23 Assessing Disability in the Pain Patient

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Key Points

- Assessing disability in the pain patient is often difficult due to both administrative and clinical issues, yet this assessment is essential.
- Clinically, quantifying pain remains problematic as chronic pain is a subjective phenomenon, often associated with confounding behavioral, characterological, personality, and psychological issues.
- Typically, the physician does not define "disability"; rather, the physician defines clinical issues, functional deficits, and, when requested, impairment. Disability is most often an administrative determination.
- The assessment of disability associated with chronic pain is complex, and the evaluator must approach the clinical evaluation with recognition of the many factors associated with the experience of pain and disability.
- The treating physician who has a doctor–patient relationship with the claimant may have a different perspective than the "independent" disability evaluator.
- While an independent medical evaluation has some similarities to a comprehensive medical consultation, there are significant differences.

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Introduction

Assessing disability in the pain patient is often difficult due to both administrative and clinical issues, yet this assessment is essential. Administratively, it is complicated by numerous states, federal, and private systems and policies with different definitions and benefit systems. Clinically, quantifying pain remains problematic as chronic pain is a subjective phenomenon, often associated with confounding behavioral, characterological, personality, and psychological issues. Additionally, the terms impairment and disability are often misunderstood. Furthermore, underlying personality structure and motivation are often determinates for disability. Chronic-pain complaints may be linked with significant disability [1]. Typically, the physician does not define "disability"; rather, the physician defines clinical issues, functional deficits, and, when requested, impairment. Disability is most often an administrative determination.

Pain is the most common cause of disability, with chronic low back pain alone accounting for more disability than any other condition [2]. Disability related to back pain has increased, although there is no significant change in back injuries or pain [3, 4]. Headache disorders are frequently associated with work loss [5]. Despite advances in physiologic understanding and interventions, challenges associated with chronic pain and disability increase.

The pain associated with specific recognized physical conditions needs to be distinguished from somatoform pain disorder. The essential feature of somatoform pain disorder in DSM-IV [6] is 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. Somatization is defined as a person's conscious or unconscious use of the body or bodily symptoms for psychological purposes or psychological gain [7, 8]. Somatization is characterized by the propensity to experience and report somatic symptoms that have no

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pathophysiologic explanation, to misattribute them to disease, and to seek medical attention for them. Somatization can be acute or chronic and may be associated with medical comorbidity, an underlying psychiatric syndrome, a coexistent personality disorder, or a significant psychosocial stressor [9]. Somatoform disorders, factitious disorders, and malingering represent various degrees of illness behavior characterized by the process of somatization.

It is important to recognize that in chronic-pain states, physical and psychological factors typically are both present and overlap and that a quality physical examination is critical before dismissing the problem as being purely psychological.

The *biopsychosocial* approach is currently viewed as the most appropriate perspective to the understanding, assessment, and treatment of chronic-pain disorders and disability [2–4, 10, 11]. Chronic pain reflects a complex and dynamic interaction among biological, psychological, and social factors.

Pain, impairment, and disability may coexist, or be independent [5]. Pain is a subjective experience defined by the International Association for the Study of Pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage" [12]. Impairment is defined in the AMA *Guides to the Evaluation of Permanent Impairment* (AMA *Guides*) [13] as "a significant deviation, loss, or loss of use of any body system or function in an individual with a health condition, disorder, or disease." Typically, the AMA *Guides* determines impairment on the basis of specific objective findings, rather than on subjective complaints. The AMA *Guides* defines disability as "an umbrella term for activity limitations and/or participation restrictions in an individual with a health condition, disorder or disease." Waddell notes that pain is a symptom, not a clinical sign, or a diagnosis, or a disease, whereas disability is restricted activity [14]. Managing pain does not guarantee that the disability will lessen or resolve. There is not a direct relationship between pain and disability.

Although it is appealing to define disability on the basis of objective as opposed to subjective factors, this is not always the case. The Institute of Medicine Committee on Pain and Disability and Chronic Illness Behavior concluded that "the notion that all impairments should be verifiable by objective evidence is administratively necessary for an entitlement program. Yet this notion is fundamentally at odds with a realistic understanding of how disease and injury operate to incapacitate people. Except for a very few conditions, such as the loss of a limb, blindness, deafness, paralysis, or coma, most diseases and injuries do not prevent people from working by mechanical failure. Rather, people are incapacitated by a variety of unbearable sensations when they try to work" [15].

Assessing disability in the pain patient is thus a challenging endeavor. While some individuals present with a clear and direct connection between pathology and loss of function, it is problematic to measure loss of functional ability in the individual whose behavior and perception of disability and functional loss is significant, sometimes far exceeding that which would be expected from the physical pathology. Some people with chronic pain seek the designation of being "disabled" because of perceived incapacity associated with their portrayed pain and physical dysfunction. For some, seeking such designation is a logical extension of suffering a loss of capacity and utilizing an available benefit system. Others may portray being disability as a reflection of anger, dissatisfaction, or a sense of entitlement.

For some, the designation of being disabled is more complex and may involve seeking attention and/or other benefits that for some observers may seem excessive, unreasonable, and unnecessary. The request for assistance or insurance benefits may take various forms such as a disability parking permit, avoiding waiting lines, housing assistance, help with household chores, and benefits such as monetary payments or subsidies. The individual may claim incapacity (including from work) and request disability benefits under various private, state, or federal programs.

