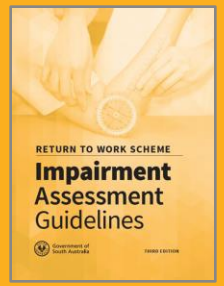
Chapters 2, 3 and CRPS

Changes and Review of the Third Edition of Impairment Assessment Guidelines



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We recognise that Aboriginal and Torres Strait Islander people are the First Peoples of Australia.

We acknowledge that we are meeting on the traditional lands of the Kaurna people and we pay our respects to the Kaurna people, and their Elders, past, present and emerging.


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2 & 3

A new Third Edition of Impairment Assessment Guidelines will commence on 1 October 2025

- Stakeholder Consultation Group was established by Minister Kyam Maher MLC
- Representatives from Australian Medical Association SA, Law Society of SA, SA Unions, and ReturnToWorkSA
- Extensive multi- round consultation

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The Third Edition of the Impairment Assessment Guidelines has been developed with a strong focus on ensuring that workers receive fair, consistent, transparent and objective assessments.

The changes support the goal that workers with similar impairments will receive similar assessments.

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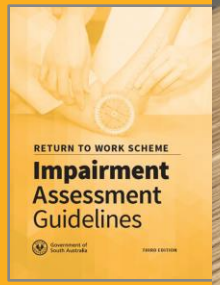
Chapter # 2 Upper Extremity

Changes in the Third Edition of Impairment Assessment Guidelines



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Presenter
Dr. Andrew Saies

Orthopaedic Surgeon specialising exclusively in Hand Upper Extremity conditions in private practice at Sportsmed for 35 years.

Extensive experience in treating upper extremity work and motor vehicle injuries.

Extensive experience providing treating practitioner, independent medical examiner, accredited ReturnToWorkSA WPI assessment and medicolegal reports.

Past: Managing Director and Chairman Sportsmed private Hospital.

Current: Chairman of the LCLHN, HOU Orthopaedics NALHN and Medical Advisor ReturnToWorkSA

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Learning Objectives

Able to:

- **Understand, identify, interpret and apply:**
    - modifications to AMA5 established by the IAG3 and the changes from IAG1
    - requirement for impairment assessment reports to include clear reasoning for the assessment method used and the rating derived
    - assessment of stability and provision of a diagnosis.

- **Document** the calculated range of motion of the relevant joints in both upper extremities.
- **Evaluate** peripheral nerve injury and assign a WPI impairment %.
- **Understand** the changes to assessment of resection arthroplasty of the shoulder.
- **Understand** that strength assessment prior recommendations are now requirements.

Chapter 2: Preamble

- The assessment report should set out the reasoning for the assessment of the work-related impairment and the relationship of the rating to the 'injury'.
- Where method selection occurs, the choice of method should be reasoned, including a description of the chosen method and its relationship to the 'injury'.

Charts and tables

- Figure 16-1a and 16-1b in AMA5 are strongly recommended for use:
  - to document findings, and
  - to assist with the assessment process.
- Are particularly useful in the assessment of the digits where they provide direction to assessors on when to add and when to combine impairments.

Assessment by range of motion (ROM)

- **2.2** - When calculating impairment using loss of range of motion (ROM), the assessor is to compare **and document** measurements of the relevant joints in both extremities.
- In the assessment of ROM, assessors should observe the direction in: -
  - 1.56 in relation to using interpolation to provide assessments for the actual measured goniometric values.
  - 1.65 in relation to the rounding method.
- **2.5** - Assessors should also be cognisant that ROM may be subject to variation due to pain or possible lack of co-operation by the person being assessed. If there is inconsistency in ROM, then it must not be used as a valid method of assessment (1.63 - 1.64 provides further direction on the management of an inconsistent presentation).

Inconsistency

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Clause 2.3 - Diagnosis and Stability (replaces MMI)

- A work injury has **stabilised** if the worker's condition is **unlikely to change substantially in the next 12 months with or without medical treatment** (regardless of any temporary fluctuations in the condition that might occur) - Defined Terms, IAG3
- There are **statutory and regulatory exceptions** to the requirement of stability.
- **The Guidelines also provide for other time frames** for the presence of the diagnosed injury with it also being noted that in some cases these Guidelines provide for exceptions to the requirement for an injury to have **stabilised**, **or provide for other or additional periods to apply** - e.g. epicondylitis, peripheral nerves, frozen shoulder
- The assessed condition must have a defined diagnosis that can be confirmed by clinical evaluation **NOT** just a " Painful Shoulder".

