Impairment Rating and Disability Determination

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Introduction

References

The medical community, the public, and the scientific literature often misunderstand the distinction between disability and impairment. This article defines the differences between disability and impairment. Furthermore, the ever-increasing numbers of people alleging disability and impairment necessitate a professional understanding of these terms, the scope of the problem, and the most effective means to deal with these issues in a medical practice.

Impairment Versus Disability

Distinction Between Impairment and Disability

Impairment

According to the fifth edition of the *Guides to the Evaluation of Permanent Impairment*, published by the American Medical Association (AMA), impairment is defined as "an alteration of an individual's health status; a deviation from normal in a body part or organ system and its functioning."[1,2,3] The World Health Organization (WHO) defines impairment as "any loss or abnormality of psychological, physiological or anatomical structure or function."[4]

The Social Security Administration (SSA) defines a medically determinable impairment as "an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques."[5,6,7,8] The SSA further states that a physical or mental impairment "must be established by medical evidence consisting of signs, symptoms, and laboratory findings—not only by the individual's statement of symptoms."

According to the AMA Guides, impairments that are to be rated are permanent impairments. A permanent impairment is defined as one that has reached maximum medical improvement (MMI) and is well stabilized and unlikely to change substantially in the next year with or without medical treatment. Each state workers' compensation system has its own definition of impairment. These definitions may vary from state to state but are generally consistent with the definition expressed in the AMA Guides.[9]

Disability

According to the fifth edition of the AMA Guides, disability is defined as "an alteration of an individual's capacity to meet personal, social, or occupational demands because of an impairment."[2,10] The WHO defines disability as an activity limitation that creates a difficulty in the performance, accomplishment, or completion of an activity in the manner or within the range considered normal for a human being. Difficulty encompasses all of the ways in which the performance of the activity may be affected.

On the other hand, the SSA defines disability as "the inability to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment(s), which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."[5,6,7,8] Workers' compensation systems usually define disability as a reduction in wage-earning capacity as a result of an injury, illness, or occupational disease that arose out of, or in the course of, employment.

Distinguishing the difference between impairment and disability is imperative. One individual can be impaired significantly and have no disability, while another person can be quite disabled with only limited impairment. For example, a person with paraplegia who is wheelchair-bound may be working full time quite successfully as an accountant and, therefore, would not meet the SSA's definition of disability. On the other hand, a concert pianist might have a relatively minor injury to a digital nerve that severely limits his/her ability to perform basic work activities (playing difficult piano concertos). In some disability systems, a person in this situation might meet the definition of disabled even though he/she can do other work.

Because of this difference between impairment and disability, physicians are encouraged to rate impairment based on the level of impact that the condition has on the performance of activities of daily living (ADL) rather than on the performance of work-related tasks.[11] According to the AMA Guides, impairment ratings derived from the AMA Guides are "not intended for use as direct determinants of work disability."

Interestingly, various professionals and institutions regularly use the AMA Guides for the direct measurement of disability. Most states recognize the impairment ratings determined by the AMA Guides as direct measures of disability, despite the stated intent of the authors.

Disability can be temporary or permanent, and it can be partial or total.[12,13] Various programs have various categories of disability. An individual can be temporarily unable to perform work activity for remuneration or profit (for example, after trauma, surgery, and/or intensive care) and can be classified as disabled under some disability programs. However, if recovery occurs within 12 months, the individual is not likely to be classified as disabled under the SSA's permanent disability program.

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Many workers' compensation systems allow for partial disability, generating a need for the AMA Guides to measure the extent of the impairment as related to normal functional capacity.[12,13,14] The SSA disability program, on the other hand, is an all-or-nothing type of program; the claimant is considered either entirely disabled or not disabled. The Americans with Disabilities Act (ADA) confuses the definition of disability even further. According to the act, disability is present if at least 1 of the following requirements has been fulfilled:

- A physical or mental impairment that substantially limits at least 1 of an individual's major life activities
- A record of such an impairment
- Being regarded as possessing this sort of an impairment

With this broad definition of what constitutes a disability, virtually everyone with a health problem could argue that they have a disability. Further complicating the ADA definition—as ADA cases are tried in the courts—is the ever-changing legal definition of disability.

Defining impairment and disability is not an easy task, as can be seen by the differences in the above-cited perceptions. The definition of these terms varies depending on the circumstances involved in a specific case. This article provides insight into the varying interpretations, definitions, and applications of the concept of disability.

Different Systems to Measure Impairment

The AMA Guides offer one system for measuring impairment, but the guidelines that are provided are not universally accepted and, in fact, are based largely on consensus rather than on scientific evidence.

California has a system for measuring workers' compensation impairment in which an individual's functional capacity is rated in relation to a work category.[12,13,16] These categories have defined ranges of performance of various work-related tasks (eg, lift/carry, stand/walk).

To determine the amount of disability compensation, some states rely completely on the percentage of whole-person impairment rating published in the AMA Guides.[18] Other states, such as Utah, have taken proactive steps to attempt to clarify specific problem areas within the AMA Guides and to establish their own impairment guides.[17]

For example, the AMA Guides measure impairment to knee joints by range of motion (ROM), gait, muscle weakness, or sensory abnormalities. Furthermore, the AMA Guides allow for impairment to be rated based on surgical procedures, such as meniscectomy, or by radiographic evidence of joint space narrowing. These assessments are all reasonable methods of determining impairment.

Unfortunately, many types of severe knee joint abnormalities are not rated by this system. For instance, if an individual experiences a traumatic knee injury that causes a severe, deep, femoral condyle cartilage lesion that is well circumscribed, that injury cannot be rated according to joint space narrowing on radiographic findings. No provision has been made for ratings based on magnetic resonance imaging (MRI) or arthroscopic findings of cartilage pathology. MRI and arthroscopy are objective measures with accepted grading systems for cartilage lesions. If the lesion causes gait abnormalities or ROM deficits, a physician can rate the impairment, and the individual can receive disability compensation. Often, however, this scenario does not occur; findings in this type of case can instead be quite variable and subject to interpretation.

