
**"Within the Four corners of the AMA Guides:
Universal Rating Principles Applicable to the Objective Determination of Impairment"**

Foundation: If the evaluating physician's rating is inconsistent with the Guides' protocol, then it is not within the four corners of the Guides. *If a rating is not within the '4 corners of the AMA Guides' can it be considered substantial medical evidence to rebut a correct rating under the Guides as per SB § 899, LC § 139.2(j)(2), LC § 4660(b)(1), LC § 4460(d) and Almaraz-Guzman-2 ?*

- **Almaraz-Guzman-2 pg. 03:**

"We emphasize that our decision does not permit a physician to utilize any chapter, table, or method in the AMA Guides simply to achieve a desired result, e.g., a WPI that would result in a permanent disability rating based directly or indirectly on any Schedule in effect prior to 2005. A physician's opinion regarding an injured employee's WPI under the Guides must constitute substantial evidence; therefore, the opinion must set forth the facts and reasoning which justify it. Moreover, a physician's WPI opinion that is not based on the AMA Guides does not constitute substantial evidence."

- **AMA Guides 5th Edition, Chapters 2, page 17, LC § 4660(b)(1), LC § 4660(d).**

If the medical evaluator provides a miscalculation of impairment and the body of the medical report supports and includes objective clinical criteria that would support a higher or lower impairment, the AMA Guides allows any knowledgeable observer to adjust the reported impairment accordingly.

- **Almaraz-Guzman- II, pg 24:**

"A physician's WPI opinion that is not based on the AMA Guides does not constitute substantial evidence because it is inconsistent with the mandate of section 4660(b)(1). (Hegglin V. Workmen's Comp. Appeals Bd. (1971) 4 Cal.3d 162, 169 [36 Cal.Comp.Cases 93, 97] ("Medical reports and opinions are not substantial evidence ... if they are based ... on incorrect legal theories"); Zemke V. Workmen's Comp. Appeals Bd. (1968) 68 Cal.2d 794, 799 [33 Cal.Comp.Cases 358, 360] ("an expert's opinion which ... assumes an incorrect legal theory cannot constitute substantial evidence")."

Commission on Health, Safety & Workers Compensation

<http://www.dir.ca.gov/chswc/Section-by-section-Review-of-SB899.pdf>

- **LC Section § 139.2(j)(2):** All Physicians are to evaluate permanent disability consistent with the ratable criteria set forth in Section 4660 which states that the 'nature of physical injury or disfigurement' shall incorporate the AMA 5th Edition for both descriptions and percentage impairments.

I. Keystone: Guides 5th Edition Rates The Objective Manifestation of Impairment

1. The AMA Guides 5th Edition defines the standard methods the medical evaluator must follow to measure the objective manifestations of impairment when considering both anatomic and functional loss, even after Almaraz-Guzman-2.

2. Definition of Objective – <http://medical-dictionary.thefreedictionary.com/objective>

- 1. Based on observable phenomena; presented factually.
- 2. Indicating a symptom or condition perceived as a sign of disease by someone other than the person affected.

Substantial Medical Evidence: Clinical Foundation of Impairment

- **Allows for consistent analysis and communication of medical information through a single set of standards.**
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- **AMA 5th Edition Section 1.2, pg. 02:**
“The Guides defines impairment as a loss, loss of use, or derangement of any body part, organ system, or organ function.”
 - **AMA Guides 5th Edition – Criteria for Rating Permanent Impairment pgs 17 & 18, 28, 65, 87, 117, 143,173, 191, 211, 245, 277, 305, 357, 373, 433, 523 and 565.**
 1. Chapter 2 establishes the foundation for how to use the Guides for consistent and reliable acquisition, analysis, communication, and utilization of medical information through a single set of standards.
 2. Chapters 3 thru 18 provide the specific objective criteria for evaluating permanent impairment and the effects of the impairment on an individual’s ability to perform activities of daily living.
 3. Introductory Chapter Sections describe the medical studies and objective procedures useful in establishing the impairments.
 - 3.1. Specific criteria is found in sections addressing specific impairment ratings.
 - 3.2. Final Tables in Chapters 6, 7, 9, 10, 11 & 13 provide an evaluation assessment summary for the specific disorders within the Chapter.
 4. Chapter 18 addresses additional Pain related assessment that can not be redundant or inconsistent with principles of impairment rating described in the other Chapters; their impairment ratings have already accounted for pain.
 5. Chapter 14 has no WPI percentages. They are found in the PDRS. But the principles of assessment, description of clinical studies and the diagnosis of impairment are still applicable in the objective determination of psychiatric impairment. The GAF Score is the 5th Axis of the DSM-IV multiaxial evaluation process.
 - **AMA 5th Edition, Section 14.2 – Psychiatric Diagnosis of Impairment , pg. 359:**
“DSM-IV calls for a multiaxial evaluation. Each of five axes refers to a different class of information. In particular, axis V is a rating of the individual's global functional capacity and, like disability, is related directly to the effects of impairments.”