The physician performing a clinical evaluation that will be used to determine disability should perform a biopsychosocial assessment, recognizing the array of factors that relate to the experience of pain and disability. From a physical perspective, it is necessary to clarify the physical pathology. Some pathology cannot be directly measured (headache, neuropathic pain, etc.), and other pathology may have been missed (tumor, herniated disk, complex regional pain syndrome). Secondary to problems with chronic pain, there may be other problems, such as physical deconditioning and secondary psychological issues. Two individuals with similar injuries and resulting pathological changes may present with distinctly different experiences and perceptions. The first may have little or no complaints or perceived disability, while the second individual may present with significant pain behavior and dysfunction.

There may be other nonphysical (psychosocial, behavioral, and cultural) ramifications that may help explain the second individual's pain presentation and assertion of functional loss despite physical findings that do not support the reported disability. Assuming the individual is presenting in an honest and credible manner, the physician then must opine on impairment or functional issues considering physical and these other nonphysical factors. If requested, the physician may also opine on disability. Opining on disability requires an understanding of specific definitions of disability and often specific occupational functional requirements.

Symptom magnification, i.e., illness behavior, is common, particularly in the context of subjective experiences such as chronic pain or litigation. When the individual is not credible or there is purposeful misrepresentation, such as malingering, it may not be possible to accurately define any disability.

The assessment of disability associated with chronic pain is complex, and the evaluator must approach the clinical evaluation with recognition of the many factors associated with the experience of pain and disability.

Symptom Magnification and Malingering

Symptom magnification, inappropriate illness behavior, and embellishment are not uncommon (malingering is less common but occurs and should be considered), particularly in medicolegal circumstances and entitlement programs. Therefore, evaluators need to consider whether the presenting complaints are congruent with recognized conditions and known pathophysiology and have been consistent over time. The evaluator should also determine if there is inappropriate illness behavior.

Pain behaviors (i.e., facial grimacing, holding or supporting affected body part or area, limping or distorted gait, shifting, extremely slow movements, rigidity, moaning, or inappropriate use of a cane) may indicate symptom magnification.

Nonorganic findings, i.e., findings that are not explained by physical pathology, may also support a conclusion of symptom magnification. Nonorganic findings have been described dating back to the early part of the twentieth century [16]. Since that time, a number of nonorganic signs have been defined [17]. In an effort to maximize information from the evaluation, physicians routinely test for nonorganic physical signs. Gordon Waddell, M.D., described five signs to assist in determining the contribution of psychological factors to patients' low back pain [18]. He was specifically interested in developing screening tests to determine the likelihood a patient would have a good outcome from surgery. The physician must perform all five Waddell tests—evaluation for excessive tenderness, regional weakness, overreaction, distraction, and simulation. Isolated positive signs have no clinical or predictive value, and only a score of three or more positive signs is considered clinically significant. These tests were not designed to detect malingering.

Malingering is defined in the *Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition-Text Revised (DSM-IV-TR)* [19] as the "intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs." The DSM-IV-TR states:

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

1. Medicolegal context of presentation (e.g., the person is referred by an attorney to the clinician for examination)
2. Marked discrepancy between the person's claimed stress or disability and the objective findings
3. Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen
4. The presence of antisocial personality disorder

Malingering occurs along a spectrum—from embellishment to symptom magnification to blatant misrepresentation. The possibility of obtaining disability benefits or financial rewards or being relieved from other responsibilities, such as work, increases the likelihood of malingering. Patients may unconsciously or consciously exaggerate their symptoms. With malingering, the intent is purposeful. Ill-defined complaints occur in a circumscribed group, perhaps in a setting of poor morale or conflict, also may be viewed with suspicion. If there are suggestions of significant illness behavior or malingering, a careful investigation including a multidisciplinary evaluation and psychological testing may be required [20, 21].

Treating Physician Versus Independent Medical Evaluation

The treating physician who has a doctor–patient relationship with the claimant may have a different perspective than the "independent" disability evaluator. The treating physician often takes a patient-advocate role and may have little desire or experience to comment on disability, nor will that physician be able to define disability in an independent manner [22].

Frequently, conflict and distrust develops between claimants and the independent evaluating physicians who evaluate them and the claims examiners handling their claim. Patients often report that their problem is being discounting, while physician disability evaluators and claims representatives may express doubt and skepticism about claimants' chronic-pain complaints and reported loss of functional capacity.

The physician has the predicament of viewing the subjective reports in relationship with the objective evidence of tissue damage or organ pathology to come up with some final assessment about the extent to which the patient really is disabled from functional activities. It is not difficult to see how the treating physician advocating for the patient will have a different perspective than the "independent" physician evaluating a claimant for disability.

The "independent" medical evaluator (IME) is also not without his or her biases, and in some jurisdictions, only plaintiff and defense IMEs are the norm. The true IME is used by both sides and in some settings is referred to as the "agreed" medical evaluator (AME).

When the physician provides treatment, the doctor–patient relationship is one of trust. The physician is acting as an agent for the patient. When performing a disability evaluation, the physician is acting as agent for the state or agency requesting the evaluation. In 1992, Sullivan and Loeser recommended that physicians refuse to do disability evaluation on patients they are treating [23].

The problem with this is that adverse consequences may ensue for the patient who may be cut off from benefits absent a signed disability form.

Disability Versus Impairment

The two main terms when discussing disability are impairment and disability. The following definitions are from the AMA *Guides,* the World Health Organization (WHO), and from various state and federal programs.

