

IAIME Core Competencies Study Curriculum

July 2021



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PART ONE: CORE COMPETENCIES

The following is a list of the Core Competencies (I-IX) relevant to the CMLE test offered by IAIME. The list is meant to be comprehensive in terms of topics and references are provided for more in-depth discussion of these topics. Some of the topics may require you to do your own research.

I. ETHICS AND MEDICOLEGAL

Key Learning:

- Describe the nature of an ethical dilemma, and the principles for resolving them
- Identify the key ethical concerns that can arise in medicolegal evaluations

Summary and Rationale:

A medicolegal evaluator is obligated to make clear to the examinee that he or she is not providing care at the time of the evaluation. Although a physician-patient relationship is not established - and a disclaimer stating that should be part of the IME report - some jurisdictions have found that there is still an obligation to the examinee, with respect to medical conditions that might be unrelated. There is an inherent potential ethical conflict in being both an evaluator and treating provider, but despite this, compensation systems often require a level of overlap that poses challenges to health providers. Beyond these issues that are specific to medicolegal evaluations, other professional ethical principles continue to apply, and a competent evaluator should be aware of potential ethical concerns, as well as strategies for managing them.

Resources:

- Ebrahim S, Sava H, Kunz R, Busse JW. Ethics and legalities associated with independent medical evaluations. *CMAJ*. 2014;186(4):248–249. doi:10.1503/cmaj.131509. (free on PubMed)
- <https://www.ama-assn.org/delivering-care/ethics/work-related-independent-medical-examinations>
- https://www.ama.com.au/sites/default/files/documents/Ethical_Guidelines_for_Conducting_Independent_Medical_Assessments.pdf

Study Guide:

- Ethical behavior for engaging with patient/examinee
- Conflict of interest between treating and examiner roles
- Duty of care and identifying medical conditions other than IME-related diagnosis

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- Methods for identifying and resolving ethical conflicts
- Define and apply the concepts of an ethical dilemma

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II. BEHAVIORAL, OCCUPATIONAL, & NON-OCCUPATIONAL RISK FACTORS

Key Learning:

- Identify psychological symptoms, and psychosocial risk factors that affect outcome.
- Identify personal, social, cultural, and workplace factors that affect outcome
- Identify strategies used for screening psychological symptoms and common psychosocial risk factors that impact medicolegal claims.

Summary and Rationale:

The biopsychosocial model is more effective than the biomedical model in evaluating disease and injury causation. The evaluator should be aware of the personal, social, cultural, and workplace factors that affect health and wellness, recovery, and return to function, including work.

Resources:

- Melhorn, Blue Book,
- AMA Guides, 6th Edition
- Talmage Work Ability and RTW
- Caruso and Kertay; Delayed and Failed Recovery and Unnecessary Disability, Part 1 and Part 2, AMA Guides Newsletter, May June (Part 1) & July/August, 2019 (Part 2)
- Edwards RR,. The Role of Psychosocial Processes in the Development and Maintenance of Chronic Pain.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5012303/pdf/nihms761719.pdf>

Study Guide:

- Definition/etiology of chronic pain (*AMA Guides, 6th Ed. Ch. 3*)
- Definition of chronic pain syndrome (*AMA Guides, 6th Ed. Ch. 3*)
- Pain behaviors: facial expression, body habitus, reactivity to touch
 - *AMA Guides to the Evaluation of Permanent Impairment 6th Ed, Glossary*
 - *Melhorn, Blue Book, Ch. 6*
- Risk factors for transition from acute to chronic pain
 - <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5012303/pdf/nihms761719.pdf>

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- Definition of and strategies for identifying malingering, symptom exaggeration, and inadequate effort
 - *AMA Guides, 6th Edition, Ch. 14*
 - *Melhorn, Blue Book, Ch. 6*
- Common psychiatric conditions that may be comorbid with, and complicate, other medical conditions in medicolegal claims
 - *Melhorn, Blue Book, Ch. 6*
 - *AMA Guides, 6th Edition, Ch. 14*
 - *Talmage Work Ability and RTW, Ch. 22 and 23*
- Common screening measures for psychological symptoms/psychiatric conditions
 - *AMA Guides, 6th Edition, Ch. 14*
- Common screening measures for psychosocial risk factors in delayed recovery and return to work
 - *Talmage, AMA guides RTW*
 - *AMA Guides, 6th Edition, Ch. 14*
 - *Caruso and Kertay; Delayed and Failed Recovery and Unnecessary Disability, Part 1 and Part 2, AMA Guides Newsletter, May June (Part 1) & July/August, 2019 (Part 2)*

