

MENTAL IMPAIRMENT RATING

OBJECTIVES – MENTAL AND BEHAVIORAL DISORDERS

1. Identify the axes used in the diagnostic and statistical manual of mental disorders - DSM.
2. Understand the relationship between diagnosis and degree of impairment.
3. List sources of information which may be used to obtain descriptions of an individual's impairment.
4. Describe the types and uses of psychological tests in the overall evaluation of impairment.
5. Apply the guides for mental impairment rating to each area of function appropriately using a case.
6. Describe the method for calculation of psychiatric impairment rating when all areas of function have been rated.
7. Define the four areas of function used in rating mental impairment and give examples of activities in each of the areas.
8. Understand the complexity of assessment of impairment due to pain perception.
9. Classify impairment due to mental and behavioral disorders using the draft method in this section.

MENTAL AND BEHAVIORAL DISORDERS

INTRODUCTION

The psychiatric examination for Workers' Compensation is more specialized than a general psychiatric exam because the examiner must assess causality, the course of the illness and the response to psychiatric treatment in addition to making a diagnosis.

Only those psychiatric diagnoses classified in the latest version of the Diagnostic Statistical Manual (DSM) can be attributable to a work injury. For purposes of impairment rating, case law directs that the mental status of a worker at the time of the injury is the baseline from which to evaluate impairment for every worker including those with a past history of psychiatric disorders.

The examiner should explain the nature and purpose of the examination to the worker at the outset. The rapport essential to conducting an accurate psychiatric rating may be difficult to establish because the worker and those supporting or opposing the application may presume the clinician is biased about the examination. The clinician must rely on his or her empathic skills while gathering information and is influenced by his or her own beliefs, attitudes and experiences regarding mental illness.

THE PSYCHIATRIC EXAMINATION

The development of rapport with the examiner is based on the examinee's compliance and cooperation and the interviewer's interpersonal skills. The claimant's general posture and issues of candor, openness, disclosure, defensiveness and resistance should be noted. An open-ended interview style is recommended. The psychiatric examination includes the following sections:

- Description of causal work event.
- History of immediate or ensuing physical injury.
- History of immediate emotional impact and ensuing psychiatric disorder (emotional injuries).
- Review of the worker's basic psychological development is best obtained in an empathic and genuine conversation which includes:
 - Composition of nuclear family including birthplace.
 - Earlier relationships with family members or those with significant influence.
 - Performance in school including highest level of education.
 - Social adjustment growing up.
- Experience with use of alcohol and or drugs.
- History of emotional, physical or sexual abuse

- Detailed history of past psychiatric treatment.
- Detailed occupational history.
- Family psychiatric history
- Legal history – previous workers’ compensation claims, motor vehicle accidents and litigations.
- Current adjustment consisting of detailed description of a typical day’s activities from getting up to going to bed.
- Description of sleep, other daily living activities and sex.
- Detailed description of current enjoyable activities including social relationships and phone calls during the day.
- Description of how the work injury has affected the worker’s life in general (in worker’s own words).
- Mental status examination – attempt to describe the claimant in a manner which allows the non-physician reader to see and hear the worker through the clinician.
 - Complete description of appearance, general behavior and demeanor.
 - Assessment of affect, mood, cognition and thought processes.
 - A detailed description of how the claimant got to the examiner’s office may aid in describing cognitive function.

PRINCIPLES CENTRAL TO ASSESSING MENTAL IMPAIRMENT:

- **Psychiatric Diagnosis**
The latest DSM is the most widely accepted classification for mental disorders. There are 5 axes:
 - Axis 1 The clinical disorders and/or problems
 - Axis 2 Personality and chronic developmental disorders
 - Axis 3 Physical disorders
 - Axis 4 Psychosocial stressors
 - Axis 5 Global assessment of functioning (0 – 100 scale)
- Axis I should reflect the work-related diagnosis.
- **Longitudinal History of Impairment and Psychiatric Treatments**
The history of the psychiatric disorder(s) and treatment(s) allows for proper interpretation of the final impairment. Consider whether the diagnosis is chronic and what treatments will be required to maintain maximal improvement. Assume that permanent psychiatric impairments will require long term treatment.

