



He Kaupare. He Manaaki. He Whakaora.
Prevention. Care. Recovery.

Impairment Assessment Services

Operational Guidelines

April 2025



He Kaupare. He Manaaki. He Whakaora.
Prevention. Care. Recovery.

These Operational Guidelines should be read in conjunction with the:

- Standard Terms and Conditions document; and
- Impairment Assessment Service Schedule (“your contract”).

The services you provide must comply with your contract. Where there are any inconsistencies between the operational guidelines and the Service Schedule, the Service Schedule will take precedence.

This is a living document and will be updated as needed – the latest version will be available on the ACC website at www.acc.co.nz.

ACC will consult with Suppliers if substantial changes to this document are proposed.



Useful contacts and telephone numbers

Your role in undertaking Impairment Assessment Services on ACC's behalf is likely to involve contact with several of our teams. Here are their contact details.

ACC Provider Contact Centre	Ph: 0800 222 070	Email: providerhelp@acc.co.nz
ACC Client Helpline	Ph: 0800 101 996	
Provider registration	Ph: 04 560 5211	Email: registrations@acc.co.nz
ACC Digital Operations eBusiness	Ph: 0800 222 994 [Option 1]	Email: ebusinessinfo@acc.co.nz
Health Procurement: Contract Administrator and Health Procurement Specialist	If you have a question about your contract or need to update your details, please contact the ACC Health Procurement team: Email: health.procurement@acc.co.nz	
Engagement and Performance Managers	Engagement and Performance Managers can help you to provide the services outlined in your contract: Contact Provider Contact Centre or go to the ACC website - contact our provider relationship team for details of the Engagement and Performance Manager in your region	
ACC Website	For more information about ACC, please visit: www.acc.co.nz	
ACC Portfolio Team	For any questions on the Impairment Assessment service for the Portfolio Manager and/or Portfolio Advisor, email medicalassessments@acc.co.nz	
Permanent Injury Compensation Team	Ph: 0800 101 996	Email: PIC@acc.co.nz



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Introduction

Welcome to the Impairment Assessment Services Operational Guidelines. The purpose of this Service is to provide an Impairment Assessment for Clients who suffer a permanent or long-term impairment resulting from an injury. This document is intended as both a guideline for those working to deliver Impairment Assessments and as a framework document for ACC.

These guidelines apply to all professions delivering services under the Impairment Assessment Services contract across all geographic regions.

These Operational Guidelines should be read in conjunction with the:

- Standard Terms and Conditions document; and
- Service Schedule for Impairment Assessment Services ('your contract').

Services must comply with the Impairment Assessment Service Schedule. Where there are inconsistencies between the Operational Guidelines and the Impairment Assessment Service Schedule, the Service Schedule will take precedence.

ACC will update these guidelines as required and they will be available on the ACC website at www.acc.co.nz.

Impairment Assessments Overview

Clients who suffer a permanent or long-term impairment resulting from an injury may be entitled to lump sum compensation or an independence allowance (IA).





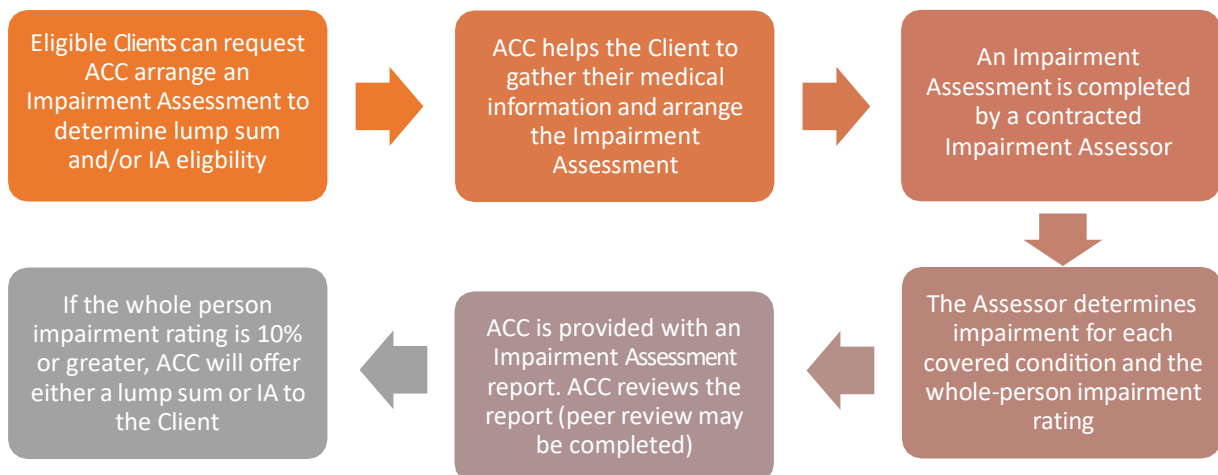
To determine the level of impairment, ACC purchases Impairment Assessment services from appropriately contracted and qualified medical practitioners. Assessing a Client’s impairment provides a fair and equitable basis for determining the level of lump sum and/or IA.

It is important to note that the concept of impairment differs from the concepts of disability and work capacity. The assessment and measure of ‘impairment’ is based on the injury effects on the person’s physical and mental function, not the impact on them personally (their disability), or their ability to work (work capacity). An Impairment Assessment does not determine diagnosis or causation. The key output from an Assessment is an Impairment Report.

All Impairment Assessments must be carried out using an Assessment Tool. Assessors are required to use the *American Medical Association’s Guides to the Evaluation of Permanent Impairment, Fourth Edition (AMA4)* and the [ACC User Handbook](#) to assess impairment related to the Client’s covered injuries. Assessors must have completed ACC approved training in applying the ACC User Handbook and the AMA4 Guides.

The Assessor is required to measure the Client’s “permanent and stable” impairment which is due to injuries covered by ACC: this measure or ‘rating’ is used to calculate a Client’s entitlement to lump sum and/or IA.

Whole person impairment ratings are determined based on the Client’s covered injuries. If a Client has a whole person impairment rating of 10% or greater and they meet eligibility criteria, they will likely be eligible for either lump sum and/or IA. There are some cases where Clients must reach higher than the 10% threshold. An overview of the process is illustrated below.



Roles and Responsibilities

Impairment Assessments require all those involved to work in partnership, with a mutual understanding of each other’s roles and responsibilities. The diagram below illustrates the roles and responsibilities of those involved in the Impairment Assessment process.





Requirements for Approved Service Providers (Assessors)

Qualifications Required

To be an ACC-approved Impairment Assessor the Assessor must be a Medical Practitioner who has at least general registration with the Medical Council of New Zealand (MCNZ) and three years' post-registration clinical experience.

They must hold a current Annual Practising Certificate. ACC relies on the MCNZ to assess the competence of a Medical Practitioner to hold a vocational Annual Practising Certificate.

Assessment Tool

The Assessment Tool refers to the:

- The ACC User Handbook for the AMA 'Guides to the Evaluation of Permanent Impairment' 4th Edition (ACC User Handbook); and
- The American Medical Association's Guides to the Evaluation of Permanent Impairment 4th Edition (AMA4 Guides).

The AMA4 Guides are explicit, but not intuitive, and are designed to require training in their use and application, as well as clinical judgement and expertise. The AMA4 Guides provide a framework for minimising interobserver variation in assessing impairment, and the ACC User Handbook stipulates how the AMA4 Guides are to be applied in New Zealand.

Types of Assessments

Assessors may only carry out the types of Impairment Assessment that they have been approved by ACC as being able to undertake. The types of assessment are:

- General assessments for physical injury; and
- Chapter 14 assessments for behavioural and mental impairment.

To complete Chapter 14 assessments for behavioural and mental impairment, the Impairment Assessor must either be a psychiatrist, or be experienced in completing general assessments for physical injury for ACC and have knowledge of psychology and the diagnostic system in psychiatry/psychology (as per the Diagnostic Statistical Manual of Mental Disorders (DSM)).



Training Requirements

To complete Impairment Assessments for ACC, Assessors must have satisfactorily completed an ACC approved training course on the use and application of the Assessment Tool.

The training involves understanding the Impairment Assessment system in New Zealand, practice in using the AMA4 Guides and the ACC User Handbook, assessment methods, calculating impairment, and report formatting.