- Stable =
  - no further Rx is possible and no further progression is anticipated within 12 months
  - no further Rx is possible, but symptoms may fluctuate over 12 months, e.g. OA
  - Further Rx possible, but Worker has unequivocally decided against any more Rx
- UNSTABLE=
- - Further Rx is possible within 12 months but only if there is likely to be substantial increase in symptoms and only if it is deemed likely that there will be an indication for that rx and that the worker would consider that rx: eg OA now sufficiently advanced to justify a joint replacement within 12 months and pt wishes to proceed

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Peripheral Nerve injury

- **2.9** - Must not be assessed until symptoms have persisted for at least 12 months (previously part of MMI clause 1.13 IAG1)
- **2.11** in relation to assessment of post-operative carpal tunnel syndrome remains. Three scenarios are provided in AMA5 with scenario two amended by IAG3. The direction must be understood and complied with by the assessor.
- A thorough examination is required including the ulnar nerve and median nerve in both hands for sensory and motor changes and an understanding that there is a voluntary subjective component to these examinations.
- As per the preamble to Chapter 2, the assessor should record, document and provide reasoning for the WPI% rating and its relationship to the 'injury'.
- The assessor must NOT routinely assign the maximum value from the available range for sensory and motor severity grades. Take into account the history, symptoms, clinical signs, pre- and post-operative nerve conduction studies, and apply sound clinical judgement. Reasoning for choice of grade and value must be provided in the report.

Shoulder Key Changes – 2.16

- Resection arthroplasty of the distal or proximal clavicle is defined as a **total** anatomical loss evidenced radiologically **or** by way of operative report from a surgeon.
- IAG1 allowed for assessment of resection arthroplasty on findings of anatomical loss on clinical examination OR x-ray.
  - Clinical assessment is no longer a valid parameter.
  - Radiology extends the imaging threshold from x-ray to other modalities eg MRI

BUT the resection must be reported as TOTAL by the radiologist or surgeon. In many cases a partial resection only of the outer clavicle has been performed leaving little or no anatomical or radiological evidence of resection.

Shoulder Key Changes – 2.16

- New - Adhesive Capsulitis cannot be rated until at least 18 months after the onset of symptoms.
- Adhesive capsulitis runs in three phases each lasting 4 to 6 months: -

1. Painful: where usual onset is spontaneous onset of pain following a minor “tweak” on stretching or moving. Thorough questioning can usually establish time of onset accurate to within a few weeks.
2. Stiff.
3. Recovery: In most cases near full ROM returns by 18 months post onset (measure ROM on the other side).

Example - Right Shoulder Injury

- 55 year old male felt pain in shoulder at work after stretching to grab a folder.
- Past history and x-rays 5 years ago show early OA of the shoulder and GP records indicate intermittent symptoms and need for NSAIDS over the 5 years. No record of ROM by GP or physio.
- Claim accepted, treated with arthroscopy acromioplasty and debridement of osteophytes on inferior surface of outer clavicle
- No further surgery planned.
- Patient has returned to work and is considered to have stabilised, seeks WPI.

Example – Right Shoulder Injury cont'd.
Rate WPI in accordance with IAG3

- ROM found to be reduced both sides R>L. ROM for both sides must be documented in the report.
- Deduct impairment identified in the 'uninjured/normal' left shoulder from the impairment identified in the subject right shoulder in accord with 2.2 of IAG3.
- Outer clavicle has minor deformity clinically.
- This does not constitute resection arthroplasty of the outer clavicle in accord with 2.16 IAG3 and should be assessed under 2.21 " where no additional impairment is to be assessed for resurfacing in the rx of localized cartilage lesions in major joints"
- Document the presence of non-work injury OA on imaging which could potentially impact on ROM.
- Explain the basis by which the pre-existing impairment from OA is or isn't disregarded (deducted).
- Assign WPI% and ensure the rationale is clearly set out in the report.

