Consultation on the Impairment Assessment Guidelines

Provided for consultation purposes only

Stakeholder Representative Consultation Group

Contents

THIRD EDITION IMPAIRMENT ASSESSMENT GUIDELINES: INVITATION TO PROVIDE FEEDBACK, PHASE 1 2

8. RESPIRATORY SYSTEM CHAPTER - RECOMMENDATIONS 4

8. RESPIRATORY SYSTEM – DRAFT CHAPTER 7

10. VISUAL SYSTEM – RECOMMENDATIONS 11

10. VISUAL SYSTEM – DRAFT CHAPTER 14

11. HAEMATOPOIETIC SYSTEM - RECOMMENDATIONS 17

12. ENDOCRINE SYSTEM CHAPTER - RECOMMENDATIONS 20

13. SKIN CHAPTER - RECOMMENDATIONS 23

13. SKIN – DRAFT CHAPTER 26

14. CARDIOVASCULAR SYSTEM CHAPTER - RECOMMENDATION 36

16. PSYCHIATRIC DISORDERS CHAPTER - RECOMMENDATION 40

16. PSYCHIATRIC AND PSYCHOLOGICAL DISORDERS – DRAFT CHAPTER 44

PROVIDED FOR CONSULTATION PURPOSES ONLY

Third Edition Impairment Assessment Guidelines: Invitation to provide feedback, phase 1

At the invitation of the Minister for Industrial Relations and Public Sector, the Hon Kyam Maher MLC, a Stakeholder Representative Consultation Group (SRCG) was established in October 2022 to co-design and consult on a draft for a Third Edition of the Impairment Assessment Guidelines (the Guidelines).

The SRCG is facilitating a review of the medical chapters of the Guidelines (Chapters 2 to 16). Twelve sub-committees have been formed to review the medical chapters, comprising 55 doctors who are impairment assessors or representatives from medical colleges. The SRCG is grateful to the 55 doctors who provided their time and expertise for this review.

The SRCG committed to taking the outputs from the medical reviews to a wider stakeholder audience for a first round of feedback. This is your opportunity to review the recommendations to the SRCG from the medical sub-committees, and in some cases a first draft of proposed amendments to the medical chapters.

We will release these outputs in two phases:

Phase 1 – recommendations and proposed changes to the following chapters are in the document attached to this email:

- Chapter 8 – Respiratory System
- Chapter 10 – Visual system
- Chapter 11 – Haematopoietic system
- Chapter 12 – Endocrine system
- Chapter 13 – Skin
- Chapter 14 – Cardiovascular system
- Chapter 16 – Psychiatric disorders

Phase 2 – to be provided in July:

- Some sections of Chapter 1* – Introduction
- Chapter 2 – Upper extremity
- Chapter 3 – Lower extremity
- Chapter 4 – Spine
- Chapter 5 – Nervous system
- Chapter 6 – Ear nose throat and related structures
- Chapter 7 – Urinary and reproductive systems
- Chapter 9 – Hearing
- Chapter 15 –Digestive system

*The SRCG is currently reviewing Chapter 1. Proposed changes will released progressively as the work is completed. The exact method for seeking stakeholder views on the potential revisions to Chapter 1 is still to be determined by the SRCG.

How to provide your feedback

We understand that not all stakeholders will be interested in every chapter. You may provide feedback for some or all of the chapters. Please bear in mind that this is a first review and you will have further opportunities to provide feedback.

PROVIDED FOR CONSULTATION PURPOSES ONLY

Please complete this online form to provide feedback for Phase 1.

The SRCG will collate and review all feedback and conduct a technical, legal and actuarial review of the Guidelines. Later in 2023 there will be full, formal consultation on a complete draft Guidelines.

This document is provided for consultation purposes only. It is subject to further extensive review, and should not be considered a final draft, nor indicative of any or all changes to the Guidelines.

We thank you for participating in the review and encourage you to give feedback.

If you have any questions for the SRCG, please direct these to the Secretariat, Mia Bell, at mia.bell@rtwsa.com.

PROVIDED FOR CONSULTATION PURPOSES ONLY

8. Respiratory system chapter - recommendations

Members of the Respiratory system sub-Committee:

- Dr Michelle Atchison (Facilitator)
- Dr David Bryant
- Dr Beata Byok
- Dr Helen Crocker
- Dr Peter Jezukaitis

The sub-Committee met on the following dates:

- 31 March 2023
- 28 April 2023

The sub-Committee reviewed Chapter 8 of the Impairment Assessment Guidelines and makes the following recommendations: **[Provided to the SRCG for consideration on 5 June 2023]**

PROVIDED FOR CONSULTATION PURPOSES ONLY

Recommendation 1

Pulmonary Embolism may have a rateable impairment under either the Cardiovascular chapter or Respiratory chapter, depending on the clinical circumstances. Corresponding wording should be inserted into **both** the Respiratory and Cardiovascular chapters to support the following:

The assessment of Pulmonary Embolism is made under the Cardiovascular chapter by an assessor accredited for the Cardiovascular system if the major impact is the development of pulmonary hypertension, or under the Respiratory chapter if the major impact is a reduction in the diffusing capacity without evidence of pulmonary hypertension. Either could cause breathlessness and the degree of this and its attributability to the pulmonary embolism needs to be considered and explained in making the assessment. The Assessor should consider the clinical circumstances and choose the test that is most abnormal, and assess under that chapter.

SRCG noted that there may be an issue which would flow from this recommendation in relation to choice of assessor (assuming that there may well be assessors who are accredited for one chapter, but not the other) – or the potential for a change of assessor during the process. The proposed clause should indicate how that might be managed.

Recommendation 2

Amend the reference to smoking at 8.2: prefer to say the assessor "should consider and report lifestyle factors. A detailed smoking history must be documented in the report."

The SRCG noted that the need for a smoking history may mean that some instructions should be included for the Requestor to obtain necessary records, or to ensure that a pre-PIA report is obtained

as to prior smoking history. It queried whether similar considerations should be given to the other non-work conditions to which para 8.2 alludes.

Recommendation 3

Clause 8.5 refers to determining impairment within ranges. The sub-Committee considers that guidance should be provided to assessors in determining where an impairment sits within a range, and recommends amending the wording of 8.5 to **add** the following:

The assessor must consider all of the available testing and ancillary investigations that assist the assessment, and must give reasons to support the %WPI selected. This may include the use of other testing (for example the six minute walk test) in establishing the value in the range. This can include the results of the Pulmonary Function Tests, the use of ancillary tests and investigations, and the clinical picture.

Recommendation 4

At 8.6, the wording around D_LCO needs to be clarified by **removing** the first sentence and **replacing** it with:

The reason for the D_LCO impairment should be fully investigated and its aetiology clarified. The assessor must provide justification for the reasoning.

The SRCG suggested that the wording might commence, "Where there is an isolated abnormal diffusing capacity for carbon monoxide (DLCO), then the reason…".

The SRCG queried whether the assessor might require a pre-PIA report on the aetiology.

Recommendation 5

Occupational Asthma: Various changes that were made in the Second Edition were contemplated when reviewing this section on occupational asthma, particularly around diagnosis, testing and treatment. The group was mindful that some testing requirements may potentially cause difficulties for rural and remote patients.

PROVIDED FOR CONSULTATION PURPOSES ONLY

With reference to Occupational Asthma, the group recommends the following changes to 8.7:

- Change the title from "Asthma" to "Occupational Asthma"
- First dot point should be: "Diagnosis of Occupational Asthma should be confirmed by a Respiratory Physician. There must have been at least one assessment by a Respiratory Physician in the 12 months prior to impairment assessment."
- Noting that a worker has the right to refuse treatment, the reference to "the worker has received optimal treatment" at dot point three should be amended to "the worker has

received the opportunity for optimal treatment including advice from a Respiratory Physician". Remove the words "and is compliant with their medication regime".

- In the circumstances where a worker is unable or incapable of providing spirometry results, there should be a requirement for an opinion from a second Respiratory Physician.

The group recommends the following changes to 8.9:

- Add at the end of 8.9: "The tests used to rate impairment must be done at a time when the person is clinically stable and within the last six months. The tests must be done by a laboratory accredited by TSANZ."

PROVIDED FOR CONSULTATION PURPOSES ONLY

Recommendation 6

Obstructive Sleep Apnoea: The sub-Committee reviewed the changes in Second Edition requiring assessment by a Respiratory or ENT Physician, and recommend that:

- The cause of the sleep apnoea as work related should be confirmed prior to assessment.
- The worker should have been assessed and advised by either an ENT Specialist who specialises in sleep disorders, or a Respiratory Physician who specialises in sleep disorders.
- It is not appropriate to require that a worker receive treatment, and so 8.11 should be amended to: "Before permanent impairment can be assessed, the person must have been assessed and advised on the available treatment options by either an ENT Specialist who specialises in sleep disorders or a Respiratory Physician who specialises in sleep disorders."
- Clauses 8.10 and 8.11 logically should be swapped around.

The SRCG noted that the first dot point above may create a procedural problem, and recommends that it be clear that what is required an opinion as to the relationship with work (or other work injury) before proceeding to assessment. The SRCG noted that this is an issue in a number of Chapters.

Recommendation 7

The heading of "Hypersensitivity Pneumonitis" should be amended to "Occupational Interstitial Lung Disease including Hypersensitivity pneumonitis and pneumoconioses".

