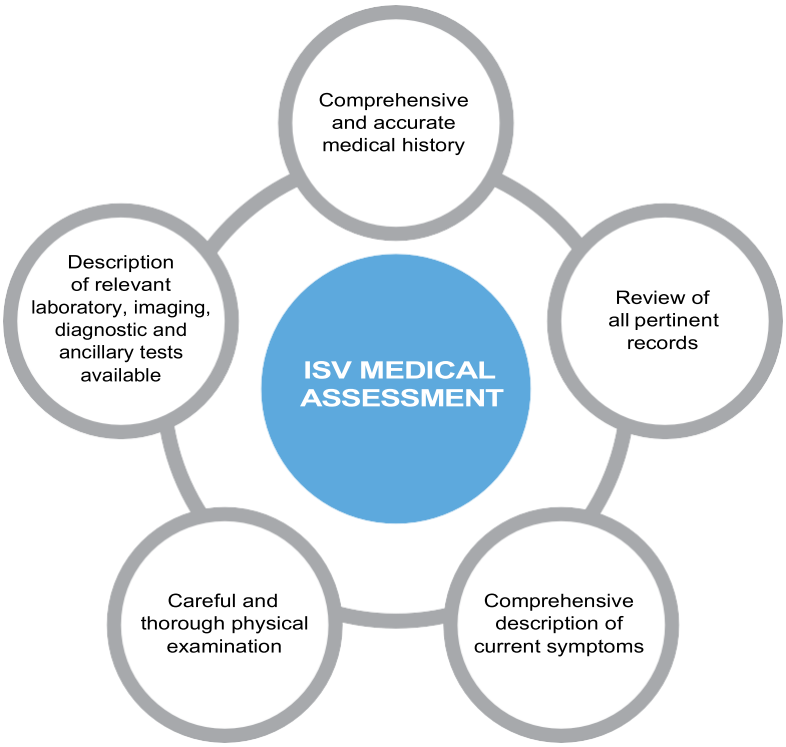
The Injury(s) Assessed must be Stable

An ISV assessment is to be undertaken when the injury has stabilised (Regulation 4 of the CLR).

In AMA 5, impairment can only be rated when Maximal Medical Improvement (MMI) has been reached. See page 9 of the Training Manual.

In accordance with Regulation 5 of the CLR, if the AMP is of the opinion that the person's injury has not yet stabilized; the ISV is not able to be determined and the AMP must provide a report to that effect.

Key Principles of Assessment



Preparing for the ISV Medical Assessment

It is recommended that AMPs read the relevant sections of the ISV Table prior to undertaking the assessment, so they are familiar with the content of the relevant Item Numbers for the injuries they have been asked to assess. Each Training Manual chapter provides an overview of all Item Numbers relevant to that chapter's body system. The full ISV Table is located in Appendix C, commencing at page 161 of the Training Manual.

Assessing Multiple Injuries

The AMP must provide a separate WPI for each injury referred to assist the parties or the Court to determine which of the multiple injuries is the dominant injury.

If multiple injuries are assessed, a combined WPI is not required.

Imaging Studies

Imaging findings that are used to support the impairment rating should be concordant with the clinical evaluation and findings on examination. The presence of certain reported/observed imaging study abnormalities does not necessarily mean that a person has an impairment related to the subject motor vehicle accident.

The AMP should record whether diagnostic tests and imaging studies were directly viewed or whether they relied on written reports.

Ordering of Investigations

If in exceptional circumstances it is determined that an ISV Medical Assessment cannot be finalised without further investigations, the AMP must notify the referrer. It is not appropriate for an AMP to order imaging studies or other investigations.

Record Additional Documentation Received

If the injured person provides additional documentation to the AMP, the assessor must list these documents and provide copies with the ISV Medical Assessment report.

Reporting Whole Person Impairment and Item Numbers for Physical Injuries

The AMP must complete a WPI assessment for each of the injuries referred.

The AMP must also provide an opinion as to the appropriate Item Number for each of the injuries detailed in the ISV Medical Assessment referral letter. If during the assessment, the AMP identifies other injuries relating to the motor vehicle accident that have not been listed in the referral letter, the assessor must comment on these in the report template headings of “History” and/or “Examination”, but they are not to be assigned a WPI or Item Number.

Regulation 16 of the CLR states that when reporting a WPI percentage based on a criteria under AMA 5, the report must state:

- the clinical findings
- how the impairment is calculated
- identification of the relevant provisions of AMA 5, and
- if a range of percentages is available under AMA 5 for an injury of the type being assessed – the reason for assessing the injury at the selected point in the range.

Reporting a GEPIC Rating and Item Numbers for Pure Mental Harm (Psychiatric Injuries)

To complete an ISV Medical Assessment for Pure Mental Harm, the AMP must be a Psychiatrist and complete a GEPIC assessment to determine a GEPIC rating.

The GEPIC rating will guide the AMP in their opinion as to the appropriate Item Number for each of the injuries of Psychiatric impairment (Pure Mental Harm only) as detailed in the ISV Medical Assessment referral letter.

If during the examination other Psychiatric conditions are evident, the assessor may comment on these in the report template headings of “History” and/or “Examination”, but they are not to be assigned a GEPIC rating or Item Number.

Please see page 119 of the Training Manual for more information on an ISV Medical Assessment for Pure Mental Harm.

2C. ISV Medical Assessment Report Templates

Templates

Under Regulation 23(2) of the CLR, an AMP must complete their assessment report in a form determined by the designated Minister (the Attorney-General) and include any information required by that form.

Two report templates have been approved by the Attorney-General:

- ISV Medical Assessment Report: Physical Injury
- ISV Medical Assessment Report: Pure Mental Harm – GEPIC report

The templates include all legislative requirements set out in Regulations 16, 23 and 24 and also 14 of the CLR for the assessment of Pure Mental Harm.

The templates are in Chapter 3 of the Training Manual and can be accessed from the MAIAS website www.maias.sa.gov.au.

Time Requirement for Provision of ISV Medical Reports

Regulation 23(1) of the CLR requires that an ISV Medical Assessment Report MUST be provided within 30 days of the assessment or examination.

Quality Compliance of ISV Medical Assessment Reports

As outlined in MAIAS Rule 7, ISV Medical Assessment Reports completed by AMPs MUST:

- use the current edition of the prescribed templates(s) with no amendment or deletion of any section, heading, or question
- contain clear rationale for the AMP's opinion
- not contain material or typographical errors such that correction of the alleged error may result in a materially different outcome of the Assessment
- provide a written report to the requestor within 30 days of the examination or assessment
- accurately record all assessment findings based on due rigour and intellectual honesty
- provide the information prescribed in Regulation 23(1) of the CLR
- conform with the guidance provided in the Training Manual

Failure to comply with completion of the published template and without alteration of the template will result in the requestor rejecting the report. The AMP will be required to resubmit a compliant report without additional charge to the requestor.

Repeated failure to comply may result in the MAIAS Administrator imposing requirements for remedial action in accordance with MAIAS Rule 14 or suspension or cancellation of accreditation in accordance with MAIAS Rule 12.

2D. General Tips when using the ISV Table

The ISV Table

The ISV table is found in Appendix C of the Training Manual, with each injury type tabbed for ease of reference.

The relevant Item Numbers for the injuries being assessed are also listed at the beginning of each of the Training Manual chapters (per body system). For example:

TRAINING MANUAL CHAPTER 16 – UPPER EXTREMITY		
Injury	**Item Number**	**Comments**
Shoulder Injury	90-93	
Amputation upper limb	94-95	
Elbow	96-99	
Wrist	100-103	
Hand	104-115	

TRAINING MANUAL CHAPTER 16 – UPPER EXTREMITY		
Injury	**Item Number**	**Comments**
Other upper limb	116-119	Includes hand and digit amputations
Limb disorders	150	Other than injury mentioned in item 90-115

When to use the ISV Table

Prior to undertaking the ISV Medical Assessment, the AMP may wish to review the Item Numbers that are relevant to the injuries they are to assess.

By reading the descriptors for each of the relevant Item Numbers, the AMP may consider the type of injuries that fall into each Item Number, and the medical evidence required to support allocating an injury with that Item Number. This may provide useful information to consider prior to the assessment.

Some Item Numbers Contain References to WPI for an Injury Type.

Allocating an Item Number

Once the AMP has completed their clinical examination and the evaluation of WPI, they must refer to the ISV table to allocate an Item Number for each of the injuries they have assessed.

The AMP is **then** required to **provide** an opinion in relation to the **determination of the Item Number** *to assist the parties and/or the Court in determining the final ISV.*

Item Numbers without WPI reference

There may be circumstances where impairment can be assessed under AMA 5, but there is not a corresponding reference to WPI in the Item Number description. AMPs are required to provide the WPI rating in the report. Where possible, AMPs should provide their opinion as to an Item Number by analogy, and explain their reasoning for this. Stay within the Chapter for the Body Part when using analogy.

2E. General Assessment Tips when using AMA 5

AMPs Should Assess Whole Person Impairment Using AMA 5

When undertaking an ISV Medical Assessment, the CLR require the AMP to complete an AMA 5 assessment for all physical injuries referred.

If there is not an appropriate assessment method available in AMA 5 for the injury referred, the assessor may choose an alternative method and describe the reasons for it. For example, an Ophthalmologist may not have the required equipment to complete an assessment using AMA 5, choosing to complete the assessment using AMA 4 instead.

In accordance with Regulation 17 of the CLR, "*in assessing an ISV a court must, unless it considers there is good reason for doing otherwise, give greater weight to a medical assessment of a whole person impairment percentage based on the criteria for the assessment of a whole person impairment provided under AMA 5 than to a medical assessment of a whole person impairment percentage not based on the criteria*".

The use of AMA 5 in MAIAS is only modified by the MAIAS Training Manual and CLR

MAIAS require AMPs to use AMA 5 except for NAL for Hearing and AMA4 for Vision. The CLR requires Psychiatrists to assess using GEPIC. AMA5 use in MAIAS ISV Medical Assessments is otherwise unfettered.

Philosophy, Purpose and use of AMA 5

AMPs are expected to be familiar with Chapters 1 and 2 of AMA 5 in relation to the philosophy, purpose and appropriate use of the AMA 5 Guides and their practical application.

Assessing Psychiatric injury – Pure Mental Harm

AMA 5 Chapter 14, "Mental and Behavioural Disorders" is NOT to be used for the evaluation of psychiatric impairment Pure Mental Harm. Pure Mental Harm is assessed using GEPIC. Only Psychiatrists can assess Pure Mental Harm. See Training Manual section 2B on page 25 for further details.

As detailed in Regulation 13 of the CLR, a psychological injury that develops from a physical injury is referred to as consequential mental harm. Consequential mental harm will be taken into account by the parties or the Court in determining the ISV within the ISV range for the physical injury and is NOT to be assessed as a separate injury by the AMP.

The Pain Chapter

The use of the AMA5 Guides Pain Chapter 18 is not excluded in ISV medical assessments. AMPs should refer to Chapter 20 of the Training Manual when using AMA5 Pain Chapter.

When Impairment Ratings are not provided in AMA 5

"In situations where impairment ratings are not provided, AMA 5 suggests that physicians use clinical judgement, 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." (See AMA 5, page 11, first paragraph.)

Remember to stay within the Chapter for the Body Part when using analogy.

Refusal of Treatment

"A patient may decline surgical, pharmacologic, or therapeutic treatment of an impairment. If a patient declines therapy for a permanent impairment, that decision neither decreases nor increases the estimated percentage of the individual's impairment. However, the physician may wish to make a written comment in the medical evaluation report about the suitability of the therapeutic approach and describe the basis of the individual's refusal. The physician may also need to address whether the impairment is at maximal medical improvement without treatment and the degree of anticipated improvement that could be expected with treatment". (See AMA 5, page 20, last paragraph, 2nd column.)

Regulation 9(3)(e) CLR states that the Courts "*may have regard to the extent to which the injured person has refused treatment that could lead to a significant improvement in the level of impairment caused by that injury or condition, reasons for any refusal of treatment, and any evidence provided by a health professional as to the likely effect of treatment".*

The AMP must, if relevant, include comments in this regard in the ISV Medical Assessment Report.

Adjustments for Effects of Treatment or Lack of Treatment

"In certain instances the treatment of an illness may result in apparently total remission of the person's signs and symptoms. Examples include the treatment of hypothyroidism and the treatment of Type 1 diabetes. Yet it is debatable whether, with treatment, the patient has actually regained the previous status of normal good health. In these instances the physician may choose to increase the impairment estimate by a small percentage (e.g., 1% to 3%)." (See AMA 5, Section 2.5g, page 20, 1st paragraph, 2nd column.)

Adding or Combining

AMPs are reminded of special situations when assessing Thumb joints, Ankle and Subtalar joints as outlined on page 10 of the AMA5.

Assessing Scars

All AMPs can assess minor scars.

"Many of the physical injuries mentioned in this Schedule involve some scarring from the initial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries" (ISV table Scarring to Body, page 323 general comments).

AMPs should refer to the section in the Training Manual that refers to Skin and Scarring. *Item Numbers 151-154* relate to non-facial scarring, and *Item Numbers 19-22* for scarring of the face.

2F. General Assessment Tips for Psychiatrists when assessing Psychiatric Impairment/Pure Mental Harm

Only AMPs who are Psychiatrists can undertake an ISV Medical Assessment for Pure Mental Harm.

AMPs evaluating Psychiatric impairment for the purpose of providing a GEPIC assessment, a GEPIC rating and an opinion on the Item Number must be a Psychiatrist and must be accredited by MAIAS.

Accredited Assessors to use GEPIC to Assess Pure Mental Harm

AMPs must use the GEPIC (see appendix B) to assess psychiatric impairment and provide a GEPIC rating and should refer to GEPIC and the notes included in this Training Manual when undertaking an assessment of Pure Mental Harm.

AMPs to Provide a GEPIC rating only in the ISV Medical Assessment Report

Unlike the requirements of Return to Work Scheme, the AMP is not required to provide a psychiatric impairment percentage. Instead, the AMP is required to provide a GEPIC rating (i.e. Class 1 or Class 4) for each of the diagnosed conditions that are considered to be Pure Mental Harm.

For more details about the assessment requirements, please refer to the Training Manual chapter on psychiatric impairment for Pure Mental Harm.

What is Pure Mental Harm?

Pure Mental Harm is a legal, not a medical, concept.

Pure Mental Harm is mental harm that arises from the motor vehicle accident but is not consequential upon any physical injuries sustained by the injured person. For example, it may include witnessing at the scene a person being killed, injured or put in peril or a family member suffering a sudden shock when hearing of the motor accident.

AMPs only review ISV Medical Assessment referrals for claims for Pure Mental Harm. A GEPIC rating is to be used to determine the psychiatric impairment of Pure Mental Harm.

What is Consequential Mental Harm?

Regulation 13 of the CLR provides that consequential mental harm (either psychiatric or psychological) is to be treated merely as a feature of the physical injury. Consequential mental harm sustained as a result of physical injury will be taken into account in determining the ISV score within the range of the appropriate Item Number for the physical injury and is not to be assessed as a separate injury by the AMP.

Regulation 3 of the CLR defines consequential harm as not including psychiatric impairment (pure mental harm).

Diagnosing and Assessing Multiple Psychiatric Conditions

A GEPIC rating is only required for the assessment of Pure Mental Harm. Therefore, when undertaking a GEPIC assessment, the Psychiatrist is required only to assess the psychiatric conditions they consider satisfy the definition of Pure Mental Harm.

The AMP is required to diagnose the conditions that are Pure Mental Harm and those that are Consequential Harm, but is only to provide a GEPIC rating and the associated Item Number for conditions of Pure Mental Harm.

Pre-existing Conditions

Regulation 15 of the CLR requires the AMP to report the effect of the motor vehicle accident on any pre-existing condition and the extent to which it has been made worse by the injury.

When conducting an ISV Medical Assessment, the AMP should complete the template report on the basis that the “pre-existing injury” includes any relevant pre-existing conditions in accordance with this regulation.

Subsequent Injury

The AMP must also report the effect of any subsequent injury and the extent to which the motor vehicle accident injury has been made worse by the subsequent injury.

Chapter 3:

ISV Medical Assessment

Templates

Date: (DD/MM/YYYY)

Requestor's name:

Company:

Address:

City / Suburb: Post Code: State:

Injury Scale Value (ISV) Medical Assessment Report
Physical Injury(ies)

Name of claimant:

Date of birth: (DD/MM/YYYY)

MVA claim number: (XXXXXXX/XXXXXXXXXX)

Date of injury: (DD/MM/YYYY)

Occupation:

Dear: (Requestor Name)

Further to your referral letter of: (DD/MONTH)

I saw: (Name) **on:** (DD/MONTH) **at:** (Location)

for the purpose of an ISV Medical Assessment Report.

You have requested a whole person impairment assessment and my opinion regarding an Injury Scale Value (ISV) Item Number for the following injury(ies):

-
-
-

Your referral letter states the injury(ies) listed above occurred as a result of the following stated cause:
Describe the stated cause as detailed in the referral letter.

The injured person attended alone/or with *(please state the name of the support person and their relationship to the injured person)*

☐ An interpreter was not present at the consultation.

☐ An official interpreter was present and assisted throughout the consultation.

Name & NAATI Number:

Approved by Attorney General under 23(2) *Civil Liability Regulations 2013* on 7 January 2019 Released 9 January 2019
Enquiries to: MAIAS Administrator | GPO Box 1095, Adelaide SA 5001 | 1300 303 558 | www.maias.sa.gov.au

I explained my role as an Accredited Medical Practitioner and that my report from this assessment would be sent to you. I acknowledge that I have received and read Division 2 of the *Supreme Court Supplementary Rules 2014* entitled *"Expert Witnesses"* and Rule 160 of the *Supreme Court Rules 2006*. I confirm that my report complies with these provisions. Further, this report has been written in accordance with the current edition of the "Training Manual for ISV Medical Assessments."

Document Review

I confirm the following documents were provided and read for this assessment:

1: _____

2: _____

3: _____

4: _____

5: _____

In addition, list any other relevant documentation provided by the examinee.

History *Include:*

☐ Relevant personal, family, occupational and past medical history

_____

☐ Mechanism of injury

_____

☐ Present status of medical condition(s), treatment and medications

_____

Examination

Detail your method of assessment and any relevant clinical findings.

_____

Review of diagnostic investigations

List the relevant diagnostic investigations and their results. In the case of medical imaging, state whether or not you have reviewed the original films or reports.

Opinion

My opinion addresses the following **for each accident-related injury** as per the referral letter:

1. **Diagnosis;**

2. **Prognosis;**

3. **Injury stability;**

4. **Whether the injury is consistent with the stated cause** *(Please refer to the stated cause contained in the referral letter);*

5. **The effect of the MVA motor accident on any pre-existing injury and the extent to which it has been made worse by the injury;**

6. **The effect of the MVA motor accident on any subsequent injury and the extent to which it has been made worse by the injury;**

7. **Whether the assessment was based on AMA 5 or other criteria with detailed reasons;**

8. **If relevant, the whole person impairment** *(Please detail the methodology used and calculations, providing relevant references to AMA5 or other criteria used);*

9. **The Injury Scale Value (ISV) Item Number** *(Please refer to the ISV table. You are not required to comment on the ISV range for the item number).*

My opinion also addresses the following matters which have been agreed between the requestor and the injured person and/or their representative/insurer and/or their representative *(delete whichever appropriate):*

☐ *Insert either* 'No further questions were provided' - OR -

☐ *Provide your opinion on the matters as requested in the referral letter*

Summary Table				
Body part or system	**AMA5 Chapter, page, table/figure**	**Other methodology used, including relevant references**	**Whole Person Impairment (WPI) %**	**ISV Item Number**

The contents of this report are true to the best of my knowledge and belief. I have made all enquires which I believe are desirable and appropriate and no matters of significance which I regard as relevant have, to my knowledge, been withheld from the Court. This report complies with the requirements under Regulation 23(1) and (2) of the *Civil Liability Regulations 2013*.

Please phone me on: _____

or email at: _____ **if I may be of further assistance.**

Yours sincerely,

Title, First Name, Surname
Accredited Medical Practitioner
Motor Accident Injury Accreditation Scheme

Date: (DD/MM/YYYY)

Requestor's name:

Company:

Address:

City / Suburb: Post Code: State:

Injury Scale Value (ISV) Medical Assessment Report
Pure Mental Harm
GEPIC Report

Name of claimant:

Date of birth: (DD/MM/YYYY)

MVA claim number: (XXXXXXX/XXXXXXXXXX)

Date of injury: (DD/MM/YYYY)

Occupation:

Dear: (Requestor Name)

Further to your referral letter of: (DD/MONTH)

I saw: (Name) **on:** (DD/MONTH) **at:** (Location)

for the purpose of an ISV Medical Assessment Report.

You have requested a GEPIC rating and my opinion regarding an Injury Scale Value (ISV) Item Number. The referral letter states the psychiatric injury occurred as a result of the following stated cause *(list the stated cause as detailed in the referral letter).*

The injured person attended alone/or with a support person *(please state their name and their relationship to the injured person).*

☐ An interpreter was not present at the consultation.

☐ An official interpreter was present and assisted throughout the consultation.

Name & NAATI Number:

I explained my role as an Accredited Medical Practitioner and that my report from this assessment would be sent to you. I acknowledge that I have received and read Division 2 of the *Supreme Court Supplementary Rules 2014* entitled *"Expert Witnesses"* and Rule 160 of the *Supreme Court Rules 2006*. I confirm that my report complies with these provisions. Further, this report has been written in accordance with the current edition of the "Training Manual for ISV Medical Assessments."

Approved by Attorney General under 23(2) *Civil Liability Regulations 2013* on 7 January 2019 Released 9 January 2019
Enquiries to: MAIAS Administrator | GPO Box 1095, Adelaide SA 5001 | 1300 303 558 | www.maias.sa.gov.au

Document Review

I confirm the following documents were provided and read for this assessment:

1: _____

2: _____

3: _____

4: _____

5: _____

In addition, list any other relevant documentation provided by the examinee.

History *Include:*

☐ Relevant personal, family, occupational and past medical history

_____

☐ Past psychiatric history including symptoms and functional status at the time of the motor vehicle accident

_____

☐ Mechanism of injury

_____

☐ Current treatment and medications

_____

☐ Past treatment and medication (pre and post motor vehicle accident)

_____

☐ Present status of medical condition(s), treatment and medications

_____

Mental Status Examination

Detail your method of assessment and any relevant clinical findings.

_____

Opinion

My opinion addresses the following for each accident-related injury as per the referral letter:

1. **Diagnosis** *(For each accident-related injury you have been referred, and in each case, whether it is pure mental harm or consequential mental harm)*

2. **Prognosis**

3. **Injury stability**

4. **Whether the injury is consistent with the stated cause** *(Refer to the stated cause contained in the referral letter)*

5. **The effect of the MVA motor accident on any pre-existing injury and the extent to which it has been made worse by the injury;**

6. **The effect of the MVA motor accident on any subsequent injury and the extent to which it has been made worse by the injury;**

7. **In a case of pure mental harm – the GEPIC rating with detailed reasons**
   Please refer back to your opinion regarding diagnosis in Question 1
   Only complete the table below and provide a GEPIC rating for diagnosed Pure Mental Harm injuries.

Evaluation of Psychiatric Impairment

Class of Impairment	1	2	3	4	5
Percentage of Impairment	0% to 5%	10% to 20%	25% to 50%	55% to 75%	Over 75%
Mental Function					
Intelligence *Capacity for understanding*	Normal to Slight ☐	Mild ☐	Moderate ☐	Moderately Severe ☐	Severe ☐
Thinking *The ability to form or conceive in the mind*	Normal to Slight ☐	Mild ☐	Moderate ☐	Moderately Severe ☐	Severe ☐

Perception *The brain's interpretation of internal and external stimuli*	Normal to Slight ☐	Mild ☐	Moderate ☐	Moderately Severe ☐	Severe ☐
Judgement *Ability to assess a given situation and act appropriately*	Normal to Slight ☐	Mild ☐	Moderate ☐	Moderately Severe ☐	Severe ☐
Mood *Emotional tone underlying all behaviours*	Normal to Slight ☐	Mild ☐	Moderate ☐	Moderately Severe ☐	Severe ☐
Behaviour *Behaviour that is disruptive, distressing or aggressive*	Normal to Slight ☐	Mild ☐	Moderate ☐	Moderately Severe ☐	Severe ☐

Summary Table

Mental Function	Class of Impairment (1–5)
Intelligence	**X**
Thinking	**X**
Perception	**X**
Judgement	**X**
Mood	**X**
Behaviour	**X**
List all classes in ascending order	**(ie. 233332) XXXXXX**
The Median Class (the middle class)	**X = GEPIC RATING**

Please provide detailed reasoning for this GEPIC rating.

8. **The Injury Scale Value (ISV) Item Number** *(Please refer to the ISV Table. You are not required to comment on the ISV range within the item number).*

My opinion also addresses the following matters which have been agreed between the requestor and the injured person and/or their representative:

☐ *Insert either* 'No further questions were provided' - OR -

☐ *Provide your opinion on the matters as requested in the referral letter*

The contents of this report are true to the best of my knowledge and belief. I have made all enquires which I believe are desirable and appropriate and no matters of significance which I regard as relevant have, to my knowledge, been withheld from the Court. This report complies with the requirements under Regulation 23(1) and (2) of the *Civil Liability Regulations 2013*.

Please phone me on: _____

or email at: _____ **if I may be of further assistance.**

Yours sincerely,

Title, First Name, Surname
Accredited Medical Practitioner
Motor Accident Injury Accreditation Scheme

Chapter 4:
Upper Extremities

4A. The Upper Extremities

AMA 5, Chapter 16, pages 433-521.

Prior to Undertaking an ISV Medical Assessment

- The AMP evaluating injuries to the upper extremity (upper limb) for the purpose of providing an ISV Medical Assessment and an opinion on the Item Number must be accredited for this body system by the responsible Minister before undertaking an ISV Medical Assessment.
- Before undertaking an ISV Medical Assessment, AMPs must be familiar with the principles of the Training Manual and Chapters 4, 15, 19, 20. AMPs should also be familiar with Chapters 1 and 2 of AMA 5 that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- The AMP may wish to review the Item Numbers that are relevant to the referred injuries prior to the assessment. By reading the descriptors for each of the relevant Item Numbers, the assessor may consider the type of injuries that fall into each Item Number, and the medical evidence required to support the selection of an Item Number.

Upper limb injuries – region	Item Numbers	Comments
Shoulder	90-93	
Amputation upper limb(s)	94-95	
Elbow	96-99	
Wrist	100-103	
Hand	104-115	Includes hand and digit amputation(s)
Other upper limb	116-119	Other than an injury mentioned in item 90-115
Limb disorders	150*	

***Limb Disorders - Item Number 150**

In most cases any upper limb injuries will be assessed using Item Numbers 90-119, however there may be some circumstances where the AMP may wish to consider the commentary in Item Number 150 when providing their opinion.

Selecting Item Number(s)

Hand Dominance

It is important that hand dominance is described in the AMP's report.

Selecting an Item Number

The AMP's approach when providing an opinion as to the most appropriate Item Number requires consideration of the nature and severity of the injury, diagnosis, the Item Number descriptors relevant to the injury type and the whole person impairment assessment of the injury.

Only Select the Item Number

AMPs give an opinion in regard to an Item Number only, for each of the injuries referred. AMPs **DO NOT** determine the value within the range given in the ISV Table.

AMPs should provide reasons to support the Item Number/s selected.

Injuries to Both Upper Extremities

Some Item Numbers include references to injuries involving both upper extremities, e.g. Item Number 104.

Amputations

Amputations of the hand, digits and thumbs are described under *Item Numbers 104-112.* The descriptors make reference to specific amputations, levels involved and combinations of injuries. AMPs should consider the descriptors when multiple amputations are rated.

Assessing Scars

> *"Many of the physical injuries mentioned in this Schedule involve some scarring from the initial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries" (ISV Table part 7, page 207 general comments).*

AMPs should refer to the section in the Training Manual that refers to Skin and Scarring. *Item Numbers 151-154* relate to non-facial scarring, and *Item Numbers 19-22* for scarring of the face.

AMA 5: Notes for the AMP Using Chapter 16

There is an Errata published for Chapter 16. Please refer to; *Errata, Guides to the Evaluation of Permanent Impairment Fifth Edition March 2002* (A separate booklet provided with AMA 5).

- Chapter 16, page 451
- Chapter 16, page 498
- Chapter 16, page 502
- Chapter 16, page 510
- Chapter 16, page 515

Assessment Procedure

AMA 5, Chapter 16, Section 16.9, page 511, describes a summary of steps for the evaluation of upper extremity impairment. The applicable upper extremity impairment evaluation record(s) that may be used are:

- Upper extremity impairment Evaluation Record Part 1 (Hand) *AMA 5 Chapter 16, page 436*
- Upper extremity impairment Evaluation Record Part 2 (Wrist, Elbow and Shoulder) *AMA 5 Chapter 16, page 437*

Multiple Injuries

An assessment of whole person impairment must be completed for each of the injuries referred. Close attention is recommended to the material detailed within the *AMA 5, Chapter 16.1, page 434,* and the relevant worksheets found in AMA 5, page 436, 16-1a and page 437, 16-1b.

Please note, if using this worksheet to assist in your assessment, that it is rare, if ever, that you will proceed to combine the injuries requested.

Range of Motion (ROM) Method

AMA 5, Chapter 16.4, page 450, describes the principles of the ROM assessment. Measures of active joint motion take precedence. The actual measurement by goniometer or linear values are recorded by the AMP. Consistency of active ROM should be established through several repetitions. Always compare measurements of the relevant joint(s) in both upper limbs.

When using the motion impairment pie charts, please note -"*The actual ROM measurements are recorded and applied to the various impairment pie charts. Impairment values for the degree measurements falling between those listed may be adjusted or interpolated proportionally in the corresponding interval." AMA 5, Chapter 16, example 16-14, page 453.*

Where possible, interpolation must be used. In the lower extremity for example, AMA5 guides that the AMP must interpolate in some areas. To provide consistency and fairness it is reasonable to standardise across both upper extremity and lower extremity. This represents **a change from previous Training Manual.** Any request for an ISVMA should note this.

Assessment of Contralateral Joint

If the contralateral "normal" joint has less than average mobility, the impairment value(s) corresponding to the uninvolved joint can serve as baseline and are subtracted from the calculated impairment for the involved joint. The rationale for this should be explained in the report.

Where the ROM method is used to assess impairment, the ISV Medical Assessment Report should always describe the ROM values for the contralateral uninvolved joint. This methodology is detailed in *AMA 5, Chapter 16, page 451 and again on page 453*.

Impairment of the Upper Extremities (Upper Limbs) due to Other Disorders

When using *AMA 5, Chapter 16.7, page 499* (Impairment of the Upper Extremities due to other Disorders) please note *"The criteria described in this section should be used only when the other criteria have not adequately encompassed the extent of the impairments".* The term "other criteria" refers to the section of *AMA 5 Chapter 16, Upper Extremity* immediately preceding *AMA 5 Section 16-7, page 498.*

Degree of Impairment

There are wide ranges for the impairment values in some categories. If a range of percentages is available under AMA 5 for an injury of the type being assessed, the AMP must provide the reason for assessing the injury at the selected point in the range. The use of the quartile range may assist in selecting within a range of given values in AMA5.In MAIAS the commonly used descriptors are minor, moderate, serious & extreme and employing this may help if you need to select within a range of 1-25 from T16=10p 482 AMA5.**T16-10.**

Chapter 5:
Lower Extremity

5A. The Lower Extremity

AMA 5, Chapter 17, pages 523-564.

