Editorial: Ipse Dixit

IAIABC Supplemental Guides for Rating Permanent Impairment: Current Status
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Malingering in Low Back Pain Assessments

Book review Writing and Defending Your IME Report: The Comprehensive Guide
CME Question Answers

Book review Gerontological Rehabilitation Nursing

Book review DeLee and Drez’s Orthopedic Sports Medicine Principles and Practice

In The Next Issue: Guest Editorial on Use and Misuse of Waddell’s Signs by Prof. Gordon Waddell, DSc, MD, FRCS
**EDITORIAL:**

**Ipse Dixit**

Physicians have traditionally been regarded as an authority in their craft and are accustomed to getting their opinions accepted as the final truth. However, in a legal proceeding the *Ipse Dixit* of the physician can lead to challenges and cause needless frustration and anxiety for the physician.

The long held notion by the public that the doctors know the best has led them to believe that medicine is based on high level of certainty and therefore, every opinion and assertion by medical professionals whether proven or not is generally accepted as a fact. This has led some to conclude that physicians, fearing the loss of positive reinforcement resulting from the public’s lack of confidence in the doctor’s abilities, have been disinclined to expose the limits of our actual scientific knowledge and abilities. As today’s media savvy health care consumer increasingly questions the science behind the doctor’s assertions and as the ivory tower image of medicine fades, doctors are increasingly faced with the challenge of an informed consumer demanding second or even third opinions.

Evidence based medicine has become part of media buzz words. No longer it is satisfactory to either an informed consumer or to a court of law when the doctor offers an opinion as a fact and says it is so because I said so. Physicians providing Independent Medical Examinations and expert testimony must be aware that their opinion must be supported by scientific evidence or they risk loosing credibility.

The standards for the admissibility of the expert testimony to provide medical and scientific evidence have been around in American Jurisprudence since the Frye case in 1920s, which established the test of “General acceptability by the scientific community” for admissibility scientific opinion of an expert witness. U.S. congress in 1975 codified the rules for expert witness testimony in rule 702 of federal rules of evidence, which essentially means that if scientific, technical or other specialized knowledge will assist the judge or jury to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education, may testify to these issues in the form of a expert opinion testimony.

The rule 702 was recently modified in December of 2002 in light of the U.S. Supreme Courts decision of *Daubert vs Merrell Dow Pharmaceuticals* and its progeny (*General Electric vs Joiner and Kuhmo Tire Company vs Carmichael*). This body of the U.S. Supreme Court case law now codified under modified rule 702 sets the appropriate review standards for the federal courts with regard to the admissibility of the scientific and expert opinion. These legal standards make the judge responsible for insuring that the scientific evidence proffered in the form of expert testimony is reliable and
reproducible. Everything from AMA Guides and standards of impairment and disability to Causality Opinions in Toxic Exposures claim are fair game for challenge under these standards. One should remember though that these federal rules of evidence do not general apply in the state and other court systems.

With regard to the admissibility of expert opinion and scientific evidence few cases have been as widely feared by experts and equally widely misunderstood and misused as Daubert, which simply was the U.S. Supreme Court’s attempt to provide a broad discretionary gate keeping power to federal trial court judges by giving them a nonexclusive list of tests so they can determine whether the scientific theory of methodology underlying the opinion of expert witness before them was reliable. Daubert tests included peer review of the method, testability and falsifiability (known error rate) of the scientific theory and finally the judge may still consider “General acceptance” by the scientific community, the old Frye test.

Even though Daubert broadened the scope of the judge’s authority by adding several other tests, it must be recognized that tests for admissibility of expert opinion or scientific testimony given in Daubert are not a “definitive checklist” but rather general guidance.

Subsequent U.S. Supreme Court decision such as Kuhmo Tire Company vs Carmichael further clarifies this authority and extends the Daubert’s approach to other kinds of expert testimony including medical testimony.

What does this all mean to us, the independent medical examiners offering medical expert testimony in legal proceedings? U. S. Supreme Court said it best in General Electric vs Joiner “the court need not accept testimony of an expert which is connected to existing data only by the Ipse Dixit of the expert.

Mohammed I. Ranavaya, M.D., M.S., FRCP, FFOM, FAADEP, CIME, Editor in Chief
Editors note:
The cost of workers compensation insurance is on the rise in general and the insurers are assigning blame on many factors including the escalating cost of impairment and disability compensation. For example, data gathered by the National Council on Compensation Insurance, Inc. (NCCI) and the Kentucky Department of Workers’ Claims recently resulted in NCCI requesting an average increase of 20.5% for workers’ compensation rates in that state.1 The request cited one reason as being; “The recent changes in American Medical Association guidelines for evaluating percentages of impairment, potentially resulting in additional compensation available for pain disability have increased the overall cost. While the estimated impact of the new fifth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment was estimated at 1 percent, the observed impact has been as much as 5 percent.”2 This contrasts with what is happening in states who have adopted the 5th Edition of the AMA Guides or who are working with the 2nd, 3rd or 4th Editions.

International Association of Industrial Accident Boards and Commissions (IAIABC) has introduced supplemental guides to the evaluation of permanent impairment which currently are in the draft form and are published here in installments with permission from IAIABC for comment and discussion purposes.

Since their draft release in 2002, the IAIABC Supplemental Guides for Rating Permanent Impairment have generated much interest. Part 1 (General Guidelines) and Part 2 (Spinal Impairment) have been revised several times by an open committee of expert physicians, made available on the IAIABC Web site (among the most frequently visited/downloaded pages on the site). Additionally, the American Medical Association (AMA) and the IAIABC have kept open dialogue about the prospects of collaborating on future editions. The IAIABC strongly supports a consistent message to doctors on how to conduct impairment ratings.

The purpose and background of the IAIABC Guides was formally presented at several conferences during 2003. Dr. Alan College, Chair of the Committee that oversees development of the guides, presented them to attendees at the IAIABC Workers’ Compensation College, the IAIABC Annual Convention, and the Iowa Workers’ Compensation Symposium. To date, the best practical application of these guides is in the State of Utah. In many respects, the IAIABC Guides resemble the administrative rules Utah adopted for the rating of permanent injuries. This is the seventh year that Utah has used such supplemental guidelines, with continuous refinements. Less than one percent of claims with permanent disability have been litigated, which has produced a dramatic cost savings to the Utah Labor Commission.

As the AMA considers their 6th Edition of the Guides, the IAIABC and the AMA continue extensive, ongoing talks with hopes of collaboration to evolve guides that have more sensitivity to injured workers.

As for the IAIABC Supplemental Guides, comments and additional input are still desired. The IAIABC is actively collaborating with Medical Directors in state agencies, trade and medical associations, and practitioners in occupational medicine. It is hoped that the publication of draft of these supplemental guides would generate a dialogue resulting in a consensus document.

Editor
Acknowledgments

The report is the result of many dedicated people who want to improve the functioning of the workers’ compensation system. In particular, the contributors share a passion for delivering fair compensation to injured workers under the laws of their jurisdiction. Fairness has many dimensions, but this committee had a particular interest in, and competency on, the reliable and valid measurement of bodily impairments due to work injury.

This work was produced by the Occupational Impairment Rating Committee of the International Association of Industrial Accident Boards and Commissions (IAIABC). Since its creation in 2000, this committee has been led by Alan L. College, MD, Medical Director of the Utah Labor Commission. Current members of the committee are found in Appendix D.

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Chapter One: Introduction

Physicians or those who make impairment ratings should understand the basic and universal principles of workers’ compensation law to respond to the clinical and procedural demands of rating the permanent residual consequences of work-related injury or disease. This introduction covers this essential background. In addition, it explains the purposes and use of this supplemental guide.

In some countries, government insurance programs cover occupational and non-occupational disability with the same administrative and benefit laws. However, in some countries, particularly Australia, Canada, and the United States, workers’ compensation uses its own distinct approach to the compensation of occupational disability. In these places where separate workers’ compensation laws exist, there is commonly a legal process for qualifying and quantifying certain injuries for a class of benefits for “permanent disability.” This process is distinct from other social insurance programs covering disability, private disability insurance, or damage measurements made in connection with civil legal proceedings. Thus, the measurement of total disability for US Social Security disability qualification has no relation whatsoever to a permanent total disability rating in workers’
compensation. Private disability insurance claims adjusters, while they may ask about permanent physical loss, are mainly concerned with vocational and job performance issues.

Knowing that it has its own distinct system, with enforced rules of adjudicating claims, may prevent the physician/rater from consciously or unconsciously misapplying techniques or methods used for evaluating other kinds of permanent injury or disability. This guide focuses on issues specific, or particularly common, to occupational injury.

Workers’ compensation is a system based on a heterogeneous collection of national and sub-national (individual state and provincial) laws. There are no binding national or international standards for how workers’ compensation impairment ratings are to be done. To illustrate the wide range of government insurance systems in the United States alone that have their own rating systems for occupational disability:

- Black Lung Benefits
- Longshore and Harbor Workers Program
- Railroad Workers Program
- Veterans Benefits
- Federal Employees Compensation Act (civilian)

The American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides), for reasons explained below, fall short of a guide for workers’ compensation. Indeed, there is much diversity among jurisdictions in the fundamentals of how and when benefits should be paid. This is especially true concerning approaches to measuring and compensating the injured worker for the lasting, or permanent, consequences of an industrial injury.

This guide is provided as an option for the IAIABC’s respective jurisdictions to consider for adopting all or part as able. Below is a brief introduction to the AMA Guides, followed by a statement of how this supplement interacts with impairment rating guides published by the AMA or jurisdiction-based impairment rating systems.

**AMA Impairment Guides**

Originally published as a series of articles in the Journal of the American Medical Association, the AMA Guides have been revised periodically, and are now in the 5th edition. As shown in Appendix A, 35 US states reference some version of the AMA Guides in their workers’ compensation law (Brigham, 2002). Other sources site a slightly different usage (AMA, 2000; Bavon, 1993). A current listing of each state and what they currently require for the impairment calculation is found in Appendix C at the end of this document.