Recommendation 8

In the section on Lung Cancer, there should be an additional requirement to specify that where surgery has occurred, assessment should not be undertaken until at least 6 months after the surgery.

Additional documents circulated and considered by the sub-Committee

No additional documents were considered.

8. Respiratory system – draft chapter

Chapter 5, AMA5 (p87) applies to the assessment of permanent impairment of the respiratory system, subject to the modifications set out below.

Before undertaking an impairment assessment, users of the Guidelines must be familiar with the following:

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

The Guidelines take precedence over AMA5.

PROVIDED FOR CONSULTATION PURPOSES ONLY

Introduction

8.1 Chapter 5, AMA5 (pp87–115) provides a useful summary of the methods for assessing whole person impairment arising from respiratory disorders.

8.2 The degree of impairment arising from conditions not caused by a work injury must be assessed and considered in determining the degree of permanent impairment, and recorded in the report. The degree to which pre-existing conditions and lifestyle activities ~~such as smoking~~ contribute to the degree of permanent impairment requires judgment on the part of the assessor. A detailed smoking history must be documented in the report. The manner in which any deduction for these is applied needs to be recorded in the assessor's report.

Pulmonary Embolism

8.3 The assessment of Pulmonary Embolism is made under the Cardiovascular chapter by an assessor accredited for the Cardiovascular system if the major impact is the development of pulmonary hypertension, or under the Respiratory chapter if the major impact is a reduction in the diffusing capacity without evidence of pulmonary hypertension. Either could cause breathlessness and the degree of this and its attributability to the pulmonary embolism needs to be considered and explained in making the assessment. The Assessor should consider the clinical circumstances and choose the test that is most abnormal, and assess under that chapter.

Examinations, clinical studies and other tests for evaluation respiratory disease (section 5.4, AMA5)

8.4~~3~~ The predicted lower limit values provided in the accredited laboratory tests (to Thoracic Society of Australia and NZ (TSANZ) standards) are applied in Table 5-12, AMA5 (p107), to determine the impairment classification for respiratory disorders. AMA5 Tables 5-2b, 5-3b, 5-4b, 5-5b, 5-6b and 5-7b should not be used.

8.5~~4~~ Table 5-12, AMA5 (p107) should be used to assess whole person impairment for respiratory disorders other than occupational asthma. The pulmonary function tests listed in Table 5-12 must be performed to TSANZ standards by a pulmonary function laboratory. Exercise testing is not required.

8.6~~5~~ Classes 2, 3 and 4 in Table 5-12, AMA5 (p107) list ranges of whole person impairment. The assessor should nominate the nearest whole percentage based on the complete clinical circumstances when selecting within the range, giving reasons to support the % WPI selected in the report. The assessor must consider all of the available testing and ancillary investigations that assist the assessment, and must give reasons to support the %WPI selected. This may include the use of other testing (for example the six minute walk test) in establishing the value in the range. This can include the results of the Pulmonary Function Tests, the use of ancillary tests and investigations, and the clinical picture.

~~8.~~7~~6~~ The reason for the D_LCO impairment should be fully investigated and its aetiology clarified. The assessor must provide justification for the reasoning. ~~An isolated abnormal diffusing capacity for carbon monoxide (DLCO) in the presence of otherwise normal results of lung function testing should be interpreted with caution and its aetiology should be clarified.~~ Where the DLCO is the key parameter used to rate impairment, its relationship to the work injury must be explained.

Occupational Asthma (section 5.5, AMA5, p102-104)

8.8~~7~~ In assessing whole person impairment arising from occupational asthma, the assessor will require evidence from the treating physician that:

- diagnosis of occupational asthma should be confirmed by a Respiratory Physician. There must have been at least one assessment by a Respiratory Physician in the 12 months prior to impairment assessment.
- the worker has received the opportunity for optimal treatment including advice from a Respiratory Physician.

PROVIDED FOR CONSULTATION PURPOSES ONLY

• an appropriate diagnosis has been established based on clinical history, physical examination and spirometry with at least one appropriate lung function test conducted by a laboratory accredited by TSANZ; and

• the clinical status has been confirmed over time with repeated spirometry.

Where the worker is unable or incapable of providing spirometry results, a second opinion is required from a Respiratory Physician.

, and

• the worker has received optimal treatment and is compliant with their medication regimen.

8.98 Bronchial challenge testing should not be performed as part of the impairment assessment. In Table 5-9, AMA5 (p104) ignore column 4 (PC20 mg/mL or equivalent, etc.).

8.109 Permanent impairment due to asthma is rated by the score for the best post-bronchodilator forced expiratory volume in one second (FEV1) (score in Table 5–9, AMA5, column 2) plus % of FEV1 (score in column 3) plus minimum medication required (score in column 5). The total score derived is then used to assess the % impairment in Table 5-10, AMA5 (p104). The same approach to determining the actual impairment within the range of % WPI discussed in 8.5 should be adopted. The tests used to rate impairment must be done at a time when the person is clinically stable and within the last six months. The tests must be done by a laboratory accredited by TSANZ.

PROVIDED FOR CONSULTATION PURPOSES ONLY

Obstructive sleep apnoea (section 5.6, AMA5, p105)

8.1110 The cause of the sleep apnoea as work related should be confirmed prior to assessment.

8.121 Before permanent impairment can be assessed, the person must have appropriate been assessed and advised on the available treatment options by an ENT Specialist who specialises in sleep disorders, or a Respiratory Physician who specialises in sleep disorders. assessment and treatment by an ear, nose and throat surgeon and a respiratory physician who specialises in sleep disorders.

8.13 This section needs to be read in conjunction with section 11.4, AMA5 (p259) and section 13.3c, AMA5 (p317).

Commented [A1]: These clauses were swapped around to be more logical.

8.142 Degree of permanent impairment due to sleep apnoea should be calculated with reference to Table 13-4, AMA5 (p317).

Occupational Interstitial Lung Disease including Hypersensitivity pneumonitis and pneumoconioseis Hypersensitivity pneumonitis (section 5.7, AMA5, p105)

8.153 Whole person impairment arising from disorders included in this section is assessed according to the impairment classification in Table 5-12, AMA5 (p107).

Lung cancer (section 5.9, AMA5, p106)

8.164 Whole person impairment due to lung cancer should be assessed using Table 5-12, AMA5 (p107) (not Table 5-11).

8.175 Persons with residual lung cancer after treatment are classified in Respiratory Impairment Class 4 (Table 5-12).

8.18 For the purpose of this section, where surgery has occurred assessment should not be undertaken until at least 6 months after the surgery.

PROVIDED FOR CONSULTATION PURPOSES ONLY

10. Visual system – recommendations

Members of the Visual System sub-Committee:

- Kristen Rogers (Facilitator)
- Prof John Crompton
- Dr Michael Steiner
- Dr Ian Wechsler

The sub-Committee met on the following dates:

- 3 April 2023

The sub-Committee reviewed Chapter 10 of the Impairment Assessment Guides and makes the following recommendations: [Provided to the SRCG for consideration on 25 May 2023]

PROVIDED FOR CONSULTATION PURPOSES ONLY

Recommendation 1

It is recommended that the Impairment Assessment Guidelines Third Edition retain AMA 4 as the reference document for Chapter 10.

The bases for Recommendation 1 are as follows:

1. AMA 4 remains the reference document for most, if not all, states and territories.
2. The equipment recommended for use in AMA5 is expensive and not owned by most privately practising ophthalmologists.
3. There is little emphasis on diplopia (double vision) in AMA5, yet this is a relatively common problem.
4. Many ophthalmologists are familiar with the Royal Australian College of Ophthalmologists' impairment guide, which is similar to AMA4.
5. Recommendation 1 is made by consensus between Professor Crompton, Dr Steiner and Dr Wechsler.

Recommendation 2

It is recommended that the Impairment Assessment Guidelines Third Edition contain provisions amending AMA4 Chapter 8 Table 3 on page 212 to allow the Ophthalmologist discretion to use the upper number with respect of pseudophakia. Additionally, that considerations that guide or support the exercise of discretion be included.

The bases for Recommendation 2 are as follows:

1. Pseudophakia refers to having an intraocular lens implant placed in the eye, following removal of the existing lens. Absent complications, an intraocular lens implant results in the vast majority of patients seeing just as well as patients who haven't had cataract surgery. The additional weighting (lower number) may, therefore, be too generous and Ophthalmologists should be able to use the upper number. Of course, allowance should be made for variations in younger people e.g. those aged under 45.

2. Aphakia refers to having no lens in the eye. Aphakia should be treated separately and the additional weighting (lower number) retained because of the increased risk of retinal detachment, macular problems and so on.

3. Recommendation 2 is made by consensus between Professor Crompton, Dr Steiner and Dr Wechsler.

PROVIDED FOR CONSULTATION PURPOSES ONLY

Recommendation 3

It is recommended that the Visual System chapter of the Impairment Assessment Guidelines Third Edition permit the assessing Ophthalmologist to rate relevant facial abnormality and/or disfigurement by including the relevant provisions of Chapter 6 Table 6.1 into the Visual System chapter.

The bases for Recommendation 3 are as follows.

1. Under South Australia's accreditation system, Assessors are accredited for specific chapters. At present, an Ophthalmologist accredited under Visual System chapter 10 cannot assess and rate "loss of eye" – the provisions for which are located in Ear, Nose, Throat and Related Structures in chapter 6 Table 6.1.