Such variable interpretation of subjective factors, such as gait or muscle weakness, leads to varying impairment ratings and litigation. The Labor Commission of Utah found great variability in ratings provided on the basis of subjective factors such as gait and muscle weakness. The commission established expert committees to determine methods of minimizing variability in impairment ratings in Utah. The result was a written guide that provides a structured evaluation process for certain common impairments. Although considered only consensus protocols, the Utah Impairment Guides have lowered variability and workers' compensation litigation significantly since 1997.[18,19]

The SSA uses a completely different method for determining disability. Because under SSA rules a person is either entirely disabled or not disabled at all, a rating system based on percentage of impairment is not necessary. To determine whether a claimant is qualified for benefits, the SSA uses a sequence of evaluations, as follows:

- If the person is performing work at a defined level, the benefits claim is denied. If the individual is not, then the next bulleted item is considered.
- If the impairment is not severe enough to limit how well an individual performs basic work activities, such as lifting, carrying, standing, walking, and sitting, the claim is denied. If the severity has caused such limitation, then the next bulleted item is considered.
- Claimants whose disability meets or equals the SSA's published criteria (which have been compiled according to body systems) or who have findings that are equivalent to them are automatically allowed to receive benefits. If the criteria are not met, then the next bulleted item is considered.
- A state agency medical consultant, employing federal form SSA-4734, evaluates the claimant's residual functional capacity, specifically, his/her physical and mental capacity to perform basic work activities.
    - Limits are defined for a variety of activities, including lifting, standing, walking, handling, concentrating, and interacting with others.
    - The limits are then organized by category: light, medium, heavy, or sedentary.
    - An adjudicator determines whether the claimant's assigned residual functional capacity allows the individual to return to his/her previous job or to perform another job in the national economy.
    - If the claimant can return to a job, then disability qualification is denied; if the individual cannot perform a job, such qualification is allowed.

The SSA's process is very different from that prescribed in the AMA Guides. Furthermore, the SSA considers age and education in the vocational analysis. For example, if a young man with a severe, permanent knee injury has a strong educational background and a sedentary job, he could be denied the classification of "disabled" because of his educational background. Conversely, a disability allowance would probably be awarded to a 57-year-old man with the exact same diagnosis but whose work experience encompasses only manual labor and who has a minimal educational background.

The International Classification of Functioning, Disability and Health (ICIDH-2) system is rarely used and has not been accepted by workers' compensation systems, SSA, or other major US disability programs. This system, which is

similar to the International Classification of Disease (ICD-9) rating system, uses a coding method to classify impairments and disabilities.

Currently, many states, along with various international organizations, are cooperating to formulate a new set of impairment rating criteria. With international cooperation, it is hoped that more consistent impairment criteria will be developed.

Different Systems to Compensate for Disability

After establishing and/or measuring impairment levels, the person rating the impairment moves to the next step, determining the extent of the impact of the claimant's injury or illness on the performance of ADL. Various systems are in place to provide compensation based on this impact.[20]

Workers' compensation

Most readers are familiar with the workers' compensation system. All employees theoretically are covered by this no-fault insurance program for any injury or illness that arises out of or in the course of employment. Workers' compensation includes coverage for medical care, temporary cash disability payments, and even permanent disability payments when indicated. Obviously, only employed individuals benefit from this type of disability program. The unemployed are not covered.

Private disability insurance policies

Private disability insurance policies are available for purchase by individuals. Some employers provide such coverage for their employees. These policies can be written to be specific to the person's occupation, meaning that the person may collect disability benefits if he/she is unable to perform their current occupation, even if they might still be capable of gainful employment within another occupation. These disability policies are broader than workers' compensation in many ways.

Unlike workers' compensation, an individual need not be injured on the job to receive disability insurance benefits; one can qualify for compensation after being disabled by an automobile accident or by cancer. In such cases, the claimant could apply for disability under the private policy. These policies generally have provisions that require the person to be disabled for 6 months before receiving benefits. Furthermore, some policies require that the person qualify for Social Security disability and that the amount of Social Security disability received be deducted from cash benefits.

State disability programs (usually temporary)

Various state agencies offer state disability programs. Some of them, such as those in California, are funded through a payroll tax. A claimant need not be injured on the job to apply for such coverage. These types of programs offer cash payments to individuals who are temporarily unable to work. For example, benefits might be received by a woman needing bed rest for a few months before childbirth or by a young man involved in an automobile accident who may be unable to work for several months while a femoral fracture heals.

SSA benefits

The SSA has several different programs that offer cash payments and eligibility for Medicare or Medicaid. Claims are allowed for children, disabled spouses, the indigent, and those insured by having contributed to the Social Security fund. From a medical standpoint, the rules for determining disability under the Social Security program are the same for each type of claim; however, each type of claim has a different set of administrative rules. For example, a 5-month waiting period precedes the beginning of payment for those who have paid into the system all of their lives and then become disabled under Title II. On the other hand, claimants who have no assets and have never worked or contributed to the fund are entitled to benefits immediately under Title XVI. Individuals who are blind get higher cash benefits than other disabled individuals.

Another difference in the SSA programs concerns medical insurance coverage. Individuals who are insured under Title II are not eligible for Medicare until 24 months after being classified as disabled. Individuals who are insured under Title XVI have instant access to Medicaid. Where workers' compensation programs can recognize a partial disability, the Social Security disability program is an all-or-nothing program. In other words, a claimant is considered either totally disabled or not disabled at all. Under SSA rules, for an impairment to be considered disabling, it must last 12 months or must result in death.

The rules for determining whether a claimant's impairments are disabling vary by age, educational level, and work history. A disability claim from a young, educated individual may be denied, while a claim for disability payments for the same impairment may be allowed in an older person with minimal education. Although SSA is a program recognizing only permanent disability, cases are reviewed periodically for determination of continuing disability. When an individual has a condition that previously was expected to be permanently disabling but then shows improvement, payments may be terminated.

Scope of the Problem and Impairment Rating Overview

Little data exist to provide accurate estimates of the number of people who have disabilities. One reason for this lack of data is because of the above-noted variations in the definitions of disability.[21] Under one system, a particular impairment may be considered a disability, but under another system, the same impairment may not be classified as such. Under the broad definition of the ADA, almost any medical condition, under the right circumstances, could be argued to be a disability.

The SSA has data on individuals receiving Social Security disability benefits in the United States. Workers' compensation data are maintained separately in state and national record keeping systems. International statistics are difficult to compile.