Substantial Medical Evidence: Consistency Testing on Examination

- **Minimizes errors due to examination techniques or normal human variability.**
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- **AMA 5th Edition Section 15.8a, pg. 399**

“The physician should seek consistency when testing active motion, strength and sensation. Tests with inconsistent results should be repeated. Results that remain inconsistent should be disregarded. When the physiological measurements fail to match known pathology, they should be repeated and, if still inconsistent, disallowed...”

- **AMA 5th Edition Section 2.5c, pg. 19:**

“The physician must use the entire range of clinical skills and judgment when assessing whether or not the measurements or tests results are plausible [credible, believable] 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.”

I. Substantial Medical Evidence: ROM Measurements

- Impairment can be evaluated by assessing range of motion abnormalities, recognizing that pain and motivation may affect the measurements.
 - Pain, fear of injury or neuromuscular inhibition may limit mobility by diminishing effort. Such limitations provide inaccurately low and inconsistent measurements that lead to improperly inflated impairment estimates.
 - **Reproducibility of abnormal motion is currently the only known criterion for validating optimum effort.** – Guides 3rd Edition, pg.78
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A. Spine – Section 15.8a – ROM Measurement Principles, AMA 5th Edition, pg. 399

1. Invalid measurements can be disallowed in part or in their entirety.
2. Minimum of 3 measurements: Repeat up to 6 times to obtain 3 consecutive measurements that meet reproducibility criteria.
3. Add all range of motion impairment values for the one region; if the region is ankylosed, use the largest ankylosis impairment value.
4. **The spine as a whole is considered equivalent to the whole person for purposes of impairment evaluation.**

B. Upper Extremities – Section 16.4 – ROM Measurement Principles, AMA Guides, pg. 450

1. Active & Passive ROM must be evaluated when active arc of motion is incomplete.
2. **Pathomechanics for the limitation of motion should be addressed.**
2a: “Limitation of active motion can be due to the failure of the nerve, muscle or tendon to execute the motion. Limitation of passive motion can be from involvement of the joint itself, a fixed contracture, or the antagonistic muscle or tendon that holds back the motion because it is adherent or too short.” – AMA 5th Edition, pg. 451
3. **Both Extremities should be compared with contralateral values used as a base.**
3a. - If contralateral values less than normal, use as baseline.
4. **Interpolate values for measurements falling between those shown in a pie chart.**
5. **When Ankylosis is present, use instead of ROM Values; do not use both.**
6. When multiple regions of an extremity are injured, overall impairment rating can not exceed that of amputation for a single upper extremity – 60% WPI.

C. Lower Extremities – Section 17.2f – ROM Measurement Principles, AMA Guides, pg. 533

- *“If it is clear to the evaluator that a restricted range of motion has an organic basis, three measurements should be obtained and the greatest range measured should be used.”*
1. **When Ankylosis is present, use instead of ROM Values; do not use both.**
 - 1.1. Values for ankylosis of specific motions are added to the neutral value with the proviso that the overall value can not exceed that of amputation of a single lower extremity – 40% WPI. – AMA 5th Edition, pg. 538

D. ROM or Strength Deficits

- Impairments can be evaluated and combined if the ROM & Strength Deficits do not share the same pathomechanics (pathogenesis).
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A. Shoulder ROM & Strength – AMA 5th Edition – Section 16.8c, pg. 509

The severity of strength deficits is classified and rated on the same principles used for the evaluation of peripheral nerves found on Table 16-11, Guides, pg. 482.

- When rating motor deficits and motor power loss not resulting from PND disorders.
- When both ROM and Strength abnormalities are present, and they share the same pathomechanics (pathogenesis), they cannot be combined. – AMA Guides 5th Edition, pg.

1. If methods and resulting impairments cannot be combined, only the impairment producing the highest rating is used.

1.2. Can this concept apply to specific unit of motions of the shoulder joint?

1.2.1. Refer to AMA 5th Edition- Table 16-35, pg. 510

- **AMA 5th Edition Section 16.7, pg. 499:**

“The criteria described in this section should be used only when other criteria have not adequately encompassed the extent of impairments [in Sections 16.1 to 16.6]. Some of the conditions described in this section can be concurrent with each other and with decrease motion because they share overlapping pathomechanics [pathogenesis]. The evaluator must have good understanding pathomechanics of deformities and apply proper judgment to avoid duplication of impairment ratings.”

- **AMA 5th Edition, Section 16.a – Principles, pg. 508:**

“Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts..., that prevent effective application of maximal force in the region being evaluated.”

- **AMA 5th Edition Section 16.8, pg. 508:**

“If the examiner judges the loss of strength should be rated separately in an extremity that presents other impairment, the impairment due to loss of strength could be combined with other impairments only if based on unrelated etiologic or pathomechanical causes.”