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III. WORK-ABILITY AND RETURN TO WORK – PRINCIPLES

Key Learning:

- Describe the key components considered in a return to work assessment
- Describe the differences between risk, capacity, and tolerance
- Describe the risk factors for failure to return to work
- Describe the role of non-occupational risk factors and psychosocial factors in returning an injured worker to work

Summary and Rationale:

The AMA Guides to the Evaluation of Work Ability and Return to Work, 2nd Ed., outlines the importance of staying at work or returning to work and how to think about work ability and restrictions. The distinction between risk, capacity, and tolerance and limitations is important, and often overlooked. For the physician, objectivity is important with respect to identifying objective medical conditions that preclude specific activities vs. the individual's reported tolerance for activities and self-limiting behavior.

Resources:

- Talmage JB, Melhorn JM, Hyman, MH. *AMA Guides to the Evaluation of Work Ability and Return to Work*, 2011 AMA, Chicago Illinois

Study Guide:

- Why staying at work or returning to work is in the patient's best interest (Ch. 1)
- **Negative prognostic factors** associated with delayed return to work, delayed recovery
 - Individual risk
 - Job risk
 - Psychosocial risk
- **Positive prognostic factors** associated with timely return to work, recovery
 - Resilience
 - Employer support
 - Psychosocial support
- **Definitions:** disability, activity, participation, activity limitation, participation restriction
- **Risk, capacity, tolerance:** (Ch. 2 and 6).

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- **Job strain:** <https://pubmed.ncbi.nlm.nih.gov/16234404/>
- **Functional Capacity Evaluation:** definition, methods, value, validity (Ch. 6).
- **Dictionary of Occupational Titles:** sedentary, light, medium, heavy, very heavy
- **Work demands:** occasional, frequent, constant
- **Cognitive and psychological demands:** assessment, impact
 - <https://pubmed.ncbi.nlm.nih.gov/28980107/>

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IV. BIOSTATISTICS AND RESEARCH COMPETENCIES

Key Learning:

- Identify and apply strategies for differentiating high quality from low- quality research
- Identify and apply strategies for applying evidence-based research findings to opinions on medicolegal issues, causation, and disability
- Define evidence-based medicine and describe its role in the field of disability

Summary and Rationale:

Evidence-based medicine can be defined as “a set of principles and methods intended to ensure that to the greatest extent possible, medical decisions, guidelines, and other types of guidance are based on and consistent with good evidence of effectiveness and benefit.”

(AMA Guides to the Evaluation of Work Ability and Return to Work 2nd E., p 69)

The application of evidence-based medicine requires critical evaluation of relevant studies, point estimates, relative risk, odds ratios, confidence intervals, bias, and confounding. This section on biostatistics is essential to ensure accurate assessment of research for practice in the return-to-work arena, and when opining on causation, medico-legal issues, and disability/return to work issues.

(AMA Guides to the Evaluation of Work Ability and Return to Work, 2nd Ed, p 69)

Understanding the relevant statistics allows us to look at data and facts, rather than relying on opinions and persuasion.

Resources:

- Chapter 5 in the AMA Guides to the Evaluation of Work Ability and Return to Work, 2nd Ed.
- Chapter 2 in the AMA Guides to the Evaluation of Disease and Injury Causation, 2nd Ed.

