

Post AG I: Addressing Duplication of Impairment Factors

Premise: Non-Medical Workers Compensation Professionals Can Address Duplication of Impairment Factors (Claim Professionals, DEU & Private Raters, Legal Professionals)

The WCAB's first Almaraz-Guzman decision was issued February 3, 2009. It was intended to be used for the *rare and unusual* case in which the AMA Guides didn't address an injured worker's impairment. However, in the 7 months and 67 days in which it was in effect it became an explosion of 'anything goes.'

By seminars, letters, webinars and many other forms of communications, physicians were told they no longer needed to abide to the rating principles of the AMA Guides and the Schedule for Rating Permanent Disabilities (PDRS). Many physicians expanded their roles to become claims administrators, DEU Rater, WCAB Judges to determine the fairness of permanent disability, and authors when re-writing the AMA Guides.

To quote Dr. John D. Warbritton in one of his recent AME reports: *"Pursuant to the Almaraz-Guzman Decision, it is mandatory to determine that the impairment rating pursuant to the "classical" interpretation of the AMA Guides is "inequitable" or "disproportionate," and once this is determined, the AMA Guides may be rebutted."*

Nothing in the first Almaraz-Guzman decision made such determination mandatory. And to avoid this type of misunderstanding in the new Almaraz-Guzman-II the WCAB made it clear that: *"Our decision... does not mandate that any party must attempt to challenge a WPI based on the Guides; it does not mandate that if any such attempt is made it must be done in any particular manner (other than it must be based on the Guides); and it does not mandate that a WCJ or Appeals Board panel must admit or follow any rebuttal evidence presented."* - Almaraz-Guzman-II, pg. 38

We analyzed a total of 75 Almaraz-Guzman ratings. From those reports we will address the duplication of impairment factors. Nothing in Almaraz-Guzman did away with universal rating principles for dealing with the avoidance of duplication found in both the AMA Guides and the PDRS. But Duplication became an issue.

We were also asked to help address a challenge to DEU Rater's ability to address duplication of impairment. We provided information in our analysis that is applicable not only to DEU, but to each and every non-medical workers compensation professional.

You don't have to be a legal professional to apply these principles in day-to-day claims handling, including the correction of misreported and duplicated impairment. Almaraz-Guzman II once again brings us back inside the four corners of the 5th Edition of The AMA Guides and the rating principles of the PDRS. The AMA 5th Edition not only addresses concepts of duplication in its opening chapters, but in every rating chapter.

- ✓ 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. — AMA Guides 5th Edition, Chapters 2, page 17

We must now look at the AMA 5th Edition as a whole. AMA's duplication principles apply universally to all determinations of impairment. We have included some references to the 3rd and 4th Editions of the AMA Guides to show the historical continuity of this crucial rating principle from prior editions of the AMA Guides. Notes and introductions of prior Schedules address the avoidance of duplication more extensively. As does the 05PDRS in its Introduction, which should be expanded in its 2009 revision.

The Points in our analysis were as follows:

1. The Disability Evaluation Unit's mission remains unchanged and in accordance with The Labor Code, LC § 4660, the California Code of Regulations and pertinent Case Law: Disability Evaluators provide an accurate translation of medical findings into California Permanent Disability.
2. It is proper for a disability evaluation specialist or any other non-medical WC professional to address/evaluate the rating aspects of a medical report and correct miscalculated impairment ratings to conform to the AMA Guides rating protocols.
3. It is proper for a disability evaluation specialist or any other non-medical WC professional to seek clarification, obtain missing information and/or request that AMA Guides protocols be applied in the proper calculation of an impairment determination.
4. It is proper for a disability evaluation specialist or any other non-medical WC professional to abide to both the 05PDRS and AMA Guides evaluation protocols to avoid the duplication and augmentation of impairment, because an unwarranted increase would result. Nothing in the AMA Guides, the 05PDRS or California Case Law allows for duplicating of methods that rate the same condition in order to improperly inflate one or more impairment ratings.
5. It is proper for a disability evaluation specialist or any other non-medical WC professional to abide to LC § 4660 (d), and promote consistency, uniformity and objectivity of disability ratings.
6. It is proper for a disability evaluation specialist or any other non-medical WC professional to abide to LC § 4660 (b)(1), by using the AMA 5th Edition standardization of evaluation and reporting procedures which allows all professionals to scrutinize the impairment determination against the objective clinical impairment findings; these are matters of fact, not opinion.
7. Chapter 2 lists the kind of information needed to document the nature of impairment and its consequences. The Guides chapters on the organ systems contain protocols of ways to evaluate a particular body part, function or system. Each individual Chapter specifies the procedures for acquiring the information and defines a structured format for analyzing, recording and reporting that information. **These Chapters also contain reference tables and instructions, which include the proper methods to combine impairments, when there are multiple impairments for the same unit or body system.** –AMA 5th p. 17, AMA 4th, pg. 2-7.
8. The method for combining impairments is based on the principle that each impairment acts not on the whole part but only on the remaining portion after the proceeding impairment has acted. Therefore the combining values determination is based on the formula: $A\% + B\% (100\% - A\%) =$ combined value of $A\% + B\%$ – AMA 3rd, pg. 19 Refer also to 05PDRS, pg 1-10
9. For the Lower Extremities, multiple methods can be used to determine impairment.- AMA 5th, Table 17-1 & 525-to-527:
10. 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. - AMA 5th, Table 17-2, pg.526

11. 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. – Master the AMA Guides 5th, Linda Cocchiarella MD & Stephen J. Lord, MD, pg 268, and AMA Guides 5th Edition, page 526
12. Impairments for different regions of the lower extremity (e.g., hip, knee or ankle), are evaluated separately. Multiple impairments within a region (e.g., the hip, knee, ankle or foot) are consolidated by body part at the lower extremity level before converting to a WPI. – AMA 5th, pg. 528
13. 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 p. page 380.
14. When impairment values due to multiple findings in the same region or body system cannot be combined, only the finding with the highest impairment value is rated – AMA 5th, pgs. 499 & 527.

PDRS: For one or more regions or body systems, multiple factors of impairment can result from a single injury. For example, an ankle injury might result in some limitation of ankle motion, atrophy of the calf, muscle weakness or diminished sensation in the ankle region. **The process of determining the final rating for each index requires that the multiple factors be combined, consideration being given to the avoidance of duplication among factors of impairment.**

1. 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. -05PDRS, page 1-5 and page 1-5
2. 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. - 05PDRS, page 1-5 and page 1-11

8 CCR § 36(e): Parties requesting a supplemental report must send request to DEU first until after initial summary rating has been issued. ??

This regulation is nonsense! In a follow-up article we will address how this is an attempt by the medical unit to remove the capacity of claims administrators to request clarification directly from physicians who provide miscalculated impairment ratings under the AMA Guides. Almaraz-Guzman II brings us back to the 4 corners of the AMA Guides. The medical unit cannot limit by regulation what LC § 4660(b)(1), LC § 4660(d) and now the WCAB allows by its en banc decision in Almaraz-Guzman II.

Q: Are There Differences Between DEU & Private Ratings? Answer: Yes

The private rater can go into greater detail in its scrutiny of the records submitted for review. To be frank: after 4+ years of use of 5th Edition of the AMA Guides, the inter-rater inconsistency between State and Private Raters has decreased substantially. We are in agreement with more than 85% of all DEU Ratings that we have been requested to review, when the information submitted is the same; i.e., no supplemental reports, job analysis, etc.

The following is an example of PQME Rating we prepared along with DEU's response, PQME's response to DEU and our review of QME's response to DEU. (Note that Almaraz-Guzman II would be applicable in this case, since PQME provided a WPI, provided no justification for his determination and contradicted his prior opinion.