- **Example: Are the pathomechanics of the ROM & Strength Deficits different?**

“It should be noted that the patient does have significant problems with rotator cuff weakness. Neither the patient's limitation of motion or pain interferes with manual muscle testing or the application of maximal forces. Based on the above, the patient's rotator cuff weakness represents true muscle weakness resulting from the residuals of the patient's injury and does result in significant impairment. It is noted that the patient was able to participate in manual muscle testing and make maximal muscular effort which was not in any way restricted by her level of pain. The patient does have pain as a result of her right shoulder problem which has resulted in both limitations of activities of daily living as well as gainful employment. Since the pain/related impairment has increased the burden of the patient's condition,, the patient is entitled to an additional whole person impairment; a 03% whole person impairment for residual pain.

1. Pathomechanics of ROM loss: Nerve Failure, Muscle or Tendon Failure, Pain?

2. Pathomechanics of Strength Loss: Rotator Cuff Weakness?
3. What is the Rotator Cuff?

3a. *The rotator cuff is an anatomical term given to the group of muscles and their tendons that act to stabilize the shoulder. It is composed of the tendons and muscles (supraspinatus, infraspinatus, teres minor and subscapularis) that hold the head of the humerus (ball) in the glenoid fossa (socket)*

4. Is the Rotator Cuff Weakness due to the surgical procedure the same pathomechanics for both the ROM loss and the strength weakness?

○ **AMA 5th Edition Section 16.8a-Principles, pg. 508:**

“Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts (e.g., thumb amputation) that prevent effective application of maximal force in the region being evaluated.”

E. Grip Testing Consistency Testing

- **Validates testing results and exerted effort for measurements of grip and pinch strength which are used to evaluate power weakness relating to structures in the hand wrist or forearm.**
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- *“Measurements of grip and pinch strength are used to evaluate power weakness relating to structures in the hand, wrist or forearm.”*
- *“Manual muscle testing of major groups is used for testing strength about the elbow and shoulder.”*
[Section 16.8c, AMA 5th Edition, pg. 509]

1. Grip Evaluation and Consistency Testing: AMA 5th Edition Section 16.8, pg. 508:

“The test is usually repeated three times with each hand at different times during the examination, and the values are recorded and later compared.”

- 1.1. *“Tests repeated at intervals during an examination are considered to be reliable if there is less than 20% variation in the readings. If there is more than 20% variation in the readings, one may assume the individual is not exerting full effort.”*
- 1.2. *“Grip strength measurements may be taken with a Jamar dynamometer. The second (4^{cm}) or third (6^{cm}) position, according to the size of the hand, usually allows the individual to apply maximal effort.”*

2. AMA 5th Edition Section 16.8b-Grip & Pinch Strength. pgs. 510:

“If there is evidence that the individual is exerting less than maximal effort, the grip strength measurements are invalid for estimating impairment.”

2.1. AMA 5th Edition, pg. 508:

“Two techniques have been reported to help detect individuals who exert less than maximal effort on grip strength testing. Stokes pointed out that the plotting of grip strength measurements from each of the five handle settings of the Jamar dynamometer would produce a bell-shaped curve. Those individuals not exerting maximal effort will produce results yielding a straight line or a flat curve.”

‘An alternate method is the rapid exchange grip technique. The grip strength is first determined by standard techniques. The individual then is instructed to grip the dynamometer with maximal effort, first with on hand, then quickly with the other hand for at least five exchanges. Individuals who did not exert maximal effort with the standard technique will record significant higher strength readings.’

● **Example: Is the analogy for a reduction of grasping power supported by AMA Guides?**

“Under Almaraz II, the above-noted rating is inaccurate. To make it accurate, I would turn, by analogy, to Table 16-34 on page 509 and note that he has the equivalent of a 31% strength loss index with a 20% upper extremity impairment. A 20% upper extremity impairment equals a 12% whole person impairment.”

- **Is rating permanent impairment by analogy permissible only if the Guides provides no other method for rating objectively identifiable impairment? - Section 1.5, AMA Guides, p. 10:**

✓ **Findings at MMI & Medical History Supporting Grip Impairment Analogy:**

- MR, pg. 01: Frequent pain in the right forearm. Constant right elbow pain that depends on his activities. Right shoulder pain that comes and goes.
- MR, pg. 03: (R) Shoulder MRI, mild tendonopathy of the long head of the biceps tendon with no discrete rupture noted.
- MR, pg. 08: Tenderness of the (R) lateral epicondyle and olecranon of the right elbow. Mild positive Grind Test of the (R) Thumb.
- MR, pg. 09: Full ROM of shoulders, elbows, forearms, wrists and all five fingers of both hands *The Triceps, biceps and brachioradialis reflexes were present and equal. There was no evidence of thenar or hypothenar muscle wasting. The radial, median and ulnar nerves were intact. Sensory examination revealed no areas of hypesthesia.*
- MR, pg. 10: *“The motor power in selectively tested muscles revealed no gross weakness”* Negative compression/entrapment testing for signs of nerve root irritation, radiculopathy or peripheral nerve injury. Testing for stenosing tenosynovitis (Finkelstein) is negative. Mill’s test was positive for the (R) Elbow.
Note: Mills’ test is used to diagnose lateral epicondylitis - tennis elbow.
- **Jamar Readings: (R) 16-22-26 (L) 28/ 28/32 [29 – 21 = 08 ÷ 29 = 28% = 10% Upper Extremity = 06% WPI**
- *X-Rays, revealed no evidence of any fracture or dislocation. There was no evidence of degenerative disease of the elbow joint. There was no evidence of fracture of the radial head or any fracture of the capitellum. There was no evidence of any loose bodies.”*
- MR, pg. 11: Diagnosis: (R) Lateral epicondylitis.

