

UNDERSTANDING PAIN RELATED IMPAIRMENT: CHAPTER 18 OF THE AMA GUIDES

INTRODUCTION

This course involves reviewing the following materials as well as Chapter 18 of the AMA Guides (5th Edition). The chapter is not provided as part of this course since it is copyrighted material. The learning objectives include:

LEARNING OBJECTIVES

Explain the 3 conditions under which Chapter 18 might apply
Explain the 3 conditions under which Chapter 18 is not to be used
Discuss the questions to help determine pain-related impairment

Even though the Guides emphasize objective assessment of impairment (Chapters 3 through 17), there is a separate allowance for up to an additional 3% whole person impairment (WPI) when pain is above and beyond what would be expected for a particular condition. However, non-verifiable pain conditions as outlined in the chapter (such as fibromyalgia) are not ratable. In California, the schedule for rating permanent disabilities (SRPD) states the following (page 1-12):

THE SRPD AND PAIN

Pursuant to Chapter 18 of the AMA Guides, a whole person impairment rating based on the body or organ rating system of the AMA Guides (Chapters 3 through 17) may be increased by 0% up to 3% WPI if the burden of the worker's condition has been increased by pain related impairment in excess of the pain component already incorporated in the WPI rating in Chapters 3-17 (AMA Guides, page 573).

A physician may perform a formal pain related impairment assessment if deemed necessary to justify the increase of an impairment rating based on the body or organ rating system (see Section 18.3F of the AMA Guides starting on page 575). The maximum allowance for pain resulting from a single injury is 3% WPI regardless of the number of impairments resulting

from that injury. The addition of up to 3% for pain is to be made at the whole person level.

In the case of multiple impairments, the evaluating physician shall, when medically justifiable, attribute the pain in whole number increments to the appropriate impairments. The additional percentage added for pain will be applied to the respective impairments as described in the preceding paragraph. Even under this condition, the total cannot be more than 3% WPI.

The add-on for pain is given in less than 1% of cases nationally. This is because the AMA Guides indicate that all normal pain is included in the underlying ratings (Chapters 3 to 17). Chapter 18 indicates that an add-on for pain is only to be given when the pain is greater than expected, the applicant is credible, and the pain significantly impacts the activities of daily living (ADL). Because of these restrictions in the Guides, evaluators nationally will rarely give the pain add-on (less than 1%). However, it is likely that the add-on for pain is higher in California, although I do not know of any data on this issue. The add-on for pain for up to 3% WPI can be done anytime there is a minimal rating of 1% WPI or greater for the industrial condition. The add-on for pain cannot be included if the underlying rating for the industrial condition is 0% WPI.

It may very well be that with the passage of SB863 that excludes psychiatric and sleep disorder impairments derivative to a physical injury, the pain add-on will become more frequent. In the past, the "additional burden" of chronic pain was likely taken into account in the derivative psychiatric injury and associated impairment rating (The GAF with associated WPI impairment). With that option no longer available (at least for recent injuries), the "additional burden" and "pain in excess of the verifiable medical condition" will likely be subsumed under the pain impairment add-on as outlined in Chapter 18. Of course, this "burden" can only add up to 3% WPI.

OVERVIEW OF CHAPTER 18

In Chapter 18 of the AMA Guides (5th Edition), it is discussed that

"It is considerably more difficult to provide a method for assessing, chronic, persistent pain than acute pain. In chronic pain states, there is often no demonstrable active disease or unhealed injury, and the anatomic changes that accompany acute pain, even in the anesthetized individual, are typically absent." (page 566).

The Guides go on to state that, historically, it was assumed that there would be a relatively high correlation between peripheral tissue pathology (or tissue injury) and an individual complaints of pain or pain behaviors. Although this is largely true in acute pain, it is often not true in chronic pain states. As discussed in our series of courses on chronic pain, the older Cartesian model of pain was termed a "specificity model." This model purported that tissue injury and pain perception are highly correlated regardless of any other factors (e.g. length of the pain, non-physical factors, etc.). However, new research has clearly demonstrated that the specificity theory does not adequately explain many pain conditions. Since Wall and Melack's ground breaking work in the early 1960's (the gate control theory of pain), newer models of pain take into account the non-anatomical contributions to an individual's perception of pain, beyond nociceptive input.

