

Appendix E—Reference Pages from the AMA Guides 5th Edition

Table 1-3 Scales for Measurement of Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL)

IADL

Scale	Design/Description	Target Population	Measures	Comment
The OECD Long-Term Disability Questionnaire ⁸	Summary of the impact of ill health on essential activities of daily living.	General population	<ul style="list-style-type: none"> • Eyesight • Hearing • Speaking • Carry an object of 5 kg for 10 meters • Run 100 meters • Walk 400 meters without resting • Move between rooms • Get in and out of bed • Dress and undress • Cut toenails • Bend and pick up a shoe from floor • Cut food • Bite and chew hard food 	An early attempt to develop an international set of disability items; European content
The Health Assessment Questionnaire ⁹	Measures difficulty in performing activities of daily living	Used to assess adult arthritics in a wide range of research settings to evaluate care	<ul style="list-style-type: none"> • Dressing and grooming • Arising • Eating • Walking • Hygiene • Reach • Grip • Outdoor activity 	Widely used instrument; pays close attention to rigorous measures
The Functional Independence Measure ¹⁰	Assesses physical and cognitive disability, monitors patient progress, and assesses outcomes of rehabilitation	General population	<ul style="list-style-type: none"> • Self-care • Sphincter control • Mobility • Locomotion • Communication • Social cognition 	Based on the Barthel index

ADL

The Barthel Index (Formerly the Maryland Disability Index) ¹¹	Measures functional independence in personal care and mobility; completed by health professionals	Used in patients with chronic conditions, before and after treatment	Ten-item version evaluates: <ul style="list-style-type: none"> • Feeding • Moving from wheelchair to bed and return • Personal toilet • Getting on and off toilet • Bathing self • Mobility • Ascending and descending stairs • Dressing • Controlling bowels • Controlling bladder 	Measures what a patient does; widely applied
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Scale	Description	Target Population	Measures	Comment
The Index of Independence in Activities of Daily Living ¹²	Describes primary biological and psychosocial function; limited information on ambulation	Originally developed for elderly and chronically ill patients with strokes and fractured hips	Assesses independence in six activities: <ul style="list-style-type: none"> • Bathing • Dressing • Toileting • Transferring from bed to chair • Continence • Feeding 	Widely used with children and adults, with the mentally retarded and the physically disabled, in the community and institutions
The Functional Status Rating System ¹³	Based on a method developed to provide national statistics on hospital utilization and treatment outcomes	Rehabilitation patients	<ul style="list-style-type: none"> • Functional Status in Self-Care (eating/feeding, personal hygiene, toileting, bathing, bowel/bladder/skin management, bed activities, dressing) • Functional Status in Mobility (transfers, wheelchair skills, ambulation, stairs, community mobility) • Functional Status in Communication (reading, talking, motor communication, written language expression) • Functional Status in Psychosocial Adjustment (emotional adjustment, social support, adjustment to limitations) • Functional Status in Cognitive Function (attention span, judgment, reasoning, memory) 	
The OARS Multidimensional Functional Assessment Questionnaire ¹⁴	A combined 7 ADL and 7 IADL scale that covers functional and services assessment	General population, especially elderly	<ul style="list-style-type: none"> • Individual functioning (basic demographics, social, economic resources) • Mental health • Physical health • ADL • Services assessment (transportation, social/recreational) 	Flexible instrument, reliable, and valid ADL and IADL sections
The Medical Outcomes Study Physical Functioning Measure ¹⁵	An extended ADL scale that is sensitive to variations at relatively high levels of physical function	General population	<ul style="list-style-type: none"> • Vigorous activities (running, lifting heavy objects, strenuous sports) • Moderate activities (moving a table, pushing a vacuum cleaner, bowling, playing golf) • Lifting or carrying groceries • Climbing <i>several</i> flights of stairs • Climbing <i>one</i> flight of stairs • Bending, kneeling, or stooping • Walking <i>more than one mile</i> • Walking <i>several blocks</i> • Walking <i>one block</i> • Bathing or dressing self 	Recognizes differences in people's values regarding functional ability by including a question on satisfaction with physical performance

2.1 Defining Impairment Evaluations

An **impairment evaluation** is a medical evaluation performed by a physician, using a standard method as outlined in the *Guides* to determine permanent impairment associated with a medical condition. An impairment evaluation may include a numerical impairment percentage or rating, as defined in the *Guides*. An impairment evaluation is not the same as an **independent medical evaluation (IME)**, which is performed by an independent medical examiner who evaluates but does not provide care for the individual. Impairment evaluations may be less comprehensive than IMEs and may be performed by a treating physician or a nontreating physician, depending upon the state's requirements and the preferences of the individual, physician, and requesting party. Examples of an impairment evaluation and components of a comprehensive IME will be discussed later in this chapter.

2.2 Who Performs Impairment Evaluations?

Impairment evaluations are performed by a licensed physician. The physician may use information from other sources, such as hearing results obtained from audiometry by a certified technician. However, the physician is responsible for performing a medical evaluation that addresses medical impairment in the body or organ system and related systems. A state may restrict the type of practitioner allowed to perform an impairment evaluation, and some require additional state certification and other criteria, such as a minimum number of hours of practice, before the physician is approved as an impairment evaluator. The physician is encouraged to check with the local workers' compensation agency, industrial accident board, or industrial commission concerning their prerequisites.

2.3 Examiners' Roles and Responsibilities

The physician's role in performing an impairment evaluation is to provide an independent, unbiased assessment of the individual's medical condition, including its effect on function, and identify abilities and limitations to performing activities of daily living as listed in Table 1-2. Performing an impairment evaluation requires considerable medical expertise and judgment. Full and complete reporting provides the best opportunity for physicians to explain health status and consequences to patients, other medical professionals, and other interested parties such as claims examiners and attorneys. Thorough documentation of medical findings and their impact will also ensure that reporting is fair and consistent and that individuals have the information needed to pursue any benefits to which they are entitled.

The skills required for impairment evaluation are usually not taught during basic medical training, although some specialties such as occupational medicine, physical medicine and rehabilitation, and orthopedics have emphasized elements of the evaluation such as occupational, functional, or anatomical assessment.

In some cases, physicians may be asked to assess the medical impairment's impact on the individual's ability to work. In the latter case, physicians need to understand the essential functions of the occupation and specific job, as well as how the medical condition interacts with the occupational demands. In many cases, the physician may need to obtain additional expertise to define functional abilities and limitations, as well as vocational demands.

As an impairment evaluator, the physician has the responsibility to understand the regulations that pertain to medical practice in his or her specific area, as in workers' compensation or personal injury evaluations. It is also the responsibility of the physician to provide the necessary medical assessment to the party requesting the evaluation, with the examinee's consent. The physician needs to ensure that the examinee understands that the evaluation's purpose is medical assessment, not medical treatment. However, if new diagnoses are discovered, the physician has a medical obligation to inform the requesting party and individual about the condition and recommend further medical assessment.

2.4 When Are Impairment Ratings Performed?

An impairment should not be considered permanent until the clinical findings indicate that the medical condition is static and well stabilized, often termed the date of **maximal medical improvement (MMI)**. It is understood that an individual's condition is dynamic. Maximal medical improvement refers to a date from which further recovery or deterioration is not anticipated, although over time there may be some expected change. Once an impairment has reached MMI, a permanent impairment rating may be performed. The *Guides* attempts to take into account all relevant considerations in rating the severity and extent of permanent impairment and its effect on the individual's activities of daily living.

Impairments often involve more than one body system or organ system; the same condition may be discussed in more than one chapter. Generally, the organ system where the problems originate or where the dysfunction is greatest is the chapter to be used for evaluating the impairment. Thus, consult the vision chapter for visual problems due to optic nerve dysfunction. Refer to the extremity chapters for neurological and musculoskeletal extremity impairment from an injury. However, if the impairment is due to a stroke, the neurology chapter is most appropriate. Whenever the same impairment is discussed in different chapters, the *Guides* tries to use consistent impairment ratings across the different organ systems.

2.5 Rules for Evaluation

2.5a Confidentiality

Prior to performing an impairment evaluation, the physician obtains the individual's consent to share the medical information with other parties that will be reviewing the evaluation. If the evaluating physician is also that person's treating physician, the physician needs to indicate to the individual which information from his or her medical record will be shared.

2.5b Combining Impairment Ratings

To determine **whole person impairment**, the physician should begin with an estimate of the individual's most significant (primary) impairment and evaluate other impairments in relation to it. It may be necessary for the physician to refer to the criteria and estimates in several chapters if the impairing condition involves several organ systems. Related but separate conditions are rated separately and impairment ratings are combined unless criteria for the second impairment are included in the primary impairment. For example, an individual with an injury causing neurologic and muscular impairment to his upper extremity would be evaluated under the upper extremity criteria in Chapter 16. Any skin impairment due to significant scarring would be rated separately in the skin chapter and combined with the impairment from the upper extremity chapter. Loss of nerve function would be rated within either the musculoskeletal chapters or neurology chapter.

In the case of two significant yet unrelated conditions, each impairment rating is calculated separately, converted or expressed as a whole person impairment, then combined using the Combined Values Chart (p. 604). The general philosophy of the Combined Values Chart is discussed in Chapter 1.

2.5c Consistency

Consistency tests are designed to ensure reproducibility and greater accuracy. These measurements, such as one that checks the individual's lumbosacral spine range of motion (Section 15.9) are good but imperfect indicators of people's efforts. The physician must use the entire range of clinical skill and judgment when assessing whether or not the measurements or tests results are plausible and consistent with the impairment being evaluated. If, in spite of an observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the physician may modify the impairment rating accordingly and then describe and explain the reason for the modification in writing.

Glossary

Abnormal illness behavior Behavior that suggests amplification of symptoms for any of a variety of psychological or social reasons or purposes.

Acquired Developed after birth. Not hereditary or congenital.

Activities of daily living (ADL) Activities of daily living include those listed in Table 1-2, reproduced below.

Table 1-2 Activities of Daily Living Commonly Measured in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Scales

Activity	Example
Self-care, teeth, personal hygiene	Urinating, defecating, brushing 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

ADL See **Activities of daily living (ADL)**.

Aggravation A factor(s) (eg, physical, chemical, biological, or medical condition) that adversely alters the course or progression of the medical impairment. Worsening of a preexisting medical condition or impairment.

Americans with Disabilities Act (ADA) A civil rights law, signed in 1990, that protects individuals with disabilities against discrimination in such diverse areas as employment, government service entitlement, and access to public accommodations.

Ankylosis Fixation of a joint in a specific position by disease, injury, or surgery. When surgically created, the aim is to fuse the joint in that position, which is best for improved function.

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

Assistive devices Devices that help individuals with a functional loss increase function. Examples include reachers, extended grabbers, hearing aids, and telephone amplifiers.

Blindness The absence of vision (no light perception, NLP).

Causalgia See **Complex regional pain syndromes**.