The AMA *Guides to the Evaluation of Permanent Impairment*, Sixth Edition (hereafter referred to as the *Guides*), defines disability as "an umbrella term for activity limitations and/or participation restrictions in an individual with a health condition, disorder or disease." The AMA *Guides* defines *impairment* as "a significant deviation, loss, or loss of use of any body system or function in an individual with a health condition, disorder, or disease." The sixth edition, published in December 2007, introduces new approaches to rating impairment. The leadership for this edition was provided by Robert Rondinelli, M.D., an experienced physical medicine and rehabilitation physician; therefore, this edition reflects principles of this specialty. An innovative methodology is used to enhance the relevancy of impairment ratings, improve internal consistency, promote greater precision, and simplify the rating process. The approach is based on a modification of the conceptual framework of the International Classification of Functioning, Disability, and Health (ICF), although the fundamental principles underlying the *Guides* remain unchanged.

The World Health Organization (WHO) defines impairment as "any loss or abnormality of psychological, physiological or anatomical structure or function." Problems in body function or structure involve a significant deviation or loss. Impairments of structure can involve an anomaly, defect, loss, or other significant deviation in body structures.

The *International Classification of Functioning, Disability, and Health* (ICF) [24] changes the emphasis from the word "disability" to *activity* and *activity limitation* (WHO 2000). ICF defines activity as "something a person does, ranging from very basic elementary or simple to complex." Activity limitation is "a difficulty in the performance, accomplishment, or completion of an activity. Difficulties in performing activities occur when there is a qualitative or quantitative alteration in the way in which activities are carried out. Difficulty encompasses all the ways in which the doing of the activity may be affected."

Federal and state agencies generally use a definition that is specific to a particular program or service. To be found disabled for purposes of Social Security disability benefits, individuals must have a severe disability (or combination of disabilities) that has lasted, or is expected to last, at least 12 months or result in death and which prevents working at a "substantial gainful activity" level (1). Impairment is described as an anatomical, physiological, or psychological abnormality that can be shown by medically acceptable clinical and laboratory diagnostic techniques.

The Americans with Disabilities Act (ADA) has a three-part definition of *disability*. Under ADA, an individual with a disability is a person who (1) has a physical or mental impairment that substantially limits one or more major life activities, or (2) has a record of such an impairment, or (3) is regarded as having such an impairment. A *physical impairment* is defined by ADA as "any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine."

Regardless of the system, the term impairment defines a measurable change (any loss or abnormality psychological, physiological, or anatomical structure or function) and is consistent and measurable across different systems and programs. On the other hand, disability is a social construct in that each program or system defines it differently and assigns different weights and benefits to those definitions. One can be "disabled" in one system of benefits and not in another despite the same impairment. Disability usually results from an impairment that results in a functional loss of ability to perform an activity.

It is imperative to distinguish the difference between impairment and disability. One individual can be impaired significantly and have no disability, while another individual can be quite disabled with only limited impairment.

For example, a person with a below-knee amputation may be working full time quite successfully as a pianist and, therefore, would not meet the Social Security Administration (SSA's) definition of being disabled. On the other hand, this same pianist might have a relatively minor injury to a digital nerve that severely limits his/her ability to perform basic work activities such as playing a difficult piano concerto. In some disability systems, a person in this situation might meet the definition of partial disabled, even though he/she can do other work.

Perhaps, another way to distinguish the terms disability and impairment is as follows: Some diseases cause a negative change at the molecular, cellular, or tissue level which leads to a structural or functional change at the organ level, a measurable impairment. At the level of the person, there is a deficit in daily activities and this is the disability.

Because of this difference between impairment and disability, and despite the fact that many disability systems are work-injury-loss related, the widely used AMA *Guides* has stated that impairment ratings are not intended for use as direct determinants of work disability. The impairment rating is rather based on universal factors present in all individuals, the level of impact of the condition on performance

of activities of daily living, rather than on performance of work-related tasks. The sixth edition of the AMA *Guides* states on p. 6 that "the relationship between impairment and disability remains both complex and difficult, if not impossible, to predict."

While it is true that the AMA *Guides* is a widely used source (the vast majority of state workers' compensation systems require some use of the different editions of the AMA *Guides*) for assessing and rating an individual's permanent impairments, there are a number of states and the federal government's SSA disability program that do not recognize the AMA *Guides* for rating impairment. In addition, the Veterans Administration has its own unique set of disability rating criteria. There is clearly no consensus on a universal system to measure impairment.

Depending upon the system, impairment is necessary for disability, but other factors are considered. Different disability programs attempt to combine medical information and the associated impairment with nonmedical factors that bear on the individual's ability to compete in the open labor market. Other considerations include age, educational level, and past work experience. Physicians typically provide the data regarding the medical condition and impairment, while nonmedical issues are the purview of disability adjudicators.

The AMA Guides and Chronic Pain

The *Guides* provides a discussion of the assessment of pain in Chapter 3—Pain-Related Impairment. The AMA *Guides* states that subjective complaints are included in the provided impairment ratings, and up to 3% whole person permanent impairment may be provided in only unusual circumstances, including that there is no other basis to rate impairment.

Pain specialist physicians may feel that the AMA *Guides* method of impairment rating do not adequately address the "disability" and functional loss caused by some chronic-pain states. Since the *Guides* limits itself for the most part to describing measurable objective changes or impairment, chronic-pain states, despite causing significant functional losses, are not provided significant impairment ratings.

The American Academy of Pain Medicine has characterized pain with updated terminology, namely, *eudynia* for nociceptive pain and *maldynia* for neuropathic pain. Eudynia (nociceptive pain) is a normal physiologic response to noxious events and injury to somatic or visceral tissue. It can be beneficial and serves as an early warning mechanism. Eudynia often is acute, but can also be persistent (e.g., cancer pain). Eudynia usually is correlated directly with the resultant impairment. In this scenario, pain would appropriately be incorporated into the organ system impairment rating. Maldynia or neuropathic pain often results in significant dysfunction. Whatever pathology exists, it is not well measured with our current testing abilities and the clinician often has difficulty correlating the pathology with the level of reported dysfunction.

