

Disability Ratings: An Art or a Science?

Chairperson: Tom Winters, MD, FACOEM, FACPM

Tuesday, March 24th, 2026

2:05-2:55pm

What Is an Impairment Rating?

Impairment is a **medical determination**, not a legal one.

- **Impairment:**

- A permanent loss or abnormality of body structure or function due to injury or disease

- **Distinct from disability:**

- Impairment = physiologic or anatomic loss

- Disability = impact on activities, work, and participation

- Typically expressed as a **percentage of whole person impairment (WPI)**

Intended to provide a **standardized, objective estimate** of permanent loss

Why Impairment Ratings Matter

Impairment ratings serve as a **bridge between medicine and compensation systems.**

Used in:

- Workers' compensation
- Personal injury and disability systems
- Case settlement and dispute resolution

Translate clinical findings into **numeric estimates** of permanent loss (lawyers will explain)

Designed to:

- Improve inter-rater reliability
- Reduce subjectivity
- Support consistency across evaluators

Widely adopted across US jurisdictions using the **AMA Guides**

MA, RI, CT - 6th Edition; RI, VT, NH - 5th Edition; ME - 4th Edition

How Impairment Ratings Are Constructed

The AMA Guides use a structured, 3-step approach:

1. Clinical Evaluation

- Review records and history
- Confirm diagnosis and permanence
- Confirm that worker is at Maximum Medical Improvement (MMI)

2. Analysis of Findings

- Correlate objective findings with functional impact
- Assess ADLs and validated deficits
- Exclude non-verifiable or inconsistent data

3. Calculation and Documentation

- Apply chapter-specific criteria
- Combine values into a final whole person impairment
- Clearly document rationale, methods, and assumptions

Key Principles:

- Only permanent impairments are rated
- Ratings must be objective, reproducible, and evidence-based
- Subjective complaints alone are generally not ratable

AMA Guidelines 6th Edition Impairment Ratings

Suzanne Miller MD

Boston Bone and Joint Institute

There are no disclosures for this presentation

Disclosures

MA – 6th Edition

Impairment: Significant deviation or loss of a body structure or function of a particular health condition, disorder, or disease

Disability: Activity limitations or restrictions with a particular disease

Impairment Evaluation

- Medical evaluation performed by a physician using the *Guides to determine* impairment
- Treating or non-treating
- Assessment of individuals medical condition and its effect on function

What the guides do not take into consideration

Restrictions or FCE results

Future Problems – ie (arthritis, joint replacement)

Multiple or number of surgeries

Multiple injuries same joint- ie (labral tear and rotator cuff tear)

Impact on ability to work

AMA Guides 6th edition

MMI (Maximal Medical Improvement) refers to a status where the person is as good as he/she is going to get from the medical and/or surgical treatment available to him/her

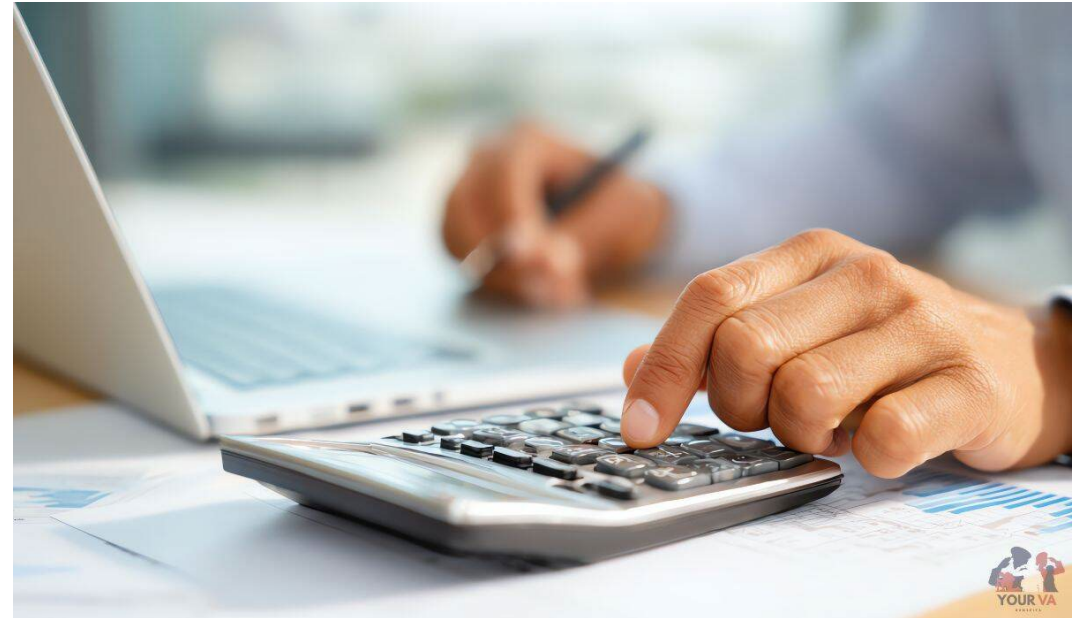
It can also be conceptualized as a date from which further recovery or deterioration is not anticipated although over time (>12 months) there may be some expected change