Prior to Undertaking an ISV Medical Assessment

- The AMP evaluating injuries to the lower extremity (lower limb) for the purpose of providing an ISV Medical Assessment and an opinion on the Item Number must be accredited for this body system by the responsible Minister before undertaking an ISV Medical Assessment.
- Before undertaking an ISV Medical Assessment, AMPs must be familiar with the principles of the Training Manual and Chapters 4, 15, 19, 20. AMPs should also be familiar with Chapters 1 and 2 of AMA 5 that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- MPs should also be familiar with *Chapters 1 and 2 of AMA 5* that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- The AMP may wish to review the Item Numbers that are relevant to the injuries prior to the assessment. By reading the descriptors for each of the relevant Item Numbers, the AMP may consider the type of injuries that fall into each Item Number, and the medical evidence required to support the selection of an Item Number.

Lower extremity (lower limb) injuries – region	Item Numbers	Comments
Pelvis or Hip	120-123	
Amputations Above and below the Knee	124-127	
Lower limb other	128-131	
Knee	132-135	
Ankle	136-139	
Amputations Foot and Ankle	140-141	
Foot	142-145	
Amputations Digits	146.1-1,2,3	
Toe	147-149	
Limb disorder	150*	*See note below*

***ISV 150**

The ISV for a limb disorder must be assessed having regard to the item of this Schedule that—

(a) relates to the part of the body affected by the disorder; and

(b) is for an injury that has a similar level of adverse impact to the disorder.

Selecting Item Number(s)

The AMP's approach when providing an opinion as to the most appropriate Item Number requires consideration of the nature and severity of the injury, diagnosis, the Item Number descriptors relevant to the injury type and the whole person impairment evaluation of the injury.

Only Select the Item Number

AMPs give an opinion in regard to an Item Number only, for each of the injuries referred. AMPs DO NOT determine the value within the range given in the ISV table.

AMPs should provide reasons to support the Item Number/s selected.

Limb Disorders - Item Number 150

In most cases any lower limb injuries will be assessed using *Item Numbers 120-149*, however there may be some circumstances where the AMP may wish to consider the commentary in *Item Number 150* when providing their opinion.

ISV for Pelvis or Hip

Items Numbers 120-123 apply for the assessment of pelvic or hip injuries.

Generally there will be one Item Number for the hip and pelvis region for each side. If someone has sustained a hip and pelvic injury they are to be assessed as separate injuries and each will be assigned an Item Number.

Amputations

The Item Number descriptors make reference to specific amputations, levels involved and combinations of injuries. AMPs should carefully consider the descriptors when multiple amputations are rated.

Assessing Scars

> *"Many of the physical injuries mentioned in this Schedule involve some scarring from the initial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries"* (ISV table part 7, page 207 general comments).

AMPs should refer to the section in the Training Manual that refers to Skin and Scarring. *Item Numbers 151-154* relate to non-facial scarring, and *ISV Item Numbers 19-22* for scarring of the face.

AMA 5: Notes for the AMP Using Chapter 17

AMA 5's Errata

There is an Errata published for Chapter 17. Please refer to; *Errata, Guides to the Evaluation of Permanent Impairment Fifth Edition March 2002* (A separate booklet provided with AMA 5).

- Chapter 17, page 558

Assessment Procedure

AMA 5, Section 17.3, page 555, describes a summary of steps for the evaluation of lower extremity impairment. This summary guides the AMP to determine an accurate and comprehensive impairment rating for the lower extremity.

The lower extremity impairment evaluation record *(AMA 5, Figure 17-10, page 561)* may be used as it provides a logical and detailed record of the AMP's examination findings and calculations.

AMA 5 Chapter 17 provides limited descriptors for the assessment of pelvic injuries. Where relevant, AMP may apply *AMA 5, Chapter 15, Section 15.14 The Pelvis, page 427,* using *Table 15-19, page 428,* as indicated in the foot note to *AMA 5, Chapter 17, Table 17-33 page 546.*

AMA 5 Lower Extremity Table Locator

Impairment	AMA 5 table	AMA 5 page
Limb length discrepancy	17-4	528
Gait derangement	17-5	529
Unilateral muscle atrophy	17-6	530
Muscle weakness	17-8	532
Range of motion	17-9	537
Joint ankyloses	17-15 to 17-30	538-543
Arthritis	17-31	*544*
Amputation	17-32	*545*
Diagnosis-based estimates	17-33 to 17-35	546-549
Skin loss	17-36	550
Peripheral nerve deficit	17-37	552
Complex regional pain syndrome	Section 16.5e	495-497
Vascular disorders	17-38	554
Cross usage chart	17-2	526

Cross Usage Chart

"The cross usage chart (AMA 5, table 17-2, page 526) indicates which methods and resulting impairment ratings may be combined. It is the responsibility of the physician to explain in writing why a particular method/s to assign the impairment rating was chosen. When uncertain about which method to choose, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating."

Multiple Injuries

An assessment of whole person impairment must be completed for each of the injuries referred.

Adding and Combining

Further to Chapter 2 of the Training Manual, close attention is recommended to the material within *AMA 5, Chapter 17* to determine when adding or combining values applies.

The AMP must provide a WPI rating for each of the injuries referred. A combined WPI rating for multiple injuries is not required unless specifically requested or clinically indicated

Range of Motion (ROM) Method

For ROM Measurements, refer to *AMA 5, Chapter 17, Figures 17-1 to 17-6, pages 534 to 536.*

AMA 5, Section 17.2f, page 523 describes the principles of ROM assessment. Active ROM should be established through several (3) repetitions to establish consistency in the recordings.

A helpful general definition of consistency for measurements may be found in *AMA 5, Section 2.5d, page 20.*

Gait Derangement and Assistive Devices

AMA 5 Section 17.2c, page 529, describes the assessment of gait derangement. *"Except as otherwise noted, the percentages given in Table 17-5 are for full time gait derangements of persons who are dependent on assistive devices. Whenever possible the evaluator should use a more specific method".*

Leg Length Discrepancy

AMA 5, Section 17.2b, page 528, describes the methods used to determine limb length discrepancy. The AMP should confirm that the limb length discrepancy is consistent with the stated cause. AMA 5 refers to clinical methods and teleroentgenography. Where alternate radiographic methods are used, this is to be described in the ISV Medical Assessment Report.

Arthritis

Refer to *AMA 5, Section 17h, pages 544-545.* The impairment rating for a person with arthritis *(Table 17-31)* is based on standard x-rays, with the individual standing if possible. AMPs are referred to the text on page 544 for additional detail.

As arthritis may be a pre-existing condition or affected by the motor vehicle accident, the AMP must comment on Regulation 23 (1)(e) of the CLR *"the effect of the MVA motor accident on any pre-existing injury/condition and the extent to which it has been made worse by the injury".*

Hip and Pelvis Injuries

Where an AMP is accredited for the lower extremities, a pelvic injury can be assessed with reference to *AMA 5, Chapter 15, Section 15.14,* as described at the footnote to *table 17-33.*

Causalgia and Complex Regional Pain Syndrome

When complex regional pain syndrome occurs in the lower extremity, it is assessed as detailed in *AMA 5 Section, 17.2m, page 553* which refers the AMP on to the method described in *AMA 5 Chapter 13 "The Central and Peripheral Nervous System".*

Degree of Impairment

There are wide ranges for the impairment values in some categories. If a range of percentages is available under AMA 5 for an injury of the type being assessed, the AMP must provide the reason for assessing the injury at the selected point in the range.

Chapter 6:
Spine

6A. The Spine

AMA 5, Chapter 15, pages 373-429

Unfettered use of AMA5 means Spine ROM must be considered and Pelvic Injury is rated from this Chapter

Prior to Undertaking an ISV Medical Assessment

- The AMP evaluating injuries to the spine for the purpose of providing an ISV Medical Assessment and an opinion on the Item Number must be accredited for this body system by the responsible Minister before undertaking an ISV Medical Assessment.
- Before undertaking an ISV Medical Assessment, AMPs must be familiar with the principles of the Training Manual and Chapters 4, 15, 19, 20. AMPs should also be familiar with Chapters 1 and 2 of AMA 5 that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- AMPs should also be familiar with *Chapters 1 and 2 of AMA 5* that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- The AMP may wish to review the Item Numbers that are relevant to the injuries prior to the assessment. By reading the descriptors for each of the relevant Item Numbers, the AMP may consider the type of injuries that fall into each Item Number, and the medical evidence required to support the selection of an Item Number.

Spinal Injuries – Region	Item Numbers	Comments
Quadriplegia, hemiplegia or severe limb paralysis Cervical Spine	1-3	
Cervical Spine	80-84	
Thoracic or Lumbar	85-89	
Pelvis* and Hip	120-123*	Only pelvis applies *Pelvic injuries include the sacrum, coccyx and pelvic ring.

Thoracic and Lumbar Spine Injuries

The AMP should provide an Item Number for each of the lumbar and thoracic spine regions if relevant.

Selecting Item Number(s)

Selecting an Item Number

The AMP's approach when providing an opinion as to the most appropriate Item Number requires consideration of the nature and severity of the injury, diagnosis, the Item Number descriptors relevant to the injury type and the whole person impairment evaluation of the injury.

In giving an opinion to an Item Number, the assessor should give consideration to the Item Number Descriptors included in the ISV Tables.

Only Select the ISV Item Number

AMPs give an opinion in regard to an Item Number only, for each of the injuries referred. AMPs DO NOT determine the ISV within the range given in the ISV Table.

AMPs should provide reasons to support the Item Number(s) selected.

Item Numbers for Pelvic Injury

The *Item Numbers 120-123* apply for the assessment of Pelvic or Hip injuries.

Where an AMP is accredited for the spine, then an isolated pelvic injury can be assessed using AMA 5 and applying the appropriate Item Number.

Where there are combined hip and pelvic injuries, the AMP will need to be accredited for both the spine and lower extremity.

In the circumstance where the ISV Medical Assessment and opinion as to the Item Number is incomplete, this is to be indicated in the report and summary table provided by the AMP.

Incomplete Paralyses

When considering incomplete paralyses, the AMP should refer to *Item Numbers 3, 3.1, 3.2 and 4*, taking note of the additional comment for *Item Number 3*: *"Incomplete paralyses causing WPI of less than 40% must be assessed under orthopaedic injuries if it is the only injury or the dominant injury of multiple injuries."* This applies to the cervical, thoracic and/or lumbar regions.

Assessing Scars

> *"Many of the physical injuries mentioned in this Schedule involve some scarring from the initial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries"* (ISV Table part 7, page 207 general comments).

AMPs should refer to the section in the Training Manual that refers to Skin and Scarring. *Item Numbers 151-154* relate to non-facial scarring, and *Item Numbers 19-22* for scarring of the face.

AMA 5: Notes for the AMP Using Chapter 15

Method of Assessment: Diagnostic Related Estimate (DRE) and Range of Motion (ROM).

There are two methods of assessment for the spine. The AMP must determine the appropriate method of assessment for the injury/ies they have been referred. The AMP's reason for choosing either method should be clearly documented in their ISV Medical Assessment Report.

To select a method the following need to be considered:

- *AMA 5, Section 15.2, page 379,* under the heading *"Determining the appropriate method for assessment."* This section states *"The DRE method is the principal methodology used to evaluate an individual who has a distinct injury."*
- *AMA 5, Figure 15-4, page 380 Spine Impairment Evaluation Process*
- *AMA 5, Section 15.2, pages 379-381.* This is an important reference for the evaluation of WPI of spinal injuries using *AMA 5 Chapter 15. Pages 379-380* describe several situations where the ROM method is used and should be read with reference to *Figure 15-4.*

Combining Injuries within the Spine Region

An assessment of WPI must be completed for each of the injuries referred.

AMPs should not combine multiple injuries between spinal regions (i.e. cervical, thoracic, lumbar, sacrum, coccyx.). Each region must be assessed separately so that the assessor can provide a WPI and their opinion on the Item Number for each injury referred.

Corticospinal Tract

Corticospinal tract WPI is evaluated by applying *AMA 5, Section 15.7, page 395 and table 15-6, page 396.*

Definitions of Clinical Findings used to place an Individual in a DRE Category

AMA 5, Box 15-1 Page 382 provides a definition of objective clinical findings used to place an individual in a DRE category,

AMA 5's Errata

There is an Errata published for Chapter 15. Please refer to; *Errata, Guides to the Evaluation of Permanent Impairment Fifth Edition March 2002* (A separate booklet provided with AMA 5).

- Chapter 15, page 378, figure 15-3a
- Chapter 15, page 379, figure 15-3b and 15-3c
- Chapter 15, page 381, Section 15.3
- Chapter 15, page 383
- Chapter 15, page 394
- Chapter 15, page 406
- Chapter 15, page 424, table 15-17, and 15-18.
- Chapter 15, page 425
- Chapter 15, page 426
- Chapter 15, page 429, table 15-20

Degree of Impairment

There are wide ranges for the impairment values in some categories. If a range of percentages is available under AMA 5 for an injury of the type being assessed, the AMP must provide the reason for assessing the injury at the selected point in the range. Allocating at the higher range in the DRE categories may involve a Pain rating so be aware not to duplicate this rating from Chapter 20 Pain. There may be occasions where both DRE & ROM are appropriately rated and, if so, the higher rating is used to determine the ISV Item Number.

Chapter 7:
Nervous System

7A. The Central & Peripheral Nervous System

AMA 5, Chapter 13, pages 305-353.

Prior to Undertaking an ISV Medical Assessment

- The AMP evaluating injuries to the central and peripheral nervous system for the purpose of providing an ISV Medical Assessment and an opinion on the Item Number must be accredited for this body system by the responsible Minister before undertaking an ISV Medical Assessment.
- Before undertaking an ISV Medical Assessment, AMPs must be familiar with the principles of the Training Manual and Chapters 4, 15, 19, 20. AMPs should also be familiar with Chapters 1 and 2 of AMA 5 that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- AMPs should also be familiar with *Chapters 1 and 2 of AMA 5* that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- The AMP may wish to review the Item Numbers that are relevant to the injuries prior to the assessment. By reading the descriptors for each of the relevant Item Numbers, the AMP may consider the type of injuries that fall into each Item Number, and the medical evidence required to support the selection of an Item Number.

Nervous system injuries – Region/Injury	Item Numbers	Comments
Quadriplegia	1	
Paraplegia	2	
Hemiplegia or severe paralysis of more than 1 limb	3	Incomplete paralysis causing a WPI of less than 40% must be assessed under orthopaedic injury*
Monoplegia 4	4	For information
Brain injuries	5-8	
Minor head injury, other than a skeletal injury of the facial area	9	

*Orthopaedic Item Number Descriptors for the upper and lower limbs and the spine may include neurological and/or peripheral nerve injuries. AMPs for the central and peripheral nervous system need to refer to these Item Numbers. Where there are concurrent injuries to the affected body regions, the assessment may be incomplete.

Selecting Item Number(s)

Hand Dominance

It is important that hand dominance is described in the AMP's report.

Selecting an Item Number

The AMP's approach when providing an opinion as to the most appropriate Item Number requires consideration of the nature and severity of the injury, diagnosis, the Item Number descriptors relevant to the injury type and the WPI evaluation of the injury.

Only Select the Item Number

AMPs give an opinion in regard to an Item Number only, for each of the injuries referred.

AMPs **DO NOT** determine the value within the range given in the ISV Table.

AMPs should provide reasons to support the Item Number(s) selected.

Item Numbers Relevant to Nervous System Injuries

Once WPI has been assessed, the AMP refers again to the ISV Table relevant to the nervous system to provide their opinion as to an Item Number:

Brain Injury ISV

The brain injury Item Numbers contain descriptions of the evidence for physical injury causing brain damage. For *Item Numbers 5 to 8*, the AMPs should satisfy themselves *there is evidence for a physical injury causing brain damage.*

EXAMPLES OF FACTORS AFFECTING ISV SCALE

Severity of any physical injury causing brain damage, having regard to –

(a) Any medical assessment made immediately after the injury was caused, for example, CT or MRI scans, an ambulance officer's assessment or hospital emergency unit assessment; and

(b) Significant post traumatic amnesia

Peripheral Nerve Injury

AMPs should refer to the descriptors found in the relevant orthopaedic Item Numbers under the spine, upper and lower limb.

Assessing Scars

> *"Many of the physical injuries mentioned in this Schedule involve some scarring from the initial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries"* (ISV table part 7, page 207 general comments).

AMPs should refer to the section in the Training Manual that refers to Skin and Scarring. *Item Numbers 151-154* relate to non-facial scarring, and *Item Numbers 19-22* for scarring of the face.

AMA 5: Notes for the AMP Using Chapter 13

AMA 5's Errata

There is an Errata published for Chapter 13. Please refer to; *Errata, Guides to the Evaluation of Permanent Impairment Fifth Edition March 2002* (A separate booklet provided with AMA 5).

- Chapter 13, page 345
- Chapter 13, Section 13.9, pages 345-346
- Chapter 13, page 346, table 16-13
- Chapter 13, page 348
- Chapter 13, page 348, table 13-24

Degree of Impairment

There are wide ranges for the impairment values in some categories. AMPs should use their clinical judgement and the available information to express a specific percentage within the range suggested. Reasoning for the selected rating is to be detailed in the ISV Medical Assessment Report.

Assessment Procedure

When assessing WPI using this chapter, AMPs should be thoroughly familiar with *AMA 5, Section 13-1, page 305* which details the principles of assessment, the interpretation of symptoms and signs, and describes the role of clinical studies.

Evaluation Methods

AMA 5, Table 13-25, page 352 provides a summary of evaluation methods for the assessment of nervous system impairment.

Olfaction and Taste

AMA 5 describes two ways of assessing olfaction and taste; loss of smell as described in *Section 13.4a page 327* and as it is discussed on *Section 11.4C page 262.* AMPs may use either method.

Visual Impairment

The general principles of vision assessment in this chapter are outlined in *AMA 5 Chapter 13, page 327.* This section refers the assessor to the Chapter 12, the Visual System. An ophthalmologist should assess all impairments of visual acuity, visual fields, extra-ocular movements or diplopia. Only AMPs in the Visual System may complete an assessment using Chapter 12.

In the circumstance where the ISV Medical Assessment and opinion to as to the Item Number is incomplete as a result, this is to be indicated in the report and summary table provided by the AMP.

Where there are concurrent injuries involving the same extremity that may influence the Item Number selected, and the AMP considers that the assessment may be incomplete as a consequence, this is to be indicated in the ISV Medical Assessment Report.

Central Nervous System

AMA 5, Section 13.2, page 308 describes the criteria for rating an impairment due to central nervous system disorders. When an injury affects the central nervous system several areas of function may be impaired. Therefore, the most severe category of impairment is based on the neurologic evaluation and relevant clinical investigations in four categories:

(1) state of consciousness and level of awareness;

(2) mental state evaluation and integrative functioning;

(3) use and understanding of language; and

(4) influence of behaviour and mood.

The AMP is to follow the 5 steps of this process as outlined in *AMA 5, Section 13.2, page 308,* second column.

Emotional or Behavioural Impairments

Emotional or behavioural disturbances, psychiatric manifestations and impairments that do not have documented neurologic impairments are to be evaluated using the criteria section *AMA 5, Section 13.3f, page 325.*

Arousal and Sleep Disorders

It is expected that the diagnosis of excessive daytime sleepiness has been supported by formal studies in a sleep laboratory. *AMA 5, Section 13.3c, page 317.*

Chapter 8:
Ear, Nose, Throat

8A. Ear, Nose, Throat and Related Structures

AMA 5, Chapter 11, pages 245-275.

Prior To Undertaking An ISV Medical Assessment

- The AMP evaluating injuries to the ear, nose and throat and related structures for the purpose of providing an ISV Medical Assessment and an opinion on the Item Number must be accredited for this body system by the responsible Minister before undertaking an ISV Medical Assessment.
- MAIAS also accredit medical specialists for facial injury and facial scarring. Plastic surgeons, Craniofacial and Faciomaxillary Surgeons may assess facial injuries and facial scarring in this chapter.
- Before undertaking an ISV Medical Assessment, AMPs must be familiar with the principles of the Training Manual and Chapters 4, 15, 19, 20. AMPs should also be familiar with Chapters 1 and 2 of AMA 5 that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- AMPs should also be familiar with *Chapters 1 and 2 of AMA 5* that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- The AMP may wish to review the Item Numbers that are relevant to the injuries prior to the assessment. By reading the descriptors for each of the relevant Item Numbers, the AMP may consider the type of injuries that fall into each Item Number, and the medical evidence required to support the selection of an Item Number.
- For the assessment of teeth and gums, please see page 50.

Region/Injury	Item Numbers	Comments
Ear injury	30 – 33	Includes hearing loss, tinnitus and vestibular disturbance
Facial Injury*	14 – 17	
Facial Scarring	19 – 22	
Loss of taste or smell or both	34 – 35	

Facial Injuries

** Civil Liability Regulations 2013 - Regulation 3 – Interpretation –*

"Le Fort I fracture" means a horizontal segmented fracture of the alveolar process of the maxilla;
"Le Fort II fracture" means a unilateral or bilateral fracture of the maxilla—

(a) in which the body of the maxilla is separated from the facial skeleton and pyramidal in shape; and

(b) that may extend through the body of the maxilla down the midline of the hard palate, through the floor of the orbit and into the nasal cavity;

"Le Fort III fracture" means a fracture in which the entire maxilla and one or more facial bones are completely separated from the brain case.

Selecting Item Number(s)

The AMP's approach when providing an opinion as to the most appropriate Item Number requires consideration of the nature and severity of the injury, diagnosis, the Item Number descriptors relevant to the injury type and the whole person impairment evaluation of the injury.

Only Select the Item Number

AMPs give an opinion in regard to an Item Number only, for each of the injuries referred.

AMPs **DO NOT** determine the value within the range given in the ISV Table.

AMPs should provide reasons to support the Item Number(s) selected.

Item Numbers relevant to injuries of the ear, nose, throat and related structures

Once WPI has been assessed, the AMP refers again to the ISV Table relevant to the ear, nose, throat and related structures to provide their opinion as to an Item Number:

Assessment Methodology for Binaural Hearing Loss

The Item Numbers related to hearing refer to binaural hearing loss - *ISV items 30-33.3*.

The assessment of binaural hearing loss in Australia generally utilises the method in current clinical practice described in *National Acoustics Laboratory (NAL) 1988 tables from the NAL report 118, Improved procedure for determining percentage loss of hearing (January 1988). AMA 5, Chapter 11 page 245* describes a method of assessing hearing impairment that is not in common use in Australia and does not equate to the descriptors used in the ISV. MAIAS recommends this NAL methodology on page12.

When assessing hearing loss, the AMP is to provide a binaural hearing loss percentage and is not required to provide a WPI percentage for hearing loss for the purpose of an ISV Medical Assessment Template.

The AMP should describe which method is used such as the NAL1988 Tables, report 118.

Assessing Scars

> *"Many of the physical injuries mentioned in this Schedule involve some scarring from the initial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries"* (ISV table part 7, page 207 general comments).

AMPs should refer to the section in the Training Manual that refers to Skin and Scarring. *Item Numbers 151-154* relate to non-facial scarring, and *Item Numbers 19-22* for scarring of the face.

Brain Injury ISV Items

Item Numbers relating to brain injury already include the consideration of some conditions involving the ear, smell and taste. These injuries are recommended to be assessed as part of the primary (brain) injury.

Item Number 23

Item Number 23 describes total visual and hearing loss. Confirmation of visual loss will require the involvement of an AMP accredited for that system.

AMA 5: Notes for the AMP Using Chapter 11

Multiple Injuries

An assessment of WPI must be completed for each of the injuries referred (with exception to hearing loss which is assessed in accordance to NAL). A combined WPI rating for multiple injuries is not required.

Assessment Methodology for Facial Injuries

AMA 5, Chapter 11 describes the methods of assessing permanent impairment involving facial injuries. AMPs should be familiar with the relevant sections that discuss the criteria for rating impairments due to facial disorders and or disfigurement. *AMA 5, Chapter 11, table 11 – 5, page 256* provides a summary of the criteria.

Describing Facial Scarring

Scars should be described by anatomic location, relationship to lines of election, length, colour and colour contrast, presence of trophic changes, suture marks, contour defects, tethering/adherence to underlying structures, and whether or not the scar would be covered by usual hairstyle, any consequential mental harm, and likelihood of the scar fading/becoming less noticeable over time. Any limitation of activities of daily living caused by the scarring, ongoing treatment, use of pressure garments, sunblock and need for protective clothing should be described.

Tinnitus

As detailed in *AMA 5, Section 11.2a, Page 246* the AMP should describe the nature and severity of tinnitus and its impact on the person's ability to perform activities of daily living.

The AMP should also comment on the severity of the tinnitus when providing an opinion of the level of binaural hearing loss and record this in the ISV Medical Assessment Report.

Equilibrium

The assessment of impairment due to disorders of equilibrium as detailed in *AMA 5, Section 11.2b, pages 252-255* is dependent on objectively demonstrable findings of vestibular dysfunction. The results of laboratory tests should be correlated with validated clinical measures of balance and ambulation to determine the true state of equilibratory dysfunction.

Degree of Impairment

There are wide ranges for the impairment values in some categories. If a range of percentages is available under AMA 5 for an injury of the type being assessed, the AMP must provide the reason for assessing the injury at the selected point in the range.

Teeth and Gums

- It is unlikely that an AMP will receive a referral for an assessment of the teeth and gums, as the referring parties should obtain relevant information from a Dentist or Orthodontist.
- However, if an AMP is asked to provide an assessment for teeth and gums, the AMP must ensure that sufficient relevant medical evidence has been included with the referral, and select an Item Number from the ISV Table below.
- By reading the descriptors for each of the relevant Item Numbers, the AMP may consider the type of injuries that fall into each Item Number, and the medical evidence required to support allocating an injury into that Item Number.

Teeth or Gums – Region/Injury

Comment

There will generally have been a course of treatment as a result of the injury. Examples of factors affecting ISV scale

- Extent and degree of discomfort during treatment
- Difficulty with eating

Comment about appropriate level of ISV

If protracted dentistry causes the injury, the ISV may be higher than the ISV for the same injury caused by something else.

18.1 Loss of or serious damage to more than 3 teeth, serious gum injury or serious gum infection

18.2 Loss of or serious damage to 2 or 3 teeth, moderate gum injury or moderate gum infection

18.3 Loss of or serious damage to 1 tooth, minor gum injury or minor gum infection

Selecting Item Number(s)

AMPs are to provide a written rationale to support the Item Number(s) selected.

Chapter 9:
Urinary & Reproductive

9A. The Urinary and Reproductive Systems

AMA 5, Chapter 7, pages 143-171.

IMPORTANT NOTE

For dysfunction of the reproductive system and bladder as a consequence of spinal cord, cauda equina or central nervous system, impairment is generally assessed under the specific body system and relevant Item Number by an AMP in those body systems.

IMPORTANT NOTE

The Item Numbers for injuries to the male and female reproductive system apply to injuries caused by physical trauma rather than as a secondary result of psychiatric impairment, Pure Mental Harm.

Prior to Undertaking an ISV Medical Assessment

- The AMP evaluating injuries to the urinary and reproductive systems for the purpose of providing an ISV Medical Assessment and an opinion on the Item Number must be accredited for this body system by the responsible Minister before undertaking an ISV Medical Assessment.
- Before undertaking an ISV Medical Assessment, AMPs must be familiar with the principles of the Training Manual and Chapters 4, 15, 19, 20. AMPs should also be familiar with Chapters 1 and 2 of AMA 5 that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- AMPs should also be familiar with *Chapters 1 and 2 of AMA* 5 that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- The AMP may wish to review the Item Numbers that are relevant to the injuries prior to the assessment. By reading the Item Numbers descriptors for each of the relevant Item Numbers, the assessor may consider the type of injuries that fall into each Item Number, and the medical evidence required to support the selection of an Item Number.

Urinary and Reproductive System injuries – Region/Injury	Item Numbers	Comments
Impotence and sterility	44	
Loss of part or all of the penis	45	
Loss of both testicles	46	See item 44 where sterility results
Loss of 1 testicle	47	
Infertility	48	
Any other injury to the female reproductive system	49	
Injury to kidneys or ureters	58-61	
Bladder, prostate or urethra injury	70-73	

Selecting Item Number(s)

The AMP's approach when providing an opinion as to the most appropriate Item Number requires consideration of the nature and severity of the injury, diagnosis, the Item Number descriptors relevant to the injury type and the whole person impairment evaluation of the injury.

Only Select the Item Number

AMPs give an opinion in regard to an Item Number only, for each of the injuries referred.

AMPs **DO NOT** determine the value within the range given in the ISV Table. AMPs should provide reasons to support the ISV Item Number/s selected.

Item Numbers Relevant to Urinary and Reproductive System Injuries

Once WPI has been assessed, the AMP refers again to the ISV Table relevant to the urinary and reproductive system to provide their opinion as to an ISV Item Number:

No Matching Item Number

There may be rare circumstances where an impairment under the urinary and reproductive system can be assessed under AMA 5, but where there is not a corresponding Item Number. AMPs are required to provide the WPI rating in the report and indicate that there is no matching Item Number. Where possible, AMPs should provide their opinion as to an Item Number by analogy, and explain their reasoning for this.

Assessing Scars

> *"Many of the physical injuries mentioned in this Schedule involve some scarring from the inibtial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries"* (ISV table part 7, page 207 general comments).

AMPs should refer to the section in the Training Manual that refers to Skin and Scarring. *Item Numbers 151-154* relate to non-facial scarring, and *Item Numbers 19-22* for scarring of the face.

AMA 5: Notes for the AMP Using Chapter 7

AMA 5 Chapter 1 and 2

Before undertaking an ISV Medical Assessment, AMPs should be familiar with *AMA 5, Chapters 1 and 2* that discuss the purpose, applications and methods for performing and reporting impairment evaluations, and the introductory chapter of this Training Manual.

Assessment Procedure

AMA 5, Section 7.1, page 144 provides the AMP with an evaluation summary for the assessment of impairment.

AMPs must exclude all of these methods, and follow the instructions provided within *AMA 5 Chapter 7*.

Degree of Impairment

There are wide ranges for the impairment values in some categories. If a range of percentages is available under AMA 5 for an injury of the type being assessed, the AMP must provide the reason for assessing the injury at the selected point in the range.