The AMA Guides are a tool that can be used to convert medical information about permanent losses into numerical values. Sometimes the AMA Guides are advisory. In other cases only parts of the AMA Guides are used, or are supplemented with jurisdiction specific guidance. Many US states do not recognize the AMA Guides for rating impairment and have instead developed their own internal standards or guides to raters.

The AMA Guides attempt to provide a reasonable method to evaluate impairment and attempt to minimize inter-rater variability. Each chapter in the AMA Guides focuses on a single organ system and provides a description of the diagnostic and evaluative methods for assessing specified impairments. Each impairment is assigned a rating, expressed as a percentage of loss of function for that system. Organ-based ratings are then translated into impairment ratings for the whole person. The AMA methodology is not universally accepted and is based largely on consensus rather than scientific evidence (Holmes, 2002).

Those jurisdictions that utilize the AMA Guides note difficulty and confusion in coming to a consistent rating between different raters for the same condition (Texas Monitor, 1999). This difficulty provokes calls for revisions of the AMA Guides to address this issue (Barth, Burton, Himmelstein, Rudolph & Spieler, 2000; Stern, Peterson, Reville & Vaiana, 1997). Some jurisdictions disallow parts of the 4th edition of the AMA Guides in that it violates their
compensation laws (BNA, 1997). Additionally, a number of studies demonstrate poor reliability (reproducibility of results) of the methods used in the *AMA Guides*, especially relating to the spine. In fairness, these studies have dealt with older editions of the *AMA Guides.*

**IAIABC Guides**

Most jurisdictions that utilize some edition of the *AMA Guides* for injured workers’ impairment ratings note unnecessary physician/rater reporting variability in the impairment rating for what appears to be the same physical loss. This variability creates unnecessary patient anger, suspicion, hostility, litigation, and costs that are attributed to several non-medical factors. These factors include the individual examining physicians, lack of knowledge and skills by physicians, difficulties in differentiating subjective complaints from objective findings, confusion between the concepts of impairment and disability, bias, poor quality medical reports, determining causation analysis, and the apportionment processes. Members of the IAIABC Occupational Impairment Rating Guide Committee (Committee) believe that by improving the rating criteria requirements, physicians/raters can reduce variability for the impairment ratings. For this reason, the IAIABC Executive Committee, in October of 2001, commissioned the Impairment Rating Committee to address the needs of workers’ compensation claims payers and system administrators in rating permanent impairment.

The IAIABC contacted the AMA, seeking to work with them in this endeavor. The AMA responded favorably to the request and expressed hope of future coordination.

After reviewing current impairment rating systems, the Committee developed the present supplemental guide specific to problem areas in workers’ compensation. These guidelines do not fit all administrative situations. Each jurisdiction has a significant history of legislation, rules, and case law that will require these guidelines to be adjusted for parts of the rating process, or in specific injuries. This work is provided as model for jurisdictions to consider as their particular jurisdiction needs develop. The Committee’s vision is to evolve toward the best practices in rating methodology. Additional supplemental bulletins or guides will be periodically issued as medical science evolves and updated by the IAIABC for the voluntary use by member organizations.

**Legal and Historical Background**

Processing claims information can be extremely frustrating and time consuming for physicians/raters and their support staff. This section reviews legal and administrative issues that equip physicians and staff to better respond to the demands made on their time and medical expertise by disability and workers’ compensation claims processors. It explains benefit types and nomenclature.

**Overview of Occupational Benefits**

The categories listed below describe benefits payable under workers’ compensation. Terminology may differ from jurisdiction to jurisdiction, but most recognize these four broad divisions of claims and their common abbreviations:

- **Medical-only**
- **Temporary disability, for wage loss indemnity (TTD)**
- **Permanent disability, divided into Permanent Total (PT) and Permanent Partial Disability (PPD)**
- **Death (including burial)**

Most workers’ compensation injuries require only medical attention and do not involve lengthy time away from work, nor do they leave residual effects on the worker. In the United States, “medical-only claims” are about 72 percent of all compensable injuries (Telles, 2001). These are claims that do not involve compensation for lost work time, only medical expenses related to an injury. The percentage of medical-only claims in a jurisdiction is a function of the quality and speed of medical care, the length of lost time required before an injury qualifies for indemnity benefits, and how scrupulously employers report claims as workers’ compensation.
Under workers' compensation, when the injured worker has missed a predetermined amount of time from work, he/she is eligible for wage indemnification, with the amount determined by each jurisdiction. Wage loss benefits continue until the disabling condition either permits a return to work, or reaches a plateau where healing ends and no significant improvement is likely. The concept of “maximum medical improvement” will be discussed at greater length in a later section. When this occurs, the injured worker may be entitled to another class of benefits to compensate for any permanent residual loss, i.e., PPD or PT.

Most state, provincial, and national systems make some allowance in the law for payment of cash benefits upon proof of objective or reasonably inferred permanent injury to a worker. A permanent injury is one that causes damage to an organ or bodily system that reduces its function and is expected to last for life. These permanent injury benefits presumably compensate the worker for likely or inferred loss of income from the bodily injury. This tie-in between income loss and permanent disability benefits is approximate and highly inconsistent from jurisdiction to jurisdiction. It is worth noting that some jurisdictions do not compensate for objective permanent injury to the body, only for permanent wage loss due to the injury or likely to ensue from the injury.

Fortunately, claims for death benefits are relatively infrequent. In 1999, there were 6,023 fatal work injuries out of 5.7 million Occupational Safety & Health Administration (OSHA) reportable injuries (.1%) (NASI, 2001).

As Table 1 below shows, about a quarter of claims in the United States involve permanent injury benefits, yet they produce about two thirds of the cash benefits paid. Of the $25.3 billion in cash benefit payments going directly to injured workers in 1999, nearly $19 billion were for compensation of permanent injury.

<table>
<thead>
<tr>
<th>Type of Workers’ Compensation Claim</th>
<th>Percentage of Cases</th>
<th>Percentage of Cash Benefits</th>
</tr>
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<tbody>
<tr>
<td>Temporary</td>
<td>72%</td>
<td>25%</td>
</tr>
<tr>
<td>Permanent Partial</td>
<td>27</td>
<td>62</td>
</tr>
<tr>
<td>Permanent Total</td>
<td>1</td>
<td>13</td>
</tr>
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In summary, several different classes of benefits are paid under workers’
compensation. Permanent injury claims account for a very large share of benefits paid. These benefits are largely controlled by medical judgments made by physicians and communicated in reports to claims adjusters and workers’ compensation administrators. Physician-raters must be cognizant that statutes, administrative rules, and case law are state or jurisdiction specific and at times may seem impractical as one reviews the relative severity of injury for purposes of quantifying benefits to be awarded for permanent injury.

**Measuring Permanent Loss from Injury**

The impairment rating process for workers’ compensation is part of a larger process of claim adjudication. Medical issue and reports drive the settlement of most claims. The medical issues can be divided into three phases:

1. Verifying that a specific injury or disease has occurred
2. Establishing the causation
3. Measuring the physical, personal, or vocational consequences of the injury.

This section deals only with the third task. Measuring the consequences of injury can be subdivided into two very distinct areas:

1. The physical loss of use or capacity of a body part or bodily system
2. The consequences of this physical loss on activities of daily living or vocational pursuits.

The former is technically referred to as “impairment rating” and the latter as “disability rating.” Confusion between the two concepts is rampant.

Some of the varying definitions of “impairment” found in the literature:

- Alteration of an individual’s health status that is assessed by medical means (J.B. Moore, Disability Systems).
- A medical assessment of a patient’s physical or anatomical deficit or loss use of function, represented by a percentage value for each deficit or functional loss, expressed in terms of the whole person (Gerald Lipinsky, “Spinal Impairment and Disability”).
- Alteration of an individual’s health status; a deviation from normal in a body part or organ system and its functioning (AMA Guides, 5th Edition).
- Any loss or abnormality of psychological, physiological or anatomical structure or function. (World Health Organization).
- An impairment that results from anatomical, physiological, or psychological abnormalities, which can be shown by medically acceptable clinical and laboratory diagnostic techniques. (US Social Security Administration).

Disability rating, on the other hand, measures a patient’s inability to perform specific and important activity of daily living or work. In some contexts this might be ordinary household tasks, in others, schoolwork. For occupational disability the focus is on:

1. The tasks that the patient was previously able to do in their job or profession, and, if pre-injury work is impossible,

2. The alternative tasks that a person might perform.

Disability and Impairment seldom match closely. Classic examples of the lack of correspondence of physical and economic/job limits are:

- A piano player losing an index finger might be rated with 2 percent whole body impairment. Yet, also be rated as 100 disabled for that the preinjury occupation, and 50 disabled from a loss of earning capacity (because there are other related careers).
- An attorney could loss his or her eyesight and receive a total impairment rating in a given system. Yet, with proper accommodation might not lose their preinjury job, or suffer any loss of income.

A given physical loss would have dramatically different effects on a worker depending on:

- Occupation
- Education
- Age
- Language skills
- Geographical opportunities
- Employer’s flexibility to modify job duties
One of the ongoing challenges in workers’ compensation is to define how permanent physical loss is calculated in a defensible and consistent way. The AMA Guides is the most common methodology utilized to calculate impairment.\(^5\) The AMA Guides adopt the widely accepted view that impairment is a deviation in a body part or organ system and its functioning. Impairment is not equivalent to disability.

The consequences of any given limitation are difficult to generalize to the whole working population. Moreover, these consequences may differ dramatically from what the injured worker was able to do before the injury. Similarly, how these consequences relate to other jobs, other activities of daily life, or personal happiness varies considerably. Facial scarring, for example, may not impede any activity of work or daily life, but may be a cause for significant psychological and social dysfunction of the individual.