Substantial Medical Evidence: Calculating the Impairment Rating

- **Allows for review & correction of miscalculated impairments by any knowledgeable observer.**
- AMA Guides 5th Edition, Chapters 2, page 17, LC § 4660(b)(1), LC § 4660(d).

● **AMA 5th Edition Section 2.6b, pg. 22:**

“Compare the medical findings with the impairment criteria listed within the Guides and calculate the appropriate impairment rating. Discuss how specific findings relate to and compare with the criteria described in the applicable Guides Chapter.”

● **AMA 5th Edition Section 2.6c, pg. 22:**

“[Evaluating physician] includes an explanation of each impairment value with reference to the applicable criteria of the Guides.”

- **Almaraz-Guzman- II, pgs 23 & 24:**

*“This does not mean, of course, that a physician may arbitrarily assess an injured employee’s impairment. As stated by the AMA Guides, “[a] clear, accurate, and complete report is essential to support a rating of permanent impairment” and the report should “explain” its impairment conclusions. (AMA Guides, § 2.6, at pp. 21-22) **In other words, a physician’s WPI opinion must constitute substantial evidence upon which the WCAB may properly rely, including setting forth the reasoning behind the assessment.** (See Escobedo vs. Marshalls (2005) 70 Cal.Comp.Cases 604, 620-621 (Appeals Board en banc).”*

*“**A physician’s WPI opinion that is not based on the AMA Guides does not constitute substantial evidence because it is inconsistent with the mandate of section 4660(b) (1).** (Hegglin V. Workmen’s Comp. Appeals Bd. (1971) 4 Cal.3d 162, 169 [36 Cal.Comp.Cases 93, 97] (“Medical reports and opinions are not substantial evidence ... if they are based ... on incorrect legal theories”); Zemke V. Workmen’s Comp. Appeals Bd. (1968) 68 Cal.2d 794, 799 [33 Cal.Comp.Cases 358, 360] (“an expert’s opinion which ... assumes an incorrect legal theory cannot constitute substantial evidence”).)*

- **Example: Is Cervical DRE Rating Substantial Medical Evidence?**

*“DRE method was selected. Significant signs of radiculopathy such as pain and/or sensory loss in a dermatomal distribution, loss of relevant reflex (es). loss of muscle strength, or unilateral atrophy compared with the unaffected side, measured at the same distance above or below the elbow; the neurologic impairment may be verified by electrodiagnostic findings. **Cervical Spine DRE is classified as Category III that calculates 15 % Impairment.**”*

1. **AMA 5th Edition, Section 15.3 – Diagnosis-Related Estimates Method, pg 381:**

“In assigning the individual to the correct DRE category, one of two approaches is used. The first is based on symptoms and signs and appropriate diagnostic test results.”

2. **AMA 5th Edition, - Section 15.3: Diagnosis Related Method, pg. 383:**

“The impairment rating is based on the condition once MMI is reached, not on prior symptoms and signs.”

➔ **Only quoting the specific language that defines a DRE Category is not a legitimate support for a whole person impairment rating. At MMI, evaluating physicians are required to discuss how specific objective clinical findings relate to and compare with the objective rating criteria required to support a rating impairment rating. –AMA 5th Chapters 1, 2 , Section 2.6b, pg. 22**

Substantial Medical Evidence: Preventing Duplication & Overlap

- Duplication and overlap of methods that rate the same condition twice must be avoided in order to improperly inflate the whole person impairment or one or more of the adjusted disability rating formulas.

- **AMA Guides, page 09, Sections 1.4, pages 19 to 20, Section 2.4 & 2.5.**

Even when there are multiple rating methodologies, only the one producing the highest rating is used.

- When clinical and measurable factors support more than one evaluation method, evaluate the individual using different alternatives and choose the final method that gives the most clinically accurate & highest impairment rating. AMA 5th pages 380, 499 and 527.

- **AMA 5th Edition, Section 16.5a – Evaluation Principles, pg. 480:**

“Characteristic deformities and manifestations resulting from peripheral nerve lesions, such as restricted motion, atrophy, and vasomotor trophic and reflex changes have been taken into consideration in the estimated impairment values shown in this Section [Peripheral Nerve Disorders]. ...in the absence of CRPS, the motion impairment values derived from Section 16.4 are not applied to this section to avoid duplication or unwarranted increase in the impairment estimation.”