Chapter 10: Respiratory

10A. The Respiratory System

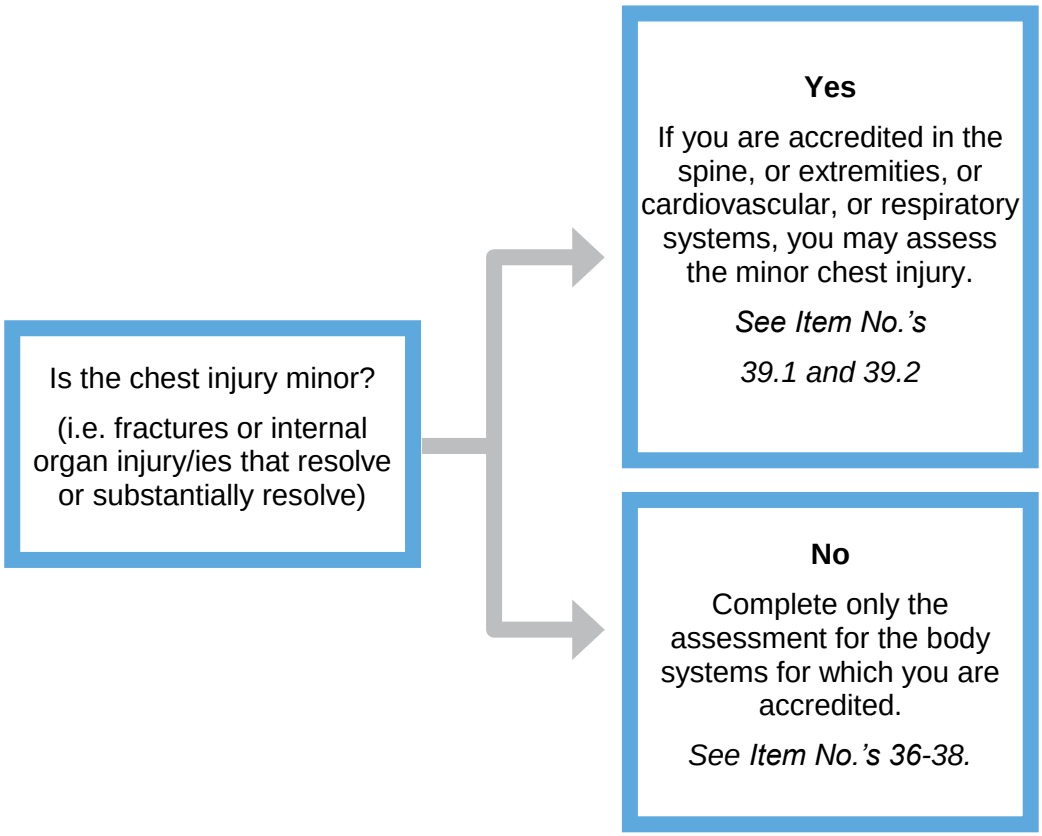
AMA 5, Chapter 5, pages 87-115

IMPORTANT NOTE

Respiratory System Assessments of Chest Injuries

There may be circumstances where a respiratory system injury forms part of a chest injury assessment. The Item Number descriptors for the chest include considering the nature and severity of injury to the internal organs (respiratory, cardiovascular or digestive systems) of the chest and chest wall structures. AMPs should refer to the chest injury flow chart below.

Chest Injury Assessment Flow Chart: Who can assess Chest Injuries?



Prior to Undertaking an ISV Medical Assessment

- The AMP evaluating injuries to the respiratory system for the purpose of providing an ISV Medical Assessment and an opinion on the Item Number must be accredited for this body system by the responsible Minister before undertaking an ISV Medical Assessment.
- Before undertaking an ISV Medical Assessment, AMPs must be familiar with the principles of the Training Manual and Chapters 4, 15, 19, 20. AMPs should also be familiar with Chapters 1 and 2 of AMA 5 that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- AMPs should also be familiar with Chapters 1 and 2 of AMA 5 that discuss the purpose, applications and methods for performing and reporting impairment evaluations.

- The AMP may wish to review the Item Numbers that are relevant to the injuries prior to the assessment. By reading the descriptors for each of the relevant Item Numbers, the AMP may consider the type of injuries that fall into each Item Number, and the medical evidence required to support the selection of an Item Number.

Chest and lung – Region/Injury	Item Numbers	Comments
Chest injury	36-39	
Lung injury	40-43	Includes pulmonary embolism*

*Pulmonary Embolism

Pulmonary embolism may be assessed under the cardiovascular system in *AMA 5 Chapter 5*. Item Numbers for the lungs may be considered from *ISV Item Numbers 40-43.*

To assess WPI for pulmonary embolism, AMPs need to be accredited for the cardiovascular body system.

Selecting Item Number(s)

The AMPs approach when providing an opinion as to the most appropriate ISV Item Number requires consideration of the nature and severity of the injury, diagnosis, the ISV Item Number descriptors relevant to the injury type and the whole person impairment evaluation of the injury.

Only Select the Item Number

AMPs give an opinion in regard to an Item Number only for each of the injuries referred. AMPs **DO NOT** determine the value within the range given in the ISV Table. AMPs should provide reasons to support the Item Number(s) selected.

Complex and Incomplete Assessment

AMPs should apply the body systems that they have been accredited for and describe the WPI in their report and the Item Number if there is sufficient information to do so, and describe the reasons in the report or describe why an assessment may be incomplete. An administrative process may need to follow in some circumstances to determine the final Item Number where multiple body systems are involved due to the chest injury.

Assessing Scars

> *"Many of the physical injuries mentioned in this Schedule involve some scarring from the initial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries"* (ISV table part 7, page 207 general comments).

AMPs should refer to the section in the Training Manual that refers to Skin and Scarring. *ISV Item Numbers 151-154* relate to non-facial scarring, and *ISV Item Numbers 19-22* for scarring of the face.

AMA 5: Notes for the AMP Using Chapter 5

Multiple Injuries

An assessment of WPI must be completed for each of the injuries referred. A combined WPI rating for multiple injuries is not required.

Assessment Procedure

AMA 5, Chapter 5 describes the method for assessing permanent impairment arising from respiratory disorders.

- *Table 5-12, (page 107)* lists the criteria for estimating permanent impairment for respiratory disorders.
- *Table 5-13 (page 112)* provides a summary of respiratory impairment evaluation.

Pre-existing Conditions to Exposure to Tobacco Smoke

The AMP is required to consider the effect of the motor vehicle accident on any pre-existing condition and extent to which it has been made worse by the injury. *AMA 5, Section 5.3, page 90* makes reference to exposure to tobacco smoke and other environmental and occupational factors.

If considered clinically appropriate to apportion for any such effect, it is expected reasons must be provided to support the determinations made.

Degree of Impairment

There are wide ranges for the impairment values in some categories. If a range of percentages is available under AMA 5 for an injury of the type being assessed, the AMP must provide the reason for assessing the injury at the selected point in the range.

Chapter 11: Hearing

11A. Hearing - Item Number derived from BHI%

AMA 5, Chapter 11, pages 245-275 MAIAS recommends NAL Table use but the general principles in AMA5 apply

AMPs are to refer to *Chapter 8 (Training Manual page 47)* for the assessment of hearing.

Hearing loss can be multifactorial in origin and includes congenital, noise induced and non- injury related causes. AMPs are asked to review the relevant history and clinical information. The AMP should expressly describe pre-existing conditions and their relationship to the degree of hearing loss, and the extent of the loss related to the injury.

Chapter 12: Visual

12A. The Visual System (AMA 4 may be used)

AMA 5, Chapter 12, pages 277-303

Prior to Undertaking an ISV Medical Assessment

- The AMP evaluating injuries to the visual system for the purpose of providing an ISV Medical Assessment Report must be accredited for this body system by the responsible Minister before undertaking an ISV Medical Assessment.
- Before undertaking an ISV Medical Assessment, AMPs must be familiar with the principles of the Training Manual and Chapters 4, 15, 19, 20. AMPs should also be familiar with Chapters 1 and 2 of AMA 5 that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- AMPs should also be familiar with Chapters 1 and 2 of AMA 5 that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- The AMP may wish to review the Item Numbers that are relevant to the injuries prior to the assessment. By reading the descriptors for each of the relevant Item Numbers, the AMP may consider the type of injuries that fall into each Item Number, and the medical evidence required to support the selection of an Item Number.

Visual systems injuries – Region/Injury	Item Numbers	Comments
Total sight and hearing impairment	23	Hearing impairment – see note re: Item number 23 over the page
Total sight impairment	24	
Complete sight impairment in 1 eye with reduced vision in the other eye	25	
Complete sight impairment in 1 eye or total loss of 1 eye	26	
Eye injury serious, moderate, minor	27-29	

Selecting Item Number(s)

The AMP's approach when providing an opinion as to the most appropriate Item Number requires consideration of the nature and severity of the injury, diagnosis, the Item Number descriptors relevant to the injury type and the WPI assessment of the injury.

Only Select the Item Number

AMPs give an opinion in regard to an Item Number only, for each of the injuries referred. AMPs **DO NOT** determine the value within the range given in the ISV Table. AMPs should provide reasons to support the Item Number(s) selected.

Hearing Loss ISV Item Number 23

ISV Item Number 23 addresses injuries resulting total sight and hearing impairment. Where an AMP is accredited for the visual chapter, an isolated visual impairment can be assessed as discussed below – notes for using Chapter 12.

The AMP provides an opinion as to the appropriate Item Number. Where there are combined visual and hearing injuries, the AMP will provide their opinion on the Item Number for the body system they are accredited for.

In the circumstance where the ISV Medical Assessment is incomplete as a result, this is to be indicated in the ISV Medical Assessment Report and a summary table provided by the AMP.

Assessing Scars

> *"Many of the physical injuries mentioned in this Schedule involve some scarring from the initial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries"* (ISV table part 7, page 207 general comments).

AMP should refer to the section in the Training Manual that refers to Skin and Scarring. *Item Numbers 151-154* relate to non-facial scarring, and *Item Numbers 19-22* for scarring of the face.

AMA 5: Notes for the AMP Using Chapter 12

Multiple Injuries

An assessment of WPI must be completed for each of the injuries referred. A combined WPI rating for multiple injuries is not required.

Assessment Procedure

If an appropriate assessment method is not available in AMA 5 for the injury referred, the AMP may choose an alternative method and describe the reasons for it in their report *(for example, an Ophthalmologist may not have the required equipment to complete*

An Assessment using AMA 5, choosing to complete the assessment using a different accepted methodology of assessment) and explain their reason for selecting this.

If the AMP has the equipment required to undertake an assessment for visual impairment as per *AMA 5, Chapter 12, page 277,* the methodology of *Chapter 12* should be used. If not, the AMP should undertake an alternative assessment by accepted methodology, such as AMA 4.

Testing Required to Assess Whole Person Impairment

The AMP should perform, or review, all tests necessary for the assessment of permanent impairment, rather than relying on tests, or interpretations of tests, done by the orthoptist or optometrist.

Degree of Impairment

There are wide ranges for the impairment values in some categories. If a range of percentages is available under AMA 5 for an injury of the type being assessed, the AMP must provide the reason for assessing the injury at the selected point in the range.

Chapter 13: Haematopoietic

13A. The Haematopoietic System

AMA 5, Chapter 9, pages 191-209

Prior to Undertaking an ISV Medical Assessment

- The AMP evaluating injuries to the haematopoietic system for the purpose of providing an ISV Medical Assessment and an opinion on the Item Number must be accredited for this body system by the responsible Minister before undertaking an ISV Medical Assessment.
- Before undertaking an ISV Medical Assessment, AMPs must be familiar with the principles of the Training Manual and Chapters 4, 15, 19, 20. AMPs should also be familiar with Chapters 1 and 2 of AMA 5 that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- AMP should also be familiar with *Chapters 1 and 2 of AMA 5* that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- The AMP may wish to review the Item Numbers that are relevant to the injuries prior to the assessment. By reading the descriptors for each of the relevant Item Numbers, the AMP may consider the type of injuries that fall into each Item Number, and the medical evidence required to support the selection of an Item Number.

Hematopoietic System – Region/Injury	ISV Item Numbers	Comments
Loss of spleen (complicated)	75	
Injury to the spleen or uncomplicated loss of spleen	76	

No Matching Item Number

There may be circumstances where an impairment under the haematopoietic system can be assessed under AMA 5, but where there is not a corresponding ISV Item Number, AMPs are required to provide the WPI rating in the report and indicate that there is no matching Item Number. Where possible, AMPs should provide their opinion as to an Item Number by analogy, and explain their reasoning for this.

Selecting Item Number/s

The AMP's approach when providing an opinion as to the most appropriate Item Number requires consideration of the nature and severity of the injury, diagnosis, the Item Number descriptors relevant to the injury type and the WPI evaluation of the injury.

Only Select the Item Number

AMPs give an opinion in regard to an Item Number only, for each of the injuries referred.

AMPs **DO NOT** determine the value within the range given in the ISV Table.

AMPs should provide reasons to support the Item Number/s selected.

Long Term Anticoagulation

Item Numbers may apply for long term anticoagulation based on body part involvement under the upper limb, lower limb, chest and lung regions. The Item Numbers are to be determined as part of the relevant regional injury assessment under the appropriate body system.

Assessing Scars

> *"Many of the physical injuries mentioned in this Schedule involve some scarring from the initial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries"* (ISV table part 7, page 207 general comments).

AMPs should refer to the section in the Training Manual that refers to Skin and Scarring. *Item Numbers 151-154* relate to non-facial scarring, and *Item Numbers 19-22* for scarring of the face.

AMA 5: Notes for the AMP Using Chapter 9

Multiple Injuries

An assessment of WPI must be completed for each of the injuries referred. A combined WPI rating for multiple injuries is not required.

Assessment Procedure

AMA 5, Chapter 9, table 9.7, page 208 provides a haematological impairment methods summary.

The haematopoietic system includes the bone marrow, lymph nodes, and spleen that produce a heterogeneous population of blood-circulating cells and a complex family of proteins critical for blood clotting and immune defences.

Degree of Impairment

There are wide ranges for the impairment values in some categories. AMPs should use their clinical assessment and the available information to express a specific percentage within the range suggested. Reasoning for the selected rating must be described in the report.

Spleen

AMA 5 does not provide an impairment level for injury of the spleen. In situations where impairment ratings are not provided, AMA 5 suggests that physicians use clinical judgement. The AMP may compare 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 (see *AMA 5, Chapter 1, page 11*). Reasoning for the selected rating must be described in the report.

Reporting Units

The AMA Guides refers to pathology values and references ranges. Pathology results in Australia are generally reported in units and ranges as recommended by the Royal Australasian College of Pathologists. AMPs should explain their choice of units and ranges in the report.

WSR from AMA 5

The Westergren erythrocyte sedimentation rate (WSR) is equivalent to the ESR.

Chapter 14: Endocrine

14A. The Endocrine System

AMA 5, Chapter 10, pages 211-244.

Prior to Undertaking an ISV Medical Assessment

- The AMP evaluating injuries to the endocrine system for the purpose of providing an ISV Medical Assessment and an opinion on the ISV Item Number must be accredited for this body system by the responsible Minister before undertaking an ISV Medical Assessment.
- Before undertaking an ISV Medical Assessment, AMPs must be familiar with the principles of the Training Manual and Chapters 4, 15, 19, 20. AMPs should also be familiar with Chapters 1 and 2 of AMA 5 that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- AMPs should also be familiar with *Chapters 1 and 2 of AMA 5* that discuss the purpose, applications and methods for performing and reporting impairment assessments.
- The AMP may wish to review the ISV Item Numbers that are relevant to the injuries prior to the assessment. By reading the descriptors for each of the relevant Item Numbers, the AMP may consider the type of injuries that fall into each Item Number, and the medical evidence required to support the selection of an ISV Item Number.

Endocrine System – Region/Injury	ISV Item Numbers	Comments
Injuries to the pancreas*	74	
Brain injury*	5-8	Consider primary injury and whether the assessment should be conducted in accordance with Chapter 9, Urinary and Reproductive Systems.

*Endocrine Dysfunction due to Injury

Endocrine dysfunction due to injuries may be described as part of the Item Number descriptors for the *Reproductive system (ISV 44-49.4) or Brain Injury (ISV 5-8).*

*Brain Injury

Item Numbers relating to brain and reproductive injury already include the consideration of some conditions involving the endocrine system. These injuries are recommended to be assessed as part of the brain and reproductive injury.

Selecting ISV Item Number/s

The AMP's approach when providing an opinion as to the most appropriate Item Number requires consideration of the nature and severity of the injury, diagnosis, the Item Number descriptors relevant to the injury type and the WPI evaluation of the injury.

Only Select the Item Number

AMPs give an opinion in regard to an Item Number only, for each of the injuries referred.

AMPs **DO NOT** determine the value within the range given in the ISV Table.

AMPs should provide reasons to support the Item Number(s) selected.

No Matching Item Number

There may be rare circumstances where an impairment of the endocrine system can be assessed under AMA 5, but where there is not a corresponding Item Number. AMPs are required to provide the WPI rating in the report and indicate that there is no matching Item Number. Where possible, AMPs should provide their opinion as to an Item Number by analogy, and explain their reasoning for this.

Assessing Scars

> *"Many of the physical injuries mentioned in this Schedule involve some scarring from the initial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries"* (ISV table part 7, page 207 general comments).

AMPs should refer to the section in the Training Manual that refers to Skin and Scarring. *Item Numbers 151-154* relate to non-facial scarring, and *Item Numbers 19-22* for scarring of the face.

AMA 5: Notes for the AMP Using Chapter 10

Before undertaking a ISV Medical Assessment, AMPs should be familiar with *AMA 5, Chapters 1 and 2* that discuss the purpose, applications and methods for performing and reporting impairment evaluations, and the introductory chapter of this Training Manual.

Multiple Injuries

An assessment of whole person impairment must be completed for each of the injuries referred. A combined whole person impairment rating for multiple injuries is not required.

Assessment Procedure

AMA 5, Chapter 10, table 10-10 pages 242-243 describes the endocrine system evaluation summary.

Reporting Units

The AMA Guides refers to values and references ranges. Pathology results in Australia are generally reported in units and ranges as recommended by the Royal Australasian College of Pathologists. AMPs should choose a suitable methodology and explain their choice in their report

WSR from AMA 5

The Westergren erythrocyte sedimentation rate (WSR) is equivalent to the ESR.

Degree of Impairment

There are wide ranges for the impairment values in some categories. If a range of percentages is available under AMA 5 for an injury of the type being assessed, the AMP must provide the reason for assessing the injury at the selected point in the range.

Chapter 15:
Skin & Scarring

15A. Skin and Scarring

AMA 5, Chapter 8, pages 173-190.

IMPORTANT NOTE

This chapter includes the assessment of -

- body and facial scarring,
- head hair loss,
- burns, and
- skin from AMA 5 Chapter 8

Assessments under this chapter are likely to be infrequent as a consequence of injuries arising from a motor vehicle accident, since scarring is usually considered in the Item Number for the injury.

Prior To Undertaking An ISV Medical Assessment

- The AMPs evaluating scarring, burns, loss of hair and minor facial scarring (ISV 22) must be accredited by the responsible Minister before undertaking an ISV Medical Assessment.
- AMPs evaluating skin conditions using AMA 5 must be accredited for the Skin body system by the responsible Minister before undertaking an ISV Medical Assessment.
- AMPs evaluating Moderate to Extreme scarring to the face (ISV 19-21) will need to be accredited for the assessment of ENT system
- The AMP may wish to review the Item Numbers that are relevant to the injuries they are to assess prior to the assessment. By reading the descriptors for each of the relevant Item Numbers, the AMP may consider the type of injuries that fall into each Item Number, and the medical evidence required to support allocating an injury into that Item Number.

Region/Injury	ISV Item Numbers	Comments
Facial scarring	22	Minor facial scarring can be undertaken by non ENT Accredited Assessors.
Facial scarring	19-21	Accreditation for ENT system required.
Scarring to a part of the body other than the face	151-154	
Loss of head hair, loss of body hair	155-157	158 or 159

Selecting Item Number/s

In most circumstances, an assessment for scarring is included within the ISV assessment for the injury.

The following is from the *ISV table. Part 7 of the Civil Liabilities Regulations 2013- Scarring to parts of the body other than the face.*

- *This part applies to the external appearance and physical condition of the skin only, and includes scarring of the scalp, trunk and limbs.*

- *Facial scarring must be assessed under Part 3, Division 2*
- *This Part does not apply to adhesions, or scarring, of internal organs*
- *This Part will usually apply to an injury involving skeletal damage only if the skeletal damage is minor*
- ***Many of the physical injuries mentioned in this Schedule involve some scarring from the initial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries.***

EXAMPLE

The ISV range for an injury causing a closed fracture of a limb takes into account the potential need for open reduction and internal fixation of the fracture and the resulting surgical wound and scar.

EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT FOR ITEM NUMBERS 151 TO 154

- *Location of a scar*
- *Age*
- *Consequential mental harm*
- *Likelihood of a scar fading or becoming less noticeable over time.*

Describing Scars

For the purpose of the ISV Medical Assessment, it is preferable that scars be described by anatomic location, length, colour contrast, presence of trophic changes, suture marks, contour defects, tethering/adherence to underlying structures, and whether or not the scar would be covered by usual hair style, apparel or clothing, any consequential mental harm, and likelihood of scar fading/becoming less noticeable over time. Any limitation of activities of daily living caused by the scarring, ongoing treatment, use of pressure garments, sun block and need for protective clothing should be described.

Selecting an Item Number

The AMP's approach when providing an opinion as to the most appropriate Item Number requires consideration of the nature and severity of the injury, diagnosis, the Item Number descriptors relevant to the injury type and the WPI evaluation of the injury.

Only Select the Item Number

AMPs give an opinion in regard to an Item Number only, for each of injuries referred. AMPs **DO NOT** determine the value within the range given in the ISV Table. AMPs should provide reasons to support the Item Number/s selected.

AMA 5: Notes for the AMP Using Chapter 8

- Before undertaking an ISV Medical Assessment, AMPs must be familiar with Chapters 1 and 2 of the Training Manual.
- AMPs should also be familiar with *Chapters 1 and 2 of AMA 5* that discuss the purpose, applications and methods for performing and reporting impairment evaluations.

Assessments under this chapter are likely to be infrequent as a consequence of injuries arising from a motor vehicle accident since they are usually specifically considered in the Item Numbers dealing with scarring (facial and non-facial) and burns, or the specific injury.

Assessment Procedure

AMA 5, Chapter 8, table 8-3, page 188 provides a skin impairment evaluation summary.

Degree of Impairment

There are wide ranges for the impairment values in some categories. If a range of percentages is available under AMA 5 for an injury of the type being assessed, the AMP must provide the reason for assessing the injury at the selected point in the range.

No Matching Item Number

There may be circumstances where an impairment under Skin system can be assessed under AMA 5, but where there is not a corresponding Item Number. AMPs are required to provide the WPI rating in the report and indicate that there is no matching Item Number. Where possible, AMPs should provide their opinion as to an Item Number by analogy, and explain their reasoning for this.

Chapter 16: Cardiovascular

16A. The Cardiovascular System

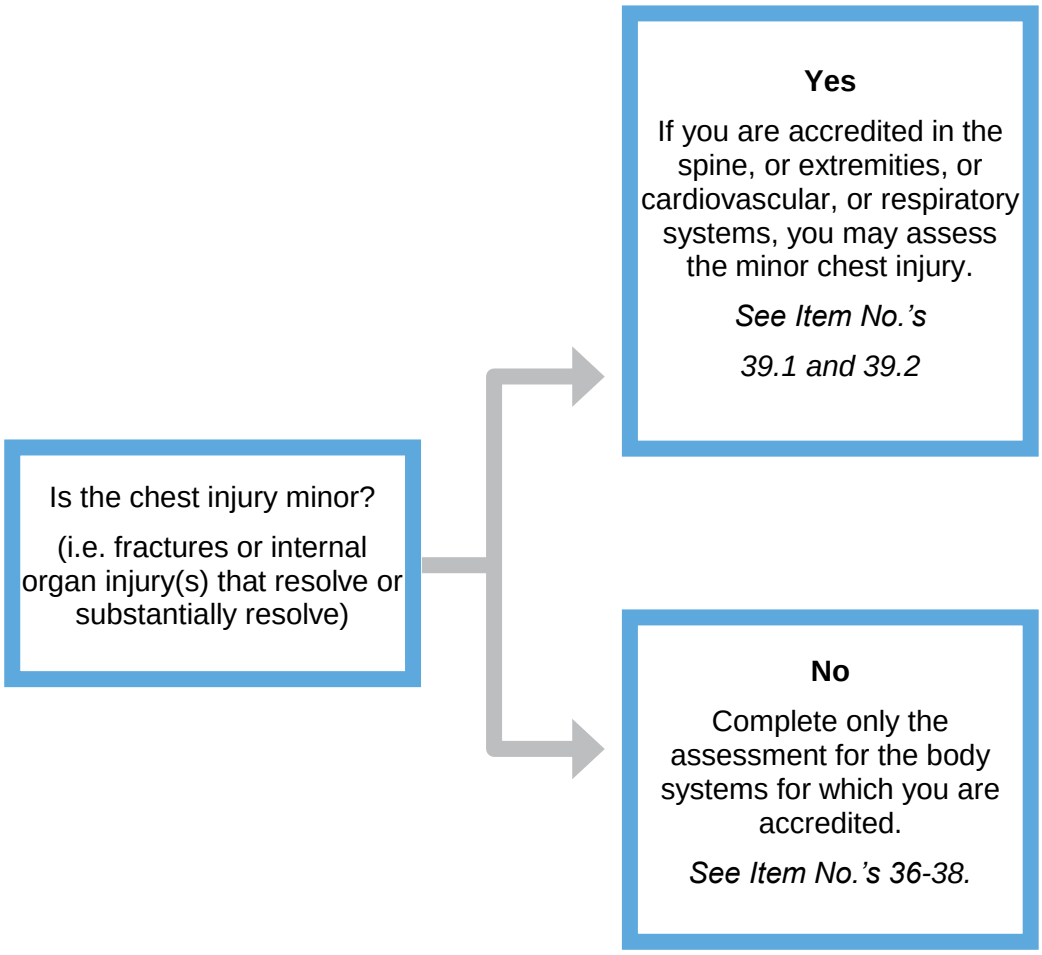
AMA 5, Chapter 3, pages 25-63: Heart and Aorta

AMA 5, Chapter 4, pages 65-85: Systemic and Pulmonary arteries

IMPORTANT NOTE

There may be rare circumstances where a cardiovascular system injury forms part of the chest injury assessment. The chest Item Number descriptors include considering the nature and severity of injury to the internal organs (respiratory, cardiovascular or digestive systems) of the chest and chest wall structures. AMPs should refer to the chest injury flow chart below and complex and incomplete assessments.

Chest Injury Assessment Flow Chart: Who can assess Chest Injuries?



Prior to Undertaking an ISV Medical Assessment

- The AMP evaluating injuries to the cardiovascular system for the purpose of providing an ISV Medical Assessment and an opinion on the Item Number must be accredited for this body system by the responsible Minister before undertaking an ISV Medical Assessment.

- Before undertaking an ISV Medical Assessment, AMPs must be familiar with the principles of the Training Manual and Chapters 4, 15, 19, 20. AMPs should also be familiar with Chapters 1 and 2 of AMA 5 that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- AMPs should also be familiar with *Chapters 1 and 2 of AMA 5* that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- The AMP may wish to review the Item Numbers that are relevant to the injuries prior to the assessment. By reading the descriptors for each of the relevant Item Numbers, the AMP may consider the type of injuries that fall into each Item Number, and the medical evidence required to support the selection of an Item Number.

Cardiovascular System – Region/Injury	Item Numbers	Comments
Chest injury	36-39	Chest injury Cardiovascular
Upper limb	116-119	
Lower limb	128-131	
Lung injury	40-43	Pulmonary embolism

AMPs for the cardiovascular system need to refer to these Item Numbers. Where there are concurrent injuries to the affected body regions, the assessment may be incomplete.

Pulmonary Embolism

Pulmonary embolism may be assessed under the cardiovascular system in AMA 5 Chapter 5. Item Numbers for the lungs may be considered from *ISV Item Numbers 40-43.*

Complex and Incomplete Assessment

AMPs should apply the body systems that they have been accredited for and describe the WPI in their report and the Item Number if there is sufficient information to do so, and describe the reasons in the report or describe why an assessment may be incomplete. An administrative process may need to follow in some circumstances to determine the final Item Number where multiple body systems are involved due to the chest injury.

Selecting Item Number(s)

The AMP's approach when providing an opinion as to the most appropriate Item Number requires consideration of the nature and severity of the injury, diagnosis, the Item Number descriptors relevant to the injury type and the whole person impairment evaluation of the injury.

Only Select the Item Number

AMPs give an opinion in regard to an Item Number only, for each of injuries referred. AMPs **DO NOT** determine the value within the range given in the ISV Table. AMPs should provide reasons to support the Item Number(s) selected.

Assessing Scars

> *"Many of the physical injuries mentioned in this Schedule involve some scarring from the initial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries"* (ISV table part 7, page 207 general comments).

AMPs should refer to the section in the Training Manual that refers to Skin and Scarring. *Item Numbers 151-154* relate to non-facial scarring, and *Item Numbers 19-22* for scarring of the face.

AMA 5: Notes for the AMP Using Chapters 3 & 4

Multiple Injuries

An assessment of WPI must be completed for each of the injuries referred. A combined WPI rating for multiple injuries is not required.

AMA 5's Errata

There is an Errata published for Chapter 4. Please refer to; *Errata, Guides to the Evaluation of Permanent Impairment Fifth Edition March 2002* (A separate booklet provided with AMA 5).

- Chapter 4, page 75

Assessment Procedure

AMA 5 Chapter 3, Section 3.8, table 3-12, Page 60 summarises impairment evaluation for the heart and aorta.

AMA 5 Chapter 4, table 4-7, page 82 provides a summary of the impairment evaluation of the systemic and pulmonary arteries.

Lower and Upper Extremity Peripheral Vascular Assessments

AMA 5, table 4-4, page 74, and *Table 4-5, page 76* refer to percentage impairment of the upper or lower extremity. An assessment of impairment of the upper extremity or lower extremity requires that the percentages identified in *tables 4-4 and 4-5* be converted to WPI.

The table for conversion of the upper extremity is located in *AMA 5, table 16-3, page 439* and the table for conversion of the lower extremity is *table 17-3, page 527.*

Peripheral vascular disease in the upper and lower extremities is also assessable from their respective chapters in AMA 5:

- *Table 16-17 page 498 for upper extremity*
- *Table 17-38 page 554 for lower extremity*

Degree of Impairment

There are wide ranges for the impairment values in some categories. If a range of percentages is available under AMA 5 for an injury of the type being assessed, the AMP must provide the reason for assessing the injury at the selected point in the range.

Chapter 17: Digestive

17A. The Digestive System

AMA 5, Chapter 6, pages 117-142.

Prior to Undertaking an ISV Medical Assessment

- The AMP evaluating injuries to the digestive system for the purpose of providing an ISV Medical Assessment and an opinion on the Item Number must be accredited for this body system by the responsible Minister before undertaking an ISV Medical Assessment.
- Before undertaking an ISV Medical Assessment, AMPs must be familiar with the principles of the Training Manual and Chapters 4, 15, 19, 20. AMPs should also be familiar with Chapters 1 and 2 of AMA 5 that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- AMPs should also be familiar with *Chapters 1 and 2 of AMA 5* that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- The AMP may wish to review the Item Numbers that are relevant to the injuries prior to the assessment. By reading the descriptors for each of the relevant Item Numbers, the AMP may consider the type of injuries that fall into each Item Number, and the medical evidence required to support the selection of an Item Number.