Support for new Assessors

Following successful completion in the ACC training ACC may assign a mentor to the new assessor for a 12 month mentorship from an experienced assessor. The mento will provide support and feedback and through Peer Review will ensure compliance and quality of the Impairment Assessment reports.

Maintaining Skills and Knowledge

ACC requires Assessor's Impairment Reports follow the correct report format and provide accurate ratings in accordance with the AMA4 Guidelines, ACC User Handbook, the Service Schedule and current Operational Guidelines.

ACC provides the following activities for Assessors to maintain competence in Impairment Reporting:

- Refresher training for both general assessments for physical injury, and Chapter 14 assessments for behavioural and mental impairment, including policy and process updates.
- Updated guidance on consistency of approach in the Operational Guidelines - refer to the most recent version online.
- Newsletter updates
- Formal Peer Review. This is part of ACC's quality assurance program where an experienced Impairment Assessor provides formal Peer Review services including Impairment Report critique and direct feedback to the assessor.

ACC expects Assessors to participate in continuous improvement activities which includes regular participation in refresher training and to attend and contribute to monthly peer-led peer group meetings to present and discuss case studies and reports on a rotational basis. The cost of in person attendance at training is borne by the Assessor.



To ensure the competency of the clinical application of the rating methodology an Assessor that has not been providing regular impairment assessments for two years will not be able to take new referrals until they have successfully completed ACC's impairment assessment training again.

Updating Provider Details

Assessors must keep their details up to date. Whenever contact details change, they should email PICreferrals@acc.co.nz or phone 0800 101 996 to confirm their current:

- postal address;
- courier delivery address;
- e-mail address;
- telephone contact details, including the number that:
 - can be disclosed to the Client;
 - is for ACC use only.

Telehealth

Telehealth may be used instead of an in-person consultation on a case-by-case basis to meet Client need. Clinical appropriateness (including the potential need for a physical examination) needs to be determined by the assessor to ensure that a Telehealth consultation is appropriate.

A Telehealth consultation replaces an in-person consultation. This means that Assessors should not hold a Telehealth consultation and then require an in-person consultation to undertake a physical examination as part of the initial consultation.

When delivering a service via telehealth, the assessor will need to include a statement within the accompanying report to confirm the client did not need to be assessed in-person or physically examined, for the assessor to be able to form an opinion.

Services delivered by Telehealth must adhere to the requirements outlined in the Service Schedule. This includes following the expectations as set out in ACC's Telehealth guide (ACC8331) which is available on ACC's website.



Client's Eligibility and Referral Process to Assessors

Impairment Assessment Eligibility

A registered medical practitioner can apply for an IA/Lump sum entitlement (or both) at any time for their patient. To determine eligibility for an Impairment Assessment, the Client and their doctor may have to complete an ACC554 Medical Certificate and provide relevant medical records relating to the Client's injury(s).

If the Client meets the following criteria ACC will arrange an Impairment Assessment to determine the level of impairment.

Independence Allowance (Date of Injury: 1 April 1974 – 31 March 2002)

- The Client's condition is either stable or not stable and there is a likely impairment from injury.

Lump Sum (Date of Injury: 1 April 2002 to present)

- the Client's condition is stable and there is a likely impairment from injury;
- the Client's condition is not stable, but there is a likely impairment and it is two years or more since the injury.

Children under the age of 16 are not eligible to have the impairment effects of a mental injury assessed for lump sum unless there are compelling reasons. This is because long-term mental impairment effects cannot be accurately established.

Reassessment Eligibility

A Client is eligible for an Impairment Reassessment if the ACC554 Medical Certificate states that:

- the impairment may have increased since the date of Assessment;
- the impairment may have decreased since the date of Assessment (where the Client is in receipt of an IA).

A Client is not entitled to have more than one Reassessment in any 12-month period. A Client is not required to undergo more than one Reassessment in any 5-year period.

It is not considered a Reassessment if the Client was previously certified likely to have an impairment, but unstable and a new ACC554 Medical Certificate now certifies the injury as stable.



ACC may request for a Reassessment when:

- there are reasonable grounds to believe the impairment may have decreased since the last Assessment; and/or
- it has been five years or more since the last Reassessment.

Impairment Assessment Referrals

Once an application via the ACC554 for an IA or lump sum is deemed complete by ACC, ACC then determines whether the Client is eligible for an Impairment Assessment. If the Client is eligible, ACC will ensure there is enough information before completing the Impairment Assessment referral to an Assessor.

ACC will send the Client a letter confirming the referral and advising them that the Impairment Assessor will contact them within 10 business days to arrange the assessment. Clients are instructed to advise the Impairment Assessor if they will be bringing a support person with them. If the Client is unable to attend the assessment, they are instructed to phone ACC at least five business days prior to the date of appointment.

ACC will electronically send the Impairment Assessor a referral letter, containing the Client's contact details and requesting they make contact within 10 business days. The referral letter will clearly outline the covered injuries which need assessing. The following supporting documentation will be enclosed in the referral pack:

- medical certificates;
- medical notes;
- consent form.

After reviewing the referral information, if the Impairment Assessor determines they need additional specialist reports or travel to complete the Assessment they should contact ACC prior to the Assessment. If the Assessor notices anything inconsistent regarding the covered injuries, they should contact ACC (PIC@acc.co.nz).

Assessors must only assess the covered conditions that have been requested by ACC.

Multiple or Additional Impairment Assessments

ACC may need to arrange two separate Assessments by two appropriately qualified Impairment Assessors when both of the following apply:

- a Client suffers injuries that mean they need a physical Assessment and a mental and behavioural Assessment; and
- there is no Assessor available and qualified to conduct both Assessment types.



If ACC discovers that new information about a Client was available at the date of an Assessment or Reassessment but wasn't made available to the Assessor at the time they conducted and rated the impairment of the Client, ACC can arrange an additional Assessment to include the new information so that it can be considered.

A Client can arrange for an additional Assessment at any time at their own cost. If there are any points of difference because of this Assessment, ACC will investigate further.

Urgent Referrals

To be eligible for a lump sum entitlement, a deceased Client must have been assessed prior to their death and all the following must apply:

- the Client suffered a personal injury for which they have cover;
- the Client survived the injury for no fewer than 28 days;
- the Assessment established that the Client's injury resulted in a whole person impairment (WPI) of 10% or above.

The rules for assessing the impairment for an IA differ from those for lump sums.

If a Client requests an Impairment Assessment and has a terminal or rapidly deteriorating condition, such as mesothelioma, the Assessment process can be completed urgently.

ACC can prepare the claim(s) file records for the assessment process while the claim for cover is still being considered. This will reduce any delay between cover acceptance and the Assessment outcome. Where possible an Assessment based on the medical documents, without the need to see the Client in person may be completed.