Injury Date:	2004	Age	38
Injury to:	Bilateral Upper Extremity – Wrists		
AMA Analysis: PQME Report Dated 06-30-06			
<p>1. For grip loss, using the strength loss index formula, she has a 25% grip loss on the right and a 0% grip loss on the left. ??</p> <p>2. Using Table 16-34 on page 509, a 25% grip loss results in a 10% upper extremity impairment and a 60% grip loss results in a 20% upper extremity impairment. Using Table 16-3 on page 439, a 10% upper extremity impairment results in a 6% -whole person impairment and a 20% upper extremity impairment results in a 12% whole person impairment. Corrected: In compression neuropathies, additional values are not given for decreased grip strength. Grip Strength Reduction cannot be combined with ROM deficits or peripheral nerve disorders. - AMA Guides, p. 494, 16-5d Principles.</p> <p>3. Using the Combined Values chart on page 604, she has a 17% whole person impairment. Corrected: Before combining with other regional impairments in the same/opposite extremity and/or other body systems, regional impairments are converted to a whole person impairment and adjusted by the 05PDRS modifiers: Then they are combined using Tables on Section 8 of the 05PDRS on pages 8-2 & 8-3. - AMA Guides, pg. 10 & 2005 PDRS, page</p>			
Reported Examination Findings. – Report Dated 2006			
<p>1. EMG/NCS,/NCS, normal – 06-2004. 5-05 studies, mild carpal tunnel syndrome.</p> <p>2. Neurovascular / Provocative Testing: Motor Strength 5/5, sensation is intact all dermatomes and reflexes are 2+ bilaterally Positive Phalen test bilaterally – finger numbness. Her sensory decrease is global and is not ratable – Med Rpt., pg. 05.</p> <p>3. ROM: Full/symmetrical ROM of all major joints and digits of the hand.</p> <p>4. No evidence of focal atrophy, localized weakness, muscular wasting or asymmetry</p> <p>5. Note; No Grip measurements are reported.</p>			
Our Rating Recommendation on 07-22-2006			
No Recommended Rating – Bilateral Arm Strength (Grip)			
Provisional Rating – CTS Criteria on AMA 5th Ed, pg 495			
<p>1. Clinical Findings Supporting CTS Rating: Med Rpt., pg. 04: Positive examination findings at MMI, nerve conduction studies positive for mild left carpal tunnel syndrome, slightly decreased sensation to pinwheel volar aspect of the palm and fingers of both hands, <u>positive volar wrist compression test bilaterally</u>, positive Phalen's test bilaterally.</p> <p>1.1. Med Rpt., pg. 05: Evaluator states that sensory decrease is global and is not ratable.</p> <p>1.2. Non-dermatomal diminished sensation makes a rating under Section 16.5 - Peripheral Nerve Disorders not possible.</p> <p>2. Supplemental Report is Required.</p>			
Recommended Rating After Analysis & Consideration of Duplication Among Ratable Factors			
<p>When clinical findings are fully described, any knowledgeable observer may check the findings with the Guides criteria and determine the proper calculation of impairment. – <i>AMA Guides</i>, Chapters 2, page 17</p> <p style="text-align: right;">Right Arm Left Arm</p> <p style="text-align: center;">16.01.02.02 - 03 - [4] - 4% - (111 - G) - 5 – 05 16.01.02.02 - 03 - [4] - 4% - (111 - G) - 5 – 05 05 C 05 = 10%</p>			
Post/Pre Surgery -Wrist Entrapment/Compression Neuropathy - Section 16.5d			
<p>AMA 5th, pages 493-495 - ©CAL/LPC – January 11,2005</p> <p>AMA 5th pg 20: The impairment determination/calculation of an individual's impairment neither decreases nor increases when declining surgical, pharmacologic, therapeutic treatment of an impairment. Positive NCS/EMG. allow for an impairment rating by analogy when no surgical decompression has taken place.</p>			
Carpal Tunnel AMA pg. 495	CTS	UE To WPI	WPI For PDRS Adjustments
NCS/ EMG = Yes (Positive Phalen Tests)	UEI = 05%	05 = 03	03 WPI
<p>*AMA 5th page 495: "...following surgical decompression 3 following scenarios can be present:</p> <p>1. <u>Positive clinical findings of median nerve dysfunction, is rated according to sensory/motor deficits.</u> AMA Guides, page 480 – Peripheral Disorders Impairment.</p> <p>2. <u>Residual Carpal tunnel syndrome is still present</u> – impairment of 05% UEI may be justified.</p> <p>3. <u>Normal clinical findings, including 2-point discrimination</u> – no objective basis for an impairment rating.</p>			