The AMA Guides and Maximal Medical Improvement (MMI)

The AMA *Guides* states that an impairment rating can only be done when the individual has reached maximal medical improvement (MMI), i.e., "the point at which a condition has stabilized and is unlikely to change (improve or worsen) substantially in the next year, with or without treatment." It is necessary to determine that the patient is stable and that no further restoration of function is probable. If the examinee shows up and is in the middle of a flare-up or has had a new injury that interferes with the examination, it is premature to do an impairment rating. In other words, the examinee must be stabilized medically for the physician to fairly assess the impairment rating. If the condition is changing or likely to improve substantially with medical treatment, the impairment is not permanent and should not be rated.

The AMA Guides and Activities of Daily Living (ADL)

The AMA *Guides* reflects the severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common activities of daily living (ADL), *excluding* work.

Throughout the fifth edition of the AMA *Guides*, the examiner is given the opportunity to adjust the impairment rating based on the extent of any activities of daily living (ADL) deficits (5th Ed). The fifth edition of the AMA *Guides* describes typical ADLs as:

- Self-care and personal hygiene (urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating)
- Communication (writing, typing, seeing, hearing, speaking)
- Physical activity (standing, sitting, reclining, walking, climbing stairs)
- Sensory function (hearing, seeing, tactile feeling, tasting, smelling)
- Nonspecialized hand activities (grasping, lifting, tactile discrimination)
- Travel (riding, driving, flying)
- Sexual function (orgasm, ejaculation, lubrication, erection)
- Sleep (restful, nocturnal sleep pattern)

In the sixth edition, a distinction is made between ADLs, basic activities (such as feeding, bathing, hygiene), and instrumented ADLs, complex activities (such as financial management and medications). This edition also distinguishes

between activity "execution of a task or action by an individual" and participation "involvement in a life situation" and between activity limitations "difficulties an individual may have in executing activities" and participation restrictions "problems an individual may experience in involvement in life situations."

AMA Guides Impairment Rating Percentages

A 0% whole person impairment (WPI) rating is assigned to an individual with an impairment if the impairment has no significant organ or body system functional consequences and does not limit the performance of the common activities of daily living. A 90–100% WP impairment indicates a very severe organ or body system impairment requiring the individual to be fully dependent on others for self-care, approaching death. The *Guides* impairment ratings reflect the severity and limitations of the organ/body system impairment and resulting functional limitations.

The AMA *Guides* provides weighted percentages for various body parts, but since the total impairment cannot exceed 100%, the Guides provides a combined values chart to enable the physician to account for the effects of multiple impairments with a summary value. Subjective concerns, including fatigue, difficulty in concentrating, and pain, when not accompanied by demonstrable clinical signs or other independent, measurable abnormalities, are generally not given separate impairment ratings. Impairment ratings in the Guides already have accounted for commonly associated pain, including that which may be experienced in areas distant to the specific site of pathology.

The Guides does not deny the existence or importance of these subjective complaints to the individual or their functional impact but notes that there has not yet identified an accepted method within the scientific literature to ascertain how these concerns consistently affect organ or body system functioning. The physician is encouraged to discuss these concerns and symptoms in the impairment evaluation.

The AMA Guides and Work Disability

Impairment assessment is provided by the *Guides*; however, the *Guides* does not define disability. An individual can have a disability in performing a specific work activity but not have a disability in any other social role. An impairment evaluation by a physician is only one aspect of disability determination. A disability determination also includes information about the individual's skills, education, job history, adaptability, age, and environment requirements and modifications. Assessing these factors can provide a more realistic picture of the effects of the impairment on the ability to perform complex work and social activities. If adaptations can be made to the environment, the individual may not be disabled from performing that activity (in this scenario though, the impairment is still present).

The *Guides* is not intended to be used for direct estimates of loss of work capacity (disability). Impairment percentages derived according to the Guides criteria do not measure work disability. Therefore, it is inappropriate to use the *Guides*' criteria or ratings to make direct estimates of work disability.

Independent Medical Evaluation (IME)

While an independent medical evaluation has some similarities to a comprehensive medical consultation, there are significant differences. An independent medical evaluation involves an examination by a health care professional at the request of a third party in which no medical care is provided.

The terminology for these evaluations varies in different areas of the country and includes terms like independent medical evaluation or examination (IME), or in California, an agreed medical evaluation (AME) or qualified medical evaluation or examination (QME). The AME serves both sides of a dispute at the same time and, in a sense, serves as the "medical judge." These evaluations otherwise are typically at the request of one side or the other (defense or plaintiff/applicant).

Medicine and law have different approaches. The practice of law is based on the advocacy system and is contentious and argumentative in nature by design. It is a system that allows different and conflicting points of view to be heard with resolution achieved by way of a jury, judge, or through arbitration. The practice of medicine is focused on diagnosing and treating patients to the best of the physician's ability to help them regain and maintain good health.

Physicians providing either a one-time consultation or ongoing medical care are accustomed to having their advice sought and followed by a usually grateful patient. Whereas in the legal system, physicians can expect to have their opinions challenged vigorously and in detail by skilled attorneys. In some cases, physicians may have their credentials and ability to testify as an expert questioned in a harsh and demeaning manner. While the attack may seem personal, in fact, it is only a method used by attorneys to discredit physicians' testimony to either have it thrown out or its value minimized. A skilled attorney will ask questions that are often difficult to answer, and physicians may find that the opportunity for explanation may be limited.

Possible Versus Probable

The gold standard for a medical opinion is "beyond a reasonable degree of medical probability." Physicians do not have to be 100% certain, but they must form opinions that are

medically probably or greater than a 50% chance of being correct. Anything less than this is termed "possible." Anything is possible, but to be accepted as medically reasonable, with a causal relationship, the term probable must be used. It is actually wise to keep away from using specific percentages, as this is hard to substantiate.

Evaluation Process

An independent medical evaluation involves an examination by a health care professional at the request of a third party in which no medical care is provided or suggested. The physician is not involved in the medical care of the examinee (there is no physician/patient relationship or privilege with some exceptions—please see liability issues below) and serves to provide a medical opinion to clarify issues associated with the case. The disability evaluation report is not necessarily to facilitate the well-being of the patient. Medical expertise is assumed for a disability evaluation, as is impartiality and objectivity, but such is not always the case. Unlike a medical consultation, the disability evaluation is not confidential and, further, should be easily read and understood by nonmedical personnel. Standards for independent medical evaluations have been published [25].

Referral Sources

Disability evaluations are an integral part of case management and are utilized widely by insurers and attorneys in a variety of arenas, including workers' compensation, personal injury, and long-term disability.

Workers' compensation systems are no fault, but litigation issues often center around causation, the extent and duration of medical care needs, the length of temporary disability, the extent and cost of permanent impairment and/or disability, and issues of apportionment to nonindustrial causation. An insurance carrier or third-party administrator typically handles claims. Some employers are partially or fully self-insured.

Personal injury litigation including malpractice cases involves primarily the cause and extent of injuries and the level of associated disability. Once a lawsuit is filed, the defendant is generally allowed one IME. In these cases, the defendant is counting on the IME to be unusually thorough as the case may hinge on the examination findings and report conclusions.

Long-term disability cases range from Social Security benefits for persons expected to be totally disabled for at least 12 months to individuals who have purchased or been provided by their employer private disability insurance policies.

Report Quality Issues

While the quality of the physician's testimony at a deposition, arbitration, or trial may be critical, the initial-typed report is typically most important. This report is relied upon in any settlement negotiation and often becomes part of the evidence. The disability evaluation report should be valid, defensible, and readable. A well-written report will assist the physician during cross-examination and may even discourage the opposing attorney from calling the physician to testify. The report itself may lead to early case settlement or resolution. Most often, the physician will be judged by the quality of the written report.

A quality evaluation report is responsive to the specific questions asked by the referral source. The report should be understandable by nonmedical individuals. Often, a verbal report is provided prior to submission of a written report, thus giving the referrer the opportunity to further direct specific questions or concerns or to even defer on receiving a written report. The physician should always maintain integrity but should remember that there is no traditional doctor–patient relationship and the payer is the client.

Report Writing Technique

Evaluation reports should be without spelling errors and should be grammatically correct. The report structure should include appropriate formatting with headings and categories. Bold lettering, italics, underlining, numbering, and bullet points can be used for clarity and emphasis. All material and records reviewed should be listed. Paragraphs should be kept relatively short, and separate ideas should be put in distinct categories. Unnecessary repetition should be avoided. It is of critical importance to use unambiguous language that can be easily understood by the referral source.

Pre-evaluation Issues

Prior to examining the claimant, the physician's office will receive a request for a disability evaluation by the referral source. A chart should be made up and all verbal and written correspondence noted in the record. It is important to provide documentation regarding charges, and usually a curriculum vita will be requested. Some physicians insist on a prepayment advance prior to reviewing records, providing an examination report, or attending a deposition, arbitration, or trial. Charges should include costs for late cancellations, records review, the actual examination, report writing, research, meeting time with the referral source, deposition, arbitration, and trial testimony time. It is important to identify who will

be notifying the examinee of the appointment date and time. It is appropriate to review records in advance to assure that all historical items are reviewed with the examinee.

Interactions with the Examinee

If the evaluation is being accomplished at the request of the examinee's attorney or as an agreed medical examiner, there is an implied understanding that the physician is serving in that individual's best interest. When examining for the defense (the "other side"), it is not uncommon to find an examinee who is, at a minimum, suspicious and maybe even hostile.

Depending on the jurisdiction, the claimant's attorney or representative and sometimes even a court reporter may attend the evaluation. This may or not be permissible, dependent on the setting. Any other individual attending the appointment should remain silent and not provide information except for significant others. The claimant may request to tape record the examination; however, whether this is permissible is dependent on the jurisdiction.

It is important in any scenario to carefully explain your role including the fact that the disability evaluation is not meant to be a comprehensive medical evaluation covering all possible problems and that no doctor–patient relationship is implied. Risk is reduced by having the examinee signed an informed consent form. There is usually no confidentiality. Typically, the disability evaluation physician's opinions and any recommendations are not discussed with the examinee unless such is specifically requested by the referral source.

It is recommended that the examinee be told to not perform any maneuver that her or she feels will be harmful to them. Adequate gown coverage is important and a chaperone is recommended.

Evaluation Report Writing

Introduction

Physicians are well aware of the usual details covered in a standard history and physical examination. The disability evaluation report goes into much greater detail in certain areas as compared to a medical consultation since often other factors contribute to the issues of portrayed pain and disability.

The examinee's pre-injury status is carefully detailed. It is very important to determine if there was any disability predating the injury. The history of the injury, subsequent events, and medical care up to the present time are carefully ascertained.

Any inconsistency between the individual's report and information found in the medical record is noted. It is important to remember that individuals often have selective memories and, sometimes, what they remember is not accurate. The medical record is of critical importance; however, it is possible that the health care professional left something out or misunderstood the examinee. Therefore, just because something is not reported in the medical record does not mean that it did not happen as described by the examinee.

A quality disability evaluation report takes all of these factors into consideration. The disability evaluation physician is neither a magician nor fortune-teller, but must assess all the information available and provide a medically reasonable explanation. All the disability evaluation physician can do is to give a sincere and honest opinion and state what is medically probable.

Identifying Information

The report starts out with the identifying information consisting of the date of the report, the name of address of the referral source(s), the name of the examinee, the claim or other identifying numbers (like the date of injury), and the date of the exam if different than the report date. For workers' compensation cases, the employer's name is often listed as well.

Purpose of the Examination

The report should be addressed directly to the referral source. The first report paragraph typically notes the purpose of the exam and any other specific questions asked or reasons for the evaluation. You may add a paragraph noting that the report is based upon the personal interview and examination of the examinee, combined with review of available medical records and radiographs and other submitted information. A list of all records reviewed is either listed in the body of the report or attached as an addendum. You may choose to ask to see examinee picture identification such as a driver's license. You should identify if the examinee was accompanied by an interpreter or any other person (significant other, friend, relative, lawyer, nurse, etc.) and whether the examinee tape recorded the examination. Document that the examinee was informed the purposes of the examination and that there was no doctor–patient relationship and that the examinee should not perform any maneuvers that the individual would consider harmful or injurious.

Examinee Introduction

The next paragraph lists the examinee's age, handedness, and marital status. In the workers' compensation arena, the employer, years on the job, and current work status can be listed.

Pertinent History

For most evaluations, there is a point in time when problems surfaced either due to a specific injury or illness or on a cumulative trauma basis, and this should be identified. You may identify that prior to some identified point in time, the examinee described being in good health without ongoing disability, or that second, the examinee had a pre-injury (or illness) history of pertinence. You should describe any *relevant* prior history of injuries or illness (this might include auto accidents, illnesses, prior work or other injuries, surgeries, etc.) and document a history from the examinee regarding the injury/illness itself and subsequent symptoms and medical care (including medications prescribed and tests/procedures accomplished). You should assess whether the history is consistent with the records, recognizing that examinees do not always recollect their medical history correctly nor are medical records always correct.

Current Symptoms

The current symptoms are carefully documented. A pain diagram can be useful. The examinee is given the opportunity to detail all symptoms and complaints. Any loss of function (activities of daily living) or loss of pre-injury capacity is described. Body parts involved include location and radiation of symptoms and referral patterns along with spatial characteristics, duration periodicity, and intensity/severity.

Pain complaints associated with disability are often described with two components: the character of the pain (i.e., continuous, non-fluctuating; continuous fluctuating; episodic; paroxysmal, etc.) and the quality of the pain (e.g., burning; freezing; sharp; pins and needles; aching; dull; hot; cold; numbing; and electrical).

Additional descriptors should be listed (tingling, numbness, weakness, swelling, color change, temperature change, sweating, skin or hair growth changes, etc.). Provocative or aggravating factors that worsen the pain and palliative factors that alleviate the symptoms should be detailed. The current intensity of the pain is described on a 10-point scale, where “0” represents no pain and “10” represents the worst pain imaginable. Any bowel, bladder, sexual, or sleep dysfunction should be described.

The presence of any examinee-perceived emotional (anxiety, depression, etc.) or cognitive dysfunction should be noted. Additional relevant information may be obtained from significant others.

Assess

1. What is the *cause of the pain* (the examinee’s perspective of what tissue abnormalities are causing the current problem)?
2. The *meaning of the pain* (what is and is not causing further tissue damage, and what is the meaning of the complaint is, i.e., whether there is progression, sinister illness, and/or concern present).
3. The *impact of the pain* on the examinee’s life including interference in vocational, social, recreational activities, etc. We recommend a listing of an average day and daily activities.
4. Note the examinee’s *perception of appropriate treatment*. An individual who is directed toward a passive treatment approach will have little interest in an active, functional restoration approach.
5. Note the examinee’s *goals* to be achieved with further treatment.

Functional History

Obtain information regarding activities of daily living (ADLs—feeding, grooming, bathing, dressing, and toileting) and physical functional activities during an average day (exercise, outdoor activities, shopping, recreation, household chores, etc.). A description of the examinee’s daily routine and changes from pre-injury status are documented.

Current and Past Medications

Obtain a list of past and current medications. We find it helpful to request that the examinee brings all current medications to the examination. The examiner should assess medication effectiveness, side effects, and any evidence of misuse or abuse.

Review of Systems

Consider constitutional, head and neck, cardiovascular, respiratory, genitourinary, gastrointestinal, neurological, psychiatric, and musculoskeletal symptoms in the review.

Past Medical and Surgical History

The examiner should especially note relevant injuries and illnesses including accidents (auto and other). There should be a review of all past significant or similar medical diagnoses, treatments, allergies, previous hospitalizations, and surgical procedures plus any history of psychiatric disorders/treatments/hospitalizations. Note potentially significant other medical problems like diabetes, cardiovascular or pulmonary disease, hypertension, arthritis, gout, etc.

Family History

The examinee should be questioned about relevant family history issues especially any alcoholism, substance abuse, major injuries, disability, pain, etc. Disability, illness, or death in the family may affect how the individual responds to his or her own medical problems. A family history of certain diseases may explain symptoms in the examinee that have not previously been well explained.

Personal History

Information in this section can be of critical importance, and areas of concern include the following:

- Childhood, i.e., was the examinee's childhood normal, dysfunctional, or abusive (sexual/verbal/physical)?
- Education, i.e., years of formal education, military service, and any legal history (litigation or incarceration).
- Marital status, i.e., has the examinee ever been married, how many times, and for how long? Was there any associated abuse history?
- Children, i.e., if there are children, what ages and how many? Is there a significant other and is that person working or disabled?
- Current living situation.
- Illicit substance use or abuse? If positive, provide previous and current usage level.
- Tobacco, caffeine, and alcohol usage.
- Current income source, if any (family members, workers' compensation, pension, long-term disability, state disability, Social Security, etc.).
- Work history: The occupational history should include not only the titles, types, and physical intensity of previous jobs but also continuity and length of previous positions. Attitudes about work (work "ethic") can be of considerable importance.

Physical Examination

The physical examination is similar for the disability evaluation as it is for a medical consultation, but it is important to document negative, positive, and nonorganic findings. If you are performing an impairment evaluation, perform the assessment according to specific examination requirements in the AMA *Guides*. When giving testimony, an opposing attorney can make the disability evaluating physician feel quite uncomfortable when parts of the examination are not documented.

The examination integrates information obtained from physical findings to support or refute diagnoses suggested during the history taking. The examination may uncover physical findings not readily apparent from the history or even known to the patient.

The physical examination is not limited to but is directed to the concerned body parts, and when a change or abnormality is identified, the appropriate regional examination is expanded.

The *general observation* of the examinee includes a behavioral examination including such issues as cooperation and attentiveness, along with any pain behaviors or unusual activities. The individual's sitting and standing tolerance is noted and all measurements recorded. Nonphysiologic findings are also noted.

Patient descriptors can include the patient as a good, poor, or fair historian and, when appropriate, can include such terms as pleasant and cooperative (vs. unpleasant and uncooperative), angry or hostile, and/or garrulous or loquacious.

Any *pain behavior* should be noted (verbal—sighing, moaning, groaning and nonverbal—grimacing, guarding, splinting, clutching, bizarre gait).

Constitutional findings refer to the examinee's general appearance (e.g., body habitus, deformities, development, nutrition, and attention to grooming) and vital signs (e.g., height, weight, temperature, blood pressure, pulse, respirations). Any adaptive aids such as braces/splints and walking aids/wheelchair are noted including whether such is appropriate or inappropriate.

Other physical examination findings, dependent on the context of the evaluation, may include:

- *Head, eyes, and ears*—General appearance, deformities, assistive devices (e.g., hearing aids, glasses), and visual/auditory acuity.
- *Mouth, throat, and nose*—General appearance, general dental condition, and patency of airway.
- *Neck*—General appearance, vascular distension, auscultation for bruits, active range of motion (AROM) and passive range of motion (PROM), and lymph nodes.
- *Cardiovascular*—Auscultation of the heart, examination of peripheral pulses, inspection of vascular refilling, varicosities, swelling, and edema.
- *Respiratory and chest*—General appearance of the chest, breasts for masses or tenderness, auscultation of lungs and upper airways, observation of breathing pattern, and examination for peripheral clubbing or cyanosis.
- *Gastrointestinal/genitourinary*—Inspection of abdomen and pelvis, auscultation of bowels, palpation of abdominal organs, and rectal examination.
- *Genitourinary*—Directed as appropriate.
- *Integumentary*—Inspection and palpation of skin and subcutaneous tissues for color, mottling, sweating, temperature changes, atrophy, tattoos, lesions, scars, rashes, ulcers, and surgical incisions.
- *Musculoskeletal*—Inspection, percussion, and palpation of joints, bones, and muscles/tendons noting any deformity, effusion, misalignment, laxity, crepitation, masses, or tenderness; assessment of AROM and PROM and stability of joints; inspection of muscle mass, spinal alignment, and symmetry; and assessment of muscle strength and tone.

- *Provocative tests*—Maneuvers for thoracic outlet syndrome, Phalen's and Tinel's for carpal tunnel, foraminal compression for cervical radiculopathy, straight leg raising for sciatica, etc.
- *Neurologic*—Assessment of level of consciousness (alert, lethargic, stuporous, comatose) and mental status (e.g., orientation, memory, attention and concentration, thought processes and content, speech and communication/language and naming, fund of knowledge, insights into current condition) and assessment of cranial nerves. The neurologic examination also includes assessment of (1) sensation to pinprick, two-point discrimination, sensibility, vibration, and proprioception; (2) assessment of sphincter tone and reflexes (e.g., bulbocavernosus); (3) assessment of deep tendon reflexes (DTR) in the upper and lower extremities, including pathologic reflexes (e.g., Babinski, Hoffman, palmomental, etc.); (4) assessment of coordination (e.g., finger/nose, heel/shin, rapid alternating movements) and tandem gait; and (5) functional mobility including gait and station.
- *Nonphysiologic behaviors*—assessed such as Waddell signs (e.g., superficial skin tenderness, stimulation of back pain by axial loading or trunk rotation, differences in straight leg raising response between supine and sitting positions, regional nonanatomic weakness or numbness, and overreaction/disproportionate pain responses).

Impression

List the diagnostic categories and/or the differential diagnoses.

Discussion

We recommend a succinct summary of the history and physical examination followed by opinions (when requested) on the specific issues requested by the client.

Causation and apportionment are often critical issues to be discussed along with prognosis. The evaluator must be able to determine whether the problem or disability was preexisting or caused by an event or occurrence, which is not a subject of the claim. If there is a basis for causation for the claim in question, is it fully or partially responsible?

The evaluator must be able to distinguish between an *aggravation and an exacerbation*. An aggravation results from a new event or injury causing a worsening, hastening, or deterioration of a preexisting condition. An exacerbation is a temporary increase in the symptomatology of a preexisting condition.

The issue of whether and when the examinee has reached *maximal medical improvement* (MMI) may also be addressed. The disability evaluator may also be asked to discuss the *prognosis and future medical care* needs of the condition and other costs as part of a life-care plan.

Lastly, the *face-to-face time* spent with the examinee should be listed (some physicians also document records review, research, and report preparation time as well) followed with the examiner's name and signature. Copies of the report to the appropriate parties should be noted.

Functional Capacity Evaluation

The disability evaluator may be asked to address the examinee's functional ability or work capacity. The opinion is based on a review of medical records, the historical and physical examination, test results, and the examinee's functional capacity. The evaluation is made difficult when the individual demonstrates pain behaviors and a suboptimal effort on examination and testing.

The report should include the number of hours to be worked per day, sitting, standing, and walking tolerance, as well as lifting and carrying capabilities. For the upper extremities, the ability to perform forceful and repetitive activities should be discussed. Other factors to be considered are reaching, pushing, pulling, grasping or gripping, bending, crouching, squatting, climbing, balancing, working on uneven terrain, and working at heights. For difficult cases, a formal functional capacity evaluation (FCE) may be helpful.

A physical or functional capacity evaluation (FCE) is a systematic process of assessing an individual's physical capacities and functional abilities. Testing, lasting one-half day to several days, is usually carried out by a physical or occupational therapist with special training and expertise in this area.

The FCE matches human performance levels to the demands of a specific job or work activity or occupation. The FCE establishes the physical level of work an individual can perform. The FCE is useful in determining job placement, job accommodation, or return to work after injury or illness. An FCE can provide objective information regarding functional work ability in the determination of occupational disability status.

The FCE is a tool that can be used to make objective and reliable assessments of the individual's condition. Its precise data format provides information that can be used in various contexts. The FCE may be used (1) to determine the individual's ability to safely return to work full time or on modified duty; (2) to determine if work restrictions, job modifications, or reasonable accommodations are necessary to prevent further injury; (3) to determine the extent to which impairments exist, or the degree of physical disability for compensation purposes; and (4) to predict the potential ability to perform work following acute rehabilitation or a work-hardening/work-conditioning program.

A physical or functional capacity evaluation (FCE) provides additional information beyond what can be determined by the physician-directed disability evaluation, but the FCE does have its limitations as well. The functional capacity of the examinee who does not provide a full effort cannot be accurately assessed. Further, while providing a greater depth of testing than the physician physical examination, the FCE can only measure capacity in a controlled environment over a short period of time and does not necessarily equate with full-time, real-world, everyday life and job tasks.

Reason for the Opinion

The evaluation physician cannot base opinions solely on only the basis of "education, training, and experience." Rather, the disability evaluator must provide a clear description of why a conclusion has been reached. What are the facts in the case that cause you to formulate that opinion? It is important to discuss unusual or abnormal findings.

Post-evaluation Issues

Disability evaluation reports should be completed and sent with appropriate billing to the referral source. The examinee and the treating physician are not provided copies of the disability evaluation report unless requested by the referral source although this is uncommon. Depending upon the particular situation, the referral source should be contacted by phone so the disability evaluator can discuss any opinions or recommendations. In some cases, a written report may not be required or desired at that time. This is particularly true when the opinion generated is not deemed to be in the best interest of the referral source's case.

Testimony

The disability evaluator should be prepared to be deposed and to attend an arbitration hearing or trial. Depositions are usually requested by the opposing counsel to gauge the potential effectiveness of the physician as a witness. Should the case go forward to arbitration or trial, the effectiveness of the disability evaluation physician goes beyond medical knowledge, but also involves the individual's presentation and demeanor in front of a judge and/or jury.

Credibility is always increased through the observer's perception of the physician's honesty and integrity. It is always best to be honest and not appear to be trying to "help" the case of the referral source. Any potential negative information or opinions should have been discussed previously with the referring attorney or claims person as to how to deal with it in the least damaging manner. While honesty and integrity are essential, there is no need to volunteer information that might be damaging to your referral source. It is ultimately the job of the disability evaluation physician to be an expert witness, not to "make" the case for the referral source. It is never appropriate to demean or demonize the claimant or treating physicians.

Physician Disability Evaluation Liability Issues

The claimant may not be pleased with the disability evaluator's opinions. In recent years, medical malpractice lawsuits against physicians who conduct disability evaluations have become more common. Despite the absence of a traditional physician–patient relationship, physicians who conduct disability evaluations still have various legal duties to the examinee, although this issue is in flux and ever changing [26]. Examinees generally can successfully sue IME physicians for negligently causing physical injury during the examination, failing to take reasonable steps to disclose significant medical findings to the patient, and disclosing confidential medical information to third parties without authorization, but they *cannot* successfully sue for inaccurate or missed diagnoses.

Summary

The evaluation of pain and disability is complex and multifaceted. The evaluating physician must approach such an evaluation from a biopsychosocial perspective. Often, these evaluations are performed in the context of an independent medical evaluation, i.e., an examination by a health care professional at the request of a third party in which no medical care is provided. The evaluation results in a report that must reflect a thorough evaluation, answer the specific issues requested by the client, and be easily understandable by nonmedical individuals. These evaluations are part of the legal or advocacy system that may be contentious and argumentative. The skilled independent medical examiner must always maintain impartiality and provide conclusions that are supportable. A thoughtful and thorough evaluation is of considerable value to all involved.

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