Impairment Assessment Service Requirements

Impairment Assessment Process

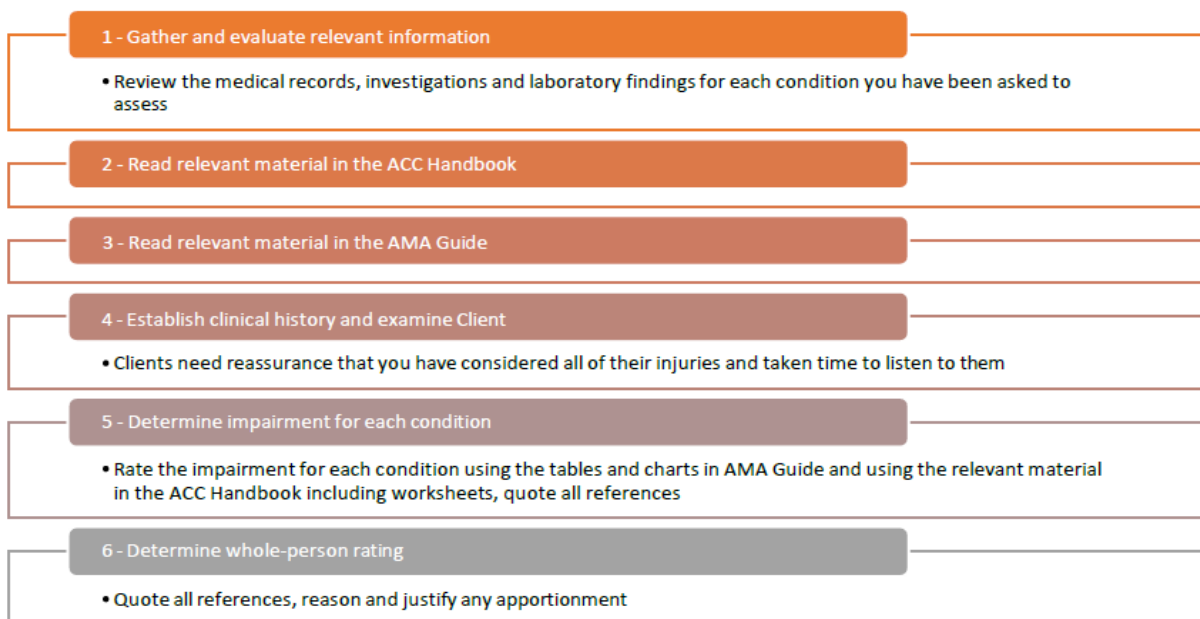
The Assessment Tool is used during an Impairment Assessment to provide an objective measure of a Client's impairment for ACC. The ACC User Handbook sets out the procedures, formatting and other requirements for the Assessment and Impairment Report in full detail.

The Impairment Assessor must, but is not limited to:

- Introduce themselves to the Client and provide an explanation of the Impairment Assessment process and what the assessment involves;



- Obtain and review any additional information required for a comprehensive Assessment of the Client;
- Complete a medical examination of the Client, see image below;
- Complete an Impairment Report in accordance with the formatting and procedural requirements of the ACC User Handbook, including a whole-body impairment rating.
- Discuss with the Client the findings of the assessment. The medical examination of the Client follows the process below:



When required, the Impairment Assessor may be required to submit a revised Impairment Report to ACC if feedback is received from ACC, or a reviewer engaged by ACC that the initial Impairment Report is unsatisfactory.

Impairment Assessments on Medical Records

In certain circumstances a Client may not be able to attend an Assessment due to being overseas or being physically unable to attend due to injury or illness. In these cases, ACC may ask an Assessor to complete the Assessment based on medical records. The Assessor will determine and advise ACC whether an accurate Assessment of their level of impairment can be completed from the medical records.



Impairment Assessments for Overseas Clients

In certain circumstances, ACC may request a Client return to New Zealand for an Impairment Assessment.

Where ACC allows an Impairment Assessment to be carried out overseas, ACC may require overseas Medical Practitioners to provide relevant medical reports. The overseas Medical Practitioner must meet the following criteria:

- hold registration in the country in which they are practising;
- hold a medical degree from a medical school approved by the New Zealand Medical Council. This includes universities listed in the WHO World Directory of Medical Schools.

ACC is not required to meet either of the following costs:

- any costs incurred by the Client overseas;
- any costs relating to the return of the Client to New Zealand for Assessment.

Impairment Assessment Reports

Prior to ACC issuing an IA and/or lump sum decision or sending a report for Peer Review, ACC will check the Impairment Report to ensure it meets the basic criteria required (refer to the Impairment Assessment Report Checklist). If an error in the Impairment Assessment Report is identified, ACC will contact the Assessor to discuss the error prior to issuing a decision or sending a report for Peer Review.

The ACC User Handbook contains a description of the format required for the Impairment Reports. The report format for general assessments for physical injury is found on page 11. The report format for chapter 14 assessments (behavioural and mental impairment) is found on page 41. The report format for an ACC4152 Impairment Assessment Accredited Employer Report is found at www.acc.co.nz.

The injuries assessed should be listed and consistent with those specified in the referral documents. Only include additional injuries when they have been requested or approved by ACC to be included. A list of the documents used in the assessment should also be listed. This should include any notes from the Client.

Impairment Reports should include a comment that 'apportionment' has been considered. Apportionment is the rating value that is deducted at the Whole Person level for impairment



that is due to non-covered conditions and must be clearly described and justified by the assessor.

When completing a **Reassessment**, it is also important to provide a clear clinical opinion on changes since the previous Assessment. This ensures the Client understands the reasoning for their entitlement decision.

Accredited Employer Reports need to be comprehensive enough for the employer to understand how the Assessor reached their conclusion. When writing the Accredited Employer Report, it is important that only details about the Client that relate to the injury covered by the employer are included.

It is also important to avoid making small errors. Any error, even in the spelling of a Client's name, can lead a Client to doubt the Impairment Report, raise concerns about possible rating errors and request a review of ACC's decision.

Service Timeframes

The Impairment Assessor must...	Within...
Contact the Client and arrange an assessment	10 business days of receiving the referral
Assess the Client	30 business days of receiving the referral, or notify ACC if this is not possible
See the Client at their Assessment appointment	30 minutes, or else give the Client a full explanation of why they were made to wait
Supply an Impairment Report to ACC	10 business days of assessing the Client
<ul style="list-style-type: none">• NOTE: Assessors who travel and complete Assessments offsite are required to contact the Client with the Assessment date, time and location, 10 days before their clinic.• NOTE: ACC recognises that Assessors will not be able to assess everyone within 30 days.• NOTE: Where Assessors require more than 10 business days to complete the Impairment Report then they should notify ACC. ACC recognises that situations will arise where the report will require more than 10 days to complete.	



Peer Reviews

Purpose

ACC checks the quality of Impairment Reports and impairment rating through a Peer Review process. Peer Reviews ensure the consistent and equitable provision of IA and lump sum entitlements to Clients.

Not all Impairment Reports are Peer Reviewed. The Treatment and Support Assessor will determine if an Impairment Report requires a Peer Review and may consider various criteria including the complexity of the injuries and the level of the rating.

When ACC refers for a Peer Review, ACC will send a referral letter, including the Impairment Report and the relevant medical records to the appropriately qualified Impairment Assessor to undertake the review.

A letter will also be sent to the Client informing them of the Peer Review taking place.

Who can provide a Peer Review Assessment

A small number of Impairment Assessors are approved by ACC to provide Peer Reviews. The Impairment Assessors who provide Peer Reviews must:

- have the necessary qualifications to be an Impairment Assessor;
- have completed the necessary training to be an Impairment Assessor;
- have maintained their competency through attending refresher training as well as providing Impairment Assessment services; and,
- have demonstrated their ability to produce Impairment Assessment reports of a consistently high standard.

Peer Reviewer's Role

The peer reviewer determines whether the Impairment Assessment Report:

- complies with the correct use of AMA Guides 4th Edition and the ACC User Handbook to AMA4;
- reflects the available information;
- draws the correct conclusions from the findings;
- applies the correct rating methodology;



- has correct calculations;
- contains the impairment rating for all injuries for which a rating has been sought;
- contains no apparent conflict between the records provided and the clinical findings; and,
- ensures apportionment is correctly applied and justified.

No Amendments to the Impairment Assessment Report

If the Peer Review service Provider considers that the Impairment Report complies with the report requirements and accepts the impairment percentage, they will provide ACC with a Peer Review Report. This report should comment on the above, along with general comments on the quality of the report. The Peer Review Service Provider should also provide the Impairment Assessor with a copy of the Peer Review Report.