DETERMINING MMI

Workers who have not received medically necessary and appropriate treatment are not at psychiatric MMI. For example, the examiner must assess whether maximal doses of medications and psychiatric therapy have been utilized to abate symptoms before the worker is considered at psychiatric MMI.

CHRONIC PSYCHIATRIC DIAGNOSES

If a psychiatric diagnosis preceded the injury, several sources can be used to establish the degree of prior impairment. Medical records from hospitals, clinics, psychiatrists and psychologists should be used to document psychiatric disorders.

Non-medical records from family members and any other sources can be used to document activities of daily living, social functions, concentration and response to stress.

USEFULNESS OF PSYCHOLOGICAL TESTS

Primary physicians should consider using standardized, brief tests to screen for the presence of depression, anxiety and other similar symptoms, requiring a psychiatric evaluation.

Other well-standardized tests such as the Rorschach, Thematic Apperception Test (TAT) and the MMPI (Minnesota Multiphasic Personality Inventory) may be useful in establishing diagnosis and chronicity. The WAIS (Wechsler Adult Intelligence Scale) may be useful in determining mental retardation. In cases of closed head injury, broad-based neuropsychological assessments such as the Halstead-Reitan or Luria-Nebraska may aid in determining brain function deficiencies. A list of available tests is found in the tabbed section of this notebook designated "Mental Impairment Forms."

SOCIAL SECURITY ASSESSMENT METHODS

The Social Security Administration suggests four areas for assessing the severity of mental impairments which have been adopted by the AMA Guides and are used by the Division of Workers' Compensation impairment rating system.

1. Activities of daily living
2. Social functioning
3. Concentration, persistence and pace
4. Adaptive functioning and response to stress

DIVISION OF WORKERS' COMPENSATION PSYCHIATRIC IMPAIRMENT RATING SYSTEM

General Instructions

In order to determine impairment for each subcategory of the areas of function, the examiner must first determine the individual's pre-injury performance in that area. The baseline performance descriptions for each subcategory are based on a population "norm." If the examinee's pre-injury performance falls below the baseline or norm and into an impaired category, determine whether any additional impairment has occurred from this work-related condition. Some patients with a pre-injury performance at variance from the stated population norm do not have a specific DSM diagnosis. The pre-injury performance level is merely a reflection of that individual's general level of function. Therefore, a lower than "normal" baseline performance need not be considered an apportionable condition requiring a separate worksheet.

For example, an individual who functioned pre-injury without a significant other, who has no close friends, meaningful relationship or group affiliations, has a low baseline in interpersonal relationships and should not be rated as impaired if their level of function did not change after the injury. By contrast, the previously gregarious or friendly worker who becomes less involved and avoidant after the injury should be rated with an impairment.

After the baseline performance of the individual has been determined, assign an appropriate impairment category to the individual. In general **minimal** impairment reflects a small amount of impairment in the subcategory, within which the patient is able to function without externally noticeable difficulty. An impairment for which the individual is able to self-correct without external assistance would be considered minimal. A **mild** impairment is one which has a greater effect on an individual's function and may require a small amount of interaction with others to correct. A **moderate** impairment is one in which others have noted the individual's functional deficit and requires external interaction with the individual for correction. A **marked** impairment is one in which the individual suffers frequent external problems secondary to the functional deficit despite interventions from others to correct the impairment. Very few individuals fall into the **extreme** or **maximum** impairment category. **Extremely** impaired individuals require frequent and concentrated intervention by others in order to maintain a minimally acceptable level of function within the subcategory. **Maximum** impairment is one in which the individual requires constant supervision or help from others in order to maintain any control over the subcategory.

For example, an individual who is frequently late for work resulting in suspension has a marked impairment in performing activities on schedule. An individual who needs help from his family to stay organized in order to get to work on time has a mild impairment in performing activities on schedule.