**Impairment / Disability Relationship in Workers’ Compensation**

An impairment rating is given as the first component of many, that acts as a threshold determinate for certain benefits needed to calculate the financial compensation for the residual deficits from the injury or event, after an injured worker reaches medical stability (see Glossary). Many states use physical impairment ratings as one step in calculating compensation but do not stop there, recognizing that a physical impairment can have a differing impact on a worker’s future earnings, depending on the worker’s occupation, age, education, and other factors.

The goal of the IAIABC Guides is to improve the uniformity and accuracy of impairment ratings, but not to suggest that physical impairment be the only factor considered. The standard impairment schedule considers percentage of loss on an arbitrary continuum, with 0% reflecting no residual or loss and 100% whole person impairment equaling a state approaching death.\(^6\) As an example, a complete amputation of the ring or little finger equals a 6% whole person impairment. For the complete loss of an eye, one is awarded 24%, and for the complete loss of a leg at the hip, 40% is awarded.

In order to understand impairment ratings, it is also necessary to understand the relationship between impairment and disability. Although the impairment rating number is derived from a structured set of observations, it does not convey information about the impact of the anatomical and/or functional impairment on a worker’s capacity to meet certain demands. The AMA Guides define “disability” as an alteration of an individual’s capacity to meet personal, social, or occupational demands, or statutory or regulatory requirements because of impairment (AMA 5\(^{th}\) Edition, p. 8). Therefore, impairment percentages estimate the extent of anatomical and/or functional loss as it relates to a perfect “whole” individual. Impairment assessment is a necessary first step for determining disability (Ibid, p. 13).

To provide a uniform platform of consistency, the physician/rater should understand that jurisdictions are generally first looking for physicians to provide objective and consistent information about the physical limitations, losses, or abnormalities of the body and its function, or an impairment. Jurisdictions may or may not want the physician/rater to discuss how this impairment affects the issues of life, i.e., disability rating. Workers’ compensation laws are usually not asking for a disability rating, which would require an assessment of employability in a specific region and is outside of the medical expertise.

As a general rule, not all harm, damage to, or suffering of the injured worker from a covered injury is compensated under the law. Pain, scarring, or disfigurement in some jurisdictions, are not compensable, no matter how serious.\(^7\) This is different from civil law, or tort, where these issues are a major part of lawsuits. Workers’ compensation is a system of laws that departs from the principles of tort law. In exchange for prompt and predictable payments for covered injuries, it limits or excludes subjective or difficult-to-
quantify harm to the worker. Once understood, this tradeoff between speed and predictability for compensation can help to make the benefit limits of workers’ compensation seem more reasonable and fair.

In most states, the use of the impairment rating provided by the medical practitioner is converted by law into “weeks of disability payments.” There is no consistency between the states for the weeks awarded for the loss of a body part or function. So, the loss of a hand may be 100 weeks in one jurisdiction and 200 weeks in another. Widening the range of benefits is the fact that PPD benefit weeks are compensated by different weekly amounts, ranging from small, fixed amounts like $100 per week to 150% of the state average weekly wage.

Thus, consistently following the same impairment guides, two physicians might rule the loss of four fingers a total loss of function to the hand. The loss of a hand (1997 benefits) would produce a scheduled benefit of less than $45 thousand in Arkansas, Mississippi, and North Dakota, but more than $110 thousand in Michigan, Hawaii, and Illinois (US Chamber of Commerce, 1997).

Physician-raters must remember that the range of benefit outcomes is beyond the role of medical practice in the workers’ compensation claims adjustment, and impairment ratings should not be manipulated by the physicians to adjust for perceived low or high state benefit payments.

We have stated above that jurisdictions are very inconsistent on the monetary awards they make for various permanent injuries. This is an important controversy, but it is beyond the scope of this manual. Rather, we focus on what can be controlled and improved within the scope of medicine practice.

The inconsistencies and inaccuracies in current systems used to calculate an injured worker’s residual loss or impairment can be frustrating for patients, physicians, risk managers, government administrators, and payers.

We propose two standards by which rating systems, including instructions and guides to raters, should be evaluated. The first is consistency of ratings across injuries and raters. The second is the validity of the ratings. Departures from either of these weakens the workers’ compensation system.

Problems with Impairment Ratings

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Why is consistency important? Without physician consistency, impairment ratings become a source of dispute. Claimants often get upset when they learn what they are going to receive in compensation for the ongoing residual symptoms. Remember, workers’ compensation benefits are seldom generous and are often arbitrary in the level of compensation for different injuries. When workers discover that peers with similar injuries received significantly more money than what they were offered by the claims adjuster, they become even angrier. Their confusion and anger often motivates them to seek legal counsel, formally complain to the regulatory agency, complain to their elected representatives, and launch a legal action. All of these reactions impose financial costs and administrative burdens on the system, and often delays in the worker adapting to their loss and moving on with their lives. Formal legal disputes are a sign of breakdown of exclusive remedy, that is in the efficient and fair administration of the workers’ compensation law.
Perfect reliability is unachievable. Even the same physician/rater may produce a slightly different rating on the same fact situation for time to time. Cross rater variation is unavoidable given different backgrounds, training and clinical practices. However, as a practical goal for workers’ compensation, the same diagnosis and same patient characteristics should produce ratings that are consistent within a tolerable range of random variation.

Validity is the second test for a good impairment system. By this we mean that the rating assigned to a given bodily loss should measure what it intends to measure. If the goal is quantify loss of use or function due to the injury, then the rating should have a logical and factual basis for the measure or score. A second goal might be that the ratings for different injuries bear a logical and defensible ordinal or cardinal ranking. The most common scale is the percentage of loss to the body as a whole. Using this, the relationship between individual body part losses should receive reasonably related percentages for whole body loss. Thus, the loss of a single digit on a finger should be less than the loss of the whole finger, which in turn is less than the loss of a hand, and the hand less than the loss of the arm.

As the long list of critical papers in the literature will attest, the calculation of impairment is not an objective science (Gloss & Wardle, 1982; Disler, Battrass & Nischke, 1999; Clark et. al, 1988). [GK1] Ongoing debates center on the lack of empirical support or an objective basis reliably and validly convert a given physical condition to an impairment rating.

The reliability and validity of impairment rating can be improved by clear guidance to raters in three areas:

1. The scale or measures of impairment to a given body part.
2. How to perform or record measurements that support the scale given in (1) above.
3. How to convert loss to a specific body part to loss to the body as a whole.

The remainder of this chapter, we offer guidance in each of these areas based on the consensus of practitioners with considerable experience in occupational medicine and the administration of impairment ratings.

**General Guidance for Raters**

Workers’ compensation law places great deference on medical evidence and judgment in administrating permanent disability benefits. Except in some isolated cases, the qualification of an individual for a permanent injury benefit must be triggered by a doctor’s written opinion as to a qualifying event, condition, or rating. Rating applies to those cases where the physician/rater must quantify the degree or extent of some value that triggers a benefit. This quantification process is often complex, requiring careful measurement, thorough evaluation, and combinations of other related factors. The process is not simply empirical. Expert judgment is often called for.

The following principles apply to all impairment ratings. Specific injuries, such as to upper or lower extremity and the spine, will be treated in later chapters.

**Duties of Rating Physician or Rater**

The impairment rating should be based on the objective condition of the patient along with the credible subjective findings. The credibility of patient representations should be interpreted in light of their consistency across time and accordance with objective findings. Also, subjective findings should be considered reasonable and necessary for those workers who have residual loss resulting from an occupational injury.

In making these interpretations and judgments the physician/rater has duties and obligations that are distinct from the duty of care as a treating physician. The impairment rating is not considered a portion of any medical service previously rendered and is not included in routine post-operative care. Unless treating physicians are uncomfortable with this process, they are encouraged to complete the case, declare the patient stable, and, if applicable and they are qualified, calculate an impairment rating. The
skills involved in assessing impairment are two-fold: clinical assessment and criteria application. An experienced attending clinician may be unfamiliar with the correct process of rating impairment.

If for any reason the attending physician prefers not to make this evaluation, he/she should notify the responsible party adjusting the claim for an insurance carrier or government payer. The treating physician may then refer the patient, or request that the adjuster refer the patient to a physician with training and expertise in the patient’s condition, and with knowledge of the impairment rating methodology adopted by the jurisdiction or with knowledge of the IAIABC’s impairment rating methodology. The rating physician/rater needs to ensure that the examinee understands that the evaluation’s purpose is medical assessment, not medical treatment. However, if significant new diagnoses are discovered, the physician has a medical obligation to inform the requesting party and individual about the condition and to recommend or refer for further medical assessment. It is recommended that the evaluating physician not cross the boundaries and become a treating physician for that patient. This “medical obligation” is important for identifying significant, previously unrecognized medical conditions, such as hypertension or a malignancy.

The attending physician is frequently the person most knowledgeable regarding the condition, progress, and final status of the injured employee. Therefore, the treating physician is usually encouraged to render the final impairment rating (AMA 5th Edition, p. 18). When the physician/rater is uncertain about which method to use in the calculation of an impairment rating, or if more than one method can accurately be used, the physician/rater should calculate the impairment rating using different alternatives and choose the method or combination of methods that best represents the functional impairment of the examinee (Ibid, p. 526-527).

Depending on the jurisdiction, there may be specific constraints and duties on how the rating is to be done. In such cases, the law trumps physician discretion.

The patient’s history should be based primarily on the individual’s own statements rather than secondhand information. The physician should consider information from sources, including medical records. However, caution should be used in the interpretation of subjective information, particularly in the context of litigation and the potential of secondary gain. Although it is not appropriate to question the individual’s integrity, it is appropriate to comment on the individual’s credibility. If information from the individual is inconsistent with what is known about the medical condition, circumstances, or written reports, the physician should comment on the inconsistencies and base ratings on consistent historical reports and findings (Ibid, p. 374 & p. 524).

What Metric to Use?