Amendments to the Impairment Assessment Report

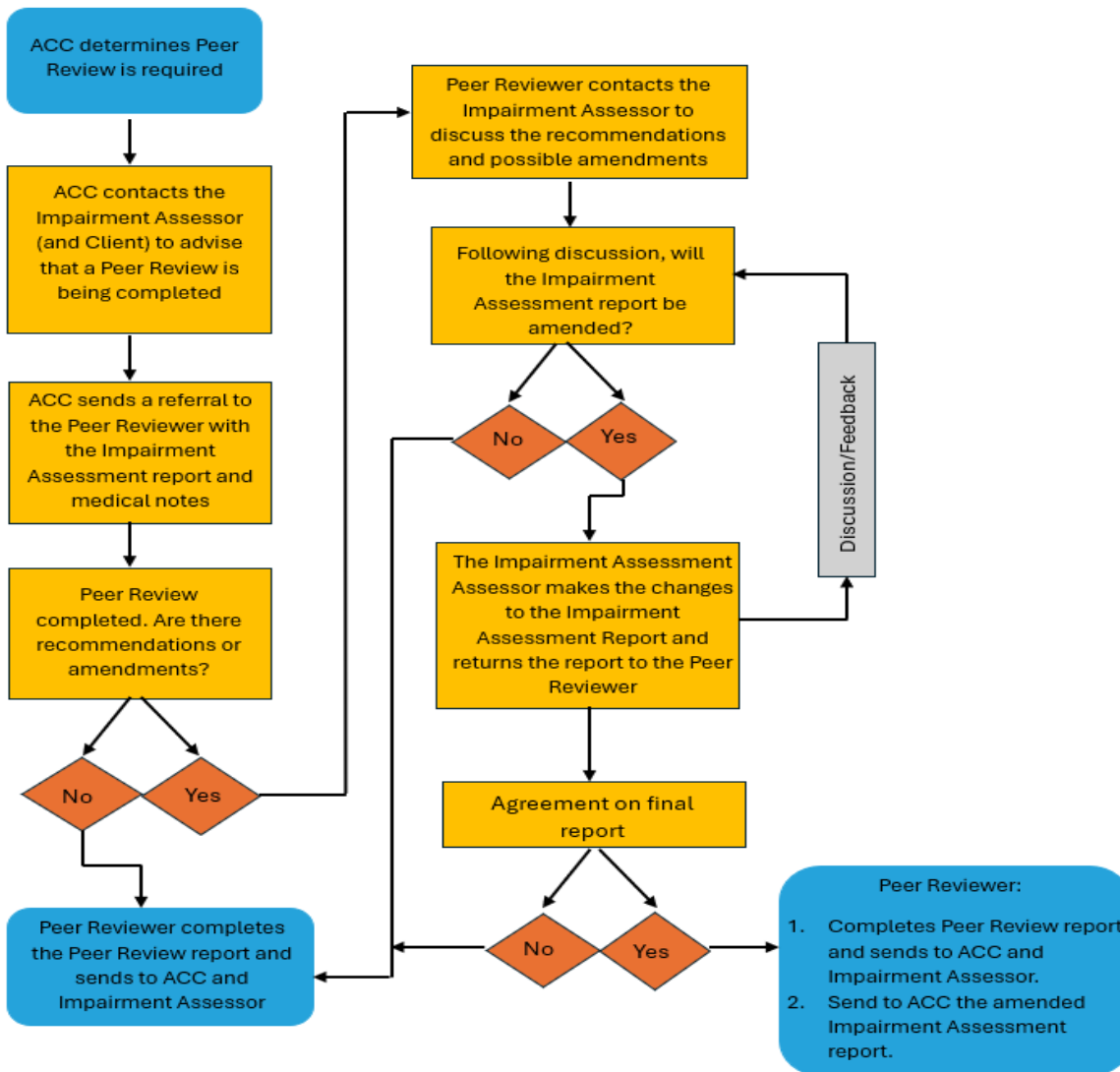
If the Peer Review service Provider considers the Impairment Report requires amendment, they will return the Impairment Report to the Assessor with the Peer Review Report and their suggested comments and amendments.

The Peer Review service Provider should call the Impairment Assessor to discuss the aspects of the Impairment Report that require amendment. The Impairment Assessor is required to make the amendments required to the Impairment Report and return it to the Peer Review Service Provider. Once the Peer Review Service Provider receives the amended Impairment Report and reviews it, if satisfactory, they will send it with the Peer Review Report to ACC.

If the Impairment Assessor disputes the Peer Review service Provider's findings, the Impairment Assessor can contact the Treatment and Support Assessor or ACC's Clinical Services Subject Matter Expert. The Clinical Advice Subject Matter Expert may discuss the suggested amendments with the Impairment Assessor (and Peer Reviewer if required) and provide advice. The Impairment Assessor will then make agreed amendments to the Impairment Assessment report and return it to the Peer Review service Provider.

If the Impairment Assessor still disputes the Peer Review service Provider's findings and the advice of ACC's Clinical Subject Matter Expert, the Peer Review Service Provider will note this on the Peer Review Report and return it without signing it off. ACC will then make a final decision. This may include sending the Impairment Report and Peer Review Report to another Peer Review Service Provider to conduct a Peer Review or arranging another assessment.

The Peer Review process is outlined below:



NOTE: The Peer Review Report should be provided to both the Impairment Assessor and ACC whether amendments are required or not.

Peer Review Timeframes

The peer review service Provider must...	within...
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Complete a standard Peer Review (no amendments)	5 Business days from the date the Peer Review referral was received
Complete a complex Peer Review (amendments required)	10 Business Days from the date the Peer Review referral was received
Inform ACC if the Impairment Assessor has taken longer than	5 Business Days to amend an Impairment Report



Mentoring for new Assessors

Purpose

Assessors who have recently undertaken and passed the ACC training for Impairment Assessments may be assigned a Mentor for the first 12 months of undertaking assessments. The period of mentorship is to provide support and feedback to these Assessors and to ensure compliance and quality of the Impairment Assessment reports.

ACC will notify the Mentor with the Mentee's details and the start and finish date of the mentoring period.

Expectation of the Mentor:

The Mentor will:

- establish an agreed communication format and structure with the Mentee;
- facilitate learning conversations with the Mentee that challenge and support them;
- provide advice and support on ACC Impairment Assessments such as:
 - the day to day of undertaking Impairment Assessments for ACC e.g. communicating with the PIC team, what can be expected on Purchase Orders, invoicing, etc.
 - technical aspects of the impairment rating methodology as prescribed in the AMA4 Guides and the ACC User Handbook.
- undertake Peer-Review of Impairment Assessment reports:
 - General assessments for physical injury assessments: the first 10 assessments
 - Chapter 14 assessments for behavioural and mental impairment assessments: the first 4 assessments.

The Mentor will undertake a Peer-Review as outlined in Section 8 of these Operational Guidelines.

- Provide two reports:
 1. Following completion of either the first 10 physical injury assessments and/or the first 4 mental injury assessments to confirm:
 - Impairment Assessment reports follow the formats outlined in the ACC User Handbook to the AMA4 guides; and



- if undertaking Impairment Assessment Physical Injury Assessments has completed ten Physical Injury Impairment Assessment reports to a satisfactory level.
 - if undertaking Impairment Assessment Mental Injury Assessments has completed four Mental Injury Impairment Assessment reports to a satisfactory level.
2. Final report following the 12 month mentorship outlining the support provided through the mentorship and providing any further comments or feedback.

Expectations of the Mentee

- Actively engage with the Mentor and participate in learning conversations.
- To send through the required completed Impairment Assessment report directly to their Mentor for Peer-Review.
 - General assessments for physical injury assessments - the first 10 Impairment Assessment Reports
 - Chapter 14 assessments for behavioural and mental impairment assessments – the first 4 Impairment Assessment Reports

If the Assessor or Mentor has any concerns about the mentorship, these should be raised through the local Engagement and Performance Manager (EPM) or directly to ACC's portfolio team via medicalassessments@acc.co.nz.



Impairment rating issues

The topics covered in this section are not intended to provide training or clinical guidance in Impairment Assessment, but they are helpful to understand.

Apportionment

Apportionment needs to be considered when a condition not covered by ACC is contributing to the impairment as non-covered conditions are not compensable. Clients with cover for an injury often assume that all the impairment in the injured area is part of their Lump Sum or Independence Allowance rating, but that may not be the case. The assessor will use their clinical judgement and objective evidence to determine whether part of the impairment rating has to be 'apportioned' to non-injury related factors (see page 10 of the ACC User Handbook for apportionment methods).

The reasons for apportionment need to be clearly explained in the report in a way that the client, ACC, GP, and/or Reviewer can understand. Clients often want to discuss the reasoning when we advise them of our decisions, and it helps to reduce the risk of Clients requesting reviews of our decisions.

Example on:

Mr Z fractures his ankle; it heals with 10 degrees of angulation. The healed fracture with angulation was a 6% whole-person impairment (AMA Guides. Table 64. page 86). He does not qualify for Lump Sum.