Pain

The rating of chronic pain is controlled by the statute. Chronic pain can only be rated when there is presence of an “anatomic or physiological correlation. Anatomical correlation must be based on objective findings.” §8-42-101(3.7), C.R.S. (2004). Therefore, a rating for pain cannot be given unless there is objective, physical presence of an injury. The AMA Guides, 3rd Edition (revised) does not encourage a rating of chronic pain in any areas other than those covered by the physical impairment rating system. (Refer to definition of chronic pain and impairment in appendix B, p. 252.) Psychiatric impairment ratings should be restricted to DSM diagnosis such as depression, adjustment or anxiety disorder, or other appropriate diagnosis and should not include pain disorder associated with psychological factors (307.80) nor pain disorder associated with general medical condition, which has no code in the DSM. The third possible category, pain disorder associated with both psychological factors and the general medical condition (307.89), would require the presence of other documented psychiatric symptoms which are usually found under depressive disorders, anxiety disorders, adjustment disorder or social phobia. Therefore, its use is not recommended. Evaluators should use the appropriate DSM categories for these disorders rather than “pain disorder with both associated psychological factors and the general medical condition”.

These principles apply to the following example. A worker’s ability to travel is impaired due to chronic back pain. This impairment is rated as part of the “anatomic or physiological” physical impairment. On the other hand, if a worker were injured in a truck accident, and is avoiding interstate freeways due to a phobia or post traumatic stress disorder, this impairment is rated as a psychiatric travel impairment under activities of daily living.

Medications

Any patient on medication must be rated as they are while using the medication. If a patient has refused to take a recommended medication or treatment, the patient is rated as he/she presents, without the medication or treatment recommended.

If a patient takes maintenance medications which enable him/her to function with no psychiatric impairment—in other words, all Areas of Function on the worksheet are rated as “zero” impairment—1-3% may be assigned for the use of the medication (see section V on the Mental Impairment worksheet). This 1-3% is assigned solely due to the requirement for medication maintenance treatment that did not exist previously. This applies to patients who take new or additional medication due to the work-related condition, as well as a worker who has not taken such medication prior to the injury. Patients who merit ratable mental impairments as assessed on the worksheet should not be assigned this 1-3% under Sec. V.

Patients may also experience side effects from maintenance medication. These side effects from psychiatric medication can be rated under the psychiatric subcategories or physical impairment as appropriate. Patients who are non-compliant with their prescribed medication should be rated as they are, but no additional points should be allowed for medication use.

The physician under these circumstances may consider adjusting the final calculation using Section IV, Final Calculation.

Evaluator Beware

Many of the functions found on the psychiatric worksheet overlap impairments which may also be present due to the physical injury. If the patient has an impairment due to a physical problem, for example chronic low back pain affecting sleep, then the condition may not be rated on the psychiatric worksheet. Only conditions caused by the DSM established diagnoses can be rated on the worksheet. This is particularly important to remember in the areas of self-care and hygiene, travel, sexual function and sleep.

Remember that neurological function and other rating sections may overlap with mental and behavioral function. The same patient may not receive an impairment for loss of thinking, judgment, etc., under the neurological rating and the psychiatric rating. A patient cannot receive ratings for the same functional impairment from two sections of the AMA Guides.

Many of the subcategories under the Area of Function “Thinking, Concentration and Judgment” can be affected by brain pathology rather than psychiatric disorders. If abnormalities are found which are inconsistent with the patient’s established diagnosis or medication use, the patient should be referred for specialty consultation. If the patient is impaired due to a brain injury, the cognitive impairment must be rated in the neurological section and not on the mental disorder worksheet.

Occasionally workers with scars or disfigurement may qualify for an impairment rating if the scar or disfigurement causes a psychiatric disorder classified in the DSM. Any psychiatric component that is combined with the functional rating would need to be substantiated. There must be demonstrable changes in daily tasks or usual activities due to the psychological effect of the scar only, not due to any physiological effects of the scar, such as decreased range of motion.

Activities of Daily Living

No category sheets have been provided for the subcategories Self-care and Hygiene and Travel. Self-care and hygiene are usually not permanently affected by work-related psychiatric problems unless there is very severe depression which cannot be reversed with treatment. Therefore the majority of self-care and hygiene problems will be due to physical problems or pain secondary to the physical diagnosis. These issues **cannot** be rated on the psychiatric worksheet. Travel is most often affected by a physical diagnosis, such as low back pain or neck pain, rather than psychiatric diagnoses. The same precautions are true for sexual functions and sleep since these functions are commonly affected by pain from a physical source, which is rated in the physical impairment rating section rather than as a psychiatric problem. Note, however, that many psychotropic medications do cause sexual side effects which require a psychiatric impairment rating.