Region/Injury	Item Numbers	Comments
Injury to the upper digestive tract caused by trauma	50-53	
Injury to the digestive system not caused by trauma	54-57	
Injury to liver, gall bladder or biliary tract	62-65 7	
Bowel injuries	66-69	
Pancreas	74	
Hernia	77-78	

Complex and Incomplete Assessment

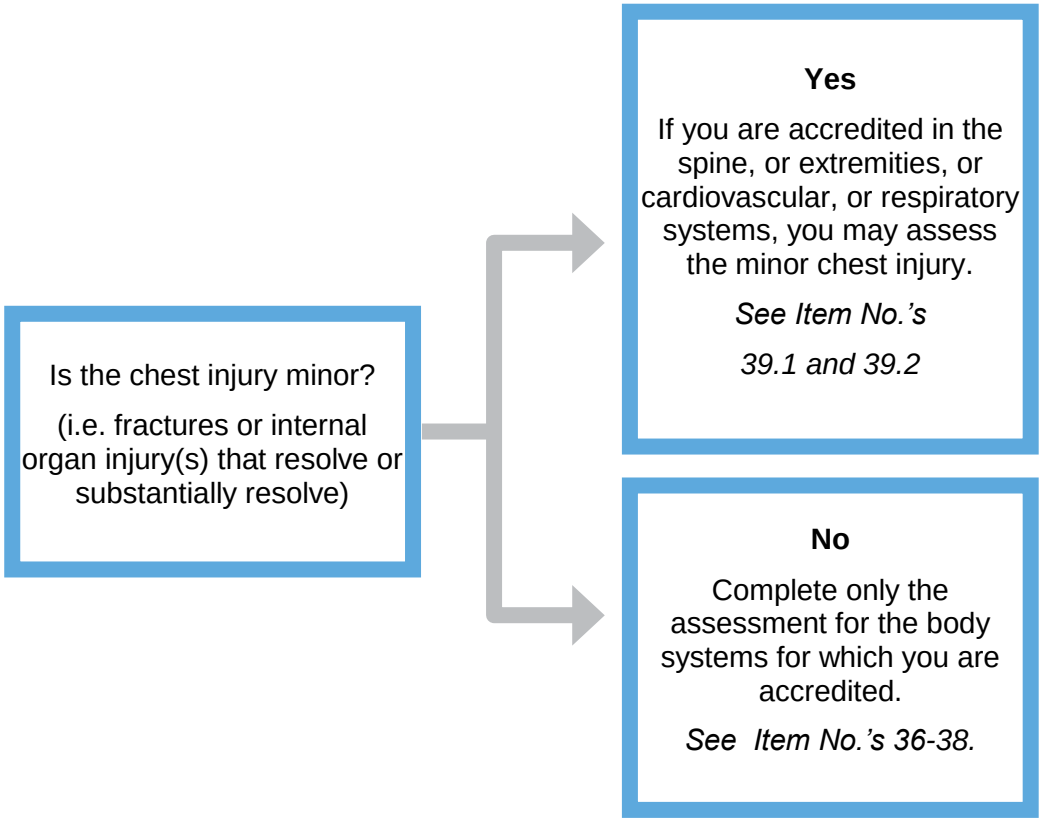
AMPs should apply the body systems that they have been accredited for and describe the WPI in their report and the Item Number if there is sufficient information to do so, and describe the reasons in the report or describe why an assessment may be incomplete. An administrative process may need to follow in some circumstances to determine the final Item Number where multiple body systems invalid due to the chest injury.

IMPORTANT NOTE

Digestive System Assessments of Chest Injuries

There may be **rare** circumstances where a digestive tract injury forms part of the chest injury assessment. The chest Item Number descriptors include considering the nature and severity of injury to the internal organs (respiratory, cardiovascular or digestive systems) of the chest and chest wall structures. AMPs should refer to the chest injury flow chart.

Chest Injury Assessment Flow Chart: Who can assess chest injuries?



Selecting Item Number(s)

The AMP's approach when providing an opinion as to the most appropriate Item Number requires consideration of the nature and severity of the injury, diagnosis, the Item Number descriptors relevant to the injury type and the whole person impairment evaluation of the injury.

Only Select the Item Number

AMPs give an opinion in regard to an Item Number only, for each of the injuries referred. AMPs **DO NOT** determine the value within the range given in the ISV Table.

AMPs should provide reasons to support the Item Number(s) selected.

Assessing Scars

> *"Many of the physical injuries mentioned in this Schedule involve some scarring from the initial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries"* (ISV table part 7, page 207 general comments).

AMPs should refer to the section in the Training Manual that refers to Skin and Scarring. *Item Numbers 151-154* relate to non-facial scarring, and *Item Numbers 19-22* for scarring of the face.

AMA 5: Notes for the AMP Assessor Using Chapter 6

AMA 5 Chapter 1 and 2

Before undertaking a WPI assessment, AMPs should be familiar *with AMA 5, Chapters 1 and 2* that discuss the purpose, applications and methods for performing and reporting impairment evaluations, and the introductory chapter of this Training Manual.

Multiple Injuries

An assessment of whole person impairment must be completed for each of the injuries referred. A combined whole person impairment rating for multiple injuries is not required.

Impairment of the Digestive System

The impairment evaluation of the digestive system is described in *AMA 5, Section 6.7, page 138* and *table 6-10, pages 138-141* provides an evaluation summary.

Hernias

Hernias as a result of injury are assessed with reference to *AMA 5, table 16-9, page 136.* The AMP should document the clinical findings and confirm that those clinical findings relate to the presence of a proven hernia related to the motor accident claim.

Degree of Impairment

There are wide ranges for the impairment values in some categories. If a range of percentages is available under AMA 5 for an injury of the type being assessed, the AMP must provide the reason for assessing the injury at the selected point in the range.

Chapter 18: Psychiatric Disorders / Pure Mental Harm

18A. Psychiatric Impairment for Pure Mental Harm

Prior To Undertaking An ISV Medical Assessment

- AMPs evaluating psychiatric impairment (injuries of Pure Mental Harm) for the purpose of providing a GEPIC rating and an opinion on the ISV Item Number must be a Psychiatrist and must be accredited for this body system by the responsible Minister before undertaking an ISV Medical Assessment.
- AMA 5 is not to be used to assess psychiatric impairment. Psychiatrists must only use the *Guide to the Evaluation of Psychiatric Impairment (GEPIC).* A copy of GEPIC may be found at Appendix A, page 145 of the Training Manual.
- Before undertaking an ISV Medical Assessment, AMPs must be familiar with Chapters 1 and 2 of the Training Manual, particularly Chapter 2F, page 29, "General Assessment Tips for Psychiatrists when assessing Psychiatric Impairment/Pure Mental Harm."
- The AMP is required to undertake a GEPIC assessment to determine a *GEPIC* class rating and provide their opinion regarding an Item Number. The "severity range" and "WPI%" is not required when undertaking an ISV Medical Assessment.
- The AMP may wish to review the Item Numbers that are relevant to the injuries they are to assess prior to the assessment (see ISV Table excerpt below.)
- The AMP provides an opinion regarding an Item Number ONLY and does not comment on the range.

Region/Injury	ISV Item Numbers	Comments
Pure mental harm	10-13	

- It is important for the AMP to read the "ISV Medical Assessment - Pure Mental Harm" report template prior to undertaking the assessment. A copy is available at Chapter 3 of the Training Manual. The requirements and legislated questions of this template are significantly different from Return to Work Scheme.

GEPIC: Notes for the AMP

AMPs to provide a GEPIC rating only

Unlike the requirements of Return to Work Scheme, *t*he AMP is not required to provide a psychiatric impairment percentage or WPI. Instead, the AMP is only required to provide a *GEPIC* class rating (i.e. Class 1 to Class 5 for each of the diagnosed conditions that are considered to be pure mental harm.

What is Pure Mental Harm?

Pure mental harm is a legal concept, not a medical concept.

Pure mental harm is mental harm that arises from the motor vehicle accident but is not consequential upon any physical injuries sustained by the injured person. For example, it may include witnessing at the scene a person being killed, injured or put in peril, or a family member suffering a sudden shock when hearing of the motor accident.

AMPs should only receive an ISV Medical Assessment Referral for claims for Pure Mental Harm. A *GEPIC* rating is to be used to determine the psychiatric impairment of Pure Mental Harm.

What is Consequential Mental Harm?

Regulation 13 of the *Civil Liability Regulations 2013* provides that consequential mental harm (either psychiatric or psychological) is to be treated merely as a feature of the physical injury. Consequential mental harm sustained as a result of physical injury will be taken into account in determining the ISV score within the range of the appropriate Item Number for the physical injury and is not to be assessed as a separate injury by the AMP.

Diagnosing and Assessing Multiple Psychiatric Conditions

A GEPIC rating is only required for the assessment of Pure Mental Harm. Therefore, if undertaking a GEPIC assessment, the Psychiatrist is required only to assess the psychiatric conditions they consider satisfy the definition of pure mental harm.

The AMP is required to diagnose the conditions that are Pure Mental Harm and those that are Consequential Harm, *but is only to provide a GEPIC rating and the associated Item Number for conditions of Pure Mental Harm.*

It is expected medical evidence will be available for the AMP which considers the issue of causation of any ongoing psychiatric impairment.

Consideration of Pre-existing/Post-accident Incurred Conditions

The “ISV Medical Assessment – Pure Mental Harm” report template requires AMPs to provide their opinion as to:

- the effect of the motor vehicle accident on any pre-existing injury and the extent to which it has been made worse by the injury
- the effect of the motor vehicle accident on any subsequent injury and the extent to which it has been made worse by the injury

Comments should be made about the relationship between the diagnosis and the motor vehicle accident and any other diagnosis that may be unrelated to the motor vehicle accident. Any non-accident related impairment should be assessed as at the time of the assessment, not as it may have been at the time of the accident.

Evaluation of Psychiatric Impairment

Please undertake a GEPIC assessment, as detailed in the *Guide to the Evaluation of Psychiatric Impairment for Clinicians*. (see Appendix A) The evaluation of psychiatric impairment in accordance with the *GEPIC* is meant to be informed by clinical judgement and supported by the AMP’s training and experience. The specific rating criteria are not meant to be used in a “cookbook” fashion.

The AMP’s evaluation involves the assessment of the severity of six specific mental functions (classes) being:

- Intelligence
- Thinking
- Perception
- Judgement
- Mood and
- Behaviour.

The different classes are combined to produce a median class of impairment. AMPs record their assessment outcomes on the table provided in the ISV Medical Assessment Report template (see Chapter 3 of the Training Manual).

Determining the Median Class and the *GEPIC* rating

The AMP determines the median class of impairment for the whole person by identifying the middle number in the final series (e.g. 12345, the middle number is 3).

If the middle number is a fraction (i.e. 2.5) the AMP must round it up to the next highest class, with the WPI becoming the lowest percentage number in that class. This forms the *GEPIC* rating and is recorded on the ISV Medical Assessment Report template.

Determining the median of the severity range and Whole Person Impairment percentage (WPI %)

The AMP IS NOT required to determine the severity range or WPI% when completing an ISV Medical Assessment for this Scheme.

Selecting Item Number(s)

The AMP's approach when providing an opinion as to the most appropriate Item Number requires consideration of the level of psychiatric impairment assessed and the Item Number Descriptors relevant to the injury type (the *GEPIC* rating.)

Only Select the Item Number

AMPs give an opinion in regard to an Item Number only for each of the injuries referred. AMPs **DO NOT** determine the value within the range given in the ISV Table.

AMPs should provide reasons to support the Item Number(s) selected.

Item Numbers Relevant to Psychiatric Impairment (Pure Mental Harm) Injuries

The AMP must refer to the ISV Table, Part 2 "Pure Mental Harm" to allocate the appropriate Item Number.

AMP must read the descriptors within each of the Item Numbers No's 10-13 to ensure the appropriate number is selected, with consideration to the GEPIC rating scored through the *GEPIC* assessment.

The AMP selects the Item Number only. It is not the role of the AMP to modify or change the Item Number due to factors of pre-existing conditions or post-motor accident injuries. Only the parties or the court can do this.

Chapter 19: Chest Injuries

19A. Minor Chest Injuries

IMPORTANT NOTE

The Item Numbers describing minor chest injuries refer to conditions of the chest wall, internal organs and airways.

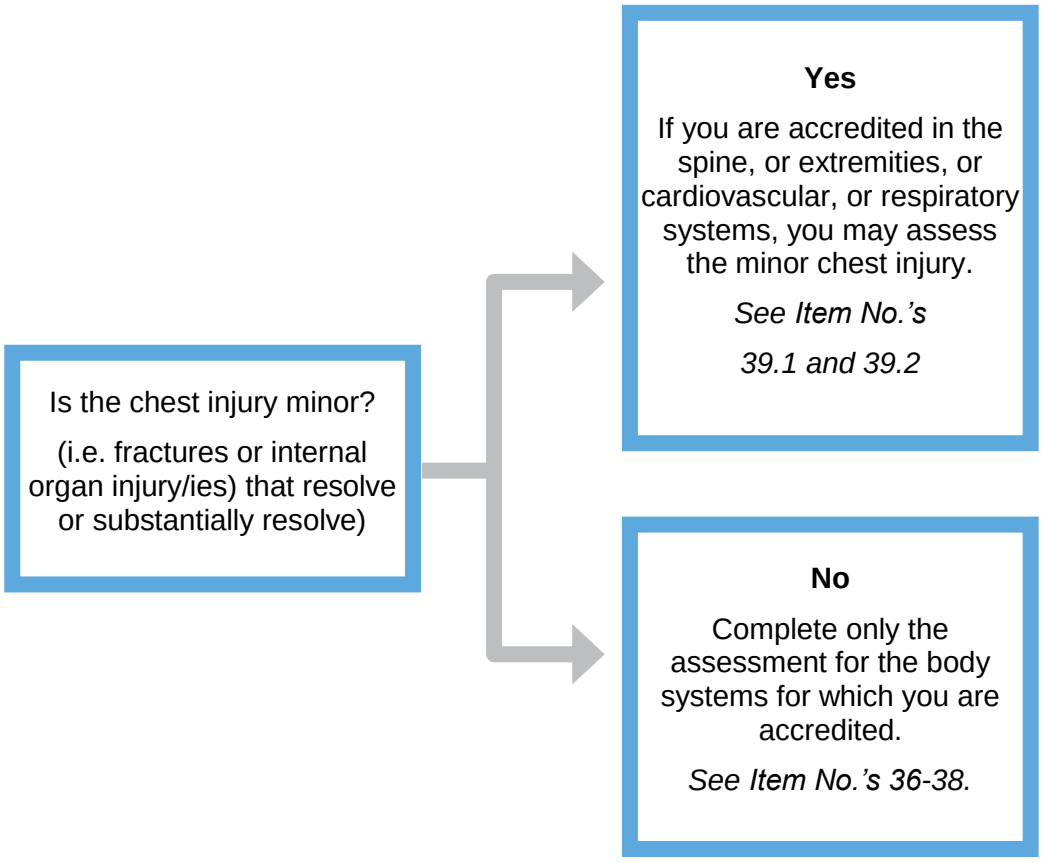
Assessments can occur in 2 circumstances.

- Minor chest injury, or internal chest organ injury that substantially resolves or with non-permanent or minor internal organ injury (Item Numbers 39.1 and 39.2).
- Injuries involving the chest wall and internal chest organs or airways (Item Numbers 36-38).

Accreditation

- For the assessment of minor chest injury AMPs must be accredited by the responsible Minister before undertaking an ISV Medical Assessment.
- AMPs evaluating chest injuries with internal organ injury using AMA 5 must be accredited for the relevant system involved by the responsible Minister before undertaking an ISV Medical Assessment. This accreditation includes the ability to consider concurrent chest wall injury.

Chest Injury Assessment Flow Chart: Who can assess Chest Injuries?



Prior to Undertaking an ISV Medical Assessment

Minor Chest Injuries

- The AMP evaluating injuries for the purpose of providing an ISV Medical Assessment and an opinion on the Item Number must be accredited for relevant body system by the responsible Minister before undertaking an ISV Medical Assessment.
- Before undertaking an ISV Medical Assessment, AMPs must be familiar with Chapters 1 and 2 of the Training Manual.
- The AMP may wish to review the Item Numbers that are relevant to the injuries assess prior to the assessment. By reading the descriptors for each of the relevant Item Numbers, the assessor may consider the type of injuries that fall into each Item Number, and the medical evidence required to support allocating an injury into that Item Number.
- AMA 5 has limited methods for the assessment of many injury types affecting the chest wall in particular. AMPs are reminded to consider the Item Number descriptors.

Region/Injury	ISV Item Numbers	Comments
Chest injury (non minor)	36-38	For ISV 36-38 there is additional material in the relevant organ system chapter of this manual.
Minor chest injury	39.1-39.2	

Chapter 20:
Pain

20A. Pain

AMA 5, Chapter 18, pages 565-591.

Prior to Undertaking an ISV Medical Assessment

- There is no ISV Item Number for pain-related impairment or consequential mental harm.
- AMA 5 provides a method for rating %WPI due to pain in Chapter 18.
- Any impairment arising from pain including any consequential mental harm is treated merely as a feature of the physical injury.
- Any AMPs may consider assessment under this chapter.
- Before undertaking an assessment under *Chapter 18, AMA 5,* AMPs should be familiar with Chapters 1 and 2 of the Training Manual.
- AMPs should also be familiar with *Chapters 1 and 2 of AMA 5* that discuss the purpose, applications and methods for performing and reporting impairment evaluations.
- Pain may have been accounted for in the ISV Item Number, so it is important for AMPs not to doubly rate Pain from this Chapter.

Selecting ISV Item Number/s

There are no ISV Item Numbers to consider for pain-related impairment.

AMA 5: Notes for the AMP Using Chapter 16

AN INTRODUCTION TO ASSESSING PAIN

The chapter includes discussion on when to use the methods described in the chapter, and how they can be integrated with the impairment rating methods used in other chapters of the Guides.

Select and use the AMA 5 Chapter where the Dysfunction is greatest

Generally the organ system where the problems originate or where the dysfunction is greatest is the chapter to be used for evaluating impairment *(AMA 5, Section 1.5, page 10).*

Impairment Ratings within AMA 5 Chapters have accounted for Commonly Associated Pain

Impairment ratings as detailed within each of the chapters of AMA 5 already have accounted for commonly associated pain, including that which may be experienced in areas distant to the specific site of pathology.

AMPs should ensure that impairments are not double rated by factoring them within the body system applied AND also *Chapter 18, AMA 5, Pain*.

Impairment Assessment Methodology

When proceeding to undertake an assessment using *Chapter 18, AMA 5*, the AMP will be required to:

- detail the rationale for applying the Pain Chapter;
- determine whether a pain-related impairment is rateable or unrateable; and

- document the full methodology for the assessment within the report; providing reasons for the value selected.

Factors to Consider

AMPs applying Chapter 18 will need to consider all aspects of the chapter.

Reference is particularly made to *AMA 5 Section 18.3a, page 570 "When this Chapter Should be used to Evaluate Pain-Related Impairment"* and *AMA 5 Section 8.3b, page 571 "When This Chapter Should Not Be Used to Rate Pain-Related Impairment."*

How to Rate Pain-Related Impairment; Overview

The following is reproduced from the published erratum to AMA 5 as pertaining to *Chapter 18*.

"AMA 5 Chapter 2, page 20 – 2.5e Pain

The impairment ratings in the body organ system chapters make allowance for expected accompanying pain. Chronic pain, also called chronic pain syndrome, is discussed in the Chapter 18, Pain.

How to Rate Pain-Related Impairment: Excerpt from AMA 5, Section 18.3d, page 573 – Errata

The AMP is advised to be aware of, and refer to, the *AMA 5 Errata (March 2002*) which applies significant corrections to *AMA 5, Section 18.3d (p573).* The corrected version from the Errata must be followed in the event of the AMP undertaking an assessment for pain impairment.

> *"The system described in this chapter relies largely on self-reports by individuals. Thus, it differs significantly from the conventional rating system, which relies primarily on objective indices of organ dysfunction or failure.*
>
> *The present system assesses pain intensity, emotional distress related to pain, and ADL deficits secondary to pain. ADL deficits are given the greatest weight. An individual's pain-related impairment evaluation should be aborted if his or her behaviour during the evaluation raises significant issues of credibility. If an individual has clinical findings atypical of a well-accepted medical condition, or is diagnosed with a condition that is vague or controversial, his or her pain- related impairment evaluation should be completed, but the results of the evaluation must be interpreted differently. Specifically, an examiner should characterise the resulting pain-related impairment as unrateable, and should not award quantitative impairment.*
>
> *A detailed protocol for assessing pain-related impairment is described below and outlined in Figure 18-1 "(See AMA 5 Errata replacement figure 18-1)*
>
> *I. Evaluate the individual according to the body part or organ rating system (i.e. the conventional rating system), and determine an impairment percentage. During the evaluation, the examiner should informally assess pain-related impairment.*
>
> *II. If the body system impairment rating appears to adequately encompass the pain experienced by the individual due to his or her medical condition, his or her impairment rating is as indicated by the body system impairment rating.*
>
> *III. If the individual appears to have pain-related impairment that has increased the burden of his or her condition slightly, proceed to Step VI.*
>
> *IV. If the individual appears to have pain-related impairment that has increased the burden of his or her condition substantially, perform a formal pain-related impairment assessment (Step V). Then proceed to Step VI.*
>
> *V. In a formal pain-related impairment assessment, the examiner administers and scores the inventory shown in Table 18-4 and provides quantitative ratings of an individual's pain behaviour and credibility. The examiner then calculates the individual's total pain- related impairment as shown in Table 18-6, and determines the individual's pain-related impairment class as shown in Table 18-7.*

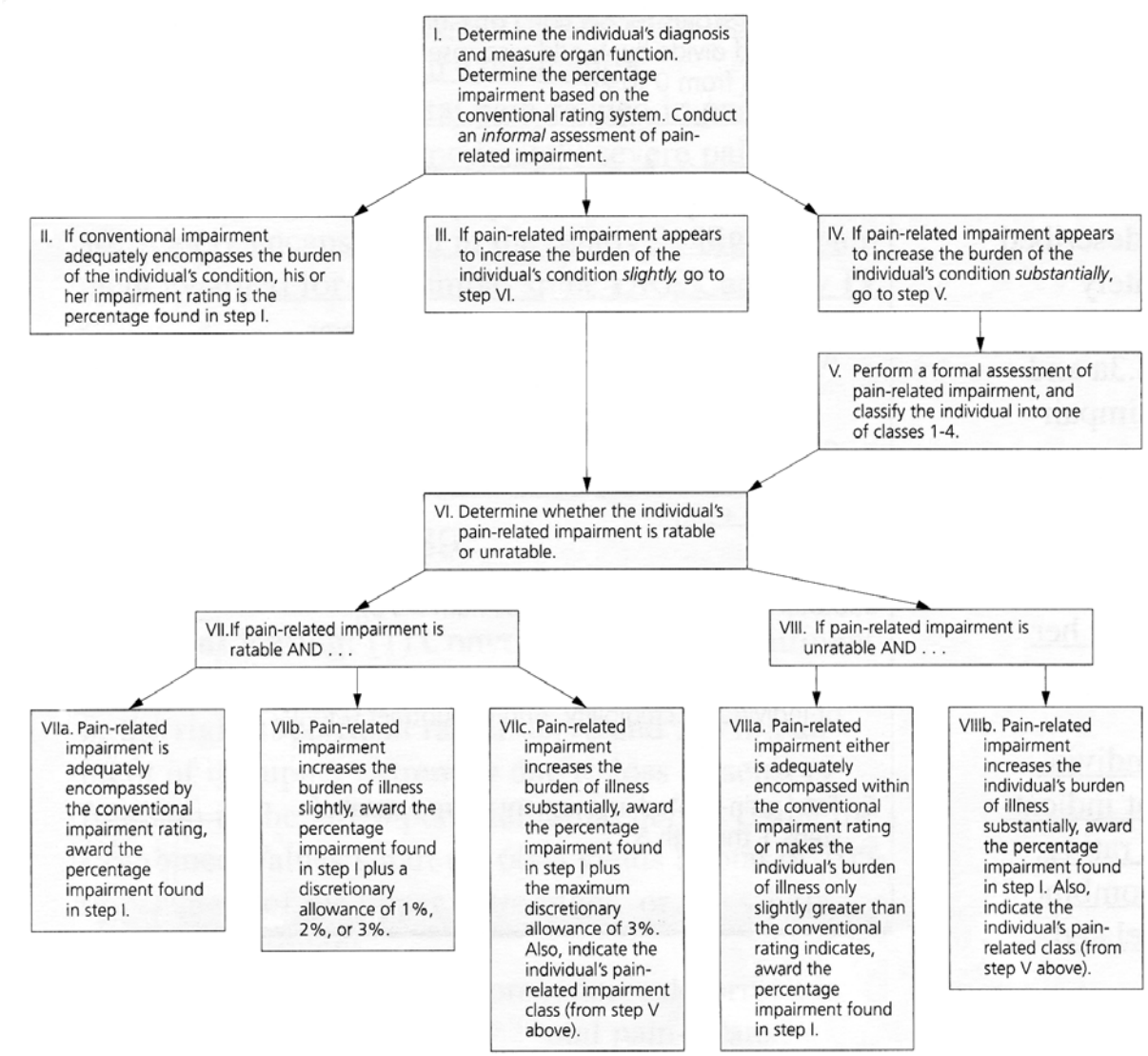
VI. Determine whether the individual's pain-related impairment is rateable or unrateable.

VII. If pain-related impairment is rateable, the examiner may award quantitative pain-related impairment of up to 3% and should (when appropriate) also designate the qualitative pain- related impairment class that best characterises the individual's condition.

VIII. If pain-related impairment is unrateable, the examiner should not award quantitative pain- related impairment but should (when appropriate) designate the pain-related impairment class that best characterises the individual's condition."

AMA 5 excerpt, Figure 18-1, Errata – Replacement figure

Algorithm for rating pain-related impairment in conditions associated with conventionally rateable impairment.



Chapter 21:
Other Resources

Appendix A: Supreme Court Civil Rules 2006 & Supplementary Rules 2014

Court Rules

Supreme Court Civil Rules 2006

(as varied to the 9 October 2014 – Amendment No. 27)

160—Pre-trial disclosure of expert reports

(1) A party must, before the relevant time limit—

(a) obtain all expert reports that the party intends to obtain for the purposes of the trial of the action; and

[paragraph 160(1)(b) inserted by Supreme Court Civil Rules 2006 (Amendment No. 26)]

(b) serve on every other party to the action a copy of each expert report in the party's possession relevant to the subject matter of an action (whether the party intends to rely on it at the trial or not) not previously served on that party.

Exception—

This rule does not apply to reports obtained, or to be obtained from a shadow expert (see rule 161(1)).

(2) The ***relevant time limit*** is the end of a period of 60 calendar days after the time limited for making an initial disclosure of documents.

(3) An expert report should—

[paragraph 160(3)(a) amended by Supreme Court Civil Rules 2006 (Amendment No. 26)]

(a) set out the expert's qualifications to make the report;

[paragraph 160(3)(b) amended by Supreme Court Civil Rules 2006 (Amendment No. 26)]

(b) set out the facts and factual assumptions on which the report is based;

[paragraph 160(3)(c) amended by Supreme Court Civil Rules 2006 (Amendment No. 26)]

(c) identify any documentary materials on which the report is based;

[paragraph 160(3)(d) amended by Supreme Court Civil Rules 2006 (Amendment No. 26)]

(d) distinguish between objectively verifiable facts and matters of opinion that cannot be (or have not been) objectively verified;

[paragraph 160(3)(e) inserted by Supreme Court Civil Rules 2006 (Amendment No. 26)]

(e) set out the reasoning of the expert leading from the facts and assumptions to the expert's opinion on the questions asked;

[paragraph 160(3)(f) inserted by Supreme Court Civil Rules 2006 (Amendment No. 26)]

(f) set out the expert's opinion on the questions asked;

[paragraph 160(3)(e) renumbered to 160(3)(g) by Supreme Court Civil Rules 2006 (Amendment No. 26)]

(g) comply with any requirements imposed by Supplementary Rules.

(4) However, if an expert has provided a previous expert report to a party, a report complies with subrule (3) if it refers to material contained in the previous report without repeating it.

(5) A party who has disclosed an expert report, and proposes to rely on evidence from the expert at the trial, must, at the request of another party, provide the party making the request with—

(a) a copy of documentary material (including material in the form of computer data) on which an expert has relied for making a report; and

(b) details of any fee or benefit the expert has received, or is or will become entitled to receive, for preparation of the report or giving evidence on behalf of the party; and

[paragraph 160(5)(c) amended by Supreme Court Civil Rules 2006 (Amendment No. 27)]

(c) copies of written communications and details of any oral communications relevant to the preparation of the report—

(i) between the party, or any representative of the party, and the expert; and

(ii) between the expert and another expert.

(6) The Court may, on application by a party, relieve the party from an obligation to disclose an expert report or information relating to it under this rule.

(7) An application under subrule (6)—

(a) must be made before or within 7 business days after the time for disclosure of the expert report; and

(b) must be accompanied by a copy of the relevant report enclosed in a sealed envelope (which is only to be opened at the direction of the Court); and

(c) may be made without notice to other parties to the action.

Note—

It should be noted that failure to comply with this rule may result in the exclusion of expert evidence at trial (see rule 214(2)). The expert's report may become in effect the expert's evidence-in-chief at trial (see rule 169).

Supreme Court Civil Supplementary Rules 2014

(as varied to the 9 October 2014 – Amendment No. 1)

Part 9—Notice of evidence to be introduced at trial

Division 2—Expert reports

155—Introduction

(1) The provisions of rule 160 of the Rules and this Division apply to any person called as an expert witness or providing an expert report in the action, even if the expert is, or is employed by or otherwise associated with, a party to the action.

(2) This Division must be complied with for an expert to comply with rule 160(3) of the Rules.

(3) This Division is not intended to address exhaustively all aspects of an expert's report and an expert's duties.

156—General duty to the Court

(1) An expert witness has an overriding duty to assist the Court on matters relevant to the expert's area of expertise.

(2) An expert is not an advocate for a party.

(3) An expert's paramount duty is to the Court and not to the person retaining the expert.

(4) If a draft of the expert's report (in whole or in part) or any of the content of a draft report has been provided or communicated to a party, a party's representative or a third party, a copy of the draft so provided or communicated is to be retained by the expert.

157—Form of expert report

(1) The report is to set out separately from the factual findings or assumptions each of the opinions that the expert expresses.

(2) The expert is to give reasons for each opinion, leading from identified factual findings or assumptions to the opinion.

(3) If tests or experiments are relied upon by the expert in compiling the report, the report is to contain details of the qualifications of the person who carried out the tests or experiments.

(4) When an expert's report refers to photographs, plans, calculations, analyses, measurements, survey reports or other extrinsic matter, they are to be provided to the opposite party at the same time as delivery of the report.

(5) If an expert opinion is not fully researched because the expert considers that insufficient information is available or for any other reason, this is to be stated with an indication that the opinion is no more than a provisional one.

(6) If an expert believes that a report may be incomplete or inaccurate without some qualification, that qualification is to be stated in the report.

(7) The expert is to make it clear when a particular question or issue falls outside his or her field of expertise.

(8) The expert's report is to contain—

(a) an acknowledgement that the expert has been provided with copies of rule 160 of the Rules and this Division before preparing the report and that the expert has read and understood them;

(b) a declaration that the expert has made all inquiries that the expert believes are desirable and appropriate and no matters of significance that the expert regards as relevant have, to the expert's knowledge, been withheld from the Court.

