American Medical Association
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Master the AMA Guides Fifth

A Medical and Legal Transition to the Guides to the Evaluation of Permanent Impairment, Fifth Edition

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AMA press
To my sister Janet, for being the very best sister, for her unconditional love, support, wisdom, and integrity; for my mother, who showed me the meaning of responsibility; and for my father, who encouraged me to strive for my dreams.

My sincerest gratitude to my mentors and dear friends who helped me complete this project: M. Robling, A. Bove, D. Bennett, S. Darnell, and V. Persky. Your vision, integrity, determination, and faith have inspired me, strengthened my senses, and enriched my life.

For all injured workers; may your impairments be appropriately assessed, and may your abilities be recognized and encouraged.

—Linda Cocchiarella

To my son Max, for the countless hours he patiently waited for me to finish researching and writing so we could finish homework or go for a walk, and to my coauthor for her patience and perseverance in completing this work with me.

—Stephen Lord

What is man? the Bible asks.

A voter, the politician answers,  
A machine, the engineer replies,  
A worker, the economist proclaims.

To the poet, a person is neither an economic entity nor a statistical cipher.  
A person’s a person with a mind that can perceive the truth, with a heart that understands love and beauty, with eyes that can behold the glories of the sunset, and cheeks that can feel the gentle winds of morning.

—Adapted from Henry H. Kessler,  
Disability Determination and Evaluation
Preface

The American Medical Association’s (AMA's) new book Master the AMA Guides Fifth (Master) enables the experienced Guides user to quickly make the transition from the Fourth Edition of the AMA Guides to the Fifth Edition. Master introduces the new Guides user to the fundamentals and subtleties of using the Guides for impairment and disability rating.

The Guides’ recommendations for assessment of permanent impairment are sometimes complex. Since the Guides books are “guidelines,” they have been interpreted in many different ways. The purposes of this book are to provide greater clarity on why certain recommendations were made, to show how to incorporate them into clinical practice, and to explain how to assess their impact on medical, legal, and state practices. Master also provides a state-by-state legal analysis for readers to understand how the Guides is used and interpreted in their own state.

Key features of Master that assist readers’ understanding of the Fifth Edition of the AMA’s Guides to the Evaluation of Permanent Impairment include:

- table-by-table comparisons of changes between the fourth and fifth edition tables
- a summary of new and key points within each chapter for easy reference and review
- detailed analysis of complicated cases not addressed in the Guides
- clarification of complex chapters, such as The Spine and Pain
- medical and legal tips for applying the Guides within your practice
- greater guidance regarding the assessment of pain
- analysis of different assessment methods for complex conditions, such as carpal tunnel syndrome and reflex sympathetic dystrophy
- information on how to assess causation from a medical and legal perspective
- state-by-state analysis of different applications and uses of the Guides.
Acknowledgments

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The authors would like to give special thanks to the coauthors and reviewers, listed below, whose significant and valued insights from a medical, legal, practice, and scientific perspective improved this book.

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LuAnn Haley, JD

“The strongest bond of human sympathy outside the family relation should be one uniting all working people of all nations and tongues and kindreds.”

—Abraham Lincoln, 1864
Table of Contents

Chapter 1  Introduction to the Philosophy, Purpose, and Appropriate Use of the *Guides* .................. 1

Chapter 2  Practical Application of the *Guides* .................. 27

Chapter 3  The Cardiovascular System: Heart and Aorta ............... 47

Chapter 4  The Cardiovascular System: Systemic and Pulmonary Arteries .................. 55

Chapter 5  The Respiratory System .................. 63

Chapter 6  The Digestive System .................. 77

Chapter 7  The Urinary and Reproductive Systems .................. 87

Chapter 8  The Skin .................. 97

Chapter 9  The Hematopoietic System .................. 107

Chapter 10  The Endocrine System .................. 115

Chapter 11  Ear, Nose, Throat, and Related Structures .......... 123

Chapter 12  The Vision System .................. 133

With August Colenbrander

Chapter 13  The Central and Peripheral Nervous System .......... 145

Chapter 14  Mental and Behavioral Disorders .................. 167

Chapter 15  The Spine .................. 179

Chapter 16  The Upper Extremities .................. 229

Chapter 17  The Lower Extremities .................. 263

Chapter 18  Pain .................. 277

With Dennis C. Turk, John D. Loeser, and James P. Robinson

Appendix A  Judging Causation .................. 327

Appendix B  Analysis of US Workers’ Compensation Statutes .......... 343

Index .................. 389
Introduction

This chapter provides an overview of key points and changes (identified with an icon 🔄) made in Chapter 1 of the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition (Guides 5th), illustrates these changes in a table comparison, and discusses the purpose and implications of the major changes, with illustrative examples. The numbered section titles within this chapter correspond to sections within Chapter 1 of Guides 5th. Only key principles or important changes are included in this chapter.

Chapters 1 and 2 of the Guides 5th present the philosophy and key principles that are applied throughout the book. It is essential that users of the Guides 5th read the first two chapters before using the Guides. Concepts that were previously discussed in the Fourth Edition Appendix have been revised and incorporated into the first two chapters.

Key Points and Changes

History 🔄

The AMA Guides incorporates scientific evidence from the major medical specialties and consensus opinions, where evidence was lacking.

The objective of the Guides is to provide a standardized method to assess permanent impairment and the impact of the permanent impairment on the ability to perform activities of daily living (ADL). It is strongly recommended that physicians and other users refer to this latest Guides Fifth Edition, since the Fifth Edition encompasses the most current criteria and procedures for impairment assessment.
Impairment, Disability, and Handicap

Impairment
Impairment is a loss of use or derangement of any body part, organ system, or organ function (Guides 5th, p 2).

Permanent impairment is assessed by a physician; each state will determine, on the basis of its statutes, what constitutes a physician.

Impairment is no longer defined as a condition that interferes with an individual’s ability to perform activities of daily living (ADL).

Under the Fifth Edition, impairments can be classified as nonratable or ratable.

Medical impairment can develop from an injury or illness.

Not all impairments interfere with ADL. These are not ratable impairments.

Only impairments that interfere with ADL qualify for an impairment rating based on the Guides. Such impairments are ratable in terms of a percentage of the whole person.

Impairment assessment includes both anatomic and functional loss, with some body systems emphasizing one type (ie, either functional or anatomic loss).

Functional loss means a reduction in the ability of a body part or system to perform a task in its normal or usual way, compared with either known populations or the individual’s prior known history.

Anatomic loss means any measurable diminution of “normal” anatomic integrity, compared with either known populations or the individual’s prior known history.

ADL include self-care, communication, physical activity, sensory function, nonspecialized hand activity, travel, sexual function, and sleep.

ADL no longer include social activities, recreational activities, and work. The ability to perform social and recreational activities or work is important in the assessment of disability and is not considered when determining an impairment rating.

Under the Americans With Disabilities Act, federal law treats an impairment as protected from a variety of defined forms of discrimination if the impairment “substantially interferes with a major life activity.”

Physicians need to consider the impact of the condition on individuals’ ability to perform ADL.

Maximal (or maximum) medical improvement (MMI) refers to a condition or state that is well stabilized and unlikely to change substantially in the next year with or without medical treatment.
An impairment is permanent when it has reached MMI.

*Permanent* no longer refers to a change by more than 3%, since it is not possible to accurately assess a 3% change in an impairment.

