

EXPLANATORY STATEMENT

Issued by the authority of the Minister for Social Services

Social Security Act 1991

Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2023

GENERAL MATTERS

Purpose and operation

The *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2023 (Determination)* sets out the rules decision-makers must use when assessing a person's work-related impairment for the disability support pension under the *Social Security Act 1991 (Act)*.

A critical element of qualification for disability support pension is that a person must have a physical, intellectual or psychiatric impairment and a total impairment rating of 20 points or more under the impairment tables (Tables). This Determination provides the Tables for that purpose.

Commencement

This instrument commences on 1 April 2023. It applies to claims for disability support pension made on or after 1 April 2023 (Act, section 27).

The Secretary must apply the *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011 (2011 Determination)* to any claim for disability support pension made, or taken to have been made, on or before 31 March 2023.

Rules for applying the Impairment Tables

Part 2 describes the application of the Tables.

Impairment Tables

The Tables are contained in Part 3 of the Determination. There are 15 Tables intended to assess impairment in relation to work. Ratings depend on the level of impairment on function as it relates to work performance.

- Table 1 - Functions requiring Physical Exertion and Stamina
- Table 2 – Upper Limb Function
- Table 3 – Lower Limb Function
- Table 4 – Spinal Function

- Table 5 – Mental Health Function
- Table 6 – Functioning related to Alcohol, Drug and Other Substance Use
- Table 7 – Brain Function
- Table 8 – Communication Function
- Table 9 – Intellectual Function
- Table 10 – Digestive and Reproductive Function
- Table 11 – Hearing and other Functions of the Ear
- Table 12 – Visual Function
- Table 13 – Contenance Function
- Table 14 – Functions of the Skin
- Table 15 - Functions of Consciousness.

Sunsetting

The 2011 Determination was due to sunset on 1 April 2022. The *Legislation (Deferral of Sunsetting – Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011) Certificate 2022* deferred this to 1 April 2023.

This instrument replaces the 2011 Determination, but is generally based upon the wording of the 2011 Determination. It includes a number of changes to ensure the Tables and rules to improve the consistency between Tables, clarify policy intent and reflect relevant advances in medical technology, assessments and terminology.

Disallowance

The Determination is a legislative instrument for the purposes of the *Legislation Act 2003* and subject to disallowance.

Provision-by-provision explanation

An explanation of the purpose and scope of each clause and each Table in the instrument commences from page 18.

Legislative authority

The Determination is made under subsection 26(1) of the Act. The Minister has the power to determine tables relating to the assessment of work-related impairment for disability support pension by legislative instrument.

The Minister may also determine the rules to be complied with in applying the Tables (subsection 26(3)). The instrument may contain such ancillary or incidental provisions

relating to the Tables and the rules, as the Minister considers appropriate (subsections 26(2) and 26(4)).

The Determination relies on the *Acts Interpretation Act 1901* (subsection 33(3)) for its authority to repeal the 2011 Determination.

Consultation

The department undertook a review of the 2011 Determination, including extensive consultation with a range of stakeholders to inform the development of the Determination. Consultations were multi-phased allowing feedback on both the 2011 Determination and Exposure Draft of the Determination.

Consultation – Phase 1

Four stakeholder consultation streams were identified and, where applicable, contacts established to ensure a broad and comprehensive representation on issues and to inform potential amendments on to the Impairment Tables. These were:

- Disability peak bodies and advocacy groups
- Medical professionals
- People with lived experience of disability
- Internal Government stakeholders (for example, Services Australia).

The department released an issues paper on its Engage website in early June 2021 (see: <https://engage.dss.gov.au/review-of-the-disability-support-pension-dsp-impairment-tables/>). The issues paper provided a broad overview of the review process, key issues previously raised by stakeholders and background information on the 2011 review of the Impairment Tables.

Accessible versions of the issues paper were made available on the Engage website including audible PDF, EasyRead and Auslan.

Disability peak bodies and the department's Community Services Advisory Group (CSAG) members were advised of the review and the publication of the issues paper on the Engage Platform on 3 June 2021 via email. Stakeholders and interested parties were able to contribute to the review by either completing the guided questionnaire on the Engage website, or by lodging a written submission to the department. The department received 80 submissions during the first phase of consultation on Engage.

In the development of the Determination, the department also considered feedback related to the Impairment Tables contained in submissions to the Senate Standing Committee on Community Affairs Inquiry into the Purpose, Intent and Adequacy of the Disability Support Pension (Senate Inquiry), as well as evidence presented at public hearings.

The department also held a series of video conferences with disability peak bodies and advocacy groups that were members of the CSAG and Services Australia's Civil Society Advisory Group. The peak bodies consulted were:

- Anglicare
- Australian Council of Social Service
- Australian Federation of Disability Organisations
- Baptist Care Australia
- Blind Citizens Australia
- Carers Australia
- Children and Young People with Disability
- Council on the Ageing
- Disability Advocacy Network Australia
- Down Syndrome Australia
- Economic Justice Australia
- Federation of Ethnic Communities Councils of Australia
- Inclusion Australia
- Mission Australia
- National Aboriginal Community Controlled Health Organisation
- National Disability Services
- National Ethnic Disability Alliance
- People with Disability Australia
- Salvation Army
- Southern Youth and Family Services Association
- St Vincent de Paul Society.

A dedicated lived experience consultation was established and one-on-one consultations conducted by the Content Group Pty Ltd, who conducted consultations with participants in a manner that best suited the individual's needs. 25 individuals participated via one-on-one interviews (with a support person if requested) and 2 submitted written responses. De-identified transcripts were then provided to the department.

A targeted consultation period with medical experts, on specific issues raised through consultations, then commenced either via video conference and/or written correspondence.

Medical bodies consulted (on issues relevant to their area of expertise) during this phase were:

- Arthritis Australia
- Australian Association of Psychologists Incorporated
- Australian and New Zealand Society of Nephrology
- Australian Medical Association
- Australian Physiotherapy Association
- Autism Spectrum Australia
- Associate Professor Jacqui Hughes, Menzies Centre
- Cancer Council
- Oncology Social Work Australia and New Zealand
- Ehlers-Danlos Australia
- Epilepsy Australia
- ME/CFS Australia Ltd
- ME/CFS and Lyme Association of WA Inc.
- National Aboriginal Community Controlled Health Organisation
- National Organisation for Fetal Alcohol Spectrum Disorder Australia
- Occupational Therapy Australia
- Pain Management Research Institute
- Royal Australian College of General Practitioners
- Royal Australasian College of Physicians
- Royal Australian and New Zealand College of Psychiatrists
- Speech Pathology Australia
- Tourette Syndrome Association of Australia.

Consultation – Phase 2

The department released the Exposure Draft and accompanying explanation paper on the department's Engage website on 19 October 2022 (see: <https://engage.dss.gov.au/proposed-changes-to-the-disability-support-pension-dsp-impairment-tables/>). The explanation paper

highlighted key changes to the Impairment Tables and how they would impact disability support pension claimants.

Accessible versions of the explanation paper were made available on the Engage website including audible PDF, EasyRead and Auslan.

Stakeholders and interested parties were able to contribute to the review by completing a guided questionnaire and several also took the opportunity to provide a written submission. The department received 272 responses to the online questionnaire and 8 written submissions.

The department also held one-on-one meetings with stakeholders on specific issues.

As part of this phase of consultation, the department invited disability peak bodies and members of their CSAG and the Services Australia Civil Society Advisory Group to participate in town hall style meetings to provide feedback on the Exposure Draft. Based on stakeholder preferences, one video conference and one face-to-face meeting in Sydney were held. Stakeholders that participated in these meetings included:

- Anglicare
- Australian Council of Social Service
- Australian Federation of Disability Organisations
- Carers Australia
- Council on the Ageing
- Illawarra Legal Centre
- Inclusion Australia
- National Disability Services
- National Ethnic Disability Alliance
- People with Disability Australia
- Social Security Rights Victoria
- St Vincent de Paul Society
- Welfare Rights Centre.

In addition the Minister for Social Services, the Hon Amanda Rishworth MP, conducted a Roundtable discussion with senior representatives of disability peak bodies, the CSAG and the Services Australia Civil Society Advisory Group. Organisations that attended the discussion were:

- Anglicare

- Australian Council of Social Service
- Carers Australia
- Children and Young People with Disability Australia
- Council on the Ageing
- Disability Advocacy Network Australia
- Economic Justice Australia
- Inclusion Australia
- National Aboriginal Community Controlled Health Organisation
- National Ethnic Disability Alliance
- People with Disability Australia
- St Vincent de Paul Society
- Uniting Care Australia.

In the October 2022 Budget, the Government reversed the measure to remove Table 6 - Functioning related to Alcohol, Drug and Other Substance Use. To ensure Table 6 is fit for purpose and accurately captures the functional impacts of substance use disorders, the department consulted extensively with the Australian Alcohol and Other Drugs Council (AADC) via video conferences and written correspondence. The Foundation for Alcohol Research and Education (FARE) and specialist addiction clinicians were also involved in these discussions, as invited by AADC.

Further, to ensure the breadth of functional impairments experienced by those with neurodiverse conditions were captured in the Tables, particularly Table 7 – Brain Function, the department consulted with Autism Spectrum Australia and the Australian Psychological Society via video conference and written correspondence.

The department consulted with Services Australia Assessment Services and Health Professional Advisory Unit staff throughout the drafting process, drawing on their extensive experience in the application of the Tables. These experienced Health and Allied Health Professionals include:

- Medical practitioners
- Psychologists
- Physiotherapists
- Occupational Therapists
- Registered Nurses

- Exercise Physiologists
- Social Workers
- Rehabilitation Counsellors

Statement of compatibility with human rights

A statement of compatibility commences from page 70.

COMMON INSTRUMENT SPECIFIC MATTERS

Availability of independent merits review

A decision on the assessment of a claimant's qualification for disability support pension, which involves an assessment of the person's work-related impairment covered by this Determination, is subject to internal and external merits review under the *Social Security (Administration) Act 1999* (Parts 4 and 4A).

Incorporation of documents by reference

The Determination does not incorporate documents by reference.

Regulatory Impact Statement

The Determination does not require a Regulatory Impact Statement (Reference OBPR23-04167). It is not regulatory in nature nor will it affect business activity. It will have no, or minimal, compliance cost or competition impact.

EXPLANATION OF PROVISIONS

The Determination comprises three parts:

- Part 1 – Preliminary
- Part 2 – Rules for applying the Impairment Tables
- Part 3 – The Tables.

Part 1 - Preliminary

Section 1

This section provides that the name of the Determination is the *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2023*.

Section 2

This section provides that the Determination shall commence on 1 April 2023.

Section 3

This section provides that the legislative authority for making the Determination is subsection 26(1) of the Act.

Section 4

This section provides that each instrument specified in a Schedule to this instrument is amended or repealed, as set out in the applicable items in the Schedule concerned. Any other item in a Schedule to this instrument has effect according to its terms.

Section 5

This section provides the meaning of terms used in the Determination.

Act means the *Social Security Act 1991*.

appropriately qualified medical practitioner means a medical practitioner whose qualifications and practice are relevant to diagnosing a particular condition. The Act defines medical practitioner (subsection 23(1)).

assistance means assistance from another person rather than any aids, equipment or assistive technology the person may use, unless specified otherwise.

condition means a diagnosed medical condition or disorder.

descriptor means the information set out under the column headed “Descriptors” in each Table set out in Part 3 of this instrument, describing the level of functional impact resulting from a condition.

health or allied health practitioner includes, but is not limited to, chiropractor, exercise physiologist, physiotherapist, psychologist, occupational therapist, osteopath, pharmacist, podiatrist, rehabilitation counsellor or registered nurse.

health professional means an appropriately qualified medical practitioner or an allied health practitioner.

impairment means a loss of functional capacity affecting a person's ability to work that results from the person's condition.

impairment rating is the number in the column in a Table headed "Points" corresponding to a descriptor, which are set out in Part 3 of this instrument.

significant functional improvement is improvement that is likely to enable the person to undertake work in the next 2 years.

Tables means the tables relating to the assessment of work-related impairment for disability support pension which are set out in Part 3 of this instrument.

treating doctor means the medical practitioner who has, or has had, the responsibility for the treatment of a person's condition.

Section 6

This section provides an overview of the interaction between the Rules for applying the Impairment Tables (Part 2) and the Tables (Part 3).

Part 2 – Rules for applying the Impairment Tables

Part 2 (sections 7 to 13) contain the rules for applying the Tables to assess a person's work-related impairment for disability support pension.

Section 7

This section provides the principles that inform the design of the Tables and their scaling system and descriptors. The Tables are only to be applied to assess whether a person satisfies the qualification requirement for disability support pension in paragraph 94(1)(b) of the Act, and for no other purpose, unless authorised by law. No other use of the Tables is currently authorised.

The Tables are function based rather than diagnosis based. For example, a diagnosis of a condition that does not result in a functional impact will result in the person not being assigned points under a Table.

The Tables describe functional activities, abilities, symptoms and limitations against which a person's impairments are to be assessed in order for an impairment rating to be assigned.

The Tables are designed to assign ratings to determine the level of functional impairment, rather than to assess a person's conditions/s. The functional capacity change may result from the condition, but it is the level of impairment which must be assessed.

The Tables contain descriptors. Where a descriptor applies in relation to an impairment, a rating can be assigned to the impairment.

The italicized first line of each descriptor describes the level of impairment to be identified by reference to the particular functional activities, abilities, symptoms and limitations contained in the numbered paragraphs below it.

Section 8

This section provides guidance as to the application of the Tables to assess the level of a person's functional impairment and assigning impairment ratings.

When assessing a person's functional capacity, an assessment of their impairment must be made on the basis of what a person can, or could do, not on the basis of what the person chooses to do or what others do for the person. It is not appropriate to rely on the person's own assessment of their ability to perform tasks or activities. Nor is it appropriate to rely on domestic arrangements, which may reflect cultural traditions regarding the performance of activities and not the person's abilities. Corroborating evidence is required.