Some of the most publicized data are compiled from census surveys that ask individuals if they are disabled. Some researchers have estimated that there are 43 million persons in the United States alone who have a disability corresponding to the ADA definition. These numbers suggest a resulting economic cost of approximately $176 billion. According to 1990 Centers for Disease Control and Prevention (CDC) data, the direct and indirect costs of medical care, as well as the value of lost wages, stemming from physical, mental, or other health conditions reaches about $111.6 billion annually in the United States.[22]

According to self-reported data of the 1990 US Census, an estimated 12.8 million persons aged 16-64 years had a work disability; 6.6 million of these disabilities were described as severe, and 6.2 million were described as nonsevere.

The data regarding the prevalence of work disability show wide variance among states. The breakdown is roughly along socioeconomic lines. The lowest prevalence was reported in New Jersey (61.8 cases per 1000 people), and the highest prevalence of disability was reported in West Virginia (126.2 cases per 1000 people). Some of the poorest states had the highest prevalence rates, such as Kentucky (114.3 cases per 1000 people), Arkansas (111.7 cases per 1000 people), Louisiana (102.9 cases per 1000 people), and Mississippi (109.8 cases per 1000 people).

An interesting question to ponder is whether poverty developed before the high rate of impairment did in the high prevalence states, or whether the high rate of impairment came first. From 1980 to 1990, the prevalence of work disability actually declined in the United States, dropping from 85.2 to 81.5 per 1000 people. In the 1990 census, questions regarding health problems of at least 6 months' duration were asked. These included the following:

- Does the person have difficulty going outside of the home alone (for example, to go shopping or visit a doctor's office)?
- Does the person find it difficult to take care of his/her personal needs, such as bathing, dressing, or moving about the home?

Based on these questions, persons with disability were categorized as having either (1) mobility disability or (2) self-care disability, respectively. In 1990, 13.2 million persons (70.5 people per 1000) older than 16 years had some mobility or self-care disability, according to answers to these census questions. Among individuals older than 65 years, the rate was 201.1 persons per 1000. Beginning in about 1997, a workgroup was put together to attempt to rewrite the disability questions for the 2000 census, and new questions were ultimately recommended.[23]

In 2004, benefits were granted for nearly 800,000 disability claim applications. The sheer volume of disability claims evaluated becomes evident, given an approval rate well under 50% of applicants (just over 37% in 2004). As of June 2001, almost 7 million individuals were receiving cash benefits and medical benefits under the SSA disability insurance program, totaling over $59 billion dollars that year. In 2004, SSA paid out over $78 billion dollars in cash disability benefits alone, with nearly 8 million in payment status. Little information is available regarding the rates of similarly defined disability among residents of other nations.

Overview of impairment rating

Ill or injured persons suffering from permanent impairments may become disabled. As a result, many different compensation systems have been developed. For these systems to standardize the compensation process, impairments need to be measured and rated.

The Labor Commission of Utah's Impairment Guides state the following:

> Texas reports that 83% of injured workers receiving impairment ratings in the range of 1-14% reported experiencing personal hardships. Of those workers receiving an 8% rating, 11% never returned to work, whereas 22% of workers with a 14% rating did not return to work. Likewise a study of California's vast workers' compensation system found that workers who suffer workplace injuries resulting in a permanent disability experience large and sustained wage losses.[24,25]

Impairment ratings that are made on the same individual by various examiners are often quite divergent, leading to an unacceptable level of inconsistency.[26] Such inconsistency is not unique to worker's compensation programs and the AMA Guides. The SSA has found inconsistencies in interpretation and implementation within their uniform nationwide rules.

This lack of consistency has provoked calls for serious revisions of the AMA Guides. In one example, a single hypothetical case was sent out to 65 independent medical examiners with experience in rating disabilities under the California system. After being supplied the specifics of the case, physicians were asked to estimate the level of disability. The resulting degree of disability awarded differed by as much as 85 percentile points.[3]

The Utah Impairment Guides state the following[18]:

> Texas reported significant variation using the Guides for workers receiving more than one rating of impairment for the same condition, showing 25% of these ratings could differ more than 10%, with 65% of those who disputed their ratings, doing so on the methodology of how the rating was calculated. Other studies have demonstrated lack of relationship of an impairment rating and true residual physical function.

Many factors may influence the variability of impairment ratings, including the competency and experience of the examiner, the patient's personality, and even financial motives. California has documented a steady inflation for the average Disability Evaluation Unit rating, even though there has been no official change in rating guidelines. From 1992 to 1996, impairment ratings for back injury increased 14%, with a 16% increase for upper extremity ratings.[26,27,28,29,30] Approximately a 3% difference was noted in ratings for the same condition in northern California compared with southern California. This degree of variability can be quite costly in highly litigated impairments. In Utah, for example, cases with impairment ratings that vary by more than 3% are appealed to an administrative law judge. By standardizing the impairment rating process and eliminating some of the subjective factors that add variability, Utah wasableto reduce its workers' compensation litigation rate to less than 1%.[19]

AMA Guides, Litigation, and Fitness for Duty Evaluations

The AMA Guides are used by many different systems to determine compensable levels of impairment. Civil cases involving motor vehicle accident litigation, many workers' compensation systems, and even some insurance companies use the impairment rating system found in the AMA Guides to determine the overall level of impairment after injury or disease.

Originally published as a series of articles in the *Journal of the American Medical Association* (*JAMA*), the AMA Guides have been revised periodically. They are a sometimes inaccurate, but nevertheless standardized, tool that can be used to convert medical information about permanent impairments into numerical values. Each chapter focuses on an organ system and provides a description of the methods used for assessing impairments. The findings can then be converted into whole-person impairment percentages.

Considerable controversy exists in the professional community regarding the accuracy and usefulness of the AMA Guides.[31,32] Studies have consistently shown that the AMA Guides have significant limitations in their ability to accurately measure impairment. Research has demonstrated that spinal ROM is not a reliable measure of true functional impairment and is dependent on such factors as the age and sex of the patient, whether osteoarthritis is present, and the time of day that measurements are taken.[33,34,35,36,37,38,39]

Serious criticisms have been directed at the AMA Guides. First, commentaries have noted that the AMA Guides do

not provide a valid, reliable, evidence-based system for the rating of impairments.[40] Some have argued that the impairment ratings do not reflect an individual's actual loss of function and quality of life (QOL). Largely because of these concerns, California, which has the largest state workers' compensation system, has declined to use the AMA Guides.[19] Second, criticisms have focused on the fact that the ratings are improperly used as a substitute for a full assessment of the impact of impairment on an individual's capabilities on or off the job.