Numbers help third parties, such as attorneys, administrative law judges, and claims adjusters understand the extent of a patient’s residual limitations from injuries. A numerical rating is a bridge between medical issues and legal determinations of fault, compensability, or benefit entitlements. For example, a claims adjuster may not understand the clinical significance of a medical report citing “L4/L5 disc herniation with L5 radiculopathy,” but with a percentage rating in hand they can apply statutory benefits. There is generally a rule that converts percentage loss into weeks of indemnity compensation.

One of the sources of error and frustration in impairment rating is the measurement system to be used. Percentages of loss make intuitive sense. However, there is sometimes doubt about whether the percentage applies to a limb, organ, or the whole body.

The 100 percentage-point scale mentioned above that is used by the AMA Guides illustrates the challenge. It is difficult to form a consensus on how badly impaired an organ or body system must be to merit a 100% impairment rating. The AMA Guides
speak of “a state that is approaching death” as the standard for 95-100% Whole Person Impairment. Some writers have commented that the standards for scaling impairment in the *AMA Guides* are unduly stringent and depreciate the loss of function.

Similarly, consensus is not complete on what it means to have zero impairment. What is normal function? Should it be adjusted for predictable differences by age and gender of the worker? How should the baseline function be adjusted to reflect preexisting conditions?

By developing solutions to these problem areas, the variability in calculating impairment ratings can be reduced. This has significant benefits to the workers’ compensation system:

- Greater equity across injured workers, regardless of who rated their impairment.
- Speedier payments to workers because of fewer questions and challenges by claims adjusters.
- Resolution of injured worker frustration with facilitation of them moving forward with their lives.
- Less disputes and litigation because the rules on calculating an impairment rating are clear and consistently applied.
- Less administrative costs.
- Jurisdiction comparisons, tracking, and research.
- Evolution of an international standard for jurisdictions to consider.

### The Medical Report at Stability

The medical report at “stability” is a comprehensive report prepared after the injured worker is medically stable, sometimes referred to as MMI or fixed state of recovery. This concept is called by different names from place to place, with sometimes important local distinctions. See Table 2 below for examples of jurisdictional differences.

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Nomenclature</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>Maximum Medical Improvement</td>
<td>Means a point in time when any impairment resulting from the injury has become stable and when no further treatment is reasonably expected to improve the condition.</td>
</tr>
<tr>
<td>Florida</td>
<td>Maximum Medical Improvement</td>
<td>The date after which further recovery from trauma, or lasting improvement to an injury or disease can no longer reasonably be anticipated, based upon reasonable medical probability.</td>
</tr>
<tr>
<td>Tennessee</td>
<td>Maximum Medical Improvement</td>
<td>Not defined by rules or case law.</td>
</tr>
<tr>
<td>Vermont</td>
<td>Medical End Result</td>
<td>Medical condition has plateaued such that significant further improvement is not expected.</td>
</tr>
</tbody>
</table>

Because it serves administrative and legal purposes, the final report of the examiner should include the following information:

- **Diagnosis.** The examiner needs to clearly state the diagnosis as substantiated from the medical record and any clinical assessment. The examiner should also define, as clearly as possible, the relationship of the diagnosis to the industrial event. It is recognized that in many cases, specific pathologic diagnoses are not clearly evident. The examiner has the responsibility to provide a diagnostic impression that is as closely correlated to the clinical findings as possible.
- **Stability.** Medical stability, MMI, “fixed state of recovery,” or “permanent and stationary” refers to a date when the period of healing has ended. It is important to note that medical stability may not be used to terminate necessary medical care. The date of medical stability and the date when the worker qualifies for an impairment rating can be two separate dates. Impairment rating is not to be calculated before that day. This situation can be best understood with the example of an amputated finger. If after 8 weeks of treatment, the patient’s condition has reached a plateau, and it is determined that what can be done to improve his/her condition has been done, he/she would be at MMI. Once the patient returns to work, temporary disability benefits (TTD) cease. However, it is obviously too early to determine that this individual has a permanent...
lifetime loss. It would be appropriate to have the patient wait at least six months to determine the issues of permanency. In some jurisdictions this must be done at time of MMI. (See discussion of time periods for certain conditions to reach medical stability below.)

• Calculation of Impairment. Using these IAIABC Guides (or the AMA Guides or other jurisdictional methodology for those conditions not found in the IAIABC Guides), the examiner should calculate the residual impairment, based on clinical findings established during the medical examination and information found in the medical records.

• Apportionment. The examiner must identify and list any factors, occupational and non-occupational, which add to or are a part of the impairment, but are not a direct result from the injury. (See apportionment section.)

Time Periods for Certain Conditions to Reach Medical Stability

Those who perform impairment ratings must be aware that for some conditions there is a certain time period that must pass before a condition is considered to be at MMI. Some suggested guidelines are listed below:

• Soft Tissue Spinal Complaints. The majority of patients with soft tissue spinal complaints recover without any permanent residual impairment. Therefore, before considering any patient with residual soft tissue, developmental and degenerative spine complaints for an impairment, the patient’s symptoms must have been present for a minimum of six consecutive months. In jurisdictions where impairment rating must be done at the time of MMI, the physician/rater may reasonably determine that the examinee’s condition is expected to continue six months and longer after the injury in order to perform the rating.

• Range of Motion. Often, maximum range of motion is not obtained until one year from the time of the accident or surgery. Loss of motion is not to be considered permanent until it is demonstrated that the patient is at least six months (or applicable statutory limits) from accident or surgery and has reached a plateau in his/her progress.

Capabilities Assessment

When appropriate, the physician should discuss any impairment of daily living activities, and give clear examples. For example, if after knee surgery, an examinee has no restriction other than downhill skiing, that restriction should be clearly stated. The impairment rating report should reflect how the actual impairment impacts with daily living. The physician therefore is to make a statement as to the current functional capacity of the patient as it relates to the impairment’s impact on daily living activities. It is the physician’s responsibility to determine if the impairment results in functional limitations and to inform the employee and the employer about an individual’s abilities and limitations. The physician should state whether the work restrictions are based on limited capacity, on risk of harm, or on subjective patient tolerance for the activity in question. It is the employer’s responsibility to identify and determine if reasonable accommodations are possible to enable the individual’s performance of the essential job activities. Physicians can often and should be encouraged to suggest possible reasonable accommodations.

Not only do such suggestions clearly establish physical abilities, they also facilitate the patient/employer relationship for return to work. Functional ability evaluations should be only performed or requested if the claim administrator makes a specific request for this service. These assessments, also known as Functional Capacity Evaluations, may also be recommended by the treating or evaluating physician if the physician feels the information from such testing is crucial (an uncommon situation).

Future Medical Treatment

Depending on the jurisdiction, the physician may be required to state a prognosis and the need for any possible required medical treatment in the future as a direct result of the industrial accident. This information is critical in those states that required to pay lifetime medical benefits for the establishment of financial reserves. This would also certainly be the case if a lump sum
settlement of the claim was being negotiated by the claimant and payer.

Patient Declining Surgical, Pharmacological, or Therapeutic Treatment of an Impairment

If the patient declines recommended treatment for an injury or illness, that decision neither decreases nor increases the estimated percentage of the individual’s impairment. However, the physician is to make a written comment in the medical evaluation report about the suitability of the therapeutic approach, and to describe the basis of the individual’s refusal. The physician will need to address whether the patient is medically stable without treatment and estimate the permanent impairment that would be expected to remain after the recommended correction.

Administrative Issues

While not directly related to a medically correct impairment rating, certain administrative issues need to be understood by the physician/rater to insure prompt handling of benefits to the patient and payment to the provider. Even a highly professional impairment rating founded on excellent medical reasoning may encounter administrative problems if a jurisdiction’s procedures are not followed closely. This results in delay of payment to the worker and to the medical provider and additional calls and administrative work between the agency and provider’s office. Jurisdictions have their own idiosyncratic forms and completion rules, so it is difficult to offer detailed guidance. However, the following are some principles that broadly apply to rating permanent impairment across jurisdictions.

Who Is to Perform Impairment Ratings

In general, licensed physicians should perform impairment ratings. Some jurisdictions extend the right to rate permanent impairments to dentists for dental injuries. Other exceptions may exist for special cases.

The raters should be trained in the rating process. In many jurisdictions a physician must receive specific training or a certification to submit an impairment rating. When the treating physician is unable to or is uncomfortable in performing the impairment rating, it is recommended that those involved with the impairment evaluations see that physicians who have training and expertise with the patient’s condition and the impairment rating methodology used in the jurisdiction perform the ratings. In that the IAIABC has its own comprehensive rating guidelines, training and certification courses will be offered for those physicians doing ratings for injured workers in those jurisdictions that adopt these guidelines.

Forms

Some jurisdictions have specific forms for medical reports. Different forms may be required for first reports of injury, testimony for hearings, and impairment ratings. Also, for specific impairments, special forms may be needed because of the specific physiological measurements required by law to complete a rating. Common examples of these specialty forms are vision, hearing, wrist and ankle evaluations.

Billing for Impairment Ratings

The physician is not entitled to reimbursement under the codes listed below if their report does not conform to the established criteria as outlined in these guides. However, it is required that the physician list licensure after signatures, such as M.D., D.O., D.C., D.P.M., etc., so that payers are fully aware of the physician’s licensure.

Billing for Impairment Ratings Done by the Treating Physician

Currently the AMA’s CPT book does not list specific codes for impairment ratings. For this reason, the IAIABC has recently submitted to the AMA’s CPT Committee the following codes for consideration to use when submitting impairment ratings to the insurance carrier and/or employer for billing purposes. Impairment ratings are considered an extension or continuation of the treatment process, which include the usual evaluation and management of the office visit, a review of the medical records and diagnostic studies when necessary, current physical findings on which the rating is based, and the written report.

The IAIABC recommends that universal codes be adopted for uniform international comparisons and tracking.
for these codes is variable, dependent on the complexity of the case, the time required in the evaluation and report writing, and the value of the examiner’s time.