Before assigning an impairment rating, a person's condition must meet the requirements as set out in the Determination. That is their condition must be diagnosed, reasonably treated, stabilised, and in light of available evidence likely to persist for more than 2 years. This Determination no longer uses the expression 'permanent' to describe whether a person has met these requirements, and amends the language used to describe diagnosis, treatment and stabilisation of a condition.

The legislative requirement that a condition be ‘fully’ diagnosed, treated and stabilised overstated the actual requirements. For example, guidance provided around a person’s condition being ‘fully treated’ has only required a person to undertake ‘reasonable treatment’ not ‘full treatment’. These amendments align the language of the provision with the practical application of each eligibility requirement and do not change the threshold an individual must meet.

A condition must be diagnosed by an appropriately qualified medical practitioner and supported by corroborating evidence. Where there is no corroborating evidence, or where medical evidence is contradictory to the diagnosis a condition cannot be considered diagnosed for the purpose of this Determination. In some cases, a diagnosis must be supported by evidence from another health professional as specified in the relevant Table.

The reason for this is to ensure that the person has received the necessary diagnostic input and associated treatment considerations. In these instances it is sufficient to consider clear indications that this has occurred where this information is contained within the medical records provided by the claimant or, where necessary, verbal confirmation of this by the medical practitioner at follow up, which must be clearly documented by the assessor.

When assessing whether a person’s condition has been reasonably treated, reasonable treatment may include medical treatment and therapy involving rehabilitation to restore mental or physical function.

Generally, a condition may not be considered reasonably treated if the person is awaiting surgery or undergoing treatment. However, a condition may be considered reasonably treated if:

- the time taken to complete treatment that is planned or underway is over two years

[For example, a person with a degenerative joint condition with symptoms of knee pain is on a wait list for surgery. The waiting time for surgery and time for rehabilitation will take over two years. Whilst the treatment should significantly improve the impairment, this will not occur within 2 years].

- the person’s functional capacity will not improve within the next two years even if the person continues to receive reasonable treatment

[For example, a person with severe burns needs to undertake a series of skin grafts over more than two years. Significant functional improvement is not expected within the next two years].

Generally, a condition may not be considered reasonably treated if the person has refused to undertake or persist with treatment. However, a condition may be considered reasonably treated if the person has not proceeded with treatment including because:

- the person has religious or cultural beliefs that prohibit treatment
- the person lacks insight or the ability to make appropriate judgements due to their medical condition and is unlikely to comply with treatment
- there are medical reasons for not pursuing treatment
- significant functional improvement is not expected.

The Determination sets out what constitutes reasonable treatment for the purposes of disability support pension qualification. Reasonable treatment means treatment:

- that is available at a location reasonably accessible to the person
- that is at a reasonable cost
- can reliably be expected to result in a significant functional improvement
- that is of a type regularly undertaken or performed
- that has a high success rate
- that carries a low risk to the person.

In determining whether a condition is stabilised, consideration must be given to whether or not a person has undertaken reasonable treatment, and whether any further reasonable treatment is likely to result in significant functional improvement.

A condition may be stabilised where:

- the person is in receipt of, or has undertaken reasonable treatment for the condition and any further reasonable treatment is unlikely to result in significant functional improvement
- medical evidence indicates the condition is likely to fluctuate or is episodic in nature, and the person is receiving reasonable treatment that is unlikely to result in significant functional improvement
- the person's condition is deteriorating, their prognosis is poor, significant functional improvement is not expected and active treatment is no longer effective or is no longer indicated.

A condition is not stabilised where:

- medical evidence indicates the condition is likely to persist for more than 2 years but indicates significant functional improvement is likely
- an episodic or fluctuating condition (such as epilepsy, for example) can be significantly improved through further medical treatment such that the person can control the condition and reduce the frequency of episodes. This could involve improving treatment compliance and adjusting the dosage or type of medication to reduce side effects or improve therapeutic effect.

When assessing the functional impact of pain, acute pain does not give rise to an impairment that should be assessed under the Tables.

Chronic pain may be a standalone diagnosis or a symptom of another condition (such as rheumatoid arthritis). Where chronic pain results in an impairment, this should be assessed using the Table relevant to the area of function affected.

Section 9

This section provides for information that must be considered when applying the Tables including:

- information provided by the health professionals specified in the introductions to the Tables
- any additional medical or work capacity information that may be available
- any information that is required to be taken into account under the Tables themselves.

It also provides that a person may be asked to demonstrate abilities described in the Tables. For example, bending forward to pick up a light object to assess spinal function in Table 4.

Section 10

This section sets out information that must not be considered in applying the Tables.

While the Tables allow for self-report of symptoms, this can only be taken into account where there is corroborating medical evidence. The Tables give examples of corroboration which is suitable.

The impact of non-medical factors, unless required under the Tables, may not be taken into account. This includes age, gender, level of education, and social or domestic situation.

Section 11

This section provides for the assessment of a person's impairment when they are using or wearing any aids, equipment and assistive technology that the person usually uses. It also requires that if the person could reasonably access aids, equipment or assistive technology, their impairment is assessed taking these aids into account. If a person needs, but does not have, aids, equipment and assistive technology, and cannot reasonably access them, they are to be assessed without it.

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

Example: A person's impairment attracts 20 points under Table 8 - Communication Function, where the person uses an electronic communication device (which produces electronic speech) and needs to use this technology to communicate with others in places such as shops, workplace, education or training facilities and cannot be understood without this device.

Section 12

This section contains rules for selecting the applicable Impairment Table and assessing impairments.

The following steps are required when selecting the relevant Table and identifying the level of impairment:

- identify the loss of function; then

- refer to the Table related to the function affected; then
- identify the correct impairment rating by reference to the descriptors in the Table.

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

When identifying the loss of function, consideration should be given to the ongoing side effects of prescribed medication and treatment when the impairment from, or related to, the side effects is not expected to significantly improve.

The rules contained in this section reinforce the concept that the Tables are designed to assess a person's impairment and not their conditions.

Where a single condition causes multiple impairments, those impairments should be assessed separately using the most appropriate Table.

Where multiple conditions cause a common impairment, that impairment is to be assessed under a single Impairment Table. Because the Tables are function based and not condition based, where this occurs, only one relevant Table should be applied and a single impairment rating assigned to reflect the combined impairment. A separate impairment rating for each medical condition would result in the same impairment being assessed more than once (i.e. double counting).

Only the impairment ratings as set out in the Tables of 0, 5, 10, 20 or 30 can be assigned.

These provisions also contain rules for how to determine the appropriate impairment rating. An impairment rating must not be assigned unless all the required descriptors for that level of impairment are satisfied. Some descriptors may indicate that a minimum number of at least one or more of the descriptors must apply to a person.

In all cases, the required number of descriptors in a rating level must be met before a higher level rating can be considered.

When assessing whether a person can perform an activity described in a descriptor, the descriptor applies where the person can complete or sustain that activity when they would be expected to do so and not only once or rarely. Consideration should be given to where a person performs a certain activity because they have to (i.e. they need assistance but do not have anyone to assist them), and the impact of any subsequent symptoms experienced as a result of performing that activity. It would not be reasonable to determine that a person who pushes themselves to perform the activity, despite the adverse consequences of doing so, is capable of completing or sustaining an activity.

When assessing impairments of a fluctuating or episodic nature, an impairment rating must be assigned that is reflective of the person's overall functional ability, taking into account the severity, frequency and duration of the episodes or fluctuations as appropriate.

The Determination provides specific rules about how to assess impairments, including how to deal with episodic and fluctuating presentation. The presentation of a person on the day of assessment should not be solely relied upon.

Where a person's condition results in no or minimal functional impact, the impairment should be assessed at the 0 rating.

The allocation of 0 points does not necessarily mean that there is no functional impact whatsoever. It may mean that the descriptors for an impairment rating of 5 points have not been met, and therefore the 0 rating applies. This has been reflected with the addition of the words 'or minimal' at the 0 point impairment rating level.

The Impairment Tables

Each individual Table contains a set of rules for applying that specific Table for the purposes of subsection 26(3) of the Act.

Typically, these rules, which are set out in the introduction of each Table:

- specify the area of function to which that Table should be applied;
- specify which medical practitioner can diagnose conditions causing functional impairment to be assessed under that Table;
- instruct that self-report of symptoms (by the person who is being assessed) is to be supported by corroborating medical evidence;
- provide examples of corroborating evidence that can be taken into account when applying that Table and who can provide it.

Examples of corroborating evidence in the introduction to each Table include information about the type of evidence that can be taken into account and, where appropriate, an indication of the diagnosis of conditions that are commonly associated with an impairment to be assessed under that Table.

The rating system is standardised across the Tables as follows:

- no or minimal functional impact equals an impairment rating of 0 points;
- mild functional impact equals an impairment rating of 5 points;
- moderate functional impact equals an impairment rating of 10 points;
- severe functional impact equals an impairment rating of 20 points; and
- extreme functional impact equals an impairment rating 30 points.
- After the introduction to each Table, each Table is divided into two columns. The first column sets out impairment ratings under the heading ‘Points’. The second column sets out the level of impact of the impairment to be identified by the level of functional activity, abilities, symptoms and limitations contained in the criteria of the descriptors.

The Tables also contain examples of the application of the descriptors. These examples are illustrative only, and are not binding or exhaustive. It is the criteria of the descriptors themselves that must be considered.

Table 1 – Functions requiring Physical Exertion and Stamina

Summary

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

Non-pathological causes such as lack of fitness that are not associated with a condition should not be assessed using Table 1.

Restrictions on physical activities due to musculoskeletal conditions, e.g. arthritis or spinal problems, should not be assessed under Table 1 unless the musculoskeletal Tables 2, 3 or 4 do not sufficiently capture the impairment from any associated impact on physical exertion or stamina. Conditions causing impairment commonly assessed using Table 1 include but are not limited to:

- ischaemic heart disease or coronary artery disease with exercise induced angina
- cardiac disease which has resulted in chronic cardiac failure, such as cardiomyopathy or some cardiac valvular conditions
- cardiac arrhythmias that result in exercise induced restrictive symptoms
- chronic obstructive pulmonary disease (COPD)
- restrictive lung disorders
- exercise induced asthma
- autoimmune conditions such as systemic lupus erythematosus (SLE) and rheumatoid arthritis which impact a person's physical exertion or stamina and no other Table sufficiently captures the impairment
- myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS)
- fibromyalgia
- lymphoedema
- chronic pain
- renal failure
- diabetes mellitus.

Introduction

The introduction sets out rules for Table 1.

Diagnosis and Evidence

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

As with all Tables, a self-report of symptoms alone is insufficient and must be supported by corroborating medical evidence.

The introduction to Table 1 provides for examples of corroborating evidence which include, but are not limited to:

- a report from the person's treating doctor;
- a report from a medical specialist confirming diagnosis of conditions commonly associated with cardiac or respiratory impairment (such as cardiac failure, cardiomyopathy, ischaemic heart disease, chronic obstructive airways/pulmonary disease, asbestosis, mesothelioma, or lung cancer);
- a report from a medical specialist confirming the diagnosis of conditions commonly associated with fatigue or exhaustion (such as diabetes mellitus, renal failure, end stage organ failure, widespread/metastatic cancer, chronic pain, myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), lymphoedema and fibromyalgia), and providing details of treatment, functional impact and prognosis;
- results of exercise, cardiac stress, treadmill testing or actimetry linked blood pressure and heart rate monitoring.

Relevant changes from the 2011 Determination include the removal of 'chronic pain' from a medical specialist report confirming the diagnosis of conditions commonly associated with cardiac or respiratory impairment. This follows advice from pain experts that it is not an appropriate example for that point.

New examples of conditions commonly associated with fatigue or exhaustion have been added such as myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), and a specific reference has been made to the relevant report providing details of treatment, functional impact and prognosis. Actimetry linked blood pressure and heart rate monitoring has also been added as an example of relevant testing. These changes provide greater clarity of the types of conditions that are likely to lead to impairments assessed under this Table, and greater clarity about the corroborating evidence for a diagnosed, reasonably treated and stabilised condition.

Table 1 – Impairment Rating – 0 Points

The first row of Table 1 provides for the descriptor “*There is **no or minimal** functional impact on activities requiring physical exertion or stamina*” leading to 0 impairment points.

The descriptor adds a new point under paragraph (1)(c) which provides that the person will meet the descriptor if the person can undertake personal care activities such as showering or bathing, and undertake a full range of activities in the same day. The addition of impacts on personal care activities have been added to the Table based on the recommendation of health and allied health professionals.

Table 1 – Impairment Rating – 5 Points

The second row of Table 1 provides the descriptor “*There is a **mild** functional impact on activities requiring physical exertion or stamina*” leading to 5 impairment points.

For this rating to be assigned to a person, the person must meet at least one of the criteria in subparagraphs (1)(a)(i) or (ii), and must also meet the descriptor in paragraph (1)(b).

The reference to ‘cardiac’ in relation to pain has been removed as pain experts suggested it was not appropriate. This has been extended to the 10, 20 and 30 point descriptors. Chronic fatigue experts also indicated post-exertional malaise should be listed as a symptom at paragraph (1)(a) and it’s equivalents under the 10, 20 and 30 point descriptors. The reference to equivalent assistance technology is intended to capture advancements that may occur in assistive technology. This has been extended to the 10, 20 and 30 point descriptors. Upon reviewing the examples of activities provided within the Tables, a rebalancing was required to ensure these examples reflected an appropriate level of metabolic equivalent of task (MET) for the relevant impairment rating. For example, the action of changing sheets at subparagraph (1)(a)(ii) is more appropriate at the moderate impairment level, rather than the mild impairment level, based on the activities MET value.

Table 1 – Impairment Rating – 10 Points

The third row of Table 1 provides for the descriptor “*There is a **moderate** functional impact on activities requiring physical exertion or stamina*” leading to 10 impairment points.

For this rating to be assigned to a person, the person must meet at least one of the criteria in subparagraphs (1)(a)(i), (ii) or (iii), and must also meet the criteria in both subparagraph (1)(b)(i) and (ii).

Paragraph (1)(a) now provides for ‘moderate’ shortness of breath, better reflecting the level of impairment at this rating. As indicated above, the example of changing the sheets has been moved to the 10 point impairment rating following advice from health and allied health practitioners that this was a more appropriate example for a moderate impairment based on the MET rating for this task.