He later has an arterial occlusion (blocked artery, not a covered injury) and has an amputation below the knee.

The current state is the amputation, which is a higher impairment rating, but this has 'removed' the fractured ankle and cannot itself be compensated so his WPI = 0%.



Example two:

Mr Y had a stroke causing left hemiparesis and reduced motor function in his left leg. This makes it difficult for him to walk distances and he's limited to walking on flat surfaces.

Mr Y then falls and fractures his neck of femur, which is the covered injury. A subsequent hip replacement has a poor outcome when graded using AMA-4 Guides (Table 65, page 87 and Table 64, page 85).

It is clear that Mr Y suffered a lower-limb impairment from his medical condition before the injury. The pre-existing impairment can be calculated using the AMA-4 Guides' brain and cranial nerve section (Ch 4).

At the level of the Whole Person, the assessor would calculate the rating of the impairment due to the hip replacement, and the level of the pre-existing impairment in the leg due to the stroke, and deduct a percentage from the WPI to reach the compensable WPI value.

Dividing or distributing impairment

When a client has several injuries that occurred in different time periods the overall impairment rating needs to be divided or distributed between the injuries to ensure the correct compensation value is applied. For example, there are situations in which clients are eligible for Independence Allowance in relation to injuries before 01 April 2002 who have already received a 'lump sum' payment under different legislation, and their IA has to be adjusted, and they may have injuries after 01 April 2002 which are eligible for Lump Sum.

The assessor will use the evidence in the file and their clinical judgement to assign a WPI rating to separate injuries, noting that an impairment cannot be 'compensated twice' (duplication).

Notes on some commonly encountered conditions

Mesothelioma

When we receive a claim from a Client who has mesothelioma, our staff work closely with them to establish whether the Client is well enough to attend a face-to-face assessment, or



their medical condition means the assessment needs to be done via a file review. Either way, it's important that an assessor undertakes the assessment, to ensure an official and independent interpretation of and report on the clinical information.

In 2005, ACC determined that Clients with confirmed diagnoses of mesothelioma would automatically be given a whole-person impairment rating of 80% irrespective of their clinical condition. Currently this is the only cancer rated in this manner. Clients with cancers at other body sites should be rated using the relevant chapters in the AMA4 Guides.

Asbestosis/pleural plaques

When we receive a claim from a Client who has asbestosis or pleural plaques, the assessment is based on spirometry results.

If needed, a respiratory physician may comment on the proportions of the Client's obstructive and restrictive breathing impairments to support the apportionment rationale for rating impairment from exposure to asbestos as opposed to non-ACC-covered conditions.

Lung cancer

Lung cancer is rated in accordance with Chapter 5 page164.

Clients with cancers at other body sites should be rated using the relevant chapters in the AMA4 Guides.

Visual System

Overview

The rating method for the visual system is detailed in the ACC User Handbook (pages 54-55) and the Guides.

Note a 'visual field defect' may be due to brain injury or local injury, the referral documents should include a recent optometrist's assessment on the type and extent of the field loss.

If the Client needs visual field testing beyond 30 degrees, please contact one of our service centres; they have the details of providers who undertake these (special) tests.

Using prostheses in assessment

A Client's visual system is tested with glasses or corrective lenses if they usually wear them.



- A Client with facial deformity in relation to their covered eye injury may attract a cosmetic rating; the AMA4 Guides (page 222) allow up to 10% impairment (maximum). This is combined with the impairment rating due to vision loss at the level of the Whole Person.

Mental Injury

Apportioning

- There is no apportionment of the covered mental injury – impairment due to the covered diagnosis is eligible for compensation;
- any impairments due to non-covered conditions, non-covered symptoms or behaviours (even when these don't meet a diagnostic threshold) are apportioned.

This approach can also be applied to rating behaviours and symptoms where the diagnostic criteria for a formal mental health condition that ACC has covered are no longer met. For example, if a Client has previously received mental injury cover for a particular condition, and a new assessment finds that they don't have the condition, or the condition no longer meets the full diagnostic criteria, symptoms related to the previously diagnosed condition might still continue. If there is impairment due to these symptoms it could be rated for compensation.

If you need help identifying the covered injury or extent of cover, contact the impairment assessment unit before you undertake the assessment or write your report.

Example:

A Client has cover for Post-Traumatic Stress Disorder (PTSD). The Client has another diagnosis (major depressive disorder), which isn't covered by ACC and pre-dated the injury related to the PTSD.

The Client's current presentation is thought to relate mainly to PTSD.

How should the Client's mental and behavioural impairment be rated and apportioned?

As PTSD is the covered injury, the impairment rating due to PTSD shouldn't be apportioned as cover for this episode of PTSD has been established.

The current impairment rating determined by using Chapter 14 of the AMA Guides and the ACC User Handbook is thought to relate mainly to PTSD.

Some apportionment may be made if there is evidence that there was impairment prior to the PTSD. The reasoning should include a description of the pre-existing impairment of mental and behavioural functional classifications ('activities of daily living', 'social functioning', 'concentration, persistence and pace' and 'adaptation and decompensation') to justify the extent of apportionment for non-covered conditions.



Not otherwise specified cases

There are some cases where there is no clearly specified mental injury accepted historically by ACC. This may relate to claims accepted under the 1972 or 1982 Accident Compensation Act, where cover was extended to the physical and mental consequences of injuries and accidents, or to historically accepted Sensitive claims under the 1992 Accident Rehabilitation and Compensation Insurance Act for ‘mental or nervous shock’. There may not be enough evidence for a psychiatrist who sees the Client now to determine their diagnosis at the time cover was accepted.

In these situations, the Clients are covered by ACC and have a right to apply for Independence Allowances for those covered injuries.

If a Client meets ACC’s legislative requirements for an assessment or a re-assessment of their impairment, we’re legally required to make that happen.

We’ll refer the Client to you for an assessment based on the cover granted when we first received their claim.

Pain

The pain rating method is detailed on page 42 of the Handbook. Pain isn’t separately rateable, unless it’s specifically noted in the AMA4 Guides. In general, the AMA4 Guides’ percentages for organ systems already allow for accompanying pain. Pain may be separately related for physical injuries involving specific nerves or where there is cover for Complex Regional Pain Syndrome (CRPS). The rating method for CRPS and criteria are detailed in the Handbook and in Impairment Rating training. Where there is cover for a mental injury such as Pain Disorder, pain may be rated for its effect on mental and behavioural functioning using Ch 14 by a suitably qualified and trained assessor.

However, all Impairment assessment reports must show that pain has been considered in reference to page 42 of the ACC User Handbook and Chapter 15 of the AMA4 Guides. The report should include:

- the source of a Client’s pain (e.g. injury/non-injury);
- reference to page 42 of the ACC User Handbook, and Chapter 15 of the AMA4 Guides, including the frequency and intensity of the Client’s pain;
- how the chapter on the relevant organ system has considered pain and how this is reflected in the rating;
- any other relevant information

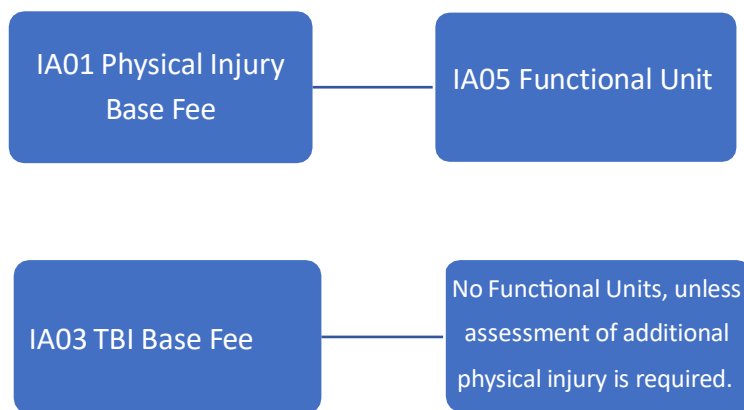


Invoicing and Purchase Orders

General Assessments

For all general Assessments, ACC will provide the Assessor with a Purchase Order containing the service item codes to be used when invoicing ACC for the service. All general assessments, excluding assessment for TBI, will have a base fee and at least one functional unit.