*Normal* refers to a range or zone that represents healthy functioning and varies with age, gender, and other factors, such as environmental conditions (Guides 5th, p 2).

*Normal* is defined from either an individual or a population perspective, depending on the preinjury information that is available and the physician’s clinical judgment concerning the best estimate of normal.

*Normal* may be determined by means other than studies of representative populations carried out with valid measures. *Normal* may also be determined by a comparison with a preinjury or preillness state or a complementary body part (eg, right and left legs).

Impairment ratings or percentages are consensus-derived estimates that reflect both the severity of the condition and the degree to which the impairment decreases an individual’s ability to perform ADL (work is excluded) (Guides 5th, p 4).

Whole person impairment percentages estimate the impact of the impairment on the individual’s overall ability to perform ADL.

A 0% impairment rating indicates that an impairment may be present, but that impairment does not impact the ability to perform ADL. This situation is considered to be a “nonratable impairment.”

Updated statistics regarding the growing use of the Guides: 40 of 51 jurisdictions use the Guides in workers’ compensation cases by statute, by regulations, or by administrative/legal practice.²

**Disability**

*Disability* is an alteration of an individual’s capacity to meet personal, social, or occupational demands or statutory or regulatory requirements because of an impairment (Guides 5th, p 8).

Impairments can but do not necessarily lead to functional limitations or disability.

Functional limitations or disability can both lead to further impairment.
The Organ System and Whole Body Approach to Impairment
Individuals with impairments in organs or body systems are given regional impairments.

All regional impairment ratings are converted to a whole person impairment rating.

Philosophy and Use of the Combined Values Chart
The Combined Values Chart combines multiple impairments into a summary value, so that the whole person impairment is equal to or less than the sum of all the individual impairments.

Combine multiple regional body impairments by means of the Combined Values Chart.

Incorporating Science With Clinical Judgment
Subjective concerns, such as fatigue, pain, and difficulty in concentrating, when not accompanied by measurable abnormalities, are not given separate impairment ratings.

Where impairment ratings are not provided for a particular impairment, the Guides suggests that physicians use clinical judgment to discuss impairment and its impact on ADL.

Causation, Apportionment Analysis, and Aggravation
Causation, for application of the Guides (by physicians), refers to an identifiable factor (eg, accident or exposure) that results in a medically identifiable condition.

Determining medical causation requires a detailed analysis of whether the factor could cause the permanent impairment and whether circumstances in the individual case support causation.

Legal standards for causation vary from state to state.

Use of the Guides
The most recent edition of the Guides is recommended as the latest blend of science and medical consensus.

Impairment Evaluations in Workers’ Compensation
Physicians need to identify the state workers’ compensation law that applies to the situation they are asked to evaluate.
Determine which edition of the *Guides* or other state guidelines are required for the assessment.

Impairment ratings or percentages should not be used as direct estimates of disability (*Guides 5th*, p 13).

Impairment assessment is a necessary first step for determining disability.

**Employability Determinations**

The physician needs to establish whether the individual can perform essential job functions, without endangering himself or herself, others, or the environment.

**The Physician’s Role Based on the Americans With Disabilities Act (ADA)**

Definition of disability under the ADA differs with the application in the *Guides*.

It is the physician’s responsibility to determine if the impairment results in functional limitations.

**Comparison of Tables Between the Fifth and Fourth *Guides* Editions**

The following table summarizes the key points and changes in tables between the fourth and fifth editions of the *Guides*.

<table>
<thead>
<tr>
<th>Table Topic</th>
<th>5th Edition Table Number</th>
<th>4th Edition Table Number</th>
<th>Summary of Changes in 5th Edition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions and interpretations of impairment and disability</td>
<td>1-1</td>
<td></td>
<td>New; compares definitions from leading or typical groups.</td>
</tr>
<tr>
<td>ADL</td>
<td>1-2</td>
<td>Revised from Glossary, 4th p 317</td>
<td>Omits social and recreational activities as a component of ADL.</td>
</tr>
<tr>
<td>Scales for measurement of IADL and ADL</td>
<td>1-3</td>
<td></td>
<td>New; commonly used scales to measure ability to perform ADL and instrumental activities of daily living (IADL)</td>
</tr>
</tbody>
</table>
1.1 History

This new section discusses the development process for the Fifth Edition. The Fifth Edition is similar to the Fourth, since many of the original chapter chairs from the Fourth Edition were retained to oversee the same chapters for the Fifth Edition. For the Fifth Edition, however, new contributors were added, as major specialty societies (listed in the preface) provided nominees for reviewers, chapter chairs, and contributors. All contributors and specialty societies were encouraged to obtain and incorporate the latest scientific recommendations from their field. In some cases, chapters were circulated among committees and members holding leadership positions within the specialty society. Although a true Delphi method was not followed, each chapter had at least three scientific reviewers, and major chapters were reviewed by more than 10 people. The Fifth Edition revision focused on updating diagnostic or examination criteria, incorporating medical consensus statements when available, and correcting inconsistencies. The numbers assigned to impairment ratings were not significantly changed. However, changes in the diagnostic criteria resulted in changes in the impairment ratings for some major conditions, including low back pain. The Guides still recommends that permanent impairment be assessed by a physician. Each state determines what constitutes a physician, based on its statute.

1.2 Impairment, Disability, and Handicap

1.2a Impairment

*Impairment* is a loss, loss of use, or derangement of any body part, organ system, or organ function (Guides 5th, p 2). Impairment is no longer defined as a condition that interferes with an individual’s ability to perform activities of daily living (ADL); this concept reflects an impairment rating. Not all impairments interfere with ADL. However, an impairment that interferes with an individual’s ability to perform the ADL listed in *Guides* Table 1-2, reprinted here, generally is of sufficient severity to meet the criteria for an impairment rating. Only impairments that interfere with ADL qualify for an impairment rating based on the *Guides*. 
EXAMPLE
Bob sustains a scalp laceration at work with scarring of approximately 3 cm, which is covered by his hair and does not affect any of his ADL. He would have an impairment (eg, scalp scar) but would not be given an impairment rating since the scar does not affect his ability to perform ADL.

EXAMPLE
Susan acquires a carpal tunnel syndrome arising out of and in the course of her work as a carpenter. Two years after surgery, she has scarring, residual pain, and some permanent loss of strength in her right (dominant) hand. She has difficulty grasping objects that require fine motor activity, such as buttoning her sleeves, and her sensation in three fingers has not returned. On the basis of her impairment, median neuropathy, and its impact on the ability to perform ADL because of loss of dexterity, she would qualify for an impairment rating.

In Bob’s case, the Fourth Edition could assign a rating between 0% and 9%, although examples in the text assign a 0% impairment rating for similar impairments that don’t impact ADL. Under the Fifth Edition, Bob unequivocally has no ratable impairment. In Susan’s case, the impairment is ratable under both the fourth and fifth editions, because she has residual sensory and motor changes after her surgery that impact her ability to perform ADL.
Impairment assessment includes both anatomic and functional loss, with some body systems emphasizing one area. When anatomic changes are present, a range of functional consequences can occur, some of which may lead to ratable impairment. Impairments do not necessarily lead to functional limitations or disability; the relationships between these terms are not linear but bidirectional. Thus, functional limitations can lead to further impairment, as indicated in Figure 1-1 (Guides 5th) and reprinted here.