A new descriptor point in relation to personal care activities has been added at subparagraph (1)(a)(iii) to better capture the breadth of impacts of fatigue related conditions for a 10 point impairment rating.

Table 1 – Impairment Rating – 20 Points

The fourth row of Table 1 provides for the descriptor “*There is a **severe** functional impact on activities requiring physical exertion or stamina*” leading to 20 impairment points.

For this rating to be assigned to a person, the person must meet at least one of the criteria in subparagraphs (1)(a)(i), (ii), (iii) or (iv), and must also meet the criteria in paragraph (1)(b).

Paragraph (1)(a) now provides for ‘severe’ shortness of breath, better reflecting the level of impairment at this rating. Subparagraph (1)(a)(i) and (1)(a)(ii) have been merged to create a single descriptor as they were considered duplicative. Examples of going to a person’s local shops or supermarket, workplace, education or training campus have also been added.

Subparagraph (1)(a)(iii) now expands to acknowledge a person does not require a long recovery period after performing an activity, and the example has been expanded to include the additional daily activities of preparing a simple meal and dusting.

A new descriptor point in relation to personal care activities has been added at subparagraph (1)(a)(iv) to better capture the breadth of impacts of fatigue related conditions for a 20 point impairment rating.

The reference at paragraph 1(b) to a ‘continuous’ work shift of 3 hours has been removed and the descriptor now refers to ‘a shift of at least 3 hours’.

Table 1 – Impairment Rating – 30 Points

The fifth row of Table 1 provides for the descriptor “*There is an **extreme** functional impact on activities requiring physical exertion or stamina*” leading to 30 impairment points.

For this rating to be assigned to a person, the person must meet at least one of the criteria in paragraphs (1)(a), (b), (c) or (d).

Paragraph (1)(d) has been added based on feedback from chronic fatigue experts. Being bedbound should not just be considered point in time, rather in respect of the purposes of the Tables and the 30 point impairment rating, it should be understood to indicate the likelihood of being bedbound for a significant period of time (i.e. significant functional improvement is unlikely to occur over the next two years).

A new descriptor point in relation to personal care activities has been added at paragraph (1)(c) to better capture the breadth of impacts of fatigue related conditions for a 30 point impairment rating.

Table 2 – Upper Limb Function

Summary

Table 2 is used to assess the functional impairment of a condition when performing activities requiring the use of upper limbs. The descriptors in Table 2 refer to a range of activities relevant to a person's ability to pick up, handle, manipulate and use objects encountered in everyday life, including but not limited to, coins, pencils, cartons of liquid, computer keyboards etc. The term upper limbs is an inclusive term and refers to the limbs that extend from the shoulder to the fingers.

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

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

Conditions causing impairment commonly assessed using Table 2 include but are not limited to:

- upper limb musculoskeletal conditions including specific degenerative joint disease (osteoarthritis)
- other forms of arthritis or chronic rotator cuff lesions
- neurological conditions including cerebrovascular accident (CVA or stroke) or other brain or nerve injury causing paralysis or loss of strength or sensation
- cerebral palsy or other condition affecting upper limb coordination
- inflammation or injury of the muscles or tendons of the upper limbs
- upper limb amputations or absence of whole or part of upper limb
- chronic carpal tunnel syndrome
- chronic pain affecting the upper limbs
- lymphoedema
- peripheral neuropathy
- ulnar nerve palsies.

Introduction

The introduction sets out rules for Table 2.

Diagnosis and Evidence

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

As with all Tables, a self-report of symptoms alone is insufficient and must be supported by corroborating medical evidence.

The introduction to Table 2 provides examples of corroborating evidence which include, but are not limited to:

- a report from the person's treating doctor;
- a report from a medical specialist confirming diagnosis of conditions associated with upper limb impairment (such as arthritis or other condition affecting upper limb joints, paralysis or loss of strength or sensation resulting from stroke or other brain or nerve injury, cerebral palsy or other condition affecting upper limb coordination, inflammation or injury of the muscles or tendons of the upper limbs, chronic pain affecting the upper limbs, amputation or absence of whole or part of upper limb, lymphoedema, or peripheral neuropathy);
- a report from an allied health practitioner (such as physiotherapist, occupational therapist or exercise physiologist) confirming the functional impact;
- results of diagnostic tests (such as X-Rays or other imagery);
- results of physical tests or assessments.

Lymphoedema and peripheral neuropathy have been added as new examples of conditions associated with upper limb impairment based on feedback from cancer and oncology experts.

The introduction now includes an instruction for the assessment of a person who has a dominant upper limb impairment to include consideration of their ability to adapt and use their non-dominant upper limb to perform tasks.

Table 2 – Impairment Rating – 0 Points

The first row of Table 2 provides the descriptor “*There is **no or minimal** functional impact on activities using upper limbs*” leading to 0 impairment points.

The 0 point descriptor specifies the person has no or minimal functional impact on activities using their upper limbs. The person can carry out all activities in subsection (1).

Compared to the 2011 Determination, the reference to ‘hands and arms’ in the first line has been changed to ‘upper limbs’ upon recommendation from medical experts who indicate it’s a more inclusive description. This has been extended to the 5, 10, 20 and 30 point descriptors.

Table 2 – Impairment Rating – 5 Points

The second row of Table 2 provides the descriptor “*There is a **mild** functional impact on activities using upper limbs*” leading to 5 impairment points.

For this rating to be assigned to a person, the person must meet at least three of the criteria in paragraphs (1)(a), (b), (c) or (d). Replacing ‘most’ with a numeric value clarifies what ‘most’ meant in the context of the number of criteria required. Similar changes have been made throughout the Tables to ensure the meaning is clear.

Compared to the 2011 Determination, the example at paragraph (1)(a) has been changed from picking up a 2 litre carton of liquid or carrying a full shopping bag to picking up and using bulky tools or picking up and pouring a full kettle. A new example has been added under paragraph (1)(b) around picking up coins or picking up and using paper clips or pens. Difficulty tying laces has been added to paragraph (1)(c) and clarification has been provided in paragraph (1)(d) to specify that reaching up is to mean reaching up above head height. New examples have also been added to paragraph (1)(d) to reflect reaching overhead, stacking shelves, hanging washing and changing a ceiling lightbulb.

Table 2 – Impairment Rating – 10 Points

The third row of Table 2 provides the descriptor “*There is a **moderate** functional impact on activities using upper limbs*” leading to 10 impairment points.

For this rating to be assigned to a person, the person must meet at least four of the criteria in paragraphs (1)(a), (b), (c), (d), (e), (f) or (g).

Subsection (1) now provides that a person ‘has moderate difficulty’ rather than ‘has difficulty with’ at least four of the subsequent descriptor points, better reflecting the level of impairment required for this rating to apply.

The activity of doing up a zipper has been added to the descriptor at paragraph (1)(d) along with an example of wearing clothing that goes on over the head to avoid doing up buttons.

Paragraph (1)(e) has been added to reflect activities that require raising the arms above head height.

Difficulties using a mouse or phone functions have been added to paragraph (1)(f).

Paragraph (1)(g) has been added to capture difficulties with grip and twist or pinch and pull motions along with examples of both actions.

Table 2 – Impairment Rating – 20 Points

The fourth row of Table 2 provides the descriptor “*There is a **severe** functional impact on activities using upper limbs*” leading to 20 impairment points.

For this rating to be assigned to a person, the person must meet at least three of the descriptors in paragraphs (1)(a), (b), (c), (d), or (e).

At paragraph (1)(a), nerve damage has been added to recognise that it may render an upper limb non-functional. References to prostheses and assistive devices at paragraph (1)(b) have been removed and replaced with ‘without assistance’ to reflect the requirement that a person must use any assistive devices they have and usually use, during assessment. Paragraphs (1)(c) and (1)(d) have been combined to reflect difficulty using small objects along with an example of using a fork or spoon and using a pen or pencil. Subsequently, paragraph (1)(e) has been re-numbered and is now paragraph (1)(d). New paragraph (1)(e) has been added to

reflect functional impacts people with an upper limb impairment may have reaching above head height, along with an example. These changes have been made following the advice of health and allied health professionals.

Table 2 – Impairment Rating – 30 Points

The fifth row of Table 2 provides the descriptor “*There is an **extreme** functional impact on activities using upper limbs*” leading to 30 impairment points.

Subsection (1) provides that a person has an extreme functional impact on activities using upper limbs where the person has no function in both of their upper limbs or the person has no upper limbs.

A person is considered to have no function in both their upper limbs, if the person has no movement or coordination in both their hands or both arms or has no hands or no arms. A person will not meet the 30 point descriptor if they have some movement or function in one of their hands or arms.

Table 3 – Lower Limb Function

Summary

Table 3 is used to assess the functional impact of a condition when performing activities requiring the use of lower limbs. The descriptors in Table 3 refer to a range of activities relevant to a person's ability to move around, including walking, kneeling, squatting, standing, standing up from a seated position, using stairs, using public transport or using a motor vehicle, and (where applicable) their ability to mobilise with the use of wheelchairs or walking aids. The term lower limbs is an inclusive term and refers to the limbs that extend from the hips to the toes.

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

Conditions causing impairment commonly assessed using Table 3 include but are not limited to:

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

Introduction

The introduction sets out rules for Table 3.

Diagnosis and Evidence

The diagnosis of the condition causing the impairment must be made by an appropriately qualified medical practitioner. This includes a general practitioner, an orthopaedic surgeon, a rheumatologist, a rehabilitation physician or other relevant specialist.

As with all Tables, a self-report of symptoms alone is insufficient and must be supported by corroborating medical evidence.

The introduction to Table 3 provides or examples of corroborating evidence which include, but are not limited to:

- a report from the person's treating doctor;
- a report from a medical specialist confirming diagnosis of conditions associated with lower limb impairment (such as arthritis or other condition affecting lower limb joints, paralysis or loss of strength or sensation resulting from stroke or other brain or nerve injury, cerebral palsy or other condition affecting lower limb coordination, inflammation or injury of the muscles or tendons of the lower limbs, chronic pain affecting the lower limbs, amputation or absence of whole or part of lower limb, lymphoedema, or peripheral neuropathy);
- a report from an allied health practitioner (such as physiotherapist, occupational therapist or exercise physiologist) confirming the functional impairment;
- results of diagnostic tests (such as X-Rays or other imagery);
- results of physical tests or assessments showing impaired function of the lower limbs.

Lymphoedema and peripheral neuropathy have been added as new examples of conditions associated with lower limb impairment based on feedback from cancer and oncology experts.

Assessing impairment for persons using wheelchairs or walking aids

Where a person uses a wheelchair or certain walking aids (a quad stick, crutches or walking frame), the correct impairment rating depends, among other factors, upon the extent to which they are independent or dependent on assistance to mobilise while using a wheelchair or walking aids, and to transfer to and from a wheelchair. Within each of the 10 and 20 point impairment ratings, the descriptors state that this impairment rating level 'includes' a person who is either independent or who requires assistance to move around in or to transfer to and from a wheelchair (motorised or non-motorised), or to move around using walking aids.

For the purpose of Table 3, the term 'includes' means that a person who uses a wheelchair or certain walking aids may be included in a class or category of people who can be considered under the criteria for these impairment rating levels and may be eligible for either 10 or 20 points subject to their meeting all the requirements set out in the descriptors for these ratings.

The use of wheelchairs or walking aids is not in itself an absolute indicator of the level of severity of a person's impairment when performing activities relating to their ability to move around. Individual circumstances do differ, including reasons for which people acquire such devices, frequency of use and the tasks for which they use them. A person may have a number of assistive devices and use them for different purposes or not use them at all for certain tasks. While the vast majority of people who use wheelchairs or walking aids do so upon recommendation by appropriate professionals, this equipment can nevertheless be purchased and used in Australia without prescription.

Table 3 – Impairment Rating – 0 Points

The first row of Table 3 provides the descriptor “*There is **no or minimal** functional impact on activities requiring use of the lower limbs*” leading to 0 impairment points.

The 0 point descriptor specifies the person has no or minimal functional impact on activities using their lower limbs. The person can carry out all activities in subsection (1).

Table 3 – Impairment Rating – 5 Points

The second row of Table 3 provides for the descriptor “*There is a **mild** functional impact on activities using lower limbs*” leading to 5 impairment points.

For this rating to be assigned to a person, the person must meet at least one of the criteria in paragraphs (1)(a), (b) or (c) and at least one of the criteria in paragraphs (2)(a), (b) or (c).

Compared to the 2011 Determination, the wording in paragraphs (1)(a) and (b) have been updated to capture difficulties navigating different types of terrain such as uneven ground. The wording of the equivalent descriptors have also been updated in the 10 and 20 point impairment ratings. Paragraph (1)(b) has been updated to replace ‘without a rest’ to ‘without stopping’. At paragraph (1)(c), ‘difficulty climbing stairs’ has been changed to ‘mild difficulty negotiating stairs’ and now includes an example. Paragraph (2)(a) wording has changed from ‘unable to stand’ to ‘has mild difficulty standing’. The timeframe of standing ‘for 10 minutes’ has been replaced with standing ‘independently’. Paragraph (2)(b) has been added to capture difficulty squatting or kneeling along with an example. Subsequently, former paragraph (2)(b) is now paragraph (2)(c) and ‘prosthesis and walking stick’ has been changed to ‘walking aid’ along with reference to note the walking aid is used to assist with walking or balance issues. An example has also been added to paragraph (2)(c) to cover risk of tripping. These changes are as a result of advice from health and allied health professionals.

Table 3 – Impairment Rating – 10 Points

The third row of Table 3 provides for the descriptor “*There is a **moderate** functional impact on activities using lower limbs*” leading to 10 impairment points.

For this rating to be assigned to a person, the person must meet at least one of the criteria in paragraphs (1)(a), (b), (c) or (d), and satisfy the criteria in subsection (2).