Strength Evaluation

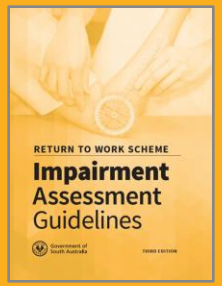
- IAG1 2.15 uses the word “should only be used” in relation to assessment via strength.
- IAG3 2.15 wording changed to “can only be used in exceptional circumstances”.
- An example of exceptional circumstances would be a lacerated ECRB tendon at the wrist level, at stability, no pain, full ROM of the wrist, but assessable residual weakness in wrist extension. Clinical testing and loading of the wrist is PAIN FREE and 4/5 weakness is detected.
- Conversely this is not the case with any residual weakness following a proximnal biceps tendon rupture with pain on movement and reduced ROM in the shoulder.

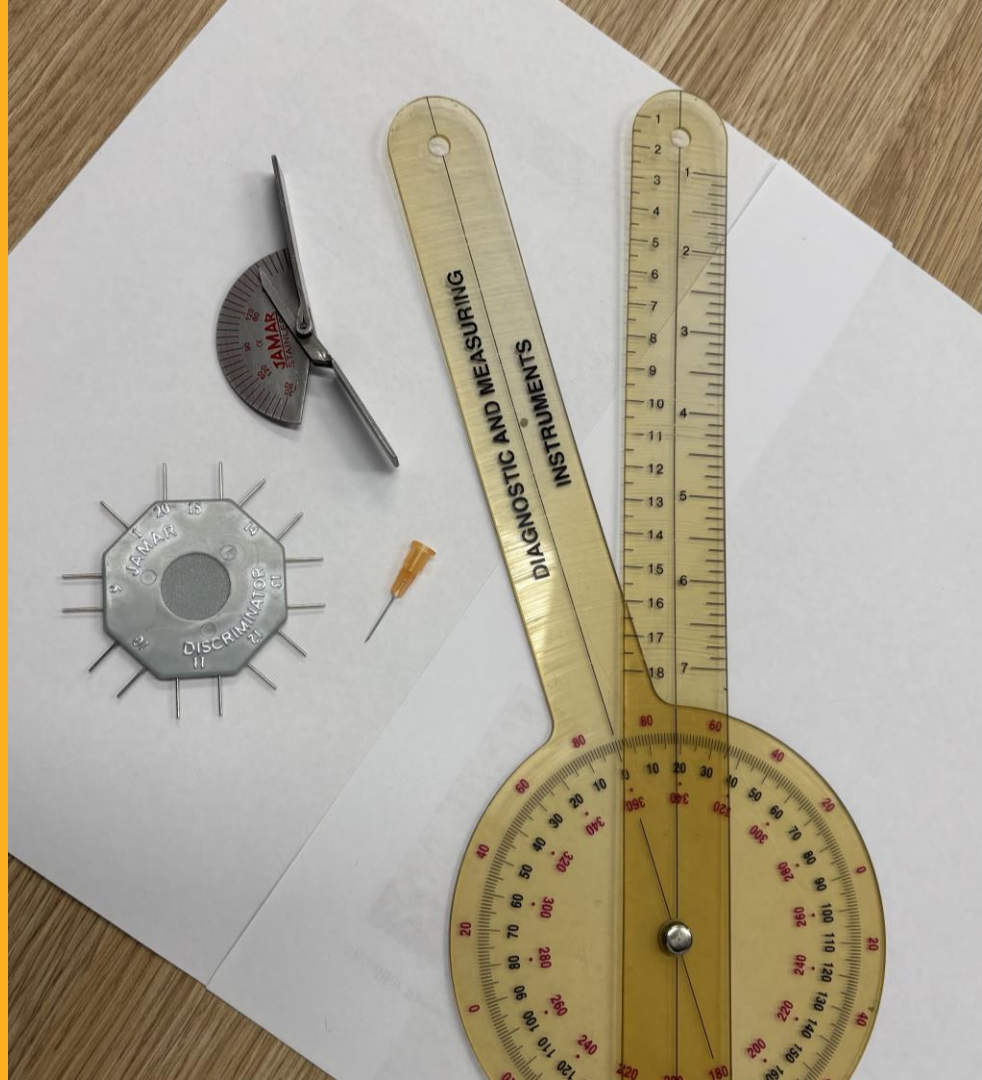
Thoracic Outlet Syndrome – 2.22

- Previously mentioned in Cardiovascular Chapter 14 of IAG1 and directed assessors to assess via the Upper Extremities Chapter 2 of IAG1 and Chapter 16 of AMA5.
- Now the same direction is included in Chapter 2 (Upper Extremities) and Chapter 14 (Cardiovascular) of IAG3.