2. There had been some attempt to address this anomaly in the revoked Impairment Assessment Guidelines Second Edition through the insertion of paragraph 10.8, albeit without the necessary provisions to include "loss of eye".

3. It makes good sense for an Ophthalmologist to be able to assess relevant facial abnormality and/or disfigurement including "loss of eye".

4. Recommendation 3 is made by consensus between Professor Crompton, Dr Steiner and Dr Wechsler.

Recommendation 4

It is recommended that the Visual System chapter of the Impairment Assessment Guidelines Third Edition permit the assessing Ophthalmologist to undertake a trigeminal nerve assessment by including relevant content from paragraph 5.14 of Chapter 5 into the Visual System chapter.

The bases for Recommendation 4 are as follows:

1. Under South Australia's accreditation system, Assessors are accredited for specific chapters. At present, an Ophthalmologist accredited under Visual System chapter 10 cannot assess and rate relevant sensory loss arising from trigeminal nerve impairment.
2. It makes good sense for an Ophthalmologist to be able to assess relevant sensory loss.
3. Recommendation 4 is made by consensus between Professor Crompton, Dr Steiner and Dr Wechsler.

Recommendation 5

In relation to the revisions contained within the revoked Impairment Assessment Guidelines Second Edition, the following recommendations are made:

5.1 It is recommended that revoked paragraph 10.8 be included, with an adaptation to include the content in Recommendation 3 above.

5.2. It is recommended that revoked paragraph 10.9 be adapted to give effect to Recommendation 2 above and, additionally, that references to "monocular" be removed.

5.3. It is recommended that revoked paragraph 10.10 be removed entirely on the basis that these provisions appear within AMA4 and this represents unnecessary duplication.

Recommendation 5 is made by consensus between Professor Crompton, Dr Steiner and Dr Wechsler.

Additional documents circulated and considered by the sub-Committee:

None.

PROVIDED FOR CONSULTATION PURPOSES ONLY

10. Visual system – draft chapter

Chapter 8, **AMA4** (p209) applies to the assessment of permanent impairment of the visual system, subject to the modifications set out below.

Before undertaking an impairment assessment, users of the Guidelines must be familiar with the following (in this order):

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter/s of the Guidelines for the body system they are assessing, and
- the appropriate chapter/s of AMA4 for the body system they are assessing.

The Guidelines take precedence over AMA4 and AMA5.

PROVIDED FOR CONSULTATION PURPOSES ONLY

Introductions and approach to assessment

10.1 The visual system must be assessed by an ophthalmologist.

10.2 Chapter 8, AMA4 (pp209–222) is adopted for the Guidelines without significant change.

10.3 AMA4 is used rather than AMA5 for the assessment of whole person impairment of the visual system because:

- there is little emphasis on diplopia in AMA5, yet this is a relatively frequent problem
- many ophthalmologists are familiar with the Royal Australian College of Ophthalmologists' impairment guide, which is similar to AMA4.

10.4 Impairment of vision should be measured with the worker wearing their prescribed corrective spectacles and/or contact lenses, if that was normal for the injured worker before the work injury. If, as a result of the work injury, the injured worker has been prescribed corrective spectacles and/or contact lenses for the first time, or different spectacles and/or contact lenses than those prescribed before injury, the difference should be accounted for in the assessment of permanent impairment.

10.5 An ophthalmologist should assess visual field impairment in all cases.

10.6 The ophthalmologist should perform or review all tests necessary for the assessment of whole person impairment rather than relying on the interpretations of tests done by the orthoptist or optometrist.

10.7 For impairment assessment for aphakia or pseudophakia, AMA4 directs that the lower numbers are used in Table 3 (p212, AMA4). However, with respect of pseudophakia, the ophthalmologist is permitted to exercise discretion to use the upper number when appropriate. The exercise of discretion may be desirable with reference to, for example, the age of the worker, complications arising from the surgery, etc.

10.8 Ophthalmologists are to assess relevant facial abnormality and/or disfigurement, if disfigurement is limited to the immediate periorbital area, being the orbital contents plus the eyelids, then it is to be assessed by the Ophthalmologist. However, if it extends to involve more of the face, it is to be undertaken in accordance with the ear, nose and throat chapter by an assessor accredited in that system.

10.9 Ophthalmologists are to rate relevant facial abnormality and/or disfigurement, as follows.

10.9.1 Relevant facial abnormality and/or disfigurement/s that do not otherwise affect ocular function are to be rated per section 8.5 of AMA 4 (p222). In section 8.5, AMA4 (p222) on other conditions, the 'additional 10% impairment' referred to means 10% WPI, not 10% impairment of the visual system.

10.9.2 Relevant facial abnormality and/or disfigurement/s that do affect ocular function are to be rated as follows:

10.9.2.1 impairment in relation to facial disfigurement, including anatomic loss, per Table 6.1 of Chapter 6 Ear, Nose, Throat and Related Structures of IAG (p76), and

10.9.2.2 the significance of the disturbance or deformity not reflected in the assessment of visual loss, including epiphora, photophobia, ghosting or metamorphopsia, per Chapter 8 paragraph 3 AMA 4 (p209).

10.10 Ophthalmologists are to undertake trigeminal nerve assessment per paragraph 5.14 of Chapter 5 Nervous System of IAG (p49).

PROVIDED FOR CONSULTATION PURPOSES ONLY

11. Haematopoietic system - recommendations

Members of the Haematopoietic System sub- Committee:

- Kristen Rogers (Facilitator)
- James Large (Facilitator)
- Dr Gary Champion
- Prof John Carter

The sub-Committee met on the following dates:

- 13 April 2023
- 18 May 2023

The sub-Committee reviewed Chapters 11 of the Impairment Assessment Guidelines and makes the following recommendations: [Provided to the SRCG for consideration on 7 June 2023]

PROVIDED FOR CONSULTATION PURPOSES ONLY

Anaemia

Paragraph 11.1

Recommend inclusion of words "*The diagnosis being rated must have been made by a Haematologist, Oncologist, Immunologist or other Specialist Internal Physician prior to the assessment*" from the IAG Second Edition.

Paragraph 11.3

Recommend inclusion of words "*non-anaemic iron deficiency*" adjacent to table or in table heading.

Recommend removal of Table 11.1, which currently states as follows

Class 1: 0–10% WPI	Class 2: 11–30% WPI	Class 3: 31–70% WPI	Class 4: 71–100% WPI
No symptoms and haemoglobin 100–120g/L and no transfusion required	Minimal symptoms and haemoglobin 80–100g/L and no transfusion required	Moderate to marked symptoms and haemoglobin 50–80g/L before transfusion and transfusion of 2 to	Moderate to marked symptoms and haemoglobin 50–80g/L before transfusion and transfusion of 2 to

		3 units required, every 4 to 6 weeks	3 units required, every 2 weeks

and insertion of the following

Class 1 mild 0–10% WPI	Class 2 moderate 11–30% WPI	Class 3 severe 31–70% WPI	Class 4 life threatening 71–100% WPI
No symptoms and haemoglobin 100–120g/L and no transfusion required	Minimal symptoms and haemoglobin 80–99g/L and no transfusion required	Moderate to marked symptoms and haemoglobin 65–80g/L before transfusion and transfusion required up to twice per month	Moderate to marked symptoms and haemoglobin less than 65g/L before transfusion and require transfusions up to weekly

PROVIDED FOR CONSULTATION PURPOSES ONLY

The descriptions (mild, moderate, severe, etc) and the haemoglobin values (100–120g/L, 80–99g/L, etc) are consistent with the grading of the "National Cancer Institute".[1]

The sub-Committee had contemplated a reduction in WPI on the bases that:

1. the WPI in IAG First Edition was considered "over generous", and
2. most workers who are seriously ill will also be represented by Table 9-3 Criteria for Rating Permanent Impairment Due to White Blood Cell Disease page 200 AMA5. I.e. those injured workers would receive a combined WPI arising from Anaemia Table 11.1 of the IAG Third Edition and White Blood Disease arising from Table 9-3 of AMA5. Consequently, it was

[1] The NCI grading of anaemia is defined as follows: "*mild (Grade 1), Hb from 10 g/dL to the lower normal limit; moderate (Grade 2), Hb 8.0–9.9 g/dL; severe (Grade 3), Hb <8 g/dL to 6.5 g/dl; life-threatening (Grade 4), Hb <6.5 g/dL*"
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6159745/#:~:text=The%20NCI%20grading%20of%20anemia,6.5%20g%2FdL%E2%80%9D2

perceived that injured workers would not be disadvantaged.

However, the sub-Committee received advice that injured workers could be disadvantaged with a reduction of WPI in the table. Specifically, the sub-Committee was advised that "*Workers who do not suffer white blood cell disease and are purely being assessed for anaemia would seemingly be disadvantaged by the proposed changes.*" Further, perceived "over generosity" of WPI percentage does not necessarily give rise to higher payment – noting that lump sum payments are capped at 50% WPI for injuries sustained after mid-2015.

It is recommended that the Assessor be required to give reason/s for why they have assigned an individual into the Class selected.

Polycythaemia and myelofibrosis

Paragraph 11.7

Recommend removal of words "*results from venesection*" and insertion of word "*exists*".

White blood cell diseases

Paragraph 11.9

Recommend removal of words "*HIV infection or auto immune deficiency disease*" and insertion of words "*white blood cell diseases*".