At paragraph (1)(b), the reference to ‘is unable to’ has been changed to ‘has moderate difficulty’ and provides that a person may use alternate methods to negotiate stairs, along with an example. At paragraph (1)(c), the reference to ‘is unable to’ has been changed to ‘has moderate difficulty’ and the previous requirement for a person to be unable to stand for more than 5 minutes has been changed to ‘has moderate difficulty standing for short periods of time’, including an example. Paragraph (1)(d) has been added to capture difficulty kneeling and squatting and includes an example. Subsection (2) has been reworded to capture difficulties navigating different terrains. The previous wording of ‘walking around in a shopping centre or supermarket’ has been more appropriately framed as an example. What was previously subsection (3) is now a note reflecting the content is guidance. Within this note ‘disabled access entries’ has been changed to ‘accessible entries’ in line with

contemporary language. These changes are as a result of advice from health and allied health professionals.

Table 3 – Impairment Rating – 20 Points

The fourth row of Table 3 provides the descriptor “*There is a **severe** functional impact on activities using lower limbs*” leading to 20 impairment points.

For this rating to be assigned to a person, the person must have severe difficulty performing all of the activities set out in paragraph (1)(a), without assistance as well as paragraph (1)(b).

Subparagraph (1)(a)(i) and (iii) have been swapped in order to effectively communicate the progression of movement within paragraph (1)(a). Subparagraph (1)(a)(i) now covers standing from a seated position and clarifies a ‘seat’ is taken to be a standard chair which is further clarified with an example. Subparagraph (1)(a)(ii) has been changed to capture difficulties remaining standing. Previous subparagraph (1)(a)(ii) has been combined with the new subparagraph (1)(a)(iii) to capture mobilising around the home and in the community. This is further clarified with an example. Previous subsection (2) is now a note reflecting the content is guidance. Within the note ‘needs assistance’ is now ‘requires assistance’ and an example has been added to clarify this may include people who are at risk of falls due to balance issues. These changes are as a result of advice from health and allied health professionals.

Table 3 – Impairment Rating – 30 Points

The fifth row of Table 3 provides the descriptor “*There is an **extreme** functional impact on activities using lower limbs*” leading to 30 impairment points.

Subsection (1) provides that a person’s impairment is such that they are unable to mobilise independently. To meet this descriptor the person must be completely unable to mobilise at all without assistance. In comparison, someone who has some ability to mobilise very short distances without assistance (such as around the home) but is unable to do the activities listed in the 20 point descriptor at subparagraphs (1)(a)(i), (1)(a)(ii) or (1)(a)(iii) and requires assistance to use public transport (paragraph (1)(b)) would meet the 20-point descriptor.

Table 4 – Spinal Function

Summary

Table 4 is used to assess the functional impact of a condition when performing activities involving spinal function, that is, bending or turning the back, trunk or neck.

Conditions causing impairment commonly assessed using Table 4 include but are not limited to:

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

Introduction

The introduction sets out rules for Table 4.

Diagnosis and Evidence

The diagnosis of the condition causing the impairment must be made by an appropriately qualified medical practitioner. This includes a general practitioner, an orthopaedic surgeon, a rheumatologist, or other relevant specialist.

As with all Tables, a self-report of symptoms alone is insufficient and must be supported by corroborating medical evidence.

The introduction to Table 4 provides examples of corroborating evidence which include, but are not limited to:

- a report from the person's treating doctor;
- a report from a medical specialist confirming diagnosis of conditions commonly associated with spinal function impairment (such as spinal cord injury, spinal stenosis, cervical spondylosis, lumbar radiculopathy, herniated or ruptured disc, spinal cord tumours, arthritis or osteoporosis involving the spine, or chronic pain affecting the spine);

- a report from an allied health practitioner (such as a physiotherapist, or occupational therapist), confirming loss of range of movement in the spine or other effects of spinal disease or injury.

Use of other Tables

The introduction to Table 4 makes clear that other Tables should be used in certain circumstances.

- Restrictions on overhead tasks resulting from shoulder conditions should be rated under Table 2.
- Restrictions resulting from hip conditions should be rated under Table 3.
- Restrictions on lower limbs resulting from lumbar spine conditions, such as nerve pain and lower limb weakness, should be rated under Table 3.
- Upper or lower limb impairment resulting from a spinal condition (such as nerve root compromise) can be additionally assessed under Table 2 or Table 3 if the Table 4 rating does not fully account for the overall level of impairment.
- Where a person has nerve damage in an upper or lower limb or an impingement in the neck affecting the upper limbs, an additional rating on Table 2 or 3 can be considered.

Compared to the 2011 Determination, chronic pain has been acknowledged as a condition commonly associated with spinal function impairment, as recommended by pain experts. Wording has been amended to clarify reports from an allied health practitioner are accepted as evidence for the purposes of this Table. This has further allowed for occupational therapists to be included as an example of practitioners who can provide evidence. Based on advice from medical experts, rehabilitation practitioners have been removed from the health practitioner examples.

Table 4 – Impairment Rating – 0 Points

The first row of Table 4 provides for the descriptor “*There is **no or minimal** functional impact on activities involving spinal function*” leading to 0 impairment points.

The 0 point descriptor specifies the person has no or minimal functional impact involving spinal function. The person can carry out all activities in subsection (1).

Table 4 – Impairment Rating – 5 Points

The second row of Table 4 provides the descriptor “*There is a **mild** functional impact on activities involving spinal function*” leading to 5 impairment points.

For this rating to be assigned to a person, the person must meet at least one of the criteria in paragraphs (1)(a), (b) or (c).

Compared to the 2011 Determination, an example has been added to paragraph (1)(b) to demonstrate the type of difficulties a person might experience bending to knee level, as recommended by health and allied health professionals.

Table 4 – Impairment Rating – 10 Points

The third row of Table 4 provides the descriptor “*There is a **moderate** functional impact on activities involving spinal function*” leading to 10 impairment points.

For this rating to be assigned to a person, the person must be able to sit in or drive in a car for at least 30 minutes and meet at least one of the criteria in paragraphs (1)(a), (b), (c) or (d).

In relation to paragraph (1)(c) a light object refers to any object that would weigh no more than a kilogram.

References to ‘unable’ at paragraphs (1)(a) and (c) have been changed to ‘moderate difficulty’ to better reflect the appropriate level of functional impairment at the 10 point level. Likewise, paragraph (1)(b) has been changed so that ‘difficulty’ has been replaced by ‘moderate difficulty’. Clarification has also been given to state that a chair is to mean a standard chair. The guidance notes from Table 3 – 10 point descriptor around wheelchair use has been added to this Table and expanded to the 20 point rating. These changes follow advice from health and allied health professionals.

Table 4 – Impairment Rating – 20 Points

The fourth row of Table 4 provides the descriptor “*There is a **severe** functional impact on activities involving spinal function*” leading to 20 impairment points.

For this rating to be assigned to a person, the person must have severe difficulty performing at least one of the activities listed in paragraphs (1)(a), (b), (c) or (d).

In relation to paragraph (1)(b) the person must either have severe difficulty turning their head without moving their trunk or have severe difficulty bending their neck without moving their trunk.

Paragraph (1)(a) now contains wording to clarify this descriptor covers the action of looking upwards to perform overhead tasks. Paragraph (1)(c) wording has been changed to clarify that bending action covers bending to hip height. This has been further clarified with an additional example. An example has been added to paragraph (1)(d) to provide a description of difficulties a person may have in remaining seated for a period of time. These changes have been made based on advice from health and allied health professionals.

Table 4 – Impairment Rating – 30 Points

The fifth row of Table 4 provides the descriptor “*There is an **extreme** functional impact on activities involving spinal function*” leading to 30 impairment points.

This rating can only be applied when the person cannot perform activities involving spinal function.

Previous paragraphs 1(a) and (b) have been merged to a single paragraph.

Table 5 – Mental Health Function

Summary

Table 5 is used to assess the functional impact of a mental health condition (including recurring episodes of mental health impairment).

Conditions causing impairment commonly assessed using Table 5 include but are not limited to:

- chronic depressive/anxiety disorders
- schizophrenia
- bipolar disorder
- feeding and eating disorders
- somatic symptom disorders
- personality disorders
- post-traumatic stress disorder
- attention deficit hyperactivity disorder (ADHD) manifesting with predominantly behavioural problems.

For mental health conditions which are episodic in nature and fluctuate in severity over time (e.g. bipolar disorder), the severity, duration and frequency of the episodes or fluctuations must be taken into account when determining the rating that best reflects the person's overall functional ability. The person's presentation on the day of assessment should not solely be relied upon.

Introduction

The introduction sets out rules for Table 5.

Diagnosis and Evidence

The diagnosis of the condition causing the impairment must be made by an appropriately qualified medical practitioner (which includes a psychiatrist or general practitioner) with evidence from a registered psychologist if the diagnosis has not been made by a psychiatrist.

As with all Tables, a self-report of symptoms alone is insufficient and must be supported by corroborating medical evidence.

The diagnosis and evidence should make appropriate reference to the diagnostic tool used, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).

The introduction to Table 5 provides for examples of corroborating evidence which include, but are not limited to:

- a report from the person’s treating doctor;
- supporting letters, reports or assessments relating to the person’s mental health or psychiatric condition;
- interviews with the person and those providing care or support to the person.

A person may not have sufficient self-awareness of their mental health impairment or may not be able to accurately describe its effects. This is to be taken into account when discussing issues with the person and reading supporting evidence.

Table 5 – Descriptors

Each descriptor in Table 5 contains the same domains of mental health impairment:

- self-care and independent living;
- social/recreational activities and interpersonal relationships;
- travel and accessing the community;
- concentration and task completion;
- behaviour, planning and decision-making;
- work/training capacity.

Table 5 – Impairment Rating – 0 Points

The first row of Table 5 provides the descriptor “*There is **no or minimal** functional impact on activities involving mental health function.*” leading to 0 impairment points.

The 0 point descriptor specifies the person has no or minimal functional impact involving mental health function. The person has no or minimal difficulties with at least four of the activities or functions in subsection (1).

Paragraphs (1)(b) and (c) have been rearranged so that social/recreation activities have been grouped with interpersonal relationships, and travel and accessing the community have been grouped together as these groupings are better related. Appropriate examples have been provided to better demonstrate this new format. These changes have been reflected throughout Table 5.

The term ‘most’ has been changed to ‘at least 4’ when referring to the number of descriptors that must be met at each impairment rating level. Replacing ‘most’ with a numeric value clarifies what ‘most’ meant in the context of the number of criteria required. Similar changes have been made throughout the Tables to ensure the meaning is clear.

Table 5 – Impairment Rating – 5 Points

The second row of Table 5 provides the descriptor “*There is a **mild** functional impact on activities involving mental health function*” leading to 5 impairment points.

For this rating to be assigned to a person, the person must have mild difficulty performing at least four of the activities or functions in subsection (1).

Table 5 – Impairment Rating – 10 Points

The third row of Table 5 provides the descriptor “*There is a **moderate** functional impact on activities involving mental health function*” leading to 10 impairment points.

For this rating to be assigned to a person, the person must have moderate difficulty performing at least four of the activities or functions in subsection (1).

Example 1 under paragraph (1)(d) now includes moderate difficulty following along with a task, along with references to activities people are more likely to undertake such as reading an article, watching a television program or playing a video game. These changes were made following advice from health and allied health professionals.

Table 5 – Impairment Rating – 20 Points

The fourth row of Table 5 provides for the descriptor “*There is a **severe** functional impact on activities involving mental health function*” leading to 20 impairment points.

For this rating to be assigned to a person, the person must have severe difficulty performing at least four of the activities or functions in subsection (1).

Example 2 under paragraph (1)(c) further clarifies that public facilities means community facilities, such as public transport. Example 1 under paragraph (1)(d) now includes severe difficulty following along with a task. These changes were made following advice from health and allied health professionals.

Table 5 – Impairment Rating – 30 Points

The fifth row of Table 5 provides the descriptor “*There is an **extreme** functional impact on activities involving mental health function*” leading to 30 impairment points.

For this rating to be assigned to a person, the person must have extreme difficulty performing at least four of the activities or functions in subsection (1).

Example 1 under paragraph (1)(d) now includes extreme difficulty following along with a task. This change was made following advice from health and allied health professionals.

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

Summary

Table 6 is used to assess the functional impact of a condition resulting from excessive use of alcohol, drugs or other harmful substances (such as glue and petrol) or the misuse of prescription drugs.

Conditions causing impairment commonly assessed using Table 6 include but are not limited to:

- alcohol use disorder
- various illicit drug use disorders
- various inhalant use disorders
- various prescription drug use disorders.

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

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

The misuse of prescription drugs means in a manner other than prescribed by a medical practitioner, and that misuse has resulted in a functional impairment.

Introduction

The introduction sets out rules for Table 6.

Diagnosis and evidence

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

As with all Tables, a self-report of symptoms alone is insufficient and must be supported by corroborating medical evidence.

The introduction to Table 6 provides examples of corroborating evidence which include, but are not limited to:

- a report from the person's treating doctor;
- supporting letters, reports or assessments relating to the person's substance use disorder;
- a report from a medical specialist (such as a general practitioner, addiction medicine specialist or psychiatrist with experience in diagnosis or treatment of substance use

disorders) confirming diagnosis of substance use disorder and resulting impairment of other body systems or functions;

- a report from an allied health practitioner (such as a psychologist) confirming the person's functional impairment;
- results of investigations (such as liver function tests, alcohol and substance use assessments scales);
- interviews with the person and those who provide care or support to the person;
- reports or other records in participation or treatment programs;
- work or training attendance records.

An additional example has been added where a person's long-term impairments should be assessed under a different Table. The example provides that a person should be assessed on Table 5 where mental health impairments result from previous alcohol, drug or other harmful substance use.

Examples of corroborating evidence have been expanded to include supporting letters, reports or assessments relating to the person's substance use, reports from an allied health practitioner such as a psychologist confirming a person's functional impairment and interviews with the person and those who provide care or support to the person.