Summary

- Note the new changes in IAG3 and their implications.
- Examine thoroughly and accurately.
- RECORD, DOCUMENT and JUSTIFY.
- Use proforma charts and tables.
- Compare with the contralateral joint and, in the case of peripheral nerves, with other nerves in the same limb.
- Check IAG3 just in case there has been a change you weren't expecting.





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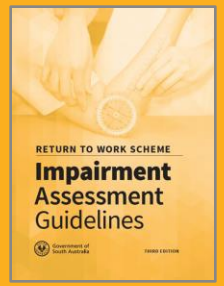
Chapter 3 – Lower Limb

Changes to the Third Edition of
Impairment Assessment Guidelines



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Presenter
Dr John Bastian

Dr John Bastian is a Senior Consultant Physician in Rehabilitation Medicine and Musculoskeletal Medicine, who for the last 30 years has worked in the area of complex Orthopaedic and Neurologic Rehabilitation, Occupational and Pain Medicine.

Past positions have included Deputy Director of Alfreda Rehabilitation, visiting Medical Specialist to the Flinders Medical Centre Pain Management Unit and COPER Programme, Internal Consultant for WorkCover and now for ReturntoWorkSA.

In addition to working in the Public Sector, Dr Bastian has spent the last 30 years in private practice, managing and treating complex motor vehicle and work-related injuries, including spinal and brain injury.

Up until 2021, towards the end of his public career, was Acting Head of Unit at the Hampstead General Rehabilitation Unit, incorporating Orthopaedic Rehabilitation, Amputee Medicine, Stroke and Burns Rehabilitation, along with patients with brain injury not requiring an enclosed ward setting. Dr Bastian was actively involved in teaching and running workshops in Musculoskeletal, General Rehabilitation and Medicolegal Medicine.

Dr Bastian has worked extensively in the medicolegal arena including in relation to clients with brain and spinal cord injury.

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Learning Objectives

- The modifications to AMA5 established by the Guidelines.
- The requirement for impairment assessment reports to include reasoning for the assessment method and impairment rating.
- The requirement to document the calculated range of motion of the relevant joint(s) in both extremities.
- The requirement for the assessor to confirm assessed limb length discrepancy was caused from the injury.

Learning Objectives

- Apply the new approaches to measuring knee, ankle, and hindfoot impairments.
- Include requirements for assessing Lis Franc injuries in evaluations.
- The inclusion of requirements for assessing Lis Franc injuries.
- Follow the updated requirements for assessing hip and knee joint replacements.
- Evaluate impairments resulting from peripheral nerve injuries

General Comments

The assessor should set out:

a) The reasoning for the assessment of the work-related impairment and the relationship of the rating to the injury.

b) Where method selection occurs, this should be reasoned with a description provided in terms of the method used and its relationship to the injury.

c) Must select the most appropriate and specific method related to the injury, and describe in the report the reason for its selection and its relationship to the injury.

Example

A worker has had a partial meniscectomy.
The diagnosis based estimate may be considered the most specific method of impairment. However, one notes the worker has severe knee pain resulting in significant arthrogenic inhibition and wasting of the thigh musculature.

This results in a higher impairment and correlates better with the worker's level of dysfunction. This would need to be explained in detail.

Impairment due to limb length discrepancy (3.9 IAG3)

The term 'leg' has been replaced with 'limb'.

It is important that when entertaining an impairment for limb length discrepancy, that this must be acquired (caused) from the injury and its relationship must be described in the report.

Manual muscle strength testing (3.16 IAG3)

If utilising muscle strength testing, it should be noted that within the AMA5 Guides, the Table 17-8 contains an anomaly for hip abduction impairment Grade 3 – this should be 37% LEI (15% WPI).