Recommend Table 9-3 on page 200 of AMA5 be amended in IAG to provide that every reference to "*leukocyte abnormality*" is to be read as "*white blood cell abnormality*".

Deep vein thrombosis

It is strongly recommended that the definition of Peripheral Vascular Disease (PVD) within Chapter 4.3 (page 73) of AMA5 – which includes arterial, venous and lymphatic disorders – be clearly adopted in the Impairment Assessment Guidelines.

Paragraph 11.13

With respect of referring assessment of "a single deep-vein thrombosis" to the cardiovascular system or upper or lower extremity system, it is recommended that the Impairment Assessment Guidelines make clear that references to Peripheral Vascular Disease (PVD) are taken to include venous disorders.

With respect of assessment of "a persistent or reoccurring thrombotic disorder" under Table 9-4 AMA5 (p203), no changes are recommended with respect of assessing this type of impairment.

Additional documents circulated and considered by the sub-Committee:

PROVIDED FOR CONSULTATION PURPOSES ONLY

Extensive email correspondence. No other documents circulated.

12. Endocrine system chapter - recommendations

Members of the Endocrine Systems sub- Committee:

- Kristen Rogers (Facilitator)
- James Large (Facilitator)
- Dr Gary Champion
- Prof John Carter

The sub-Committee met on the following dates:

- 13 April 2023
- 18 May 2023

The sub-Committee reviewed Chapters 12 of the Impairment Assessment Guidelines and makes the following recommendations: **[Provided to the SRCG for consideration on 7 June 2023]**

PROVIDED FOR CONSULTATION PURPOSES ONLY

Introduction

Paragraph 12.1

Recommend inclusion of words "*Except for Diabetes, the diagnosis being rated must have been made by an Endocrinologist with supporting evidence prior to assessment. In the case of Diabetes, the diagnosis can be made by a General Practitioner or Consultant Physician.*"

Paragraph 12.2

Recommend removal of words "*memory, chapter 13, AMA3*" and insertion of correct reference to peripheral nervous system in AMA5.

Recommend removal of words "*infertility, renal impairment*" and "*dyspepsia*".

Recommend checking all other references within paragraph 12.2.

Adrenal cortex

Paragraphs 12.4 – 12.6

Recommend this issue be referred to the Chapter 5 Nervous System Sub-Committee, noting the following.

a. In circumstances in which a traumatic brain injury affects the pituitary gland, there can be a consequent impact on the adrenal gland (in addition to sexual function, etc.).

b. Consideration needs to be given to assessment of the consequences of traumatic brain injury, with a suggestion that damage to the pituitary gland that impacts on the endocrine system be assessed by an assessor accredited in the endocrine system.

c. Suggestion that the Chapter 5 Nervous System chapter include a direction that damage to the pituitary gland also be referred to Chapter 12 Endocrine System for assessment.

PROVIDED FOR CONSULTATION PURPOSES ONLY

Diabetes mellitus

Paragraph 12.7

Recommend directions to the requestor to ensure that most recent haemoglobin A1c as well as the latest uranalysis (specifically albuminuria) are provided to assessor in advance of appointment.

Recommend IAG include appropriate changes to Table 10-8 AMA5 (page 231), on the following bases:

a. Class 1 should be less or equal to HbA1c of 7% with no complications. Most, or at least a significant number of, people with newly diagnosed diabetes will be commenced on Metformin in addition to a diet. Assuming good control is obtained, and depending on the dose of Metformin used, Class 2 would not be warranted. If extra diabetes tabs are needed, those workers should fall into Class 2.

b. The cap on Type 2 diabetes at 10% WPI is considered low and should be increased to 15% WPI.

c. Removal of "*30 mg/dL*.

d. Class 2 should be unsatisfactory control with a HbA1c greater than 7%. Class 2 can include treatment with hypoglycaemic agents or insulin. Poor control indicates a higher rating within the class.

e. Class 3 Type 1 16-30% (this class does not apply to Type 2 Diabetes Mellitus workers who require insulin).

f. Class 4 Type 1 – Recommend 31-50%. (this class does not apply to Type Diabetes mellitus workers who require insulin).

Consequently, the following Table is recommended.

Class 1 0 - 5%	Class 2 6 – 15%	Class 3 16 - 30%	Class 4 31 - 50%
Type 2 Diabetes Mellitus that is well controlled by diet +/- low dose Metformin. Good control is considered to be lower or equal to HbA1c of 7%	Type 2 Diabetes that is not controlled by diet with a HbA1c greater than 7%; hypoglycemic medication (oral or insulin) is required. May or may not have evidence of microangiopathy, as indicated by retinopathy or by albuminuria. If retinopathy has led to visual impairment, assessment per Visual System Chapter.	Type 1 diabetes mellitus, with or without evidence of microangiopathy.	Type 1 diabetes mellitus and hyperglycemia and/or hypoglycemia occurs frequently despite conscious efforts of both individual and physician

Additional documents circulated and considered by the sub-Committee:

Extensive email correspondence. No other documents circulated.

PROVIDED FOR CONSULTATION PURPOSES ONLY

13. Skin chapter - recommendations

Members of the Skin sub- Committee:

- James Large (Facilitator)
- Dr Rabin Bhandari – Chairperson, RACP State Committee for SA
- Prof David David
- Dr Walter Flapper
- Dr Corinne Maiolo – nominated by the Australasian College of Dermatologists
- Dr Cathy Reid
- Dr Annabel Stevenson

The sub-Committee met on the following dates:

- 1 March 2023
- 4 April 2023

The sub-Committee reviewed Chapter 13 of the Impairment Assessment Guidelines and makes the following recommendations: **[Considered by SRCG on 27 April 2023]**

PROVIDED FOR CONSULTATION PURPOSES ONLY

Recommendation 1

The "Face" should be defined as follows:

> *The face includes the ears, with the upper limit is the highest frown line, i.e. the attachment of the frontalis muscles, the lower is the chin and the lower border of the mandible.*

The SRCG accepted this definition of the face, and recommends inclusion of a picture to assist.

Recommendation 2

Assessors should be asked to review the scar that relates to the body part relevant to the work injury only and disregard unrelated scarring from the assessment and therefore not be deducted.

Therefore the working group agreed to recommend to the SRCG that current section 13.4 of the IAGs is amended in the next edition, to reflect that a pre-existing but unrelated non-facial scar is disregarded in the assessment of impairment.

The SRCG accepted this recommendation.

Recommendation 3

Table 13.1 (Temski) page 87 of the current IAGs should be used for scarring only, excluding the Face as opposed to other skin conditions. For the case of other skin conditions, the Class 1 Table in the AMA Guide should be utilised.

Recommendation 4

Trophic changes in the TEMSKI table could be better described to facilitate better understanding and consistency of application. The working group recommends that the following words should be included in the new IAGs "trophic changes on the skin result from interruption of nerve supply and may include changes in hair growth or sweating, sensation, changes in skin texture, tone, colour or temperature".

The SRCG requested slightly different wording to make it clear that this is due to scarring and not CRPS or other vascular causes: "for the purpose of this scale, trophic changes means trophic changes on the skin result from interruption of nerve supply and may include changes in hair growth or sweating, sensation, changes in skin texture, tone, colour or temperature but it is confined to trophic changes arising from scarring."

PROVIDED FOR CONSULTATION PURPOSES ONLY

Recommendation 5

The issue of terminal conditions, e.g. cancers how the Skin Chapter intersects with this other chapter was not considered relevant.

Recommendation 6

The rounding up of values where the impairment is not a whole number was considered appropriate practice and should be retained.

The SCRG accepted this recommendation, but noted that it more appropriately applies to Chapter 1 rather than the Skin chapter as it applies to all assessments.

Recommendation 7

It was not considered that there was a disparity between class 1 in Table 6.1 of the AMA Guide and the Temski table in Chapter 13. It was considered by the group that these relate well to each other.

Recommendation 8

The question of pigmented skin was discussed and not considered to be an issue by the group and therefore felt it did not need to be considered further.

Recommendation 9

The group considered that improved guidance should be provided to the assessor on what they are being asked to assess, including the reference to applying the 'best fit' in the use of the Temski table at the start of the chapter. The sub-committee considered the following set of words would be suitable for inclusion, "assessors when utilising the Temski table should apply a best fit approach".

The approach to applying the 'best fit' is already adequately described at the bottom of Table 13.1 on page 87 of the current IAGs and assessors when using the Temski table should apply this guidance.

Recommendation 10

The group felt it should not be the requestor who determines which method, e.g. Temski is applied in the assessment but rather this should be a matter for the assessor to determine the best method to apply.

Additional documents circulated and considered by the sub-Committee:

Paper provided by Prof David with three options for consideration by the sub-committee in defining the scope of the "Face". Option 3 was agreed by the sub-committee.

PROVIDED FOR CONSULTATION PURPOSES ONLY

13. Skin – draft chapter

Chapter 8, AMA5 (p173) applies to the assessment of permanent impairment of the skin, subject to the modifications set out below.

Before undertaking an impairment assessment, users of the Guidelines must be familiar with the following (in this order):

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

The Guidelines take precedence over AMA5.

PROVIDED FOR CONSULTATION PURPOSES ONLY

Introduction

13.1 Chapter 8, AMA5 (pp173–190) refers to skin diseases generally rather than work-related skin diseases alone. In the Guidelines, this chapter has been adopted for measuring impairment of the skin system, with the variations listed in the subsequent sections of this chapter.