Apportionment

Allocation of causation among multiple factors that contributed to the injury

1. Total Impairment
2. Baseline Impairment
3. Final Rating: Subtract baseline from total



How to rate- 6th edition

DBI (Diagnosis Based Impairment) vs **ROM** (Range of Motion)

Method producing the highest rating must be used

6th edition takes into account pain and subjective complaints

- Lower extremity- Lower Limb Questionnaire
- Upper extremity- Quick Dash

Quick Dash & LLQ

TABLE 15-39

Comparison Between QuickDASH and ADL Questionnaires

| QuickDASH question | ADL Questionnaire correlate |
|--|--|
| 1. "open a tight or new jar" | Grasping |
| 2. "heavy household chores (eg, wash walls, floors)" | Grasping and lifting |
| 3. "carry a shopping bag or briefcase" | Grasping and lifting |
| 4. "wash your back" | Grasping and bathing |
| 5. "use a knife to cut food" | Grasping and eating (perhaps tactile feeling) |
| 6. recreational activities" | Grasping, tactile feeling, lifting |
| 7. "social activities | No correlate; upper limb impairments should not produce social difficulty |
| 8. "work or ADLs" | Writing, typing, tactile feeling, grasping, lifting, and/or tactile discrimination |
| 9. "arm, shoulder, or hand pain" | No direct correlate |
| 10. "tingling" | Tactile feeling and tactile discrimination |
| 11. "sleeping" | Sleep |

Note: ADL indicates Activity of Daily Living.
Source: QuickDASH questions from Beaton et al, 2005.

Lower Limb Questionnaire

Instructions

Please answer the following questions for the lower limb being treated or followed up. If it is BOTH lower limbs, please answer the questions for your worse side. All questions are about how you have felt, on average, during the past week. If you are being treated for an injury that happened less than one week ago, please answer for the period since your injury.

1. During the past week, how stiff was your lower limb? (Circle one response.)

- 1 Not at all 2 Mildly 3 Moderately 4 Very 5 Extremely

2. During the past week, how swollen was your lower limb? (Circle one response.)

- 1 Not at all 2 Mildly 3 Moderately 4 Very 5 Extremely

During the past week, please tell us about how painful your lower limb was during the following activities. (Circle ONE response on each line that best describes your experience.)

| | Not painful | Mildly painful | Moderately painful | Very painful | Extremely painful | Could not do because of lower limb pain | Could not do for other reasons |
|------------------------------|-------------|----------------|--------------------|--------------|-------------------|---|--------------------------------|
| 3. Walking on flat surfaces? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. Going up or down stairs? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. Lying in bed at night? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

6. Which of the following statements best describes your ability to get around most of the time during the past week? (Circle one response.)

- 1 I did not need support or assistance at all.
- 2 I mostly walked without support or assistance.
- 3 I mostly used one cane or crutch to help me get around.
- 4 I mostly use two canes, two crutches or a walker to help me get around.
- 5 I used a wheelchair.
- 6 I mostly used other supports or someone else had to help me get around.
- 7 I was unable to get around at all.