Study Guide:

- **Data sources and study designs:** understand literature pyramid and the relative value of study types (RCT, blinding, retrospective v prospective, cohort vs case control vs cross-sectional study, etc.
 - *Talmage, AMA Return to Work, Ch. 5*

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- **Epidemiology:** basic terminology, nature of the study, target population, type of study (e.g., retrospective vs. prospective)
 - *Talmage, AMA Return to Work, Ch. 5*
- **Bias:** definition, three main categories – (selection, information and publication)
 - *Talmage, AMA Return to Work, Ch. 5*
- **Descriptive statistics:** statistics for concisely summarizing data; mean (average), median, mode, standard deviation, range, sample size.
 - <https://www.scribbr.com/statistics/descriptive-statistics/>
- **Inferential statistics:** statistics applied to a random sample of data from a specific population, in order to make inferences about the population; normal distribution, correlation, t-distributions, chi-square, confidence intervals, regression analysis/linear regression, factor analysis.
 - <https://www.statisticshowto.com/probability-and-statistics/statistics-definitions/inferential-statistics/>
 - <https://www.statisticshowto.com/probability-and-statistics/statistics-definitions/inferential-statistics/>
- **P-value:** the extent to which a particular result is (and is not) likely due to random variation (chance); definition, p values, thresholds for significance
 - *Melhorn, Blue Book, Ch. 2*
 - *Talmage, Return to Work, Ch. 5*
- **Validity, reliability, precision, accuracy:** definitions, relationships between them, measurement
 - <https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1744-6155.2008.00171.x>
- **Sensitivity, specificity, base rate, positive predictive value, negative predictive value:** related to classification and diagnostic accuracy; definitions, relationships, applications to understanding measures used in the diagnosis
 - *Melhorn, Blue Book Ch. 2*
- **Relative risk/Risk Ratio (RR) and odds ratio (OR):** definitions, distinctions, threshold values for relevance
 - *Melhorn, Blue Book Ch. 2*

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V. CAUSATION ANALYSIS – PRINCIPLES

Key Learning:

- Describe the key components of a causation analysis
- Describe the importance of a reproducible methodology for determining causation
- Describe the differences between medical and legal causation

Summary and Rationale:

Medical causation differs from legal causation and this distinction is important. The determination of medical causation is based on a scientific analysis using a standard methodology, discussed at length in the *AMA Guides to the Evaluation of Disease and Injury Causation, 2nd Ed, Ch. 2*

Legal causation refers to the threshold standards of the jurisdiction i.e., reasonable or simple medical probability (>50%), probable versus possible, more probable than not, or an iota of contribution. In some states, the incident need only be a contributing cause. As an expert, the criteria used to reach an opinion regarding causation and work-relatedness must be clear.

Resources:

- AMA Guides to the Evaluation of Disease and Injury Causation, 2nd Ed.
- ACOEM Guidelines, Work Relatedness, William W. Greaves, MD, MSPH, Rajiv Das, MD, MPH, MS, Judith Green McKenzie, MD, MPH, Donald C. Sinclair II, JD, and Kurt T. Hegmann, MD, MPH
- AMA Guides, 6th edition, Ch. 2.

Study Guide:

- **Causality:** types of causation, definitions, applications to IME
 - A causal event took place
 - Individual experiences a condition (exposure)
 - The event can cause the condition (epidemiological analysis)
 - The event caused or materially contributed to the condition within medical probability (causation analysis)
- **Hill criteria:** *Lucas RM, McMichael AJ. Association or causation: evaluating links between "environment and disease". Bull World Health Organ. 2005 Oct;83(10):792-5. PMID: 16283057; PMCID: PMC2626424.*

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- **Medical causation vs. legal causation:** definitions, distinctions, language, jurisdiction-specific standards.
 - *Melhorn, Blue Book, Ch. 2*
- **Pre-existing conditions**
 - *Melhorn, Blue Book, Ch. 5: Apportionment*
- **Aggravation vs. Exacerbation**
 - *AMA Guides to the Eval of Perm Impairment, 6th edition, Ch. 2*
- **Methodology for Determining Work-Relatedness/ Causation**
- **NIOSH and ACOEM Steps for the Determination of Work-Relatedness of a Disease.**
 - **6 step process**
 1. Diagnosis: evidence of disease
 2. Epidemiology
 3. Evidence of exposure
 4. Other factors
 5. Validity of testimony
 6. Conclusion

References:

- *Melhorn, Blue Book, Ch. 3.*
- <https://acoem.org/acoem/media/News-Library/JOEM-Work-relatedness-Dec-2018.pdf>
- **Occupational vs. Non-Occupational Risk Factors for Common Conditions (e.g., carpal tunnel, low back pain, CRPS, TBI)**
 - *Melhorn, Blue Book, region specific Ch. .*
- **Apportionment: allocation of causation among multiple factors**
 - *Melhorn, Blue Book, Ch. 5*