13.2 Disfigurement, scars and skin grafts may be assessed as causing significant permanent impairment when the skin condition causes limitation in the performance of activities of daily living (ADL).

13.3 Table 8-2, AMA5 (p178) provides the method of classification of impairment due to skin disorders. Three components – signs and symptoms of skin disorder, limitations in activities of daily living and requirements for treatment – define five classes of permanent impairment. The assessor should allocate a specific percentage impairment within the range for the class that best describes the clinical status of the worker and provide detailed reasons for their selection in the report.

13.4 ~~The skin is regarded as a single organ and all non-facial scarring is measured together as one overall impairment rather than assessing individual scars separately and combining the results.~~ Assessors should review the scar that relates to the body part relevant to the work injury only. Scarring that is unrelated from the assessment should be disregarded and therefore not be deducted.

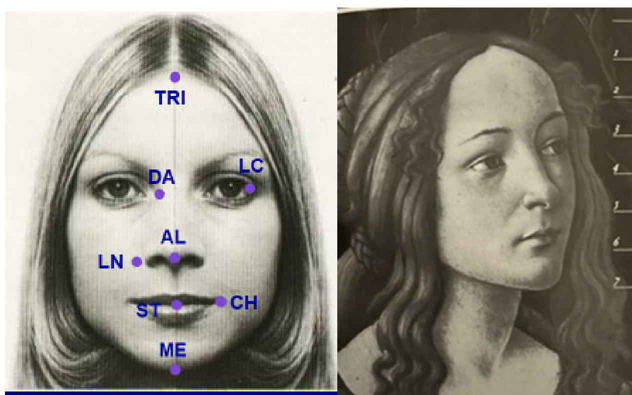
Any and all pre-existing but unrelated scars are to be disregarded in the assessment of impairment.

DRAFT

13.5 For cases of facial disfigurement (which can include scarring), refer to Table 6.1 in the Ear, Nose and Throat Related Structures chapter of the Guidelines. The face is rated separately and then combined where appropriate.

13.6 For the purpose of this chapter, the face should be defined as follows:

The face includes the ears, with the upper limit is the highest frown line, i.e. the attachment of the frontalis muscles, the lower is the chin and the lower border of the mandible.



13.7~~6~~ In cases of inflammatory conditions involving both the face and the skin of other areas of the body, assessors are advised to assess by both skin (Table 8-2 AMA5) and by face (Table 6.1, Ear, Nose and Throat chapter, p52) and then allocate whichever is the higher impairment.

13.8~~7~~ The Table for the Evaluation of Minor Skin Impairment (TEMSKI – 13.1) is an extension of Table 8-2 in AMA5. The TEMSKI divides Class 1 of permanent impairment (0-9%) due to skin disorders into five groupings of impairment. The TEMSKI may be used by assessors (who are not trained in the skin body system but who are trained in the use of TEMSKI) for determining skin impairment from 0 – 4% WPI associated with the injury which they are rating. Skin impairment from the TEMSKI greater than 4% must be assessed by an assessor who has undertaken the requisite training in the assessment of the skin body system.

13.9 Table 13.1 (TEMSKI) should be used for scarring only (excluding the Face) as opposed to other skin conditions. For the case of other skin conditions, the Class 1 Table 8.2 in AMA5 should be used.

13.10 It is a matter for the assessor (rather than the requestor) to determine the best method to be applied in the assessment and whether or not the assessor is to utilise the TEMSKI table for the assessment.

PROVIDED FOR CONSULTA... S ONLY

13.11~~8~~ Assessors when utilising the TEMSKI table should apply a best fit approach, noting the guidance at the bottom of Table 13.1.~~The TEMSKI is to be used in accordance with the principle of 'best fit'~~.

13.12 The assessor must be satisfied that the criteria within the chosen category of impairment best reflect the skin disorder being assessed. The assessor must provide detailed reasons as to why this category has been chosen over other categories.

13.13 For the purpose of this TEMSKI scale, trophic changes means trophic changes on the skin result from interruption of nerve supply and may include changes in hair growth or sweating, sensation, changes in skin texture, tone, colour or temperature but it is confined to trophic changes arising from scarring.

13.14~~9~~ A scar may be present and rated as 0% WPI.

13.15~~10~~ Where there is a range of values in the TEMSKI categories, the assessor must use clinical judgement to determine the specific degree of impairment and must provide the rationale for choosing that value in the report.

13.16~~11~~ The case examples provided in chapter 8, AMA5 do not, in most cases, relate to permanent impairment that results from a work injury. The following examples are provided for information.

13.17~~12~~ Work-related case study examples 13.1, 13.2, 13.3, 13.4, 13.5, 13.6 are included below, in addition to AMA5 examples 8.1–8.22 (pp178–187).

PROVIDED FOR CONSULTATION PURPOSES ONLY

PROVIDED FOR CONSULTATION PURPOSES ONLY

Table 13.1 For The Evaluation of Minor Skin Impairment (TEMSKI)

Criteria	0% WPI	1% WPI	2% WPI	3 – 4% WPI	5 – 9 % WPI
Description of the scar (s) and/or skin conditions(s) (shape, texture, colour)	Worker is not conscious or is barely conscious of the scar(s) or skin condition Good colour match with surrounding skin and the scar(s) or skin condition is barely distinguishable. Worker is unable to easily locate the scars(s) or skin condition No trophic changes Any staple or suture marks are barely visible	Worker is conscious of the scar(s) or skin condition Some parts of the scar(s) or skin condition colour contrast with the surrounding skin as a result of pigmentary or other changes Worker is able to locate the scar(s) or skin condition Minimal trophic changes Any staple or suture marks are visible	Worker is conscious of the scar(s) or skin condition Noticeable colour contrast of scar(s) or skin condition with surrounding skin as a result or pigmentary or other changes. Worker is able to easily locate the scar(s) or skin condition Trophic changes evident to touch Any staple or suture marks are clearly visible	Worker is conscious of the scar(s) or skin condition Easily identifiable colour contract of scar(s) or skin condition with surrounding skin as a result of pigmentary changes Worker is able to easily locate the scar(s) or skin condition Trophic changes evident to touch Any staple or suture marks are clearly visible	Worker is conscious of the scar(s) or skin condition Distinct colour contrast of scar(s) or skin condition with surrounding skin as a result of pigmentary or other changes Worker is able to easily locate the scar(s) or skin condition Trophic changes evident to touch Any staple or suture marks are clearly visible
Location	Anatomic location of the scar(s) or skin condition not clearly visible with usual clothing/hairstyle	Anatomic location of the scar(s) or skin condition not usually visible with usual clothing/hairstyle	Anatomic location of the scar(s) or skin condition is usually visible with usual clothing/hairstyle	Anatomic location of the scar(s) or skin condition is visible with usual clothing/hairstyle	Anatomic location of the scar(s) or skin condition is usually and clearly visible with usual clothing/hairstyle
Contour	No contour defect	Minor contour defect	Contour defect visible	Contour defect easily visible	Contour defect easily visible

ADL / Treatment	No effect on any ADL No treatment or intermittent treatment only, required	Negligible effect on any ADL No treatment, or intermittent treatment only, required	Minor limitation in the performance of few ADL No treatment, or intermittent treatment only, required	Minor limitation in the performance of few ADL **AND** exposure to chemical or physical agents (e.g. sunlight, heat, cold etc.) may temporarily increase limitation No treatment, or intermittent treatment only, required	Limitation in the performance of few ADL (INCLUDING restriction in grooming or dressing) **AND** exposure to chemical or physical agents (e.g. sunlight, heat, cold etc.) may temporarily increase limitation No treatment, or intermittent treatment only, required
Adherence to underlying structures	No adherence	No adherence	No adherence	Some adherence	Some adherence
This table uses the principle of 'best fit'. You should assess the impairment to the whole skin system against each criteria and then determine which impairment category best fits (or describes) the impairment. A skin impairment will usually meet most, but does not need to meet all, criteria to 'best fit' a particular impairment category. The assessor must provide detailed reasons why this category has been chosen over other categories. Refer to 13.7-13.10 regarding application of this table.					