Summary

Consistent and prompt payment of benefits to injured workers are universal goals of workers’ compensation systems. Permanent disability benefits suffer the most from delayed and inconsistent benefit evaluations. Problematic impairment ratings breed disputes over the benefits payable, delay payments, unnecessarily stress injured worker’s lives, increase administrative costs, and generally cause stakeholders to have less confidence in the system. These problems invite turmoil and increased costs in both the legislative process and in the courts.

Measuring the degree of functional loss to an organ or body system can be a very complex and challenging task. But these inherent problems are aggravated by physicians/raters evaluating permanent impairments that do not understand and use practical standards with which to measure and report on the degree of physical impairment. As the *AMA Guides* have evolved they have provided direction and a foundation of consistency and fairness to the process of rating impairments. The five editions of the *AMA Guides* demonstrate that reforming the process of rating is ongoing and fruitful. However, on some important definitional and conceptual issues, there continues to be significant evidence demonstrating that

| Table 3: Current Existing Non-specific Procedure Codes that Can Currently be Utilized When Submitting Billings for Impairment Rating Procedures |

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>99499</td>
<td>IME - Routine</td>
</tr>
<tr>
<td>99499-21</td>
<td>IME - Complex</td>
</tr>
<tr>
<td>97799</td>
<td>Permanent Impairment Assessment</td>
</tr>
<tr>
<td>99080</td>
<td>Special Report / Medical File Review</td>
</tr>
</tbody>
</table>

| Table 4: Specific Codes Submitted to the AMA’s CPT Code Committee for Adoption (Status is pending) |

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>99461</td>
<td>Impairment rating by the treating physician that includes diagnosis, stability, calculation of impairment, apportionment, future medical treatment, if requested, capabilities assessment. Initial 30 minutes.</td>
</tr>
<tr>
<td>99462</td>
<td>Each additional 30 minutes</td>
</tr>
</tbody>
</table>

| Table 5: Billing for Impairment Ratings Done by Someone Other than the Treating Physician (i.e. Rating Physician or Other Rater) |

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>99466</td>
<td>Impairment rating by a physician that includes diagnosis, stability, calculation of impairment, apportionment, future medical treatment, and may include, if requested, capabilities assessment. Initial 30 minutes.</td>
</tr>
<tr>
<td>99467</td>
<td>Each additional 30 minutes</td>
</tr>
</tbody>
</table>

the *AMA Guides* are able to meet administrative and jurisdictional needs for workers’ compensation.

This guide is a supplement to the *AMA Guides* for workers’ compensation purposes. It is to clarify the definitions and practices contained in the *AMA Guides* from a unique workers’ compensation context. It is produced by medical providers skilled in occupational medicine and impairment.
rating for workers’ compensation, with input from regulators and benefit administrators. Our goal is to add more refinement and uniformity to the process, so as to provide a more consistent, universal, and fair process. This chapter of the IAIABC Guides lays out basic principles for impairment evaluations. These principles are carried forward in other parts of the IAIABC Guides dealing with specific body parts or systems.

**Chapter 2: Pain & Apportionment**

**Pain**

Putting a dollar value on pain is a highly contentious issue. First, pain is inherently subjective with objective pathology often only showing modest correlation. Often, an examiner must rely on communications from a patient rather than on laboratory or imaging studies in order to assess pain. The awards for pain under tort law can vary enormously depending on the nature of the case involved and the judge or jury. The early framers of workers’ compensation law wanted to avoid these disputes and highly variable outcomes. Even today, most systems avoid explicit compensation for pain from a workplace injury.

Clearly, work injuries can produce excruciating pain. Moreover, pain can manifest itself in predictable physical outcomes, some of which can be measured with a reasonable degree of precision. If not measurable, some symptoms of pain are classic and highly predictable in occupational and non-occupational contexts, e.g., phantom pain after an amputation.

Subjective pain is shown to be influenced by depression, anxiety, beliefs, expectations, rewards, attention and training. These markers reflect social and environmental factors as much as they reflect pain. Prospective studies consistently show that the onset of disabling pain is highly associated with issues such as job dissatisfaction, lack of support at work, stress and perceived inadequacy of income. Financial compensation, receipt of work-related sickness payments and compensation-related litigation are also associated with chronicity, as are social and economic factors such as poor education, language problems and low income. Once initiated, the progression of pain to chronicity is contingent upon similar factors (AMA 5th Edition, p. 581).

**Pain Rating Guidelines and Examples of Application**

Impairing conditions can leave the patient with residual pain that is extraordinary and not fully accounted for with the existing impairment rating. After reviewing this complicated issue, the IAIABC Impairment Committee agreed that any methodology to rate pain must be reproducible, consistent, objective, defensible and be uniform throughout all chapters of the IAIABC Guides. The medical literature has been considered and incorporated into what appears to be a reasonable and logical approach to improve uniformity and reliability in rating pain. Therefore, the committee has adopted the following rating guidelines. This pain model is designed to evolve as related objective and reproducible medical studies are published. For conditions where there is only the subjective complaint of pain, that is not accompanied by any demonstrable objective clinical signs, significant history of trauma or other independent, measurable abnormalities. No separate impairment rating is given for pain.

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**IAIABC Recommended Practices**

### Residual Pain Intensity

<table>
<thead>
<tr>
<th>Unratable</th>
<th>Residual Pain Expected with Typical Impairment Rating for Injury</th>
<th>Pain Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective Only</td>
<td>Unbearable Severe Pain</td>
<td>Subjective</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ratable</th>
<th>Extraordinary</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Pain</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This follows the AMA Guides. (5th edition of the AMA Guides, p 10.)

**Example 1:** A 23 year-old male continues to complain bitterly of excruciating, intolerable, disabling back pain after picking up a 15 lb. skill saw off the floor 6 months ago. He has undergone extensive treatment by a number of examiners who have noted significant embellishment of symptoms, with all neurological testing normal. Images, including MRI, are within normal limits. He has not been able to go back to work and has been declared medically stable and he would receive no additional impairment for his subjective complaints of pain.

*Residual Pain Normally Associated With an Injury (Objectifiable)*

For most conditions qualifying for an impairment rating with the 5th edition of the AMA Guides or these IAIABC Guides, the rating is presumed to account for the commonly associated pain for that condition, including that which may be experienced in areas distant to the specific site of pathology. (See 5th edition of the AMA Guides, p 10.) This includes Chronic Regional Pain Syndromes and nerve injuries where the neurologic deficit includes “sensory loss and pain” (Ibid, p. 482, Table 16-10).

**Example 2:** Eight months ago, a 45 year-old female fell and twisted her right knee at work. She had immediate pain and swelling with the inability to fully extend her knee. She was diagnosed with a right medial meniscal tear and underwent arthroscopic surgery for a partial tear. Her post operative and rehabilitate course was unremarkable. She has been declared medically stable and has been left with some residual aching in her right knee that she did not have before, for which she takes an anti inflammatory daily. Her impairment is 2% lower extremity for the partial meniscectomy, which includes the accompanying residual chronic pain. There is no additional award for pain.

*Extraordinary Severe Chronic Pain (ESCP)*

Extraordinary pain complaints present in one of the following three categories:

1. **Persistent, severe painful conditions that are typical of a medical disorder that is well recognized and relatively uncommon.** These are conditions that are widely accepted by the medical community as having a well-defined pathophysiological basis and have extraordinary pain associated with them that was not adequately encompassed by the typical rating methodology as described above. These conditions are limited to those listed in Table 6 below.

2. **Severe subjective extraordinary pain for common conditions for which an impairment rating is calculated.** These are painful conditions that are typical of a medical disorder that is well recognized and is common. These are conditions that are widely accepted by the medical community as qualifying for an impairment rating with the 5th edition of the AMA Guides or these IAIABC Guides, however these patients have persistent subjective complaints of pain that exceed what is usually observed.

3. **Persistent, severe subjective painful conditions that have a controversial diagnosis.** These are conditions with a controversial diagnosis such as fibromyalgia, chronic fatigue syndrome, Sick Building Syndrome, multiple chemical sensitivities, other functional somatic syndromes, or with an idiosyncratic set of symptoms and signs that are not characteristic of any well-recognized medical disorder.

*Rating Extraordinary Chronic Pain (ESCP)*

Rating unusual pain is a delicate judgment that tries to balance medical evidence, the requirements of law, and fairness to the patient. Below we consider three classes of patient complaints that are easily separated and for which different degree of latitude in assigning a rating for pain should be allowed.

**Persistent painful conditions that are typical of a medical disorder that is well recognized and relatively uncommon.**

If, after six months, there is persistent extraordinary pain for conditions such
as those listed in Table 6, then the impairment is calculated as described. These conditions typically have objective findings that are demonstrable on physical examination, laboratory or imaging evaluation. These conditions are generally rare and the impairment is calculated utilizing Table 7 (see next page) to establish credibility and the Impairment Impact Inventory (I³) to determine the additional impairment, up to a maximum of 3% whole person (Turk et. al, 2001). The I³ is utilized to assess the 3 main dimensions of chronic pain:

1. Intensity and frequency of pain
2. Emotional distress associated with pain
3. The perceived impact that pain has on an individual’s ability to function

The I³ requires only 10 minutes to complete, and is easy to administer and score. The initial research on the I³ demonstrates that it has established norms in a population of claimants undergoing impairment or disability evaluations. Using the I³ as found on pages 576 & 577 of the AMA Guides, calculate the score as directed to assess the severity of the extraordinary pain on the individual’s life. Use Table 8 to assign percent whole person for that which is related to the extraordinary painful conditions. This value would be combined with other ratings.