General practitioner has been added as an example of a medical specialist who can provide corroborating evidence for this Table. Additional guidance has been added to state evidence from a range of sources should be considered in determining which impairment rating applies to a person. Further guidance has been added to state that the person being assessed may not have sufficient self-awareness of their substance use disorder or may not be able to accurately describe its effects, which is to be kept in mind when discussing issues with the person and reading supporting evidence. The introduction also addresses the episodic and fluctuating presentation of conditions, recognising that the signs and symptoms of such conditions may vary over time and as such, the presentation of a person on the day of assessment should not be solely relied upon.

All changes made to this Table are based on advice from health and allied health practitioners who have expertise relevant to substance use disorders.

Table 6 – Impairment Rating – 0 Points

The first row of Table 6 provides the descriptor “*There is **no or minimal** functional impact from alcohol, drugs or other harmful substance use*” leading to 0 impairment points.

The 0 point descriptor specifies the person has no or minimal functional impact attending to all aspects of self-care and daily living tasks, and is able to attend and effectively participate in work, education and training activities.

Previous paragraphs (1)(a) and (b) have been condensed into one simplified statement as subsection (1).

Table 6 – Impairment Rating – 5 Points

The second row of Table 6 provides the descriptor “*There is **mild** functional impact from alcohol, drugs or other harmful substance use*” leading to 5 impairment points.

For this rating to be assigned to a person, there must be a functional impact due to the person’s substance use disorder where at least one of paragraphs (1)(a), (b) or (c) apply.

Changes have been made to all descriptors in this impairment rating to clarify the functional impacts resulting from a person’s substance use disorder that are intended to be captured within each descriptor. Further clarification has been provided within the examples for paragraphs (1)(a), (b) and (c). Changes of the same nature have been extended through the 10, 20 and 30 point impairment ratings, along with appropriate examples.

Table 6 – Impairment Rating – 10 Points

The third row of Table 6 provides the descriptor “*There is **moderate** functional impact from alcohol, drugs or other harmful substance use*” leading to 10 impairment points.

For this rating to be assigned to a person, there must be a functional impact due to the person’s substance use disorder where at least three of paragraphs (1)(a), (b), (c), (d) or (e) apply.

The previous reference to daily tasks and responsibilities in paragraph (1)(b) has been clarified to mean activities involving self-care, hygiene, nutrition and general health. Previous subsection (2) around a person who is in receipt of treatment and in sustained remission has been removed as it is a guidance point.

Table 6 – Impairment Rating – 20 Points

The fourth row of Table 6 provides the descriptor “*There is **severe** functional impact from alcohol, drugs or other harmful substance use*” leading to 20 impairment points.

For this rating to be assigned to a person, there must be a functional impact due to the person’s substance use disorder where at least three of paragraphs (1)(a), (b), (c), (d) or (e) apply.

The previous reference to personal care in paragraph (1)(a) has been changed to self-care based on advice from medical experts and to ensure consistency in reference to these activities across impairment levels under Table 6.

Table 6 – Impairment Rating – 30 Points

The fifth row of Table 6 provides the descriptor “*There is an **extreme** functional impact from alcohol, drugs or other harmful substance use*” leading to 30 impairment points.

For this rating to be assigned to a person, there must be a functional impact due to the person’s substance use disorder where at least three of paragraphs (1)(a), (b), (c) or (d) apply.

The language in previous paragraph (1)(a) has been simplified and included as an example under existing paragraph (1)(d) as medical experts indicate it is best placed as an example under this paragraph. Previous paragraph (1)(b), which covered self-care activities, family relationships, social interactions and community involvement, has been separated into new paragraphs (1)(a) and (c). The language in previous paragraph (1)(c) has been simplified and is now at paragraph (1)(b).

Table 7 – Brain Function

Summary

Table 7 is used to assess the functional impact of a condition related to neurological or cognitive function.

Conditions causing impairment commonly assessed using Table 7 include but are not limited to:

- chronic pain affecting cognitive function
- acquired brain injury (ABI)
- stroke (cerebrovascular accident (CVA))
- conditions resulting in dementia
- brain tumours
- some neurodegenerative disorders
- Autism Spectrum Disorder (ASD) with no low intelligence quotient (IQ)
- Foetal Alcohol Spectrum Disorder (FASD) without an interpretable full-scale IQ 85 or below
- migraine that results in impairment to neurological or cognitive function (but not loss of consciousness or altered states of consciousness)
- myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS)
- attention deficit hyperactivity disorder manifesting with predominantly attention and concentration problems.

People with ASD or FASD can be assessed using Table 7. However, if they have an IQ of between 70 and 85 the person should be assessed under Table 9, as their condition results in an intellectual impairment originating before they turned 18 years of age.

A person with cognitive impairment whose IQ is not most meaningfully summarised by a full scale IQ (for example, this could be due to a significant variation in their cognitive profile) may be assessed using Table 7.

Introduction

The introduction sets out rules for Table 7.

Diagnosis and Evidence

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

As with all Tables, a self-report of symptoms alone is insufficient and must be supported by corroborating medical evidence.

The introduction to Table 7 provides examples of corroborating evidence which include, but are not limited to:

- a report from the person's treating doctor;
- a report from a specialist health practitioner supporting the diagnosis of conditions associated with neurological or cognitive impairment such as an acquired brain injury, stroke (CVA), conditions resulting in dementia, tumour in the brain, some neurodegenerative disorders, chronic pain, myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), attention deficit hyperactivity disorder (ADHD) or autism spectrum disorder (ASD);
- results of diagnostic tests (such as Magnetic Resonance Imagery (MRI), Computerised (Axial) Tomography (CT) scans, Electroencephalography (EEG));
- results of cognitive function assessments;
- interviews with the person and those providing care or support to the person.

On the advice of medical experts, interviews with the person providing care or support to the person can be considered as corroborating evidence for the purpose of this Table. This is followed by the addition of a point to note that the person may not have sufficient self-awareness of their cognitive function or may not be able to accurately describe its effects, which must be considered when discussing issues with the person and reading supporting evidence.

ME/CFS, ADHD and ASD have been added as new appropriate examples of conditions that can be assessed under Table 7.

Table 7 – Descriptors

Each descriptor in Table 7 contains the same domains of neurological or cognitive impairment including:

- memory;
- attention and concentration;
- problem solving and cognitive flexibility;
- planning;
- decision making;
- comprehension;
- visuo-spatial function;
- behaviour regulation;

- social skills;
- self-awareness.

Social skills has been added as a new domain, and cognitive flexibility has been added to the problem-solving domain to better capture impairments of people with ASD as suggested by relevant medical experts. This has been expanded to all impairment ratings throughout this Table.

All changes on this Table are based on advice from health and allied health professionals.

Table 7 – Impairment Rating – 0 Points

The first row of Table 7 provides for the descriptor “*There is **no or minimal** functional impact on activities involving brain function*” leading to 0 impairment points.

The 0 point descriptor specifies the person has no or minimal functional impact resulting from a neurological or cognitive condition.

Table 7 – Impairment Rating – 5 Points

The second row of Table 7 provides the descriptor “*There is a **mild** functional impact on activities involving brain function*” leading to 5 impairment points.

For this rating to be assigned to a person, the person must be able to complete most activities of daily living without assistance and have mild difficulties in at least two of the domains of neurological or cognitive impairment listed.

Following the addition of the new domain, the number of descriptors required for an impairment rating to be assigned has been increased from one to two, which is also required at the 10, 20 and 30 point descriptors and has been supported by medical experts. This follows the approach on Table 5 – Mental Health Function, where a functional impairment in multiple domains is required for an impairment rating to be assigned.

Visuo-spatial function, behavioural regulation and self-awareness domains have been added across all impairment rating levels for consistency, along with appropriate examples. Under paragraph (1)(b) example 3 has been added to capture difficulties concentrating due to sensory issues. Throughout this rating level, references to difficulty have been clarified to mean mild difficulty.

Table 7 – Impairment Rating – 10 Points

The third row of Table 7 provides the descriptor “*There is a **moderate** functional impact on activities involving brain function*” leading to 10 impairment points.

For this rating to be assigned to a person, the person will require occasional (less than once a day) assistance with activities of daily living and have moderate difficulties in at least two of the domains of neurological or cognitive impairment listed.

Throughout this impairment rating, references to ‘need’ have been changed to ‘require’. Amendments have also been made throughout this impairment rating to clarify that difficulty is to mean moderate difficulty. Example 2 under paragraph (1)(b) has been expanded to cover difficulties experienced by those with sensory issues. The reference to ‘day-to-day activities’ in paragraphs (1)(g) and (j) have been simplified to read ‘activities of daily living’. A second example has been added to paragraph (1)(h) to demonstrate difficulties with self-limiting behaviours.

Table 7 – Impairment Rating – 20 Points

The fourth row of Table 7 provides the descriptor “*There is a **severe** functional impact on activities involving brain function*” leading to 20 impairment points.

For this rating to be assigned to a person, the person will require frequent (at least once a day) interactive assistance with activities of daily living and have severe difficulties in at least two of the domains of neurological or cognitive impairment listed.

Throughout this impairment rating, references to ‘need’ have been changed to ‘require’. Amendments have also been made throughout this impairment rating to clarify that previous references to ‘unable’ or ‘difficulty’ are to mean severe difficulty to better represent the level of impairment. In the example at paragraph (1)(e) references to a person being ‘unable to prioritise or make complex decisions’ have been amended to a person having ‘severe difficulty with prioritising and making simple decisions’. Example 2 under paragraph (1)(b) has been expanded to cover difficulties experienced by those with sensory issues. A second example has been added to paragraph (1)(h) to demonstrate difficulties with self-limiting behaviours. The reference to ‘day-to-day activities’ in paragraph (1)(j) have been simplified to read ‘activities of daily living’.

Table 7 – Impairment Rating – 30 Points

The fifth row of Table 7 provides the descriptor “*There is an **extreme** functional impact on activities involving brain function*” leading to 30 impairment points.

For this rating to be assigned to a person, the person will require continual interactive assistance and supervision and have extreme difficulties in at least two of the domains of neurological or cognitive impairment listed.

Throughout this impairment rating, references to ‘need’ have been changed to ‘require’. Amendments have also been made throughout this impairment rating to the wording around being ‘unable’ to perform an activity to having ‘extreme difficulty’ performing an activity. Example 2 under paragraph (1)(b) has been expanded to cover difficulties experienced by those with sensory issues. Additional wording has been added to the example under paragraph (1)(e) to reference a person needs substantial support from another person to make decisions. A second example has been added to paragraph (1)(h) to demonstrate difficulties with self-limiting behaviours.

Table 8 – Communication Function

Summary

Table 8 is used to assess the functional impact of a condition affecting communication functions.

Conditions causing impairment commonly assessed using Table 8 include but are not limited to:

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

Table 8 covers both receptive communication, which is understanding language, as well as expressive communication, which is producing speech. Table 8 also covers the use of alternative or augmentative communication such as sign language, technology that produces electronic speech or the use of symbols or a note taker to assist in communication, which has been added as an additional guidance point to the introduction of this Table.

If the person uses recognised sign language or other non-verbal communication method as a result of hearing loss only, the person's hearing and communication function should be assessed using Table 11.

Introduction

The introduction sets out rules for Table 8.

Diagnosis and Evidence

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

As with all Tables, a self-report of symptoms alone is insufficient and must be supported by corroborating medical evidence.

The introduction to Table 8 provides examples of corroborating evidence which include, but are not limited to:

- a report from the person's treating doctor;
- a specialist assessment by a speech pathologist, neurologist or psychologist;

- a report from a medical specialist confirming diagnosis of conditions associated with communication impairment (such as stroke (cerebrovascular accident (CVA)), other acquired brain injury, head, neck or throat cancer, cerebral palsy, neurodegenerative conditions, or damage to the speech-related structures of the mouth, vocal cords or larynx);
- results of diagnostic tests (such as X-Rays or other imagery);
- results of functional assessments.

Head, neck and throat cancer have been added as new examples of conditions that may be associated with communication impairment, after consultation with cancer experts.

Table 8 – Impairment Rating – 0 Points

The first row of Table 8 provides the descriptor “*There is **no or minimal** functional impact on communication in the person’s main language*” leading to 0 impairment points.

The 0 point descriptor specifies the person is usually understood by those who speak the same language and has no or minimal difficulty understanding or engaging in meaningful conversation.

Wording around meaningful conversation has been clarified to mean, ‘has no or minimal difficulty understanding or engaging in meaningful conversation’.

Table 8 – Impairment Rating – 5 Points

The second row of Table 8 provides the descriptor “*There is a **mild** functional impact on communication in the person’s main language*” leading to 5 impairment points.

For this rating to be assigned to a person, there must be a mild functional impact on communication in the person’s main language where either paragraph (1)(a) or (b) applies.

Paragraph (1)(b) and its equivalents in the 10, 20 and 30 point descriptors separate out the reference to speech production or content from the example of ‘a stutter or stammer, or vocal cord, larynx damage’ in recognition that difficulties may arise from many possible causes.

Table 8 – Impairment Rating – 10 Points

The third row of Table 8 provides the descriptor “*There is a **moderate** functional impact on communication in the person’s main language*” leading to 10 impairment points.

For this rating to be assigned to a person, there must be a moderate functional impact on communication in the person’s main language and one of paragraph (1)(a), (b) or (c) must apply. If paragraph (1)(a) applies, only one of the subparagraphs (1)(a)(i) or (1)(a)(ii) need to apply.

The reference to ‘strangers’ in paragraph (1)(b) has been amended to ‘unfamiliar people’ as this is considered more appropriate terminology based on stakeholder feedback.

Table 8 – Impairment Rating – 20 Points

The fourth row of Table 8 provides the descriptor “*There is a **severe** functional impact on communication in the person’s main language*” leading to 20 impairment points.

For this rating to be assigned to a person, there must be a severe functional impact on communication in the person’s main language and one of paragraphs (1)(a), (1)(b), (2)(a), (2)(b), (2)(c) or (2)(d) must apply. If paragraph (1)(b) applies, only one of the subparagraphs (1)(b)(i) or (ii) or (iii) or (iv) need to apply. If subsection (2) applies, then at least one of paragraphs (2)(a), (2)(b), (2)(c) or (2)(d) must also apply.

Table 8 – Impairment Rating – 30 Points

The fifth row of Table 8 provides the descriptor “*There is **extreme** functional impact on communication in the person’s main language*” leading to 30 impairment points.