- **AMA 5th Edition, Section 16.5b – Grading Motor Deficits or Loss of Power, pg. 484:**
“Loss of strength relating to conditions not resulting from peripheral nerve disorders is discussed in Section 16.8. The evaluator should not apply impairment values from both sections to the same condition.”
- **AMA 5th Edition Section 16.7, pg. 499:**
“Some of the conditions described in this section can be concurrent with each other and with decreased motion because they share overlapping pathomechanics. The evaluator must have good understanding of pathomechanics of deformities and apply proper judgment to avoid duplication of impairment ratings.”
- **AMA 5th, Table 17-2, pg.526:**
When more than one method can be used to rate impairment, the method that provides the higher rating should be adopted, if the methods cannot first be combined under Table 17-2.
“After all potentially impairing conditions have been identified and the correct ratings recorded, the evaluator should select the clinically most appropriate (i.e., most specific) methods and record the estimated impairment for each.”
- **Master the AMA Guides 5th, Linda Cocchiarella MD & Stephen J. Lord, MD, pg 268:**
*“To facilitate use and discussion in the AMA Guides 5th Edition the multiple assessments of the lower extremity were organized into three types. They are anatomic, functional and diagnosis-based, recognizing that these ‘types of assessment’ and the dysfunction within each method overlaps (duplicates). For the same region, only some methods can be combined to avoid duplication with methods that overlap in characterizing impairment. **Table 17-2, Guide to the Appropriate Combination of Evaluation Methods, lists the methods that can be combined.**”*
- **05PDRS, page 1-5 & 1-11:**
*“It is not always appropriate to combine all impairment standards resulting from a single injury, since two or more impairments may have duplicative effect on the function of the injured body part. The **AMA Guides provides direction on what impairments can be used in combination.**”*
*“Multiple impairments involving a single region of an extremity level are first combined at the upper or lower extremity level. Then they are converted to a whole person impairment and adjusted by the 05PDRS modifiers before combining with other body parts of the same extremity. **Not all impairments for the same body region may be combined because of duplication.**”*

Substantial Medical Evidence:

Misuse of AMA Guides 5th Edition, pg. 427 - Section 15.13:

Criteria for Converting WPI Impairment to Regional Spine Impairment

“The Spine as a whole is considered equivalent to the whole person for purposes of impairment evaluation.” – AMA Guides 1st & 2nd Edition pg 1, 3rd Edition, pg. 79, 4th Edition pg.94 and 5th Edition, pg. 398

- **Issue:** Rating ‘by analogy’ using a percentage of functional loss to calculate WPI using Spinal Regional Values of Figure 15-19.
- The AMA Guides has already converted all objective and functional loss spinal impairments into whole person impairments.
- For purposes of impairment evaluation the physician must consider the spine as a ‘whole.’
- Percentages of functional loss cannot be used to obtain an inflated WPI which fails to consider duplication among the regional values of the spine.
- **AMA Guides 4th Edition, pg. 3/95 – The Spine**
“It is difficult to separate the cervical, thoracic, lumbar, and sacral spine regions functionally, because the signs related to the different regions commonly overlap. ... With both the Injury Model and the Range of Motion Model, the normal percent of function of the spine or the whole person is 100%.”

A. Understanding the Objective Impairment Foundation of the Regional Spine Percentages

- 1. The ROM regional values used in Section 15.13 were established in the 3rd Edition of the AMA Guides. The DRE values were established in the 4th Edition, when there were eight (8) DRE Categories.**
- 2. In the 1st and 2nd editions of the AMA Guides, ROM was rated for only two segments. The cervical spine and dorsolumbar or thoracolumbar regions. The concept of the spine as three distinct segments first appears in the AMA Guides 3rd Edition and for the first time so does the conversion formula of spinal whole person impairments to regional impairments in Section 3.3a – General Principles of Measurement, AMA Guides 3rd Edition, pg. 78. The considerations for the regional values included not only the whole person impairment percentages for ROM abnormalities but also for diagnosis-related factors such as structural abnormalities, musculoskeletal or neurologic factors that required physiologic measurements.**
- 3. In the 4th Edition, on the basis of objective clinical findings, the ‘Injury’ or DRE Model was introduced as an alternate approach to the ROM Model or ‘Functional Model.’ – AMA Guides 4th Edition, pg. 94**

Substantial Medical Evidence: Pain, Functional Loss for ADL or Work Functions

- Without an Objective Clinical foundation, pain can not be rated standing alone.**
 - Standing Alone, ratings for activities of daily living or work functional loss are not ratable under the Guides.**
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- AMA 5th Edition, Section 1.5, pg. 10:**
“Subjective concerns, including fatigue, difficulty in concentrating, and pain, when not accompanied by demonstrable clinical signs or other independent, measurable abnormalities, are generally not given separate impairment ratings. Rating permanent impairment by analogy is permissible only if the Guides provides no other method for rating objectively identifiable impairment. “In situations where impairment ratings are not provided, the AMA Guides suggests that physicians use clinical judgment, comparing measurable impairment resulting from the unlisted condition to measurable impairment resulting from similar conditions with similar impairment of function in performing activities of daily living.”