7. How difficult was it for you to put on or take off socks/stockings during the past week? (Circle one response.)

- 1 Not at all difficult 2 A little bit difficult 3 Moderately difficult 4 Very difficult 5 Extremely difficult 6 Cannot do it at all

Using DBI Method

1. Determine the Diagnosis (There is a range)
2. Add or Subtract the Grade Modifiers

Grade Modifiers

- Functional History
- Physical Examination
- Clinical Studies

3. Calculate the final impairment

| CLASS 1 | | | | |
|---|---|---|---|---|
| 1%–13% UE | | | | |
| A | B | C | D | E |
| 1 | 2 | 3 | 4 | 5 |
| History of painful injury, residual symptoms without consistent objective findings (this impairment can only be given once in an individual's lifetime) | | | | |
| 3 | 4 | 5 | 6 | 7 |
| Residual loss, functional with normal motion | | | | |

Example:

Full thickness Rotator Cuff Tear

- Class 1
- Start with default Grade C
- Either 3% or 5%

TABLE 15-5 Shoulder Regional Grid: Upper Extremity Impairments

| IMPAIRMENT CLASS | CLASS 0 | CLASS 1 | CLASS 2 | CLASS 3 | CLASS 4 |
|---|--|--|--|------------|-------------|
| IMPAIRMENT RANGES (upper extremity %) | 0 | 1%-13% UE | 14%-25% UE | 26%-49% UE | 50%-100% UE |
| GRADE | | A B C D E | A B C D E | A B C D E | A B C D E |
| LIGAMENT/BONE/JOINT* | | | | | |
| Rotator cuff injury, full-thickness tear* | 0 No significant objective abnormal findings at MMI | 1 2 3 4 5 History of painful injury, residual symptoms without consistent objective findings (this impairment can only be given once in an individual's lifetime) 3 4 5 6 7 Residual loss, functional with normal motion | | | |
| Acromioclavicular (AC) joint injury or disease* | 0 No significant objective abnormal findings at MMI | 1 2 3 4 5 History of painful injury, residual symptoms without consistent objective findings (this impairment can only be given once in an individual's lifetime) 1 2 3 4 5 Residual loss, functional with normal motion 8 9 10 11 12 s/p Distal clavicle resection or AC separation type III (complete disruption AC joint capsule and coracoclavicular ligaments) | 16 18 20 22 24 AC separation type IV (complete disruption AC joint capsule and coracoclavicular ligaments and avulsion of coracoclavicular ligament from clavicle) or higher severity | | |

(contin

Functional History Modifier

-Grade Modifier 2

-Quickdash 41

TABLE 15-7

Functional History Adjustment: Upper Extremity

| | Grade Modifier 0 | Grade Modifier 1 | Grade Modifier 2 | Grade Modifier 3 | Grade Modifier 4 |
|--------------------------|------------------|--|---|---|--|
| Class Definitions | No problem | Mild problem | Moderate problem | Severe problem | Very severe problem |
| | Asymptomatic | Pain/symptoms with strenuous/vigorous activity; +/- medication to control symptoms | Pain/ symptoms with normal activity; +/- medications to control symptoms | Pain/symptoms with less than normal activity (minimal); +/- medications to control symptoms | Pain/symptoms at rest; +/- medications to control symptoms |
| | | AND able to perform self-care activities independently | AND able to perform self-care activities with modification but unassisted | AND requires assistance to perform self-care activities | AND unable to perform self-care activities |
| QuickDASH Score | 0-20 | 21-40 | 41-60 | 61-80 | 81-100 |