For this rating to be assigned to a person, there must be an extreme functional impact on communication in the person’s main language and one of paragraphs (1)(a), (1)(b), (2)(a), (2)(b), or (2)(c) must apply. If either paragraphs (1)(a) or (1)(b) apply, only one of their subparagraphs, (1)(a)(i) or (ii) or (iii), or (1)(b)(i) or (ii) or (iii) or (iv) need to apply. If subsection (2) applies, then at least one of paragraphs (2)(a), (2)(b), or (2)(c) must also apply.

Table 9 –Intellectual Function

Summary

Table 9 is used to assess the functional impact of a condition resulting in low intellectual function (a meaningful intelligence quotient (IQ) score of 70 to 85), which originated before the person turned 18 years of age.

Conditions causing impairment commonly assessed using Table 9 include but are not limited to:

- Down syndrome
- congenital/perinatal or early childhood infections (e.g. rubella, cytomegalovirus (CMV), bacterial meningitis, encephalitis)
- extreme prematurity or birth trauma
- a person with either autism spectrum disorder (ASD), fragile X syndrome or foetal alcohol spectrum disorder (FASD) who also has a meaningful IQ between 70 and 85 resulting in function impairment
- childhood developmental or congenital disorders.

People with ASD or FASD who also have a meaningful IQ between 70 to 85 resulting in functional impairment should be assessed under Table 9, as their condition presented with an intellectual impairment that originated before they turned 18.

However, in cases of ASD which do not have a meaningful IQ between 70 to 85 resulting in functional impairment, Table 7 or Table 5 may be applied, where appropriate.

The assessment of IQ can be complex, for example if there are significant discrepancies in indices. In some instances, a variable cognitive profile may not make a full scale IQ score the most meaningful summary of a person's intellectual function. In some instances, the General Ability Index (GAI) or other suitable index score may be used, if appropriate. However, if these scores are not meaningful, Table 7 may be a more appropriate Table.

Consideration must be given to whether recognised assessments of intellectual function should be adapted for use with Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse (CALD) backgrounds.

For culturally and linguistically diverse (CALD) people, the Tests of Nonverbal Intelligence - Fourth Edition (TONI-4), or other equivalent tests of intelligence validated for CALD populations, may be considered.

Other assessment tools that may be appropriate include:

- Ravens Progressive Matrices (RPM)
- Universal Nonverbal Intelligence Test (UNIT-2)
- Wechsler Nonverbal Scale of Ability (WNV).

Introduction

The introduction sets out rules for Table 9.

Assessments of intellectual function and adaptive behaviour

An assessment of intellectual functioning and adaptive behaviour is to be undertaken in the form of an individually administered and psychometrically valid, comprehensive, culturally appropriate and psychometrically sound standardised assessment that:

- provides robust standardised scores and a percentile ranking; and
- demonstrates test validity and reliability based on current norms developed on a representative sample of the general population.

Examples of tools used to assess intellectual functioning include:

- the Wechsler Adult Intelligence Scale (WAIS-IV) or equivalent (which should be conducted after the person turns 16 years of age);
- the Wechsler Intelligence Scale for Children (WISC-V) (which should be completed between the ages of 12 and 16 years, but is also acceptable for people aged 18 years or under at the time of assessment).

Examples of tools used to assess adaptive functioning include:

- the Adaptive Behaviour Assessment System (ABAS-3);
- the Scales for Independent Behaviour – Revised (SIB-R);
- the Vineland Adaptive Behaviour Scales (Vineland-3).

As these measures are based on responses from carers, teachers or self-report, consideration should be given to the capacity of the person reporting on the adaptive behaviour, for example, insight, observations in various settings, and social and cultural expectations.

Consideration should be given to the validity of the assessments of adaptive function and whether the results are consistent with other corroborative evidence such as developmental history, formal assessment, school or work records and/or direct observation. If the measure of adaptive function is inconsistent with this, clinical judgement should be used to determine the level of adaptive behaviour that is consistent with the scores of adaptive behaviour found in the Table 9 descriptors.

Diagnosis and Evidence

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

The introduction to Table 9 provides examples of corroborating evidence, which include, but are not limited to:

- a report from the person’s treating doctor;
- supporting letters, reports or assessments relating to the person’s development, intellectual function, adaptive behaviour or participation in programs;
- interviews with the person and those providing care, support or treatment to the person.

Assessment tools are regularly reviewed and revised to reflect advances in medical treatments and technology. To reduce the risk of the instrument being out of step with current editions of assessment tools, references to specific tools have been removed from the instrument and placed in guidance materials. In place of specific references, an explanation of the requirements of an assessment of intellectual functioning and adaptive behaviour has been added to the introduction.

Consistent feedback from stakeholder groups indicated there was a need for culturally appropriate assessments to be recognised, as such the addition of the requirement that a ‘culturally appropriate assessment must be considered’ has been added.

Table 9 – Impairment Rating – 0 Points

The first row of Table 9 provides the descriptor “*There is **no or minimal** impact on adaptive functioning*” leading to 0 impairment points.

The 0 point descriptor specifies there is no or minimal impact on adaptive functioning. At least one of the descriptors in paragraphs (1)(a) or (1)(b) applies.

Further clarification has been added to paragraph (1)(a) to provide that an adaptive function score is to be met on an adaptive behaviour scale. This change has also been extended to paragraph (1)(a) of the 5, 10, 20 and 30 impairment ratings levels.

Table 9 – Impairment Rating – 5 Points

The second row of Table 9 provides the descriptor “*There is **mild** impact on adaptive functioning*” leading to 5 impairment points.

The 5 point descriptor specifies there is a mild impact on adaptive functioning and at least one of the descriptors in paragraphs (1)(a) or (1)(b) applies.

Table 9 – Impairment Rating – 10 Points

The third row of Table 9 provides the descriptor “*There is **moderate** impact on adaptive functioning*” leading to 10 impairment points.

The 10 point descriptor specifies there is a moderate impact on adaptive functioning and at least one of the descriptors in paragraphs (1)(a) or (1)(b) applies.

Table 9 – Impairment Rating – 20 Points

The fourth row of Table 9 provides the descriptor “*There is **severe** impact on adaptive functioning*” leading to 20 impairment points.

The 20 point descriptor specifies there is a severe impact on adaptive functioning and at least one of the descriptors in paragraphs (1)(a) or (1)(b) applies.

Table 9 – Impairment Rating – 30 Points

The fifth row of Table 9 provides the descriptor “*There is an **extreme** impact on adaptive functioning*” leading to 30 impairment points.

The 30 point descriptor specifies there is an extreme impact on adaptive functioning and at least one of the descriptors in paragraphs (1)(a) or (1)(b) applies.

Table 10 – Digestive and Reproductive Function

Summary

Table 10 is used to assess the functional impact of a condition related to digestive or reproductive system functions.

Conditions resulting in functional impairment related to digestive system functions may include diseases in or remote from the digestive tract, which have significant impacts on digestive function. Digestive conditions may include cancer and other diseases that affect the mouth, salivary glands, oesophagus, stomach, intestines (small or large intestine), pancreas, liver, gall bladder, bile ducts, rectum or anus, such as:

- reflux oesophagitis
- refractory peptic ulcer disease
- established chronic liver disease
- chronic nausea and poor appetite from kidney disease
- irritable bowel syndrome
- inflammatory bowel disease (Crohn's disease, ulcerative colitis)
- established chronic pancreatic disease, abdominal hernias.

Reproductive system conditions may include gynaecological disease as well as conditions of the male reproductive system including but not limited to:

- severe and intractable endometriosis
- pelvic inflammatory disease
- ovarian cancer
- cervical cancer
- endometrial cancer
- prostate cancer.

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

Introduction

The introduction sets out rules for Table 10.

Diagnosis and Evidence

The diagnosis of the condition must be made by an appropriately qualified medical practitioner. This includes a general practitioner, a gastroenterologist, gynaecologist, or other relevant specialist.

As with all Tables, a self-report of symptoms alone is insufficient and must be supported by corroborating medical evidence.

The introduction to Table 10 provides examples of corroborating evidence which include, but are not limited to:

- a report from the person's treating doctor;
- a report from a medical specialist (such as a gastroenterologist, a gynaecologist, an urologist or an oncologist) confirming diagnosis of a digestive or reproductive system condition;
- results of investigations (such as X-Rays or other imagery, endoscopy or colonoscopy).

Where existing references to pain are written within the introduction, pain experts indicate that this should be clarified to mean chronic pain. This change has been adopted throughout the Table.

Table 10 – Impairment Rating – 0 Points

The first row of Table 10 provides the descriptor “*There is **no or minimal** functional impact from symptoms associated with a digestive or reproductive system condition*” leading to 0 impairment points.

The 0 point descriptor specifies the person is not usually interrupted at work or other activities by symptoms or personal care needs associated with a digestive or reproductive system condition.

The first sentence of all descriptors within the Table has been amended to remove references to impact on ‘work-related or daily activities’. This has been adopted to ensure a consistent approach with all other Tables and capture the broad intention to cover functional impact, rather than those related to specific activities.

Table 10 – Impairment Rating – 5 Points

The second row of Table 10 provides the descriptor “*There is a **mild** functional impact from symptoms associated with a digestive or reproductive system condition*” leading to 5 impairment points.

For this rating to be assigned to a person, there must be a mild functional impact due to symptoms associated with digestive or reproductive functions and at least one of paragraphs (1)(a) or (1)(b) apply.

Table 10 – Impairment Rating – 10 Points

The third row of Table 10 provides the descriptor “*There is a **moderate** functional impact from symptoms associated with a digestive or reproductive system condition*” leading to 10 impairment points.

For this rating to be assigned to a person, there must be a moderate functional impact due to symptoms associated with digestive or reproductive functions and at least 2 of paragraphs (1)(a), (1)(b) or (1)(c) apply.

An amendment has been made to paragraph (1)(b) where ‘unable to sustain’ has been replaced with ‘moderate difficulty sustaining’ to better reflect the level of functional impairment at this rating level. This change has also been made in the 20 point descriptor at paragraph (1)(b) to reflect ‘severe difficulty’.

Table 10 – Impairment Rating – 20 Points

The fourth row of Table 10 provides the descriptor “*There is a **severe** functional impact from symptoms associated with a digestive or reproductive system condition*” leading to 20 impairment points.

For this rating to be assigned to a person, there must be a severe functional impact due to symptoms associated with digestive or reproductive functions and at least 2 of paragraphs (1)(a), (1)(b), (1)(c) or (1)(d) apply.

Paragraph (1)(c) has been changed to better reflect the functional impact on a person rather than how the symptoms of their condition may impact others. This descriptor now reflects difficulty a person has in travelling and participating in activities due to symptoms or management of gastrointestinal or reproductive functions along with an example. The equivalent paragraph in the 30 point descriptor has also been updated along with an example. These changes were made following advice from health and allied health professionals.

Table 10 – Impairment Rating – 30 Points

The fifth row of Table 10 provides the descriptor “*There is an **extreme** functional impact from symptoms associated with a digestive or reproductive system condition*” leading to 30 impairment points.

For this rating to be assigned to a person, there must be an extreme functional impact due to symptoms associated with digestive or reproductive functions and at least 2 of paragraphs (1)(a), (1)(b), (1)(c) or (1)(d) apply.

Table 11 – Hearing and Other Functions of the Ear

Summary

Table 11 is used to assess the functional impact of a condition when performing activities involving hearing function or other functions of the ear (such as balance).

Conditions causing impairment commonly assessed using Table 11 include but are not limited to:

- congenital deafness
- presbycusis
- acoustic neuroma
- side effects of medication, including chemotherapy
- Meniere's disease
- head and neck cancer
- noise-induced hearing loss.

Introduction

The introduction sets out rules for Table 11.

Diagnosis and Evidence

The diagnosis of the condition causing the impairment must be made by an appropriately qualified medical practitioner with corroborating evidence from an audiologist, neurosurgeon, neurologist or Ear, Nose and Throat (ENT) specialist.

As with all Tables, a self-report of symptoms alone is insufficient and must be supported by corroborating medical evidence.

The introduction to Table 11 provides examples of corroborating evidence which include, but are not limited to:

- a report from the person's treating doctor;
- a report from a medical specialist (such as an ENT specialist, neurologist or neurosurgeon) confirming diagnosis of conditions associated with hearing impairment or other impaired function of the ear (such as congenital deafness, presbycusis, acoustic neuroma, head or neck cancer, side effects of medication including chemotherapy, Meniere's disease or neurological conditions);
- results of audiological assessment undertaken by a fully qualified audiologist, audiometrist or ENT specialist.

Changes have been made to allow for corroborating evidence in support of a diagnosis to be provided by a neurosurgeon or neurologist, and examples of evidence updated to allow reports from these practitioners. Head and neck cancer, along with side effects from chemotherapy have been added as conditions associated with hearing impairment or other impaired function of the ear. Medical specialists also recommended the reference to multiple sclerosis be removed as an example. Audiometrists are now recognised as a specialist able to provide results of an audiological assessment under this Table.

Table 11 – Impairment Rating – 0 Points

The first row of Table 11 provides the descriptor “*There is **no or minimal** functional impact on activities involving hearing function or other functions of the ear*” leading to 0 impairment points.

The 0 point descriptor specifies there is no or minimal impact on activities involving hearing function or other functions of the ear. Both descriptors in paragraphs (1)(a) and (1)(b) must apply.

The word ‘communication’ has been removed from the first sentence of every rating level in this Table to avoid confusion as communication function is captured in Table 8. Previous paragraphs (1)(b) as it is already captured in paragraph (1)(a), and previous paragraph (1)(c) has been removed as during assessment a person must use assistive aids they have and usually use. This change has been reflected throughout the Table. Following consultation with medical experts new, paragraph (1)(b) captures the functional impact of balance, dizziness or ringing in the ears.

Table 11 – Impairment Rating – 5 Points

The second row of Table 11 provides the descriptor “*There is **mild** functional impact on activities involving hearing function or other functions of the ear*” leading to 5 impairment points.