In order to properly understand and utilize the principles outlined in Chapter 18, the forensic evaluator must be familiar with modern theories and principles of chronic pain. This is summarized in Chapter 18 on page 568 in the following statement:

"The behavioral concept of CPS and the neurophysiological concept of peripheral or central nervous system sensitization imply that pain and pain-related activity restrictions may be dissociated from the biological insult to which a person was exposed and from any measurable biological dysfunction in that person's organs or body parts. Both concepts thus challenge the assumed linkages among biological insult, organ, or body part dysfunction, and ADL deficits that are fundamental to AMA rating system."

Current theories of pain, and treatments, are discussed in other courses and are important to review.

WHEN TO USE CHAPTER 18

As discussed in Chapter 18 (18.3A), the pain chapter should be used under the following circumstances:

WHEN TO USE CHAPTER 18

When there is excess pain in the context of verifiable medical conditions that cause pain-

When there are well established pain syndromes without significant, identifiable organ dysfunction to explain the pain-

When there are other associated pain syndromes-

When there is excess pain in the context of verifiable medical conditions that cause pain-

In this group, individuals have pain associated with a medical condition that is verifiable by objective evidence. As discussed in the chapter, an example would be an individual who has persistent lumbar radiculopathy after undergoing a lumbar discectomy. This individual will usually have objective evidence and receive an appropriate DRE spine impairment rating as discussed in Chapter 15. In most cases, the DRE rating is appropriate; however, in some individuals, the persistent lumbar radiculopathy may be associated with "excess pain." In the Guides, "excess" pain is characterized by the pain causing severe ADL deficits that suggest an impairment level greater than the spine DRE (It should be noted that sleep is considered an ADL and that pain often disrupts sleep). In this case, the concepts and additional impairment rating discussed in Chapter 18 may be appropriate.

When there are well established pain syndromes without significant, identifiable organ dysfunction to explain the pain-

In this group, individuals demonstrate a chronic pain syndrome associated with diagnoses that characteristically do not have a definable tissue pathology, but are based on clinical presentation. These syndromes are not ratable under the conventional rating system. Examples include such things as headache, post-herpetic neuralgia, Tic Douloureux, Erythromelalgia, Complex Regional Pain Syndrome, or an injury to the nervous system (please see Table 18-1). As discussed in the Guides, individuals with these well established pain syndromes can be evaluated on the basis of concepts elaborated in Chapter 18.

When there are other associated pain syndromes-

Chapter 18 can also be used to evaluate pain related impairment when dealing with syndromes characterized by the following:

- A). They are associated with identifiable organ dysfunction, that is ratable, according to other chapters in the Guide;
- B.) They may be associated with well established pain syndromes;
- C.) The impairment ratings in other chapters do not capture the added burden of illness born by the individual. Examples of individuals in this category are provided in Table 18-2.

WHEN NOT TO USE CHAPTER 18

The chapter goes on to discuss when the chapter should not be used to rate pain related impairment. Please review these sections in detail. They include the following:

WHEN NOT TO USE CHAPTER 18

Conditions are adequately rated in other chapters of the Guides
When rating individuals with low credibility
When there are ambiguous or controversial pain syndromes

Of these three criteria, determining whether an individual has reasonable credibility is probably the most challenging. The lack of credibility of an individual may be associated with either partial or full malingering. Research has suggested that it is extremely difficult to consistently identify those individuals engaging in such behavior. The multi-modal assessment of an individual's credibility (or possible malingering) is discussed in detail in the other pain courses.

Section 18.3D provides a detailed protocol for assessing pain related impairment. This is also outlined in Figure 18-1. Please review this material as part of this course. This is also presented in a question-answer decision-making algorithm to be presented subsequently.