Range of motion (3.2 IAG3)

In regard to range of motion, the assessor must document measurements of the relevant joints (in both extremities)

Inconsistent presentation (3.17 IAG3)

Where there is inconsistency when assessing range of motion this cannot be used as a valid parameter of impairment evaluation.

In such cases, the assessor must use their judgement, based on experience, training, skill, thoroughness in clinical evaluation, and ability to apply the Guides criteria as best as possible to modify the impairment rating accordingly, and then describe and explain the reason for the modification in writing.

Example

Asked to assess Right Greater Trochanteric Bursitis

The ultrasound has revealed only mild changes in the region, as has the MRI scan. There is significant bilateral hip degenerative disease. There is marked loss of hip range of motion bilaterally, worse on the right, but with no pain in the hip reported on passive and active hip range of motion. FABER and FADE tests are negative. The only other findings are a mild right Trendelenburg gait pattern, localised tenderness over the greater trochanteric region and discomfort on isometric abduction. In this case, the most specific method would be to use diagnosis based estimates for trochanteric bursitis. The loss of hip range of movement relates to the underlying hip arthritis, and does not relate to the work related condition to be assessed, nor any clinical evidence of aggravation of underlying hip osteoarthritis.

New requirement for measuring Valgus/Varus deformity of the Knee (3.19 IAG3)

This should be taken as the angle between the line from the anterior superior iliac spine to the centre of the enlocated patella, and a line from there to the mid point between the medial and lateral malleoli of the ankle.

If a weight bearing AP view of the knees is available, the angle can be measured as that between the line from the centre of the trochlea to the centre of the femoral medulla at the limit of the film, and a line from the midpoint between the tibial spines and the centre of the tibial medulla distally.

Anatomical axis measurement technique in short knee radiography

New requirement for measuring Valgus/Varus deformity of the Knee (3.19 IAG3)

The assessor must discuss the causal connection between the varus/valgus deformity and the injury (i.e., varus deformity due to trauma to the medial joint compartment of the knee).

Measurement of Ankle and Hindfoot motion (3.21 IAG3)

The requirements include:

a) When measuring dorsiflexion at the ankle, measurements are taken with the knee in 45 degrees and in full extension. Both measurements must be provided in the report.

b) When measuring hindfoot motion, the heel (calcaneus) is placed in the long axis of the leg (tibia). Inversion and eversion are measured with reference to the angle measured between the calcaneus and tibia.

Sacroiliac Joint Arthritis (3.28 IAG3)

It is now required that the x-rays of the sacroiliac joint need to be lateral and oblique.

Combined Partial and Complete Meniscectomy on same Knee (3.31 IAG3)

- Partial meniscectomy in one compartment and total meniscectomy in the other compartment

- In the presence of a combined partial meniscectomy on one side and total meniscectomy on the other side of the same knee, this is assigned as a 14% LEI.

Total Ankle Replacement (3.36 IAG3)

This utilises the new Class descriptor framework (Class 1 to Class 4).

One requires a report from the treating Orthopaedic Surgeon to be obtained to assist between choosing between Class 3 and Class 4. The report from the surgeon will need to include how the surgery went and the workers condition at the time of the final review with the surgeon. That is, does this correlate with the workers presentation at the time of assessment.

A very poor outcome is defined as a catastrophic failure of an implant; and/or complicated by significant chronic infection.

Ankle replacement points score to LEI and WPI

Class	Descriptor	Points score	LEI %	WPI %
Class 1	Good	85–100	25	10
Class 2	Fair	50–84	46	18
Class 3	Poor	<50	63	25
Class 4	Very poor *	See text*	88	35

* A poor result with catastrophic failure of an implant; and/or complicated by significant chronic infection.

* A report from the treating orthopaedic surgeon should be obtained to assess impairment in this class.

Lis Franc Fracture/Dislocation (3.37 IAG3)

Tibia-os calcis angle, Lis Franc injuries and hindfoot, Intra-articular fractures have been combined into one clause in IAG 3.