For this rating to be assigned to a person, there must be a mild functional impact on activities involving hearing function or other functions of the ear. The person’s impairment must meet the descriptor points in paragraphs (1)(a) and (1)(b), or alternatively meet the descriptor in subsection (2).

Tinnitus has been removed as an example of a disorder of the inner ear across all impairment rating levels based on advice from medical experts.

Table 11 – Impairment Rating – 10 Points

The third row of Table 11 provides the descriptor “*There is a **moderate** functional impact on activities involving hearing function or other functions of the ear*” leading to 10 impairment points.

For this rating to be assigned to a person, there must be a moderate functional impact on activities involving hearing function on other functions on the ear. The person’s impairment must meet the descriptor points in paragraphs (1)(a), (1)(b) and (1)(c), or alternatively meet the descriptor in subsection (2).

The reference to a telephone with a T-switch has been removed from paragraph (1)(b) because the T-switch is an outdated form of technology. Dizziness has been added as an example to ensure consistency with the 5 point and 20 point rating descriptors. The level of difficulty experienced by a person at (1)(a) in the 10 point level has also been updated to indicate ‘moderate difficulty’.

Table 11 – Impairment Rating – 20 Points

The fourth row of Table 11 provides the descriptor “*There is a **severe** functional impact on activities involving hearing function or other functions of the ear*” leading to 20 impairment points.

For this rating to be assigned to a person, there must be a severe functional impact on activities involving hearing function or other functions of the ear. The person’s impairment must meet the descriptor points in paragraphs (1)(a), (1)(b) (1)(c) and (1)(d), or alternatively meet the descriptor in subsection (2).

Paragraph (1)(a) has had minor grammatical changes for greater clarity. The previous paragraph (1)(d) has been removed as caption telephones are an outdated form of technology. The level of difficulty with hearing experienced by a person at (1)(b) in the 20 point level has also been updated to indicate ‘severe difficulty’.

Table 11 – Impairment Rating – 30 Points

The fifth row of Table 11 provides the descriptor “*There is an **extreme** functional impact on activities involving hearing function or other functions of the ear*” leading to 30 impairment points.

For this rating to be assigned to a person, there must be an extreme functional impact on activities involving hearing function or other functions of the ear. A person’s impairment must meet all the descriptors at the 30-point level.

Paragraph (1)(b) has been expanded to reflect a broader range of communication methods, such as lip reading, or other non-verbal communication methods, that a person with impairments assessed on this Table may use. Paragraph (1)(c) has been added to ensure a consistent approach to assessing impacts across the range of functions of the ear, incorporating the impacts on balance.

Table 12 – Visual Function

Summary

Table 12 is used to assess the functional impact of a condition when performing activities involving visual function.

Conditions causing impairment commonly assessed using Table 12 include but are not limited to:

- diabetic retinopathy
- glaucoma
- retinitis pigmentosa
- brain tumours
- macular degeneration
- cataracts.

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

Introduction

The introduction sets out rules for Table 12.

Diagnosis and Evidence

The diagnosis of the condition must be made by an appropriately qualified medical practitioner with corroborating evidence from an ophthalmologist, optometrist, neurosurgeon or neurologist.

As with all Tables, a self-report of symptoms alone is insufficient and must be supported by corroborating medical evidence.

The introduction to Table 12 provides examples of corroborating evidence, which include, but are not limited to:

- a report from the person's treating doctor;
- a report from a medical specialist (such as ophthalmologist, ophthalmic surgeon) confirming diagnosis of conditions associated with vision impairment (such as diabetic retinopathy, brain tumours, glaucoma, retinitis pigmentosa, macular degeneration, cataracts, congenital visual impairment);
- results of vision assessments (such as assessments done by an optometrist).

Changes have been made to allow for corroborating evidence in support of a diagnosis to be provided by an optometrist, neurosurgeon or neurologist. Brain tumours have been added as an example of a condition associated with vision impairment following the recommendation from cancer specialists. The term ‘blindness’ has been replaced with ‘visual impairment’ based on advice from medical experts as this is the preferred terminology.

Table 12 – Impairment Rating – 0 Points

The first row of Table 12 provides the descriptor “*There is **no or minimal** functional impact on activities involving visual function*” leading to 0 impairment points.

For this rating to be assigned to a person, the person’s impairment must meet subsection (1) and all paragraphs 1(a), 1(b), 1(c) and 1(d).

Table 12 – Impairment Rating – 5 Points

The second row of Table 12 provides the descriptor “*There is a **mild** functional impact on activities involving visual function*” leading to 5 impairment points.

For this rating to be assigned to a person, there must be a mild functional impact on activities involving visual function. The person’s impairment must meet subsection (1) and at least one of the paragraphs (1)(a), (b), (c), (d) or (e).

A new example of mild discomfort when using a computer screen has been added to paragraph (1)(d) to capture more day-to-day activities. An equivalent example has also been added to the 10 and 20 point impairment rating levels.

Table 12 – Impairment Rating – 10 Points

The third row of Table 12 provides for the descriptor “*There is a **moderate** functional impact on activities involving visual function*” leading to 10 impairment points.

For this rating to be assigned to a person, there must be a moderate functional impact on activities involving visual function. The person must satisfy the descriptors in paragraphs (1)(a) and (b), and in addition they must satisfy one of the descriptors in subparagraphs (1)(c)(i), (ii) or (iii), and also satisfy both the descriptors in paragraphs (2)(a) and (b).

Consistent with the definition of ‘assistance’ in the Determination, references to assistance ‘from other people’ have been removed at paragraph (2)(a) as this wording is redundant. References to ‘unable to’ at subparagraph (1)(c)(ii) have been replaced with ‘moderate difficulty’ to better reflect the level of impairment.

Table 12 – Impairment Rating – 20 Points

The fourth row of Table 12 provides the descriptor “*There is a **severe** functional impact on activities involving visual function*” leading to 20 impairment points.

For this rating to be assigned to a person, there must be a severe functional impact on activities involving visual function. The person must satisfy the descriptors in paragraphs (1)(a) and (b), and in addition they must satisfy one of the descriptors in subparagraphs (1)(c)(i) or (ii), and satisfy the descriptor in paragraph (d).

References to ‘unable to’ at subparagraph (1)(c)(i) and paragraph (1)(d) have been replaced with ‘severe difficulty’ to better reflect the level of impairment.

Table 12 – Impairment Rating – 30 Points

The fifth row of Table 12 provides the descriptor “*There is an **extreme** functional impact on activities involving visual function*” leading to 30 impairment points. The person must satisfy the descriptors in both paragraphs (1)(a) and (b).

The 30 point descriptor provides that a person must not be permanently blind. If a person is permanently blind section 95 of the Act applies.

Table 13 – Continence Function

Summary

Table 13 is used to assess the functional impact of a condition related to incontinence of the bladder or bowel.

Conditions causing impairment commonly assessed using Table 13 include but are not limited to:

- some gynaecological conditions
- prostate enlargement or malignancy
- gastrointestinal conditions or malignancy
- incontinence resulting from spinal cord conditions
- spina bifida
- neurodegenerative conditions
- multiple sclerosis
- brain injuries.

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

Introduction

The introduction sets out rules for Table 13.

Diagnosis and Evidence

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

As with all Tables, a self-report of symptoms alone is insufficient and must be supported by corroborating medical evidence.

The introduction to Table 13 provides examples of corroborating evidence which include, but are not limited to:

- a report from the person's treating doctor;
- a report from a medical specialist, particularly in cases of moderate or severe incontinence, (such as urogynaecologist, gynaecologist, urologist, gastroenterologist) confirming diagnosis of conditions associated with incontinence (such as some gynaecological conditions, prostate enlargement or malignancy, gastrointestinal

conditions or malignancy, incontinence resulting from paraplegia, spina bifida, or neurodegenerative conditions);

- assessments and reports from practitioners specialising in the treatment and management of incontinence (such as urologists, urogynaecologists, continence nurses, or continence physiotherapists).

Following consultation with cancer experts, gastrointestinal condition or malignancy has been added as an example of a condition that may be assessed against this Table. Medical experts have also recommended the removal of ‘severe intellectual disability’ as an example of a condition which may be assessed on this Table. Medical experts also recommended ‘continence nurses’ is more appropriate wording when referring to a practitioner on this Table, instead of ‘continence nurse advisors’.

Table 13 – Impairment Rating – 0 Points

The first row of Table 13 provides the descriptor “*There is **no or minimal** functional impact on maintaining continence of the bladder and bowel*” leading to 0 impairment points.

All of the descriptors in subsection (1) must apply.

Table 13 – Impairment Rating – 5 Points

The second row of Table 13 provides the descriptor “*There is a **mild** functional impact on maintaining continence of the bladder and bowel*” leading to 5 impairment points.

For this rating to be assigned to a person at least one of the descriptor points in paragraphs (1)(a), (1)(b), (1)(c), (1)(d), (1)(e), or (1)(f) applies.

Table 13 – Impairment Rating – 10 Points

The third row of Table 13 provides the descriptor “*There is a **moderate** functional impact on maintaining continence of the bladder and bowel*” leading to 10 impairment points.

For this rating to be assigned to a person, subsection (1) provides that either subsection (2) - *Bladder function*, subsection (3) - *Bowel function* or subsection (4) - *Continence aids* applies.

A person must meet both descriptors in paragraphs (a) and (b) under one of subsections (2), (3) or (4).

Table 13 – Impairment Rating – 20 Points

The fourth row of Table 13 provides the descriptor “*There is a **severe** functional impact on maintaining continence of the bladder and bowel*” leading to 20 impairment points.

For this rating to be assigned to a person, subsection (1) provides that either subsection (2) - *Bladder function*, subsection (3) - *Bowel function* or subsection (4) - *Continence aids* applies.

A person must meet at least one of the descriptors in paragraphs (a), (b), or (c) under one of subsections (2), (3) or (4).

Paragraph (2)(a), (3)(a) and (4)(a) have been changed to better reflect the functional impact on a person rather than how the symptoms of their condition may impact others. This descriptor now reflects difficulty a person has in travelling and participating in activities due to symptoms or management of continence of the bladder or bowel or management of continence aids, along with an example. This wording has also been adopted in the 30 point descriptor at subsection (1). Paragraph (2)(b) has been expanded to clarify that a person's bladder impairment results in interruption to tasks, work or training on most days. Consistent with the definition of 'assistance' in the Determination, references to assistance 'from another person' have been removed from paragraph (4)(b) as this wording is redundant.

Table 13 – Impairment Rating – 30 Points

The fifth row of Table 13 provides the descriptor “*There is an **extreme** functional impact. The person is completely unable to maintain continence of the bladder or bowel*” leading to 30 impairment points.

For this rating to be assigned to a person, subsection (1) must be met and also provides that either subsection (2) - *Bladder function*, subsection (3) - *Bowel function* or subsection (4) - *Continence aids* applies.

Previous paragraphs (4)(a) and (4)(b) have been merged to state ‘the person is unable to independently manage any aspects of continence aids’.

Table 14 – Functions of the Skin

Summary

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

Conditions causing impairment commonly assessed using Table 14 include but are not limited to:

- burns
- severe eczema, psoriasis or dermatitis
- chronic pruritus
- allodynia
- ulceration or diabetic foot ulcers
- graft versus host disease
- chronic pain
- skin cancer, or long term effects of skin cancer treatment.

Introduction

The introduction sets out rules for Table 14.

Diagnosis and Evidence

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

As with all Tables, a self-report of symptoms alone is insufficient and must be supported by corroborating medical evidence.

The introduction to Table 14 provides examples of corroborating evidence which include, but are not limited to:

- a report from the person's treating doctor;
- a report from a medical specialist (such as dermatologist, burns specialist or oncologist) confirming diagnosis of dermatological conditions, burns, or cancer (such as melanoma or graft versus host disease);
- assessments or reports from practitioners specialising in the treatment and management of these conditions (such as dermatologists, burn specialists, registered nurses, physiotherapists, pain management specialists and occupational therapists).

Examples of medical professionals who can provide evidence for this Table has been expanded to include oncologists, physiotherapists, pain management specialists and occupational therapists. References to ‘clinical nurse consultants’ and ‘nurse practitioners’ have been amended and simplified to now read ‘registered nurses’. Examples of conditions which may be assessed under this Table have also been clarified to include cancer, such as melanoma and graft versus host disease, along with the recognition of chronic pain. These changes were made following advice from health and allied health professionals.

Table 14 – Impairment Rating – 0 Points

The first row of Table 14 provides the descriptor “*There is **no or minimal** functional impact on activities involving functions of the skin*” leading to 0 impairment points.

Subsection (1) has been rewritten for clarity and consistency with the format of other Tables. This has been reflected across the 5, 10, 20 and 30-point impairment rating levels.

For a person to satisfy this rating the descriptor in subsection (1) must apply.

Table 14 – Impairment Rating – 5 Points

The second row of Table 14 provides the descriptor “*There is a **mild** functional impact on activities involving functions of the skin*” leading to 5 impairment points.

For this rating to be assigned to a person, there must be a mild functional impact on activities involving functions of the skin. The person must satisfy at least one of paragraphs (1)(a), (b) or (c).

Skin ulcerations and chronic pain have been added as relevant examples to paragraphs (1)(a) and (b). This has also been extended to relevant descriptors in the 10 and 20 point impairment rating levels. New references to applying protective cream to the body and limiting repetitive tasks have been added to paragraph (1)(b) in order to maintain consistency with the other descriptors within this Table.

Table 14 – Impairment Rating – 10 Points

The third row of Table 14 provides the descriptor “*There is a **moderate** functional impact on activities involving functions of the skin*” leading to 10 impairment points.

For this rating to be assigned to a person, there must be a moderate functional impact on activities involving functions of the skin. The person must satisfy at least one of the descriptors in paragraphs (1)(a), (b), (c) or (d).

In paragraph (1)(a) the word ‘minor’ has been removed when referencing skin lesions following advice from health and allied health professionals.

Table 14 – Impairment Rating – 20 Points

The fourth row of Table 14 provides the descriptor “*There is a **severe** functional impact on activities involving functions of the skin*” leading to 20 impairment points.