Section 18.3F also discusses how to rate pain related impairments within the framework of "practical steps." This section describes a six step process which can be summarized as follows. In addition, Table 18-4 provides a

"ratings determining impairment associated with pain" questionnaire. According to Chapter 18, the questions provided in Table 18-4 can either be administered by clinician interview or to the individual to complete on his or her own. As can be seen in Table 18-4, there are three sections:

- I. Pain (self-report of severity)
- II. Activity Limitation or Interference
- III. Individuals Report of Affect of Pain on Mood

Each of these sections is added for a total score that is divided by the number of questions to provide a mean. This questionnaire, when used with the credible individual, can certainly provide valuable objective information relative to establishing the presence or absence of "excess pain" and "increased burden."

Chapter 18 goes on to address the issue of assessing whether the individual is at MMI as well as determining the severity of the pain (page 577). It also instructs the evaluator to determine activity restrictions as presented on page 578. In this section, it is discussed that it is useful to provide quantification of functional limitations via accepted standardized instruments that permit inter-rater comparison. The Guides give examples of the Pain Disability Index (PDI), the SF36, the Oswestry, and the Roland Morris. Assessment of ADLs as listed in Table 1-2 can also be completed.

On page 579, there is a discussion relative to the importance of determining the presence of emotional distress associated with the chronic pain. This may be the most difficult issue to assess if the pain impairment assessment is being completed by a non-mental health professional. Aside from possibly a physical medicine and rehabilitation physician, it would be unusual for a non-psychiatrist, non-psychologist Physician QME to complete an assessment of the individual's emotional distress. Even so, this aspect of the chronic pain syndrome should not be ignored. This section gives examples of objective measures that can be used to assess depression and/or anxiety. Alternatively, a consultation with a mental health evaluator may be appropriate.

The Chapter goes on to direct the evaluator to "determine if pain behaviors are present," (page 579). This section discusses that individuals can present in various ways relative to how they communicate their pain. Some individuals may be fairly dramatic while others appear stoic. This section discusses that an examiner has a two-fold task regarding pain behaviors demonstrated by a person undergoing an impairment rating:

- (1) To identify the pain behaviors
- (2) Interpret their significance

It should be noted that the credibility of an individual may or may not be associated with whether they "exaggerate" pain behaviors. It should also be noted that "exaggeration" and "symptom amplification" are different things. In current thinking, relative to the credible individual with a chronic pain syndrome, we refer to "symptom amplification" rather than "exaggeration". Again, the entirety of this discussion is referring to the credible individual. In the credible individual, one may find symptom amplification which is defined as pain behaviors beyond what would be expected due to nociceptive input. In fact, by definition, this is the type of individual that should be evaluated under the Guidelines in Chapter 18. On the other hand, a low credibility individual who shows exaggerated pain behaviors is likely malingering to some degree or the pain behaviors are being exaggerated purposefully (consciously). In the credible individual, although symptom amplification may be occurring, this is most often due to the contribution of non-physical factors including cognitive, affective, and operant influences. This can also be due to physical and mental deconditioning. As such, the pain behaviors are indicative of the individual's "suffering." All of these concepts should be very familiar to the forensic evaluator relative to chronic pain impairment. All of these concepts are discussed in the other pain courses.

All too often, individuals not familiar with current theories of pain and the contribution of non-physical factors in the credible individual will automatically assume that any evidence of symptom amplification is malingering or purposeful. This is absolutely not the case.

Table 18-5 suggests a method for assessing pain behavior. It suggests rating the individual's pain behaviors on a scale of -10 to +10. The lower end of the scale (-10) is defined as pain behaviors are exaggerated, non-physiologic. A score of zero indicates pain behaviors are mixed or ambiguous. The higher end of the scale, (+10) indicates pain behaviors are appropriate and tend to confirm other clinical findings.

Quite frankly, I find this aspect of assessing pain behaviors somewhat confusing and inconsistent. There are many credible individuals with a chronic pain syndrome (within the context of known medical conditions) that show "exaggerated" pain behaviors and non-physiological findings. Again, this typically falls under the rubric of symptom amplification or "pain behaviors beyond what would be expected due to nociceptive input and physical findings." This is especially true in failed spine surgery cases. In these individuals, the failed spine surgeries often results in extended

disability. This, in turn, perpetuates the mental and physical deconditioning syndrome as nicely described by Gatchel (please see the other pain courses to review this concept in detail). This develops into a full blown chronic pain syndrome. Part of this chronic pain syndrome often includes what might be termed amplified pain behaviors that have a non-physiologic distribution. It should be emphasized that these findings occur in credible individuals and do not represent malingering. Using the assessment of pain behavior as discussed in Table 18-5, these credible individuals with clear medical findings would definitely show symptom amplification and non-physiological patterns. Even so, they might very well meet the criteria of an added burden due to the chronic pain.