Other criticisms of the AMA Guides are related to the publication's chapter allowing additional impairment for the presence of pain. This provision of additional impairment based on the examiner's perception of the level of pain and its impact on functioning provides a window for discrepancies between raters for the same condition. In some states, such a window of discrepancy leads to litigation over the different impairment ratings for the same condition. Needless discrepancies can add costs, time, and frustration for all involved in this complex disability rating process.

To calculate impairment ratings, 40 state workers' compensation systems require some use of the different editions of the AMA Guides. The authors of the AMA Guides state that the publication "is the most commonly used source for assessing and rating an individual's permanent impairments." However, considering that California's workers' compensation system (the largest in the United States), 9 other states workers' compensation systems, and the federal government's SSA disability program do not recognize the AMA Guides for rating impairment, it becomes clear that there are differing opinions regarding how best to assess impairment.

The SSA uses a completely different method for assessing impairment and disability than that provided in the AMA Guides. In addition, the Department of Veterans Affairs (VA) has its own, unique set of disability rating criteria. However, although it is not universally accepted by all disability programs and is clearly not entirely evidence-based, the AMA Guides provide a reasonably consistent method by which to evaluate impairment; they also attempt to minimize interrater variability.

Various organizations offer training and certification in the process of impairment rating. Physicians can receive certification to perform impairment ratings. These training courses describe the methods to be used in applying the AMA Guides. Although not required, such training is becoming increasingly more valuable because of the inordinate complexity of the AMA Guides.

If an impairment rating based on the AMA Guides is needed, only physicians who are familiar with the AMA Guides and experienced in their use on a regular basis are recommended to conduct such ratings. When impairment ratings are performed only rarely in the office, a physician becomes unfamiliar with the complex calculations and rules in the AMA Guides. If the referral source does not require an impairment rating based upon the AMA Guides, then training in the use of the AMA Guides is less important, but general training in disability is still helpful.

Litigation

Since Utah adopted the Utah Impairment Guides, which reduce variability in impairment ratings of the most common conditions, estimates indicate that litigation over impairment ratings has dropped to less than 1%. According to the Labor Commission of Utah, this litigation reduction has helped Utah become the least costly state for manufacturers to obtain workers' compensation insurance; at the same time, the state maintains a medical fee schedule above the national average and weekly wage replacement at $529.00.

Fitness-for-duty evaluations

Other situations require different types of assessment of functional capacity. For example, when an injured or ill employee recovers sufficiently to return to work, his/her employer may require a fitness-for-duty (FFD) evaluation. Such evaluations are important in the assessment of functional capacity and in the determination of an appropriate fit between the examinee's capacities and the essential functions of the job.[41] The use of a more comprehensive reference, such as the book *Disability Evaluation,* from the AMA, can be consulted for further information on appropriate FFD evaluations.[42] The author of this article served as coauthor of a chapter on FFD evaluations in that book.

Impairment and Credibility Assessment

Functional capacity evaluations

Functional capacity evaluations (FCEs) are frequently performed by physical and occupational therapists, as well as by exercise physiologists. These evaluations can last for many hours and involve a simulated work environment. The utility of such evaluations is subject to debate in the professional community. Patients sent for an FCE know that their performance will be measured and that the results could ultimately lead to the payment of a cash settlement or to the denial of benefits. Exactly how these secondary gain issues impact the outcome of an FCE is not clear.

The assessment of true sustainable functional capacity is difficult to make with a test that takes only a few hours. However, it is even more difficult to assess true function in claimants who have not been observed in a functional test. The positive predictive value of such tests is highly debated. Various machines and methods have been marketed. Studies are under way to attempt to discriminate between test methods and determine methods that predict true functional capacity.

Who can perform an impairment rating?

The agency for which the impairment rating is being performed determines who can conduct the rating. In some settings, physical therapists provide measurements and reports of impairment ratings for orthopedic and neurologic impairments. In some states, only specialists who have been certified by the American Board of Medical Specialties (ABMS) can provide impairment ratings for workers' compensation patients. In other states, chiropractors, as well as physicians, are free to provide impairment ratings on any body system (eg, a psychiatrically, hematologically, oncologically, or neurologically related rating).

In the SSA disability program, only acceptable medical sources can provide information to establish a medically determinable impairment, and a licensed physician or (in the case of mental claims) a psychologist must sign off on the disability determination. Under SSA rules, chiropractors, naturopaths, acupuncturists, nurse practitioners, physician assistants, physical therapists, and other lay providers are not considered acceptable medical sources, but they can be used to provide third-party evidence of impairments.

In practice, given the complexity of the interactions between physical, psychological, and emotional factors in the impairment evaluation process, most systems recognize that only qualified, licensed physicians should perform impairment ratings. When the treating physician is unable to perform the impairment rating, it is recommended that employers, insurance carriers, adjusters, and workers with injuries seek to have evaluations performed by physicians who have completed a residency at an institution accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Physicians who did not do their residency training in an ABMS-recognized specialty may not be adequately trained to assess the complex and interrelated medical and psychological issues involved in the impairment rating process. Furthermore, it is believed that only institutions that have ACGME accreditation and that offer ABMS specialty training consistently offer the level of training in evidence-based medicine to support the complex decision making required in assessing permanent impairment.

Practitioners lacking such expert training and those who subscribe to unsupported unscientific or unsubstantiated alternative treatment practices are not considered qualified to perform impairment ratings. Commonly, regional referral patterns show that claimants are not sent for impairment ratings by chiropractors, acupuncturists, and massage therapists, even if these specialists are state-licensed to perform some defined scope of medically related services.

Podiatrists are one exception to the above recommendation regarding physicians qualified to perform impairment ratings. Podiatrists with an unrestricted license may provide impairment ratings for injuries around the foot and ankle. If musculoskeletal conditions involving other body regions exist in addition to foot/ankle problems, all of the assessments could be provided by a more comprehensive visit to a physiatrist (a physician specializing in physical medicine and rehabilitation, generally with expertise in musculoskeletal and neurologic conditions), an orthopedic physician, or another physician with expertise in musculoskeletal medicine.