Certainly, these factors must be applied with great care to ensure that the physician is not unfairly stereotyping the individual or biasing the evaluation based on one outstanding characteristic. In making this evaluation, objective, recordable evidence should be given greater weight than subjective, unverifiable data. Many times it is impractical for the physician to verify statements made about the mechanism of injury, ongoing job restrictions or history of employment. However, these are very important variables, and to the extent other factors present a mixed or conflicting view of the case, some confirmation with the employer may be useful.

Gross inconsistencies in these factors are warning signs that pain may be exaggerated or impossible to properly evaluate. Subjective patient reports that are inexplicably different than objective findings should alert the physician to investigate the case more fully before assigning extraordinary pain ratings. Major differences between the patient’s reports on injury, restrictions, and job duties and those of the employer should be weighed on the strength of the credibility of the parties.

Example 3-a: Twelve months ago, a 25 year-old male public transit worker fell under a moving rail car at work and incurred a complete below-the-knee amputation. His post-operative and rehabilitate course was unremarkable. He has been declared medically stable and has been left with extraordinary, severe phantom leg pain, far greater than expected. His impairment is 80% lower extremity or 32% whole person for the amputation. He scores 54 on the I³ and is given an additional 3% whole person for the accompanying extraordinary chronic pain. His total impairment is 34% whole person.

Residual severe extraordinary pain for common conditions for which an impairment rating is calculated. For most conditions that can be given an impairment rating with the 5th edition of the AMA Guides or these IAIABC Guides, the rating has “already accounted for the commonly associated pain for that condition, including that which may be experienced in areas distant to the specific site of pathology” (5th edition of the AMA Guides, p 10). This includes CRPS where pain is already included in the rating and nerve injuries where the neurologic deficit includes “sensory loss and pain” (Ibid, p. 482, Table 16-10).

Example 3-b: 8 months ago, a 45 year-old female fell and twisted her right knee at work. She had immediate pain and swelling with the inability to fully extend her knee. She was diagnosed
with a right medial meniscus tear and underwent arthroscopic surgery for a partial. Her post operative and rehabilitate course was unremarkable. She has been declared medically stable and has been left with some residual aching in her right knee that she did not have before, for which she takes an anti-inflammatory daily. Her impairment is 2% lower extremity for the partial meniscectomy, which includes the accompanying residual chronic pain. There is no additional award for pain. Until there is objective and reproducible methodology that can accurately and consistently report subjective complaints of pain, for the residual extraordinary pain that exists for common conditions, the IAIABC recommends that no additional impairment be given.

**Table 8: Factors to Consider in Evaluating Extraordinary Pain**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Definition</th>
<th>Example/Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The objective pathology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The patient’s history including the mechanism of injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observable behavior</td>
<td>Based on the clinician’s professional judgment and experience with the patient, what is the likelihood that the patient is accurately reporting events and symptoms</td>
<td>Are the patient’s movements and comportment consistent with the reports of pain; if possible observed behavior outside the examining office is helpful. Is there evidence that the patient had been “coached” or staged to say or do things to support the appearance of residual pain?</td>
</tr>
<tr>
<td>The individual’s credibility</td>
<td>Previous injury history or evidence of a difficult time acclimating to jobs or work may be considered. The length of the treatment relationship with the patient should have a bearing on how reliably the physician can judge credibility in the current case.</td>
<td></td>
</tr>
<tr>
<td>Motivation to get well</td>
<td>Factors unconnected to the injury mechanism that may be an incentive to delay or resist treatment and activities that promote full recovery</td>
<td>Studies have shown that the worker’s perceived relationship with the employing organization, especially the immediate supervisor(s) are highly influential in affecting return to work. Other family or economic factors may also be at issue.</td>
</tr>
<tr>
<td>Individual’s self report data of pain</td>
<td>Evidence that activities of daily living, including work duties, are altered or curtailed due to pain</td>
<td></td>
</tr>
<tr>
<td>Ability to function, including permanent work restrictions</td>
<td>This is not to be confused with functional impairment for other mechanical causes, e.g., amputation or loss of range of motion.</td>
<td></td>
</tr>
</tbody>
</table>

**Persistent Severe subjective painful conditions that have a controversial diagnosis.**

Conditions described under 3c that present with controversial diagnosis such as fibromyalgia, chronic fatigue syndrome, Sick Building Syndrome, multiple chemical sensitivities, functional somatic syndromes, or with an idiosyncratic set of symptoms and signs
that are not characteristic of any well-recognized medical disorder, are not to be considered for ESCP rating.

The IAIABC Impairment Rating Committee believes that future research will facilitate validation and refinement of this construct.

**Apportionment**

It is important for physicians doing impairment ratings to be aware of the laws of the jurisdiction to which they are reporting, for apportionment is jurisdiction specific. Some jurisdictions do not recognize any concept of apportionment.

To facilitate this discussion and understanding, the standard terminology “prior impairment” will be used and replaces various other descriptors, such as: preexisting conditions, preexisting symptomatic conditions, previously existing conditions, and previously existing symptomatic conditions.

The allocation of damage among possible contributing causes is naturally imprecise. The chief problem is the lack of reliable measurement on body functions involved before and after each injury or point of damage. Measuring deterioration or limitation to non-occupational disease or the aging process is also difficult.

Various assumptions are made and included based on reasonable medical probability. Statutory and case law in each jurisdiction adds its own meaning to this criterion, but generally it means greater than 50% chance.

To arrive at the most reliable and valid conclusion, the rater needs information.

Measurements on current physical condition can be ordered. Comparing these with previous measurements and history may be difficult. The physician/rater may be constrained in what is available or what he or she can request. Unfortunately, data on prior injuries is often not available.

It should also be born in mind that prior permanent impairment requires the same standards as rating present permanent impairment. If because of lack of evidence a physician/rater cannot reliably rate preexisting limits or reduced functions, the greater the share of the compensation burden that will fall on the current employer. For example, hearing loss is a very frequent source of permanent injury award.

Without a history of reliable audiometry benchmarks, especially hearing levels at the time of employment, an employer is likely to be charged with the entire hearing deficit of a worker filing a loss of hearing claim.

**IAIABC Recommended Practices**

**When and How Impairments are Apportioned**

When and how impairment is apportioned varies widely from state to state. In some states there is an “offset,” rather than an apportionment if there is a preexisting workers’ compensation award. An apportionment occurs when there is an accepted “combined condition,” which is determined as a percentage. There are also some attempts to consider a “new” loss only with injuries involving arms and legs, but to allow contralateral comparisons except where there is a history or disease to the other limb.

When a permanent impairment results from the addition or combination of a prior impairment with the existing impairment from the industrial accident, then the permanent impairment is apportioned (or distributed) between the current injury and the prior impairment condition(s).

Physicians must understand that apportionment generally applies only to permanent impairments. Apportionment of the final rating is necessary if there is objective medical documentation that a prior ratable impairment existed before the current injury for the same anatomical area, structure, or condition. In order to apportion any condition as a prior impairment, the condition needs to have been ratable by either the AMAGuides or the IAIABC Guides before the industrial event and must be based on reasonable medical probability (i.e., greater than 50%). The total impairment is calculated and then the prior impairment is calculated and deducted. The remaining amount would then be due to the industrial accident.

Not all cases can be apportioned. If the physician cannot, with a reasonable degree of medical probability, estimate the level of impairment that would have existed (absent the injury), the physician cannot apportion the final impairment.

Most jurisdictions do not base apportionment solely on the existence of a disease, abnormality, or disorder. If a person has an asymptomatic occult disorder (spondylolysis, spondylolisthesis, significant degenerative changes, etc.) that would not qualify for a rating before an event, then the final rating is
typically not subject to apportionment. Such a condition, while not clearly increasing the incidence of injury, does increase the morbidity, lessen the degree of recovery, and increase the likelihood of surgery. Those issues that cannot be measured in any reasonable, objective way cannot qualify for an apportionment.

**The Schedule to Use When Apportioning Preexisting Conditions**

If an individual has received a prior rating from the 4th or 5th edition of the AMA Guides or from the IAIABC Guides, involving the same anatomical area as the industrial accident, then the prior rating is subtracted from the new rating using this current guide. For those conditions not found in these guides, the rater is to use the 5th (or most current) edition of the AMA Guides. Additionally, the rater is not to subtract ratings that were incorrectly calculated to begin with. If the individual has received a prior rating for conditions from any other schedule than those listed above, the rater is to subtract the prior rating from the new rating, up to the amount the individual would have received for the same condition under this schedule. If the individual has a preexisting condition that is listed in the said guidelines, and has not been rated for the problem, the rater is to use the guidelines to document, as best he/she can, a rating for the preexisting condition(s), which is then subtracted from the current rating.

If the individual has preexisting impairment that is not found in the IAIABC Guides and has not been rated for these problems, the rater should use the 5th (or most current) edition of the AMA Guides to document, as best he/she can, a rating for the preexisting conditions, which is then subtracted from the current rating.