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VI. PAIN, OPIOIDS AND OTHER PHARMACOLOGY

Key Learning:

- Describe the key pharmacology (& psychopharmacology) of opioids and other analgesic medications, with appropriate uses, misuses, and potential abuse
- Identify and describe the key features of relevant guidelines for the use of opioid and other analgesic medications
- Describe the current state of knowledge about, and uses of marijuana and derivatives (including cannabinoid/CBD and psychoactive/THC components)

Summary and Rationale:

Pain is a common part of medicolegal claims and evaluations, and because of that claimants are often taking analgesics, including opioids. Medicolegal evaluators need to be aware of the basic pharmacology of these medications, current guidelines for appropriate use, and how to address the impact of these medications on examination findings. Knowledge of alternative analgesics (e.g., NSAIDs, acetaminophen), with indications and contraindications is also necessary, as is an understanding of medications used for neuropathic pain. Finally, with the growing use of medical marijuana, recreational marijuana, and cannabinoids, medicolegal evaluators should be aware of the current state of research on the use of these drugs.

Resources:

- CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. Recommendations and reports/ March 18,2016 / 65(1); 1-49
- AMA Guides, 6th edition, Ch. 3
- Nonopioid Pharmacologic Treatments for Chronic Pain. Comparative Effectiveness Review No. 228. Agency for Healthcare Research and Quality; April 2020. <https://effectivehealthcare.ahrq.gov/products/nonopioid-chronic-pain/research>
- Clinical Practice Guidelines for Pain Management: J Orthopedics, DOI: https://journals.lww.com/jorthotrauma/Fulltext/2019/05000/Clinical_Practice_Guidelines_for_Pain_Management.11.aspx

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Study Guide:

- **Use of common pharmaceuticals for treating pain (e.g., analgesics, gabapentin, pregabalin, antidepressants and anticonvulsants);**
 - *Nonopioid Pharmacologic Treatments for Chronic Pain. Comparative Effectiveness Review No. 228. Agency for Healthcare Research and Quality; April 2020. DOI: <https://doi.org/10.23970/AHRQEPCCER228>*
- **Long-term use of opioids for non-malignant pain**
 - Hyperalgesia
 - Opioid use disorder (definition)
 - Physical dependence, tolerance, addiction (definition)
- **Indications for appropriate use of opioids**
 - *CDC Guideline for Prescribing Opioids for Chronic Pain–United States, 2016.*
<https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>
- **Indications and pharmacology for NSAIDS**
 - <https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/nonopioid-chronic-pain.pdf> (summary p 47-54)
- **Indications and pharmacology for anticonvulsant medications in treating pain**
 - As above
- **Guidelines for analgesic medications**
 - https://journals.lww.com/jorthotrauma/fulltext/2019/05000/clinical_practice_guidelines_for_pain_management.11.aspx
- **Current state of knowledge for cannabis-related drugs**
 - *Cannabidiol adverse effects and toxicity. Current Neuropharmacology 2019;27:974-989. DOI: <https://doi.org/10.2174/1570159X17666190603171901> (Review article includes indications)*

Notes:

VII. HISTORY & PHYSICAL; GENERAL & MUSCULOSKELETAL CONDITIONS

Key Learning:

- Describe the key components of a clinical examination for independent medical opinion and other work-relevant clinical purposes
- Describe the importance of the interview and the significance of medical history as documented in the medical records
- Understand the contribution of non-occupational risk factors to a condition

Summary and Rationale:

Competence in disability medicine involves the appropriate application of clinical competence across a variety of evaluations and assessment of treatment in the context of workplace absence and return to work.

Causality examinations, examinations undertaken for impairment ratings, and other services delivered in medico-legal circumstances differ from a traditional clinical evaluation and treatment. Examination findings must be interpreted in terms of relevance to daily activities, including those required to perform job-related functions. A more detailed history and review of records are necessary. Clinical examination will frequently include adjacent joints, contralateral side and specific measurements/clinical tests. For example: in a case of an injured Right shoulder, the examination of the Left shoulder is necessary to establish normal - and examination should include the cervical spine.