Performing the impairment rating

Because the SSA impairment rating and disability determination process is a closed system that is performed only by agents authorized by the Social Security commissioner, this section does not describe the process in great detail. The Veterans Benefits Administration's (VBA's) compensation and pension rating process also is a closed system, being performed only by agents of the VA or VBA. Most impairment ratings performed by practicing physicians are in the workers' compensation or personal injury arenas. In these cases, the AMA Guides are frequently used; therefore, this section summarizes the process used in these guides.

Prior to conducting an impairment rating, physicians should thoroughly study the AMA Guides. Various rules and conventions must be understood prior to use. When performing an impairment rating with the AMA Guides, the most important thing to remember is that the key elements required by the AMA Guides must be fulfilled; if they are not, the rating is not considered complete or accurate.

The physician should bring the particular chapter and tables for the body system being evaluated at the time of the examination. In this way, all measurements can be performed in a single visit, nothing is likely to be missed, and the methods of measurement prescribed by the AMA Guides can be used. After the measurements and findings have been recorded carefully according to the criteria within the AMA Guides, the examiner can compile the report.

Performing the impairment rating is much more complex than just performing the physical examination. Depending on the source (eg, workers' compensation, SSA, private disability) of the evaluation request, the examiner is required to report on the patient's overall functional ability and limitations. This comprehensive review should include, but is not limited to, the following:

- Physical examination
- Assessment of motivation and sincerity of effort
- Credibility of alleged pain and other limitations
- Assessment of causation

Assessing motivation and sincerity of effort

The Performance APGAR (Acceptance, Pain, Gut [intuition], Acting, Reimbursement) model offers an approach to quantifying effort and motivation. Colledge and Holmes developed a model for assessing patient motivation and sincerity of effort.[43] Validation studies are underway, but the process seems likely to be a quite useful method by which adjudicators and physicians can rate the effort that a patient is expending in recovery.

Like an infant Apgar score, the Performance APGAR has a score between 1 and 10. Several factors (ie, acceptance, pain, gut intuition, acting, reimbursement) are considered and scored (see Table 1). A score of 10 is consistent with outstanding motivation to recover. This model allows for the tracking of changes in motivation, for early intervention with low motivation patients, and for potentially different reimbursement levels that are linked to the sincerity of effort put forth by the injured individual. As more professionals use the Performance APGAR model to grade motivation, the predictive value of the score can be studied.

Pain and the credibility assessment

The fifth edition of the AMA Guides included a new chapter on pain. In addition, it provided charts in the neurologic, upper extremity, and lower extremity sections allowing subjective pain to be rated. Using these charts, a physician who is providing a rating can give an additional 3% whole-person impairment rating if the rater feels that an individual has a pain-related impairment that has increased the burden of his/her condition.

Significant concerns have been expressed that this new, unproven methodology may increase interrater variability and secondary litigation. To minimize this possibility, some states are not allowing ratings to be increased for pain alone. As a potential tool in this dilemma, this section describes how to assess credibility of alleged pain limitations in a systematic way.

Credibility assessment

Physicians involved in the evaluation of impairment, the determination of disability, and the evaluation of FFD regularly make judgments regarding the veracity and reliability of a patient's alleged symptoms. Determining whether or not a patient is reporting the truth is a difficult process. The determination becomes even more difficult as the amount of potential secondary gain increases. Experienced clinicians become skilled in the art of distinguishing between real and fabricated allegations. The process may seem subjective and judgmental, but experienced physicians, working with the multifaceted issues involved in functional limitation determination, are keenly aware of the need to make a judgment regarding the credibility of a patient's allegations.

A credibility assessment is not to be thought of as a judgment about a patient's character. A credibility determination is designed to be used in making an informed judgment about the truthfulness of the alleged symptoms or limitations that are being evaluated. The current symptoms and limitations may be entirely credible in an otherwise dishonest individual.

The credibility determination process

Caution should be exercised when symptoms alone are used to establish the existence of permanent impairment. For example, the SSA rules state that such a determination should never be made based only on symptoms. With regard to disability evaluation, the SSA further states that regardless of how many symptoms a patient alleges or how genuine the patient's complaints may be, impairment cannot be established in the absence of objective medical abnormalities.

If there are clinically accepted medical signs and laboratory findings of an impairment or a diagnosis that reasonably could cause the alleged symptoms or limitations, then further evaluation of the alleged limitations is warranted. The examiner initially makes a professional assessment of the extent to which the symptoms can reasonably be accepted as consistent with the objective evidence and other information available in the case file.

Credibility factors to consider

When making a credibility assessment, it is useful to consider the guidance provided by the SSA. The SSA disability determination process closely evaluates the credibility of symptoms and their true effect on function. The SSA lists several factors to consider before making a final judgment about the limiting effects of the alleged symptoms. Some factors to consider include the following:

- Effects of symptoms or impairment on performance of ADL
  - How is the claimant reporting on functioning with regard to shopping, cooking, self-care, housework, and yard work?
  - Is the pain so severe that the patient cannot even cook or wash dishes?
- Type, dosage, effectiveness, and side effects of medications
  - Is the claimant in need of large doses or multiple medications to relieve discomfort?
  - Is the medication addicting?
  - Is there evidence of behaviors associated with seeking of narcotic drugs?
  - A clear pattern of progressively increasing use of narcotics, well monitored with no indication of abuse, could provide a reasonable basis for determining the legitimacy of the pain allegations. This pattern could also legitimize limitations caused by medication side effects.
  - Are there legitimate side effects to required medications that limit functional ability in a work setting?
- Treatment sought and received
  - Has the claimant sought professional help for the relief of the alleged symptoms?
  - Has there been extensive searching for relief by attempting multiple treatments, even unconventional treatment?
  - Has the claimant been compliant with appropriate treatment recommendations? (Someone who has been repeatedly noncompliant with mainstream medical treatment on a repeated basis and is using unproven, ineffective treatment alternatives may be less credible than a fully compliant patient.)
- Opinions that have been recorded by professionals who have treated and/or examined the patient - If the patient has been examined and treated by various specialists who have been able to examine the full medical record, their opinions about the true impact of symptoms on functional capacity can be valuable in a credibility assessment.
- Inconsistencies or conflicts in the allegations, statements, or medical evidence in the file
  - Inconsistencies and conflicting statements make a significant contribution to the overall credibility assessment. Consistency is very important in determining credibility; however, it obviously is not the only measure. A strong indication of credibility is given by the degree to which the allegations are consistent with the objective evidence. For example, a patient with completely nonphysiologic pain that is unrelated to objective test results has a conflict in the findings compared to the allegations. These kinds of discrepancies can lead to doubts about the credibility of the alleged limitations.
  - Another area in which consistency is important is in the history given at different examinations. For example, a patient who presents with severe allegations of a certain pain or injury at one physician evaluation but presents with completely different allegations at another physician evaluation demonstrates inconsistency.
    - The history of the injury/illness, the onset and duration of symptoms, and the functional effects on ADL should be fairly consistent as reported to various medical professionals. The initial history and physical examination should be reasonably consistent with the independent medical evaluations (IMEs) for worker's compensation; they should also be consistent with other specialist consultations in the file.
    - Furthermore, the longitudinal medical record should be consistent in demonstrating the attempts to treat the condition. The practitioner also may make some limited inferences about the overall credibility of the allegations based on the frequency of treatment. If the allegation is quite severe, yet no medical treatment has been sought, the credibility of the allegation comes into question. The examiner then needs to consider whether there were financial or other impediments to obtaining the appropriate level of treatment for the diagnosis.