158—Further obligations of an expert and the party retaining the expert

If, after exchange of reports or at any other stage, an expert changes his or her view on a material matter, having read another expert's report or for any other reason, the change of view is to be communicated in writing (through lawyers) without delay to each party to whom the expert's report has been provided and, when appropriate, to the Court.

159—Consequences of non-disclosure

If a party fails to comply with the Rules or this Division in respect of an expert's report, the Court may—

(a) adjourn the hearing or trial at the cost of the party in default or his or her lawyer;

(b) direct that evidence from that expert not be adduced by that party at the trial in the action; and/or

(c) award costs incurred or thrown away due to the failure in favour of the other parties.

160—Expert's conference

(1) If experts retained by the parties meet at the direction of the Court, or at the request of lawyers for the parties, an expert must not be given or accept instructions not to reach agreement.

(2) If, at a meeting directed by the Court, the experts cannot reach agreement on matters of expert opinion, they are to specify their reasons for being unable to do so.

161—Shadow experts

A certificate under rule 161(2) of the Rules is to be in form 32.

Appendix B:
The GEPIC
(a copy)

Victoria Government Gazette *G 30 27 July 2006* *1*

THE GUIDE TO THE EVALUATION OF PSYCHIATRIC IMPAIRMENT FOR CLINICIANS (GEPIC)

Prepared by

M.W.N. Epstein, G. Mendelson, N.H.M. Strauss

Revised December 2005

Melbourne

For citation:
Epstein MWN, Mendelson G, Strauss NHM. The Guide to the Evaluation of Psychiatric Impairment for Clinicians. Melbourne: The Authors, 2005.

Introduction

The Guide to the Evaluation of Psychiatric Impairment for Clinicians (GEPIC) is a revision of the Clinical Guidelines to the Rating of Psychiatric Impairment (Clinical Guidelines), which has been in use for seven years. In general the Clinical Guidelines has performed very well but some concerns have emerged that this revision intends to correct.

The name has been changed to distinguish the new edition from its predecessor, and to provide a convenient acronym. The basic aim of the Clinical Guidelines remains, being to improve the inter-rater reliability of psychiatric impairment assessments.

It has been made explicit that the descriptors associated with each class for a particular mental function are intended to be indicative examples of the type of symptoms one could expect to see in that class range. The list of descriptors is not intended to be all-encompassing, as the Guide is designed to be used only by qualified psychiatrists who have completed the prescribed training course. To provide an exhaustive list of descriptors would be an impossible and ultimately unnecessary task. Furthermore, such a document would be so voluminous as to be practically useless as a handy guide for the clinician, and would amount to a textbook of psychiatry.

There has been some re-wording of the definitions of some mental functions, and some descriptors have been added to provide a more comprehensive range of examples for each class. The changes implemented in this revision are designed to further improve the inter-rater reliability of the GEPIC.

The Clinical Guidelines were developed from the User's Manual to the second edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment, which was prepared by the authors with the assistance of other members of the Psychiatric section of the Victorian WorkCover Medical Panel in 1994.

There had been considerable concern about the lack of reliability of impairment assessment by psychiatrists using the second edition of the AMA Guides. The User's Manual was an attempt to provide definitions of the terms which were used in the second edition, with an explanation of the various changes that would be observed with increasing levels of impairment. In addition, the User's Manual developed a method, now known as the "median method", to determine whole person impairment.

The User's Manual had no official status but was widely used for assessment of psychiatric impairment. The User's Manual had considerable impact in improving the inter-rater reliability of assessments.

The changeover in various legal jurisdictions from the second to the fourth edition of the AMA Guides proved to be a particular concern with regard to psychiatry. Chapter 14 of the fourth edition of the AMA Guides provides a classification which is impossible to quantify, and it fails to provide any method of maintaining reliability of assessments.

It was with these concerns in mind that the authors of the User's Manual further refined and developed the Clinical Guidelines to the Rating of Psychiatric Impairment, with the assistance of other members of the Psychiatric Medical Panel.

The GEPIC maintains the principles found in both the User's Manual and the Clinical Guidelines. The six terms which had originally been used to assess mental function, that is, Intelligence, Thinking, Perception, Judgement, Affect, and Behaviour, have remained substantially the same. (The Clinical Guidelines replaced "Affect", which was technically an inaccurate term, with the word "Mood".)

The final two items in the Table which was adapted from the second edition of the AMA Guides, that is, "Ability" (in terms of "Activities of Daily Living") and "Potential" (in terms of "Rehabilitation or Treatment Potential") were removed in the Clinical Guidelines, as it was considered that they do not reflect impairment. ("Ability" is a measure of disability rather than impairment, and "potential" involves a prediction of the future, which is problematical at best, and not a measure of current psychiatric impairment.)

The table in the Clinical Guidelines included a footnote: In evaluating the "whole person psychiatric impairment", intermediate values may be used that are not included in the individual classes.

This footnote has been removed from the GEPIC as it undermined the intention of the authors to force assessors to make clear choices in determining both individual classes and whole person psychiatric impairment.

As with the Clinical Guidelines, the GEPIC must be considered in the context of the fourth edition of the AMA Guides, and any explanatory or other information provided in that edition of the AMA Guides is applicable to the Clinical Guidelines and to the GEPIC.

Psychiatric Impairment Evaluation

The assessment of psychiatric impairment is based on the systematic application of empirical criteria, and takes into consideration both the diagnosis and other factors unique to the individual. It is also relevant to consider motivation, and to review the history of the illness, as well as the treatment and rehabilitation methods. These considerations can be summarised in the following five principles:

Principle 1:

In assessing the impairment that results from any mental or physical disorder, readily observable empirical criteria must be applied accurately. The mental state examination, as used by consultant psychiatrists, is the prime method of evaluating psychiatric impairment.

Principle 2:

Diagnosis is among the factors to be considered in assessing the severity and possible duration of the impairment, but is by no means the sole criterion.

Principle 3:

The evaluation of psychiatric impairment requires that consideration be also given to a number of other factors including, but not limited to, level of functioning, educational, financial, social and family situation.

Principle 4:

The underlying character and value system of the individual is of considerable importance in the outcome of the disorder, be it mental or physical. Motivation for improvement is a key factor in the outcome.

Principle 5:

A careful review must be made of the treatment and rehabilitation methods that have been applied or are being used. No final judgement can be made until the whole history of the illness, the treatment, the rehabilitation phase, and the individual's current mental and physical status and behaviour have been considered.

Use of the Guide

The presence and extent of impairment is a medical issue, and is assessed by medical means. This Guide has been designed for use by medical practitioners; in evaluating psychiatric impairment in accordance with this Guide clinical information has to be obtained and assessed, together with an examination of the individual's mental state.

The evaluation of psychiatric impairment in accordance with the Guide is meant to be informed by clinical judgement, based on appropriate training and experience, and the specific rating criteria are not meant to be used in a "cookbook" fashion.

The descriptors associated with particular classes for each mental function are intended to be indicative only. They are intended to provide an overview of the type and severity of symptoms expected for each particular class. It would be futile to attempt to list all relevant symptoms and would be onerous for the assessor. The absence of a particular symptom in the list of descriptors does not mean that that symptom is to be disregarded. The assessor may be required to justify why that/those symptom(s) is/are associated with a particular class of severity.

It is ultimately for the clinician, and no one else, to make the *clinical judgement* whether a specific rating criterion is present. If the clinician doubts that a particular symptom or abnormality of mental function is present, even after hearing the patient describe it, the item should be rated as not present. This convention is advocated in the Structured Clinical Interview for DSM-IV Axis I Disorders, and it is important to emphasise that the evaluation of psychiatric impairment, like diagnosis, is based on "ratings of criterion items, not of answers to questions".

The method described in this Guide involves the assessment of the severity of six specific mental functions into five classes of increasing severity. The different classes are combined to produce a total psychiatric impairment. Use is made of a modified form of the table that was in the second edition of the AMA Guides.

Impairment of Perception

According to Sims, "There can be few areas where the work of assessment by the psychiatrist is more misunderstood than in the psychopathology of perception".

In clinical psychiatry, impairments of perception are disturbances of one or more of the five sensory modalities (hearing, vision, smell, taste and touch). Possible disturbances of perception that need to be assessed as part of the mental state examination are hallucinations and illusions. Hallucinations are subjective sensory perceptions in the absence of an actual external stimulus; these may occur in any one of the five sensory modalities. Illusions are defined as distorted perceptions of real external stimuli, usually visual. Where the person indicates an awareness that hallucinations are imaginary (not real, lacking an external source or stimulus) the term pseudohallucinations is used.

The concept of perception in clinical psychiatry is narrower than the definition of perception in the Concise Oxford Dictionary, which reads "the intuitive recognition of a truth, aesthetic quality, etc…". Thus, phrases such as "a sudden perception of the true position" or "he perceives the world to be a very fearful place" do not refer to perception in the technical sense in which the term is used in clinical psychiatry.

Definitions

The assessor must be mindful that in some jurisdictions an evaluation of impairment needs to be made according to the methods specified in this Guide after a period of time when the claimant's entitlement to certain statutory benefits needs to be determined, and at a time when the impairment may not be permanent.

In developing this Guide, the authors made use of the following definitions:

Impairment: The World Health Organization has defined impairment in the following terms: "In the context of health experience, an impairment is any loss or abnormality of psychological, physiological, or anatomical structure or function".

Permanent impairment is impairment that has become static or well stabilised with or without medical treatment and is not likely to remit despite future medical treatment. If an impairment is not permanent, it is inappropriate to characterise it as such.

Disability: The World Health Organization has defined disability in the following terms: "In the context of health experience, a disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being".

Possibility. Probability: These are terms that refer to the likelihood or chance that an injury or illness was caused or aggravated by a particular factor. "Possibility" sometimes is used to imply a likelihood of less that 50 per cent; "probability" sometimes is used to imply a likelihood of greater than 50 per cent.

Hallucinations. Abnormalities of sensory perception in the absence of external stimuli.

Illusions. Distortions of real sensory stimuli – illusions can be a normal phenomenon as well as indicating psychopathology.

Pseudohallucinations. Hallucinations that are recognised by the person as being imaginary (not real, lacking an external source or stimulus).

EVALUATION OF PSYCHIATRIC IMPAIRMENT

Class of Impairment	**1**	**2**	**3**	**4**	**5**
Percentage of Impairment	**0% to 5%**	**10% to 20%**	**25% to 50%**	**55% to 75%**	**over 75%**
MENTAL FUNCTION					
Intelligence *(Capacity for understanding)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Thinking *(The ability to form or conceive in the mind)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Perception *(The brain's interpretation of internal and external stimuli)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Judgement *(Ability to assess a given situation and act appropriately)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Mood *(Emotional tone underlying all behaviours)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe
Behaviour *(Behaviour that is disruptive, distressing or aggressive)*	Normal to Slight	Mild	Moderate	Moderately Severe	Severe

Whole person psychiatric impairment

The second edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment stated that "the overall rating of a patient [is] based upon the mental status and upon the current condition as observed by the evaluator. The rating is based upon observed attributes and phenomena that are somewhat interrelated, and it necessarily must be considered to be somewhat subjective".

In developing the Clinical Guidelines, and also in the current revision, the authors have taken this comment into consideration.

It remains our considered view that the "median method" is the most appropriate and fairest of the three statistical methods available by which the overall level of the whole person psychiatric impairment can be calculated, based on each of the six items reflecting mental functions. The three methods are the "mean" (or average), the "median", and the "mode". The advantage of using the median is that it is not influenced by extreme scores (as is the "mean" or averaging method), yet it is significantly more sensitive to variability of scores than the mode, especially with the modification implemented in this Guide.

Because each of the six aspects of mental functioning that constitute the Guide is rated on what is essentially an ordinal scale, the median method is technically the most appropriate method of determining the overall rating.

For that reason, the determination of the "class" of the overall collective whole person psychiatric impairment assessed in accordance with this Guide is to be undertaken in accordance with the median method. The median is the middle number of a series; a typical result of scores for the six individual aspects of mental function may be 112233, and thus the middle number is 2. "Class 2" is therefore the correct class for the "whole person psychiatric impairment" in this example.

The overall collective percentage impairment is within the percentage range of the median class. The final figure is determined by taking into account the person's level of functioning, on the basis of clinical judgement.

Each median class includes descriptors which indicate a range of symptoms within that class. Each class has a low range, a mid range, and a high range.

The indicative ranges for each class are as follows:

	Low range	Mid range	High range
Class One	0–1%	2–3%	4–5%
Class Two	10–12%	14–16%	18–20%
Class Three	25–30%	35–40%	45–50%
Class Four	55–60%	65–70%	70–75%
Class Five	75–80%	85–90%	95–100%

In coming to the final rating of the whole person psychiatric impairment the assessor should consider the range of descriptors and/or equivalent symptoms that emerged during the interview, as well as the findings on mental state examination.

The assessor should consider both the descriptors for each class and equivalent symptoms that might not be listed amongst the descriptors. The assessor should assess the severity of each symptom or descriptor and/or the number of symptoms or descriptors present. As a result of this clinical assessment the assessor should use clinical judgment to determine where the final figure lies.

The assessor should consider in which part of the median class these descriptors and/or equivalent symptoms would fall, e.g. if the individual assessed has symptoms which lie within median class 2, and these symptoms were relatively minimal in severity or there were only a few symptoms this indicates a final value in the low range for class 2 (10–12%). If the descriptors and/or

equivalent symptoms were more numerous and/or more severe the final value is likely to be mid range (14–16%). If the individual has most of the descriptors and/or equivalent symptoms for median class 2 or fewer but more severe descriptors and/or equivalent symptoms the final value would be in the upper range (18–20%). These indicative ranges are to provide guidance to clinicians and do not preclude the use of final values lying between them, e.g., 13%.

It may be the case that the median of a series is not a whole number, e.g., 111233: the median of this series is 1.5; similarly, a series such as 222334 has a median of 2.5. There are problems of legality, equity and simplicity with a number of proposed solutions to this dilemma.

When the Clinical Guidelines were developed, the Medical Panel considered that an appropriate and simple solution is to promote the median figure to the next highest class and allow, except in unusual circumstances, only the lowest percentage in that class. This practice should also be followed when using this revised Guide.

Using the examples given therefore:

- Series 111233, median 1.5 becomes 2, and therefore the whole person psychiatric impairment is 10 per cent ("Class 2" range 10–20 per cent);
- Series 222334, median 2.5 becomes 3, and therefore the whole person psychiatric impairment is 25 per cent ("Class 3" range 25–30 per cent).

If the distribution of scores is skewed, with four or more scores in the "Class 1" range and one or two higher scores, the highest possible "whole person" psychiatric impairment rating is ten (10) per cent.

INTELLIGENCE

Capacity for understanding and for other forms of adaptive behaviour. Impairments of intelligence are a consequence of brain injury or disease. Generally, before impairment of intelligence is confirmed neuropsychological assessment should be undertaken. (Care has to be exercised to ensure that there is no overlap between an assessment of impairment of intelligence made during a psychiatric evaluation and an assessment of impairment of higher cerebral functions made by an assessor in accordance with Chapter 4 of the 4th edition of the American Medical Association's Guides.)

Guides for the rating of impairment of intelligence:

Class	Impairment	Description
1	0–5%	Normal to Slight – there is no evidence of cognitive impairment on mental state examination, and the individual does not report any difficulties in everyday functioning that can be attributed to cognitive difficulties
2	10–20%	Mild – some interference with everyday functioning.
3	25–50%	Moderate – a reduction in intelligence that significantly interferes with everyday functioning.
4	55–75%	Moderately Severe – a reduction in intelligence which makes independent living impossible.
5	over 75%	Severe – needs constant supervision and care.

THINKING

The ability to form thoughts and conceptualise. Impairment is both a matter of degree and type of disturbance, which may involve stream, form and content.

Guides for the rating of impairment of thinking:

Class	Impairment	Description
1	0–5%	Normal to Slight – includes mild transient disturbances that are not disruptive and are not noticed by others.
2	10–20%	Mild – mild symptoms that usually cause subjective distress, for example: thinking may be muddled or slow; may be unable to think clearly; mild disruption of the stream of thought due to some forgetfulness or diminished concentration; may have some obsessional thinking which is mildly disruptive; may be preoccupied with distressing fears, worries or experiences, and by inability to stop ruminating; an increased sense of self-awareness or a persistent sense of guilt; some other thought disorder that is minimally disruptive, such as overvalued ideas or delusions; some formal thought disorder that does not interfere with effective communication.
3	25–50%	Moderate – manifestations of thought disorder, to the extent that most clinicians would consider psychiatric treatment indicated, for example: severe problems with concentration due to intrusive thoughts or obsessional ruminations; marked disruption of the stream of thought due to significant memory problems or diminished concentration; persistent delusional ideas interfering with capacity to cope with everyday activities, e.g., severe pathological guilt; formal thought disorder that interferes with verbal and other forms of communication.
4	55–75%	Moderately Severe – disorders of thinking that cause difficulty in functioning independently and usually require some external assistance.
5	Over 75%	Severe – disorders of thinking that cause such a severe disturbance that independent living is impossible.

PERCEPTION

The individual's interpretation of internal and external experience received through the senses. Stimuli arise from the five senses – the form is relevant, not necessarily the content. (Refer to discussion above of the concept of perception in clinical psychiatry.)

Definitions:

Hallucinations	Abnormalities of sensory perception in the absence of external stimuli.
Illusions	Distortions of real sensory stimuli – illusions can be a normal phenomenon as well as indicating psychopathology.
Pseudohallucinations	Hallucinations that are recognised by the person as being imaginary (not real, lacking an external source or stimulus).

Guides for the rating of impairment of perception:

Class	Impairment	Description
1	0–5%	Normal to Slight – transient heightened, dulled or blunted perceptions of the internal and external world, but with no or little interference with function
2	10–20%	Mild – persistent heightened, dulled or blunted perceptions of the internal and external world, with mild but noticeable interference with function – pseudohallucinations
3	25–50%	Moderate – presence of hallucinations (other than hypnagogic or hypnopompic) that cannot be attributed to a transitory drug-induced state; – obvious illusions (when associated with a diagnosable mental disorder).
4	55–75%	Moderately Severe – hallucinations and/or illusions (as above) cause subjective distress and disturbed behaviour.
5	Over 75%	Severe – hallucinations and/or illusions (as above) cause disturbed behaviour to the extent that constant supervision is required.

JUDGEMENT

Ability to evaluate and assess information and situations, together with the ability to formulate appropriate conclusions and decisions. This mental function may be impaired due to brain injury, or to conditions such as schizophrenia, major depression, anxiety, dissociative states or other mental disorders.

Guides for the rating of impairment of judgement:

Class	Impairment	Description
1	0–5%	Normal to Slight – may lack some insight and misconstrue situations but with little interference with function
2	10–20%	Mild – persistently misjudges situations in relationships, occupational settings, driving and with finances. The misjudgements are noticed by others but are accommodated.
3	25–50%	Moderate – misjudging social, work and family situations repeatedly leading to some disruption in relationships, occupational settings, living circumstances and financial reliability. – inappropriate spending of money or gambling
4	55–75%	Moderately Severe – moderately severe misjudgement with regular failure to evaluate situations or implications, causing actual risk or harm to self or others – failure to respond to any regular guidance and requirement for constant supervision.
5	Over 75%	Severe – persistently assaultive due to misinterpretation of the behaviour or motives of others; – sexually disinhibited (may occur following a head injury).

MOOD

Mood is a pervasive lasting emotional state. Affect is the prevailing and conscious emotional feeling during the period of the mental state examination.

Affect observed during the mental state examination is a reflection of the subject's mood, and has a number features, including:

Range:	Variability of emotional expression over a period of time, i.e., if only one mood is expressed over a period of time, the affective range is restricted.
Amplitude:	Amount of energy expended in expressing a mood, i.e., a mild amplitude of anger is manifested by annoyance and irritability.
Stability:	Slow shifts of mood are normal. Rapid shifts (affective lability) may be pathological.
Appropriateness:	The "fit" (or congruency) between the affect and the situation.
Quality of Affect:	Suspicious, sad, happy, anxious, angry, apathetic.
Relatedness:	Ability to express warmth, to interact emotionally and to establish rapport.

Guides for the rating of impairment of mood:

Class	Impairment	Description
1	0–5%	Normal to Slight – relatively transient expressions of sadness, happiness, anxiety, anger and apathy; – normal variation of mood associated with upsetting life events.
2	10–20%	Mild – mild symptoms: some or all of the below mild depression; subjective distress leading to some mild interference with function; reduced interest in usual activities; some days off; reduced social activities; fleeting suicidal thoughts; some panic attacks; heightened mood; – may experience feelings of derealisation or depersonalisation.
3	25–50%	Moderate Impairment – moderate symptoms: some or all of the below frequent anxiety attacks with somatic concomitants; inappropriate self-blame and/or guilt; persistent suicidal ideation or suicide attempts; marked lability of affect; significant lethargy; social withdrawal leading to major problems in interpersonal relationships; anhedonia; appetite disturbance with significant weight change; psychomotor retardation/agitation; hypomania; – severe depersonalisation.

4	55–75%	Moderately Severe – cannot function in most areas constant agitation; violent manic excitement; repeated suicide attempts; remains in bed all day; extreme self neglect; extreme anger/hypersensitivity; requires supervision to prevent injury to self or others.
5	Over 75%	Severe – severe depression, with regression requiring attention and assistance in all aspects of self care; – constantly suicidal; – manic excitement requiring restraint.

BEHAVIOUR

Behaviour is one's manner of acting. It is considered with regard to its appropriateness in the overall situation. Disturbances vary in kind and degree. Behaviour may be destructive either to self and/or others, it may lead to withdrawal and isolation. Behaviour may be odd or eccentric. Particular mental disorders may be manifested by particular forms of behaviour, e.g., compulsive rituals associated with Obsessive Compulsive Disorder.

Guides for the rating of impairment of behaviour:

Class	Impairment	Description
1	0–5%	Normal to Slight – transient disturbances in behaviour that are understandable in the context of this person's situation, excessive fatigue, intoxication, family or work disruption.
2	10–20%	Mild – persons who generally function well, but regularly manifest disturbed behaviour under little extra pressure that nevertheless is able to be accommodated by others – persistent behaviour that has some adverse effect on relationships or employment.
3	25–50%	Moderate – occasional aggressive, disruptive or withdrawn behaviour requiring attention or treatment; – obsessional rituals interfering with but not preventing goal-directed activity; – repeated antisocial behaviour leading to conflict with authority.
4	55–75%	Moderately Severe – persistently aggressive, disruptive or withdrawn behaviour requiring attention or treatment; – behaviour significantly influenced by delusions or hallucinations; – behaviour associated with risk of self harm outside the hospital setting, but not requiring constant supervision – manic overactivity associated with inappropriate behaviour; – significantly regressed behaviour, e.g., extreme neglect of hygiene, inability to attend to own bodily needs
5	Over 75%	Severe – requiring constant supervision to prevent harming self or others (repeated suicide attempts, frequently violent, manic excitement); – catatonic excitement or rigidity; – incessant rituals or compulsive behaviour preventing goal-directed activity.

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A series of discussion papers, "Annotations to the Guide for the Evaluation of Psychiatric Impairment for Clinicians", are available for further reference. These may be obtained by contacting the Authors.

Appendix C:
The Injury Scale Value

Extract: *Civil Liability Regulations 2013 – Schedule 1*

Item Number Selection & Guidance For AMPs

Central Nervous System & Head Injuries

1-9

Central Nervous System and Head Injuries 1-9

Item No	Injury
1	**Quadriplegia**
	EXAMPLES OF FACTORS AFFECTING ISV SCALE • Presence and extent of pain • Extent of any residual movement • Consequential mental harm • Level of function and pre-injury function • Degree of independence • Ability to participate in daily activities, including employment • Presence and extent of secondary medical complications • Loss of reproductive or sexual function • Bowel or bladder incontinence **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate only if the injured person has assisted ventilation, extreme physical limitation and gross impairment of ability to communicate.
2	Paraplegia
	EXAMPLES OF FACTORS AFFECTING ISV SCALE • Presence and extent of pain • Extent of any residual movement • Consequential mental harm • Level of function and pre-injury function • Degree of independence • Ability to participate in daily activities, including employment • Loss of reproductive or sexual function • Bowel or bladder incontinence • Presence and extent of secondary medical complications
3	**Hemiplegia or severe paralysis of more than 1 limb**
	EXAMPLES OF FACTORS AFFECTING ISV SCALE FOR ITEM 3 The same examples apply as for item 2. **Additional comment for item 3** Incomplete paralyses causing whole person impairment of less than 40% must be assessed under orthopaedic injuries if it is the only injury or the dominant injury of multiple injuries.
3.1	*Complete or nearly complete paralysis*
3.2	*Other paralysis, causing whole person impairment of at least 40%*
4	**Monoplegia**
	Comment See items 5, 6 and 7 and orthopaedic injuries section.

Item No	Injury
5	**Extreme brain injury**
	Comment The injury will involve major trauma to the brain with severe permanent impairment for which there is radiological evidence **Comment about appropriate level of ISV** • An ISV at or near the top of the range will be appropriate only if the injured person needs full-time nursing care and has the following— – gross disturbance of brain function – significant physical limitation and destruction of pre-existing lifestyle – epileptic seizures – double incontinence – little or no language function – little or no meaningful response to environment • An injured person with an injury for which an ISV at or near the top of the range is appropriate may have some ability to follow basic commands, recovery of eye opening, return of postural reflex movement and return to pre-existing sleep patterns. EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT FOR ITEM 5: • Degree of insight • Life expectancy • Extent of bodily impairment
6	**Serious brain injury**
	Comment The injured person will be very seriously disabled and substantially depends on others for professional and other care EXAMPLE OF THE INJURY Serious brain damage causing— (a) physical impairment, for example, limb paralysis; or (b) cognitive impairment with marked impairment of intellect and personality EXAMPLES OF FACTORS AFFECTING ISV SCALE • Life expectancy • Extent of physical limitations • Extent of cognitive limitations • Extent of sensory impairment, for example, loss of hearing or sense of taste or smell • Level of function and pre-existing function • Degree of independence • Ability to communicate • Behavioural or psychological changes • Epilepsy confirmed by EEG or evidenced through a requirement for prophylactic medication for 6 months • Presence of and extent of secondary medical complications **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate only if the injured person substantially depends on others and needs professional and other care, that is, passive overnight care and more than 6 hours of care per day

Item No	Injury
7	**Moderate brain injury**
	Comment The injured person will be seriously disabled, but the degree of the injured person's dependence on others, although still present, is lower than for an item 6 injury. EXAMPLES OF FACTORS AFFECTING ISV SCALE • Life expectancy • Extent of physical limitations • Extent of cognitive limitations • Extent of sensory limitation, for example, limitation of hearing or sense of taste or smell • Level of function and pre-existing function • Degree of independence • Ability to communicate • Behavioural or psychological changes • Epilepsy or a high risk of epilepsy confirmed by EEG or requiring prophylactic medication for 6 months • Presence of, and extent of, secondary medical complications
7.1	An ISV in this item will be applicable if there is no capacity for employment, and 1 or more of the following: • moderate to severe cognitive impairment • marked personality change • dramatic effect on speech, sight or other senses • epilepsy or a high risk of epilepsy confirmed by EEG or evidenced through a requirement for prophylactic medication for 6 months.
7.2	An ISV in this item will be applicable if there is an increased risk of epilepsy confirmed by EEG requiring prophylactic medication for 6 months and— • a moderate cognitive impairment • loss of, or greatly reduced capacity for, employment • noticeable interference with lifestyle
8	**Minor brain injury**
	Comment An ISV under this item will be applicable if there is evidence of physical injury causing the brain damage. The injured person will make a good recovery and be able to take part in normal social life and to return to work. There may be minor problems persisting that prevent a restoration of normal function. EXAMPLES OF FACTORS AFFECTING ISV SCALE • Severity of any physical injury causing the brain damage, having regard to— (a) any medical assessment made immediately after the injury was caused, for example, CT or MRI scans, an ambulance officer's assessment or hospital emergency unit assessment; and (b) significant post-traumatic amnesia. • Extent of any ongoing, and possibly permanent, disability • Extent of any personality change • Depression • Extent of physical limitations • Extent of cognitive limitations

Item No	Injury
	• Extent of sensory limitation, for example, limitation of hearing or sense of taste or smell • Level of function and pre-existing function • Degree of independence • Ability to communicate • Behavioural or psychological changes • Presence of, and extent of, secondary medical complications **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if: • the injured person has epilepsy or an increased risk of epilepsy confirmed by EEG and the use of prophylactic medication; and • there is on-going reduced concentration and memory, or reduced mood control, that does not significantly interfere with the person's ability to take part in normal social life or return to work.
9	**Minor head injury, other than a skeletal injury of the facial area**
	Comment Brain damage, if any, is minimal. EXAMPLES OF THE INJURY • Uncomplicated skull fracture • Concussion with transitory loss of consciousness and no residual effects EXAMPLES OF FACTORS AFFECTING ISV SCALE • Severity of any physical injury causing brain damage • Length of time to recover from any symptoms • Extent of ongoing symptoms • Presence, or absence of, headaches **Comment about appropriate level of ISV** • An ISV at the bottom of the range will be applicable for an injury from which the injured person fully recovers within a few weeks • An ISV at or near the top of the range will be appropriate if there is an uncomplicated skull fracture and/or there are associated concussive symptoms of dizziness, headache and memory loss (usually persisting for less than 6 months)

Pure Mental Harm

(Psychiatric)

10-13

Pure Mental Harm (Psychiatric) 10-13

Item No	Injury
	General comment This Part includes references to ratings on the psychiatric impairment scale, *Guide to the Evaluation of Psychiatric Impairment for Clinicians (GEPIC).*
10	**Extreme psychiatric impairment**
	EXAMPLE OF THE INJURY An ISV score in the lower part of the range will be appropriate if psychiatric impairment is assessed with a GEPIC rating of Class 5.
11	**Serious psychiatric impairment**
	Comment about appropriate level of ISV An ISV under this item will be applicable if psychiatric impairment is assessed with a GEPIC rating of Class 4.
12	**Moderate psychiatric impairment**
	Comment There is generally only moderate impairment. EXAMPLE OF THE INJURY An ISV score in this range will be appropriate if psychiatric impairment is assessed with a moderate GEPIC rating of Class 3
13	**Minor psychiatric impairment**
	Comment There is generally only mild impairment. **Comment about appropriate level of ISV** An ISV near the top of the range will be applicable if psychiatric impairment is assessed with a mild GEPIC rating of Class 2. An ISV near the bottom of the range will be applicable if psychiatric impairment is assessed with a GEPIC rating of Class 1.