General Assessment Service Item Codes

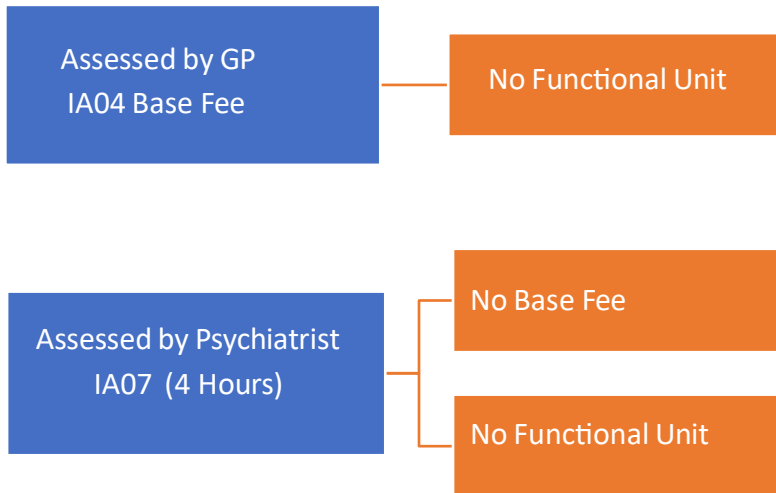


Chapter 14 Assessments

For all Chapter 14 Assessments, ACC will provide the Assessor with a Purchase Order containing the service item codes to be used when invoicing ACC for the service. All Chapter 14 Assessments completed by General Practitioners (GP) have a base fee. All Chapter 14 Assessments completed by Psychiatrists are paid based on an hourly rate, set at 4 hours per assessment. No functional units are available for Chapter 14 Assessments.



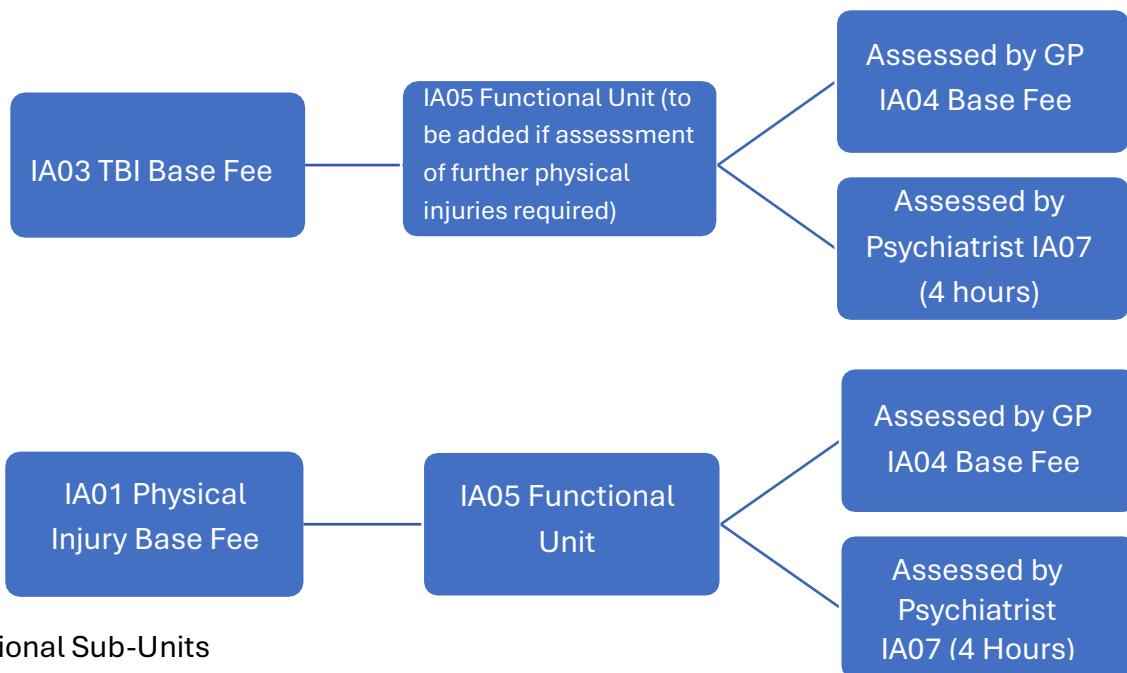
Ch 14 Assessment Service Item Codes



General Assessment and Chapter 14 Assessments

When an Assessor is required to complete both a general and Chapter 14 Assessment, the Purchase order will contain the service item components of each Assessment.

General Assessment and Ch 14 Assessment Service Item Codes



Functional Sub-Units



The whole-person is divided into functional sub-units which are detailed on page 12 of the ACC User Handbook. For the purposes of payment and invoicing, the Assessor will be provided a service item code for each functional sub-unit needing to be rated. A maximum of 7 functional units can be provided. The TBI base fee is intended to cover the entirety of the assessment for TBI. However, if the assessment is particularly complex and other functional sub-units are implicated, assessors can apply to ACC for the appropriate functional unit to be added to the purchase order. Alternatively, if the assessment requires assessment of both TBI and other covered physical injuries, ACC will include the funding for additional functional units within the referral as required.

Exceptions:

- Skin: 1 unit but cannot be counted as a second functional unit in any one claim. Scarring cannot be counted as a separate functional unit;
- Pelvis: 1 unit but is not counted as a second functional unit in any one claim. A pelvic injury is considered as a second functional unit when the injury fits into the urinary and reproductive or endocrine system. The 'Pelvic' functional unit refers to the bony pelvis.

Example:

- You're asked to rate two lumbar spine claims. As this involves considering the spine, skin and pain, your service should be invoiced as one functional unit: the spine;
- You're asked to rate injuries to both lower limbs. As this involves considering both lower extremities, skin and pain, your service should be invoiced as two functional units – left and right lower extremities.

If your purchase order doesn't match the functional units you're assessing, please contact the Treatment and Support Assessor.

Exceptional Circumstances

An Impairment Assessment can be considered exceptionally complex, and the Assessor will be entitled to utilise the IA06 code.

1. A provider can bill for a single IA06 code if either of the below two criteria are met:
 - Seven or more injuries (functional areas) are being assessed; or
 - Reviewed medical records exceed 150 pages.



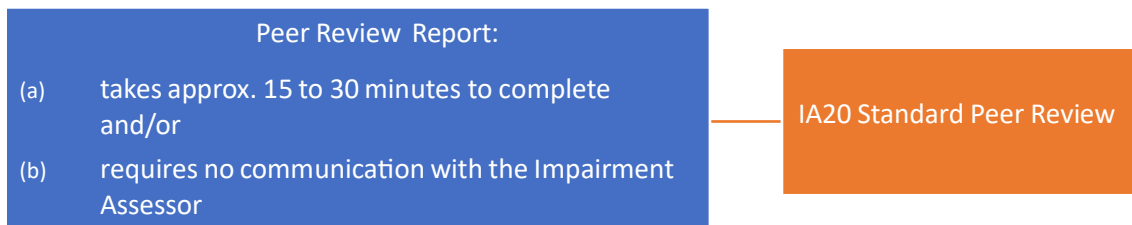
2. A provider can bill for two IA06 codes if:
 - Seven or more injuries (functional areas) are being assessed; AND
 - Reviewed medical records exceed 150 pages.