Considering medical opinions

Another component of the overall credibility determination is the emphasis given to the opinions included in the medical file by physicians who previously have examined and/or treated the patient. The opinions of other physicians regarding the patient's functional ability can vary significantly, based on the physician's role in the patient's care and the information available to that physician at the time of the evaluation. Many treating physicians inadvertently become inappropriate advocates for the patient by prolonging the disability period or by assuming work-related causal relationships without obtaining details from the employer's investigation of the alleged claim.

How does the physician evaluating functional ability determine which recommendation to follow? In this process, the evaluating physician reviews all the information regarding credibility listed above and then compares that information with the opinions of other physicians in the file. Other sources of opinion might include evidence from chiropractors, physical therapists, optometrists, and other medical professionals. Such sources can be valuable in determining the true extent of limitations and can thereby assist in the overall credibility determination.

In general, when differing opinions about function are in the file, the opinion that is the most consistent with the

evidence should be the one that is given the greatest amount of consideration. Other factors to consider when determining which source opinion to support include the following:

- Examining sources - The opinions of practitioners who have examined the patient are given greater weight than the opinions of those who have not (eg, insurance company file reviews).[44]
- Treating sources rather than providers of 1-time examinations - In general, a medical provider with a long-standing relationship may be more familiar with the patient's limitations than would a consultant who has seen the patient once.
- Supporting evidence - A source that provides supporting evidence to substantiate the opinion about functional ability should be given more weight than should a source that does not have supporting evidence.
- Consistency with the record - Obviously, opinions most consistent with the preponderance of evidence are given greater weight.
- Medical specialty - The opinion of a specialist in the field may be given greater weight than would that of a generalist, even if the length of treatment by the specialist was much less. Furthermore, the opinion of a physician who is more familiar with the demands and tasks in the workplace is likely to be given greater weight than would the opinion of a physician who is unaware of such demands.

Many sources write opinions, such as light duty, moderate lifting, or sedentary work. These generalized, nonspecific statements of functional ability are inherently unreliable and meaningless in making appropriate ability statements. The definition of light work or sedentary work is not consistent among physicians. Further confusion can come when a treating physician writes a note in the file stating the patient is disabled. No specific level of impairment that is known by all physicians is equated with the term "disabled." To one physician, a patient's inability to lift more than 50 lb may suggest a disability. To another examining physician, this same patient may be regarded as capable of performing the essential functions of his/her current job.

The important thing to remember is that the opinion of the physician who knows the patient best and who has the most knowledge about the specific limiting condition should be carefully considered in a functional evaluation and should be integrated with an understanding of the claimant's work environment. If the treating physician makes a generalization regarding the patient's functional ability, further contact with the physician may be required to clarify the patient's specific functional restrictions and true residual capacity. The relative weight to be given to various factors should be addressed in the report, giving the specific reasons why more consideration was given to one opinion over another.

The experienced clinician can make the appropriate objective medical assessment of the patient and then consider all of the factors of credibility, weigh the source opinions, and make a final determination of the patient's functional ability.

Credibility conclusions

Finally, when evaluating the credibility of a patient's allegations in a written report, the specific findings on examination, in the history, or in the test results that led to a specific credibility finding should be cited. For purposes of the Performance APGAR, there are 3 proposed credibility determinations:

- Allegations are credible - If the examiner finds that the allegations are credible and are consistent with the diagnosis and objective evidence, those allegations are given enough weight to guide the ultimate determination of patient functional ability.
- Allegations are partially credible - The examiner analyzes data and determines that the allegations of pain and/or limitation are neither completely credible nor fully consistent with the diagnosis and objective evidence. The examiner's report should cite the specific reasons and evidence that were used to make this determination.
- Allegations are not credible - Optimally, only in a rare circumstance are all allegations of pain or limitation found to be entirely unfounded.

The credibility assessment described above can be simplified by use of the Credibility Assessment tool (see Table 2). This assessment tool is used to quantify credibility into a standardized number that can be incorporated into the overall Performance APGAR score (see Table 1).

Reporting of Impairment Ratings and Apportionment

Reporting of Impairment Ratings

In general, the attending physician is the person who is the most knowledgeable regarding the claimant's condition, progress, and final status. Therefore, the attending physician is encouraged to render the final impairment rating. For various reasons, however, including litigation, geography, personality, and reimbursement, physicians other than the treating physician regularly perform impairment ratings.

Many groups have developed training programs and courses to give physicians experience and expertise in performing impairment ratings based on the AMA Guides. Other courses are directed toward the specific requirements of impairment rating in states that do not use the AMA Guides (eg, California).

Some physicians even develop a business model of providing only impairment ratings. Others, not realizing that systems such as the SSA disability program do not accept ratings based on the AMA Guides, have had trouble getting their reports accepted by the SSA and other organizations. Obviously, it is important for the physician who provides an impairment rating to know for whom the rating is being produced and to whom it is being addressed. The type of program under which a particular patient is filing determines the type of impairment rating system and report to be used.