PROVIDED FOR CONSULTATION PURPOSES ONLY

Table 13.1 For The Evaluation of Minor Skin Impairment (TEMSKI)

Criteria	0% WPI	1% WPI	2% WPI	3 - 4% WPI	5 - 9% WPI
Description of the scar(s) and/or skin condition(s) (shape, texture, colour)	Worker is not conscious or is barely conscious of the scar(s) or skin condition Good colour match with surrounding skin and the scar(s) or skin condition is barely distinguishable. Worker is unable to easily locate the scar(s) or skin condition No trophic changes Any staple or suture marks are barely visible	Worker is conscious of the scar(s) or skin condition Some parts of the scar(s) or skin condition colour contrast with the surrounding skin as a result of pigmentary or other changes Worker is able to locate the scar(s) or skin condition Minimal trophic changes Any staple or suture marks are visible	Worker is conscious of the scar(s) or skin condition Noticeable colour contrast of scar(s) or skin condition with surrounding skin as a result of pigmentary or other changes Worker is able to easily locate the scar(s) or skin condition Trophic changes evident to touch Any staple or suture marks are clearly visible	Worker is conscious of the scar(s) or skin condition Easily identifiable colour contrast of scar(s) or skin condition with surrounding skin as a result of pigmentary or other changes Worker is able to easily locate the scar(s) or skin condition. Trophic changes evident to touch Any staple or suture marks are clearly visible	Worker is conscious of the scar(s) or skin condition Distinct colour contrast of scar(s) or skin condition with surrounding skin as a result of pigmentary or other changes Worker is able to easily locate the scar(s) or skin condition Trophic changes are visible Any staple or suture marks are clearly visible
Location	Anatomic location of the scar(s) or skin condition not clearly visible with usual clothing/hairstyle	Anatomic location of the scar(s) or skin condition is not usually visible with usual clothing/hairstyle	Anatomic location of the scar(s) or skin condition is usually visible with usual clothing/hairstyle	Anatomic location of the scar(s) or skin condition is visible with usual clothing/hairstyle	Anatomic location of the scar(s) or skin condition is usually and clearly visible with usual clothing/hairstyle
Contour	No contour defect	Minor contour defect	Contour defect visible	Contour defect easily visible	Contour defect easily visible
ADL / Treatment	No effect on any ADL No treatment, or intermittent treatment only, required	Negligible effect on any ADL No treatment, or intermittent treatment only, required	Minor limitation in the performance of few ADL No treatment, or intermittent treatment only, required	Minor limitation in the performance of few ADL **AND** exposure to chemical or physical agents (e.g. sunlight, heat, cold etc.) may temporarily increase limitation No treatment, or intermittent treatment only, required	Limitation in the performance of few ADL (INCLUDING restriction in grooming or dressing) **AND** exposure to chemical or physical agents (e.g. sunlight, heat, cold etc.) may temporarily increase limitation or restriction No treatment, or intermittent treatment only, required
Adherence to underlying structures	No adherence	No adherence	No adherence	Some adherence	Some adherence
This table uses the principle of 'best fit'. You should assess the impairment to the whole skin system against each criteria and then determine which impairment category best fits (or describes) the impairment. A skin impairment will usually meet most, but does not need to meet all, criteria to 'best fit' a particular impairment category. The assessor must provide detailed reasons as to why this category has been chosen over other categories. Refer to 13.7-13.10 regarding application of this table.					

DRAFT

Example 13.1: Cumulative irritant dermatitis

~~Subject: 42 year-old man~~

Commented [A2]: Remove. Reference to age and gender is not relevant to the impairment.

History: The worker is a spray painter working on ships in dry dock who has presented with a rash on both hands. Not required to prepare surface but required to mix paints (including epoxy and polyurethane) with 'thinners' (solvents) and spray metal ship's surface. At end of each session, the worker was required to clean equipment with solvents and was not supplied with gloves or other personal protective equipment until after the onset of symptoms. Off work two months leading to clearance of the rash, but frequent recurrence, especially if the worker attempted prolonged work wearing latex or PVC gloves or wet work without gloves. Treatment by GP with topical steroid creams showed improvement.

Current: Returned to dry duties only at work. Mostly clear of dermatitis now, but flares.

Physical examination: Varies between no abnormality detected to mild self-limiting dermatitis of the dorsum of hands. On the day of the assessment there was no identifiable skin condition.

Investigations: Patch test standard + epoxy + isocyanates (polyurethanes). No reactions.

Impairment: 3% WPI as deemed to be at the lower third of the range in Class 1 from Table 8.2 in AMA5 (p178).

Comment: Intermittently present and minimal interference with activities of daily living (ADL) and occasional intermittent treatment, perhaps once per year.

Example 13.2 Burns

~~Subject: 32 year old man~~

Commented [A3]: Remove. Reference to age and gender is not relevant to the impairment.

History: The worker is an electrician. Twelve months ago he was involved in an accident in which a meter board suddenly exploded and his face was burnt. He was taken to the hospital and a second degree burn to his forehead was diagnosed.

Treatment: He was treated in hospital. He remained for 2 days and, following discharge, he attended Outpatients for several weeks until the burn eventually healed leaving a rather poorly defined, abnormally pigmented linear keloid scar across his forehead. The scar measured approximately 6cm in length and 5cm in width.

PROVIDED FOR CONSULTATION PURPOSES ONLY

Current: This is currently being treated with a silicone gel which he is applying once daily. The scar is painful when touched and when exposed to temperature. If he wears a hat, this irritates the scar. He also complains of pruritus in the scar which is present most of the time.

Investigation: Clinical examination reveals a prominent erythematous keloidal scar with the above dimensions. The scar is visible from 3 metres. He is unable to wear a hat or cap because of the irritation that this causes the scar. He is extremely embarrassed by the cosmetic appearance of this scar and has become somewhat socially withdrawn. Frowning or laughing will also cause irritation in the scar.

Impairment: 10% WPI from Table 8-2 Class 2 (p178, AMA5) at the lower end of the range.

Comment: There is a skin disorder and signs and symptoms are consistently present. There is limited performance of some of the activities of daily living (mainly social) because of his embarrassment regarding this problem. Itching is a problem and pain frequently occurs within the scar. He is always conscious of the problem and requires constant treatment in an effort to soothe this scar. The assessor was guided by the comment in Table 6.1 to refer to chapter 8 in AMA5 for skin disorders that involve hypertrophic or abnormally pigmented scars

Example 13.3: 'Cement dermatitis' due to chromate in cement

~~Subject: 43 year old man~~

History: Concreter since age 16, now in their 40s.. Eighteen-month history of increasing hand dermatitis eventually on dorsal and palmar surface of hands and fingers. Off work and treatment led to limited improvement only. Referred to Dermatologist and prescribed strong steroid ointment and cleansing lotion in lieu of soap.

Physical examination: Fissured skin, hyperkeratotic chronic dermatitis.

Investigation: Patch test. Positive reaction to dichromate.

Current: Intractable, chronic, fissured dermatitis.

Impairment: Mid-range from Class 2 in Table 8.2 (p178, AMA5) selected at 17% WPI.

Comment: Unable to obtain any employment because has chronic dermatitis ~~and on disability support pension.~~ Difficulty gripping items including steering wheel, hammer and other tools. Unable to do any wet work, (e.g. painting). Former

Commented [A4]: Remove. If age or length of employment is relevant, add this to the History.

Commented [A5]: Reword this, as the DSP is not relevant to being unable to obtain employment.

PROVIDED FOR CONSULTATION PURPOSES ONLY

home handyman, now calls in tradesman to do any repairs and maintenance. Limited performance in some ADLs and requires intermittent treatment.

Example 13.4: Latex contact urticaria/angioedema with cross reactions

Subject: Female nurse, age 40

Commented [A6]: Remove. Refer to their occupation in the History instead.

History: Nurse with sSix-month history of itchy hands minutes after applying latex gloves at work. Later swelling and redness associated with itchy hands and wrists and subsequently widespread urticaria. One week off led to immediate clearance. On return to work wearing PVC gloves developed anaphylaxis on first day back.

Physical examination: No abnormality detected or generalised urticaria/angioedema.

Investigation: Latex radioallergosorbent test, strong positive response.

Current: The subject experiences urticaria and anaphylaxis if she enters a hospital, some supermarkets or other stores (especially if latex items are stocked), at children's parties or in other situations where balloons are present, or on inadvertent contact with latex items including sports goods handles, some clothing, and many shoes (latex based glues). Also has restricted diet (must avoid bananas, avocados and kiwi fruit).

Impairment: 22% WPI. At the higher end of the range within Class 2 selected from Table 8.2 (p178, AMA5).

Comment: Severe limitation in some ADLs and uncertainty of when she could next experience an anaphylactic reaction.

Example 13.5: Non-melanoma skin cancer

Subject: 53-year-old married man

Commented [A7]: Remove. Marital status and gender are not relevant to the impairment. If length of employment is relevant, include this in the History.

History: 'Road worker' since 17 years of age, now 53 years. Has had a basal cell carcinoma on the left forehead, squamous cell carcinoma on the right forehead (graft), basal cell carcinoma on the left ear (wedge resection) and squamous cell carcinoma on the lower lip (wedge resection) excised since 45 years of age. No history of loco-regional recurrences. Multiple actinic keratoses treated with cryotherapy or Efudix (fluorouracil) cream over 20 years (forearms, dorsum of hands, head and neck).

PROVIDED FOR CONSULTATION PURPOSES ONLY

Current: New lesion right preauricular area. Concerned over appearance "I look a mess."

Physical examination: Multiple actinic keratoses forearms, dorsum of hands, head and neck. Five millimetre diameter nodular basal cell carcinoma right preauricular area, hypertrophic red scar 3cm length left forehead, 2cm diameter graft site (hypopigmented with 2mm contour deformity) right temple, non-hypertrophic scar left lower lip (vermilion) with slight step deformity and non-hypertrophic pale wedge resection scar left pinna leading to 30% reduction in size of the pinna. Graft sites taken from right post auricular area. No regional lymphadenopathy.

Impairment rating: 9% WPI

Comment: 6% WPI for facial disfigurement. This facial disfigurement was selected at the lowest range within this Class 2 (Table 6.1 in these Guidelines) and combined with 3% WPI for non-facial scarring of the upper extremities from Table 8.2 in AMA5. This non-facial scarring was clinically determined to be in the lower third percentile within Class 1 from Table 8-2. Total is 6% WPI combined with 3% WPI.

Example 13.6: Non-melanoma skin cancer

~~Subject: 35-year-old single female professional surf life-saver~~

Commented [A8]: Remove. Refer to occupation in the History.