Facial Injuries

14-17

Facial Injuries 14-17

Item No	Injury
	EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT FOR ITEMS 14 TO 22 • Extent of skeletal or functional damage • Degree of cosmetic damage or disfigurement • Consequential mental harm • Availability of cosmetic repair
14	**Extreme facial injury**
	Comment The injury will involve severe traumatic injury to the face requiring substantial reconstructive surgery. EXAMPLES OF THE INJURY • A Le Fort I fracture or Le Fort II fracture if the degree of incapacity and disfigurement after reconstructive surgery will be very severe • A Le Fort III fracture causing incapacity in daily activities ADDITIONAL EXAMPLE OF FACTOR AFFECTING ISV SCALE The extent of any neurological impairment or effect on the airway NOTE: Le Fort I fracture, Le Fort II fracture and Le Fort III fracture are defined in regulation 3.
15	**Serious facial injury**
	Comment The injury will involve serious traumatic injury to the face requiring reconstructive surgery that is not substantial. EXAMPLES OF THE INJURY • A Le Fort I fracture or Le Fort II fracture if the degree of incapacity and disfigurement after reconstructive surgery will not be very severe • A Le Fort III fracture if no serious deformity will remain after reconstructive surgery • A serious or multiple fracture of the nasal complex either or both— (a) requiring more than 1 operation; and (b) causing 1 or more of the following— – permanent damage to the airway – permanent damage to nerves or tear ducts – facial deformity. • A serious cheekbone fracture that will require surgery and cause serious disfigurement and permanent effects despite reconstructive surgery, for example, hyperaesthesia or paraesthesia • A very serious multiple jaw fracture that will— (a) require prolonged treatment; and (b) despite reconstructive surgery, cause permanent effects, for example, severe pain, restriction in eating, paraesthesia or a risk of arthritis in the joints. • A severed trunk of the facial nerve (7th cranial nerve), causing total paralysis of facial muscles on 1 side of the face

Item No	Injury
	ADDITIONAL EXAMPLES OF FACTORS AFFECTING ISV SCALE • Any neurological impairment or effect on the airway • Permanent cosmetic deformity **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if the injury causes permanent cosmetic deformity, asymmetry of 1 side of the face and limited consequential mental harm. • An ISV at or near the top of the range will be appropriate if the injury causes serious bilateral deformity and significant consequential mental harm.
16	**Moderate facial injury**
	EXAMPLES OF THE INJURY • A simple cheekbone fracture, requiring minor reconstructive surgery, from which the injured person will fully recover with little cosmetic damage • A fracture of the jaw causing— (a) permanent effects, for example, difficulty in opening the mouth or in eating; or (b) hyperaesthesia or paraesthesia in the area of the fracture. • Damaged branches of the facial nerve (7th cranial nerve) with permanent paralysis of some of the facial muscles • A displaced fracture of the nasal complex from which the injured person will almost fully recover after surgery • A severed sensory nerve of the face with minor permanent paraesthesia
17	**Minor facial injury**
	EXAMPLES OF THE INJURY • A simple cheekbone fracture, for which surgery is not required and from which the injured person will recover fully • A simple jaw fracture, requiring immobilisation and from which the injured person will recover • A stable fracture of the joint process of the jaw • A displaced fracture of the nasal complex requiring only manipulation • A simple undisplaced fracture of the nasal complex, from which the injured person will fully recover • A severed sensory nerve of the face, with good repair causing minimal or no paraesthesia

Teeth & Gums

18

Teeth, Gums 18

Item No	Injury
18	**Injury to teeth or gums**
	Comment There will generally have been a course of treatment as a result of the injury. EXAMPLES OF FACTORS AFFECTING ISV SCALE • Extent and degree of discomfort during treatment • Difficulty with eating **Comment about appropriate level of ISV** If protracted dentistry causes the injury, the ISV may be higher than the ISV for the same injury caused by something else.
18.1	*Loss of or serious damage to more than 3 teeth, serious gum injury or serious gum infection*
18.2	*Loss of or serious damage to 2 or 3 teeth, moderate gum injury or moderate gum infection*
18.3	*Loss of or serious damage to 1 tooth, minor gum injury or minor gum infection*

Facial Scarring

19-22

Facial Scarring 19-22

Item No	Injury
	General comments This Division will usually apply to an injury involving skeletal damage only if the skeletal damage is minor.
19	**Extreme facial scarring**
	EXAMPLES OF THE INJURY • Widespread area scarring, for example, over the side of the face or another whole area • Severe contour deformity • Significant deformity of the mouth or eyelids with muscle paralysis or tic **Comment about appropriate level of ISV** • An ISV in the upper half of the range may be appropriate if the injured person is relatively young, the cosmetic damage is very disfiguring and the consequential mental harm is severe • An ISV at or near the top of the range will be appropriate if the injury is caused by burns that resulted in loss of the entire nose, eyelids or ears.
20	**Serious facial scarring**
	EXAMPLES OF THE INJURY • Substantial disfigurement and significant consequential mental harm • Discoloured hypertrophic or keloid scarring • Serious contour defects • Severe linear scarring • Extensive atrophic scarring
21	**Moderate facial scarring**
	Comment Any consequential mental harm is minor, or having been considerable at the outset, has greatly diminished. EXAMPLES OF THE INJURY • Scarring, the worst effects of which will be reduced by plastic surgery that will leave minor cosmetic damage • Scars crossing lines of election with discoloured, indurated, hypertrophic or atrophic scarring, of moderate severity
22	**Minor facial scarring**
	EXAMPLES OF THE INJURY • A single scar able to be camouflaged • More than 1 very small scar if the overall effect of the scars is to mar, but not markedly to affect, appearance and consequential mental harm is minor • Almost invisible linear scarring, in lines of election, with normal texture and elevation

Eyes

23-29

Eyes 23-29

Item No	Injury
	General comments Injuries mentioned in this Part are commonly symptoms of brain and nervous system injury.
23	**Total sight and hearing impairment**
	Comment The injury ranks with the most devastating injuries. EXAMPLES OF FACTORS AFFECTING ISV SCALE • Degree of insight • Age and life expectancy
24	**Total sight impairment**
	EXAMPLES OF FACTORS AFFECTING ISV SCALE • Degree of insight • Age and life expectancy
25	**Complete sight impairment in 1 eye with reduced vision in the other eye**
	Comment about appropriate level of ISV An ISV at or near the top of the range will be appropriate if there is serious risk of further significant deterioration in the remaining eye.
26	**Complete sight impairment in 1 eye or total loss of 1 eye**
	EXAMPLES OF FACTORS AFFECTING ISV SCALE • The extent to which the injured person's activities are adversely affected by the impairment or loss • Associated scarring or cosmetic damage 26 30 **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is a minor risk of sympathetic ophthalmia.
27	**Serious eye injury**
	EXAMPLES OF THE INJURY • A serious but incomplete loss of vision in 1 eye without significant risk of loss or reduction of vision in the other eye • An injury causing double vision that is not minor and intermittent
28	**Moderate eye injury**
	EXAMPLE OF THE INJURY Minor but permanent impairment of vision in one eye, including if there is double vision that is minor and intermittent

Item No	Injury
29	**Minor eye injury**
	EXAMPLES OF THE INJURY A minor injury, for example, from being struck in the eye, exposed to smoke or other fumes or being splashed by liquids— (a) causing initial pain and temporary interference with vision; and (b) from which the injured person will fully recover within a relatively short time

Ears

30-33.3

Ears 30-33.3

Item No	Injury
30	**Extreme ear injury**
	Definition of injury The injury involves a binaural hearing loss of at least 80%. **Additional examples of factors affecting ISV scale** • Associated problems, for example, severe tinnitus, moderate vertigo, a moderate vestibular disturbance or headaches • Availability of hearing aids or other devices that may reduce the hearing loss **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if the injury happened at an early age so as to prevent or to seriously affect the development of normal speech
31	**Serious ear injury**
	Definition of injury The injury involves— (a) a binaural hearing loss of at least 50% but less than 80%; or (b) severe permanent vestibular disturbance. **Comment about appropriate level of ISV** • An ISV in the lower half of the range will be appropriate if there is no speech impairment or tinnitus • An ISV in the upper half of the range will be appropriate if there is speech impairment and tinnitus.
32	**Moderate ear injury**
	Definition of injury The injury involves— (a) a binaural hearing loss of at least 20% but less than 50%; or (b) significant permanent vestibular disturbance. **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there are problems associated with the injury, for example, severe tinnitus, moderate vertigo, a moderate vestibular disturbance or headaches.

Item No	Injury
33	**Minor ear injury**
	Definition of injury The injury involves a binaural hearing loss of less than 20%. **Comment** • This item covers the bulk of hearing impairment cases • The injury is not to be judged simply by the degree of hearing loss • There will often be a degree of tinnitus present • There may also be minor vertigo or a minor vestibular disturbance causing loss of balance • A vestibular disturbance may increase the level of ISV.
33.1	*Moderate tinnitus and hearing loss*
33.2	*Mild tinnitus with some hearing loss*
33.3	*Slight or occasional tinnitus with slight hearing loss or an occasional vestibular disturbance, or both*

Taste/Smell

34-35

Taste/Smell 34-35

Item No	Injury
34	**Total loss of taste or smell, or both**
	Comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate if there will be a total loss of either taste or smell • An ISV at or near the top of the range will be appropriate if there will be a total loss of both taste and smell.
35	**Partial loss of smell or taste, or both**
	Comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate if there will be a partial loss of either taste or smell • An ISV at or near the top of the range will be appropriate if there will be a partial loss of both taste and smell.

Chest Injuries

(including Internal Organs)

36-39.2

Chest Injuries including Internal Organs 36-39.2

Item No	Injury
	EXAMPLE OF FACTORS AFFECTING ISV ASSESSMENT FOR ITEMS 36 TO 39 The level of any reduction in the capacity for employment and enjoyment of life
36	**Extreme chest injury**
	Comment The injury will involve severe traumatic injury to the chest, or a large majority of the organs in the chest cavity, causing a high level of disability and ongoing medical problems. **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there will be total removal of 1 lung or serious heart damage, or both, with serious and prolonged pain and suffering and significant permanent scarring.
37	**Serious chest injury**
	Comment The injury will involve serious traumatic injury to the chest or organs in the chest cavity, causing serious disability and ongoing medical problems. EXAMPLES OF THE INJURY A trauma to 1 or more of the following, causing permanent damage, physical disability and impairment of function— • the chest (eg the chest wall mechanics with consequent restrictive ventilatory impairment) • the heart • 1 or both of the lungs (eg scarring or restrictive pleural disease) • the diaphragm (eg rupture or phrenic nerve injury) • an injury that causes the need for oxygen therapy for about 16 to 18 hours a day EXAMPLE OF FACTORS AFFECTING ISV SCALE The need for a permanent tracheostomy **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if, after recovery, there are both of the following— (a) serious impairment to cardio-pulmonary function; (b) whole person impairment for the injury of, or of nearly, 40%.

Item No	Injury
38	**Moderate chest injury**
	EXAMPLE OF THE INJURY The injury will involve serious traumatic injury to the chest or organs in the chest cavity, causing moderate disability and ongoing medical problems. EXAMPLES OF FACTORS AFFECTING ISV SCALE • Duration and intensity of pain and suffering (eg chronic inter costal neuralgia) • The degree of permanent impairment of lung or cardiac function, as evidenced by objective test results • The need for a temporary tracheostomy for short-term airway management **Comment about appropriate level of ISV** An ISV at or near the top of the range will be applicable if there are multiple rib fractures causing— (a) a flail segment (flail chest) requiring mechanical ventilation in the acute stage; and (b) moderate permanent impairment of cardio-pulmonary function. An ISV at near the bottom of the range will be appropriate if there will be a partial loss of a breast without significant consequential mental harm. An ISV in the lower half of the range will be appropriate if there was a pneumothorax, or haemothorax, requiring intercostal catheter insertion.
39	**Minor chest injury**
	EXAMPLES OF FACTORS AFFECTING ISV SCALE FOR ITEMS 39.1 AND 39.2 • complexity of any fractures • extent of injury to underlying organs • extent of any disability • duration and intensity of pain and suffering
39.1	*Complicated or significant fracture, or internal organ injury, that substantially resolves*
	Comment The injury will involve significant or complicated fractures, or internal injuries, that cause some tissue damage but no significant long-term effect on organ function. EXAMPLES OF THE INJURY • Multiple fractures of the ribs or sternum, or both, that may cause cardio-pulmonary contusion • Internal injuries that cause some tissue damage but no significant long-term effect on organ function **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a fractured sternum that substantially resolves, and there is some ongoing pain and activity restriction • An ISV at or near the top of the range will be appropriate if the injury causes significant persisting pain and significant activity restriction.

Item No	Injury
39.2	*Soft tissue injury, minor fracture or minor internal organ injury*
	Comment • The injury will involve a soft tissue injury, minor fracture, or minor and non-permanent injury to internal organs • There may be persistent pain from the chest, for example, from the chest wall or sternochondral or costochondral joints. EXAMPLES OF THE INJURY • A single penetrating wound, causing some tissue damage but no long-term effect on lung function • An injury to the lungs caused by the inhalation of toxic fumes or smoke that will not permanently interfere with lung function • A soft tissue injury to the chest wall, for example, a laceration or serious seatbelt bruising • Fractured ribs or a minor fracture of the sternum causing serious pain and disability for weeks, without internal organ damage or permanent disability **Comment about appropriate level of ISV** An ISV at or near the bottom of the range will be appropriate if there is a soft tissue injury from which the injured person will fully recover

Lung Injuries other than Asthma

40-43

Lung Injuries other than Asthma 40-43

Item No	Injury
	General comments The level of an ISV for lung disease often reflects the fact that the disease is worsening and there is a risk of the development of secondary medical conditions. EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT FOR ITEMS 40 TO 43 Consequential mental harm may increase the level of ISV
40	**Extreme lung injury**
	EXAMPLES OF THE INJURY • Lung disease involving serious disability causing severe pain and dramatic impairment of function and quality of life • A recurrent pulmonary embolism resulting in failure of the right side of the heart requiring a lung transplant, heart transplant or both ADDITIONAL EXAMPLES OF FACTORS AFFECTING ISV SCALE • Age • Likelihood of progressive worsening • Duration and intensity of pain and suffering
41	**Serious lung injury**
41.1	*Serious lung injury if progressive worsening of lung function*
	EXAMPLE OF ITEM 41.1 Lung disease, causing— • significantly reduced and worsening lung function • prolonged and frequent coughing • restriction of physical activity, employment and enjoyment of life. ADDITIONAL EXAMPLES OF FACTORS AFFECTING ISV SCALE FOR ITEM 41.1 • The possibility of lung cancer developing may increase the level of ISV • The need for continuous oxygen therapy
41.2	*Serious lung injury if no progressive worsening of lung function*
	EXAMPLES OF ITEM 41.2 • Lung disease causing breathing difficulties, short disabling breathlessness, requiring frequent use of inhaler • Lung disease causing a significant effect on employment and social life, including inability to tolerate a smoky environment, with an uncertain prognosis • A recurrent pulmonary embolism causing pulmonary hypertension and cor pulmonale
42	**Moderate lung injury**
	EXAMPLE OF THE INJURY A pulmonary embolism requiring anticoagulant therapy for at least 1 year or pulmonary endarterectomy

Item No	Injury
43	**Minor lung injury**
	EXAMPLES OF THE INJURY • Lung disease causing slight breathlessness, with— (a) no effect on employment; and (b) the likelihood of substantial and permanent recovery within a few years after the injury is caused • A pulmonary embolism requiring anticoagulant therapy for less than 1 year **Comment about appropriate level of ISV** An ISV under this item will also be appropriate if there is lung disease causing temporary aggravation of bronchitis, or other chest problems, that will resolve within a few months.

Male Reproductive

44-47

Male Reproductive 44-47

Item No	Injury
	General comment • This Division applies to injuries caused by physical trauma rather than as a secondary result of psychiatric impairment • For psychiatric impairment that causes loss of reproductive system function, (see psychiatric impairment) • Sterility is usually either— (a) caused by surgery, chemicals or disease; or (b) caused by a traumatic injury that is often aggravated by scarring. EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT FOR ITEMS 44 TO 47 • Consequential mental harm • Effect on social and domestic life
44	**Impotence and sterility**
	Additional examples of factors affecting ISV scale • Age • Whether the injured person has children • Whether the injured person intended to have children or more children
44.1	**Comment about appropriate level of ISV** • An ISV at or near the top of the range will be appropriate if a young injured person has total impotence and loss of sexual function and sterility • An ISV in the upper half of the range will be appropriate if a young injured person without children has uncomplicated sterility, without impotence or any aggravating features • An ISV near the middle of the range will be appropriate if a middle-aged injured person with children has sterility and permanent impotence • An ISV in lower half of the range will be appropriate if an injured person with children may have intended to have more children and has uncomplicated sterility, without impotence or any aggravating features • An ISV at or near the bottom of the range will be applicable if the sterility has little impact.
45	**Loss of part or all of the penis**
	Comment about appropriate level of ISV • Extent of penis remaining • Availability of prosthesis • Extent to which sexual activity will be possible

Item No	Injury
46	**Loss of both testicles**
	See item 44 where sterility results
47	**Loss of 1 testicle**
	Additional example of factors affecting ISV scale Age, cosmetic damage or scarring **Comment about appropriate level of ISV** An ISV at or near the bottom of the range will be appropriate if the injury does not reduce reproductive capacity.

Female Reproductive

48-49.4

Female Reproductive 48-49.4

Item No	Injury
	General comment • This Division applies to injuries caused by physical trauma rather than as a secondary result of psychiatric impairment • For psychiatric impairment that causes loss of reproductive system function, (see psychiatric impairment). EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT FOR ITEMS 48 TO 49 • Extent of any physical trauma • Whether the injured person has children • Whether the injured person intended to have children or more children • Age • Scarring • Depression or consequential mental harm • Effect on social and domestic life
48	**Infertility**
48.1	*Infertility causing severe effects*
	EXAMPLE Infertility with severe depression, anxiety and pain
48.2	*Infertility causing moderate effects*
	EXAMPLE Infertility without any medical complication if the injured person has children **Comment about appropriate level of ISV** An injury under this item is applicable even if there is consequential mental harm
48.3	*Infertility causing minor effects*
	EXAMPLE Infertility if— (a) the injured person was unlikely to have had children, for example, because of age; and (b) there is little or no consequential mental harm

Item No	Injury
49	**Any other injury to the female reproductive system**
49.1	*Injury to female genitalia or reproductive organs, or both*
	Comment about appropriate level of ISV • An ISV at or near the top of the range will be appropriate if the injury causes the early onset of menopause or irregular hormonal activity • An ISV at or near the middle of the range will be appropriate if the injury causes: – development of a prolapse or fistula – a laceration or tear with good repair.
49.2	*Female impotence*
	Comment The injury may be correctable by surgery. ADDITIONAL EXAMPLES OF FACTORS AFFECTING ISV SCALE The level of sexual function or the extent of any corrective surgery
49.3	*An injury causing an inability to give birth by normal vaginal delivery, for example, because of pelvic ring disruption or deformity*
	Comment The injury may be correctable by surgery.
49.4	*Reduced fertility, caused by, for example, trauma to ovaries or fallopian tubes*

Digestive Tract & System

50-57

Digestive Tract & System 50-57

Item No	Injury
Subdivision 1—Upper digestive tract	
50	Extreme injury to the digestive system caused by trauma
	EXAMPLES OF THE INJURY • Severe permanent damage to the upper digestive system, with ongoing debilitating pain and discomfort, diarrhoea, nausea and vomiting that— (a) are not controllable by drugs; and (b) causes weight loss of at least 15%. • An injury to the throat requiring a permanent gastrostomy **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is an injury to the oropharynx/oesophagus (throat) requiring a temporary gastrostomy for more than 1 year and permanent dietary changes, for example, a requirement for a soft food diet • An ISV at or near the top of the range will be appropriate if there is an injury to the oropharynx/oesophagus (throat) requiring a permanent gastrostomy, with significant ongoing symptoms. EXAMPLES OF FACTORS AFFECTING ISV SCALE • the extent of any voice or speech impairment • need for ongoing endoscopic procedure
51	**Serious injury to the digestive system caused by trauma**
	EXAMPLES OF THE INJURY A serious injury causing long-term complications and requiring continuous medication EXAMPLES OF FACTORS AFFECTING ISV SCALE • The extent of any ongoing voice or speech impairment • Whether a feeding tube was required, and if so, for how long it was required • Urgent and/or uncontrolled bowel use An ISV under this item is applicable if a feeding tube is required for between 3 and 12 months
52	**Moderate injury to the digestive system caused by trauma**
	EXAMPLES OF THE INJURY • A blunt trauma or a penetrating stab wound, causing some permanent tissue damage, but with no significant long-term effect on digestive function • An injury requiring a feeding tube for less than 3 months EXAMPLE OF FACTORS AFFECTING ISV SCALE • Whether a feeding tube was required, and if so, for how long it was required • Whether dietary changes are required to reduce the risk of aspiration because of impaired swallowing

Item No	Injury
53	**Minor injury to the digestive system caused by trauma**
	EXAMPLES OF THE INJURY • A soft tissue injury to the abdomen wall, for example, a laceration or serious seatbelt bruising to the abdomen or flank, or both • A minor injury to the throat or tongue causing temporary difficulties with swallowing or speech • A laceration of the tongue requiring suturing
Subdivision 2—Injuries to the digestive system not caused by trauma	
	General comments There is a marked difference between those comparatively rare cases having a long term or even permanent effect on quality of life and cases in which the only ongoing symptom is an allergy, for example, to specific foods, that may cause short-term illness.
54	**Extreme injury to the digestive system not caused by trauma**
	EXAMPLE OF THE INJURY Severe toxicosis— (a) causing serious acute pain, vomiting, diarrhoea and fever, requiring hospitalisation for days or weeks; and (b) also causing 1 or more of the following: • ongoing incontinence • haemorrhoids • irritable bowel syndrome; and (c) having a significant impact on the capacity for employment and enjoyment of life. **Comment about appropriate level of ISV** An ISV in the lower half of the range will be appropriate if the injury causes a chronic infection that requires prolonged hospitalisation that will not resolve after antibiotic treatment for a year.
55	**Serious injury to the digestive system not caused by trauma**
	EXAMPLES OF THE INJURY Constant abdominal pain, causing significant discomfort, for up to 18 months caused by a delay in diagnosis of an injury to the digestive system **Comment about appropriate level of ISV** • An ISV at or near the top of the range will be appropriate if there is an adverse response to the administration of a drug that— (a) requires admission to an intensive care unit; and (b) does not cause any permanent impairment; and (c) causes the need for ongoing drug therapy for life. • An ISV in the upper half of the range will be appropriate if a chronic infection— (a) requires prolonged hospitalisation and additional treatment; and (b) will be resolved by antibiotic treatment within 1 year. • An ISV at or near the bottom of the range will be appropriate if there is an adverse response to the administration of a drug that— (a) requires admission to an intensive care unit; and (b) does not cause any permanent impairment; and (c) does not cause the need for ongoing drug therapy for life.

Item No	Injury
56	**Moderate injury to the digestive system not caused by trauma**
	EXAMPLES OF THE INJURY • An infection that is resolved by antibiotic treatment, with or without additional treatment in hospital, within 3 months after the injury is caused • An adverse response to the administration of a drug, causing any of the following continuing over a period of more than 7 days, and requiring hospitalisation: (a) vomiting; (b) shortness of breath; (c) hypertension; (d) skin irritation
57	**Minor injury to the digestive system not caused by trauma**
	EXAMPLES OF THE INJURY • Disabling pain, cramps and diarrhoea, ongoing for days or weeks • A localised infection, requiring antibiotic treatment, that heals within 6 weeks after the start of treatment • An adverse response to the administration of a drug, causing any of the following continuing over a period of not more than 7 days, and not requiring hospitalisation: (a) vomiting; (b) shortness of breath; (c) hypertension; (d) skin irritation • Intermittent abdominal pain for up to 6 months caused by a delay in diagnosis of an injury to the digestive system

Kidneys & Ureter

58-61

Kidneys & Ureter 58-61

Item No	Injury
	An injury to a ureter or the ureters alone, without loss of, or serious damage to, a kidney will generally be assessed under items 60 or 61. EXAMPLES OF FACTOR AFFECTING ISV ASSESSMENT FOR ITEMS 58 TO 61 • Age • Risk of ongoing kidney or ureter problems, complications or symptoms • Need for future medical procedures
58	**Extreme injury to kidneys or ureters**
58.1	*Loss of both kidneys causing loss of renal function and requiring permanent dialysis or transplant*
58.2	*Serious damage to both kidneys, requiring temporary or intermittent dialysis*
	EXAMPLES OF FACTORS AFFECTING ISV SCALE • The effect of dialysis and loss of kidney function on activities of daily living • The length of time for which dialysis was required or the frequency of intermittent dialysis • Ongoing requirement for medication, for example, to control blood pressure • Whether the injury caused the need for dietary changes **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if dialysis was required for an initial 3 months period, with intermittent dialysis required after that • An ISV at or near the top of the range will be appropriate if the injury required dialysis for about 1 year and ongoing dietary changes and medication.
59	**Serious injury to kidneys or ureters**
	Comment The injury may require temporary dialysis for less than 3 months. EXAMPLE OF THE INJURY Loss of 1 kidney if there is severe damage to, and a risk of loss of function of, the other kidney **Comment about appropriate level of ISV** The higher the risk of loss of function of the other kidney, the higher the ISV.
60	**Moderate injury to kidneys or ureters**
	EXAMPLES OF THE INJURY • Loss of 1 kidney, with no damage to the other kidney • An injury to a ureter or the ureters that requires surgery or placement of stents

Item No	Injury
61	**Minor injury to kidneys or ureters**
	EXAMPLE OF THE INJURY A laceration or contusion to 1 or both of the kidneys confirmed by imaging **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is an injury to a kidney causing a contusion • An ISV at or near the top of the range will be appropriate if a partial removal of a kidney is required

Liver, Gall Bladder or Biliary Tract

62-65

Liver, Gall Bladder or Biliary Tract 62-65

Item No	Injury
	EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT • Whether there are recurrent episodes of infection or obstruction • Whether there is a risk of developing biliary cirrhosis
62	**Extreme injury to liver, gall bladder or biliary tract**
	EXAMPLE OF THE INJURY Loss, or injury causing effective loss of liver function **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there are recurrent episodes of liver failure that require hospital admission and medical management but do not require liver transplantation • An ISV at or near the top of the range will be appropriate if the injury requires liver transplantation
63	**Serious injury to liver, gall bladder or biliary tract**
	EXAMPLE OF THE INJURY Serious damage causing physical loss of over 30% of the tissue of the liver, but with some functional capacity of the liver remaining
64	**Moderate injury to liver, gall bladder or biliary tract**
	EXAMPLE OF THE INJURY A laceration, contusion or trauma damage to the liver, with a moderate permanent effect on liver function, confirmed from imaging The removal of the gall bladder that causes ongoing symptoms **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if the injury causes impaired liver function with symptoms of intermittent nausea and vomiting and weight loss • An ISV at or near the bottom of the range will also be appropriate if there is a gall bladder injury with recurrent infection or symptomatic stone disease, the symptoms of which may include, for example, pain or jaundice • An ISV at or near the middle of the range will be appropriate if the injury involves removal of the gall bladder causing a bile duct injury • An ISV at or near the top of the range will be appropriate if— (a) surgery is required to remove not more than 30% of the liver; or (b) bile ducts require repair, for example, placement of stents. • An ISV at or near the top of the range will also be appropriate if there is an injury to the gall bladder, that despite biliary surgery, causes ongoing symptoms, infection or the need for further endoscopic surgery

Item No	Injury
65	**Minor injury to liver, gall bladder or biliary duct**
	Comment An injury within this item should not require surgery to the liver. EXAMPLE OF THE INJURY A laceration or contusion to the liver, with a minor effect on liver function and confirmed from imaging **Comment about appropriate level of ISV** An ISV in the lower half of the range will be appropriate if there is an uncomplicated removal of the gall bladder with no ongoing symptoms.

Bowel

66-69

Bowel 66-69

Item No	Injury
	EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT FOR ITEMS 66 TO 69 • Age • Risk of ongoing bowel problems, complications or symptoms • Need for future surgery • The degree to which dietary changes are required to manage chronic pain or diarrhoea caused by the injury
66	**Extreme bowel injury**
	EXAMPLE OF THE INJURY An injury causing a total loss of natural bowel function and dependence on colostomy
67	**Serious bowel injury**
	EXAMPLE OF THE INJURY A serious abdominal injury causing either or both of the following: (a) impairment of bowel function (which often requires permanent or long-term colostomy, leaving disfiguring scars); (b) permanent restrictions on employment and diet and/or requiring nutritional supplements
68	**Moderate bowel injury**
	EXAMPLE OF THE INJURY (a) the injury requires temporary surgical diversion of the bowel, for example, an ileostomy or colostomy; and (b) there is ongoing intermittent abnormal bowel function requiring medication; and (c) some loss of bowel, weight loss and permanent restriction on diet and/or requiring nutritional supplements
69	**Minor bowel injury**
	EXAMPLE OF THE INJURY An injury causing tears to the bowel, with minimal ongoing bowel problems

Bladder, Prostate or Urethra

70-73

Bladder, Prostate or Urethra 70-73

Item No	Injury
	EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT FOR ITEMS 70 TO 73 • Age • Risk of ongoing bladder, prostate or urethra problems, complications or symptoms • Need for future surgery
70	**Extreme bladder, prostate or urethra injury**
	EXAMPLE OF THE INJURY An injury causing a complete loss of bladder function and control, with permanent dependence on urostomy
71	**Serious bladder, prostate or urethra injury**
	EXAMPLE OF THE INJURY An injury causing serious impairment of bladder control, with some incontinence **Comment about appropriate level of ISV** An ISV in the upper half of the range will be appropriate if there is serious ongoing pain.
72	**Moderate bladder, prostate or urethra injury**
	EXAMPLE OF THE INJURY An injury causing continued impairment of bladder control, with minimal incontinence and minimal pain **Comment about appropriate level of ISV** An ISV at or near the top of the range will be applicable if— • an ongoing requirement for minor surgery, for example, cystoscopy or urethral dilation; or • other surgery due to being unresponsive to treatment
73	**Minor bladder, prostate or urethra injury**
	EXAMPLE OF THE INJURY A bladder injury that may require conservative intermittent medical treatment for which surgery is not required and from which the injured person will fully recover

Spleen & Pancreas

74-76

Spleen & Pancreas 74-76

Item No	Injury
74	**Injuries to the pancreas**
	EXAMPLES OF FACTORS AFFECTING ISV SCALE • The extent of any ongoing risk of internal infection and disorders, for example, diabetes • The need for, and outcome of, further surgery, for example, surgery to manage pain caused by stone disease, infection or an expanding pseudocyst • An ISV at or near the middle of the range will be appropriate if there are chronic symptoms, for example, pain or diarrhoea, and weight loss • An ISV at or near the top of the range will be appropriate if— (a) there are chronic symptoms with significant weight loss of between 10% and 20% of body weight, and pancreatic enzyme replacement is required; or (b) an injury to the pancreas causes diabetes.
75	**Loss of spleen (complicated)**
	EXAMPLE OF THE INJURY Loss of spleen if there will be a risk, that is not minor, of ongoing internal infection and disorders caused by the loss **Comment** • An ISV at or near the top of the range will be appropriate if the injury leads to a splenectomy, with portal vein thrombosis after the splenectomy • An ISV at or near the middle of the range will be appropriate if— (a) the injury leads to a splenectomy, with serious infection after the splenectomy; and (b) the infection requires surgical or radiological intervention
76	**Injury to the spleen or uncomplicated loss of spleen**
	EXAMPLE OF THE INJURY Laceration or contusion to the spleen that— (a) has been radiologically confirmed; (b) has no ongoing bleeding; (c) is managed conservatively; and (d) resolves fully **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there has been removal of the spleen (splenectomy), with little or no risk of ongoing infections and disorders caused by the loss of the spleen.