Resources:

- AMA Guides to the Evaluation of Disease and Injury Causation, 2nd Ed. (Ch. 6).
- The State of Washington Department of Labor & Industries Medical Examiners' Handbook <https://www.lni.wa.gov/forms-publications/F252-001-000.pdf>
- Stanley Hoppenfeld, Orthopaedic neurology; a diagnostic guide to neurologic levels. 1977 Lippincott Williams & Wilkins, ISBN13:9780397503681 (available on eBay)
- Stanley Hoppenfeld, Physical Examination of the spine and extremities. Prentice Hall PTR, 1976 (available on eBay)

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Study Guide:

- **Common definitions:**
 - *AMA Guides Ch. 1 and 2, Glossary*

- **History and physical:** including but not limited to:
 - Cultural awareness, detailed documentation, handedness
 - Extremity evaluation: document bilateral findings; uninjured contralateral side may serve as a baseline for defining normal for impaired extremity
 - Validity indicators: Waddell's signs, behavioral observations, formal assessment, documentation
 - History of previous injuries, illnesses, surgeries
 - Relevant psychosocial history
 - Consistency: between self-report and medical records, between providers, across time, between symptoms and signs, between stated capacity and behavioral observations
 - Two-point discrimination, sensation, sensibility
 - When are clinical tests such as SLR and Spurling's considered positive - what do they test?
 - Circumferential measurements
 - Joints matched with provocative maneuvers
 - Nerve Roots matched to DTR, Myotomes, and Dermatome

- **Other data analysis:**
 - Imaging and labs: review of available imaging/ labs; obtain necessary imaging for personal review
 - Differential diagnosis: hip pain vs. sciatica, neck vs. shoulder pathology, decision trees, rule-outs
 - Motor evaluation: Grip strength, dexterity, motor speed; normal distribution, dominant vs. non-dominant expectation, variability over trials
 - Functional correlations: ADLs, IADLs, work tasks

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- **Common musculoskeletal disorders and relevant occupational vs. non-occupational risk factors:** neck pain, low back pain, shoulder (RCT); dislocations of large joints; radiculopathy, peripheral nerve entrapment, dupuytrens, carpal tunnel syndrome, ganglions, avascular necrosis (AVN), CRPS
 - *AMA Guides, 6th edition, Ch. 15, 16, and 17*
 - *Melhorn, Blue Book*
 - *Talmage, AMA Guides to Return to Work*

- **Common medical conditions and relevant risk factors:** inflammatory arthritides (i.e., Gout), lung conditions (i.e., Asthma, Asbestosis), vestibular dysfunction, hearing loss, visual system, diseases matched with anatomical findings
 - *AMA Guides, 6th edition*
 - *Melhorn, Blue Book*
 - *Talmage, AMA Guides to Return to Work*

- **Common psychiatric condition and relevant risk factors:** PTSD, adjustment disorder, depressive disorders, anxiety disorders, personality disorders, somatic symptom disorders.
 - *AMA Guides, 6th edition, Ch. 14*
 - *Melhorn, Blue Book*
 - *Talmage, AMA Guides to Return to Work*

- **Common musculoskeletal/ neurologic disorders and relevant occupational vs. non-occupational risk factors:**
 - *AMA Guides, 6th edition, Ch. 13*
 - *Melhorn, Blue Book*
 - *Talmage, AMA Guides to Return to Work*

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VIII. CLINICAL COMPETENCIES: PSYCHOLOGY AND PSYCHIATRY

Key Learning:

- Describe the key components of a psychological clinical examination for independent medical opinion and other work-relevant clinical purposes
- Describe the importance of the interview and the significance of medical history and records for the psychological evaluation
- Understand the key concepts and diagnoses of psychiatric conditions as they apply to disease and injury causation
- Understand the contribution of occupational and non-occupational risk factors to a psychological condition
- Identify the neuropsychological standards by which cognitive impairments are defined.

Summary and Rationale:

The *AMA Guides to the Evaluation of Permanent Impairment*, 6th Ed., provide a framework for IMEs and impairment rating of psychiatric issues. Editions differ in how to evaluate and rate pain, which inherently involves psychological and social concerns, in addition to medical conditions. A competent Behavioral Health medicolegal evaluator must be an expert in diagnosing and treating psychiatric conditions, including diagnosing psychiatric conditions, psychological symptoms, and/or psychosocial factors that are relevant to the evaluation and should be considered in the forensic evaluation.