For this rating to be assigned to a person, there must be a severe functional impact on activities involving functions of the skin. The person must satisfy at least two of the descriptors in paragraphs (1)(a), (b), (c), (d) or (e).

In paragraph (1)(a) references to ‘unable to’ have been replaced with ‘severe difficulty’ to better reflect the level of impairment.

Table 14 – Impairment Rating – 30 Points

The fifth row of Table 14 provides the descriptor “*There is an **extreme** functional impact on activities involving functions of the skin*” leading to 30 impairment points.

For this rating to be assigned to a person, subsection (1) and, in addition, at least one of paragraphs (1)(a), (b) or (c) must apply.

Table 15 – Functions of Consciousness

Summary

Table 15 is used to assess the functional impact of a condition due to involuntary loss of consciousness or altered state of consciousness (such as epilepsy, some forms of migraine, transient ischaemic attacks, or brain tumours).

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

Conditions causing impairment commonly assessed using Table 15 include but are not limited to:

- epilepsy
- brain tumours
- cardiac or other forms of syncope
- migraine that results in loss of consciousness or altered states of consciousness
- the person experiences loss of consciousness or altered states of consciousness, or are more rarely unconscious
- narcolepsy.

Poorly controlled diabetes mellitus has been removed, and brain tumours added as examples of conditions which may be assessed on this Table as advised by medical experts.

Introduction

The introduction sets out rules for Table 15.

Diagnosis and Evidence

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

As with all Tables, a self-report of symptoms alone is insufficient and must be supported by corroborating medical evidence.

The introduction to Table 15 provides examples of corroborating evidence which include, but are not limited to:

- a report from the person's treating doctor;
- a report from a medical specialist (such as neurologist, endocrinologist or physician) confirming diagnosis of conditions associated with episodes of loss of or altered state

of consciousness (such as epilepsy, transient ischaemic attacks, some forms of migraine, brain tumours, narcolepsy, or cardiac or other forms of syncope);

- assessments or reports from practitioners specialising in the treatment and management of these conditions (such as neurologists, endocrinologists, or registered nurses).

Brain tumours, narcolepsy, or cardiac or other forms of syncope have been added as examples of conditions that may be assessed under this Table, following consultation with cancer and other medical experts.

Reports from registered nurses have replaced reports from clinical nurse consultants and nurse practitioners specialising in diabetes management under examples of corroborating evidence following the removal of poorly controlled diabetes mellitus from this Table.

Table 15 – Impairment Rating – 0 Points

The first row of Table 15 provides the descriptor “*There is **no** functional impact from loss of consciousness or altered state of consciousness*” leading to 0 impairment points.

For this rating to be assigned to a person the descriptor in subsection (1) must apply.

Based on advice from medical experts, the first sentence in every impairment rating level has been amended to remove ‘during waking hours when occupied with a task or activity’ as this would disadvantage people who suffer from nocturnal seizures. The term ‘during waking hours’ has also been removed from subsection (1) of the 0 point rating.

Table 15 – Impairment Rating – 5 Points

The second row of Table 15 provides the descriptor “*There is a **mild** functional impact from loss of consciousness or altered state of consciousness*” leading to 5 impairment points.

For this rating to be assigned to a person, there must be a mild functional impact from loss of consciousness or altered state of consciousness. The person must meet both subparagraphs (1)(a)(i) and (1)(a)(ii), paragraph (1)(b), and paragraph (1)(c).

Paragraph (1)(a) has been simplified by consolidating the previous subparagraph (1)(a)(i) and (1)(a)(ii). The wording ‘rare episodes’ has been changed to ‘infrequent episodes’ upon recommendation of medical experts. Paragraph (1)(b) has been amended to provide further clarification that activities are taken to mean a person’s usual activities. This has been extended to the 10, 20 and 30 point impairment ratings.

Table 15 – Impairment Rating – 10 Points

The third row of Table 15 provides the descriptor “*There is a **moderate** functional impact from loss of consciousness or altered state of consciousness*” leading to 10 impairment points.

For this rating to be assigned to a person, there must be a moderate functional impact from loss of consciousness or altered state of consciousness. The person must meet either both sub-subparagraphs (1)(a)(i)(A) and (B), or both the descriptors in

sub-subparagraph (1)(a)(ii)(A) and (B). In addition, the person must also meet paragraphs (1)(b), (c) and (d).

The previous sub-subparagraph (1)(a)(ii)(B) which referenced ‘involuntary altered state of consciousness of less than 30 minutes duration’ has been removed based on advice from medical experts. The requirement for a person to receive first aid measures due to involuntary loss of consciousness has been softened with the addition of ‘may’ as a qualifier. This has been extended to the 20 and 30 point impairment ratings.

Table 15 – Impairment Rating – 20 Points

The fourth row of Table 15 provides the descriptor “*There is a **severe** functional impact from loss of consciousness or altered state of consciousness*” leading to 20 impairment points.

For this rating to be assigned to a person, there must be a severe functional impact from loss of consciousness or altered state of consciousness. The person must meet either both sub-subparagraphs (1)(a)(i)(A) and (B), or both in sub-subparagraphs (1)(a)(ii)(A) and (B). In addition, the person must also meet paragraphs (1)(b), (c) and (d).

Paragraph (1)(c) has been updated to identify that a person may not necessarily be unable to obtain a drivers licence but may instead have significant restrictions on their licence as a result of their condition.

Table 15 – Impairment Rating – 30 Points

The fifth row of Table 15 provides the descriptor “*There is an **extreme** functional impact from loss of consciousness or altered state of consciousness*” leading to 30 impairment points.

For this rating to be assigned to a person, there must be an extreme functional impact from loss of consciousness or altered state of consciousness. The person must meet either both sub-subparagraphs (1)(a)(i)(A) and (B), or both sub-subparagraphs (1)(a)(ii)(A) and (B). In addition, the person must also meet paragraphs (1)(b), (c) and (d).

Statement of Compatibility with Human Rights

Prepared in accordance with Part 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*

Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2023

Overview of the Determination

The Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2023 (the Determination) is made under subsections 26(1) and 26(3) of the *Social Security Act 1991 (the Act)*.

The Determination provides for Tables (**the Impairment Tables**) and the rules for the assessment of work-related impairment for the disability support pension under the Act. The Impairment Tables made under the Determination are used to determine whether a person whose qualification for the disability support pension is being considered as meeting a qualifying impairment threshold stipulated under the Act. This threshold is an impairment rating of 20 or more points under the Impairment Tables.

The Impairment Tables set out the criteria by which physical, intellectual or psychiatric impairments are assessed, and the relevant impairment rating for the different levels of functional impairment. Achieving an impairment rating of least 20 points does not mean that the person qualifies for the disability support pension but merely indicates that the impairment-related qualification criterion has been satisfied. An impairment rating under the Impairment Tables can only be assigned to an impairment if the condition has been diagnosed by an appropriately qualified medical practitioner, has been reasonably treated, the condition has stabilised, and, in light of available evidence, the condition and the resulting impairment is likely to persist for more than 2 years. The impairment ratings are based on a functional assessment of the person, rather than on their diagnosis. The Impairment Tables describe the functional activities, abilities, symptoms and limitations of a person. The descriptors of each impairment rating in an Impairment Table should be compared to determine which impairment rating is to be applied. All the indicators in an impairment rating must be satisfied before a higher-level impairment rating can be considered.

The disability support pension provides income support to people that are prevented from fully engaging in work because of an ongoing physical, intellectual or psychiatric impairment (paragraph 94(1)(a) of the Act). The qualification for disability support pension requires, amongst other things, a claimant's impairment rating is 20 points or more under the Impairment Tables (paragraph 94(1)(b) of the Act). These are the impairments determined under paragraph 94(1)(a) of the Act.

Without a legislative instrument in place for the purposes of paragraph 94(1)(b) there is no legal basis to assess and grant disability support pension claims to new claimants who otherwise meet the qualification criteria.

Human rights implications

The Determination is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

This Determination engages the following rights:

- the right to social security (International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 9 and Convention on the Rights of Persons with Disabilities (CRPD) Article 28(2)(b));
- the right to an adequate standard of living (ICESCR Article 11 and CRPD Article 28(2)(a));
- the right to equality and non-discrimination in the exercise of these rights (ICESCR Article 2(2); International Covenant on Civil and Political Rights (ICCPR) Articles 2, 16 and 2; Convention on the Rights of the Child (CRC) Article 2; and Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) Articles 2, 3, 4 and 15).

The right to social security and right to an adequate standard of living

The Determination engages the right to social security under Article 9 of the ICESCR and Article 28(2)(b) of the CRPD. The right to social security requires that a system be established under domestic law, and that public authorities must take responsibility for the effective administration of the system. The social security scheme must provide a minimum essential level of benefits to all individuals and families that will enable them to acquire at least essential health care, basic shelter and housing, water and sanitation, foodstuffs, and the most basic forms of education.

Article 28(2)(b) provides the recognition of the rights of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability, and the appropriate steps to safeguard and promote the realisation of that right including access by persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection programmes and poverty reduction programs. Social security is one example of a social protection programme.

The UN Committee on Economic Social and Cultural Rights (the Committee) has stated that social security, through its redistributive character, plays an important role in poverty reduction and alleviation. It has also stated that social security prevents social exclusion and promotes social inclusion. The Committee has stated that qualifying conditions for social security benefits must be reasonable, proportionate and transparent.

Article 11 of the ICESCR recognises the right of individuals and their families to an adequate standard of living. Article 28(2)(a) of the CRPD recognises the right of persons with disabilities to an adequate standard of living for themselves and families. The right to an adequate standard of living recognises the right of everyone to an adequate standard of living for all individuals and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions.

The Determination will operate beneficially by providing a mechanism to assess whether a person has functional impairments that result in a continuing inability to work. If a person is found to have a continuing inability to work as a result of their physical, intellectual or psychiatric conditions that lead to impairments, they may be eligible for a disability support pension under the *Social Security Act 1991*. The person must also meet other eligibility criteria such as age (at least 16 years old), residency and an income and assets test.

The disability support pension is an income support payment provided to persons with functional impairments that prevent them from working over 15 hours per week, or from working at all. Where a disability does not prevent a person from working 15 hours per week, that person may still be eligible for other income support payments under the social security law, and may still be eligible for other commonwealth supports for their disability, such as under the National Disability Insurance Scheme.

The disability support pension is also subject to an income and assets test. A person may not be eligible for the disability support pension due to their income or assets because in these cases it follows that the affected person is not being denied the ability to fulfil their basic needs, or the needs of their families, as by definition they have either the income or assets to provide for those needs.

Without the Determination in place there is no criteria to assess whether a person has a continuing inability to work and no basis to assign an impairment rating. Under the current legislative provisions this would mean that no new claim for the disability support pension could be granted for most conditions.

The Determination has been drafted following extensive consultation with individuals with lived experience, medical professionals, disability peak representative bodies and advocacy groups and internal government stakeholders such as Services Australia. It has been drafted to be reasonable, proportionate and transparent. Changes have been made to improve the consistency between Tables, clarify policy intent and reflect relevant advances in medical technology, assessments and terminology.

Care has been taken to ensure that indigenous people and ethnic and linguistic minorities are not excluded from access to the disability support pension through direct or indirect discrimination. For example, Table 9 provides that consideration must be given to whether recognised assessments of intellectual function should be adapted for use with Aboriginal and Torres Strait Islander peoples and for culturally and linguistically diverse people.

Disability support pension is designed to support people with disability if they are unable to work for at least 15 hours per week at or above the relevant minimum wage, due to a physical, intellectual or psychiatric impairment. This means not all people with a condition will be eligible for disability support pension.

This may limit their right to social security and an adequate standard of living because they cannot be assigned a rating, or their impairments are not severe enough to be assigned 20 points under the Determination. For example, a person cannot be assigned a rating if they do not have a diagnosed condition or their condition has not been reasonably treated or stabilised, or, in light of available evidence, their condition and resulting impairment is not likely to persist for more than 2 years.

These limitations achieve a legitimate objective. They balance a person's right to social security with the resources of the community. They also recognise that a person who is not eligible for disability support pension may access a range of other Government benefits, including Medicare, the National Disability Insurance Scheme and other social security payments including jobseeker payment.

The Determination is therefore consistent with the promotion of the right to social security and the right to an adequate standard of living.

Right to Equality and Non-Discrimination in the Exercise of these Rights

The right to equality and non-discrimination is protected by articles 2, 16 and 26 of the ICCPR and article 2 of the CRC.

This is a fundamental human right that is essential to the protection and respect of all human rights. It provides that every person is entitled to enjoy their rights without discrimination of any kind on the basis of a number of prohibited grounds, and that all people are equal before the law and entitled without discrimination to the equal and non-discriminatory protection of the law.

The ICCPR defines 'discrimination' as a distinction based on a personal attribute (for example, race, sex or religion), which has either the purpose (called 'direct' discrimination), or the effect (called 'indirect' discrimination), of adversely affecting human rights. The UN Human Rights Committee has explained indirect discrimination as 'a rule or measure that is neutral on its face or without intent to discriminate', which exclusively or disproportionately affects people with a particular personal attribute. Views of the Committee are influential but not binding on States Parties to the ICCPR.

Articles 2, 3, 4 and 15 of CEDAW further describes the content of these rights, describing the specific elements that state parties are required to take into account to ensure the rights to equality for women.

The Determination promotes a person's rights of equality and non-discrimination. It does so by regulating the manner in which a person's eligibility for disability support pension is determined. In particular, the Determination sets out what constitutes reasonable treatment for the purposes of disability support pension qualification, recognising differences in individual circumstances. Reasonable treatment means treatment:

- that is available at a location reasonably accessible to the person
- that is at a reasonable cost
- can reliably be expected to result in a significant functional improvement
- that is of a type regularly undertaken or performed
- that has a high success rate
- that carries a low risk to the person.

Conclusion

This Determination is compatible with human rights because it advances the protection of human rights, it does not limit or preclude people from gaining or maintaining access to social security in Australia and ensures the equitable assessment of people with disability, based on functional ability.

**[Circulated by the authority of the Minister for Social Services,
the Hon Amanda Rishworth MP]**