Lis Franc injuries were not directly mentioned in the previous Guidelines. Lis Franc injuries are:

- Assessable using a new Table 3.3 in IAG3 that forms part of Table 17-33 in AMA5 and is part of the sub-section on forefoot deformity.
- Tarso-metatarsal (TMT) motion deficits are to be assessed by clinical appraisal.
- Impairment should not be assessed before 18 months following the date of injury.

Lis Franc Injuries

Table 3.3:

Diagnostic criteria Lis Franc Fracture/Dislocation	WPI % (lower extremity) [foot]
Healed, no objective deficits	0 (0) [0]
Non-displaced and symptomatic	1 (3) [4]
Mild displacement &/or angulation with mild TMT motion deficits	3 (7) [10]
Moderate to severe malalignment and moderate TMT motion deficits	6 (16) [23]
Very severe malalignment or malunion WITH angulation or involvement of 4th and 5th TMT	12 (30) [43]

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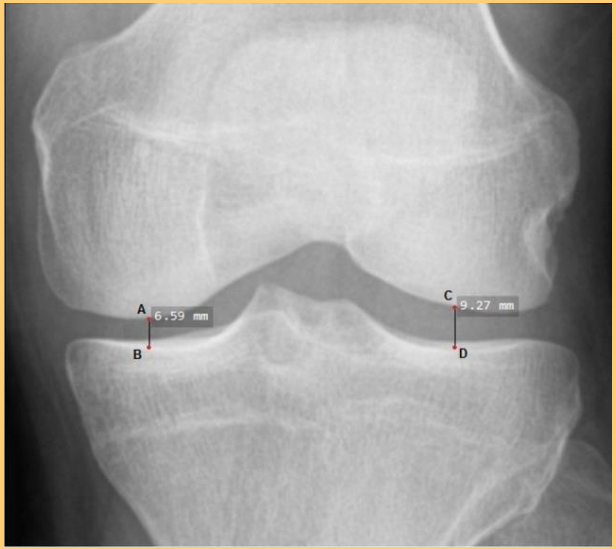
Knee Arthritis

- Measuring knee joint space



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Hip and Knee replacement (3.40 IAG3)

There has been a new combined heading in IAG3.

Hip and Knee replacement

Hip and knee replacement points score to LEI and WPI

Class	Descriptor	Points score	LEI %	WPI %
Class 1	Good	85–100	25	10
Class 2	Fair	50–84	46	18
Class 3	Poor	<50	63	25
Class 4	Very poor *	See text*	88	35

Again, a poor result with catastrophic failure of an implant; and/or complicated by a significant chronic infection requires a report from the treating Orthopaedic Surgeon to clarify as to whether the worker fits Class 3 or Class 4.

Table 17-35K

Table 17-35K: Rating knee replacement results

			Number of points
a	**Pain**		
	None		25
	Occasional	Mild	20
		Moderate	15
		Severe	10
	Continual	Mild	15
		Moderate	10
		Severe	5
b	**Function**		
	Supportive Device (required due to TKR)	None	5
		1 cane or 1 crutch for long walks	4
		Cane/crutch	3
		Two canes	1
		Two crutches/walker	0
	Distance Walked (inclusive of aid)	Unlimited	10
		1–5 km	9
		250m – 1km	7
		Indoors home and/or office only	5
		Transfers only	0
	Stair climbing	Unlimited	10
		Rail required – one foot per step	8
		Rail required – two feet per step	5
		Unable to climb	0
c	**Range of Motion**		
	Add 1 point for every 5 degrees of flexion up to 125°		25 (maximum)
d	**Stability**		
	(maximum movement in any position)		
	Anteroposterior	<5mm	10
		5–9mm	5
		>9mm	0
	Mediolateral	5°	15
		6–9°	10
		10–14°	5
		>14°	0
		Sub total	

			Number of points
Deductions (minus) e, f, g			
e	**Flexion contracture**	0–4°	0
		5–9°	2
		10–15°	5
		16–20°	10
		>20°	20
f	**Extension Lag**	0°	0
		1–9°	5
		10–20°	10
		>20°	15
g	**Tibio-femoral alignment***	>15° valgus	20
		10–15° valgus	3 points per degree of difference from normal
		3–9° valgus	0 (normal)
		0–2° valgus	3 points per degree of difference from normal
		Any varus	9 points + 3 points per degree of varus above 0 to a max of 21
		Deductions subtotal	

*Can only be rated based on post-operative x-rays. If x-rays are not available then rating should be 0.