Resources:

- DSM5, American Psychiatric Association
- AMA Guides to the Evaluation of Permanent Impairment 6th Ed, Ch. 1, 2, 3, 14 and Glossary
- Melhorn, Blue Book, Ch. 6, 7, and 16
- Work Ability and Return to Work, Ch. 22 and 23
- Edwards RR,. The Role of Psychosocial Processes in the Development and Maintenance of Chronic Pain.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5012303/pdf/nihms761719.pdf>
- Nonopioid Pharmacologic Treatments for Chronic Pain. Comparative Effectiveness Review No. 228. Agency for Healthcare Research and Quality; April 2020. DOI: <https://doi.org/10.23970/AHRQEPCCER228>

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Study Guide:

- **Principal of Beneficence**
- **Common definitions:** *AMA Guides Ch. 1 and 2, Glossary*
 - Definition/*etiology* of chronic pain (*AMA Guides, 6th Ed. Ch. 3*)
 - Definition of chronic pain *syndrome* (*AMA Guides, 6th Ed. Ch. 3*)
 - Pain *behaviors*: facial expression, body habitus, reactivity to touch
 - *AMA Guides to the Evaluation of Permanent Impairment 6th Ed, Glossary*
 - *Melhorn, Blue Book, Ch. 6*
- Risk factors for transition from acute to chronic pain
 - *Edwards RR,. The Role of Psychosocial Processes in the Development and Maintenance of Chronic Pain.*
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5012303/pdf/nihms761719.pdf>
- Definition of and strategies for identifying malingering, symptom exaggeration, and inadequate effort
 - *AMA Guides, 6th Edition, Ch. 14*
 - *Melhorn, Blue Book, Ch. 6*
- Common psychiatric conditions that may be comorbid with, and complicate, other medical conditions in medicolegal claims
 - *Melhorn, Blue Book, Ch. 6*
 - *AMA Guides, 6th Edition, Ch. 14*
 - *Talmage Work Ability and RTW, Ch. 22 and 23*
- Common screening measures for psychological symptoms/psychiatric conditions
 - *AMA Guides, 6th Edition, Ch. 14*

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- Common screening measures for psychosocial risk factors in delayed recovery and return to work
 - *Talmage, AMA guides RTW*
 - *AMA Guides, 6th Edition, Ch. 14*
 - *Caruso and Kertay; Delayed and Failed Recovery and Unnecessary Disability, Part 1 and Part 2*
 - *AMA Guides Newsletter, May June (Part 1) & July/August, 2019 (Part 2)*

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IX. IMPAIRMENT RATINGS:

Key Learning:

- Identify definitions and common features of impairment ratings, their applications, and potential misuses
- Describe and be able to apply the key edition-independent methods for evaluating and rating impairment

Summary and Rationale:

Impairment ratings are designed to assess objective findings associated with a condition, rather than subjective complaints, although the ability to perform ADLs may be taken into consideration, depending on the version of *the Guides* being used. In some jurisdictions, chronic pain may be rated, in other jurisdictions, it is excluded, as are functional limitations. Some features are edition-specific, and others are general principles that apply across editions and systems. Medicolegal evaluators should also have a working knowledge of alternative methods for determining impairment, including jurisdiction-specific methodology and the WHO approach to identifying and describing impairment and disability.

Resources:

- AMA Guides to the Evaluation of Permanent Impairment, 6th edition, Ch. 1 & 2 and Glossary
- AMA Guides to the Evaluation of Permanent Impairment, 6th edition, System specific Chapter
- AMA Guides to Disease and Injury Causation

Study Guide:

- Maximum medical improvement (MMI): definition, evaluation, and applications
- ADLs and IADLs vs. other activities, including driving as a special case
- Range of motion measurements
- Extension lag versus flexion contraction
- Digit/thumb % of hand, and % of UE, etc.
- Adding joints versus combining
- Pulmonary function tests and impairment
- Hearing impairment
- Visual impairment