**Figure 1-1:** The Relationship Among the Concepts of Normal Health, Impairment, Functional Limitation, and Activity Disability (Performance Limitation)

<table>
<thead>
<tr>
<th>Normal Health</th>
<th>Impairment</th>
<th>Functional Limitation</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>(eg, healthy back)</td>
<td>(eg, disk herniation L5/S1, decreased range of motion)</td>
<td>(eg, unable to lift 45 kg [100 lb])</td>
<td></td>
</tr>
<tr>
<td>Normal Health</td>
<td>Impairment</td>
<td>Functional Limitation</td>
<td>Disability</td>
</tr>
<tr>
<td>(eg, healthy back)</td>
<td></td>
<td>(eg, unable to perform basic activities of daily living)</td>
<td></td>
</tr>
</tbody>
</table>

**Activities of daily living,** historically and in the Fifth Edition, are listed in Table 1-2. For the Fifth Edition, ADL include self-care, communication, physical activity, sensory function, nonspecialized hand activity, travel, sexual function, and sleep. ADL no longer include social and recreational activities or work. The ability to perform social and recreational activities or work is important in the assessment of disability and is not considered when an impairment rating is determined.

The concept of excluding work or complex social or recreational activities was developed during the initial creation of the Guides and its impairment ratings in 1958. “Evaluation (rating) of permanent impairment is an appraisal of the nature and extent of the patient’s illness or injury as it affects his personal efficiency in the activities of daily living. These activities are self-care, normal living postures, ambulation, elevation, traveling and nonspecialized hand activities. It is not and never can be the duty of physicians to evaluate the social and economic effects of permanent impairment.”

The following table lists the differences in all the editions of the Guides pertaining to the impact of ADL.
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-care</strong></td>
<td>Self-care</td>
<td>Self-care and personal hygiene: urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating</td>
<td>Self-care and personal hygiene: urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating</td>
<td>Self-care and personal hygiene: eliminating, grooming, bathing, dressing, eating</td>
<td>Self-care and personal hygiene: urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating</td>
</tr>
<tr>
<td><strong>Normal living postures</strong></td>
<td>Normal living postures</td>
<td>Normal living postures: sitting, lying down, standing</td>
<td>Normal living postures: sitting, lying down, standing</td>
<td>Physical activity, intrinsic: standing, sitting, reclining, walking, stooping, squatting, kneeling, reaching, bending, twisting, leaning</td>
<td>Physical activity: standing, sitting, reclining, walking, climbing stairs</td>
</tr>
<tr>
<td><strong>Ambulation</strong></td>
<td>Ambulation</td>
<td>Ambulation: walking, climbing stairs</td>
<td>Ambulation: walking, climbing stairs</td>
<td>Sensory function: hearing, seeing, tactile feeling, tasting, smelling</td>
<td>Sensory function: hearing, seeing, tactile feeling, tasting, smelling</td>
</tr>
<tr>
<td><strong>Elevation</strong></td>
<td>Elevation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Traveling</strong></td>
<td>Traveling</td>
<td>Travel: driving, riding, flying</td>
<td>Travel: driving, riding, flying</td>
<td>Travel: driving, riding, traveling by airplane, train, or car</td>
<td>Travel: driving, riding, flying</td>
</tr>
<tr>
<td><strong>Nonspecialized hand activities</strong></td>
<td>Nonspecialized hand activities</td>
<td>Nonspecialized hand activities: grasping, lifting, tactile discrimination</td>
<td>Nonspecialized hand activities: grasping, lifting, tactile discrimination</td>
<td>Hand functions: grasping, holding, pinching, percussive movements, sensory discrimination</td>
<td>Nonspecialized hand activities: grasping, lifting, tactile discrimination</td>
</tr>
</tbody>
</table>

*continued on page 10*
<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual function</td>
<td></td>
<td>Having normal sexual function and participating in usual sexual activity</td>
<td>Having normal sexual function and participating in usual sexual activity</td>
<td>Participating in desired sexual activity</td>
<td>Orgasm, ejaculation, lubrication, erection</td>
</tr>
<tr>
<td>Sleep</td>
<td></td>
<td>Restful nocturnal sleep pattern</td>
<td>Restful nocturnal sleep pattern</td>
<td>Restful sleep pattern</td>
<td>Restful nocturnal sleep pattern</td>
</tr>
<tr>
<td>Social and recreational activities</td>
<td></td>
<td>Ability to participate in group activities</td>
<td>Ability to participate in group activities</td>
<td>Participating in individual or group activities, hobbies, or sports</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td>Writing, typing, seeing, hearing, speaking</td>
<td>Writing, typing, seeing, hearing, speaking</td>
<td>Writing, using keyboard, reading, hearing, speaking</td>
<td>Writing, typing, seeing, hearing, speaking</td>
</tr>
</tbody>
</table>
The concept of ADL is important, since the ability to perform ADL is historically and currently a major determinant of the numeric percentage impairment rating. An impairment that has a minimal effect on ADL will have a lower impairment rating than one that affects many ADL. Different researchers and users identify different key activities as ADL; hence, there is no one standardized list. During the 1970s, the category of ADL use in non-Guides applications was expanded to account for activities performed by those living in the community, such as mobility, cooking, etc, and is referred to as IADL (instrumental activities of daily living).

The Fifth Edition chose to use the original ADL concept, which reflects the initial Guides interpretation of ADL and was the basis for the development of the impairment ratings. It seemed inappropriate to significantly alter the ADL without making comparable changes in the numeric ratings.

Assess the individual’s ability to perform ADL in the most appropriate way for each individual and the impairment. First, consider the condition and identify what ADL it impacts. This determination is based on clinical judgment and knowledge of the medical literature concerning the condition. Then, on the basis of the complexity of the condition and the number and severity of ADL impacted, the physician may choose one of the following options to obtain a more objective assessment than self-reporting:

1. For some sensory impairments (eg, hearing loss), the impairment is the ADL (eg, hearing is an ADL). The impairment rating then accounts for ADL.

2. Use clinical judgment to determine the extent and number of ADL affected. For some limited conditions, such as a nasal fracture, a clinical assessment is likely to be reproducible and accurate. For more complex conditions with many functions affected, such as a major stroke, a more comprehensive assessment with greater reproducibility and accuracy is warranted.

3. Use a scale to assess ADL that has been developed specifically for the condition and, for some conditions, is referenced in the Guides (eg, assessment of hip replacement results, p 548, Table 17-34).

4. Use a functional capacity evaluation or similar tool to assess the impact of the condition on ADL.

5. Use one of the questionnaires referenced in Chapter 1 used to assess ADL. These questionnaires have been validated and use a combination of observed and self-reported abilities to perform ADL.
**EXAMPLE**

Jeff sustains a documented herniated disk at L4-5 with bilateral radiculopathy and loss of reflexes. After therapy, he has some improvement in pain. He refuses surgery, since his father died shortly after an elective surgery, and they had similar health histories. Jeff at MMI would meet criteria for diagnosis-related estimate (DRE) category lumbar III (10%-13%). Because of the severity of his condition and symptoms, he has difficulty performing most physical activity ADL (eg, walking and climbing stairs), and his sleep is disturbed. He is unable to ride in a car for more than 30 minutes without considerable exacerbation of his symptoms. The difficulty in performing basic ADL has been observed and documented in his physical therapy notes. Jeff would qualify for a 13% whole person impairment based on the severity of his condition and its impact on ADL. Given his condition, the pain is expected and already accounted for within the current rating. An additional rating for pain, based on the Pain chapter (Chapter 18), is not warranted.

**MEDICAL TIP**

Physicians need to consider the impact of the condition on an individual’s ability to perform ADL before assigning an impairment rating. For many impairments, a range of ratings can be assigned, on the basis of the extent of limitations of ADL.

**LEGAL TIP**

Administrators and adjudicators should ascertain that the physician evaluator has adequately accounted for the impact of the condition on the ability to perform ADL. Absence of an account for impact on ADL may make the rating (or lack of one) questionable. However, in some states’ benefit systems, any anatomic or functional loss constitutes a ratable impairment, regardless of its impact on ADL.

**Impairment Ratings or Percentages**

*Impairment ratings or percentages* are consensus-derived estimates that reflect both the severity of the condition and the degree to which the impairment decreases an individual’s ability to perform ADL (work is excluded). Impairment ratings for the *Guides* were first developed for sequential body systems, beginning with the extremities and back. Numeric ratings were assigned on the basis of a relative value weighting, using values from published disability tables, and perceived value, depending on the severity of the condition and its impact on ADL. Numeric ratings also provide a quantitative, standardized interpretation to qualitative terms such as *slight*, *marked*, and *moderate*, which vary in interpretation. It was a simpler task to achieve greater consistency when impairment ratings were developed with a body system, among a group of related specialists, eg, orthopedists. However, when
Impairment ratings were developed for all the body systems, without a uniform set of criteria for comparison being regularly used, differences in weighting systems arose for different organ systems, based on specialty opinions. Using a common reference system, such as ADL, can decrease variability among specialties in assigning impairment ratings.

Total body functioning and the ability of the body to perform the ADL were the uniform criteria to which the impairment ratings referred, but these activities were never weighted or compared with each other. Thus, when the eight categories of ADL as listed in Table 1-2, Fifth Edition, are examined, are they weighted equally? Would the ability to see be given a higher weight, since it can significantly impact all the other categories? Would it be given less weight, since in highly adapted individuals, almost all the other ADL can be performed (except for driving or flying)? These are complex questions and decisions, requiring the study and incorporation of many perspectives. Answers to these questions were not developed during the revision of the Fifth Edition or any previous editions, but they may be addressed in a subsequent edition. Moreover, answers to questions like these may be as much about social, economic, and political values of certain human activities and body functions as about anything uniquely medical. Nonetheless, an evaluating physician may consider and discuss these factors in detail in the report.

Since impairment ratings in the Guides have been changed in earlier editions, without regard to the above considerations, it was decided that this edition would not significantly alter the impairment ratings, unless it was necessary to rectify inconsistencies or errors. Numeric ratings that have been changed in the Guides 5th will be discussed within each chapter, along with the rationale for each change.

Impairment ratings based on primarily anatomic criteria have incorporated the functional consequences of that condition. Therefore, when an individual is given an impairment rating of 5% for loss of the little finger (e.g., amputation), it is assumed that hand function will be limited in terms of some non-specialized hand activities. Individuals may experience some differences in terms of function without their little finger, based on their individual abilities to adapt. Unless other impairments are present, the impairment rating for this condition is fixed at 5%. In contrast, in the neurology chapter, an individual with a mononeuropathy, affecting mainly the fifth finger, may have a nerve impairment ranging from 1% to 5% depending on the severity of the condition and its impact on that individual’s ability to perform ADL. The physician evaluating an impairment needs to be conversant in criteria for rating impairments for each body system and incorporate the extent of individual assessment of anatomic or functional losses within the impairment ratings. In cases where the impairment rating is fixed (usually on the basis of
anatomic loss), the physician can comment on the extent of functional adaptation, in comparison with what is normally seen for that condition or with what may have been considered normal for that individual before the injury. When impairments affect multiple body systems, the physician may need to combine multiple approaches. Chapters with the greatest emphasis on the anatomic approach are the upper extremity, lower extremity, and spine, in descending order. Both the lower extremity and spine chapters take function and ability to perform ADL into greater consideration.

Impairment ratings are not rounded to the nearest 5% as indicated in earlier editions of the *Guides*, since this would artificially inflate or lower the impairment rating, possibly with significant consequences to an individual who could be denied any disability coverage, even if errors are balanced out on a population basis. Impairment ratings for individual body parts or organs are combined by means of the Combined Values Chart. The Combined Values Chart combines multiple impairments into a summary value, so that the whole person impairment is equal to or less than the sum of all the individual impairments.

**EXAMPLE**

John falls while skiing and sustains a compound and displaced nasal fracture with noticeable and permanent disfigurement. One of John’s major hobbies is cooking. Since his sense of smell has markedly diminished, he has decreased his cooking and experienced a permanent change in his eating habits, and has lost 15 lb in the 4 months following the skiing accident. On the basis of Table 11-5, page 256, John has two of three criteria within class 1, placing him at 3%, and considering the impact of his impairment on his sense of smell and eating with documented, consistent weight loss, his impairment could be increased up to 5%, the maximum level in this category.

**MEDICAL TIP**

Despite limitations, whole person impairment (WPI) percentages estimate the impact of the impairment on the individual’s overall ability to perform ADL.

Combine multiple regional body impairments by means of the Combined Values Chart.

All regional impairment ratings are converted to a WPI rating.

A 0% impairment rating indicates that an impairment may be present, but that impairment does not impact the ability to perform ADL.

A 90% to 100% WPI rating indicates “a very severe organ or body system impairment requiring the individual to be fully dependent on others for self-care, approaching death” (*Guides 5th*, p 5).
1.2b Disability

Disability is an alteration of an individual’s capacity to meet personal, social, or occupational demands or statutory or regulatory requirements because of an impairment. Impairment ratings should not be used as direct estimates of disability unless the impairment results in no more interference with personal, social, or occupational demands than is already considered in the anatomic or functional loss implicit in the impairment rating. Impairment assessment is a necessary first step for determining disability.

In workers’ compensation, disability traditionally refers to the loss of income-earning capacity caused by an impairment. If an impairment is not ratable, it usually means that no disability exists, since a ratable impairment is usually a legal requirement for calculating further disability.

**LEGAL TIP**

Impairment ratings, although used more or less directly to determine disability awards in some states, have a different use in the *Guides*. The *Guides* warns that impairment ratings should not be the sole basis for a disability award, because the *Guides*’ WPI ratings do not account for social, recreational, or occupational impact. Not accounting for social, recreational, or occupational impact constitutes grounds for this warning.

**MEDICAL TIP**

Physicians who assess disability need to understand the impairment, its impact on ADL, and the interaction of the impairment with the environment (work, social) for which a disability determination is requested.

**LEGAL TIP**

Under the Fifth Edition guidelines, some disability claims will be defeated because of the Fifth Edition’s nonratable impairments (those that are recognizable anatomic losses that do not interfere with any ADL). A disability award also accounts for the anatomic or functional loss measured by the impairment. Common phrases used in workers’ compensation are “disability in excess of impairment” and “disability inclusive of impairment.”
Normality

The definition of normal in the Fifth Edition has been expanded from the Fourth Edition. Both editions acknowledge that normal represents a range or zone and can vary with age, sex, and other factors. However, the Fourth Edition definition indicates that “normal is determined by sufficient, valid studies of representative populations” (Guides 5th, p 2). Although the Fourth Edition approach is appropriate for population comparisons, it is not the most accurate comparison on an individual basis because of individual variability. Both population and individual normal values need to be integrated by the physician who evaluates an individual under the Fifth Edition guidelines. The Fifth Edition’s approach to “normal” may be considered in assessing both anatomic and functional loss.

For example, when an individual has a chest radiograph or electrocardiogram performed, those individual measures of chest and cardiac function are compared both with population known normal values and, ideally, with the individual’s previous radiograph or electrocardiogram. Therefore, what was “normal or customary” for the individual serves also as the baseline for comparison with the individual’s current condition.

EXAMPLE

John, a former college track champion, is drawn to work as a wilderness area park ranger partly because of his interest in continuing to work outdoors with vigorous physical activity. As part of his yearly checkup, John has pulmonary function studies, which show his pulmonary function to be within the top 5% of the population in terms of physical fitness. John is the lead player on his league’s basketball team and helps his team win local championships. While fighting a forest fire, John’s self-contained breathing apparatus fails, and John develops a significant inhalation injury. Resultant physical changes are most evident on his pulmonary function studies, which now show his respiratory function to be within normal for his age and height, but at a 20% decline from their value 6 months earlier. John can no longer compete athletically at the level he was accustomed to. John would not qualify for an impairment rating by means of the population pulmonary function criteria, but his impairment evaluation assessment needs to indicate this change, as well as its impact on his career and social activities.

Another question that frequently arises with normality is the question of “normal aging.” Certain chapters, such as the respiratory and musculoskeletal chapters, base some normal values on age-adjusted population values. Although many functions decline over time, such as hearing and vision, many scientists assert that these changes are partly caused by continued environmental exposures (eg, ambient, urban noise exposure, or unprotected
sun exposure). Aging changes are believed to be caused by a mixture of environmental, genetic, and personal behaviors (eg, nutrition, exercise). The question of major interest for many readers of this book is whether the observed change is really the result of “normal aging” (eg, the compilation of genetic, lifestyle, and nonwork, environmental exposures) or whether it is caused by work or a specific event.

**EXAMPLE**

Jim, aged 43, has been a carpet installer for 20 years and, on a daily basis, uses knee flexion and extension movements as a “carpet kicker” for several hours a day to ensure that carpet edges are installed flat along the wall and corners. Although he played some basketball and football informally during high school, he never had any knee injuries. Both knees show arthritic changes, without arthritis elsewhere, and it is becoming more difficult to do his job. Are his knee changes caused by many years of knee stress on his job or the other “environmental” mixture?

Although the *Guides* does not specifically address this challenging question, it does provide a framework, indicating that normal values for the population, individual norms, scientific precedence (eg, epidemiologic studies on carpet installers), and clinical judgment (knowledge of preexisting conditions, family history) are all needed to assess the “normal pattern” for an individual and what contribution, if any, is work related. A discussion of causation is presented in Appendix A.

**MEDICAL TIP**

*Normal* is defined from either an individual or a population perspective, depending on the preinjury and health history information available, as well as the physician’s clinical judgment concerning the best estimate of normal.

*Normal* may be determined by means other than studies of representative populations carried out with valid measures. *Normal* may also be determined by a comparison with a preinjury or preillness state, or a complementary body part (eg, right and left legs).

**LEGAL TIP**

The Fifth Edition recognizes that smaller losses may have greater limitations in individuals who are aged or may have other preexisting impairments. The Fifth Edition, because of the ability to determine a rating within a range, allows for an increased impairment rating for the same injury in an individual for whom it has a greater impact on the ability to perform ADL, as may be the case with older or more infirm individuals, compared with an individual who is at or near the center of the “normal” curve of the population.
1.3 The Organ System and Whole Body Approach to Impairment

The concepts in this section are unchanged from the Fourth Edition. The Fifth Edition continues to use the same relative weights for body parts as in the Fourth Edition, except for the upper extremity chapter, which changed the weighting system or relative importance of the fingers. All other weights were retained, since they have been widely used and there is not a scientific consensus as to how the weights should be changed.

1.4 Philosophy and Use of the Combined Values Chart

The Combined Values Chart was unchanged from the Fourth Edition. This chart, listed on pages 604 to 606 of the Fifth Edition, enables the user to combine multiple body part impairments into a single, whole person impairment rating, which reflects the impact of the condition on the whole person. The formula and chart were designed to be nonadditive and to ensure that multiple impairments would not exceed 100% WPI.

In general, combine all impairment ratings from one body part or system with another. The few exceptions, when impairment ratings are added, are when a single joint involves complex motions, for example, at the thumb or elbow. Impairment ratings around these joints would be added as detailed in the respective chapter.

Note that the Combined Values Chart, in using a single combination method for all impairments, does not account for combinations of multiple impairments that can have a greater than additive effect on function. In such circumstances, the Combined Values Chart could provide a lower WPI rating than is functionally indicated. For example, loss of both legs is not equivalent functionally to loss of a leg and a nondominant hand. The physician can explain the functional implications of multiple, combined impairments when the WPI rating does not fully portray whole person function.
1.5 Incorporating Science With Clinical Judgment

This new section indicates that the physician needs to acknowledge the presence of subjective complaints and findings, such as fatigue and pain, but unless these are accompanied by objective or measurable abnormalities, subjective complaints cannot independently receive an impairment rating. Also new and noteworthy is the acknowledgment that the Guides cannot provide an impairment rating for all impairments, and if a condition is unlisted, the physician is to use his or her best judgment and compare the unrated condition to a similar rated condition as a guide. Impairment rating requires both the art and science of medicine, which practically refers to the need to incorporate clinical judgment, anecdotal experience, and scientific findings or plausibility into a supported medical opinion.

1.6 Causation, Apportionment Analysis, and Aggravation

1.6a Causation

Determining causation is discussed in greater detail in the Fifth Edition than in the Fourth Edition. Causation, for purposes of the Guides, refers to an identifiable factor (eg, accident or exposure) that results in a medically identifiable condition, usually injury or disease. Determining medical causation requires a detailed analysis of whether the factor could cause the permanent impairment and whether circumstances in the individual case support causation. Legal standards for causation vary from state to state.

Definitions of causation differ in the medical and legal arena. Indeed, even medically, cause may have multiple definitions. A popular set of standards to distinguish causal from noncausal associations was proposed by Hill, which, from an epidemiologic perspective, has some significant limitations. Readers interested in causation are referred to Appendix A of this book, where these issues are discussed in greater detail.

On the basis of statistical analysis, a factor is considered causative if the probability of achieving an association by chance is less than 5%. In other words, a factor is causative of the observed condition if the probability of achieving an association other than by chance is 95% or greater. For legal applications, however, causation often refers to a state of probability of more likely than not, or greater than 51%, or through the use of the “but for” test, all of which may be lower levels of association than is typically
used in scientific assessment. The Guides recommends a synthesis of medical, clinical, and scientific judgment in determining causation.