In the table, ***extension lag*** means loss of full active extension in the presence of passive extension and is usually due to a defective extensor mechanism.

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Peripheral Nerve Injury (3.43 IAG3)

Peripheral nerve injuries must not be assessed until symptoms have persisted for at least 12 months.

Peripheral Nerve Injury (3.45 IAG3)

Table 17-37 does not include the tibial nerve.

This should be rated as:

Motor 13% WPI (33% LEI);

Sensory 5% WPI (12% LEI);

Dysaesthesia 3% WPI (7% LEI)

This has been derived by subtracting the rating of the common peroneal nerve from the sciatic nerve.

Break

Presenter

Dr Dilip Kapur

Dr Kapur is currently the Dean at the ANZCA faculty. He was previously a Senior Lecturer in Pain Medicine at Flinders University, and also held the position of Director of the Pain Management Unit at Flinders Medical Centre.

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Learning Objectives

Able to:

- Understand the detailed changes to the assessment of Complex Regional Pain Syndrome (CRPS).

WPI CRPS Pre-requisites

Changes to CRPS pre-requisites from IAG1 to IAG3

The Impairment Assessment Guidelines (IAG) Edition 1 provide the current requirements that must be met prior to an Impairment Assessment being conducted. The IAG Third Edition is due to Go Live from **1 October 2025.**

IAG Edition 1

- Must be present at least one year;
- There should be agreement on the diagnosis by at least two examiners.

IAG Edition 3

- The condition must have been present for at least 18 months and have stabilised;
- The diagnosis has been established by an appropriate medical specialist and advice as to treatment has been offered;
- Prior to the assessment the diagnosis has been confirmed by at least one other medical specialist;
- There is no other diagnosis that better explains the signs and symptoms;
- A report has been obtained from the treating specialist that includes specific reporting on signs, symptoms, treatment.
- Where there is a rateable impairment for a peripheral nerve injury(ies) then the method giving the highest rating applies.

CRPS WPI Assessment

Changes to CRPS assessment criteria from IAG1 to IAG3

The Impairment Assessment Guidelines (IAG) Edition 1 provide the current requirements that must be met prior to an Impairment Assessment being conducted. The IAG Third Edition is due to Go Live from **1 October 2025.**

IAG Edition 1

- Different assessment methodology for CRPS I and CRPS II.
- Diagnostic criteria:
  - Continuing pain
  - At least one symptom in each of the 4 categories
  - At least one physical sign in each of the 4 categories
  - There is no other diagnosis that better explains the signs and symptoms

IAG Edition 3

- Single methodology for CRPS, encompassing CRPS I and CRPS II.
- Impairment assessment can only be performed by an assessor trained in the assessment of CRPS.
- The table used for the purpose of meeting criteria to undergo impairment assessment for CRPS is a modified form of the Budapest Criteria.
- At least one symptom in each of the 4 categories
- At least one physical sign in three of the four categories
- ADL functioning assessment tool now used when rating impairment.

Diagnosis

Budapest Criteria

1	2	3	4
Continuing pain that is disproportionate to any inciting event.	Must report at least one symptom in three (clinical diagnostic criteria) or four (research diagnostic criteria) of the following categories: • Sensory • Vasomotor • Sudomotor/oedema • Motor/trophic	Must display at least one sign at the time of diagnosis in two or more of the following categories: • Sensory • Vasomotor • Sudomotor/oedema • Motor/trophic	No other diagnosis better explains the signs and symptoms.