The examiner's report should at minimum include the following elements:

- History and physical examination findings
- Statement about medical stability
- Medical record review

- Diagnosis
- Whole-person impairment percentage (with calculations)
- Apportionment of the permanent impairment to prior conditions (when appropriate)
- Functional ability statement regarding the individual's residual functional capacity
- An assessment of the credibility of alleged pain and limitations
- Future medical treatment recommended or required
- Some statement about sincerity of effort or motivation, such as the Performance APGAR model (see Table 1)
- Statement about causation of the impairment
- Answers to any other specific questions posed by the requesting adjuster or agency
- References

Medical stability

The examining physician should declare the patient to be medically stable (that is, to have reached MMI), stating that it is his/her medical opinion that all care that is reasonably necessary for the diagnosis, cure, or significant relief of a condition has been rendered and that the patient's whole-person impairment rating is not expected to change more than 3% in the following year.

Medical record review

The records reviewed should be summarized (as appropriate). Lengthy discussions of every progress note are not encouraged. A concise summary of the pertinent evidence is recommended.

Diagnosis

The examiner needs to state the diagnosis clearly as substantiated from the medical record. The examiner should also define, as clearly as possible, the relationship of the diagnosis to the industrial event. In many cases, it is recognized that specific pathologic diagnoses are not clearly evident. The examiner has the responsibility to provide a diagnostic impression that is correlated as closely as possible to the clinical findings.

The whole-person impairment percentage

Using the rating criteria for the specific case (usually the AMA Guides in workers' compensation cases), the tables, figures, and numbers used to calculate each particular body system impairment, extremity impairment, and whole-person impairment should be cited. The physician should also state which impairments were added and which were combined.

Apportionment

The physician should state what portion of the impairment is directly related to the event or injury in question. In most cases, this determination requires sufficient information on the unrelated impairments. A separate rating for unrelated impairments is calculated and then deducted from the whole-person impairment. (See Apportionment, below.)

Residual functional capacity

Most reports should contain a statement of the residual functional capacity or, in some cases, the specific functional limitations of the individual. This determination is usually necessary for proper vocational decisions to be made. The information allows rehabilitation counselors and others to make the best determination of the type of job that the person is fit to perform. In an ADA analysis, the information can be used to match capability with essential job functions.

Credibility of symptoms

See Impairment and Credibility Assessment.

Future medical treatment

The physician should be specific in identifying medical treatment that is or will be required in the future as a direct result of the industrial injury or disease.

Sincerity of effort

The Performance APGAR model (see Table 1) or a similar model should be used to estimate the sincerity of effort put forth by the injured worker.

Causation

The National Institute for Occupational Safety and Health (NIOSH) is a valuable resource for causation criteria for the work relatedness of injury and disease. Proper training and an understanding of statistical concepts is required to accurately assess causation. Physicians should familiarize themselves with Sir Bradford Hill's criteria for establishing causation. Many phenomena are statistically associated with each other but have no causative relationship. Association does not equate to causation.

References

The physician should provide references for any articles or studies cited in the decision.

Apportionment

What is apportionment and why is it performed? Pre-existing conditions, pre-existing symptomatic conditions, previously existing conditions, previously existing symptomatic conditions, and prior impairment are all terms used to describe conditions that caused functional impairment but were unrelated or predated the injury in question.

When such conditions exist, the examining physician should attempt to sufficiently reconstruct the evidence to establish a percent impairment rating for the pre-existing condition, based on reasonable medical probability. The rating from the pre-existing condition is then subtracted from the current whole-person impairment rating to arrive at

the apportioned rating that is attributable to the current injury or condition.

Various rules may be in place in different states to address the process of apportionment. It is recommended that reviewing physicians familiarize themselves with the rules for their state of practice. The Utah State Labor Commission describes apportionment as follows:

> 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). Apportionment generally means that the employer is not required to pay for that portion of the total impairment that is due to a prior impairment.

Physicians must understand that apportionment applies only to permanent impairments, not to medical care or to compensation for lost time. Before apportioning an impairment rating, the physician identifies the impairment that existed before the industrial injury and clearly shows how the current, permanent impairment is greater because of the prior impairment. This evaluation must be based on reasonable medical probability (ie, >50%) before it is subject to apportionment.

Apportionment of the final rating is necessary (1) if there is objective medical documentation that a ratable impairment existed for the same anatomical area, structure, or condition before the industrial event occurred and (2) if the 2 impairments combine to produce a greater impairment rating than would be present from the industrial event alone. (In other words, to apportion any condition as a prior impairment, the examiner needs to demonstrate that the condition would have been ratable by the AMA Guides or Utah's 2001 Impairment Guides before the industrial event.[16]) The total impairment is calculated, and then the prior impairment is calculated and deducted. The remaining amount of impairment, then, would be considered attributable to the industrial accident.

Not all cases can be apportioned. If the physician cannot estimate with a reasonable degree of medical probability the level of impairment that would have existed without the injury, then the physician cannot apportion the final impairment.

Apportionment cannot be based solely on the existence of a disease, abnormality, or disorder. If a person has an occult disorder that would not have qualified for a rating before an event (eg, spondylolysis, spondylolisthesis, significant degenerative changes), then the final rating is 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 necessity for surgery. Issues that cannot be measured in any reasonable, objective way cannot qualify for an apportionment.)

Billing, Current Controversies, and Combination of Impairment Value

Billing

Billing for evaluation services is conducted differently in different cases, depending on the requesting entity, the program being applied for, and the state jurisdiction. In most states, a flat fee is used to pay for an evaluation for the SSA disability program. Workers' compensation carriers may pay a flat fee, a fee per billing code, or an hourly fee. In complex cases, the fee structure should be negotiated in advance to avoid misunderstandings. From an ethical point of view, the examining physician should provide an honest examination of the individual; the physician's opinion should not be dictated by the referral source.

Current controversies

Testing of grip strength is another area of significant controversy. Even experienced hand specialists can have great difficulty in determining a claimant's true grip and pinch strengths. Subjective factors, as well as examiner skill, play significant roles in the accurate assessment of grip strength. Poor effort or motivation may impair the examiner's ability to properly quantify losses of grip strength. According to the AMA Guides, conditions that can still be resolved and treated are not to be rated. This rule differs from the SSA evaluation process, which considers the current or past functional capacity of individuals in the presence of impairments, regardless of cause.