History: Professional surf life-saver with o~~O~~ccupational outdoor exposure since 19 years of age. Basal cell carcinoma on tip of nose excised three years ago with full thickness graft following failed intralesional interferon treatment.

Current: Poor self-esteem because of cosmetic result of surgery and facial disfigurement.

Physical examination: 1cm diameter graft site on the tip of nose (hypopigmented with 2mm depth contour deformity, cartilage not involved). Graft site taken from right post-auricular area.

Impairment rating: 10% WPI was selected at the highest range in Class 2 (Table 6.1 in these Guidelines) as it involved structural change in the nose and impact on her hair-line around the right ear.

Comment: Refer to Table 6.1 (facial disfigurement) on page 52 of Guidelines.~~.~~

PROVIDED FOR CONSULTATION PURPOSES ONLY

14. Cardiovascular system chapter - recommendation

Members of the Cardiovascular Sub Committee

- Guy Biddle (Facilitator)
- Dr Beata Byok
- Dr Leo Mahar
- Dr Justin Ardill

The Sub-Committee met on the following dates:

- 29 March 2023
- 12 May 2023

The Sub Committee reviewed Chapter 14 of the Impairment Assessment Guidelines and makes the following recommendations: [Considered by SRCG on 13 June 2023]

PROVIDED FOR CONSULTATION PURPOSES ONLY

Recommendation 1

That there be a preamble to the chapter to outline the key requirements and considerations for an assessment.

Potential wording as follows:

> "Cardiovascular assessment for whole person impairment requires a detailed history and examination and accompanying relevant documentation including results of objective tests.
>
> For a whole permanent assessment, the condition should be at Maximum Medical Improvement (MMI) and stable for the foreseeable future as defined in AMA5.
>
> The worker should be adherent to nationally accepted regimens of treatment as recommended by the Cardiac Society (CSANZ) and other relevant authorities. Any cardiovascular event or condition prior to the injury (currently being assessed) will also be assessed and an appropriate deduction from the total whole person impairment percentage assessed on the day of examination will be made where this is appropriate. "

The SRCG noted that a worker can refuse medical treatment. Therefore, the preference would be that the wording specifies that the worker has received management under a suitably qualified specialist.

Basis for Recommendation

There was uniform concern by all three doctors, that when a person presents for an impairment assessment, there was often the history of the patient but then limited information as to their general medical condition and cardiac history. Further, there was often limited if any objective evidence as to the nature and extent of any cardiac condition. It being noted that on many occasions persons were presenting for a whole person impairment assessment without having been properly assessed or treated for any cardiac condition before a whole person impairment assessment was requested.

Recommendation 2

This is directed to paragraph 14.2 concerning ranges for impairment values in each category. It was noted that whilst there is reference to clinical judgment having regard to AMA5, and for example, page 30 table 3-5, that where there are wide ranges within, categories there needed to be consideration of both objective clinical data and the functional difficulties that a person describes having regard to page 26, Table 3-1 of AMA5. It being noted that the New York Heart Association classification is considered to be appropriate.

The point being that objective signs and the impact activity as described in the classes (i) to (iv) inclusive of Table 3-1. Need to be considered. A direction for assessors to have regard to both, would assist in assessors more consistently classifying persons within both a class and within a range of that class.

It being noted that the examples in AMA5 were considered to be good examples, but again, it was noted that they provided a range which did not always assist with determining where within a range a person should sit. The synthesis of the factors for assessment being:

1. Taking a comprehensive history as to the effect on a person of the cardiac condition including issues with respect to daily activity. As an example it was considered that if causation was an issue a detailed history concerning what the person was doing at the time of the cardiac event was critical.
2. There would then be regard to objective factors such as the results of testing and monitoring.
3. Taking these objective and subjective features to then look to apply the criteria being a combination of Table 3.1 and the relevant tables within Chapters 3 and 4 of AMA5 depending on the nature of the cardiac condition to be assessed.

Recommendation 3

It was considered that the section regarding exercise stress testing should be expanded to be a Section with respect to testing broadly.

PROVIDED FOR CONSULTATION PURPOSES ONLY

Testing and relevant medical history is considered critical to being able to provide a fair and reasoned assessment.

It was considered that having access to stress test results and other measurements of cardiac function was appropriate.

It was considered that page 121 of the Appendices should be brought in to the chapter where it refers to "Clinical studies and other Tests". It says: "The requestor should ensure that, prior to requesting an assessment, any relevant clinical studies, radiological investigations and tests have been completed and the results forwarded to the assessor with the request for assessment and reports."

It is also recommended that there be reference to providing details of the medication that persons were taking. This being in addition to other forms of treatments being undertaken. It being noted that for example in Class 2 there was reference to the taking of medication, and as well the evidence of dysfunction of the cardiac chamber having regard to the undertaking of testing.

Recommendations regarding other parts of the Chapter

Paragraphs 14.6 and 14.7 were considered to be appropriate.

Pulmonary Embolism

It was agreed that there needed to be a delineation between the respiratory effect of an embolism and its cardiac effect. It being noted, post the meeting that a specific provision has been recommended to be placed in both the Respiratory and Cardiovascular chapters concerning where such an assessment is to be made.

Treatment

Paragraph 14.9 was considered to be appropriate with it being noted that it was unusual for people in the cardiac area not to have had appropriate treatment. There was however discussion in the context of MMI that in some circumstances where treatment had not been undertaken, or was in progress, that it would be appropriate to not assess because MMI had not been reached.

Pre-existing condition

In relation to the issue of pre-existing conditions and any deductions for the same, it was noted that in approaching the relevance of pre-existing conditions, that the methodology would be to assess the person as a whole, and to determine having regard to any pre-existing condition, where it sat within a class rating and to give a percentage impairment to then be deducted.

PROVIDED FOR CONSULTATION PURPOSES ONLY

An example was in Class 1, page 30 AMA5, Table 3-5. If there was evidence of previous valvular heart disease and the person was asymptomatic, then consideration would be had of Class 1, 0%-9% impairment. Regard then being had to such factors as in Table 3-1 in relation to effects on ADL. To then assess a person between 0%-9% depending on those factors. This to then form the basis for a deduction.

A general observation was made that the assessment of prior impairment and making deductions was not considered to be a significant issue for the assessors within the cardiovascular group.

Recommended Testing

It was further recommended that there be an identification in the Chapter of appropriate investigations. The potential wording being:

> "To assess the workers current cardiovascular status appropriate investigations and tests include:
>
> - exercise test for fitness and to detect myocardial ischemia is appropriate when assessing for coronary artery disease.
> - echocardiography is necessary to assess ejection fraction and myocardial function and any valvular heart disease.
> - ambulatory blood pressure recording for the assessment of hypertension - control on current medication.
> - ambulatory ECG for assessment of arrythmias and their control

These tests should be arranged by the worker's general practitioner or cardiologist prior to the assessment and included in the documents forwarded."

The SRCG noted that there may be circumstances where there are already available suitable investigations with the potential to unnecessarily repeat these, or have tests that may not be related to the impairment assessment. The SRCG noted that there may be a training requirement for requestors.

PROVIDED FOR CONSULTATION PURPOSES ONLY

16. Psychiatric disorders chapter - recommendation

Members of the Psychiatric Disorders sub- Committee:

- Dr Michelle Atchison (Facilitator)
- Prof Alexander (Sandy) McFarlane
- Dr Alison Moffatt
- Dr Michael Schirripa – nominated by the Royal Australian and New Zealand College of Psychiatrists – SA Branch (RANZCP)
- Tamara Cavenett, President – Australian Psychological Society

PROVIDED FOR CONSULTATION PURPOSES ONLY

The sub-Committee met on the following dates:

- 8 March 2023
- 22 March 2023

The sub-Committee reviewed Chapter 16 of the Impairment Assessment Guides makes the following recommendations: **[This was provided to the SRCG for consideration on 27 April 2023]**

Recommendation 1

The same Impairment guidelines should be able to be used across platforms, eg RTWSA, Centrelink, NDIS.

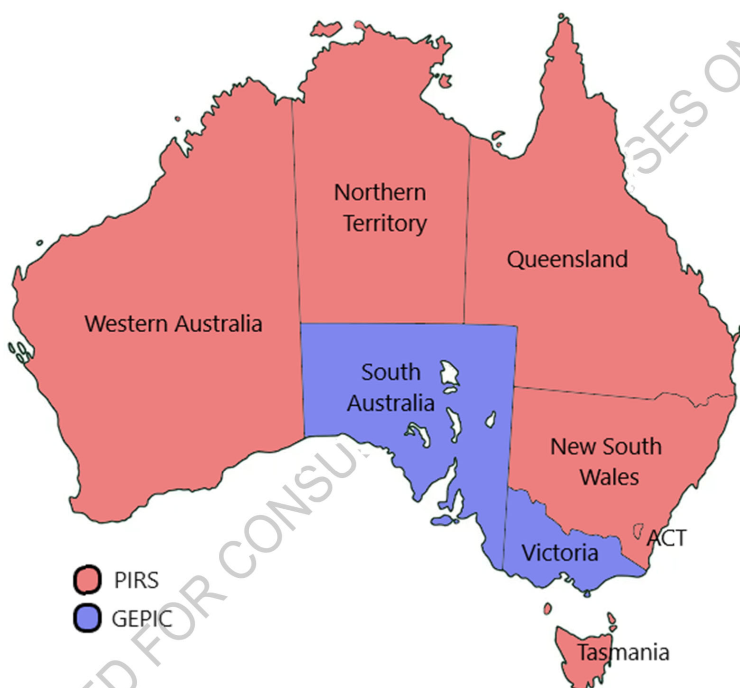
Recommendation 2

In the sub-committee there was general consensus that the GEPIC is flawed. There was not full consensus, with one member preferring the GEPIC model. Issues concerning continuing to use the GEPIC included:

a. The GEPIC rates symptoms, symptoms do not equal impairment.
b. The sub-committee reported on poor inter-rater reliability. Discussion on whether this could be improved with further assessor training.
c. It is not clear where to rate some symptoms, eg dissociative flashbacks, behavioural avoidance. It was clear that some raters have ready access to Dr Epstein (creator of the GEPIC) to ask these questions, but most raters do not.
d. Sometimes not enough information available collaterally or from the worker to come up with a clear rating.

e. Certain psychiatric diagnoses are harder to score highly on the GEPIC, leading to inequity. Some disorders do not include symptoms or phenomena in all of the GEPIC categories, leading to an underestimate of impairment in certain DSM5 disorders.