1. Substantial Medical Evidence: Pain

- Subjective information standing alone can not serve as the sole criterion for a WPI Rating.**
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- AMA 5th Edition Section 1.2, pg. 02:**
“Subjective symptoms are considered within the diagnostic criteria.”
 - AMA 5th Edition Section 2.5e, pg. 20:**
“The impairment ratings of the body organ system chapters make allowance for expected pain.”
 - AMA Guides 5th Edition – Principles of Assessment, pgs 18, 26, 65, 88, 118, 144,174, 192, 212, 246, 278, 305, 358, 374, 434, 524 and 566.**
“Some impairment classes refer to limitations in the ability to perform activities of daily living because of symptoms. When this information is subjective and possibly misinterpreted, it should not serve as the sole criterion upon which decisions about impairment are made. Symptomatic assessment... is diagnostically useful, but it provides limited quantitative information and should not serve as the sole criterion upon which to make decisions about impairment.”

2. Substantial Medical Evidence: Functional Loss As Defined by the AMA Guides

- Refers to a change in function for an organ or body system.

• AMA 5th Edition Section 1.2, pg. 04:

“In evaluating impairment the Guides considers both anatomic and functional loss.

- **Anatomic Loss refers to damage to the organ system or body structure, while**

- **Functional Loss refers to a change in function for the organ or body system.”**

→ **Example: Heart function, kidney, lungs, etc.**

- Functional Loss as defined and used in the AMA 5th Edition does not relate to work related loss of function as defined by work restrictions and/or their assigned levels of functional loss. Whether by using analogies of functional loss from prior schedules, and or by analogy to scheduled impairment values, based in overall loss of function.

1. Example of a Work Restriction & Functional Loss

1.1. The Work Restriction: No Heavy Lifting

1.2. The level of functional loss: (Usually defined by the work restriction), contemplates *that an individual has lost approximately 50% of pre-injury capacity for lifting.* – 97PDRS, pg. 2-14

○ Example # 1: Impairment of Functional Loss ‘By Analogy’ Invoking Almaraz-Guzman-2

It is my opinion that a strict adherence of the AMA Guides, Fifth Edition, does not sufficiently address this applicant's present disability. Therefore, based upon the Almaraz-Guzman en banc decision of September 2009, I have elected to utilize an alternative impairment rating within the 4 corners of the AMA Guides, Fifth Edition.

“It is my opinion that Mr. ‘H’ has suffered a 40% loss of his preinjury capacity for gripping, grasping, holding, carrying, lifting or other commensurate activities relative to usual and customary work activities and/or activities of daily living with the left upper extremity. Therefore, given that the upper extremity has a 60% Whole Person Impairment possible impairment rating, I would multiply 60% X 40% loss which would equal 24% Whole Person Impairment as a result of his Left Upper Extremity Impairment.”

- 60% Value is obtained from Table 16-4.
- 40% is a personal estimation by the evaluating physician.

Amputation Levels	Impairment % of			
	Digit	Hand	Upper Extremity	Whole Person
Shoulder disarticulation	—	—	100	60
Arm deltoid insertion and proximally	—	—	100	60

- **AMA 5th Edition, pg. 440: Table 16-4-Impairment Estimates for Upper Limb Amputation at Various Levels**
- **Table Is Modified To Reflect Specific Example**

✓ Findings at MMI & Medical History Supporting UE Impairment ‘By Analogy’ for AG2:

- Exam Findings: Bilateral Forearm / Wrist range of motion is limited in flexion, extension and radial-ulnar deviation. Forearm motion is also limited in pronation and supination. (See verification tables.) Well-healed surgical scars multiple areas of the left upper extremity. Circumferences (R/L): Biceps 30.5 /30^{cm}, forearms 28/27.5^{cm}. **Grip: (R/L): 48.5/35.6 - [49 - 36 = 13 ÷ 49 = 27% = 10% Upper Extremity = 06% WPI]**
- ADL: Present Complaints. Pain readily increases with heavy lifting, gripping/grasping, holding or carrying greater than 30lbs.
- Diagnosis: **Status post (L) forearm fracture and surgical repair.** Status post carpal-tunnel surgical release.

○ **Example # 2: Impairment of Functional Loss ‘By Analogy’ Invoking Almaraz-Guzman-2**

“It is my opinion that when one takes into account the effect the back disorder is having on the activities of daily living, and the effect it is having on the ability to compete in the open labor market, the injured worker has a 61.2% whole person impairment associated with the lower back disorder.”

