

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

7 CCR 1101-3

WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 12 Permanent Impairment Rating Guidelines

12-1 STATEMENT OF PURPOSE

Pursuant to §8-42-101(3.5)(a)(II), C.R.S., all permanent impairment ratings shall be based upon the American Medical Association Guides to the Evaluation of Permanent Impairment, Third Edition (Revised), in effect as of July 1, 1991, (AMA Guides). This rule implements the Division's permanent impairment rating guidelines on how to appropriately utilize and report permanent impairment ratings.

12-2 PROVIDER RESPONSIBILITIES

- (A) Where the authorized treating physician has determined that the injured worker is at maximum medical improvement (MMI) and has not returned to his/her pre-injury state, physically and/or mentally, the treating physician shall determine or cause to be determined a permanent medical impairment rating in accordance with this Rule 12.
- (B) Any Level II accredited physician determining permanent impairment shall rate in accordance with their administrative, legal and medical roles as established by Level II accreditation.

12-3 APPORTIONMENT

- (A) For claims with a date of injury prior to July 1, 2008, a Level II accredited physician ("the Physician") shall apportion any preexisting medical impairment, whether work-related or non work-related, from a work-related injury or occupational disease using the AMA Guides, 3rd Edition, Revised, where medical records or other objective evidence substantiate a preexisting impairment to the same body part. Any such apportionment shall be made by subtracting from the injured worker's impairment the preexisting impairment as it existed at the time of the subsequent injury or occupational disease. The physician shall explain in their written report the basis of any apportionment. If there is insufficient information to measure the change accurately, the physician shall not apportion.
- (B) For claims with a date of injury on or after July 1, 2008, the Physician may provide an opinion on apportionment for any preexisting work related or non work-related permanent impairment to the same body part using the AMA Guides, 3rd Edition, Revised, where medical records or other objective evidence substantiate a preexisting impairment. Any such apportionment shall be made by subtracting from the injured worker's impairment the preexisting impairment as it existed at the time of the subsequent injury or occupational disease. The Physician shall explain in their written report the basis of any apportionment. If there is insufficient information to measure the change accurately, the Physician shall not apportion. If the Physician apportions based on a prior non work-related impairment, the Physician must provide an opinion as to whether the previous medical impairment was identified, treated and independently disabling at the time of the work-related injury that is being rated. Identified and treated

in this context requires facts reflecting that a medical provider previously noted and provided some level of treatment for the non work-related impairment.

- (1) The effect of the Physician's apportionment determination is limited to the provisions in section 8-42-104. When filing an admission an insurer shall provide documentation reflecting compliance with section 8-42-104.
- (2) If the Physician provides an opinion on the apportionment of medical and temporary disability benefits, the claimant's receipt of medical and temporary disability benefits shall not be reduced based upon any such opinion.

12-4 PERMANENT PHYSICAL IMPAIRMENT RATINGS

Any physician determining permanent physical impairment shall:

- (A) Limit such rating to physical impairments not likely to remit despite medical treatment; and
- (B) Use the instructions and forms contained in the AMA Guides and,
- (C) Convert scheduled impairment rating to whole person impairments.
- (D) Report final whole person and/or scheduled impairment rating percentages in whole numbers.

12-5 PERMANENT MENTAL AND BEHAVIORAL DISORDER IMPAIRMENT RATINGS

- (A) Any physician determining permanent mental or behavioral disorder impairment shall:
 - (1) Limit such rating to mental or behavioral disorder impairments not likely to remit despite medical treatment; and
 - (2) Use the instructions contained in the AMA Guides giving specific attention to:
 - (a) Chapter 4, "Nervous System"; and
 - (b) Chapter 14, "Mental and Behavioral Disorders"; and
 - (3) Complete a full psychiatric assessment following the principles of the AMA Guides, including:
 - (a) A nationally accepted and validated psychiatric diagnosis made according to established standards of the American Psychiatric Association as contemplated by the AMA Guides; and
 - (b) Complete history of impairment, associated stressors, treatment, attempts at rehabilitation and premorbid history so that a discussion of causality and apportionment can occur.
- (B) If the permanent impairment is due to organic deficits of the brain and results in disturbances of complex integrated cerebral function, emotional disturbance or consciousness disturbance, then Chapter 4, "Nervous System," shall be consulted and, may be used, when appropriate, with Chapter 14, "Mental and Behavioral Disorders."

The same permanent impairment shall not be rated in both sections. The purpose is to rate the overall functioning, not each specific diagnosis. Determination of the appropriate chapter(s) is left to the professional judgment of the physician.

- (C) The permanent impairment report shall include a written summary of the mental evaluation and the work sheet incorporated herein as part of this rule (Division form WC-M3-PSYCH). The impairment rating shall be established using the “category definition guidelines” set forth in this rule, and which shall supplement the related instructions in the AMA guides. When appropriate, the physician shall address apportionment.
- (D) Where other work-related permanent impairment exists, a combined whole-body permanent impairment rating may be determined by the authorized treating physician providing primary care if Level II accredited. Where the authorized treating physician providing primary care is not determining permanent impairment, it shall be determined by the Level II accredited rating physician designated by the authorized treating physician providing primary care.

12-6 PERMANENT IMPAIRMENT RATINGS OF THE EXTREMITIES

- (A) The AMA Guides do not provide for permanent impairment ratings specifically for the partial loss of use of the following:
 - (1) Forearm at the elbow;
 - (2) Joints at the wrist or ankle;
 - (3) Leg at the knee; or
 - (4) Toes at the metatarsal.

The AMA Guides define these as permanent impairments of the:

- (1) Entire finger, whole hand, or whole upper extremity; or
 - (2) Entire toe, whole foot, or whole lower extremity.
- (B) When an injury causes the partial loss of use of any member specified in the scheduled injuries, as set forth in §8-42-107(2), C.R.S., the physician shall use the most distal body part. The most distal body part is the body part farthest away from the central body.
 - (C) In calculating partial loss-of-use benefits, the most distal permanent impairment rating provided by the physician shall be multiplied by the number of weeks corresponding to the scheduled injury for the appropriate entire finger, whole hand, or whole upper extremity, or the appropriate entire toe, whole foot, or whole lower extremity, then multiplied by the amount pursuant to §8-42-107(6), C.R.S.

12-7 PERMANENT IMPAIRMENT RATINGS FOR CUMULATIVE TRAUMA

- (A) The Cumulative Trauma Disorder (CTD) rating system is designed for disorders that primarily involve muscular, tendinous, ligamentous and bony structures. It follows the same general principles set forth in section 3.1j of the AMA Guides and has similar relative values for traumatic soft tissue conditions. Disorders that have vascular or neurologic involvement are rated by other sections of the AMA Guides.

- (B) Impairments secondary to Cumulative Trauma Disorders may be accompanied by impairments that are ratable using existing portions of the AMA Guides. The Level II accredited physician shall first calculate any applicable impairment from range of motion, neurologic and/or vascular findings, or other disorders (section 3.1j) excluding grip strength. If no impairment exists under these sections of the AMA Guides and the physician has determined that the claimant has an impairment of daily living activities with anatomic and physiologic correlation, the physician shall proceed to rate the impairment as follows:
- (1) Multiple joint and upper extremity sites can be involved in CTD. Limit the impairment determination to areas of primary pathology, with anatomic or physiologic correlation based on objective findings. Do not rate areas of reactive muscular spasm and radiating or referred pain.
 - (2) Determine the stage of cumulative trauma for each joint involved, Stage 1 is 0-10%, Stage 2 is 11-20%, Stage 3 is 21-30%, and Stage 4 is 31-40%. Refer to Rule 17, Exhibit 2.
 - (3) Identify the appropriate joint impairment found on Table 17 of Chapter 3 of the AMA Guides.
 - (4) Multiply the joint impairment from Table 17 by the CTD stage impairment from step B to yield an upper extremity impairment.
 - (5) If there is anatomic and physiologic basis to rate other joints in the same extremity, complete the rating in the manner described and combine the extremity ratings distal to proximal.
 - (6) If extremity impairment is bilateral, convert each upper extremity impairment to whole person rating and then combine whole person ratings for both right and left upper extremities as referenced in the AMA Guides. Complete the upper extremity worksheets, Figure 1 of Chapter 3 of the AMA Guides, for each extremity separately.
- (C) The CTD rating system is preferred to impairment determined by decrease in grip strength. If grip strength is used, the CTD rating system shall not be used as it would be duplicative. Similarly, care must be taken to avoid duplicative ratings with other associated disorders where there is significant neurovascular involvement or where there is limitation in ranges of motion. For further reference to these cautions, refer to the AMA Guides, section 3.1j.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation

PERMANENT WORK-RELATED MENTAL IMPAIRMENT RATING
REPORT WORK SHEET

Since the AMA Guides to the Evaluation of Permanent Impairment, 3rd Edition (Revised) does not provide a quantified method for assigning permanent impairment percentages under Chapter 14, "Mental and Behavioral Disorders," the provider shall utilize this form.

Patient Name _____ Date of Service: _____
WC # _____ Carrier # _____

SCORING INSTRUCTIONS:

1. This form should only be used to determine an impairment after the case has been found to meet all of the specific criteria for a Diagnostic and Statistical Manual (DSM) diagnosis.
2. The AMA Guides to Permanent Impairment, 3rd Edition (Revised) should be consulted for guidance in determining these ratings.
3. Determination of a rating of permanent mental or behavioral impairment shall be limited to mental or behavioral disorder impairments not likely to remit with further mental health treatment.
4. Impairment ratings based on chronic pain are not applicable within the mental/behavioral domain, but are restricted to physical examination with evidence of anatomic or physiologic correlation and included within a physical impairment rating.
5. To obtain the final overall impairment rating:
 - a. The elements to be rated are divided into four Areas of Function: Activities of Daily Living; Social Functioning; Thinking, Concentration and Judgment; and Adaptation to Stress.
 - b. Assign a rating (0-6) to each subcategory of the areas of function based on patient self-report, other sources of information, and the physician's clinical assessment. (See Category Definitions on page 6 of this form.) Given the heavy reliance on the patient's subjective report for information in some of the ratings, the physician should give careful consideration to any corroborating evidence that might be available.
 - c. Average the two highest subcategory ratings within each Area of Function to obtain the overall category rating. For example, if the two highest scores are 2 and 5, the category score is 3.5.
 - d. To calculate the overall impairment rating, average the two highest category ratings and then, if appropriate in the case, use clinical judgment to add or subtract up to 0.5 point from the result. If the score is modified in this fashion due to clinical judgment, ***justification for doing so must be documented***. Factors influencing the physician's discretion may include the following:
 - i. Factors influencing the patient's believability, such as the presence of symptom magnification, or the presence or absence of corroborating information from psychological or neuropsychological testing;
 - ii. The extent to which medication ameliorates the effects of the condition;
 - e. Use the Category Conversion Table in these instructions to convert the final number to a percentage.
6. Include the DSM diagnosis at the top of the worksheet.

The final determination must include ratings for all of the elements in each area of function, the category averages reached in each area of function, the overall average, the final assigned overall permanent impairment rating, and documentation for any divergence (± 0.5) from the calculated score.

CATEGORY CONVERSION TABLE	
Final Score	Percentage
0	0
0.25	0
0.5	1
0.75	1
1	1
1.25	2
1.5	3 to 4
1.75	5
2	6 to 7
2.25	8 to 9
2.5	10 to 12
2.75	13 to 15
3	16 to 18
3.25	19 to 21
3.5	22 to 23
3.75	24 to 25
4	26 to 32
4.25	33 to 38
4.5	39 to 44
4.75	45 to 50
5	51 to 56
5.25	57 to 62
5.5	63 to 68
5.75	69 to 75
6	76 to 83
6.25	84 to 91
6.5	92 to 100

7. If apportionment is applicable, complete a separate form calculating the pre-injury rating to be subtracted from the total current rating.
8. If there is a finding of no impairment, refer to Part V on the worksheet, if appropriate.

WORKSHEET

Patient Name _____ Date of Service: _____
WC # _____ Carrier # _____

NOTE: Determination of a rating of permanent mental or behavioral impairment shall be limited to mental or behavioral disorder impairments not likely to remit with further mental health treatment. Further, impairment ratings based on chronic pain are not applicable within the mental/behavioral domain, but are restricted to physical examination with evidence of anatomic or physiologic correlation and included within a physical impairment rating.

I. DSM Diagnosis: Axis I: _____ Axis II: _____

II. LEVELS OF PERMANENT MENTAL IMPAIRMENT

Category

0. No permanent impairment
1. Minimal Category of Permanent Impairment
2. Mild Category of Permanent Impairment
3. Moderate Category of Permanent Impairment
4. Marked Category of Permanent Impairment
5. Extreme Category of Permanent Impairment
6. Maximum Category of Permanent Impairment

III. AREAS OF FUNCTION¹

1. Activities of Daily Living. *Rate only impairments due strictly to the psychiatric condition.*

- 0 1 2 3 4 5 6 Self care and hygiene (dressing, bathing, eating, cooking)
0 1 2 3 4 5 6 Travel (driving, riding, flying) i.e. impairments in driving, riding,
flying which are generally a result of symptoms of affective or
anxiety disorders
0 1 2 3 4 Sexual function (participating in usual sexual activities)
0 1 2 3 4 Sleep (restful sleep pattern)

Overall Category Rating:
(average of 2 highest)

2. Social Functioning

- 0 1 2 3 4 5 6 Interpersonal relationships
0 1 2 3 4 5 6 Communicates effectively with others
0 1 2 3 4 5 6 Participation in recreational activities (consider pre-injury activities
of the patient)
0 1 2 3 4 5 6 Manage conflicts with others--negotiate, compromise

Overall Category Rating:
(average of 2 highest)

¹ See attached Appendix for further description of all or part of the listed areas of function.

3. Thinking, Concentration & Judgment

- 0 1 2 3 4 5 6 Ability to perform complex or varied tasks
- 0 1 2 3 4 5 6 Judgment
- 0 1 2 3 4 5 6 Problem solving
- 0 1 2 3 4 5 6 Ability to abstract or understand concepts
- 0 1 2 3 4 5 6 Memory, immediate and remote
- 0 1 2 3 4 5 6 Maintain attention, concentration on a specific task
- 0 1 2 3 4 5 6 Perform simple, routine, repetitive tasks
- 0 1 2 3 4 5 6 Comprehend/follow simple instructions

Overall Category Rating:
(average of 2 highest)

4. Adaptation to Stress

- 0 1 2 3 4 5 6 Set realistic short & long term goals
- 0 1 2 3 4 5 6 Perform activities (including work) on schedule
- 0 1 2 3 4 5 6 Adapt to job performance requirements

Overall Category Rating:
(average of 2 highest)

IV. FINAL CALCULATIONS:

Average the two highest Area of Function ratings: _____ + _____ divided by 2 = _____

Add or subtract up to 0.5 from the completed calculation above, if appropriate, based on clinical judgment.

Justify this deviation below or attach a separate sheet: _____

Using the Category Conversion Table on page 2 of this form, convert the final number to a percentage for the overall permanent impairment rating:

Overall Psychiatric Permanent Impairment
Rating _____ %

OR

V. If this patient has ZERO impairment according to the above criteria and requires continuing medication for their DSM diagnosis, an impairment of 1-3% may be assigned _____%.

<i>IF ZERO % PSYCHIATRIC RATING</i>
<i>RATING</i> _____ %

VI. TOTAL IMPAIRMENT RATING (if applicable)
Total Whole Person *Physical* Impairment = _____%

Combined with psychiatric permanent impairment equals:

Total Whole Person Impairment (including psychiatric impairment)
_____ %

Physician: _____ Date: _____
(Signature)

APPENDIX

1. Activities of Daily Living

Sexual Function: Scoring categories 5 and 6 are not available because the maximum impairment allowed per the AMA Guides for total loss of sexual function is 30% for a male less than 40 years of age; 20% for a male 40 or older.

Sleep: Scoring categories 5 and 6 are not available because the AMA Guides allow a maximum of 50% impairment for sleep or arousal disorders. To reach a 20% rating the activities of daily living must be affected to the extent that supervision is required in some areas. To reach a 50% rating, supervision by caretakers is required.

2. Social Functioning

Social functioning refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. Social functioning includes the ability to get along with others, such as with family members, friends, neighbors, grocery clerks, landlords or bus drivers. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, etc. Strength in social functioning may be documented by an individual's ability to initiate social contacts with others, communicate clearly with others, interact and participate in group activities, etc. Cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity also need to be considered. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority, such as supervisors, or cooperative behaviors involving co-workers.

Again, it is not the number of areas in which social functioning is impaired, but the overall degree of interference with a particular functional area or combination of such areas of functioning. For example, a person who is highly antagonistic, uncooperative, or hostile, but is tolerated by local storekeepers may nevertheless have marked restrictions in social functioning because that behavior is not acceptable in other social contexts, such as work. (*AMA Guides, 3rd Edition (revised)*, p. 237)

3. Thinking, Concentration and Judgment

Thinking, concentration, and judgment refer to the ability to sustain focused attention sufficiently long to permit the timely completion of tasks and to make reasoned or logical decisions as to alternative courses of action. Deficiencies in concentration and judgment are best observed in work and work-like settings. Major impairment in this area can often be assessed through direct psychiatric examination and/or psychological testing, although mental status examination or psychological test data alone should not be used to accurately describe concentration and sustained ability to perform work-like tasks. On mental status examinations, concentration is assessed by tasks requiring short-term memory or through tasks such as having the individual subtract serial sevens from 100. In psychological tests of intelligence or memory, concentration can be assessed through tasks requiring short-term memory or through tasks that must be completed within established time limits. Strengths and weaknesses in areas of concentration can be discussed in terms of frequency of errors, time it takes to complete the task, and extent to which assistance is required to complete the task. (*Disability Evaluation Under Social Security*, p.88, Social Security Administration Pub. No. 64-039)

4. Adaptation to Stress

The individual should be able to set realistic and appropriate goals. Given that the work-related injury may have induced various limitations, the individual should demonstrate realistic adaptations to the medical/physical situation. He/she should be able to accommodate changes from pre-injury status to the current status. Adapting to performance standards requires that the individual can adequately cope with job performance and time expectations. Further, the individual should demonstrate the capacity to follow rules and policies, respond appropriately to changes in the work setting, and utilize resources available within the community, medical and family areas.

PERMANENT WORK-RELATED MENTAL IMPAIRMENT RATING
REPORT WORK SHEET
CATEGORY DEFINITION GUIDELINES

CATEGORY 0: - No Permanent Impairment.

Mental symptoms arising from the work-related psychiatric diagnosis have been absent for the past month. ADLs are not affected. Functioning is at pre-injury baseline in social and work activities in all areas; no more than everyday problems.

CATEGORY 1: Minimal Category of Permanent Impairment.

Mental symptoms, arising from the work-related psychiatric diagnosis and not likely to remit despite medical treatment, minimally impair functioning.

CATEGORY 2: Mild Category of Permanent Impairment.

Mental symptoms, arising from the work-related psychiatric diagnosis are not likely to remit despite medical treatment, and are mildly impairing. ADLs are mildly disrupted. Functioning shows mild permanent impairment in social or work activities.

CATEGORY 3: Moderate Category of Permanent Impairment.

Mental symptoms, arising from the work-related psychiatric diagnosis and not likely to remit despite medical treatment, are moderately impairing. ADLs are moderately disrupted. Functioning shows moderate permanent impairment. Activities sometimes need direction or supervision.

CATEGORY 4: Marked Category of Permanent Impairment.

Mental symptoms, arising from the work-related psychiatric diagnosis and not likely to remit despite medical treatment, are seriously impairing. ADLs are seriously disrupted. Functioning shows serious difficulties in social or work activities.

CATEGORY 5: Extreme Category of Permanent Impairment.

Mental symptoms, arising from the work-related psychiatric diagnosis and not likely to remit despite medical treatment, are incapacitating. At times, ADLs require structuring. Functioning is quite poor, unsafe in work settings, at times requires hospitalization or full-time supervision. Most activities require directed care.

CATEGORY 6: Maximum Category of Permanent Impairment.

This impairment level precludes useful functioning in all areas. These individuals are generally appropriate for institutionalized settings, if available. All activities require directed care.