This led to a discussion of what might replace the GEPIC, including GEPIC plus more training or the PIRS, which was raised as an alternative. There was consensus, but again not full consensus, that the PIRS should be put forward as the preferred rating model.



PROVIDED FOR CONSULTATION PURPOSES ONLY

Recommendation 3

Group would like guidance on what to do if an assessor suspects malingering or has concerns about the correctness of answers. This is a particular issue in psychiatry where the diagnosis and degree of impairment is largely made on the patient's self-reporting. At present it is based on a combination of self-report and observation during the interview. If a decision is made to not rate, what happens then? Should there be a referral to a clinical psychologist for assessment of ?malingering.

Recommendation 4

Impact of prior mental harm. Group agreed there should be no deduction if there is no previous impairment, but need to have the best information on level of functioning and symptoms prior to the work injury, including GP reports or contemporaneous accounts.

Recommendation 5

Maximum medical improvement: Consensus that psychiatric illnesses often take longer than two years to reach MMI. Because of this it is important to identify any psychiatric work injury early and refer for appropriate treatment as early as possible. The recommendation is to assess and treat as soon as a work related psychiatric injury is identified.

PROVIDED FOR CONSULTATION PURPOSES ONLY

Recommendation 6

The group agreed that having more than one assessment by different assessors helps to achieve a good consensus in rating.

Recommendation 7

More than one physical injury can be added together, but not more than one psychiatric injury. This points to discrimination in the Act against psychiatric injuries.

Recommendation 8

Discussion around the role of the treating psychiatrist in assessments. It is recognised that not all workers will have a treating psychiatrist and that the independent examiner must come to their own conclusion about diagnosis. Where possible, the examiner should have a report from the treating psychiatrist and at times a phone discussion is helpful for the assessor. Agreement that it is helpful for the assessor to have information from the treating psychiatrist but that the treating psychiatrist may not want to jeopardise the therapeutic relationship by being involved. If the treating psychiatrist does not want to be part of the discussion, the assessor should continue with the assessment with the information they have.

Recommendation 9

Discussion around the use of a % cut off to describe a seriously injured worker. The committee also noted that it should not be assumed that a PIRS rating of 30% is equivalent to a GEPIC rating of 30%, potentially leading to discrimination against injured workers if a new rating system is used.

Additional documents circulated and considered by the sub-Committee

- A McFarlane, "The International Classification of Impairments, Disabilities and Handicaps: Its usefulness in classifying and understanding biopsychosocial phenomena".
- RANZCP Civil Forensic Group SA Feedback on the 2021 Consultation for the proposed Second Edition changes to the Impairment Assessment Guidelines (2021) .
- Suicide the constant Battle. Investigation into suicides of Australian veterans. Senate of Australia.2016.
- RACP Australasian Faculty of Occupational and Environmental Medicine "It Pays to Care: Bringing Evidence-Informed Practice to Work Injury Schemes Helps Workers and their Workplaces: an imperative for change and call to action" (April 2022)
- Senate Report from the Education and Employment References Committee, "Report on Mental Health of First Responders" (February 2019)
- Investigation into the management of complex workers compensation claims and WorkSafe oversight - Victorian Ombudsman Compensation Enquiry (September 2016)
- NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment, Psychiatric and Psychological Disorders

PROVIDED FOR CONSULTATION PURPOSES ONLY

16. Psychiatric and psychological disorders – draft chapter

AMA5 chapter 14 is excluded and replaced by this chapter. This chapter is based on the *Guide to the Evaluation of Psychiatric Impairment for Clinicians* (GEPIC) written by Dr Michael Epstein, Dr George Mendelson and Dr Nigel Strauss assisted by members of the Victorian Medical Panel.

Before undertaking an impairment assessment, users of the Guidelines must be familiar with the following (in this order):

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

Introduction

16.1 This chapter sets out the method for assessing psychiatric impairment. The evaluation of impairment requires a medical examination by an accredited Psychiatrist.

16.2 Evaluation of psychiatric impairment is conducted by a psychiatrist who has undergone appropriate training in the assessment method and is accredited under the Act. Where possible there should be a discussion with the treating Psychiatrist. If the treating Psychiatrist does not want to be part of the discussion, the Assessor should continue with the assessment with the information that they have.

16.3 A psychiatric disorder (the term is synonymous with a mental disorder or a psychological disorder) is a syndrome characterised by clinically significant disturbance in an individual's cognition, emotion regulation or behaviour that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational or other important activities. An expected or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above (adapted from DSM5).

16.4 Prior to assessment, the worker must have had a psychiatric diagnosis, made by the treating psychiatrist, based on the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and the condition must have reached maximum medical improvement (MMI - refer introduction 1.13-1.14). The disorder must be accepted as work related.

Commented [A9]: Corrected spelling

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

16.6 Impairment resulting from physical injury is to be assessed separately from impairment relating to psychiatric injury.

16.7 In assessing the degree of impairment resulting from physical injury or psychiatric injury, no regard is to be had to impairment that results from consequential mental harm.

[Clauses 16.8 to 16.22, which are the GEPIC method of assessment, have been removed and replaced with the PIRS assessment method from the NSW Guidelines.]

Co-morbidity

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

Psychiatric impairment rating scale (PIRS)

Commented [A10]: Removed GEPIC tool and worksheet being clauses 16.8 – 16.22, and replaced with PIRS at clauses 16.8 – 16.18 and PIRS worksheet

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

1. Self care and personal hygiene (Table 16.1)
2. Social and recreational activities (Table 16.2)
3. Travel (Table 16.3)
4. Social functioning (relationships) (Table 16.4)
5. Concentration, persistence and pace (Table 16.5)
6. Employability (Table 16.6).

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

PROVIDED FOR CONSULTATION PURPOSES ONLY

Table 16.1: Psychiatric impairment rating scale - self care and personal hygiene

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

PROVIDED FOR CONSULTATION PURPOSES ONLY

Table 16.2: Psychiatric impairment rating scale - social and recreational activities

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

Table 16.3: Psychiatric impairment rating scale - travel

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

Table 16.4: Psychiatric impairment rating scale - social functioning

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

PROVIDED FOR CONSULTATION PURPOSES ONLY

Table 16.5: Psychiatric impairment rating scale - concentration, persistence and pace

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

PROVIDED FOR CONSULTATION PURPOSES ONLY

Table 16.6: Psychiatric impairment rating scale – employability

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

Class 4	Severe impairment: cannot work more than one or two days at a time, less than 20 hours per fortnight. Pace is reduced, attendance is erratic.
Class 5	Totally impaired: Cannot work at all.

Using the PIRS to measure impairment

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

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

Determining the median class score

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

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

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

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

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

PROVIDED FOR CONSULTATION PURPOSES ONLY

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

Median class score and percentage impairment

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

Class 1 = 0 - 3%

Class 2 = 4 - 10%

Class 3 = 11 - 30%

Class 4 = 31 - 60%

Class 5 = 61 - 100%

Calculation of the aggregate score

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

PROVIDED FOR CONSULTATION PURPOSES ONLY

Use of the conversion table to arrive at percentage impairment

16.16 The aggregate score is converted to a percentage score using the conversion Table 16.7, below.

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

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

Table 16.7: Conversion table

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

Conversion table — explanatory notes

a. Distribution of aggregate scores

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

- The conversion table distributes the impairment percentages across aggregate scores.

b. Same aggregate score in different classes

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

Examples: ~~(Using the previous cases)~~

Example A

PIRS scores / Median Class

1	2	3	3	4	5		= 3

Aggregate score / Total / % impairment

1 +	2 +	3 +	3 +	4 +	5	= 18	22%

Example B

PIRS scores / Median Class

1	2	2	3	3	4		= 3

Aggregate score / Total / % impairment

1 +	2 +	2 +	3 +	3 +	4	= 15	15%

PROVIDED FOR CONSULTATION PURPOSES ONLY

Example C

PIRS scores | | | | | | Median Class

1	2	3	5	5	5	= 4

Aggregate score | | | | | | Total | % impairment

1 +	2 +	3 +	5 +	5 +	5	= 21	44%

PROVIDED FOR CONSULTATION PURPOSES ONLY

Consultation on the Impairment Assessment Guidelines

Provided for consultation purposes only

Stakeholder Representative Consultation Group