
SB 899 - California Workers Compensation:

From Packard Thurber to The AMA Guides Transference of Evaluation Methodology

1.1 – Introduction

Understanding the evaluation and determination of permanent disability, it is important for the physician to keep in mind the difference between “Impairment” and “Disability”. Impairment is a medical term. Disability is not. As David C. Craddock points out, “The concepts of disability and impairment necessarily start with definitions; however, it is important to understand how these concepts relate to real-life situations.”

As defined by the AMA Guidelines, **impairment** is the loss of use or derangement of any body part, system or function. The definition of **disability** varies with the purpose and intellectual disciplines of the definers.

California has allowed for ratings for both specific and regional anatomic measurable impairment (objective) factors ratings. But the determination of these impairment ratings has always been incomplete.

Evaluating physicians will now follow more exacting procedures and specific criteria in both the manner in which they obtain this information and present it in their comprehensive medical reports, which will now be referred to as - Maximum Medical Improvement Report – MMI Report

Measurable objective anatomic, clinical findings, imaging studies, tests results, individual complaints, pain and other subjective factors, information that the medical evaluator has been providing in their comprehensive P&S Report, is now to be incorporated into one overall percentage of permanent impairment.

The determination of a rating formula based only on a partial and disjointed measurable objective/impairment factor will no longer be the function of non-medical personnel.

What the AMA Guides brings to California Workers Compensation is the complete and objective determination of permanent impairment ratings based on criteria provided by the AMA Guides that takes into consideration all the objective measurable (anatomic/clinical) factors of impairment. Factors previously overlooked will now be incorporated into the ratable impairment factors of all musculoskeletal injuries.

For example, as outlined in the various chapters of the AMA Guides, objective clinical findings, imaging study results, neurological residuals, bone deformities and joint replacements will be considered in the overall determination of the impairment percentages.

SB 899, via the new schedule for Rating Permanent Disabilities that will be effective on 2005, recommends the use of a **cohesive impairment percentage** (be it for a specific body part - a regional percentage - or a whole person percentage) to be adjusted for the age and occupation of the injured worker on the Date of the vocational event.

For compensation purposes, there is continuity in the AME/IME/QME’s reporting of factors of impairment and disability. They are and will be translated into a rating formula. The rating formula has always been a correlation of impairment and/or disability with occupation and age. That is the primary function of the Schedule for Rating Permanent Disabilities.

This is the first in a series of articles meant to help the physician recognize what is still in effect in the evaluation and determination of anatomic and functional loss when addressing work related injuries and how to transition that data to impairment evaluation/determination as per the 5th Edition of the AMA Guides. This and the following articles are evolving documents and your comments and criticisms are very welcome.

SB 899 - California Workers Compensation:

From Packard Thurber to The AMA Guides Transference of Evaluation Methodology

This first article will emphasize the current standards and evaluation data that the AME, IME and QME should incorporate into the comprehensive Permanent & Stationary medical report – P&S Report. Under the AMA Guides will now refer to it as the MMI Report.

Current California Code of Regulations guidelines are the building blocks and logical components in the preparation of any **(MMI) Report**. It is our intention to introduce the new components physicians' will be required to provide and incorporate into these reports. **The evaluation of permanent impairment is addressed with proper references and tables** from the 5th Edition of The AMA Guides.

1.1(a) – Training Considerations

The transition, from a system in which physicians only presented impairment information without concern for how that information was used in the determination of permanent disability, will require time and training.

Only portions of that information were taken by claims examiners, attorneys, other physicians, private/state raters and translated into loss of work capacity (permanent disability) rating formulas, adjusted by the age and occupation of the injured worker on the date of injury.

Some recommendations for the evaluating physician, AME/IME/QME who wishes to transition smoothly into 2005, their current expertise in the evaluation of anatomic/organic/functional damage due to a specific vocational (work-related) incident are as follows:

Attend seminars and conventions presented by non-medical personnel. Do not discard the inclination of the presenting 'expert' panelists to help avoid fragmented or askewed interpretations of how to use The Guides.