Hernia

77-79

Hernia 77-79

Item No	Injury
77	**Severe hernia**
	EXAMPLE OF THE INJURY An incisional hernia if after repair there is either or both— (a) ongoing pain; and (b) a restriction on physical activities, sport or employment **Comment about appropriate level of ISV** An ISV at the top of the range will be appropriate if— (a) the incisional hernia is reoccurring; and (b) has a whole of person impairment of 10% or more
78	**Moderate hernia**
	EXAMPLE OF THE INJURY An incisional hernia that after repair has some real risk of recurring in the short-term
79	**Minor hernia**
	EXAMPLE OF THE INJURY An uncomplicated incisional hernia, whether or not repaired

Cervical Spine

80-84

Cervical Spine 80-84

Item No	Injury
	General comment for items 80 to 84 This Division does not apply to the following injuries (that are dealt with in items 1 to 3): • quadriplegia • paraplegia • hemiplegia or severe paralysis of more than 1 limb. There must be clinical findings present at the time of examination. Clinical findings must be consistent with radiological objective evidence where present. • Cervical spine injuries, other than those dealt with in items 1 to 3, range from cases of very severe disability to cases of a minor strain, with no time off work and symptoms only suffered for 2 or 3 weeks • Symptoms associated with nerve root compression or damage cannot be taken into account in assessing an ISV under items 80 to 82 unless objective signs are present of a permanent nerve root compression or damage, or other specific imaging findings as defined— – CT and/or MRI scans or other appropriate imaging evidence of disc herniation (as distinct from merely a disc bulge and/ or annular tear), and residual and corresponding objective neurological impairment, for example— ▪ sensory loss ▪ loss of muscle strength and/or corresponding atrophy ▪ impaired reflexes
80	**Extreme cervical spine injury**
	Comment These are extremely severe injuries that cause gross limitation of movement and serious interference with performance of daily activities. The injury will involve significant upper or lower extremity impairment and may require the use of an adaptive device or prosthesis. EXAMPLES OF THE INJURY • A total neurological loss at a single level • Severe multilevel neurological dysfunction • Structural compromise of the spinal canal with extreme upper or lower extremity motor and sensory impairments • Fractures involving more than 50% compression of a vertebral body with neural compromise **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is whole person impairment of about 35% • An ISV at or near the top of the range will be appropriate if there is a cervical spine injury causing monoplegia of the dominant upper limb and WPI of at least 60%

Item No	Injury
81	**Serious cervical spine injury**
	Comment • The injury of the cervical spine will cause serious neurological upper extremity impairment or serious permanent impairment of the cervical spine for which there is radiological evidence • The injury may involve— (a) a change of motion segment integrity; or (b) bilateral or multilevel nerve root compression or damage; or (c) a fracture involving more than 25% compression of 1 vertebral body or a fusion (either traumatic or post-surgical);or (d) an injury showing objective signs of nerve root damage after surgery. EXAMPLES OF THE INJURY Loss of motion in a motion segment because of a surgical or post- traumatic fusion **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if— (a) the injured person has had surgery and symptoms persist; or (b) there is a fracture involving 25% compression of 1 vertebral body. • An ISV in the middle of the range will be appropriate if there is a fracture involving about 50% compression of a vertebral body, with ongoing pain • An ISV at or near the top of the range will be appropriate if— (a) the injured person has had a fusion of vertebral bodies that has failed, leaving objective signs of significant residual nerve root damage and ongoing pain, affecting 1 side of the body; and (b) there is whole person impairment of about 28%.
82	**Moderate cervical spine injury—fracture, disc prolapse (herniated disc) or nerve root compression or damage**
	Comment An ISV for this item will be appropriate if— (a) there is a herniated disc for which there is radiological evidence corresponding to an anatomically correct level of objective neurological impairment; and (b) there are symptoms of pain and 3 or more of the following objective signs that are anatomically localised to an appropriate spinal nerve root distribution: (i) sensory loss; (ii) loss of muscle strength and/or corresponding atrophy; (iii) impaired reflexes; (iv) unilateral atrophy; and (c) the impairment has not improved after non-operative treatment

Item No	Injury
83	**Moderate cervical spine injury—soft tissue injury**
	Comment The injury will cause moderate permanent impairment, for which there is a clinical history and examination findings that are compatible with a specific injury for which there will be 2 or more objective signs. **Comment about appropriate level of ISV** An ISV at the top half of the range is appropriate if there is a whole of person impairment of 8% caused by a traumatic soft tissue injury
84	**Minor cervical spine injury**
	Comment • Injuries within this item include a whiplash injury with minor ongoing symptoms, and/or dysfunction including symptoms, remaining for more or expected to remain more than 18 months after the injury is caused; and • There are no objective signs of a neurological impairment (for example, a radiculopathy) at the time of assessment. **Comment about appropriate level of ISV** • A low range ISV under this item will be applicable if the injury will resolve within months after the injury is caused; and • A high range ISV under this item will be applicable if, the injury causes persistent headaches, significant neck stiffness and some ongoing pain and/or dysfunction

Thoracic Spine or Lumbar Spine

85-89

Thoracic Spine or Lumbar Spine 85-89

Item No	Injury
	General comments • This Division does not apply to the following injuries (that are dealt with in items 1 to 3): – quadriplegia – paraplegia – hemiplegia or severe paralysis of more than 1 limb. • Thoracic or lumbar spine injuries, other than those dealt with in items 1 to 3, range from cases of very severe disability to cases of a minor strain, with no time off work and symptoms suffered only for 2 or 3 weeks • Symptoms associated with nerve root compression or damage cannot be taken into account in assessing an ISV under item 85 to 87 unless objective signs are present of nerve root compression or damage, for example— – CT or MRI scans or other radiological evidence – muscle wasting – clinical findings of deep tendon reflex loss, motor weakness and loss of sensation. There must be clinical findings present at the time of examination. Clinical findings must be consistent with radiological objective evidence where present.
85	**Extreme thoracic or lumbar spine injury**
	These are extremely severe injuries causing gross limitation of movement and serious interference with performance of daily activities. There may be some motor or sensory loss, and some impairment of bladder, ano-rectal or sexual function. EXAMPLE OF THE INJURY A fracture involving compression of a thoracic or lumbar vertebral body of more than 50%, with neurological impairment **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is whole person impairment for the injury of 25% • An ISV at or near the top of the range will be appropriate if there is whole person impairment for the injury of at least 45%.
86	**Serious thoracic or lumbar spine injury**
	Comment • The injury will cause serious permanent impairment in the thoracic or lumbar spine • The injury may involve— (a) bilateral or multilevel nerve root damage; or (b) a change in motion segment integrity, for example, because of surgery. EXAMPLE OF THE INJURY A fracture involving at least 25% compression of 1 thoracic or lumbar vertebral body **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if— (a) the injured person has had surgery and symptoms persist; or (b) there is a fracture involving 25% compression of 1 vertebral body.

Item No	Injury
	• An ISV in the middle of the range will be appropriate if there is a fracture involving 50% compression of a vertebral body, with ongoing pain • An ISV at or near the top of the range will be appropriate if the injured person has had a fusion of vertebral bodies that has failed— (a) leaving objective signs of significant residual nerve root damage and ongoing pain, affecting 1 side of the body; and (b) causing whole person impairment of 24%.
87	**Moderate thoracic or lumbar spine injury—fracture, disc prolapse or nerve root compression or damage**
	Comment An ISV for this item will be appropriate if— (a) there is a herniated disc for which there is radiological evidence corresponding to an anatomically correct level of objective neurological impairment; and (b) there are symptoms of pain and 3 or more of the following objective signs that are anatomically localised to an appropriate spinal nerve root distribution— (i) sensory loss; (ii) loss of muscle strength, and/or corresponding atrophy; (iii) impaired reflexes; (iv) unilateral atrophy; and (c) the impairment has not improved after non-operative treatment.
88	**Moderate thoracic or lumbar spine injury—soft tissue injury**
	Comment The injury will cause moderate permanent impairment, for which there is a clinical history and examination findings that are compatible with a specific injury for which there will be 2 or more objective signs. **Comment about appropriate level of ISV** An ISV at the top half of the range is appropriate if there is a whole of person impairment of 8% caused by a traumatic soft tissue injury
89	**Minor thoracic or lumbar spine injury**
	EXAMPLE OF THE INJURY A soft tissue injury of the thoracic or lumbar spine with no— • significant clinical findings • fractures • documented neurological impairment • significant loss of motion segment integrity • other objective signs of impairment relating to the injury **Comment about appropriate level of ISV** • An ISV at or near the top of the range will be appropriate, whether or not the injured person continues to suffer some ongoing pain, if the injury will substantially reach maximum medical improvement, with only minor symptoms, within about 18 months after the injury is caused • An ISV at or near the bottom of the range will be appropriate if the injury will resolve without any ongoing symptoms within months after the injury is caused

Shoulder

90-93

Shoulder 90-93

Item No	Injury
	General comments Injuries under items 90 to 93 include subluxations or dislocations of the sternoclavicular joint, acromioclavicular joint or glenohumeral joint. • Soft tissue injuries may involve the musculoligamentous supporting structures of the joints • Fractures may involve the clavicle, the scapula (shoulder blade) and the humerus **Comment about appropriate level of ISV for items 90 to 93** An ISV at or near the top of the range will generally only be appropriate if the injury is to the shoulder of the dominant upper limb.
90	**Extreme shoulder injury**
	Comment These are the most severe traumatic injuries causing gross permanent impairment. EXAMPLES OF THE INJURY • A severe fracture or dislocation, with secondary medical complications • Joint disruption with poor outcome after surgery • Degloving • Permanent nerve palsies **Additional comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is whole person impairment of 45% and complete loss of all shoulder function of the dominant upper limb.
91	**Serious shoulder injury**
	Comment The injury will involve serious trauma to the shoulder causing serious permanent impairment. EXAMPLES OF THE INJURY • A crush injury • A serious fracture with secondary arthritis • Nerve palsies from which the injured person will partially recover • Established non-union of a clavicular or scapular fracture despite open reduction and internal fixation (ORIF) • Established non-union of a clavicular or scapular fracture if surgery is not appropriate or not possible, and there is significant functional impairment **Additional comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is whole person impairment for the injury of 25% and the injury is to the dominant upper limb.

Item No	Injury
92	**Moderate shoulder injury**
92.1	**Comment** An ISV under this item will be applicable if there is a whole of person impairment of 10—12% EXAMPLES OF THE INJURY • Traumatic adhesive capsulitis with discomfort, limitation of movement and symptoms persisting or expected to persist for about 2 years • Permanent and significant soft tissue disruption, for example, from tendon tears or ligament tears • A fracture, from which the injured person has made a reasonable recovery, requiring open reduction and internal fixation • Nerve palsies from which the injured person has made a good recovery • Painful persisting dislocation of the acromioclavicular joint • An injury to the sternoclavicular joint causing permanent, painful instability **Comment about the appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if the injury is to the non-dominant upper limb • An ISV at or near the top of the range will be appropriate if the injury is to the dominant upper limb
92.2	**Comment** An ISV under this item will be appropriate if there is a whole person impairment for the injury of less than 10% EXAMPLES OF THE INJURY • Traumatic adhesive capsulitis with discomfort, limitation of movement and symptoms persisting or expected to persist for about 2 years • Permanent and significant soft tissue disruption, for example, from tendon tears or ligament tears • Nerve palsies from which the injured person has made a good recovery • Painful persisting dislocation of the acromioclavicular joint • An injury to the sternoclavicular joint causing permanent, painful instability **Comment about this level of ISV** • An ISV at or near the bottom of the range will be appropriate if the injury is to the non-dominant upper limb • An ISV at or near the top of the range will be appropriate if the injury is to the dominant upper limb
93	**Minor shoulder injury**
	EXAMPLES OF THE INJURY • Soft tissue injury with considerable pain from which the injured person makes an almost full recovery in less than 18 months • Fracture from which the injured person has made an uncomplicated recovery • Strain injury of the acromioclavicular joint or sternoclavicular joint

Upper Limb Amputation

94-95.3

Upper Limb Amputation 94-95.3

Item No	Injury
	Comment about appropriate level of ISV for items 94 to 95 An ISV at or near the top of the range will generally only be appropriate if the amputation is of the dominant upper limb
94	**Loss of both upper limbs, or loss of 1 arm and extreme injury to the other arm**
	Comment The effect of the injury is to reduce the injured person to a state of considerable helplessness EXAMPLES OF FACTORS AFFECTING ISV SCALE • Whether the amputations are above or below the elbow (the loss of the elbow joint adds greatly to the disability) • The length of any stump suitable for use with a prosthesis • Severity of any phantom pains **Additional comment about appropriate level of ISV** • An ISV of 70 to 85 will be appropriate if— (a) both upper limbs are amputated at the shoulder; or (b) 1 arm is amputated at the shoulder, and there is a loss of function in the other arm, causing whole person impairment of 60%. • An ISV of 65 to 80 will be appropriate if— (a) both upper limbs are amputated through the elbow or above the elbow but below the shoulder; or (b) 1 arm is amputated through the elbow or above the elbow but below the shoulder, and there is a loss of function in the other arm, causing whole person impairment of 57%. • An ISV of 55 to 75 will be appropriate if— (a) both upper limbs are amputated below the elbow; or (b) 1 arm is amputated below the elbow, and there is a loss of function in the other arm, causing whole person impairment of 54%.
95	**Loss of 1 upper limb**
	EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT • Whether the amputation is above or below the elbow (the loss of the elbow joint adds greatly to the disability) • Whether the amputation was of the dominant arm • The length of any stump suitable for use with a prosthesis • Severity of any phantom pains • Extent of any disability in the other arm
95.1	*An upper limb amputation at the shoulder*
95.2	*An upper limb amputation through the elbow or above the elbow but below the shoulder*
	Additional comment about appropriate level of ISV • An ISV at or near the bottom of the range will generally be appropriate if there is an amputation through the elbow • An ISV at or near the top of the range will be appropriate if there is a short stump because a short stump may create difficulties in the use of a prosthesis

Item No	Injury
95.3	*An upper limb amputation below the elbow*
	Additional comment about appropriate level of ISV An ISV at or near the top of the range will be appropriate if there is an amputation through the forearm with residual severe pain in the stump and phantom pains

Elbow

96-99

Elbow 96-99

Item No	Injury
	Comment about appropriate level of ISV for items 96 to 99 An ISV at or near the top of the range will generally only be appropriate if the injury is to the elbow of the dominant upper limb
96	**Extreme elbow injury**
	Comment The injury will involve an extremely severe elbow injury, falling short of amputation, leaving little effective use of the elbow joint EXAMPLES OF THE INJURY • Whole person impairment for the injury of between 24% and 42% • A complex elbow fracture, or dislocation, with secondary complications • Joint disruption, with poor outcome after surgery • Degloving • Permanent nerve palsies • An injury causing severe limitation of elbow movement with the joint constrained in a non-functional position
97	**Serious elbow injury**
	Comment The injury will involve significant disability and require major surgery. EXAMPLES OF THE INJURY • A serious fracture with secondary arthritis • A crush injury • Nerve palsies from which the injured person will partially recover • Permanent, poor restricted range of movement with the elbow constrained in a satisfactory functional position **Additional comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is whole person impairment for the injury of 23% and the injury is to the elbow of the dominant upper limb.
98	**Moderate elbow injury**
	Comment The injury will cause moderate long-term disability but does not require multiple surgeries. EXAMPLES OF THE INJURY • A fracture, from which the injured person has made a reasonable recovery, requiring open reduction and internal fixation • Nerve palsies from which the injured person has made a good recovery

Item No	Injury
	Additional comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate if there is whole person impairment for the injury of 5% • An ISV at or near the top of the range will be appropriate if there is a moderately severe injury to the elbow of the dominant upper limb— (a) requiring prolonged treatment; and (b) causing whole person impairment of 10%.
99	**Minor elbow injury**
	Comment The injury will cause no permanent damage and no permanent impairment of function. EXAMPLES OF THE INJURY • A fracture with an uncomplicated recovery • A soft tissue injury with pain, minor tennis elbow syndrome or lacerations

Wrist

100-103

Wrist 100-103

Item No	Injury
	Comment about appropriate level of ISV for items 100 to 103 An ISV at or near the top of the range will generally only be appropriate if the injury is to the wrist of the dominant upper limb.
100	**Extreme wrist injury**
	Comment The injury will involve severe fractures, or a dislocation, causing a high level of permanent impairment. EXAMPLES OF THE INJURY • A severe fracture or dislocation with secondary joint complications • Joint disruption with poor outcome after surgery • Degloving • Permanent nerve palsies **Additional comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is whole person impairment for the injury of 36% and the injury is to the wrist of the dominant upper limb.
101	**Serious wrist injury**
	EXAMPLES OF THE INJURY • An injury causing significant permanent loss of wrist function, for example, severe problems with gripping or pushing objects, but with some useful movement remaining • Non-union of a carpal fracture • Severe carpal instability **Additional comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is whole person impairment for the injury of 20% and the injury is to the wrist of the dominant upper limb.

Item No	Injury
102	**Moderate wrist injury**
102.1	EXAMPLES OF THE INJURY A wrist injury, confirmed from imaging that causes some permanent disability, for example, some persisting pain and stiffness— • Persisting radio-ulnar instability • Moderate carpal instability • Recurrent tendon subluxation or entrapment **Additional comment about appropriate level of ISV** An ISV under this item will be appropriate if there is a whole person impairment for the injury of greater than or equal to 10%
102.2	EXAMPLES OF THE INJURY A wrist injury, that is not serious and causes some permanent disability, for example, some persisting pain and stiffness— • Persisting radio-ulnar instability • Carpal instability • Recurrent tendon subluxation or entrapment **Comment about this level of ISV** An ISV under this item will be appropriate if there is a whole person impairment for the injury of less than 10%
103	**Minor wrist injury**
	EXAMPLES OF THE INJURY • A fracture from which the injured person almost fully recovers • A soft tissue injury, for example, severe bruising • Continued pain following carpal tunnel release

Hand

104-115

Hand 104-115

Item No	Injury
	General comment for items 104 to 115 Hands are cosmetically and functionally the most important part of the upper limbs. **Comment about appropriate level of ISV for items 104 to 115** • The appropriate ISV for loss of a hand is only a little less than the appropriate ISV for the loss of the relevant arm • An ISV at or near the top of the range will generally be appropriate if the injury is to the dominant hand.
104	**Total or effective loss of both hands**
	EXAMPLE OF THE INJURY A serious injury causing extensive damage to both hands making them little more than useless EXAMPLES OF FACTORS AFFECTING ISV SCALE • The level of residual capacity left in either hand • Severity of any phantom pains if there has been an amputation or amputations **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if both hands remain attached to the forearms and are of some cosmetic importance • An ISV at or near the top of the range will be appropriate if both hands are amputated through the wrist.
105	**Serious injury to both hands**
	Comment The injury will involve significant loss of function in both hands, for example, loss of 50% or more of the use of each hand.
106	**Total or effective loss of 1 hand**
	EXAMPLES OF THE INJURY • A crushed hand that has been surgically amputated or rendered functionally useless • Traumatic amputation of all fingers and most of the palm EXAMPLE OF FACTOR AFFECTING ISV SCALE Severity of any phantom pain if there has been an amputation **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there has been an amputation of the fingers at the metacarpophalangeal joints, but the thumb remains, and there is whole person impairment for the injury of 32% • An ISV at or near the top of the range will be appropriate if— (a) there has been amputation of the dominant hand at the wrist; and (b) there is residual severe pain in the stump and ongoing complications, for example, chronic regional pain syndrome or neuroma formation.

Item No	Injury
107	**Amputation of the thumb or part of the thumb**
	EXAMPLES OF FACTORS AFFECTING ISV SCALE • The level of amputation, for example, at carpo metacarpal (CMC) joint, through the distal third of the thumb metacarpal, at the metacarpophalangeal (MCP) joint or thumb interphalangeal (IP) joint • Whether the injury is to the dominant hand • The extent of any damage to the fingers **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if— (a) there has been an amputation through the interphalangeal joint of the thumb; and (b) there is whole person impairment for the injury of 11%. • An ISV at or near the middle of the range will be appropriate if there has been an amputation through the proximal phalanx • An ISV at or near the top of the range will be appropriate if— (a) there has been an amputation at the base of the thumb at the carpometacarpal (CMC) joint level of the dominant hand; and (b) there are ongoing debilitating complications.
108	**Amputation of index, middle and ring fingers, or any 2 of them**
	Comment The amputation will cause complete loss or nearly complete loss of 2 or all of the following fingers of the hand: • index finger • middle finger • ring finger • little finger EXAMPLE OF FACTOR AFFECTING ISV SCALE The level of the amputation, for example, whether the hand has been made to be of very little use and any remaining grip is very weak **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if 2 fingers, whether index, middle or ring fingers, are amputated at the level of the proximal interphalangeal joints • An ISV at or near the middle of the range will be appropriate if there is whole person impairment for the injury of 19% • An ISV at or near the top of the range will be appropriate if— (a) the index, middle and ring fingers are amputated at the level of the metacarpophalangeal joint (MCP joint) or there is whole person impairment for the injury of at least 27%; and (b) the injury is to the dominant hand.

Item No	Injury
109	**Amputation of individual fingers**
	EXAMPLES OF FACTORS AFFECTING ISV SCALE • Whether the amputation was of the index or middle finger • The level of the amputation • Any damage to other fingers short of amputation **Additional comment about appropriate level of ISV** • An ISV at or near the top of the range will be applicable if there is complete loss of the index or middle finger of the dominant hand, and serious impairment of the remaining fingers causing whole person impairment of at least 15% • An ISV of not more than 10 will be applicable if— (a) there has been an amputation of the index or middle finger at the proximal interphalangeal joint (PIP joint); or (b) there is whole person impairment for the injury of 8%. • An ISV at or near the bottom of the range will be applicable if— (a) there has been an amputation at the level of the distal interphalangeal joint of the little or ring finger; or (b) there is whole person impairment for the injury of 3%.
110	**Amputation of thumb and all fingers**
	Comment As the injury will cause effective loss of the hand, see item 106.
111	**Any other injury to 1 or more of the fingers or the thumb**
	Comment about appropriate level of ISV for items under 111 An ISV of not more than 5 will be appropriate if substantial function of the hand remains. EXAMPLES OF FACTORS AFFECTING ISV • Whether the injury is to the thumb, or index or middle finger • Any damage to other fingers • Whether the injury is to the dominant hand
111.1	*Extreme injury to 1 or more of the fingers or the thumb*
	EXAMPLE OF THE INJURY Total loss of function of 1 or more of the fingers, with the joints ankylosed in non-functional positions **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is whole person impairment for the injury of 14% • An ISV at or near the top of the range will be appropriate if there is an injury to the thumb of the dominant hand causing total loss of function of the thumb
111.2	*Serious injury to 1 or more of the fingers or the thumb*
	EXAMPLES OF THE INJURY • A severe crush injury causing ankylosis of the fingers • A bursting wound, or an injury causing severe finger damage, causing residual scarring and dysfunction • An injury leaving a digit that interferes with the remaining function of the hand • Division of 1 or more of the long flexor tendons of the finger, with unsuccessful repair

Item No	Injury
111.3	*Moderate injury to 1 or more of the fingers or the thumb*
	Comment There will be permanent discomfort, pain or sensitive scarring EXAMPLES OF THE INJURY • Moderate injury to the thumb or index finger causing loss of movement or dexterity • A crush injury causing multiple fractures of 2 or more fingers • Division of 1 or more of the long flexor tendons of the finger, with moderately successful repair **Additional comment about appropriate level of ISV** An ISV under this item will be appropriate if there is whole person impairment for the injury of 8% and the injury is to the dominant hand.
111.4	*Minor injury to 1 or more of the fingers or the thumb*
	EXAMPLE OF THE INJURY An uncomplicated fracture or soft tissue injury that has healed with minimal residual symptoms **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a straight forward fracture of 1 or more of the fingers, with complete resolution within a short time • An ISV at or near the top of the range will be appropriate if there has been— (a) a fracture causing minor angular or rotational malunion of the thumb, or index or middle finger, of the dominant hand; or (b) some adherence of a tendon following surgical repair, limiting full function of the digit
112	**Extreme hand injury**
	Comment • The injury will involve a severe traumatic injury to the hand that may include amputation of part of the hand, causing gross impairment of the hand • A hand injury causing whole person impairment for the injury of 35% will generally fall within this item EXAMPLES OF THE INJURY • An injury reducing a hand's capacity to 50% or less • An injury involving the amputation of several fingers that are re-joined to the hand leaving it clawed, clumsy and unsightly • An amputation of some fingers and part of the palm causing grossly reduced grip and dexterity and gross disfigurement **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if the injured hand has some residual usefulness for performing activities of daily living • An ISV at or near the top of the range will be appropriate if the injured hand— (a) has little or no residual usefulness for performing activities of daily living; and (b) is the dominant hand

Item No	Injury
113	**Serious hand injury**
	EXAMPLES OF THE INJURY • A severe crush injury causing significantly impaired function despite surgery • Serious permanent tendon damage • Serious nerve damage **Additional comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is whole person impairment for the injury of 20%
114	**Moderate hand injury**
	EXAMPLES OF THE INJURY • A crush injury, penetrating wound or deep laceration, requiring surgery • Moderately serious tendon or nerve damage • A hand injury causing whole person impairment for the injury of between 5% and 12%
115	**Minor hand injury**
	EXAMPLES OF THE INJURY A soft tissue injury, minor fracture or an injury that does not require surgery, with nearly full recovery of hand function

Other Upper Limb Injuries

116-119

Other Upper Limb Injuries 116-119

Item No	Injury
	Comment about appropriate level of ISV for items 116 to 119 An ISV at or near the top of the range will generally only be appropriate if the injury is to the dominant upper limb.
116	**Extreme upper limb injury, other than an injury mentioned in items 90 to 115**
	Comment The injury will involve an extremely serious upper limb injury, falling short of amputation leaving the injured person little better off than if the whole arm had been lost. EXAMPLES OF THE INJURY • A serious brachial plexus injury affecting peripheral nerve function • A non-union of a fracture, with peripheral nerve damage to the extent that an arm is nearly useless **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is whole person impairment for the injury of 31% • An ISV at or near the top of the range will be appropriate if— (a) there is a complete brachial plexus lesion shown by a flail arm and paralysis of all muscles of the hand; and (b) the injury is to the dominant limb. • An ISV at or near the top of the range will also be appropriate if there is a serious crush injury that causes whole person impairment for the injury of 55%
117	**Serious upper limb injury, other than an injury mentioned in items 90 to 115**
	EXAMPLES OF THE INJURY • A serious fracture of the humerus, radius or ulna, or any combination of the humerus, radius and ulna, if there is significant permanent residual impairment of function • A brachial plexus injury requiring nerve grafts with partial recovery of shoulder and elbow function and normal hand function **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is whole person impairment for the injury of 16% • An ISV at or near the top of the range will be appropriate if there is an injury to the dominant limb causing whole person impairment of 30%.

Item No	Injury
118	**Moderate upper limb injury, other than an injury mentioned in items 90 to 115**
	EXAMPLES OF THE INJURY • A fracture that causes impairment of associated soft tissues, including nerves and blood vessels • A fracture with delayed union or infection • Multiple fractures of the humerus, radius or ulna, or multiple fractures of any combination of the humerus, radius and ulna
118.1	**Comment about appropriate level of ISV** An ISV under this item will be applicable if there is a crush injury causing significant skin or muscle loss with permanent residual impairment, or there is whole person impairment for the injury of 15%
118.2	**Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is whole person impairment for the injury of 6% • An ISV in the lower half of the range will be appropriate if there is a complicated fracture of the humerus, radius or ulna, or any combination of the humerus, radius and ulna— (a) requiring open reduction and internal fixation; and (b) from which the injured person has recovered or is expected to recover.
119	**Minor upper limb injury, other than an injury mentioned in items 90 to 115**
	EXAMPLE OF THE INJURY An uncomplicated fracture of the humerus, radius or ulna, or any combination of the humerus, radius and ulna, from which the injured person has fully recovered within a short time **Additional comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there are soft tissue injuries, lacerations, abrasions and contusions, from which the injured person will fully or almost fully recover • An ISV at or near the top of the range will be appropriate if there is a brachial plexus injury from which the injured person has substantially recovered within a few weeks, leaving some minor functional impairment.

Pelvis or Hip

120-123

Pelvis or Hip 120-123

Item No	Injury
	General comment for items 120 to 123 • The most serious injuries to the pelvis or hips can be as devastating as a leg amputation and will have similar ISVs • However, the appropriate ISV for other injuries to the pelvis or hips will generally be no higher than about 20. EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT FOR ITEMS 120 TO 123 • Exceptionally severe specific sequelae will increase the level of ISV • The availability of remedies, for example, a total hip replacement is an important factor in assessing an ISV • Age
120	**Extreme pelvis or hip injury**
	EXAMPLES OF THE INJURY • An extensive pelvis fracture • Degloving • Permanent nerve palsies **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is whole person impairment for the injury of 40% • An ISV at or near the top of the range will be appropriate if the injured person is not able to mobilise without a wheelchair and is relatively young.
121	**Serious pelvis or hip injury**
	Comment There will be substantial residual disability, for example, severe lack of bladder and bowel control, sexual dysfunction, or deformity making the use of 2 canes or crutches routine. EXAMPLES OF THE INJURY • A fracture dislocation of the pelvis involving both ischial and pubic rami • Traumatic myositis ossificans with formation of ectopic bone around the hip • A fracture of the acetabulum leading to degenerative changes and leg instability requiring an osteotomy, with the likelihood of future hip replacement surgery **Comment about appropriate level of ISV** An ISV at or near the bottom of the range will be appropriate for an injury causing whole person impairment for the injury of 20%.

Item No	Injury
122	**Moderate pelvis or hip injury**
	EXAMPLES OF THE INJURY • A significant pelvis or hip injury, with no major permanent disability • A hip fracture requiring a hip replacement • A fracture of the sacrum extending into the sacro-iliac joint causing ongoing significant symptoms and whole person impairment of at least 10% **Comment about appropriate level of ISV** An ISV for this item will be appropriate if there is a fracture requiring a hip replacement that is only partially successful, so that there is a clear risk of the need for revision surgery. An ISV in this range will be appropriate if there is whole person impairment for the injury of 10%.
123	**Minor pelvis or hip injury**
	EXAMPLES OF THE INJURY • An uncomplicated fracture of 1 or more of the bones of the pelvis or hip that does not require surgery or cause permanent impairment • Undisplaced coccygeal fractures • Undisplaced or healed pubic rami fractures • An injury to the coccyx requiring surgery, that is successful. **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a soft tissue injury from which the injured person fully recovers • An ISV of not more than 7 will be appropriate if there is whole person impairment for the injury of 5% • An ISV at or near the top of the range will be appropriate if the person has ongoing coccydynia and difficulties with sitting.