<table>
<thead>
<tr>
<th>M E D I C A L  T I P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians should determine the definition of causation in the state where they practice and make a decision based on their clinical and scientific knowledge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>L E G A L  T I P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple statistical references to “causation” frequently beg the question of how to determine a cause for a condition when multiple causes are or may be present. Multiple causes of a condition lead to our later discussion of “apportionment.” For most legal purposes, a cause-and-effect relationship is established if the effect (usually a disease or injury) would not have occurred “but for” the purported cause (usually an accident or exposure). Medical evidence in such instances usually requires a physician’s testimony or report that, on a medically more probable than not basis, the identified “cause” resulted in the observed medical condition. All users of the Guides should be aware that the definitions of causation are many. A practical tip for eliminating confusion in this area is to supply a definition of causation when asking questions about the causes of a condition or when rendering an opinion about a condition’s cause.</td>
</tr>
</tbody>
</table>

1.6b Apportionment Analysis

Apportionment refers to a distribution or allocation of causation among multiple factors that caused or significantly contributed to the injury or disease and resulting impairment.

**EXAMPLE**

Ted is involved in a motor vehicle accident arising out of and in the course of his employment and suffers a concussion, torn rotator cuff, and multiple fractured ribs. The rib fractures heal uneventfully; he has occasional headaches, which are new. The rotator cuff surgery creates a mixed result with permanent residual loss of range of motion. Ted had also been a major league pitcher, and previously had had several elbow surgeries and one prior rotator cuff surgery that led to his retirement. The upper extremity had been rated at a 7% loss of the whole person as a result of the prior surgeries, but after the industrial accident, the rating increased to 13% whole person impairment. Only 6% of the impairment is “apportionable” to the industrially related motor vehicle accident.
**Aggravation** refers to a factor(s) that alters the course or progression of the medical impairment. Aggravation is a legal concept as well as a medical one. Aggravation may be a form of subsequent causation that also requires apportionment.

**EXAMPLE**

Ted, from the previous example, slips and falls at home after recovering from the motor vehicle accident. He suffers another concussion, his headaches increase in severity and frequency, and his mentation is less clear. He claims that the concussion, headaches, and difficulties with mentation from the motor vehicle accident became more symptomatic as a consequence of the slip and fall. His employer claims that the slip and fall is a separate, unrelated event and that there is no “causal” connection between the two events. Physicians’ opinions are likely necessary regarding the role of the concussion in the now chronic headaches and mentation changes that followed the slip and fall. The slip and fall injury “aggravated” the preexisting headaches.

**1.7 Use of the Guides**

The most recent edition is recommended as the latest and most accurate blend of science and medical consensus. This revised section discusses the increasing use of the *Guides* in the United States and abroad, either used as the standard or adapted, as in Florida or Oregon, for their state use. The table on page 22, Using *Guides* to Evaluate the Degree of Medical Impairment, based on surveys collected in 1999, shows which states use the *Guides*, the edition in use at the time of the survey, and which states automatically shift to the most recent, ie, Fifth Edition. Note also that states listed as using the Fourth Edition but not required to use a guide should use the Fifth Edition. Appendix B provides an updated list of states that use the Fifth Edition.
## Using *Guides* to Evaluate the Degree of Medical Impairment

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Guide Used</th>
<th>Guide Required</th>
<th>Guide in Use</th>
</tr>
</thead>
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<td>X</td>
<td></td>
<td>AMA Guides, 4th edition</td>
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<td>X</td>
<td>AMA Guides, 4th edition</td>
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<td>AMA Guides</td>
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<td>X</td>
<td>State’s own guide</td>
</tr>
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</tr>
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<tr>
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<td>Tennessee</td>
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<td>AMA Guides, 4th edition, and Manual for Orthopedic Surgeons</td>
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<td>Utah</td>
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<td>Vermont</td>
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<td>AMA Guides, latest edition</td>
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<tr>
<td>Virginia</td>
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<td></td>
<td>AMA Guides, 4th edition, is most commonly used</td>
</tr>
<tr>
<td>Washington</td>
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<tr>
<td>Wyoming</td>
<td>X</td>
<td>X</td>
<td>AMA Guides, 4th edition</td>
</tr>
</tbody>
</table>

1.8 Impairment Evaluations in Workers’ Compensation

This revised section outlines the general principles pertaining to workers’ compensation in the United States, acknowledging that despite similar features, no two states are exactly alike. This section emphasizes, as in the Fourth Edition, that “impairment percentages derived from the Guides criteria should not be used as direct estimates of disability. Impairment percentages estimate the extent of the impairment on whole person functioning and account for basic activities of daily living, not including work” (Guides 5th, p 13).

1.9 Employability Determinations

Employability assessment determines an individual’s ability to perform the essential requirements of the job without endangering himself or herself, others, or the work environment. Several jurisdictions use vocational experts to assess disability as a function of employability. Impairment is, again,

<table>
<thead>
<tr>
<th>Jurisdictions That Use Vocational Experts to Rate Disability</th>
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</thead>
<tbody>
<tr>
<td>Alabama</td>
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<td>Arizona</td>
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<tr>
<td>Idaho</td>
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<tr>
<td>Iowa</td>
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</tbody>
</table>

a necessary predicate for the rating. The following tables identify how some states determine vocational restrictions.\footnote{11}

### 1.10 Railroad and Maritime Workers

This section was unchanged from the Fourth Edition and pertains only to the use of the *Guides* for railroad and maritime workers.

### 1.11 The Physician’s Role Based on the Americans With Disabilities Act (ADA)

This section was included to provide physicians with some understanding of the ADA and to indicate its differences from the AMA *Guides*. The purpose of the ADA was to end discrimination against individuals with disability. Hence, the terms and application would understandably differ from those of workers’ compensation statutes, which were designed to compensate for workplace injury and illness and their wage-earning consequences.

Under the ADA, *disability* is a physical or mental impairment that substantially limits a major life activity. Interference with a major life activity
requires much more proof than interference with an activity of daily living. Moreover, disability under the ADA is intended to be measured with corrective or ameliorative aids such as eyeglasses or contact lenses. Impairments that may constitute significant disabilities under other social benefit systems may constitute no disability at all under the ADA. Complete loss of vision in one eye, an impairment under the Fifth Edition and previous editions and a presumptive disability under many workers’ compensation laws, may not even be a disability under the ADA, where the other eye retains normal or exceptional vision.

Although definitions of disability differ between the ADA and workers’

<table>
<thead>
<tr>
<th>MEDICAL TIP</th>
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<tbody>
<tr>
<td>The physician is responsible for assessing impairment and its corresponding functional limitations and, if requested, to notify the employer about an individual’s abilities and limitations.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEGAL TIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attorneys, employers, and benefit administrators should be aware that medically identified limitations do not necessarily indicate a substantial limitation on a major life activity.</td>
</tr>
</tbody>
</table>

compensation, both systems require a medical basis, ie, impairment, for the finding that a disability exists. Under the ADA, the impairment usually must have more severe consequences for ADL than in workers’ compensation, and the ADA consequence may or may not be related to ability to work.

1.12 Summary

This new section indicates that the role of the physician is to evaluate all the medical information and provide as comprehensive a medical picture of the individual as possible, beyond an impairment rating, including a discussion of the person’s abilities and limitations. Combining the medical and nonmedical information discussed in Chapter 1 will provide an improved understanding regarding how the impairment may affect the individual’s work ability.
References


Chapter 14

Mental and Behavioral Disorders

Introduction

This chapter provides an overview of key points and changes (identified with an icon) made in Chapter 14 of the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition (Guides 5th), illustrates these changes in a table comparison, and discusses the purpose and implications of the major changes, with illustrative examples. The numbered section titles within this chapter correspond to sections within Chapter 14 of the Guides 5th. Only key principles or important changes are included in this chapter.