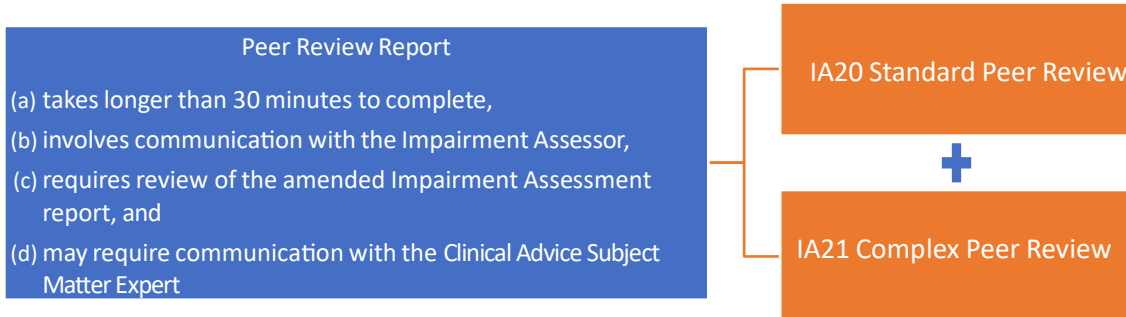
3. Where complexity results in an Assessment taking much longer, but the above criteria are not met, then the Assessor may contact the Treatment and Support Assessor after the Assessment and request an IA06. The Assessors must advise ACC of:
 - The total time taken to complete the Assessment, including the pre-reading, assessment, apportioning and report writing.
 - The reason for the increased complexity. For example, reasons may include, but are not limited to:
 - the covered injuries being assessed cover two legislative periods;
 - the Client has a communication impairment which limits their ability to communicate;
 - the Client has complex apportionment requirements e.g. progression of cancer, or another condition where the Client had pre-existing non-injury impairment prior to the injury occurring.

Using the information provided by the Assessor, ACC will determine the entitlement to the IA06 based on the service items already provided, for example, where an IA01, IA04 and multiple IA05 service items are provided, this will be expected to take much longer than a single IA01. In rare cases a second IA06 code may be approved. This will only be considered after the Assessment has been completed.

Peer Reviews

For all Peer Reviews, ACC will provide the Peer Review Service Provider with a purchase order containing the service item codes to be used when invoicing ACC for the service.





Non-Attendance Fee (DNA)

Clients have a responsibility to participate and co-operate in the Impairment Assessment process. Clients should notify their Treatment and Support Assessor and the Impairment Assessor if they are unable to keep their appointment, or where there are unexpected changes in their circumstances.

Impairment Assessors can invoice ACC for a Client non-attendance fee if the Client does not attend their appointment and fails to give two working days' notice. ACC expects that Impairment Assessors will make all reasonable efforts to remind the Client of the appointment 4 days before the scheduled time, such as an appointment card, a reminder letter, a phone call, or a text message to the Client. This fee can only be charge once for any referral.

Where the Assessor is holding a travelling clinic, the Assessor may receive more than one non-attendance fee where the Treatment and Support Assessor arranges a subsequent Assessment and the Client fails to attend again. Travelling assessors may also be entitled to a non-attendance fee in other circumstances outside of the Assessors control. ACC's Treatment and Support Assessor will consider this on a case-by-case basis.

If the appointment is an onsite appointment, the Assessor can claim 40% of the base fee. If it was an offsite appointment, the Assessor can claim 60% of the base fee. The base fee may vary depending on which type of Assessment has been referred. If there was more than one Assessment referred, the Assessor can invoice for the Assessment with the higher amount.



To claim the non-attendance fee the Assessor must include:

- assessment date;
- DNA reason (if you have been provided one); and
- copies of relevant correspondence with the Client, or copies of file notes recording communication with the Client before the scheduled appointment date.

Travel

Off-Site Assessments

There may be circumstances where the assessment must be undertaken in a location away from the Supplier's facility due to Client circumstances or physical condition. The Supplier will require ACC prior approval to travel to the alternative location and ACC will cover cost for the travel as outlined in the Travel Policy for Providers that can be found on our website (acc.co.nz).

Assessors who travel

Impairment Assessors can nominate to travel and hold clinics in different locations if there is a shortage of local Assessors in that area.

ACC will contact the Impairment Assessors who have agreed to travel once there are several Clients needing Impairment Assessment in an area. The Impairment Assessor will be required to confirm their availability to complete the Impairment Assessments. ACC will work with the Impairment Assessor to ensure all available appointments times are filled.

In scheduling assessments, we always consider whether there are qualified Assessors close to where our Clients live. However, if a Client wishes to see someone else and has a valid reason for doing so, ACC will arrange for an Assessor to travel to them and try to make at least two Assessment appointments in the area on the same day.

Any travel required outside the areas Assessors are usually contracted to go to will need to get prior approval from ACC. Assessors may need to travel outside their usual areas when:

- there is a shortage of Impairment Assessors in the area;
- a Psychiatrist is required;
- an Assessor is required for a specific reason.



ACC will not normally pay Assessors for travelling beyond their usual contracted locations for one Client. However, one-off situations can be discussed with the PIC Team (PIC@acc.co.nz).

Accommodation

ACC will pay actual and reasonable accommodation costs when:

- prior approval is gained from ACC and receipts provided
- ACC requests that you travel outside your home/practice region (somewhere that is not where you live or usually practice) and you need overnight accommodation.
- a meal allowance when you are staying overnight.

Note: ACC does not reimburse for alcohol, including mini-bar expenses

Remote Access Fee

This fee is payable where we request the assessor to conduct a clinic in an area outside of their usual area of residence or practice and as a result, they're required to hire rooms for the specific purpose of providing Services.

Culturally Competent Services

Impairment Assessments should be conducted in a Client-centred manner and tailored to meet the cultural needs of Clients. Services delivered will recognise and respect individual cultural and spiritual values and beliefs. Impairment Assessors should check with Clients that information is communicated in a way Clients and their family / whānau understand.

Meeting the Cultural Needs of Māori Clients

Impairment Assessors will ensure services are delivered to Māori Clients in a way that recognises and respects Māori values and beliefs, and information is communicated in a way that they and their family / whānau understand.

For further information see: Te Whānau Māori me ō mahi - guidance on Māori Cultural Competencies for Providers which can be downloaded from the acc.co.nz website. Adhering to the requirements of these guidelines will assist Suppliers in meeting their responsibilities for cultural competence and deliver positive health outcomes for Māori clients.



Clients who Require an Interpreter

If there are any interpreting or cultural needs identified, the Impairment Assessors should discuss these with the Treatment and Support Assessor. If the Client needs an interpreter, a professional interpreter will be provided by ACC to ensure the Impairment Assessment is conducted in a way that is confidential, effective, and ensures the Client is fully aware of what's being asked of them.

The cost of the interpreter service is met by ACC. Payment is conditional on ACC's prior approval that an interpreter is needed, cost effective and appropriate.

Multiple Support People

To complete a good Assessment the Client should feel comfortable and relaxed. This may be helped with the support of a friend or relative.

The Client has the right to bring a support person/s (friends, family members / whānau, or other representatives) with them for support, provided that the safety of all involved can be assured and the effectiveness of the Assessment is preserved. Clients do not have to explain or justify why they want a support person and it may involve more than one person.

However, if the Impairment Assessor is not comfortable with the situation and consider that they cannot undertake the Assessment (e.g. a support person/s becomes disruptive and/or obstructs the Assessment process) this should be discussed with the Client. If the Impairment Assessor cannot resolve the issue they may need to terminate the Assessment and contact the Client's Treatment and Support Assessor.

Working with Clients who may pose a Health and Safety Risk

ACC may not always have access to detailed information concerning a Client's history, but if a Client has been identified as posing a risk, the Treatment and Support Assessor will be able to provide information relevant to the Impairment Assessor to help mitigate health and safety risks.

ACC Clients who meet two or more of the following criteria are considered to pose a potential risk to safety, and will have a Care Indicator activated by ACC:

- Have continued to demonstrate intimidating and/or offensive behaviour (e.g. body language and verbal dialogue has made employees feel unsafe);



- Been abusive, verbally or in writing;
- Made racist or sexist comments;
- The current actions being undertaken on their claim by ACC are known to have caused or are expected to cause a significantly negative response from the Client. For example, prosecution, fraud investigation, cessation of Weekly Compensation, etc.

Clients who meet any one of the following criteria are also considered a hazard and will also have a Care Indicator activated:

- Have been or are physically violent (this unacceptable behaviour may not have occurred directly towards ACC employees);
- Have a history of violence or aggressive behaviour, have known convictions for violence;
- Made threats previously against ACC, ACC employees or agents acting on ACC's behalf;
- Intimidated an employee through written abuse or verbal abuse (face-to-face or over the telephone) to the extent they felt unsafe;
- Exhibited homicidal ideation.

If, for some reason, such as a safety risk or an inability to obtain a history or undertake a physical assessment, the Impairment Assessor considers that the Assessment may not be able to continue, they should discuss the situation with the Client and try and resolve the situation. Another reason for stopping the Assessment is when a Client withdraws their consent to continue with the Assessment.