Many in the field believe that the AMA Guides do not adequately provide recognition for impairment caused by anatomical deformity. The lower extremity and the upper extremity sections of the AMA Guides lack significant methods for evaluating cartilage injuries seen on MRI scans or on arthroscopic images; yet, these types of injuries can be quite a problem for joint function on a weight-bearing surface.[45]

For example, the lower extremity section of the fifth edition of the AMA Guides allows for the rating of impairments based on the highly subjective factor of gait. However, it does not allow for a specific rating based on arthroscopic findings from a large, weight-bearing cartilage defect (unless the cartilage is so degenerated that joint-space narrowing is seen on plain radiographs). Many scenarios can be imagined. For example, a relatively young individual with healthy cartilage suffers a traumatic cartilage injury that causes symptoms and limitations, as well as early joint deterioration. In such a case, the joint is no longer normal and may be rated with minimal, if any, permanent impairment according to the AMA Guides. However, the trauma may cause significant injury to the cartilage, thus impairing current and future functional ability

The Labor Commission of Utah has developed a model to rate impairment in the upper or lower extremities caused by cartilage lesions. A copy of the Utah Impairment Guides is available upon request from the Labor Commission of Utah, PO Box 146610, Salt Lake City, Utah 84114-6610, USA.

Rules for when to combine and when to add impairment values

When using the AMA Guides, multiple impairments to a member or to the whole person can be combined or added. Combining impairments requires the use of the combined values table provided in the AMA Guides. Essentially, this table reduces the remaining portion of the whole person that is available for the second impairment. In other words, if a claimant has 2 different impairments and each impairment has a 10% whole-person impairment rating, the total whole-person impairment rating is not 10%+10%=20%. The actual rating is 10% plus a 10% impairment of the remaining 90% of the individual that is unimpaired. Therefore, the combined value is 19% whole-person disability. The differences become even more dramatic in larger impairments. The Labor Commission of Utah has provided guidelines for determining when to combine and when to add impairments. These guidelines are largely consistent with the AMA Guides and are a useful short reminder list, as follows:

- Always combine all of the ratings of a region (eg, digit, hand, upper extremity) prior to converting to the next higher level (eg, hand, upper extremity, whole person). The same process is used in the lower extremity.
- When more than 1 impairment exists for an individual (eg, abnormal motion, neurologic loss, and amputation), the impairments must be combined at the lowest level before conversion to the next larger unit.

- ROM loss in the same joint is added.
- ROM loss in multiple joints is combined. The exception to this rule is that the carpometacarpal (CMC), metacarpophalangeal (MP), and interphalangeal (IP) joints of the thumb are added because each provides a portion of a complex motion. The ankle and subtalar joints also are added for the same reason.
- Impairment percentages for the thumb and index, middle, ring, and little fingers are added, not combined.
- If multiple ankyloses are present in the same joint or area, the largest figure for the rating is used.
- Spinal impairments for multiple regions are combined.
- Everything else is combined.

Conclusion and Figures

The distinction between disability and impairment is often misunderstood by the medical community and by the general public, as well as in the scientific literature. The ever-increasing numbers of people alleging disability and impairment necessitates a professional understanding of these terms, the scope of the problem, and the most effective means of dealing with these issues in a medical practice.

Describing impairment so that a proper administrative disability determination can be made is a complex process that varies according to the particular disability program that has jurisdiction. Physicians are encouraged to become educated in the process of proper impairment rating so that objective functional deficits may be considered properly by administrators and adjudicators within the varying disability programs. Table 1. Performance APGAR Measurement of the Sincerity of Effort an Individual Puts Forth

Open table in new window

Criterion			Scoring Options			Score up to 2 points
			0	1	2	
A	Acceptance (choose best test or average)	If this just does not get any better, what will you do?	I can't live like this	I am going to have some problems	I will live with it	A=___
		Are you satisfied with your job?	Not satisfied	Partially satisfied	Satisfied	
P	Pain (choose best test or average)	Pain drawing	Nonphysiologic	Some of it is physiologic	Physiologic	P=___
		Pain behaviors score (AMA Guides table 18-5)	Exaggerated or nonphysiologic	Mixed or ambiguous	Appropriate and confirm clinical findings	
G	Gut (intuition) (choose best test or average)	Credibility tool (see Table 2)	Not credible	Partially credible	Credible	G=___
		Intuition of effort	Poor effort	Partial effort	Excellent effort	
		Duration	Much longer than expected	Longer than expected	As expected	
A	Acting (choose best test or average)	Consistency with distractions	Poor consistency	Partial consistency	Excellent consistency	A=___
		Waddell signs	More than 2 Waddell signs	2 Waddell signs	0-1 Waddell sign	
		Grip-strength testing	Unreliable grip strength (high variance, etc.)	Partial validity	Reliable grip strength	
R	Reimbursement	Compensation/litigation	Someone else liable WC, PI, Disability Application Attorney Representing	Someone else liable WC, PI, Disability Application	No one Liable	R=___
		Total Performance APGAR Score=____ (Add A, P, G, A, R sections for a maximum of 10)				

Under each letter (ie, APGAR), (1) choose the most applicable test for the particular patient or (2) perform more than 1 test per section, using an average score for that section. A total score of 8-10 is consistent with what is optimally expected from a motivated patient; a score of 4-7 indicates concern about motivation; and a score of 0-3 suggests poor motivation by the patient to improve his/her functional abilities.

Table 2. Credibility Assessment Tool

Open table in new window

Criterion	Not consistent with the	Partially consistent with the objective	Fully consistent with the objective

	objective evidence and/or expected outcome/severity (0 points)	evidence and/or expected outcome/severity (1 point)	evidence and/or expected outcome/severity (2 points)
Impact of symptoms or condition on ADL			
Type, dosage, effectiveness, and side effects of medications			
Treatment sought and received			
Opinions about function given by other treating and examining sources in the file			
Inconsistencies or conflicts in the allegations, statements, or medical evidence in the file			
		Total credibility score=_____ (0-10)	
Credibility determination: Total credibility score of 0-3=Not credible Total credibility score of 4-7=Partially credible Total credibility score of 8-10=Fully credible			Result of credibility determination to be used in the APGAR table

Use this table to make an assessment of allegation credibility for the Performance APGAR score. Each of the 5 areas should be scored 0, 1 or 2 points. The 5 area scores are then totaled for an overall credibility score of x/10. This score is used in the credibility section of Table 1 (not credible, partially credible, or fully credible).

Keywords

impairment rating, disability determination, disability ratings, independent medical evaluation, IME, maximum medical improvement, MMI, permanent and stationary, motivation, sincerity of effort, performance APGAR

More on Impairment Rating and Disability Determination

References

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