Key Points and Changes

Establish and document any mental and behavioral diagnosis by means of DSM-IV criteria.

Use established psychological tests when needed to increase diagnostic acumen.

This edition provides only qualitative or ordinal ratings for mental and behavioral disorders, including none, mild, moderate, marked, and extreme impairment.

Numerical impairment ratings are not assigned, since these spheres of functioning are most indicative of disability rather than impairment.

Qualitative assessment of mental and behavioral impairments depends on assessing the degree of functioning in four spheres: activities of daily living (ADL), social functioning, concentration, and adaptation.

The degree of functioning is described ordinarily in terms of none, mild, moderate, marked, and extreme impairment.
Extreme impairment in one or more spheres, or marked impairment in two or more spheres, probably precludes the performance of most complex tasks, such as work, without considerable support or accommodation.

Effects of medication, as indicated in Chapter 2 of the *Guides*, may warrant an increase in the impairment rating, by up to 3%, if they are necessary and impact ADL.

The chronic nature of some mental and behavioral impairments indicates there may be remissions, rather than a cure. Thus, individuals can still have a permanent impairment, even if their condition is in remission.

An individual with a somatoform pain disorder does not receive an additional rating in the pain chapter.

Somatoform pain disorder is diagnosed only for individuals who meet *DSM-IV* criteria.

A new Table 14-2 lists some commonly diagnosed impairments, their signs and symptoms, and the areas of function commonly affected by each diagnosis.

**Comparison of Tables Between the Fifth and Fourth *Guides* Editions**
The following table summarizes the key points and changes in tables between the fourth and fifth editions of the *Guides*.

<table>
<thead>
<tr>
<th>Table Topic</th>
<th>5th Edition Table Number</th>
<th>4th Edition Table Number</th>
<th>Summary of Changes in 5th Edition</th>
</tr>
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<tr>
<td>Impairment due to mental and behavioral disorders</td>
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<td>None</td>
</tr>
<tr>
<td>Selected impairments and common limitations in ability</td>
<td>14-2</td>
<td></td>
<td>New; provides examples of limitations in ability associated with several mental impairments</td>
</tr>
</tbody>
</table>
Introduction

The Fifth Edition mental and behavioral disorder chapter was slightly revised, and additional case studies were included. A qualitative assessment, without numerical impairment ratings, was retained. There was not sufficient scientific evidence, nor was a consensus developed, as to what numerical ratings could be assigned. The Guides approach does not recommend use of numerical ratings as was used in the Third Edition. The Fifth Edition removed much of the Fourth Edition discussion of Social Security criteria, which pertained to disability assessment.

Unlike the other chapters in the Guides, the mental and behavioral chapter provides several unique challenges for its application. First, mental and behavioral disorders frequently accompany other medical impairments. The physician who is evaluating low back pain or carpal tunnel syndrome may not have the expertise necessary to identify concomitant psychological disorders. Second, in many cases where a concomitant mental or behavioral disorder was suspected, the condition may not have been thoroughly evaluated because of the stigma still assigned to mental and behavioral disorders, or because, in the case of workers’ compensation, an additional impairment rating and award was not provided. Third, assessing and separating medical impairment from the disability of mental and behavioral disorders is very problematic and has not been successfully achieved. Because of its very nature, the brain and its behavioral function encompass complex activities, such as behavior in work or social settings, which apply primarily to disability assessment. The functions of the brain, such as cognition, which do not involve complex interactions with the environment, can be assessed within the neurology chapter. However, it is the complex functions of the brain, the individual, the emotional totality, and his or her interactions with the environment, either in social or work settings, that is commonly assessed by psychiatry. These complex interactions and adaptations refer more to disability assessment than to medical impairment. Hence, in the mental and behavioral chapter, the distinctions between impairment (eg, brain function) and disability (eg, interaction of one’s mental functions with the environment) become blurred, and an assessment of solely permanent impairment is difficult and probably not very meaningful.

Since the changes to the Fifth Edition are limited, the purpose of this chapter is to illustrate ways in which the mental and behavioral chapter can be used.
14.1 Principles of Assessment

As outlined in the Fourth Edition, the Fifth Edition recommends that the physician evaluate the condition on the basis of DSM-IV criteria. The evaluator performs a comprehensive review of the condition and assesses the individual’s ability to function over time and the response to treatment and rehabilitation. In assessing mental and behavioral impairment, the physician must obtain information from both medical and nonmedical sources that indicate the individual’s ability to perform daily activities, including the ability to concentrate, be persistent, pace oneself, and tolerate mental demands, including stress. Assess behaviors over time, so that any patterns are identified, since functioning can vary considerably when evaluated in a single moment.

Well-established psychological tests, such as the Wechsler Adult Intelligence Scale (WAIS) and the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), may improve diagnostic acumen.
14.2 Psychiatric Diagnosis and Impairment

This section of the Guides 5th incorporates and reorganizes information in sections 14.1 and 14.4 of the Fourth Edition. The DSM-IV criteria have replaced the DSM-III-R criteria cited in the Fourth Edition for assessing permanent impairment. The DSM-IV criteria are not a detailed description of psychiatric disorders. DSM-IV includes symptoms necessary to make a DSM-IV diagnosis but does not enumerate all symptoms and signs seen with a diagnosis. Axis IV, which assesses psychosocial and environmental problems, and Axis V, which provides a global assessment of functioning, including an assessment of some disabilities, are important to incorporate into the impairment assessment.

In evaluating psychiatric impairments, consider the effects of medication, which can lead to an increase in the impairment when side effects are present that impact the ADL. Also consider the effects of motivation, which often link impairment and disability. Thus, an individual with a psychiatric condition such as a personality disorder may be more motivated to adapt with increased functioning in a supportive environment, compared with a more stressful, demanding environment.

Rehabilitation may be able to improve function, lessening the impairment and certainly the disability. The discussion on rehabilitation is slightly increased in the Fifth Edition, indicating again that a psychiatric impairment, like a physical one, may never regain full function, but it may attain sufficient function to minimally impact ADL.
14.3 A Method of Evaluating Psychiatric Impairment

The *Guides 5th* retains some concepts developed by the Social Security Administration (SSA) to assess impairment severity; however, the report now needs to include detailed information on the ability to perform ADL. To assess psychiatric impairment, determine function in four major spheres: (1) ability to perform ADL; (2) social functioning; (3) concentration, persistence, and pace; and (4) deterioration or decompensation in work or worklike settings.

Note that the mental and behavioral impairment assessment encompasses disability-related aspects, such as adaptability to work, critical to mental and behavioral health. Recall also that some functions, though not narrowly defined within ADL, can impact ADL in significant ways. For example, social functioning and concentration, persistence, and pace may also have significant ramifications for ADL. For example, limited social functioning can prevent shopping for groceries. Problems with concentration, persistence, and pace may limit preparation of meals or simple household cleanliness.

Assess the degree of impairment—either none, mild, moderate, marked, or extreme in each sphere—as indicated in Table 14-1 of the Guides. The *Guides* notes that the qualitative or ordinal scales are not equally distributed, meaning that a moderate impairment does not imply a 50% reduction in functioning. The degree of impairment is defined in the *Guides* as follows: none: no impairment in function; mild: the impairment is compatible with most useful functioning; moderate: the impairment is compatible with some, but not all, useful functioning; marked: the impairment significantly impedes useful functioning; and extreme: the impairment is not compatible with useful functioning. Extreme signifies complete dependency on another person for care.