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Terminology

Objective Signs in CRPS

Vasomotor

- Temperature asymmetry
- Skin colour changes
- Skin colour asymmetry

Terminology

Objective Signs in CRPS

Vasomotor

- Temperature asymmetry
- Skin colour changes
- Skin colour asymmetry

Terminology

Objective Signs in CRPS

Vasomotor

- Temperature asymmetry
- Skin colour changes
- Skin colour asymmetry

Terminology

Objective Signs in CRPS

Sudomotor

- Oedema and diffuse oedema
  (oedema specified as diffuse oedema of the affected area in the IAG3)
- Sweating changes
- Sweating asymmetry

Terminology

Objective Signs in CRPS

Motor/trophic

- Decreased range of motion
- Motor dysfunction – weakness, tremor or dystonia
- Trophic changes – hair, nails, or skin

Changes from IAG 1 to 3

IAG's 1

3	At the time of evaluation at least one **physical sign** must be elicited in the affected part in each of the following four categories: ***Sensory: Evidence of:*** • *Hypoaesthesia* to sensory stimulus • *Mechanical allodynia* to deep somatic pressure and/or joint movement ***Motor/trophic: Evidence of:*** • Joint stiffness and decreased passive motion • Motor weakness • Wasting • Motor dysfunction – tremor, dystonia • Trophic changes – hair, nails, skin ***Vasomotor: Evidence of:*** • Temperature asymmetry • Asymmetric skin colour changes ***Sudomotor: Evidence of:*** • Oedema • Sweating asymmetry
4	**There is no other diagnosis that better explains the signs and symptoms.**

IAG's 3

3 from 4 Categories

Scoring system For each to be compared with class rating score table

Detailed ADL scoring

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Changes from IAG Ed 1 to 3

2.29 Table 2.2: Complex Regional Pain Syndrome (CRPS) Class Rating Score (CRS)

Sensory:	**Points**
Hyperaesthesia to sensory stimulus (to include hyperalgesia)	1
Mechanical and or touch allodynia	1
Severe pain assessed by clinical appraisal*	Add 2
Motor/trophic:	**Points**
Joint stiffness and decreased passive motion	1
Motor weakness	1
Wasting	1
Motor dysfunction – tremor	1
Motor dysfunction with dystonia hand or wrist[a]	1
Motor dysfunction with dystonia involving both hand and wrist[a]	2
Trophic changes – hair, nails or skin (one or two categories)[aa]	1
Trophic changes including all 3 of hair, nails and skin[aa]	1
Elbow involvement with 2 signs out of the 4 sign categories in Table 2.1	1
Shoulder involvement with 2 signs out of the 4 sign categories in Table 2.1	1
Vasomotor:	**Points**
Temperature asymmetry	1
Asymmetric skin colour changes**	1
Sudomotor:	**Points**
Diffuse oedema in the region affected by CRPS	1
Sweating asymmetry	1

These are summed to give the Clinical Severity Score

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WPI CRPS Assessment

What a typical permanent impairment assessment involves for the assessor

These are from the clinical assessment

These are from the ADL Functioning Assessment Tool

2.30 Table 2.3: CRPS Class and Rating table

Class 1 CRS 3 – 7 15% – 29% UEI		Class 2 CRS 8 – 13 30% – 49% UEI		Class 3 CRS 14 or more 50% – 100% UEI	
Median	UEI%	Median	UEI%	Median	UEI%
1	15–17	1	30–33	1	50–60
2	18–20	2	34–37	2	61–70
3	21–23	3	38–41	3	71–80
4	24–26	4	42–45	4	81–90
5	27–29	5	46–49	5	91–100

UEI = Upper Extremity Impairment

2.31 Table 2.4: ADL Functioning Assessment Tool

	Self-care	Cleaning	Meal Preparation	Gardening	Transport	Shopping	Social Activity
Rating							

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Changes from IAG Ed 1 to 3 - Use of ADL Table 2.4

Application of Table 2.4

1. The impact of the condition on ADL is to be assessed using Table 2.4.
2. The determination of impact on ADL is not solely dependent on self-reporting, but is an assessment based on all clinical findings and other reports. The ADL tool is to be used in accordance with the principle of 'best fit'. The assessor must be satisfied that the ratings selected within an ADL category best reflect the category being assessed.
3. A value of 0 to 5 is assigned to each ADL.

   The reasoning for the application of each value is to be documented in the report.

Values are assigned as follows:

- Independent – 0
- Independent with difficulty – 1
- Able to perform independently with aids – 2
- Able to perform with assistance – 3
- Able to perform with aids AND assistance – 4
- Unable to perform – 5

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IR Thermometers – Examples

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