If despite discussion the Impairment Assessor is unable to reach a resolution and feels that the Assessment should not or cannot continue, they should explain this to the Client and terminate the Assessment. In this situation, the Impairment Assessor will notify the Client's Treatment and Support Assessor as soon as possible and fully document the reasons for the termination of the Assessment in their Impairment Report.

Communication Regarding Clients with a Care Indicator (Risky)

The Treatment and Support Assessor of a Client with a Care Indicator will advise the Supplier in writing, either:

- Prior to the Suppliers initial contact with the Client; or
- If the Supplier is already providing services to the Client, as soon as possible when ACC receives new information about Client risk.



Please report any threatening behaviour to the police immediately if you feel that it is warranted in the circumstances and advise ACC and any other parties that are at risk as soon as possible. All threats by Clients or their representatives must be reported to ACC in writing using the online form on our website. ACC ask that Suppliers report threats for the protection and safety of ACC staff and other providers that are working with the Client.

Supplier safety is a priority and any Assessment should be terminated if the Client, their advocate or support persons make the Impairment Assessor feel threatened or unsafe in any way. If the Impairment Assessor's safety is at risk, please notify:

- The Client's Treatment and Support Assessor as soon as possible and fully document the reasons for the termination of the Assessment in the Impairment Report;
- The police warranted in the circumstance.

If the Impairment Assessor choose to continue with Assessment of a care indicated Client and wish to employ a security guard, then please contact the Treatment and Support Assessor.

Reporting Health and Safety Risks and Incidents

Health and safety risks and incidents (including notifiable events (as defined by WorkSafe), threats, and other health and safety risks, must be reported to ACC using the procedure and online form on the [ACC website](#).



Privacy and Storage of Client Health Information

You are bound by the Health Information Privacy Code 2020. This code sets specific rules for agencies in the health sector. It covers health information collected, used, held and disclosed by health agencies and takes the place of the information privacy principles for the health sector. It is important you comply with the code.

Practical meaning of this code in relation to the Impairment Assessment Services:

Practical Meaning of the Code

- The Assessor must check they've been sent the right information;
- Use a secure email address for correspondence which includes personal Client health information. Secure email is an email account with password and security features that only you and authorised people can access;
- Check every email address to ensure that the email is going to the intended recipient;
- Documents which are password protected may be blocked by ACC's fire wall;
- Store information responsibly. For example, personal Client information shouldn't be left unattended in your car or unsecured at your personal residence;
- Further information and advice on ACC's requirements for supplier storage of personal and health information can be found on our website ("Protecting privacy as a supplier or provider" acc.co.nz).

Service Management

Matters requiring clarification

Impairment Assessors should contact the Treatment and Support Assessor in the first instance if there are any matters requiring clarification. Examples could include:

- Poor or inadequate information in the referral;
- There is a requirement for verbal instructions to be put into writing;
- Issues regarding timeliness of the assessment;
- A change to a purchase order;
- Prior approval is required.



Raising issues with ACC

When an Impairment Assessor or Supplier raises an issue with ACC and the issue is not able to be resolved directly with the Treatment and Support Assessor, it may need to be escalated to a senior staff member, e.g. a Team Manager or Engagement and Performance Manager (EPM). If required, they will seek advice and guidance from the Portfolio Advisor.

If the issue cannot be resolved by a Team Manager or EPM the Treatment and Support Assessor must follow line management escalation processes for that issue, e.g. escalate the issue to an Area Leader, EPM, Portfolio or Health Procurement. This is especially important for any issue with the potential to be high risk, involves risk to a Client, or risk to ACC's reputation. For contact details please see list of contacts at beginning of this document.

If there has been a high risk or adverse event such as a:

- Privacy breach;
- Personal or Client harm or safety issue;
- Contract breach;
- Media risk.

The Impairment Assessor or Supplier must tell ACC immediately by either:

- Contacting the EPM;
- Contacting the Provider Contact Centre on 0800 222 070.

It is important to make contact and not just leave a message. For issues not able to be resolved using the process outlined above please refer to ACC's website and/or your Standard Terms and Conditions.

Quality and performance measures

Performance

The performance of Impairment Assessors is measured against the quality and performance measures listed in the Service Schedule. The key measures are:

- To provide Impairment Reports assessed by ACC as complete, accurate and of suitable quality;
- To complete the services within the timeframes set out.



The quality of the Impairment Assessment reports is reviewed by the Treatment and Support Assessor using the Impairment Assessment Report Checklist. Peer reviews may also be completed to check the quality of Impairment Reports and the impairment rating. ACC can use data from invoices submitted to measure if services are being delivered within contractual timeframes.

Engagement and Performance Managers (EPM) may meet with Impairment Assessors where quality issues need addressing.

Engagement and Performance Manager (EPM) Meetings

EPMs may meet with Assessors as arranged between the parties to discuss any issues which have been escalated to the EPMs from ACC, Clients, other health providers, or other stakeholders. Assessors are encouraged to raise any issues in relation to meeting their performance requirements with the EPM in the first instance.



Appendices

Glossary

ACC Claims Assessment Unit	The unit within ACC which is responsible for determining complex cover, treatment and support decisions.
ACC User Handbook	The ACC User Handbook to the AMA4 “Guides to the Evaluation of Permanent Impairment” 4th edition” as published by ACC from time to time.
AMA4 Guides	The American Medical Association’s Guides to the Evaluation of Permanent Impairment (4th edition).
Assessor or Impairment Assessor	The approved assessors listed in Part A, clause 3 of the Service Schedule approved by ACC to provide Impairment Assessments/Reassessments.
Assessment or Reassessment	The services described in the Service Schedule for Impairment Assessment Services , particularly the assessment of the Client.
Assessment Tool	The American Medical Association’s Guides to the Evaluation of Permanent Impairment (4th edition) and the ACC User Handbook to AMA4.
Client	The injured person receiving cover and support from ACC.
Impairment Report	The report prepared by an Assessor based on the results and recommendations arising from an Assessment.
Medical Practitioner	A person registered or deemed to be registered under the Medical Practitioners Act 1995 (see that Act, ss12, 144);
Clinical Services Subject Matter Expert	The ACC Medical Advisor who provides clinical oversight and ensures quality of the Impairment Assessment Reports and whole-person impairment rating.



Peer Review	The services described in the Service Schedule for Impairment Assessment Services , particularly the Peer Review assessment.
Peer Review Report	The report prepared by a Peer Review Service Provider based on the results and recommendations arising from the Peer Review.
Supplier	The Supplier is the legal holder of the contract and has the full and final responsibility for the delivery of the service. The Supplier can also be a service provider and/or the employer of service providers.
Treatment and Support Assessor	The ACC staff member responsible for the independent allowance and lump sum entitlement decision.



Impairment Assessment Report Checklist

General		
Client Name/address/DOB correct:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date/time of appointment and duration of assessment noted:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of Accident/s correct:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Injuries correctly described:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Treatment history discussed (where appropriate):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Details of medical records received:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pre-existing medical conditions/non-accident related injuries noted:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Adequate Analysis		
Permanence stated:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stability stated:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Adequacy of medical records referenced and noted in report:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Scaring considered and rated (even if 0%):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Discussion with Client noted:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Impairment Rating		
Have all injury related impairments been considered?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are calculations of impairment referenced to the AMA4 guides?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



Have the appropriate worksheets been used and enclosed? Yes No

- Upper extremity
- Visual impairment
- Brain and cranial nerves
- Lower extremity

Has apportionment been considered and justified where appropriate? Yes No

Have all the relevant injuries been combined for the correct date ranges (pre 01/07/99; 01/07/99-31/03/02; post 31/03/02)? Yes No

Have enough details been obtained (for head injuries or mental injuries only)

Current personal circumstances: Yes No

Personal history: Yes No

Medical history: Yes No

Psychiatric history: Yes No

Drug, alcohol, forensic history: Yes No

Mental status examination: Yes No

Activities of daily living: Yes No

Social functioning: Yes No

Concentration persistence and pace: Yes No

Fatigue/sleep disorder: Yes No

Apportionment discussed and justified where appropriate: Yes No

Comments