Physical Exam Modifier

Grade Modifier 1

- Palpatory findings

TABLE 15-8

Physical Examination Adjustments

Upper Extremities

| | Grade Modifier 1 | Grade Modifier 2 | Grade Modifier 3 | Grade Modifier 4 | |
|---|--|--|---|---|--|
| Class Definitions | No problem | Mild problem | Moderate problem | Severe problem | Very severe problem |
| Observed and Palpatory Findings (tenderness, swelling, mass, or crepitation) | No consistent findings | Minimal palpatory findings, consistently documented, without observed abnormalities | Moderate palpatory findings, consistently documented, and supported by observed abnormalities | Severe palpatory findings, consistently documented, and supported by observed moderate or greater abnormalities | Very severe palpatory findings, consistently documented, and supported by observed severe abnormalities |
| Stability | Stable | Instability | Grade 2 (moderate) instability | Grade 3 (serious) instability | Gross instability |
| Hand/finger/thumb | | Pain with stressing of ligament, but no opening of joint with stress | Pain and slight opening | Pain and >5 mm of joint opening with stress | Severe instability |
| Wrist | | Clicking or clunking by history, but not reproducible | Clicking or clunking by history, and reproducible on physical examination | | |
| Wrist excessive passive/active mediolateral joint deviation degrees compared to normal | | <10° passive <20° active | 10°–20° passive 20°–30° active | >20° passive >30° active | |
| Shoulder | | Grade 1 (slight) instability; subluxable | Grade 2 (moderate) instability; easily subluxable | Grade 3 (serious) instability; dislocatable with anesthesia or sedation | |
| Alignment/Deformity | Normal for individual with symmetry to opposite side | Mild | Moderate | Severe | Very severe |
| Range of Motion (reference Section 15.7) | None | Mild decrease from normal or uninjured opposite side For digit impairments only, this reflects a total digit impairment <20% digit impairment. For wrist, elbow, and shoulder this reflects a total joint impairment of <12% upper extremity impairment. | Moderate decrease from normal or uninjured opposite side For digit impairments only, this reflects a total digit impairment of 20% to 39% digit impairment. For wrist, elbow, and shoulder this reflects a total joint impairment of 12% to 23% upper extremity impairment. | Severe decrease from normal or uninjured opposite side For digit impairments only, this reflects a total digit impairment of 40% to 70% digit impairment. For wrist, elbow, and shoulder this reflects a total joint impairment of 24% to 42% upper extremity impairment. | Very severe decrease from normal or uninjured opposite side For digit impairments only, this reflects a total digit impairment >70% digit impairment. For wrist, elbow, and shoulder this reflects a total joint impairment >42% upper extremity impairment. |
| Muscle Atrophy (asymmetry compared to opposite normal) | <1 cm | 1.0–1.9 cm | 2.0–2.9 cm | 3.0 cm–3.9 cm | 4.0 cm + |

Note: ROM indicates range of motion; GH indicates Glenohumeral.

Clinical studies

Grade Modifier 2

- Imaging confirmed diagnosis

TABLE 15-9

Clinical Studies Adjustment: Upper Extremities

| | Grade Modifier 0 | Grade Modifier 1 | Grade Modifier 2 | Grade Modifier 3 | Grade Modifier 4 |
|---|--|---|---|---|---|
| Class Definitions | No problem | Mild problem | Moderate problem | Severe problem | Very severe problem |
| Imaging Studies | No available clinical studies or relevant findings | Clinical studies confirm diagnosis, mild pathology | Clinical studies confirm diagnosis, moderate pathology | Clinical studies confirm diagnosis, severe pathology | Clinical studies confirm diagnosis, very severe pathology |
| Shoulder | | | Clinical studies confirm one of the following symptomatic diagnoses: rotator cuff tear, SLAP or other labral lesion, biceps tendon pathology | | Clinical studies confirm more than one of the following symptomatic diagnoses: rotator cuff tear, SLAP or other labral lesion, biceps tendon pathology. The most significant diagnosis is the only one rated. |
| X rays | | | | | |
| Arthritis | | Cartilage interval normal or mild joint space narrowing and/or osteophytes | Cartilage interval: moderate joint space narrowing with cystic changes on 1 or both sides of joint and/or osteophytes; radiographic evidence of mild posttraumatic arthrosis; avascular necrosis without collapse | Cartilage interval severe joint space narrowing with cystic changes on both sides of joint and/or osteophytes; or avascular necrosis with bony collapse/fragmentation | No cartilage interval; radiographic evidence of severe posttraumatic arthrosis |
| Stability | | | | | |
| Joint laxity (based on stress testing) | | <10° Instability | 10°–20° Instability | 20°–30° Instability | >30° Instability |
| Wrist (see text for explanation) | | Radiolunate angle 11°–20° Scapholunate angle 61°–70° Scapholunate gap 3–5 mm Triquetrolunate stepoff >1 mm Ulnar translation mild | Radiolunate angle 21°–30° Scapholunate angle 71°–80° Scapholunate gap 6–8 mm Triquetrolunate stepoff >2 mm Ulnar translation moderate | Radiolunate angle >30° Scapholunate angle >80° Scapholunate gap >8 mm Triquetrolunate stepoff >3 mm Ulnar translation severe | |
| Nerve Conduction Testing | Normal | Conduction delay (sensory and/or motor) | Motor conduction block | Partial axonal loss | Total axonal loss/denervation |