SUMMARY RATING DETERMINATION Dated 11-18-2008 – EAMS # DEUXXX9518
THE QUALIFIED MEDICAL EXAMINER REPORTS THAT THERE IS A BILATERAL (CARPAL TUNNEL SYNDROME) WITH POSITIVE CLINICAL FINDINGS ON EXAM AND AN EMG WHICH IS POSITIVE ON THE LEFT, PLEASE SUBMIT A SUPPLEMENTAL REPORT FROM THE QME WHICH ADDRESSES THE CARPAL TUNNEL IMPAIRMENT USING THE PROTOCOLS ON PAGE 495, AMA GUIDES, 5TH EDITION.
A Workers' Compensation Judge has determined that apportionment is not consistent with the law.
NO RATING IS SCHEDULED OR RECOMMENDED FOR THE DESCRIBED DISABILITY.
Response of PQME – Report Dated 02-02-2009
“Computer Program Worksheet Attached to 2 page supplemental report: PND Sensory Impairment of Median Nerve Below Midforearm (39% Max) Grade 4 / 25% Sensory Deficit = .25 X .39 = 10% UEI bilaterally Chap 16, pgs 480-493, T16-10 & 16-15, AMA Guides, 5th Edition.
Examination Findings. – None – (No Examination)
Review of Submitted Medical Records by Claims Administrator
.August 2, 2007, Michael Butler, M.D., Neurologist. electrodiagnostic evaluation. EMG/Nerve Conduction Studies, normal. No evidence of median or other peripheral nerve compression.
Our Rating Recommendation 09-18-2009 (Short Version)
1. No Recommended Rating Under PND Section 16.5 –AMA 5 th p. 480
2. There was no medical re-evaluation by PQME to support a rating under PND abnormalities, which is in contradiction to PQME’s own examination findings of his report dated 06-30-2006 in which he sates that: Her sensory decrease is global and is not ratable – Med Rpt., pg. 05.
3. WCAB’s Almaraz-Guzman II decision requires that for an opinion to be considered ‘substantial medical evidence’ the physician must set forth the reasoning behind his/her opinion. <i>“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.)</i>
4. Weblink For a Long Version of Almaraz-Guzman-II Analysis.: http://www.pdratings.com/AlmarazGuzman2AnalysisLongVersion.pdf
No Ratable Impairment under AMA Guides Evaluation & Rating Criteria
SUMMARY RATING DETERMINATION Dated ?? – EAMS # DEUXXX9518

We concur with Phil Walker’s statements in his recent seminars on Almaraz-Guzman II, that physicians are purposely providing wrong ratings under the AMA Guides to force their depositions and/or the need for additional supplemental reports. In legal seminars, physicians are being encouraged not to answer your questions, and never to change their opinion, even when confronted with clear inconsistencies within their reports.

As of 10-02-2008 we have done 18 rating analysis under Almaraz-Guzman II. This decision must be celebrated for bringing back the ability to question these inflationary practices by physicians.

The WCAB restores the concept of the burden of proof for the correct AMA Guides Impairment Rating, removes the subjectivity of impairment determinations from all physicians, and establishes that the assessment of Impairment utilizing all of the 5th Edition of the AMA Guides must be substantial medical evidence, under not one but two WCAB en-banc decisions.

Our Advise: Don’t let misguided regulations take away from claims handling what both the AMA Guides and the WCAB allows. Don’t let misguided legal or medical professionals break your spirit with their insults and belief that you don’t have the right to question a miscalculated impairment.

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Certified, AMA Guides Impairment & California Disability Rating Specialists
American College of Disability Medicine & American Board of Independent Medical Examiners

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