As an overall comment, I am not sure what value the assessment provided in Table 18-5 provides relative to the Pain Impairment Add-On. If one establishes that the individual is credible, then simply discussing observable pain behaviors and their impact on ADLs would seem to be adequate.

In addition, it appears that the impairment classes as discussed in Table 18-3 provide limited usefulness. In California, as will be discussed, the evaluator can add up to 3% whole person impairment (in total) for chronic pain. Assigning whether an individual falls in one of the classes outlined in 18-3 (mild, moderate, moderately-severe, severe) does not correlate with any objective impairment value. For some clinicians, providing this analysis may help determine a specific value of chronic pain impairment ranging from 0% to a maximum of 3% WPI. Beyond that, I am not sure of the usefulness of this evaluation.

Section 18.5 provides a sample protocol for assessing pain related impairment. Please review that section in its entirety. Again, related to my previous comments, this section discusses that the evaluator is to assign a score between -10 and +10 relative to pain behaviors (Table 18-5). Under the instructions for this sample protocol (page 583) it discusses that the evaluator is to assign a score and that -10 indicates "very low credibility" and +10 indicates "very high credibility." I do not know of any research that supports this conclusion since many individuals with a legitimate chronic pain syndrome, and of high credibility, will demonstrate "exaggerated" pain behaviors (or more appropriately termed "symptom amplification" along with non-physiological findings). Therefore, I do not believe that evaluating pain behaviors in this manner is an indicator of credibility. This is similar to the common mistake and assumption that Waddell signs are an indicator of malingering or credibility. Waddell signs simply assess the possibility that the individual is showing pain behaviors beyond what might be expected due to physical findings. The reason for these positive findings is not discussed by Dr. Waddell in terms of malingering. Rather, they are simply an

assessment of whether other non-physical factors may be contributing to the individual's presentation of pain behaviors (whatever those other factors might be). Again, these issues underscore the importance of having a good understanding of the multi-modal causative factors in a chronic pain syndrome.

The chapter goes on to discuss such issues as psychogenic pain and malingering. Section 18.9 provides case examples. Please review all of this material as part of this course.

SUMMARY:

As discussed in the previous overview of the chapter, the following criteria must be met to give an additional impairment rating for pain:

When there is excess pain in the context of verifiable medical conditions that cause pain

When there are well established pain syndromes without significant, identifiable organ dysfunction to explain the pain

It should be noted that the pain impairment is not to be used under the following conditions:

A low credible individual,
Non-verifiable medical conditions, or
Ambiguous/controversial pain syndromes.

To justify an additional impairment rating for pain, the following questions must be answered. This is consistent with the six steps outlined in Chapter 18. Considering these questions relative to the chronic pain patient can help the evaluator determine the appropriateness of the pain impairment add-on.

DETERMINING PAIN-RELATED IMPAIRMENT: QUESTIONS

Does the body system impairment rating (from Chapters 3-17) adequately encompass the individual's pain?

- A) Yes - stop here, you cannot give an additional impairment for pain.
- B) No - go to the next question.

Does the pain related impairment increase the burden of the individual's condition slightly or severely?

- A) No - stop here.
- B) Yes - go on to the next question.

Is the individual credible?

- A) No - stop here.
- B) Yes - go on to the next question.

Does the individual's pain symptoms and/or physical findings match any known medical condition?

- A) No - stop here.
- B) Yes - go on to the next question.

Is the individual's pain presentation typical of the diagnosed condition?

- A) No - stop here.
- B) Yes - go on to the next question.

Is the diagnosed pain condition one that is widely accepted by physicians as having a well defined pathophysiological basis?

- A) No - stop here.
- B) Yes - you can give up to an additional 3% WPI rating by body region.