Final Calculation

Start with Default Rating

- Class C, Grade 1, 5%

Net adjustment Formula

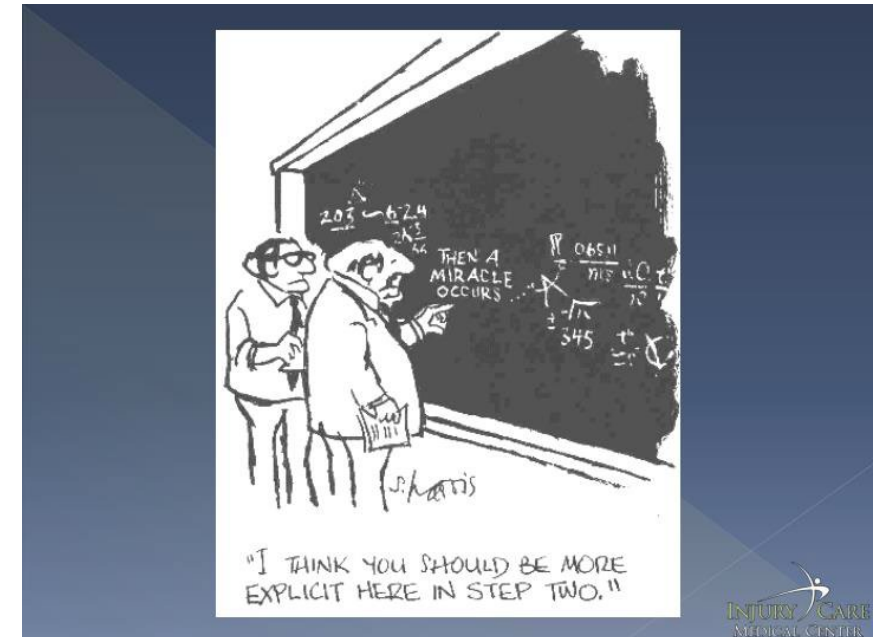
- Functional History modifier 2- ($2-1=1$)
- Physical Exam modifier 1- ($1-1=0$)
- Clinical Studies modifier 1- ($2-1=1$)

Final Net Adjustment is +2

Final Impairment is 7% upper extremity

TABLE 15-5 Shoulder Regional Grid: Upper Extremity Impairments

| IMPAIRMENT CLASS | CLASS 0 | CLASS 1 | CLASS 2 | CLASS 3 | CLASS 4 |
|---|--|---|------------|------------|-------------|
| IMPAIRMENT RANGES (upper extremity %) | 0 | 1%–13% UE | 14%–25% UE | 26%–49% UE | 50%–100% UE |
| GRADE | | A B C D E | A B C D E | A B C D E | A B C D E |
| LIGAMENT/BONE/JOINT* | | | | | |
| Rotator cuff injury, full-thickness tear* | 0 No significant objective abnormal findings at MMI | 1 2 3 4 5 History of painful injury, residual symptoms without consistent objective findings (this impairment can only be given once in an individual's lifetime) 3 4 5 6 7 Residual loss, functional with normal motion | | | |



Range of Motion

Use ROM when there is no DBI

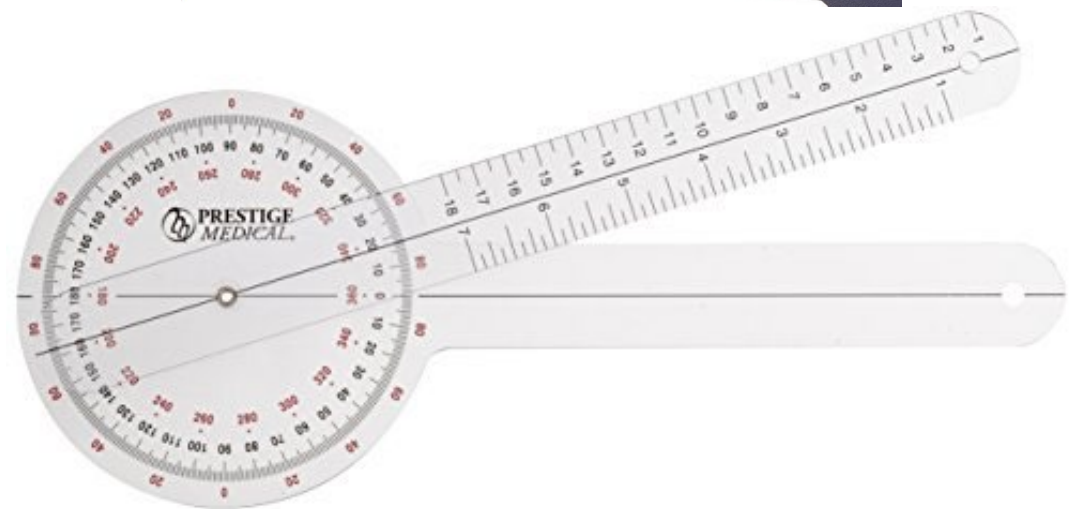
Must take into consideration opposite side if no disease or prior surgery