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- Principles for calculating impairment ratings, and general differences between editions of the *AMA Guides*
- General knowledge of jurisdiction-specific impairment ratings, including for federal employees
- Including a demonstration of how an impairment rating was determined, for including in a medicolegal report

Upper Extremity Impairments:

AMA Guides 6th edition, Ch. 15, or equivalent earlier edition:

Melhorn, Blue Book, Ch. 9

Hoppenfeld S, Physical Examination of the Spine and Extremities

- Principles of Assessment and Impairment Classes
- Functional history
- Steps in performing an impairment rating
- Diagnosis Based Impairment
- UE Regional Grids and their use
- CRPS Impairment
- Peripheral Nerve Impairment
- Amputation Impairment
- Range of Motion Impairment
- Definitions of hypoesthesia, hyperesthesia and allodynia (*AMA Guides 6th ed Ch. 3*)
- Injury to opposite extremity (*Melhorn, Blue Book Ch. 33*)

Lower Extremity Impairments:

AMA Guides 6th edition, Ch. 16 or equivalent earlier edition

- Principles of Assessment and Impairment Classes
- Functional history
- Steps in performing an impairment rating
- Diagnosis Based Impairment
 - UE Regional Grids and their use
 - Carpal Tunnel (Basic Anatomy and Melhorn, Blue Book Ch. 9)

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- CRPS Impairment
- Peripheral Nerve Impairment
- Amputation Impairment
- Range of Motion Impairment
- Injury to opposite extremity (*Melhorn, Blue Book Ch. 33*)

The Spine and Pelvis:

AMA Guides 6th edition, Ch. 17 or equivalent earlier edition

- Principles of Assessment
- Diagnosis Based Impairment
 - Adjustment Grid and Grade Modifiers
- Alteration of Motion Segment Integrity (AOMSI)
- Pelvic Impairment
- Pain Disability Questionnaire (PDQ)

The Central and Peripheral Nervous System:

AMA Guides 6th edition, Ch. 13 or equivalent

- Principles of Assessment
- Method and criteria for Rating Cerebral Impairments
- Rating Spinal Cord dysfunction and Movement Disorders
- Rating the Upper extremities due to CNS dysfunction
- Rating neurogenic bowel, bladder and sexual dysfunction
- Rating respiratory dysfunction
- Rating Peripheral neuropathies
- Rating CRPS
- Rating neuropathies of the trunk
- Basic anatomy of dermatomes/myotomes/ reflexes

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X. REPORT WRITING

Key Learning:

- Describe the core elements of a thorough report for medico legal purposes, and features of the variations based on specific settings (e.g., workers compensation, public disability, private disability, accident/personal injury, etc.)
- Describe the features of language, presentation style, and tone that are important to promote the integrity of the report and maximize the credibility of findings

Summary and Rationale:

Independent medical evaluations and record reviews are intended to present an unbiased assessment of the individual's complaints and physical examination findings. History, physical examination findings, past medical history and the other standard parts of an evaluation should be documented clearly. Opinions related to diagnosis, causation analysis, return to work, etc. should be clear and concise, and may contain references to support those opinions.

Resources:

- AMA Guides to the Evaluation of Disease and Injury Causation, 2nd Ed (Ch. 7)
- The State of Washington Department of Labor & Industries Medical Examiners' Handbook <https://www.lni.wa.gov/forms-publications/F252-001-000.pdf>

Study Guide:

- **Language:** choice of words that reflect bias, all-or-none language, modifiers (inflators and minimizers), pejorative terms.
 - <https://academicguides.waldenu.edu/writingcenter/scholarlyvoice/avoidingbias>
 - <https://apastyle.apa.org/style-grammar-guidelines/bias-free-language/general-principles>
- **Identifying inconsistencies:** symptom report, history, medical records, examination findings, expected course of recovery, behavioral observations, daily activities
 - *Melhorn, Blue Book, Ch. 6*
- **Jurisdictional language:** reasonable degree of medical probability, reasonable degree of medical certainty, more probable than not
 - *Melhorn, Blue Book, Ch. 2*

IAIME Core Competencies Study Curriculum



- **The rationale for using references (or not):** “authoritative text,” citations, guidelines, AMA texts (pro/con)
 - *Melhorn, Blue Book, Ch. 2*

Notes: