IAIABC 2002
Supplemental Impairment Rating Guides®
Part 1

Draft

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The report is the copyrighted product of the Occupational Impairment Rating Committee of the International Association of Industrial Accident Boards and Commissions (IAIABC).

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The committee contained two working groups:

A. Development Subcommittee – Physicians that assisted in the development of draft guidelines.

B. Review Subcommittee – Knowledgeable individuals from the business, payer, administrative, and legal community that reviewed draft reports and assisted in organization and expression of material.

A complete listing of the committee members and their affiliations is contained in Appendix A to this report.

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Introduction: Legal and Historical Background

Physicians who make findings of impairment ratings and those who calculate them must understand the basic and universal principles of workers' compensation law to understand the medical and clinical issues of rating the permanent residual consequences of work-related injury or disease. This introduction will also explain the reason this supplemental guide was developed.

First, workers' compensation uses its own distinct approach to the compensation of permanent injury. It is unlike Social Security, personal injury or disability income insurance. Knowing that it has its own distinct system, with enforced rules of adjudicating claims, may prevent the physician from consciously or unconsciously misapplying techniques or methods used for evaluating other kinds of permanent injury or disability.

Second, workers' compensation is a system based on individual state and provincial laws. Thus, there are no binding national or international standards for how workers' compensation impairment ratings are to be done, as might be found in other systems, i.e., the US Social Security disability system. The *American Medical Association Guides to the Evaluation of Permanent Impairment* (*AMA Guides*), for reasons explained below, fall short of a universal standard for workers' compensation. Indeed, there is much diversity among jurisdictions in the fundamentals of how and when benefits should be paid.[1[a]] This is especially true concerning approaches to measuring and compensating the injured worker for the lasting, or permanent, consequences of an industrial injury.

Overview of Occupational Benefits

The categories listed below describe benefits almost universally 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

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. Nationally, medical-only claims are about 72 percent of all compensable injuries.[1]

Under workers' compensation, when the injured worker has missed a predetermined amount of time from work[2[a]], 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 point where medically all that can be done for the worker has been done (maximum medical improvement, or MMI). 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, province, 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

[1[a]] There is more commonality among Canadian provincial laws than among the states.
[2[a]] One to seven days, but most often around three days.

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%).[2]

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 1

Type of Workers' Compensation Claim	Percentage of Cases	Percentage of Cash Benefits
Temporary	72%	25%
Permanent Partial	27	62
Permanent Total	1	13

Source: National Academy of Social Insurance,
Workers' Compensation: Benefits, Coverage, and Costs, May 2001

How the award is calculated for these permanent claims differs from jurisdiction to jurisdiction. In some jurisdictions, permanent injury benefits are awarded only on the direct physical loss. Other jurisdictions compensate to some measure for: expected wage loss, the loss of employment options, extra expenses from accommodating the disability, or perhaps an implicit award for psychological loss and pain. Once again, the laws in each jurisdiction differ in philosophy and practice.

In some jurisdictions, the permanent benefit is statutory and has no medical or clinical basis. Examples of the latter statutes are those that:

- Declare a worker totally and permanently impaired if they are blinded in both eyes or suffer major amputations in two limbs.
- Award a fixed number of weeks of permanent disability benefits following certain treatments even though the outcome is perfectly satisfactory to the physician and the patient.
- Limit or disallow awards for certain conditions, such as tinnitus or psychological conditions.

Additionally, regulations or case law may constrain or define how multiple injuries may be combined for losses to the body as a whole, or how preexisting conditions should be apportioned to the loss.

In summary, 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.

Purpose of this Supplemental Guide

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 *Journal of the American Medical Association*, the *AMA Guides* have been revised periodically, and are now in the 5th edition. To calculate impairment ratings, 40 state workers' compensation systems require some utilization of the different editions of the guides. [3] [4] A current listing of each state and what they currently require for the impairment calculation is found in Appendix [to be added] 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. These in turn translate into statutory benefit payments. California (the most populous state in the nation) and nine other jurisdictions do not recognize the *AMA Guides* for rating impairment. Although not universally accepted by all jurisdictions, 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.

Those jurisdictions that utilize the *AMA Guides* note difficulty and confusion in coming to a consistent rating between different raters for the same condition.[5] This difficulty provokes calls for revisions of the *AMA Guides* to address this issue.[6] [7] Some jurisdictions disallow parts of the 4th edition of the *AMA Guides* in that it violates their compensation laws.[8] 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*. [3[a]]

While many states and provinces have adopted formally all or part of the *AMA Guides*, the *AMA Guides* by themselves are not a sufficient standard for workers' compensation. For reasons explained below, workers' compensation is a unique system. The evaluation of disability has different triggers and metrics. The IAIABC, representing administrative agencies, sought to repair some of the shortcomings or omissions that administrators were reporting about the more generic *AMA Guides*. The *IAIABC Guides* draw on the administrative expertise of jurisdictions and the specialized medical experience of physicians that specialize in the treatment and evaluation of injured workers.

The IAIABC Supplemental Guides

Most jurisdictions that utilize some edition of the *AMA Guides* for injured workers' impairment ratings note unnecessary physician 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 Occupational Impairment Rating Guide Committee believe that by improving the rating criteria requirements, physicians can reduce variability for the impairment ratings. For this reason, the IAIABC

[3(a)] Please see referenced articles: endnotes 9-15.

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 following 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.

Determining Permanent Physical Loss (Impairment)

One of the ongoing challenges in workers' compensation is to define how permanent physical loss is calculated in a defensible and consistent way. Most often, physical loss is defined and measured as an impairment.

The *AMA Guides* is the most uniform methodology utilized to calculate impairment.[4[a]] 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. Disability is how the permanent physical loss or the impairment impacts the performance of some human activity. It takes only a moment of reflection to realize that a given loss in use of a finger, limb, or sense would have dramatically different effects on a worker depending on:

- Occupation
- Education
- Age
- Geographical opportunities
- Employer's flexibility to modify job duties
- Motivation of Injured to help themselves

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 dysfunction of the individual.

Impairment / Disability Relationship

An impairment rating is given as the first factor 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 [to be added]). 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

[4[a]] 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. 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.

death. [5[a]] As an example, a complete amputation of the ring or little finger equals a 6% whole person impairment. For the compete 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.[9] 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. [10]

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.[6[a]] 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 inconsistency 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.[11] 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. Physicians are only expected to calculate the physical loss or impairment rating based on their clinical observations and the impairment guides mandated by the jurisdiction in which the injury occurred.

The physician-rater should understand that establishing fair compensation for lasting or serious harm to a worker is a mix of medical and legal issues. This report does not attempt to judge the rationale or adequacy of benefits and how individual states, provinces, and nations administer them. An appendix to this report illustrates some of the main differences among jurisdictions in their legal and administrative approaches to paying permanent disability benefits. The remaining components of this document outline the general principles for the physician to perform an impairment rating and report.

[5[a]] 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."

[6[a]] The laws of individual jurisdictions are riddled with exceptions.

Problems with Impairment Rating

The inconsistencies inherent in current rating systems used to calculate an injured worker's residual loss or impairment can be frustrating for patients, physicians, risk managers, state administrators, and payers.[6] One of the major problems with impairment ratings, and therefore a significant patient and administrative burden, is the lack of consistency between physician-raters of impairments.[12 13 14] Unfortunately, this variability becomes a source of dispute, which is both costly to the employer and stressful to the employee.

As the long list of critical papers in the literature will attest, the calculation of impairment is not an objective science. Ongoing debates center on the lack of empirical support or an objective basis for guides to precisely, objectively, and consistently convert a given physical condition to an impairment rating.

The literature has identified several problem areas for impairment ratings, among them:

1) The injuries that are compensable.
2) The scale or measures of impairment to a given body part.
3) How to perform or record measurements that support the scale given in 2) above.
4) How to convert loss to a specific body part to loss to the body as a whole.
5) Inconsistency of impairment ratings given by different raters for the same physical loss.

This Part 1 of the *IAIABC Guides* offers guidance to physicians on items 3,4, and 5. Items 2 and 3 require the application of training and skill to rating an injury. It is beyond the scope of this document, or the role of the rater, to judge the adequacy or fairness of an injured worker's compensation derived from the ratings when properly done.

The 100 percentage-point scale mentioned above that is used by the *AMA Guides* illustrates the challenge of item 1. 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?

Item 4 is a procedural issue because it involves conversion of one injury (individual body part loss) to another scale (percentage loss to body as a whole).

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.
- 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.

General Principles of Impairment Ratings

The 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 benefit must be triggered by a doctor's opinion as to a qualifying event, condition, or rating. Rating applies to those cases where the physician 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 Part 2 of the *IAIABC Guides*.

Reporting of Impairment Ratings

The impairment rating should be based solely on the objective maximum condition achieved by the patient along with the credible subjective findings interpreted in light of consistencies and inconsistencies. The calculation of an impairment rating requires that credible subjective findings be considered reasonable and necessary for those workers who have residual loss resulting from an occupational injury. 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 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 insurance carrier or agency. The treating physician may then refer the patient, or request that the carrier 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 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 further medical assessment. It is imperative 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.[15] When the physician 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 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. [16]

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.[17]

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. As this is an administrative document, the final disposition 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.[7[a]] 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, lost wages would cease at this time. 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. These standard time periods 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 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.

[7[a]] As in many aspects of workers' compensation law, states have enacted their own language to modify or clarify the concept of stability. For example, under Colorado statute a doctor cannot consider the passage of time; MMI is when no further care is expected to change the patient's condition. Thus, jurisdictional specific laws must be considered (see appendix to this report).

- **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

The physician should always 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. [8[a]] Functional ability evaluations should be performed or requested only 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

The examiner should be specific in identifying if any medical treatment may be required in the future as a direct result of the industrial accident.[9[a]]

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.

[8[a]] *The Workplace Functional Ability Medical Guidelines*, [8] published by the Utah Medical Association, provides an excellent, comprehensive system review and report form.
[9[a]] Jurisdictions vary on whether this is a legal requirement.

Pain

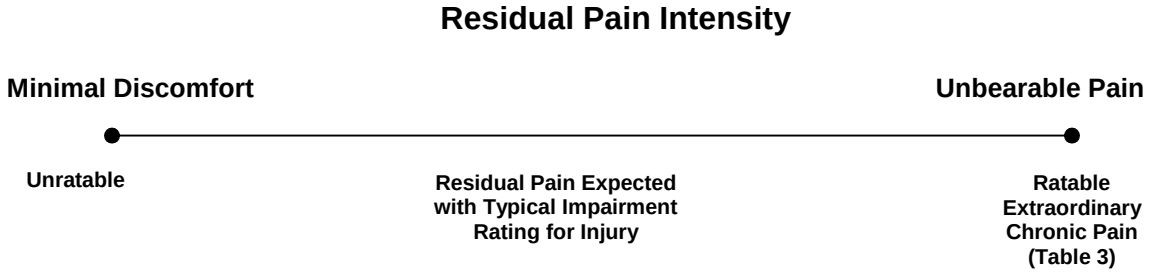
Putting a dollar value on pain is a highly contentious issue. First, pain is inherently subjective with objective pathology often only showing modest correlation. Often, an examiner must rely on communications from a patient rather than on laboratory or imaging studies in order to assess pain. The awards 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 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.[18]

Rating Guidelines

The committee understands that there are conditions where the existing impairing conditions in which the residual pain 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*. Therefore, the committee has adopted the following rating guidelines for the following three classifications of pain. The committee recognizes that this model may have some shortcomings. However, many variables, models, and the medical literature have been considered and incorporated into what appears to be a reasonable and logical approach to improve uniformity and reliability in rating pain.[10] [a] This pain model is designed to evolve as related objective and reproducible medical studies are published.



[10][a] 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.

1. Subjective Pain Only
For conditions where there is only the subjective complaint of pain, that is not accompanied by any demonstrable clinical signs, significant history of trauma or other independent, measurable abnormalities. No separate impairment rating is given for pain. (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 5lb 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 normal. He has been declared medically stable with his subjective symptoms not qualifying for an impairment rating. To reiterate, he would receive no additional impairment for his subjective complaints of pain.

2. Objectifiable Pain Normally Associated With an Injury
For most conditions qualifying for an impairment rating with the 5th edition of the *AMA Guides* or these *IAIABC Guides*, the rating calculated "already accounts 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 Chronic Regional Pain Syndromes and nerve injuries where the neurologic deficit includes "sensory loss and pain."

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.

3. Extraordinary Chronic Pain (ECP)
Extraordinary pain complaints present in the following three categories:

a. **Persistent 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 2 below.

Table 2 **Extraordinary Chronic Pain Conditions**
Amputations with Phantom Nerve Pain
Headaches Secondary To Severe Trauma, loss of Consciousness, or Skull Fractures
Post Paraplegic Pain

b. **Residual 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.

c. Persistent 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 (ECP)

a. Persistent painful conditions that are typical of a medical disorder that is well recognized and relatively uncommon.
The 3a conditions listed in Table 2 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 4 (see next page) to establish credibility and the Impairment Impact Inventory (I^3) [19] to determine the additional impairment, up to a maximum of 3% whole person. The I^3 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 I^3 requires only 10 minutes to complete, and is easy to administer and score. The initial research on the I^3 demonstrates that it has established norms in a population of claimants undergoing impairment or disability evaluations.

Using the I^3 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 3 to assign percent whole person for that which is related to the extraordinary painful conditions. This value would be combined with other ratings.

Table 3
Whole Body Impairment Percentages Associated With Scores On The I^3 Score

I^3 Score Range	Whole Person Impairment
0 - 43	0%
44 - 47	1%
48 - 52	2%
53 - 60	3%

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.

If, after six months, there is persistent extraordinary pain for conditions such as those listed in Table 2, then the impairment is calculated as described:

Example 3a: 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 I^3 and is given an additional 3% whole person for the accompanying extraordinary chronic pain. His total impairment is 34% whole person.

Table 4
Factors to Consider in Evaluating Extraordinary Pain

Factor	Definition	Example/Comment
The objective pathology		
The patient's history including the mechanism of injury		
Observable behavior		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?
The individual's credibility	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	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.
Motivation to get well	Factors unconnected to the injury mechanism that may be an incentive to delay or resist treatment and activities that promote full recovery	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.
Individual's self report data of pain		
Ability to function, including permanent work restrictions	Evidence that activities of daily living, including work duties, are altered or curtailed due to pain	This is not to be confused with functional impairment for other mechanical causes, e.g., amputation or loss of range of motion.

b. Residual 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 *IAIABC 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."

Example 3b: 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.

c. Persistent 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 ECP rating.

We believe that future research will facilitate validation and refinement of this construct.

Apportionment Overview

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 state or jurisdiction specific, with some expressing no concept of apportionment.

The 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.

It must be recalled that the awarding for permanent impairment and the allocation to prior impairing conditions is not a precise and exact formulation. Various assumptions are made and included based on reasonable medical probability, generally considered as greater than 50% chance. To arrive at the most valid conclusion, one must have available all of the applicable information that can be obtained. Assessing conclusions on incomplete data should be avoided, until such data is shown to be unobtainable. Unfortunately, data on prior injuries is often not available. It should also be born in mind that prior permanent impairment does not require higher standards than rating present permanent impairment. The more stringent the evidentiary demands on recognizing and measuring prior impairments, the greater the share of the compensation burden that will fall on the current employer. If one believes additional data may alter the conclusions, it would be wise to so state.

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 *AMA Guides* 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 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.[11[a]]

[11[a]] 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.

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*.[12[a]] 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 5
What Schedule to Use When Apportioning Prior Ratable Conditions

Patient has a prior ratable condition for the same body area being rated	What schedule to apply
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*.	Subtract prior impairment directly for the new calculated impairment.
Prior ratable condition was calculated from a different edition of the *AMA Guides*.	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.
A prior ratable condition existed that was never rated, but contributes to the final rating.	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.

[12[a]] Some states, e.g., Colorado, would make the rater recalculate the rating using the current edition under which he/she is performing the rating.

Administrative Issues

While not directly related to a medically correct impairment rating, certain administrative issues need to be understood by the physician 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 paperwork 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

Only qualified, licensed physicians should perform impairment ratings. These physicians should be trained in the rating process. 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.

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

The following listed codes should be considered for use when the physicians provide an impairment rating to the insurance carrier and/or employer. This is an extension or continuation of the treatment process. The IAIABC has submitted to the AMA's CPT Committee codes for impairment ratings 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 universal codes be adopted for uniform international comparisons and tracking.[13[a]] Payment 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.

[13[a]] They have been submitted to the AMA for possible addition to the CPT manual.

Special Procedure Codes for Impairment Rating Procedures

99499 IME - Routine

99499-21 IME - Complex

97799 Permanent Impairment Assessment

99080 Special Report / Medical File Review

Codes Submitted to the AMA's CPT code committee for adoption. Status is pending:

99461 Impairment rating by the treating physician that includes diagnosis, stability, calculation of impairment, apportionment, future medical treatment, if requested, capabilities assessment. Initial 30 minutes

99462 Each additional 30 minutes

Billing for Impairment Ratings Done by Someone other than the Treating Physician i.e. a Rating Physician:

99466 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

99467 Each additional 30 minutes

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 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 evaluating permanent impairments that do not understand and use practical standards with which to measure and report on the degree of physical impairment. The *AMA Guides* were a great step in the direction 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 is little sign that the *AMA Guides* are near closure.

This guide is a supplement to the *AMA Guides* for workers' compensation purposes. It is to clarify the definitions and practices contained in the guide 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 to the process and more uniformity to the outcomes, so as to provide a more consistent, universal, and fair process.

This Part 1 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. Evaluating pain, because of its importance and general applicability, is discussed in detail in this Part 1.

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Glossary of Terms [to be added]

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