- Subtract difference

Must use a goniometer to measure range 3 times and use the greatest measurement

Add all deficits

- Shoulder
 - Flexion
 - Extension
 - Abduction
 - Adduction
 - External Rotation
 - Internal Rotation



Range of Motion

| Grade Modifier | | 0 | 1 | 2 | 3 | 4 |
|--|--|----------------------------------|---------------------------|---------------------------------------|--|---|
| Severity | | None (Normal) | Mild | Moderate | Severe | Ankylosis |
| Motion (percentage compared to normal) | | $\geq 90\%$ | 61% to 90% | 31% to 60% | $\leq 30\%$ | |
| Joint | | | | | | |
| Shoulder | 50% Shoulder | | | | | |
| Flexion | Motion° = % Upper Extremity Impairment (% UEI) | $\geq 180^\circ = 0\%$ | 90° to 170° = 3% UEI | 20° to 80° = 9% UEI | $\leq 10^\circ = 16\% \text{ UEI}$ | 20° to 40° flexion = 15% UEI 10° flexion to extension or $\geq 50^\circ$ flexion = 25% UEI |
| Extension | | $\geq 50^\circ = 0\%$ | 30° to 40° = 1% UEI | 10° extension to 10° flexion = 2% UEI | $\geq 10^\circ$ flexion = 10% UEI | |
| Shoulder | 30% Shoulder | | | | | |
| Abduction | Motion° = % Upper Extremity Impairment (% UEI) | $\geq 170^\circ = 0\%$ | 90° to 160° = 3% UEI | 20° to 80° = 6% UEI | $\leq 10^\circ = 10\% \text{ UEI}$ | 20° to 50° of abduction = 9% UEI $\leq 10^\circ$ or $\geq 60^\circ$ abduction = 16% UEI |
| Adduction | | $\geq 40^\circ = 0\%$ | 10° to 30° = 1% UEI | 0° to 30° abduction = 2% UEI | $\geq 40^\circ$ abduction = 10% UEI | |
| Shoulder | 20% Shoulder | | | | | |
| Internal rotation (IR) | Motion° = % Upper Extremity Impairment (% UEI) | $\geq 80^\circ \text{ IR} = 0\%$ | 50° IR to 70° IR = 2% UEI | 10° ER to 40° IR = 4% UEI | $\leq 20^\circ \text{ ER} = 8\% \text{ UEI}$ | 20° to 50° IR = 6% UEI $\geq 60^\circ \text{ IR}$ or 10° IR to ER = 0% UEI |
| External Rotation (ER) | | $\geq 60^\circ \text{ ER} = 0\%$ | 50° ER to 30° IR = 2% UEI | 50° IR to 40° IR = 4% UEI | $\geq 60^\circ \text{ IR} = 9\% \text{ UEI}$ | |

Impairment Ratings

- Complex
- Ultimately the number is typically turned into a monetary award



2026
WORK RELATED
Injuries Workshop



INJURY CARE
MEDICAL CENTER

Thank you!

Impairment Ratings Enhance Settlement of Disputed Case

Attorney Deb Kohl

Legal Interpretation & Challenge of Flawed Impairment Rating

Attorney Shelley Harvey

Attorney Vincent Tentindo

MASSACHUSETTS SECTION 36 - SPECIFIC PERMANENT INJURIES

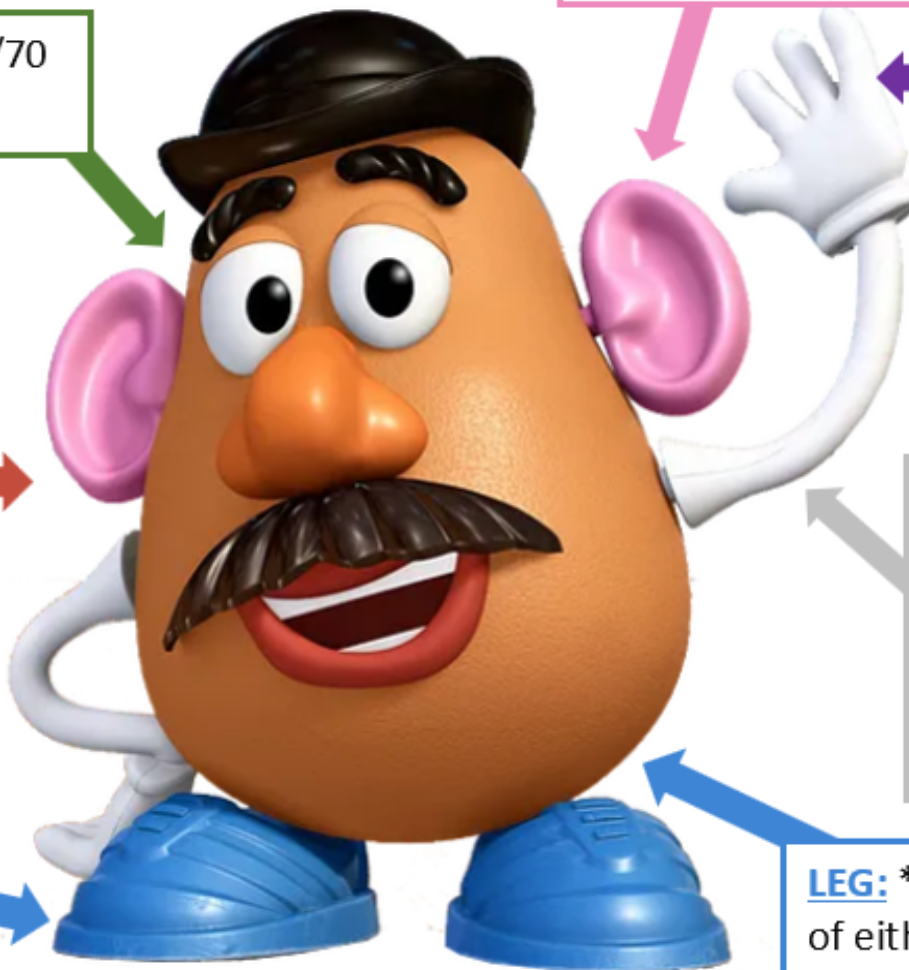
EFFECTIVE FOR INJURIES ON OR AFTER 12/23/91

EYE: total loss vision or reduction to 20/70 of both eyes with glasses = 96 x SAWW

SMELL OR TASTE:

*Total loss of either = 16 x SAWW
*Total loss of both = 32 x SAWW

FOOT: *Amputation of or perm loss of use of either foot at any point above the ankle = 29 x SAWW
*Amputation of or perm loss of use of both feet at any point above the ankle = 68 x SAWW



EAR: *Total loss of hearing in one ear = 29 x SAWW
*Total loss of hearing in both ears = 77 x SAWW

HAND: * Amputation of or perm loss of use of major hand = 34 x SAWW
*Amputation of or perm loss of use of minor hand = 29 x SAWW
* Amputation of or perm loss of use of both hands = 77 x SAWW

ARM: *Amputation of or perm loss of use of major arm = 43 x SAWW
*Amputation of or perm loss of use of minor arm = 39 x SAWW
*Amputation of or perm loss of use of both arms = 96 x SAWW

LEG: *Amputation of or perm loss of use of either leg = 39 x SAWW
*Amputation of or perm loss of use of both legs = 96 x SAWW

USE SAWW IN EFFECT ON THE DATE OF INJURY

Scarring/Disfigurement— Total allowed under §36(k) = \$15,000 (*includes mustache for MPH)

Psychological Impairment Ratings

<>
Where Medicine Psychology & Law Collide

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Disclosures

I have no disclosures

THE MOST DISABLING PART OF AN INJURY CAN BE PSYCHOLOGICAL



The clearest moment is when the Worker has reached **Maximum Medical Improvement** for their psychological symptoms.

At that point the **System** needs to know: **Is there a lasting impact?**

WHEN IS A PSYCHOLOGICAL IMPAIRMENT
RATING NECESSARY?

WC does not compensate for *sadness* in the abstract.

It compensates for loss of capacity.

A SECOND INDICATOR IS WHEN PSYCHOLOGICAL
SYMPTOMS ARE DRIVING FUNCTIONAL LIMITATIONS

When the Insurer <> Employer <> Legal Process
needs a Quantified Rating for
Settlement <> Ongoing Benefits <> Long-term Disability

A THIRD TRIGGER IS PROCEDURAL

Psychological Impairment Rating is NOT a measure of how upset someone feels, or how much we sympathize with them.

It's a structured description of functional loss that's attributable to their mental health condition.

We're rating what those conditions do to a person's real-world capacities.

THAT LEADS TO A SECOND QUESTION:
WHAT ARE WE MEASURING?

We're asking does this worker have persistent cognitive problems in concentration, decision-making, working memory that interfere with work?

Are there enduring limitations in how they relate to others, manage normal levels of stress, keep a normal pace, or tolerate environments that resemble their workplace trauma?

THAT LEADS TO A SECOND QUESTION:
WHAT ARE WE MEASURING?

Most of us work within the framework of the AMA Guides
to the Evaluation of Permanent Impairment 6th Edition

This includes a chapter on Mental Health & Behavioral Disorders

HOW DO WE DO THIS WORK?

Ground Rules the AMA 6th Edition Expects One to Follow

- ◆ Rate only permanent impairment, and only after Maximum Medical Improvement (MMI)
- ◆ Emphasizes objective/defensible methodology and a Transparent Report (how the ratings were calculated)
- ◆ The AMA Behavioral Chapter 14 is intended to quantify whole person impairment (WPI)

Common Exclusions in AMA Guides Chapter 14 MH BEH

Psychiatric reaction to pain
Somatoform disorders (including Pain Disorder)
Dissociative Disorders
Personality Disorders
Psychosexual/sexual & gender identity disorders
Factitious disorders
Substance use disorders
Dementia/delirium
Intellectual disability

We need a careful history of past psych issues, trauma exposure, the course of symptoms, treatment given and response to tx.

And how tightly this history is linked to the Work Event or not.

I listen carefully and document the worker's detailed account of the injury and its **physical** and **emotional** fallout— to get a true feel for how it turned their world upside down. This should also be corroborated by previous medical reporting.

HOW DO WE DO THIS WORK?

FIRST IS A THOROUGH CLINICAL INTERVIEW

Impairment Ratings use Standardized Scales

PCL-5 (PTSD Checklist) <> BPRS (Brief Psychiatric Rating Scale)
GAF (Global Assessment of Functioning)
PIRS (Psychiatric Impairment Rating Scale – 6 Domains)

They don't replace our judgement <> but they give us objective reference points when we later speak of "mild" "moderate" or "marked" impairment

SECOND IS THE USE OF TESTING INSTRUMENTS

How is the worker doing in Daily Activities & Managing Social Roles?

Concentration - Persistence - Adaptation to Stress

Handling a normal Work Routine & Mental Abilities & Aptitude for
Unskilled, Semi-Skilled, and Particular Types of Jobs

And how many domains are affected & how consistently?

THIRD – WE MUST LOOK DIRECTLY AT FUNCTIONAL
CAPACITY THRU A MENTAL HEALTH LENS

PIRS (Psychiatric Impairment Rating Scale –Chapter14 – 6 Domains)



Self-care ADLs

Their Roles & Social Functioning

How well they can Travel

Quality & Limitations around Interpersonal Relationships

Mental Capacity: concentration persistence pace

Resilience & Employability

AMA 6TH EDITION CHAPTER 14

A Solid Chapter 14 Impairment Report Documents:

- <> MMI and treatment course (what was tried; what remains)
- <> Record Review & Collateral Consistency among Clinicians
 - <> The writer's Clinical Interview and MSE Findings
 - <> Tables used, Scale totals, the Final Math
 - <> Discussion of inconsistencies/concerns
(symptom magnification, mismatch with longitudinal records)

FINALLY, THE LEGAL ISSUES OF
CAUSALITY & DISABILITY STATUS

It's Crucial to clearly articulate Connection to the Workplace Injury

A defensible report walks through how the psychological condition specifically arose out of the Work Event/Incident

The report needs to state why the current limitations are considered Permanent or Long-term rather than Temporary

FINALLY, THE LEGAL ISSUES OF
CAUSALITY & DISABILITY STATUS

Done well, it represents the worker's suffering without exaggeration.

It gives Employers and Insurers clear information.

And protects the integrity of both the clinical and legal systems.

It's one of the places where we can bring a bit of clarity to complexity, and little fairness to a moment in someone's life when fairness has felt in short supply.

FINALLY, THE LEGAL ISSUES OF
CAUSALITY & DISABILITY STATUS

Thank you!