How can the physician apply the following information to assessment of work ability? As listed in the *Guides*, if an individual has either an extreme impairment in one or more areas or a marked limitation in two or more spheres, it is unlikely that the individual will be able to perform complex activities, such as work, without considerable support and accommodation. The need, degree, and reasonableness of accommodation need to be assessed on an individual basis.
The aspects of functioning noted in Table 14-1 and as indicated above are unchanged from the table in the Fourth Edition, except that ADL no longer include social and recreational activities. This set of activities was also removed from the ADL list in Chapter 1, as previously noted. Since social and recreational activities are complex, they pertain more to disability than impairment assessment.

14.4 Assessing Impairment Severity

This section has been expanded in the Guides 5th. When determining the severity of an individual’s mental and behavioral impairment, consider the effects of treatment, structured settings, variability of mental disorders, effects of common mental and behavioral conditions, and the assessment of workplace function.

Determination of the ability to function within the workplace requires the assessment of general and specific workplace skills. General skills or capacities, as defined by the SSA and adapted by the Guides, include (1) understanding and memory, (2) sustained concentration and persistence, (3) social interaction, and (4) adaptation.

**MEDICAL TIP**

Before assessing the specifics of the workplace, identify the individual’s abilities in the above capacities. If insufficient ability is present within these capacities, the individual is unlikely to be able to work in a traditional work setting.

**LEGAL TIP**

These four severity criteria may in many jurisdictions be more appropriately focused on the lack of wage-earning capacity, rather than a medically determined impairment. The reader should note that these criteria were not simply adapted from the SSA’s regulations, but were created by SSA to determine the individual’s ability to work. In most workers’ compensation systems, this determination is not part of the impairment evaluation, although it may be in those state systems that apply a mathematical or algebraic multiplier to the Guides’ percentages of whole person impairment to determine a disability rating.
Section 14.4 also includes a discussion of the effects of common mental and behavioral conditions such as substance abuse, personality disorders, and somatoform pain disorders, which often accompany other medical impairments. For an individual to be classified with any of these conditions, he or she needs to meet the criteria for the condition as identified by the DSM-IV guidelines.

**EXAMPLE**

John is a bystander and witness to extreme violence in the convenience store where he works. On a windy but sunny day, a gunman enters and shoots several customers while John hides under the counter, where the wastebasket is kept. As the gunman is leaving, he notices John, fires a shot that misses, and flees to escape the authorities. Two of the customers die. John becomes depressed; is treated for depression for 9 months, including 6 months with antidepressants, with resolution of his depression; and continues in counseling at the time of the evaluation. He continues to have nightmares and sleep disturbances on a monthly basis, sometimes as often as nightly. Sleep studies, including polysomnography, indicate abnormalities, including an intermittent loss of rapid-eye-movement sleep and abnormal alpha waves. He is reminded of the events on a monthly basis when he sees something familiar, such as clothes someone wears like one of the victims or the gunman, or weather similar to the day of the event. He previously traveled but now has difficulty flying or being in confined spaces, without control, for long periods of time. John could receive between a 1% and a 9% permanent impairment from Chapter 13 (central and peripheral nervous system) on the basis of his sleep disturbance and the determined impact on his ADL.

Depending on the degree to which these disturbances affect the four areas noted above (ADL; social; pace, persistence and concentration; and adaptation), a qualitative psychiatric impairment may also be combined with the sleep disturbance impairment.

**14.4e.1 Substance Abuse and Personality Disorders**

This area poses significant problems in workers’ compensation because the substance abuse is usually not associated with a workplace accident or exposure. Apportionment of cause to the preexisting dependency that prolongs or enhances a disability is commonly found in cases where substance abuse is present. That is, if a workplace accident or exposure leads to a disability that is prolonged or heightened by a substance abuse problem, the disability caused by the substance abuse is apportioned to non–work-related cause or causes.
14.4e.2 Somatoform Pain Disorders

Somatoform pain disorder is defined in the Guides 5th as a preoccupation with pain in the absence of physical findings that adequately account for the pain and its intensity, as well as the presence of psychological factors that are judged to have a major role in the onset, severity, exacerbation, and maintenance of pain (Guides 5th, p 366).

If an individual has a somatoform pain disorder, he or she is not rated in addition by the pain chapter. An individual with another impairment, such as low back pain, may also be classified as having a somatoform pain disorder if he or she meets the criteria. In that case, the individual would be given a qualitative assessment, based on the four spheres of functioning, but would not be assigned an additional, numerical impairment rating.

14.4e.3 Malingering

Malingering refers to a simulation or exaggeration of physical illness for an external gain, such as disability payments, obtaining controlled substances, or another perceived benefit. With malingering, the individual intentionally produces symptoms or physical signs and is aware of his or her motivation for doing so. Malingering is not considered a mental disorder according to DSM-IV because, under some circumstances, malingering may be beneficial and adaptive, for instance, feigning illness in a prisoner-of-war camp. Consider malingering when there is a discrepancy between objective findings and subjective complaints, or when symptoms are ill defined or overly dramatized.2

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<th>M E D I C A L  T I P</th>
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<td>If a physician suspects malingering, indicate the areas of discrepancy, preferably multiple, between observed or expected findings and symptoms. Also identify where the discrepancy appears.</td>
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<th>L E G A L  T I P</th>
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<tr>
<td>Tests or documentation to identify malingering may significantly assist in the diagnosis and constitute legal evidence for proof of malingering. Malingering as used in the Guides and DSM-IV may be defined differently under state law.</td>
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14.5 Examples of Impairment Due to Mental and Behavioral Disorders

14.6 Format of the Impairment Report

Sections 14.5 and 14.6 of the Guides 5th are new. The case examples, in particular, illustrate the importance of identifying the areas of function, where emotional difficulties arise, and how their behaviors alter function and can lead to significant disability.

The examples in the Fifth Edition do not differentiate between those elements of assessment that should be called “impairment” as distinguished from “disability.” These aspects can be distinguished to a limited degree in the report. Section 14.6 details the essential components of the impairment report.

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<th>MEDICAL TIP</th>
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<tr>
<td>For examples such as 14-1, 14-2, and 14-3 with class 2 or greater limits in social functioning, concentration, or adaptation, identify the impact of these limitations on the ability to perform ADL.</td>
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<th>LEGAL TIP</th>
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<tr>
<td>As with the section on pain, the format of the report should closely follow both the Guides and any DSM-IV requirements. In the Fifth Edition, the outline format of the report makes its use easier for both the physician and nonphysician user.</td>
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Notwithstanding the lack of percentages in the fifth and fourth editions, the evaluator may assign a percentage of the whole person rating to a mental or behavioral disorder. In most cases, this rating will be based on the evaluator’s clinical experience, with appropriate references to the classes of impairment stated in Table 14-1 and, if the disorder is listed, from Table 14-2. The lack of percentages may be troubling in states that award disability as a mathematical or algebraic coefficient of impairment.

As will be noted in the chapter that discusses the Fifth Edition’s treatment of pain, anything less than a meticulous report, in the format stated in Chapter 14, may be subject to attack on the grounds that it fails to comply with generally and currently accepted medical standards.

References