Lower Limb Amputation

124-127

Lower Limb Amputation 124-127

Item No	Injury
Subdivision 1—Amputation of both lower limbs	
	EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT FOR ITEMS 124 AND 125 • The level of each amputation • Severity of any phantom pain • Pain in the stumps • Extent of any ongoing symptoms
124	**Loss of both lower limbs above or through the knee**
	Comment about appropriate level of ISV An ISV at or near the top of the range will be appropriate if each amputation is near the hips so neither stump can be used with a prosthesis.
125	**Below the knee amputation of both lower limbs**
	Comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate if there is whole person impairment for the injury of 48% • An ISV at or near the top of the range will be appropriate if— (a) both legs are amputated just below the knees leaving little or no stumps for use with prostheses; (b) there is poor quality skin cover; and (c) there is a chronic regional pain syndrome.
Subdivision 2—Amputation of 1 lower limb	
	EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT FOR ITEMS 126 AND 127 • The level of the amputation • Severity of any phantom pain • Whether there have been problems with a prosthesis, for example, pain and further damage to the stump
126	**Above or through the knee amputation of 1 lower limb**
	Comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate if the amputation is through or just above the knee • An ISV at or near the top of the range will be appropriate if the amputation is near the hip and a prosthesis cannot be used.
127	**Below the knee amputation of 1 lower limb**
	Comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate in a straightforward case of a below-knee amputation with no complications • An ISV at or near the top of the range will be appropriate if there is an amputation close to the knee joint, leaving little or no stump for use with a prosthesis.

Lower Limb

128-131

Lower Limb 128- 131

Item No	Injury
128	
	Comment These are the most severe injuries short of amputation; leaving the injured person little better off than if the whole leg had been lost. EXAMPLES OF THE INJURY • Extensive degloving of the lower limb • An injury causing gross shortening of the lower limb • A fracture that has not united despite extensive bone grafting • Serious neurovascular injury • A lower limb injury causing whole person impairment of 40%
129	**Serious lower limb injury, other than an injury mentioned in items 120 to 127 and 132 to 149**
	Comment • Removal of extensive muscle tissue and extensive scarring may have a significant enough impact to fall within this item • An injury to multiple joints or ligaments causing instability, prolonged treatment and a long period of non-weight-bearing may have a significant enough impact to fall within this item, but generally only if those results are combined. EXAMPLE OF THE INJURY Multiple complex fractures of the lower limb that are expected to take years to heal and cause serious deformity and serious limitation of mobility **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is whole person impairment for the injury of 16% • An ISV at or near the top of the range will be appropriate if there is whole person impairment for the injury of 25%.
130	**Moderate lower limb injury, other than an injury mentioned in items 120 to 127 and 132 to 149**
	EXAMPLES OF THE INJURY • A fracture causing impairment of associated soft tissues, including nerves and blood vessels • A fracture with delayed union or infection • Multiple fractures of the femur, tibia or fibula, or multiple fractures of any combination of the femur, tibia and fibula EXAMPLES OF FACTORS AFFECTING ISV SCALE • Period of non-weight-bearing • Presence or risk of degenerative change • Imperfect union of a fracture • Muscle wasting • Limited joint movement • Unsightly scarring • Permanently increased vulnerability to future damage

Item No	Injury
	Comment about appropriate level of ISV An ISV at or near the top of the range will be applicable if there is a deep vein thrombosis requiring treatment for life; or if there is whole person impairment for the injury of 15%. An ISV at or near the bottom of the range will be applicable if there is whole person impairment for the injury of 10%.
131	**Minor lower limb injury, other than an injury mentioned in items 120 to 127 and 132 to 149**
	EXAMPLE OF THE INJURY An uncomplicated fracture of the femur, tibia or fibula, from which the injured person has fully recovered **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is a deep vein thrombosis requiring treatment for less than 6 months, from which the injured person will fully recover • An ISV at or near the bottom of the range will also be appropriate if— (a) there are soft tissue injuries, lacerations, cuts, bruising or contusions, from which the injured person will fully or almost fully recover; and (b) any residual disability will be minor. • An ISV at or near the top of the range will be appropriate if there is a deep vein thrombosis requiring treatment for at least 1 year • An ISV at or near the top of the range will also be appropriate if the injured person is left with impaired mobility or a defective gait • An ISV at or near the top of the range will also be appropriate if there is whole person impairment for the injury of 9%.

Knee

132-135

Knee 132-135

Item No	Injury
	General comment for items 132 to 135 The availability of remedies, for example, a total knee replacement is an important factor in assessing an ISV under this Division.
132	**Extreme knee injury**
	EXAMPLE OF THE INJURY A severe knee injury if there is a disruption of the joint, gross ligamentous damage, loss of function after unsuccessful surgery, lengthy treatment and considerable pain **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is whole person impairment for the injury of 20% • An ISV at or near the top of the range will be appropriate if a total knee replacement was needed and— (a) it is very likely that the knee replacement will need to be repeated; or (b) there are ongoing severe symptoms, poor function and whole person impairment for the injury of more than 30%.
133	**Serious knee injury**
	Comment The injury may involve— (a) ongoing pain, discomfort, limitation of movement, instability or deformity; and (b) a risk, in the long-term, of degenerative changes caused by damage to the joint surfaces, muscular wasting or ligamentous or meniscal injury. EXAMPLE OF THE INJURY A leg fracture extending into the knee joint, causing pain that is constant, permanent and limits movement or impairs agility **Comment about appropriate level of ISV** An ISV at or near the middle of the range will be appropriate if there is a ligamentous injury, that required surgery and prolonged rehabilitation, causing whole person impairment of 15% and functional limitation.
134	**Moderate knee injury**
	EXAMPLES OF THE INJURY A dislocation or torn cartilage or meniscus causing ongoing minor instability, wasting and weakness **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is whole person impairment for the injury of 8%

Item No	Injury
135	**Minor knee injury**
	EXAMPLES OF THE INJURY • A partial cartilage, meniscal or ligamentous tear, that recovers with or without surgery • A laceration • A twisting or bruising injury

Ankle

136-139

Ankle 136-139

Item No	Injury
	Comment about appropriate level of ISV for items 136 to 139 The appropriate ISV for the vast majority of ankle injuries is 1 or 2.
136	**Extreme ankle injury**
	EXAMPLES OF THE INJURY • A transmalleolar fracture of the ankle with extensive soft tissue damage causing 1 or more of the following: (a) severe deformity with varus or valgus malalignment; (b) a risk that any future injury to the relevant leg may lead to a below-knee amputation of the leg; (c) marked reduction in walking ability with constant dependence on walking aids; (d) inability to place the relevant foot for even load-bearing distribution. • An ankylosed ankle in a severely misaligned position with severe ongoing pain and other debilitating complications • Whole person impairment for the injury of more than 20% EXAMPLES OF FACTORS AFFECTING ISV SCALE • A failed arthrodesis • Regular disturbance of sleep • Need for an orthosis for load bearing and walking
137	**Serious ankle injury**
	EXAMPLE OF THE INJURY An injury requiring a long period of treatment, a long time in plaster or insertion of pins and plates, if— (a) there is permanent significant ankle instability; or (b) the ability to walk is severely limited on a permanent basis EXAMPLES OF FACTORS AFFECTING ISV SCALE • Unsightly scarring • The significance of any malunion • A requirement for modified footwear • Whether, and to what degree, there is swelling following activity **Additional comment about appropriate level of ISV** An ISV under this item will be applicable if there is whole person impairment for the injury of 10—19%

Item No	Injury
138	**Moderate ankle injury**
	EXAMPLES OF THE INJURY A fracture, ligamentous tear or similar injury, as evidenced by imaging and causing moderate disability, for example— • difficulty in walking on uneven ground • awkwardness on stairs • irritation from metal plates • residual scarring **Additional comment about appropriate level of ISV** An ISV in this range will be appropriate if there is whole person impairment for the injury of 6—9%
139	**Minor ankle injury**
	EXAMPLES OF THE INJURY A sprain, ligamentous or soft tissue injury or minor or undisplaced fracture EXAMPLES OF FACTORS AFFECTING ISV SCALE • Whether the injured person has fully recovered from the injury, and if not, whether there is any tendency for the ankle to give way • Whether there is scarring, aching or discomfort

Foot Amputation

140-141

Foot Amputation 140-141

Item No	Injury
140	**Amputation of both feet**
	EXAMPLES OF FACTORS AFFECTING ISV SCALE • Severity of any phantom pain • Pain in the stumps • Extent of any ongoing symptoms **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there are amputations of both feet at the forefoot (transmetatarsal level amputations) • An ISV of about 40 will be appropriate if there are amputations of both feet at the mid foot (tarsometatarsal level or Lisfranc amputations) • An ISV at or near the top of the range will be appropriate if each amputation is at the level of the ankle (Syme's amputation) and the stumps cannot be used with prostheses.
141	**Amputation of 1 foot**
	EXAMPLES OF FACTORS AFFECTING ISV SCALE • Severity of any phantom pain • Pain in the stump • Extent of any ongoing symptoms **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if the amputation is at the forefoot (transmetatarsal level amputation) • An ISV of about 26 will be appropriate if the amputation is at the mid foot (tarsometatarsal level or Lisfranc amputation) • An ISV at or near the top of the range will be appropriate if the amputation is at the level of the ankle (Syme's amputation) and the stump cannot be used with a prosthesis.

Foot

142-145

Foot 142-145

Item No	Injury
142	**Extreme foot injury**
	Comment There will be permanent and severe pain or very serious permanent disability. EXAMPLE OF THE INJURY An unusually severe foot injury causing whole person impairment of 15% or more, for example, a heel fusion or loss of the tibia-calcaneum angle **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is subtalar fibrous ankylosis in a severely maligned position, ongoing pain and whole person impairment for the injury of 24%.
143	**Serious foot injury**
	EXAMPLES OF THE INJURY • A severe midfoot deformity causing whole person impairment of 8% • A lower level loss of the tibia-calcaneum angle
144	**Moderate foot injury**
	EXAMPLE OF THE INJURY A displaced metatarsal fracture causing permanent deformity, with ongoing symptoms of minor severity, for example, a limp that does not prevent the injured person engaging in most daily activities
145	**Minor foot injury**
	EXAMPLES OF THE INJURY A simple metatarsal fracture, ruptured ligament, puncture wound or similar injury **Comment about appropriate level of ISV** An ISV of 2 or less will be appropriate if there is a straightforward foot injury, for example, a fracture, laceration or contusions, from which the injured person will fully recover.

Toes

146-149

Toes 146-149

Item No	Injury
146	**Extreme toe injury**
	EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT FOR ITEMS 146 TO 149 • Whether the amputation was traumatic or surgical • Extent of the loss of the forefoot • Residual effects on mobility
146.1	*Amputation of all toes*
146.2	*Amputation of the great toe*
	EXAMPLE OF FACTORS AFFECTING ISV The level at which the amputation happens or any ongoing symptoms **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there is complete loss of the great toe and ball of the foot caused by an amputation through the first metatarsal bone.
146.3	*Amputation of individual lesser toes*
	EXAMPLE OF FACTORS AFFECTING ISV The level at which the amputation happens or any ongoing symptoms **Comment about appropriate level of ISV** • An ISV at or near the bottom of the range will be appropriate if there is an amputation of 1 lesser toe and— (a) there is no ongoing pain; and (b) there is little or no loss of function of the foot; and (c) the cosmetic effect of the amputation is minor. • An ISV at or near the top of the range will be appropriate if there is complete amputation of all lesser toes and part of the forefoot.
147	**Serious toe injury**
	Comment The injury will cause serious and permanent disability. EXAMPLES OF THE INJURY • A severe crush injury causing ankylosis of the toes • A bursting wound, or an injury causing severe toe damage, with significant symptoms

Item No	Injury
148	**Moderate toe injury**
	Comment There will be permanent discomfort, pain or sensitive scarring. EXAMPLES OF THE INJURY • A moderate injury to the great toe • A crush injury causing multiple fractures of 2 or more toes **Comment about appropriate level of ISV** An ISV at or near the top of the range will be appropriate if there has been more than 1 unsuccessful operation, or there are persisting stabbing pains, impaired gait or similar effects.
149	**Minor toe injury**
	EXAMPLES OF THE INJURY A relatively straightforward fracture or soft tissue injury **Comment about appropriate level of ISV** An ISV of 1 will be appropriate if there is a straightforward fracture of 1 or more toes with complete resolution within a short time.

Limb Disorders

150

Limb Disorders 150
(i.e. tenosynovitis, peripheral nerve injury, epicondylitis, vascular disorders)

Item No	Injury
150	**General comment** The ISV for a limb disorder must be assessed having regard to the item of this Schedule that— (a) relates to the part of the body affected by the disorder; and (b) is for an injury that has a similar level of adverse impact to the disorder. EXAMPLES OF A LIMB DISORDER • Tenosynovitis (inflammation of synovial sheaths of tendons usually resolving with rest over a short period and sometimes leading to ongoing symptoms of loss of grip and dexterity) • Peripheral nerve injury (the constriction of the motor or sensory nerves or thickening of surrounding tissue, for example, carpal tunnel syndrome or sciatica) • Epicondylitis (inflammation around the elbow joint, for example, medially (golfer's elbow) or laterally (tennis elbow) • Vascular disorders, for example, deep vein thrombosis EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT • Whether the disorder is bilateral or one sided • The level of pain, swelling, tenderness or crepitus or other symptoms • The capacity to avoid a recurrence of symptoms • The ability to engage in daily activities • The availability and likely benefit of surgery • Whether the disorder is to a dominant or non-dominant limb

Scarring to Body

(other than Face)

151-154

Scarring to Body (other than face) 151-154

Item No	Injury
	General comment • This Part applies to external appearance and physical condition of the skin only, and includes scarring to the scalp, trunk and limbs • Facial scarring must be assessed under Part 3, Division 3 • This Part does not apply to adhesions, or scarring, of internal organs • This Part will usually apply to an injury involving skeletal damage only if the skeletal damage is minor • Many of the physical injuries mentioned in this Schedule involve some scarring from the initial injury and subsequent surgery, including skin grafting, to repair the injury and this has been taken into account in fixing the range of ISVs for the injuries. EXAMPLE The ISV range for an injury causing a closed fracture of a limb takes into account the potential need for open reduction and internal fixation of the fracture and the resulting surgical wound and scar. EXAMPLES OF FACTORS AFFECTING ISV ASSESSMENT FOR ITEMS 151 TO 154 • Location of a scar • Age • Consequential mental harm • Likelihood of a scar fading or becoming less noticeable over time
151	**Extreme scarring to a part of the body other than the face**
	Comment about appropriate level of ISV • An ISV at or near the bottom of the range will be appropriate if there is— (a) extensive scarring to 1 or more of the limbs and significant cosmetic disfigurement; and (b) either— (i) the need to keep the limb or limbs covered or wear special clothing; or (ii) ongoing limitation in the ability to participate in activities because of cosmetic disfigurement or functional impairment. • An ISV at or near the top of the range will be appropriate if there is gross permanent scarring over an extensive area or areas of the body, with ongoing pain and other symptoms.

Item No	Injury
152	**Serious scarring to a part of the body other than the face**
	Comment There is serious scarring— (a) requiring extensive medical treatment or surgery; and (b) causing significant ongoing limitation in the ability to participate in activities because of cosmetic disfigurement or functional impairment. EXAMPLES OF THE INJURY • Significant scarring over the upper and lower arm requiring skin grafting if— (a) there are post-operative complications requiring additional medical treatment for up to 18 months; and (b) there is maximum medical improvement within 2 years after the scarring is caused. • Hypertrophic (keloid) scarring caused by a burn to the front of the neck, with an intermittent sensation of burning, itching or irritation.
153	**Moderate scarring to a part of the body other than the face**
	EXAMPLES OF THE INJURY • Several noticeable scars that are hypertrophic (keloid) • A significant linear scar in an area of major cosmetic importance, for example, the front of the neck
154	**Minor scarring to a part of the body other than the face**
	EXAMPLES OF THE INJURY • Scarring caused by a superficial burn that heals within a few weeks and causes some minor change of pigmentation in a noticeable area • A single noticeable scar, or several superficial scars, to 1 or both of the legs, arms or hands, with some minor cosmetic damage

Hair

155-157

Hair 155-157

Item No	Injury
155	
	EXAMPLE OF THE INJURY Total permanent loss of head hair
156	**Serious injury affecting head hair**
	EXAMPLE OF THE INJURY Damage to head hair— (a) the physical effect of the damage is— (i) dermatitis; or (ii) tingling or burning of the scalp, causing dry, brittle hair that breaks off or falls out, or both; and (b) the physical effect leads to depression, loss of confidence and inhibited social life **Comment about appropriate level of ISV** An ISV under this item will be appropriate if— (a) thinning continues and prospects of regrowth are poor; or (b) there is a partial loss of areas of hair and regrowth is slow.
157	**Moderate injury affecting head hair or loss of body hair**
	EXAMPLES OF THE INJURY • Hair that has been pulled out leaving bald patches • The same example applies as for item 156 but with fewer or only moderate symptoms EXAMPLE OF FACTOR AFFECTING ISV SCALE Length of time before regrowth

Burn Injuries

Part 9 – Burn Injuries

Item No	Injury
	Mapped to max body part **General comment** • The ISV for a burn injury must be assessed having regard to the item of this Schedule that— (a) relates to the part of the body affected by the burn injury; and (b) is for an injury that has a similar level of adverse impact to the burn injury. • Burns to the face must be assessed under the section on scarring to the face • In burns cases, the ISV for an injury to a part of the body causing functional impairment will generally be at or near the top of the range for an injury to that part of the body • In serious burns cases, the effects of scarring are more comprehensive and less able to be remedied than the effects of scarring from other causes.

Appendix D: MAIAS Scheme Rules

MOTOR ACCIDENT INJURY ACCREDITATION SCHEME RULES

Accreditation for Medical Practitioners

Sensitive: For Official Use Only (FOUO) – A3 – I3

Contents

MAIAS Administrator
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Approved by the Attorney-General, the designated Minister, under sections 76(2) and (3) of the *Civil Liability Act 1936*, on 7 January 2019.
Released on 9 January 2019.

Definitions

Term	Definition
Accredited Medical Practitioner	A medical practitioner who is accredited as an Accredited Health Professional under the *CLR*.
CLA	*Civil Liability Act (1936)*
CLR	*Civil Liability Regulations (2013)*
CTP Regulator	The Regulator established under Part 2 Division 1, *Compulsory Third Party Insurance Regulation Act 2016*.
CTP Scheme	Compulsory Third Party (CTP) insurance required under Part 4 of the *Motor Vehicles Act 1959* and claimant entitlements under Part 8 of the CLA.
ISV	Injury Scale Value, under Schedule 1 of the *CLR*
ISV Medical Assessment Report	A report prepared by an Accredited Medical Practitioner for the assessment of physical and Pure Mental Harm injuries using the prescribed template and determining the ISV item number in accordance with the Regulation 23 *CLR*.
MAIAS	This Accreditation Scheme established by the Minister under section 76(2) of the *CLA*.
MAIAS Administrator	Until 19 February 2019, the Panel established by the Minister to implement and administer the MAIAS and thereafter, the CTP Regulator.
Motor Accident Injury Accreditation Scheme Rules	The terms and conditions determined by the Minister under s76(2)(3) CLA.
RTW Scheme Rules	The Return to Work Scheme Rules for the accreditation and administration of the MAIAS.
Training Manual	The MAIAS Training Manual for Accredited Medical Practitioners undertaking ISV Medical Assessments.

Purpose

The purpose of the Motor Accident Injury Accreditation Scheme Rules is to prescribe the regulatory and service standards required to achieve and maintain accreditation under the MAIAS.

Introduction

A key objective of the Accreditation Scheme is to create an independent system that provides consistent, objective and reliable Injury Scale Value (ISV) Medical Assessments to determine the ISV Item Number. The ISV Medical Assessment then assists in the claims settlement process in the determination of an ISV. These Rules are to be construed so as to give effect to the key objective.

An ISV is a measure of the impact of an injury or injuries on the injured person. The ISV is primarily determined by reference to the Schedule contained in the *Civil Liability Regulations (2013)* (ISV table) that assigns a value between 0 and 100 for an injury, based on available medical evidence. A whole person impairment (WPI) percentage may be included in the description of an ISV Item Number in the ISV table, supporting the assessment and determination of the ISV.

In the CTP Scheme, a person who is injured in a motor vehicle accident may be entitled to compensation for their injuries. Their entitlement to certain types of compensation, such as non-economic loss, gratuitous services and future economic loss are subject to a threshold based on the ISV for the injuries sustained.

MAIAS Administrator

The MAIAS is established by the Minister under section 76(2) of the CLA. The Minister is the Attorney-General. Under section 76(3)(c) CLA the Minister may delegate the administration or management of any aspect of the scheme to a person or body specified by the Minister. The person or body to whom such a delegation is made is called the MAIAS Administrator.

By these Rules, the Minister appoints a panel comprised of nominees of the Minister, the Australian Medical Association (SA), the Law Society (SA) and the CTP Regulator to be the MAIAS Administrator until 19 February 2019 and the CTP Regulator to be the MAIAS Administrator thereafter.

The MAIAS Administrator administers and manages the MAIAS by:

- prescribing the processes and documentation of the Scheme
- prescribing accreditation training courses and oversee their implementation
- making recommendations to the Minister for approval of applicants who meet the accreditation criteria
- monitoring the performance of Accredited Medical Practitioners to ensure conformity with accreditation obligations
- conducting investigations into alleged breaches of these conditions and impose sanctions authorised by the Scheme
- maintaining and keep up to date a register of all Accredited Medical Practitioners
- ensuring continuing oversight of the Scheme
- doing all other things necessary to ensure that the MAIAS operates efficiently, effectively and equitably under these rules.

Motor Accident Injury Accreditation Scheme

1. Criteria for accreditation

To be considered for accreditation as an Accredited Medical Practitioner under the MAIAS, the Minister has determined an applicant must:

- be a registered Medical Practitioner (Specialist or General Practitioner)
- be accredited under the RTW Scheme as an Impairment Assessor
- satisfactorily complete the training modules required for accreditation
- satisfactorily complete the competency assessments required for accreditation
- satisfy any other conditions prescribed by this Scheme

2. Period of accreditation

Unless the Minister directs otherwise either generally or in a particular case, the accreditation of each Accredited Medical Practitioner expires on 30 June 2019 and each third year thereafter. An Accredited Medical Practitioner whose accreditation is expiring may apply for renewal of the accreditation as prescribed by these Rules.

3. Application process

To become an Accredited Medical Practitioner an applicant must:

- Complete accreditation as an Impairment Assessor for the RTW Scheme; and
- Complete MAIAS accreditation training and competency based assessments.

4. Approval process for accreditation

The MAIAS Administrator will assess each application for accreditation and recommend to the Minister which of them should be approved.

In making a recommendation, the MAIAS Administrator:

- must be satisfied that the applicant satisfies all the criteria for accreditation under the MAIAS.
- may not make a recommendation to the Minister to limit the total number of Accredited Medical Practitioners without first consulting with the Law Society (SA) and the AMA (SA).
- may take into account the number of Accredited Medical Practitioners reasonably required in each specialty for the effective operation and management of the CTP Scheme.
- on renewal, may take into account the past performance of the applicant compared with other Accredited Medical Practitioners.

5. Accreditation requirements

Subject to any direction of the Minister and to these Rules, the MAIAS Administrator must prescribe the criteria for accreditation and the training required to achieve both initial and renewed accreditation and must prepare a Training Manual.

The MAIAS Administrator must take appropriate expert medical advice before prescribing criteria or training requirements for accreditation or publishing a Training Manual.

6. Service standards

Accredited Medical Practitioners must abide by the criteria for accreditation, terms and conditions of accreditation, service standards as prescribed by the RTW Scheme for Impairment Assessors, except when they are inconsistent with the express terms of this Scheme. [1]

Additionally Accredited Medical Practitioners must:

- provide medical assessment reports using the current ISV Medical Assessment Report templates prescribed by the Minister
- comply with the timeframe for the provision of reports set out in regulation 23(1) of the CLR
- not provide comment to the media on ISV Medical Assessments that are, or have been, before them
- not identify themselves as an Accredited Medical Practitioner if providing comment to the media on matters unrelated to their assessment responsibilities
- comply with the requirements of this Scheme where they differ from service standards prescribed by the RTW Scheme for Impairment Assessors
- comply with the performance and review requirements set out in this document
- comply with the guidance material provided in the Training Manual

7. ISV Medical Assessment Report quality compliance

ISV Medical Assessment Reports completed by Accredited Medical Practitioners must:

- use the current edition of the prescribed template(s) with no amendment or deletion of any section, heading, or question (regulation 23(2) CLR)
- contain clear rationale for the Accredited Medical Practitioner's opinion
- not contain material or typographic errors such that correction of the alleged error may result in a materially different outcome of the Assessment
- provide a written report to the requestor within 30 days of the examination or assessment (regulation 23(1) CLR)
- accurately record all assessment findings based on due rigour and intellectual honesty
- provide the information prescribed by regulation 23(1) CLR
- conform with the guidance provided in the Training Manual

8. Performance monitoring

The MAIAS Administrator must monitor the performance of Accredited Medical Practitioners to ensure conformity with the CTP Scheme.

In monitoring the performance of Accredited Medical Practitioners, the MAIAS Administrator will:

- Monitor services provided by Accredited Medical Practitioners to ensure that the standards required by these Rules, the CLA and the CLR are met.
- Monitor ISV Medical Assessment Reports to ensure:

[1] For Medical Practitioner's easy reference, the service standards in the document "Return to Work Scheme: Impairment Assessor Accreditation Scheme" may be viewed online at https://www.rtwsa.com/.

- compliance with the accreditation obligations and the CLA and CLR
- accuracy in assessment methodology and calculations
- medical consistency and sound reasoning
- assessment reports are delivered within required timeframes

9. Request for assessment

Requests for an ISV Medical Assessment may be made by the CTP Insurer, a claims agent, or the claimant and/or each of their representatives. The requestor will be liable for payment of the examination or assessment and the resultant report.

The requestor is required to select an Accredited Medical Practitioner from the MAIAS register of Accredited Medical Practitioners. There is no guarantee of a minimum number of requests an Accredited Medical Practitioner might receive during the accreditation period.

The MAIAS Administrator must keep a register of Accredited Medical Practitioners and relevant accreditation information (e.g. body systems, location, etc.) and must publish the register on the MAIAS website (www.maias.sa.gov.au) and the CTP Regulator's website.

An Accredited Medical Practitioner must not accept a request if:

- the Accredited Medical Practitioner has been asked to provide an assessment of a body system for which the Practitioner is not accredited
- the Accredited Medical Practitioner is unable to see the claimant within six weeks of the appointment being requested.
- the Accredited Medical Practitioner has a conflict of interest in providing the requested service with respect to the claimant.
- the Accredited Medical Practitioner has provided or plans to provide any form of treatment, treatment advice or assessment in relation to the injured person unless there is no other assessor available to undertake the assessment.

If an Accredited Medical Practitioner believes a request for assessment is inappropriate or incomplete, the medical practitioner must discuss their concerns with the requestor and refuse the request if their concerns are not resolved.

10. Training and competency assessment

An Accredited Medical Practitioner must attend and complete the required training and assessments for any new published version of the MAIAS Rules.

An Accredited Medical Practitioner must complete any refresher training required by the MAIAS Administrator following identification of ongoing report compliance or quality issues.

11. Accredited Medical Practitioner status

An Accredited Medical Practitioner must notify the MAIAS Administrator in writing within seven days of any of the following:

- the practitioner's Australian Medical Board registration is suspended or cancelled
- the practitioner is charged with or convicted of a criminal offence that involves dishonesty or is punishable by imprisonment
- restrictions or limitations are placed on the Medical Practitioner's registration as a result of any findings or actions by the Medical Board of Australia in relation to any breaches under the Health Practitioner Regulation National Law any

- the practitioner retires from clinical practice or there is a change in their Australian Medical Board registration
- the practitioner ceases to be qualified to practice in the area of specialty for which the practitioner is qualified
- a change in services offered
- the practitioner changes practising location/s
- any other issue or event occurs that affects the practitioner's capacity to provide whole person permanent impairment services

12. Suspension and cancellation of accreditation.

Accreditation under this Scheme will automatically lapse if an Accredited Medical Practitioner ceases to be:

- registered as a medical practitioner; or
- accredited as an Impairment Assessor for the RTW Scheme

In addition, the Minister may suspend an Accredited Medical Practitioner's accreditation for such period as the Minister thinks fit or cancel the accreditation altogether if the Minister is satisfied that the practitioner is no longer qualified or competent to practice in the areas of specialty for which the practitioner is accredited or that there are other good grounds on which the accreditation should be suspended or cancelled in the interests of the integrity and effectiveness of the CTP Scheme.

If the MAIAS Administrator is of the opinion that circumstances exist that could justify the suspension or cancellation of an Accredited Medical Practitioner's accreditation, the MAIAS Administrator may make a recommendation to the Minister to that effect. The MAIAS Administrator may not make such a recommendation unless the MAIAS Administrator has first obtained expert medical advice if the circumstances relate to the medical expertise or suitability of the Accredited Medical Practitioner.

13. Complaints

Any person may make a complaint regarding a breach of conditions of accreditation by an Accredited Medical Practitioner. The complaint must be made in writing to the MAIAS Administrator.

On receipt of a complaint, the MAIAS Administrator must determine, on the face of the complaint, whether or not it warrants investigation. If it determines that the complaint warrants investigation, the MAIAS Administrator must undertake the investigation.

In undertaking an investigation, the MAIAS Administrator must:

- give the Medical Practitioner an opportunity to respond to the complaint
- provide available information to the Medical Practitioner that supports the complaint
- provide the Medical Practitioner with the opportunity to provide documentation or an alternative view regarding the complaint; and
- keep the Medical Practitioner informed of the progress of the investigation, including the provision of a copy of the final decision regarding whether the breach is confirmed

At the conclusion of the investigation, the MAIAS Administrator must make a formal finding either that the complaint is made out or that it is not.

If the MAIAS Administrator finds that the complaint is proven, it may determine, at its discretion any of the following:

- take no further action in respect of the complaint
- require the Accredited Medical Practitioner to undertake counselling or additional training;
- recommend that the Minister suspends or cancels the Accredited Medical Practitioner's accreditation (subject to the MAIAS Administrator having first obtained expert medical advice if the circumstances relate to the medical expertise or suitability of the Accredited Medical Practitioner)

In making a determination in respect of a complaint, the MAIAS Administrator must take into account the following:

- frequency of breaches, if multiple including multiple breaches of one condition or single breaches of more than one condition
- degree of participation in the investigation by the Accredited Medical Practitioner
- materiality of the breach/breaches
- whether the behaviour is considered to be deliberate or inadvertent
- demonstrated changes to performance or behaviour
- any other matters considered to be relevant by the MAIAS Administrator

14. Action other than cancellation or suspension

The MAIAS Administrator may impose requirements for remedial action as an alternative to the Minister suspending or cancelling the accreditation of an Accredited Medical Practitioner.

Examples of remedial action include retraining, monitoring of performance or peer reviews. The MAIAS Administrator reserves the right to require that remedial action be at the Accredited Medical Practitioner's cost.

15. Ministerial control and direction

The MAIAS Administrator is subject to the direction of the Minister in the performance of the MAIAS Administrator's duties and the exercise of the MAIAS Administrator's powers under these Rules.

16. Amendment of these Rules

The Minister reserves the right to vary or revoke all or any of these Rules at any time but undertakes to consult with the AMA (SA) and the Law Society (SA) before doing so.