- *“With regard to the injured worker's ability to compete in the open labor market, it is my opinion that as a result of the lower back disorder, the injured worker has lost 90% of the functional capacity to lift, 75% of the functional capacity to bend and stoop, 75% of the functional capacity to climb, 50% of the functional capacity to weightbear, and 50% of the functional capacity to sit. The average loss of functional capacity due to the lower back disorder would equal the sum of 90% loss of lifting capacity, 75% loss of bending and stooping capacity, 75% loss of climbing capacity, 50% loss of weightbearing capacity, and 50% loss of sitting capacity divided by 5. This results in an average of 68% loss of functional capacity due to the lower back disorder.”*
- *“On Figure 15-9 in the AMA Guidelines on Page 427, the whole spine has been divided into regions and the maximum whole person impairment is defined for each region. With regard to the lumbar spine, the maximum whole person impairment is 90%. Given that the injured worker has an average of 68% loss of functional capacity due to the lower back disorder, 68% of a 90% whole person impairment equals a 61.2% whole person impairment.”*

● **Example # 3: Impairment of Functional Loss ‘By Analogy’ Invoking Almaraz-Guzman-2**

“Based upon the AMA Guides, 5th Edition, DRE Table 15-3, Category II, page 384 he would no greater than 7% whole person impairment for alteration of activities of daily living and asymmetric loss of range of motion with guarding. I believe that Table 6-9 more accurately describes his work disability. Therefore based on AMA Guides, 5th Edition, Category he would have 19% Whole Person Impairment.”
*

*** Note: Isn't Work Disability, work restrictions, work capacity functional loss, loss of pre-injury capacity, etc., ratable concepts under schedules in effect prior to 2005?**

→ Does Almaraz-Guzman-2 allows for a rating ‘by analogy’ to consider any of these factors when determining an impairment rating standard?

Are the Above Examples within the ‘Four Corners of the AMA Guides’?

- **AMA 5th Edition – Chapter 16, pg. 433 & Section 16.1, pg 434:**
“This Chapter provides criteria for evaluating permanent impairment due to anatomic impairments of the hand and upper extremity. The physical evaluation determines the anatomic impairment and is based on the history and detailed examination of the individual and upper extremity. ...evaluation of anatomic impairment forms the basis of upper extremity assessment.”
- **AMA 5th Edition – Section 16.4, pg. 441:**
“Important factors to consider in evaluating amputations include not only the level of occurrence but also the presence of associated problems relating to the condition of the residual stump.”
- **Almaraz-Guzman-2 pgs. 02 & 03, 20:**
“...when determining an injured employee's WPI, it is not permissible to go outside the four corners of the AMA Guides; however a physician may utilize any chapter, table or method in the AMA Guides that most accurately reflects the injured worker's impairment. In light of these holdings, we now specifically reject the “inequitable, disproportionate, and not a fair and accurate measure of the employee's permanent disability” standard set forth in our February 3, 2009 opinion.”

o **Almaraz-Guzman-2 pg. 03:**

"We emphasize that our decision does not permit a physician to utilize any chapter, table, or method in the AMA Guides simply to achieve a desired result, e.g., a WPI that would result in a permanent disability rating based directly or indirectly on any Schedule in effect prior to 2005. A physician's opinion regarding an injured employee's WPI under the Guides must constitute substantial evidence; therefore, the opinion must set forth the facts and reasoning which justify it. Moreover, a physician's WPI opinion that is not based on the AMA Guides does not constitute substantial evidence."

o **Almaraz-Guzman- II, pg 23:**

"This does not mean, of course, that a physician may arbitrarily assess an injured employee's impairment. As stated by the AMA Guides, "[a] clear, accurate, and complete report is essential to support a rating of permanent impairment" and the report should "explain" its impairment conclusions. (AMA Guides, § 2.6, at pp. 21-22) In other words, a physician's WPI opinion must constitute substantial evidence upon which the WCAB may properly rely, including setting forth the reasoning behind the assessment. (See Escobedo vs. Marshalls (2005) 70 Cal.Comp.Cases 604, 620-621 (Appeals Board en banc)."

Closing Questions & Thoughts:

1. Have you read Almaraz-Guzman-2?
2. Is Misquoting the AMA Guides and case law (which has become part of the current trend in workers compensation), substantial medical evidence in the rebuttal of a correct impairment rating?
3. Does the AMA Guides allow an individual opinion to overrule the consensus and scientific impairment determination of the AMA Guides Chapters & Rating Protocols?
4. Within the 'four corners of the AMA Guides, can one physician's judgment bypass the diagnosis and objective measurement portions of the Guides (clinical foundation) in favor of a subjective foundation for the determination of a whole person impairment?
5. Does the AMA Guides allow impairment ratings to be only based on uncorroborated subjective complaints or work capacity functional loss?
6. Did the WCAB allow physicians to do all of the above when rebutting a correct AMA Guides Rating: *'a physician may utilize any chapter, table, or method in the AMA Guides that most accurately reflects the injured employee's impairment'*?
- 6.1. Or, isn't a physician required to support any rebuttal of a correct impairment rating with an objective clinical foundation of measurable factors of impairment, which the WCAB clearly defines as substantial medical evidence in both Escobedo and Almaraz-Guzman?
7. Where in the Guides or Almaraz-Guzman-2 is the evaluator allowed considering 'disability', and or duplicating impairment; to justify subjective the adding, combining and duplicating impairments as a more accurate reflection of an injured worker's disability?
- 7.1. Doesn't Almaraz-Guzman-2 preclude the physician from considering both disability and functional loss in his determination of an impairment rating?
 - 7.1.1. Almaraz-Guzman-2 pgs. 02 & 03: *"...when determining an injured employee's WPI, it is not permissible to go outside the four corners of the AMA Guides; however a physician may utilize any chapter, table or method in the AMA Guides that most accurately reflects the injured worker's impairment. In light of these holdings, we now specifically reject the "inequitable, disproportionate, and not a fair and accurate measure of the employee's permanent disability" standard set forth in our February 3, 2009 opinion."*

Substantial Medical Evidence

Genesis of 'Reasonable Medical Probability' – Cases dealing with AOE/COE Issues.

○ **WCAB Escobedo vs. Marshalls - 70 Cal. Comp. Cases 604, pg. 09, 12,17:**

“Apportionment of permanent disability caused by “other factors both before and subsequent to the industrial injury, including prior industrial injuries,” may include not only disability that could have been apportioned prior to SB 899, but it also may include disability that formerly could not have been apportioned (e.g., pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions), provided there is substantial medical evidence establishing that these other factors have caused permanent disability.”

WCAB Escobedo vs. Marshalls - 70 Cal. Comp. Cases 604, pg. 24:

“Thus, to be substantial evidence on the issue of the approximate percentages of permanent disability due to the direct results of the injury and the approximate percentage of permanent disability due to other factors, a medical opinion must be framed in terms of reasonable medical probability; it must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and it must set forth reasoning in support of its conclusions.”

○ **E.L. Yeager Construction vs. WCAB (Gatten), page 07:**

*“In order to constitute substantial evidence, a medical opinion must be predicated on reasonable medical probability. (McAllister vs. Workmen’s Comp. App. Bd. (1968) 69 Cal.2d 408, 413, 416-417, 419.) Also, a medical opinion is not substantial evidence if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess. (Hegglin vs. Workmen’s Comp. App. Bd. (1971) 4 Cal.3d 162, 169.) **Further, a medical report is not substantial evidence unless it sets forth the reasoning behind the physician’s opinion, not merely his or her conclusions.** (Granado vs. Workmen’s Comp. App. Bd. (1968) 69 Cal.2d 399, 407.)”*

E.L. Yeager Construction vs. WCAB (Gatten), page 10:

“We find nothing questionable about a medical expert’s reliance on an accepted diagnostic tool. A medical expert may well view a person’s history of minor back problems as being more significant in light of the evidence of substantial degeneration of the back shown by an MRI. Dr. [] did so here. His conclusion cannot be disregarded as being speculative when it was based on his expertise in evaluating the significance of these facts. This was a matter of scientific medical knowledge and the Board impermissibly substituted its judgment for that of the medical expert.”

○ **Bethlehem vs. Industrial Accident Commission, Pg 3:**

“The injury must be one arising out of the employment, and where the injury is by disease, there must exist the relation of cause and effect between the employment and the disease. It is also true that to justify an award there must be an affirmative showing of a case within the statute and it must affirmatively appear that there exists a reasonable probability that the employee contracted the disease because of his employment. ... the injury must be a natural or a reasonably probable result of the employment or of the conditions thereof.

● ***Review of evidence is important.***

*The time-honored [***18] rule, therefore, must apply, that in the case of a conflict of evidence this court may not disturb the finding of the [*751] commission where there is substantial evidence to support it. Chichester v. Seymour, 28 Cal.App.2d 696 [83 P.2d 301]; San Francisco v. Industrial Acc. Com., 183 Cal. 273 [**158] [191 P. 26]; Pacific Employers Insurance Co. v. Industrial Acc. Com., 19 Cal.2d 622 [122 P.2d 570, 141 A.L.R. 798].)*

1. **Can we justify that a standard previously used to make sure that injuries were found compensable (AOE/COE), is now used to question impairment ratings, which as per the AMA Guides require an objective clinical foundation? (Substantial Medical Evidence = Objective Clinical Foundation?)**
2. **Is reasonable medical probability a concept intended for the determination of permanent disability, or for issues of AOE/COE and apportionment, as previously applied by the courts?**
3. **Is ‘reasonable medical probability’ an attempt to undermine the objective clinical foundation required for the determination of impairment after SB 899, by cases like Almaraz-Guzman and Ogilvie?**

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