Apportionment

If at the time of the injury, the worker's functioning was impaired from a DSM diagnosis, then the examiner must apportion the past impairment from the current impairment. This is done by evaluating the four areas of function as the patient functioned immediately prior to the current injury and subtracting that impairment rating from any present rating.

Do not assume that if a worker has a past history of a psychiatric disorder, he or she was necessarily impaired at the time of the injury. Many individuals with past psychiatric disorders return to their normal or baseline functioning. Others re-stabilize at lower baselines without a DSM diagnosis; however, some are impaired with chronic DSM diagnoses.

In 2008 the law regarding apportionment of preexisting conditions changed for cases with a date of injury on or after July 1, 2008. In those cases, where the *prior* injury or condition was *non-work-related*, apportionment may only apply if that prior condition was identified, treated, and independently disabling at the time of the current work-related injury. For details, see the Apportionment of Impairment "flow chart" at the end of the "WC Reports" section of this curriculum notebook.

ISOLATED PSYCHIATRIC IMPAIRMENT UNDER THE COLORADO STATUTE

Under Colorado law mental impairment or disability can only be compensated if it occurs 1) with a work-related physical injury or 2) "as a result of an accidental injury arising out of and in the course of employment when the accidental injury involves no physical injury and consists of a psychologically traumatic event that is generally outside of a worker's usual experience and would evoke significant symptoms of distress in any worker in similar circumstances". (§8-41-301(2)(a), C.R.S.) The worker must meet one of these two definitions before impairment may be considered. In addition, the statute limits the amount of compensation for permanent impairment of mental conditions except in cases of occupational disease with neurological brain damage or victims of violent crime or physical injury. (§8-41-301(2)(b), C.R.S.) Therefore, physicians should specifically address the presence of occupational neurologic brain damage in their narrative report.

DETERMINATION OF IMPAIRMENT RATING²

1. Establish a work-related DSM diagnosis
2. Establish MMI
3. Interview the patient regarding function in each of the four areas of function

² This material, the sections on the next page and the Guidelines listed in the next section are based on the revised Division form denoted **Rev. 01/06 WC-M3-Psych**.

- a. Activities of daily living
- b. Social functioning
- c. Thinking, concentration & judgment
- d. Adaptation to stress

MECHANICS OF THE MENTAL IMPAIRMENT RATING

1. Record the DSM diagnosis on the worksheet.
2. On the worksheet, rank each element from 0 – 6 referring to the category definition guidelines and the Guidelines for elements found on the pages at the end of this section.
3. Average the two highest elements within each area of function to calculate the rating for each of the four areas of function.
4. Average the two highest areas of function ratings.
5. You may modify this number by up to 0.5 if you provide justification based on factors such as results of psychologic testing, reliability assessed on exam and compliance with treatment.
6. Convert your final category number to a percentage rating using the conversion table.
7. Combine the final rating with any physical rating.

NARRATIVE REPORT

Categorical ratings – The narrative report accompanying your impairment rating should include a thorough discussion of the criteria you used to establish your category ranking of each element in the four areas of function. Use the general categorical guidelines describing those elements to rank the category numbers. Those guidelines may be found at the end of this section. The Permanent Mental Impairment Report Work Sheet is found in this notebook behind the tab “Mental Impairment Forms.”

Continuing Medication – When maintenance medication is required, the dose of medications prescribed, the frequency of physician visits anticipated, and any monitoring laboratory tests required must be described in detail in order to obtain insurance coverage for the treatment and medication. Maintenance psychiatric visits can vary but generally should not be less frequent than every eight weeks in the first year after the worker has reached psychiatric MMI.

Work Restrictions – Some workers with a psychiatric impairment may have work restrictions due to their psychiatric condition. Any restrictions must be identified clearly in the narrative report including type and degree of stress, limitation of hours, etc. (Examples include limited interpersonal contact, difficulty in close supervisory relationship, difficulty supervising others, difficulty concentrating on complex tasks and difficulty with multi-tasking.)