**Table 9: What Schedule to Use When Apportioning Prior Ratable Conditions**

<table>
<thead>
<tr>
<th>Patient has a prior ratable condition for the same body area being rated</th>
<th>What schedule to apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior ratable condition was calculated from the same editions as the IAIABC Guides or the 4th or 5th (or most current) edition of the AMA Guides.</td>
<td>Subtract prior impairment directly for the new calculated impairment.</td>
</tr>
<tr>
<td>Prior ratable condition was calculated from a different edition of the AMA Guides.</td>
<td>Establish what the rating would have been under the IAIABC Guides or the 5th edition of the AMA Guides. Subtract this % impairment from the % total impairment.</td>
</tr>
<tr>
<td>A prior ratable condition existed that was never rated, but contributes to the final rating.</td>
<td>Establish what the rating would have been under the IAIABC Guides or the 4th or 5th edition of the AMA Guides. Subtract this figure from the new calculated total impairment.</td>
</tr>
</tbody>
</table>

**References**

1. The request was denied by the Kentucky Insurance Commissioner and set at 13.5%.
3. Utah Administrative Rules
4. One to seven days, but most often around three days.
5. Some jurisdictions have separate processes for: (1) making a finding of impairment, and (2) calculating the impairment rating. Findings of impairment are done by physicians/raters. Insurers then rate the impairment by applying state adopted rating standards to the findings. Thus, the technical aspects of coming up with an impairment “score” for benefit calculation is an administrative function.
6. While the “state approaching death” may be true for the rating of some conditions, it’s quite possible (although rare) for a worker to obtain a 100% whole person impairment rating from a combination of injuries to various body parts, resulting in severe disability, but not “near death.”
7. The laws of individual jurisdictions are riddled with exceptions.
8. The Workplace Functional Ability Medical Guidelines, published by the Utah Medical Association, provides an excellent, comprehensive system review and report form.
9. They have been submitted to the AMA for possible addition to the CPT manual.
10. The reader is reminded that the core principles of these impairment Guides must rest on the empirical foundation of techniques and a consensus of informed medical opinion on the clarity and merits of a proposed technique. Without these principles, rating opens the door to dispute and friction in the workers’ compensation system.
11. The rater must be careful to comply with the law of the jurisdiction governing the claim for benefits. In some states if any such degenerative condition exists, the combined condition can be compensated only if the industrial injury is responsible for at least some percentage of the current condition. When rating, only the disability resulting specifically from the condition attributable to the industrial injury can be rated.
12. Some states, e.g., Colorado, would make the rater recalculate the rating using the current edition under which he/she is performing the rating.

**IAIABC Supplemental Impairment Rating Guides** continued in next issue.
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Malingering is described as “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives.”

Malingering should be strongly suspected if any combination of the following is noted:

1. Medicolegal context of presentation
2. Marked discrepancy between the person’s claimed stress of disability and the objective findings,
3. Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen,

The differential diagnosis includes: Antisocial personality disorder, Dissociate disorder, and True medical or psychiatric illness related to presenting complaints.

This must also be distinguished from conversion disorder, in which the incapacity is assumed to be beyond voluntary control.

The Assessment Process

The Independent Medical Examination is set up to enable an IME to review a particular patient’s injury and comment on specific matters.

The dynamics of this relationship is that the patient (usually with a lower level of education and from a lower socio-economic group than the IME) will present to the waiting room, fill out a questionnaire, and wait a period of time before being called through to the assessment.

The nature of this assessment is usually for the Doctor to sit facing the patient across a desk. Ordinarily the Doctor will be dressed formally with the assessment following a prescribed pattern.

The patient is likely to be anxious and nervous. Account is made for this during the assessment with the Assessing Doctor treating the patient with respect, sensitivity and politeness, whilst also seeking to obtain specific information from the patient and requesting the patient to perform specific acts/activities.

Once in the hospital, they were to stop feigning any symptoms. Nevertheless, none of the pseudopatients were detected by the professional staff. At the time of their eventual discharge, their psychiatric diagnoses were not overturned. Their symptoms were said to be in remission.

Psychological Tests

Malingering is an active process with the patient attempting to create a picture of them suffering a condition. This creation must be sufficiently robust for multiple IMEs to be convinced of its validity.

Dr. Rosenhan had a series of people (pseudopatients) go to a psychiatric hospital and feign a single symptom. All of the pseudopatients were admitted to the hospital and diagnosed as having major psychiatric disorders. (Rosenhan, D. (1973) On being sane in an insane place. Science 179:250)

Once in the hospital, they were to stop feigning any symptoms. Nevertheless, none of the pseudopatients were detected by the professional staff. At the time of their eventual discharge, their psychiatric diagnoses were not overturned. Their symptoms were said to be in remission.

When Dr. Rosenhan’s results were challenged, he said he would repeat the study. Subsequently, a number of individuals were identified as Rosenhan...
pseudopatients. However, Dr. Rosenhan did not send anyone else to the hospital.

There are a variety of tests which have been used in an attempt to detect malingering in the psychological and psychiatric environment (Detecting Malingering and Deception - Forensic Distortion Analysis by Hall H V and Pritchard D A. Lucie Press, 1996. ISBN: 1-57444-023-3). This includes the MMPI, WIAS, Bender-Gestalt, Betts Test and Personality Assessment Inventory.

Testing (for malingering) may include the Minnesota Multiphasic Personality Inventory (MMPI). The MMPI-2 has an F scale that is called the malingering index. It addresses symptoms that are stereotypically associated with serious psychopathology but are rarely found in patients with serious disorders. Look at the conclusions of the report to determine if any comments were made about the F scale. The F-K score is another potentially useful indicator touted as having the ability to distinguish malingerers from non-malingering subjects. The Lee-Haley’s Fake Bad Scale, a unique combination of MMPI test items, has been investigated specifically for the purpose of identification of faking of emotional disorders.

These tests are unfortunately usually not available to the IME in the context of assessing a patient with low back pain in the compensation environment (Motor Vehicle Accidents or Workers Compensation). The IME must therefore rely on the dynamics of the examination and the presence of yellow flags in conjunction with the consistency and validity of the physical examination.

**Conduct of the Assessment**

In cases where there is an abnormal sick role (and non-organic signs) the patient is usually depressed and has taken up a passive response to pain management. Their sleep is usually broken, they have a flattened mood with a flattened affect and may have multiple positive Waddell’s signs (‘Nonorganic Physical Signs in Low Back Pain’. Waddell et al, Spine, Vol 5, Number 2, Mar/Apr 1980).

The presence of symptom exaggeration and non-organic signs does imply that there are more than just organic issues contributing to the expression of the patient’s symptom complex (which for example, may be social, psychological or industrial) but this does not necessarily imply malingering.

Contrary to the chronic pain patient, malingering is an active process, which requires the patient to be aggressive and alert in carrying out the facade.

A malingerer can use a variety of methods to decrease the likelihood of the Independent Medical Assessor detecting their facade. These include:

1. **Attempting to control the assessment process**
   The patient may use a variety of methods in which to attempt to control the process of the medical assessment in order to minimize the likelihood of the IME seeing through the pretense. Intimidation is an example (leaning over your desk or in the case of males, demonstrating their physical prowess). Physical threats such as “see you in court” or “I’ll punch you” are less common but more extreme examples. Females may also use sexual intimidation (for example, wearing inappropriate underwear and/or flirting). Other attempts to control may include attempting to befriend the Independent Assessor or alter the dynamics of the interpersonal interaction in order for the patient to be seen as an equal rather than subordinate of the IME. The patient may at times attempt to get in first to tell the Assessor the history and also providing obstacles to the IME in obtaining a history other than which the patient is offering.

2. **Making your job difficult**
   A further technique is for the patient to put as many obstacles in the path of the IME as possible to minimize the likelihood of them obtaining sufficient information to demonstrate the invalidity of the patient’s claims. Examples of this may include turning up late to the assessment (but not sufficiently late that it is rescheduled), minimizing their apparent understanding of the English language (particularly with non-English speaking background patients), avoiding answering specific questions or attempting to emotionally “wind up” the assessor.

3. **“Walk the walk”**
   Patients have access to detailed information regarding how doctors attempt to detect malingering (Symptom Magnification, Deception and Malingering:Identification Through Distraction and Other Tests and Techniques, by Brigham C R and Babitsky, S. 2001 SEAK, Inc. ISBN: 1892904136) Even if schooled however, a malingering patient is unlikely to have as solid a medical
background as the IME. This may at times result in the patient providing inappropriate answers. For example, it is extremely uncommon to have undisturbed sleep despite having chronic unremitting pain. Some patients may be unable to provide specifics of their own symptoms (again unlikely if they truly are pain-focused). There may be a mismatch between the affect/presentation and their stated symptoms (for example, reporting that they are depressed yet presenting in a relaxed and vivacious manner). They may know how to respond to a common test (for example, straight leg raise) but be unaware that the same test can be reapplied in a different manner (lying versus sitting). There may also be a mismatch between presentation (to you) and reality (as per video surveillance). In this case it is particularly useful to obtain specifics of the patient’s stated activity tolerances and what activities they are specifically unable to perform.

**Identifying the Malingerer**

The presence of multiple positive yellow flags (Figure 1), the presence of psychosocial and/or industrial issues and symptom exaggeration (including multiple positive Waddell’s signs) does not necessarily indicate that the patient is malingering. In general, a patient acting in an active manner is more likely to be malingering than a passive patient.

The diagnosis of malingering involves the application of the medical model and known disease processes, determining the likelihood of the offered history and clinical signs being genuine taking into consideration the dynamics of the relationship, possible influences of psychosocial and industrial factors and allowing for the fragilities of human memory and the propensity for patients to naturally want to overstate their case. A thorough history of the mechanism of injury, symptoms and limitations of their activities of their daily living is critical.

As with a lot of medicine, most diagnostic information is obtained through taking a thorough history. The examination supplements the history.

**Management of the Malingerer**

- Do not accuse the patient directly of faking an illness. Hostility, breakdown of the doctor-patient relationship, lawsuit against the doctor, and, rarely, violence may result.
- The more advisable approach is to confront the person indirectly by remarking that the objective findings do not meet the physician’s objective criteria for diagnosis. Allow the person who is malingering the opportunity to save face.
- The likelihood of success with such approaches is inversely related to the rewards for the malingering behavior.

**Figure 1:**

| Unwitnessed injury | Occurred at end of shift match the reported injury or disability | MOI such that the application of applied force does not
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Patient unable to give details of MOI</td>
<td>Overly dramatic presentation</td>
<td>New job</td>
</tr>
<tr>
<td>Temporal relationship</td>
<td>Constant unremitting pain</td>
<td>Sleep undisturbed despite chronic pain and disability</td>
</tr>
<tr>
<td>Patient unable to provide specific details of symptoms</td>
<td>Non-work related aggravating factors</td>
<td>Early involvement of a solicitor</td>
</tr>
<tr>
<td>Presents with folder of relevant info (early in claim life)</td>
<td>Extensive usage of medical resources</td>
<td>History changes during the assessment</td>
</tr>
<tr>
<td>Non-anatomic symptoms with affect, posture and freedom of movement</td>
<td>High APS not consistent</td>
<td>Exaggerated pain behavior</td>
</tr>
<tr>
<td>Waddell’s signs</td>
<td>Extreme disability</td>
<td>Non-organic pain diagram</td>
</tr>
<tr>
<td>Condition not improving with other patients</td>
<td>Compares their history</td>
<td>Doing tasks they state they cannot do</td>
</tr>
<tr>
<td>PH of successful claims</td>
<td>Spouse on compensation benefits</td>
<td>Concurrent personality disorder</td>
</tr>
</tbody>
</table>
The importance of a well-written IME report is obvious to most all of us, then why are there so many poorly written IME reports around? Probable answer to that is the lack of formal training of this skill in our traditional medical school training and residency programs. In fact, most IME doctors never get formal training in quality report writing and lack many of the skills required for writing an well-organized IME report. There are many good IME doctors but there are fewer good IME reports.

Now here is a tool to solve the problem of poorly written IME reports in the form of a comprehensive guide by nationally recognized experts, such as Dr. Melhorn and attorneys Babitsky and Mangraviti. The authors’ record in this field is unrivaled and they truly speak from their vast experience. This reviewer, based on the experience of reviewing IME reports over two decades from various sources, can state with confidence that most doctors who write poor IME reports are well trained and well qualified medical experts and with instructions, training and practice can acquire the skills of communicating their medical expertise in their reports. This book is the most appropriate tool to acquire those instructions.

The reviewer has also found that the majority of IME doctors, who are busy clinicians, perhaps do not recognize the importance of a well-written IME report. The report not only communicates and helps understand medical facts to the nonmedical readers and thus persuade the reader but also creates a legal document in perpetuity. Thus a well-written report projects credibility of the IME doctor as well as serves as a good marketing tool. This book addresses all of these issues in a comprehensive manner over 18 chapters.

Writing and Defending Your IME Report: The Comprehensive Guide has some very unique ways to provide the thumbnail sketch of the chapter in the form of an executive summary in the beginning of each chapter, for experienced IME doctors who may be looking for pearls as well as detail analysis of the issues for physicians seeking a more comprehensive review. One of the best features of this book is defending the report as written, which is a unique concept and gives insight to physicians into skills as to how to turn it around and “come back from a poor position and convert such a challenge into an opportunity and not roll over and play dead”. This concept will be very attractive to IME doctors who may be sweating an upcoming deposition or testimony and may have some weak areas in their IME report. This feature alone, in my opinion, is worth the price of the book.

The book points out to some very useful methodology such as how to format a report, how to site authorities in medical literature and thereby making the report a powerful persuasive product. The book at the same time also gives recommendation of what to avoid both words and actions.

In short, this book is full of detailed examples depicting tough cross-examinations, unintended consequences and how to avoid them. This book is a valuable resource that would keep paying the dividends for years to come in the form of providing the skills to the Independent Medical Examiner of preparation for report writing, communication skills, what should be the content of a good IME report, or how to support and document and enhance quality of the report, including words and actions to avoid making every report a good report and as nearly as possible bullet proof from legal challenges.
Book Review
Gerontological Rehabilitation Nursing

By: Kristen L. Easton, MS, RN, CRRN-A
Published by: W.B. Saunders Company, 1999; 372 pages, hardback

This text is written for long-term caregivers who provide services in post-acute, tertiary settings to the older, aging client. The author notes that gerontological nursing apart from rehabilitation principles and concepts simply becomes medical-surgical nursing applied to older adults. This, then is the reason for the text.

The author states the text is not comprehensive text in either gerontology or rehabilitation but begins with the premise that the reader has basic knowledge of the nursing process and aging process. Ms. Easton notes the emphasis is on health maintenance, promotion of self-care and prevention of secondary complications.

Although the author disclaims the text as comprehensive, Part I provides a competent overview of the concepts and principles of both gerontology and rehabilitation. The section would be worthy of review for individuals who wish to prepare for certifications in either field.

Part II, Promoting Wellness and Self-Care might do with a very brief description of what one might expect from the ensuing chapters since it immediately launches into the chapter, “Improving Nutritional Status.” However, each chapter in this section addresses a functional issue in useful detail beginning with assessment and nursing diagnoses, and moving to specifics for promoting independence. Each chapter emphasizes the nursing role of educator and counselor in promoting independence.

Part III considers a number of conditions that alter the health of older adults. This includes stroke, spinal cord injury, Parkinson’s disease, multiple sclerosis, Guillain-Barre Syndrome, Lupus, and Traumatic Brain Injury, as well as orthopedic problems. Critical pathways for treatment are addressed as a means to promote consistency and quality of care. The references are included at the ends of all chapters and this reviewer is impressed with the currency and appropriateness of the references.

Part IV moves to issues anticipated to invite special concern for the gerontological rehabilitation nurse specialist. Case studies are used to show the need for cultural sensitivity and competence in the care of older adults. Psychological concepts and issues, although included in each chapter in Parts II and III, are given greater emphasis in order to promote the practitioner’s understanding that the elderly have special issues related to quality of life, grief, sexuality, elder abuse, overmedicating, and suicide. Ethical principles and trends in the field are addressed in the final two chapters.

This text is highly practical and can be used in a variety of settings, including advanced practice nursing classes, as a reference in any long-term care setting, and for staff development.
The two-volume, 2600 hundred-page, second edition of Orthopaedic Sports Medicine: Principles and Practice by Dr. Jesse C. DeLee, Dr. David Drez, and Dr. Mark D. Miller, initially seems overwhelming. However, this set of books is intended to serve as a complete reference for orthopaedic surgeons and other musculoskeletal specialist who have chosen sports medicine as their subspecialty. The sheer volume of material in this set is required to provide the necessary information to provide quality care to athletes of all ages. The editors have utilized leaders in the field of sports medicine to produce this detailed discussion of medical and surgical problems involving exercising individuals.

One significant change in the second edition is the approach to the discussion of pediatric sports medicine issues. Whereas the first edition offered a third volume specifically devoted to pediatric sports medicine issues, the second edition includes one chapter entitled “Special Considerations in the Pediatric and Adolescent Athlete” and incorporates the remaining discussion of pediatric sports medicine problems into some of the final twelve chapters of the book.

This two-volume book consists of thirty chapters. The first twenty chapters are a smorgasbord of sports medicine issues, some specific to the orthopedic surgeon and some apparently designed to give the orthopedic sports medicine specialist a background in non-orthopedic sports medicine issues. These first eighteen chapters are somewhat awkwardly arranged, somewhat mysteriously organized, and at times redundant. The final twelve chapters comprising more than two-thirds of the book are arranged anatomically and include a discussion of the issues traditionally associated with orthopedic sports medicine.

Early chapters of Volume One methodically discuss basic science issues of orthopedic anatomical structures, biomechanics, some pharmacology, and principles of medical research. This is followed by a chapter entitled “Surgical Principles” devoted to basic orthopedic surgical principles. Next, non-orthopedic medical conditions affecting sports participation are discussed. This chapter provides only a brief overview of the necessary information sports medicine physicians need to treat athletes in a primary care role. A more detailed discussion is beyond the scope of the text, but is probably warranted for appropriate care. An overview of various structural heart conditions and arrhythmias is included along with appropriate recommendations regarding sports participation. Chapter 8 gives quite good in-depth review of rehabilitation principles. Chapters 9 through 16 offer discussions of a variety of topics including complex pain syndromes, sports nutrition, ergogenic and recreational drug use by athletes, sports psychology, the female athlete, the orthopedically disabled athlete, environmental stress, and imaging techniques. Chapter 17 addresses a variety of topics concerning the pediatric and adolescent athlete. Chapter 18 discusses the team physician’s role in the preparticipation examination and the management of on-field emergencies. Chapters 19 and 20 discuss head and cervical spine injuries and conditions.

The final ten chapters of the book represent two-thirds of the text and are the best organized and detailed sections of the book. These chapters discuss specific anatomical sections of the body including the shoulder, arm, elbow and forearm, wrist and hand, hip and pelvis, thigh, thoracolumbar spine, knee, leg, and foot and ankle. Each chapter generally follows a pattern of review of functional anatomy and biomechanics, specific radiographic recommendations and findings, arthroscopic recommendations where appropriate, discussion of both soft tissue pathology and bony abnormalities, and nerve entrapment syndromes. Discussion of individual pathological conditions usually includes
the clinical evaluation, treatment options, the author’s preferred method of treatment, return to participation criteria, protective splinting, and rehabilitation recommendations. The individual contributors provide a list of references at the end of each section. As usual, discussion of the knee receives the most attention and comprises 22% of the text of the entire book and 33% of the final ten chapters.

Strengths of the book include a detailed discussion of most orthopedic sports medicine conditions and injuries. The specific orthopedic sections can serve as a reference to both orthopedic and non-orthopedic sports medicine physicians. The chapter entitled “Rehabilitation” provides a good review and discussion of general rehabilitative principles. Finally, the contributors are generally well-recognized authorities in the subjects they are asked to discuss.

Non-orthopedic sports medicine specialists might at times find the discussions of some non-orthopedic issues parsimonious. Although published in 2003, bibliographical references appear somewhat dated as one does not readily find references to literature after 1999 in the book, which could be due to the enormous task of assembling this voluminous and widely varied text. The importance of this fact varies according to the nature of the issue being discussed. The argument could be made to once again separate the pediatric discussion into a third volume.

In summary, the authors have compiled a discussion of widely ranging sports medicine issues from an impressive list of contributors. The depth and adequacy of discussion varies with each topic, but is generally better in the final twelve chapters of the book. The two-volume set is intended for orthopedic physicians interested in sports medicine. Although cost may be an issue, the book could be a valuable reference to non-orthopedic physicians interested in sports medicine or musculoskeletal topics.
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