As an introduction, first attend a one-day intensive-overview seminar of the AMA Guides, and then attend the two-day seminar **case study (hands-on) approach** for Evaluating Impairment

At first the amount of information in a 1-day seminar appears overwhelming. The hands-on approach of the two day seminar helps participants understand how much of what they already do is part of the AMA Guides impairment evaluation.

1.1(b) - Transference of Evaluation Methodology –

In the determination of objective/subjective ratable factors of impairment, physicians will now incorporate, unite and join together impairment factors based on specific anatomic/clinical/functional criteria provided by The Guides for the Evaluation of Permanent Impairment, 5th Edition.

SB 899 and the AMA Guides return to our system the proviso that, in addition to the reporting of the findings, the evaluating physician will now determine the impairment percentage for both the anatomic and clinical objective factors - a function that has been performed by non-medical personnel.

SB 899 - California Workers Compensation:

From Packard Thurber to The AMA Guides Transference of Evaluation Methodology

Evaluators have historically provided Upper/Lower Extremity Measurements, Lumbar Ranges of Motion, Imaging & Test results, diagnoses, complaints, pain factors, subjective factors, etc. **Some factors were ratable** (amputation/loss of motion); **others were not** (knee joint replacement/muscle weakness in the upper extremities).

In the 1960s evaluating physicians incorporated into the P&S (MMI) Report the impairment methodology presented by Packard Thurber's **Evaluation of Industrial Disability**. (AD Rule 9725 & 9727 ~ 8 CCR 46,9725 & 9727). But with these changes also began the disconnection of individual subjective pain and other complaints from objective and clinical impairment factors.

Subjective factors of disability were given independent consideration in the determination of both impairment and permanent disability - when their degree and frequency affected function. By the end of the 20th century, the words used to describe both complaints and disability became one and the same without any apparent need to have a relationship to objective anatomic/clinical measurable factors of impairment. This severance of subjective complaints from measurable factors of impairment created a situation in which the boundaries between non-ratable individual complaints and ratable subjective factors of disability disappeared.

Now AME/IME/QME will take the multiple components from the comprehensive MMI Evaluation (i.e., diagnoses, imaging/clinical findings, provocative testing result, anatomic, clinical objective findings and subjective pain factors) and by following the proper AMA Guides criteria calculate the permanent impairment percentage without separating objective from subjective complaints.

The medical **evaluator will now render into a cohesive unit (the impairment percentage)** factors of disability, which have been rated independently from each other or never considered in the rating process,

Like for any other factors of functional loss, the evaluating physician must explain the rationale and logic of the impairment rating and reference the tables and figures used in its determination.

1.1(s) – The Permanent Impairment Percentage

The impairment percentage (%) can be based on an anatomic or functional loss for:

A specific body part [i.e., ankle, wrist],

A body region, (i.e., lower/upper extremity or spine),

The whole person.

The enhanced comprehensive permanent & stationary medical report, (P&S/MMI) Report, and the 'reasoned medical opinion' of the evaluator will now require the inclusion & mentioning of the specific tables and figures used in the determination of the impairment rating, as per the **5th Edition of The AMA Guides**.

Information regarding measurable and clinical factors has historically been and continues to be part of any comprehensive P&S Report. This information has always been required to determine a rating for permanent disability based on the objective (anatomic) measurable findings.

The California Code of Regulations Guidelines and the WCAB Decisions continue to clearly state that for all reduction of work capacity, the medical-treatment history, and clinical findings at the time of examination, (physical/neurological objective findings, standardized neurological/orthopedic testing, imaging results, etc.) **must support the reasons of the evaluating physician for the imposition of any reduction of work capacity.**

SB 899 - California Workers Compensation:

From Packard Thurber to The AMA Guides Transference of Evaluation Methodology

The evaluator continues to provide (MMI Report):

An independent, unbiased, assessment of the medical condition and its effects on function.
Abilities and continuing functional capacity, identifying limitations with a thorough documentation of supporting medical findings.

As stated by Dr. Brigham, the duty of the qualified (independent) medical examiner is:

To understand the regulations (medical-legal terminology).
To provide a clear and comprehensive medical assessment.
To perform this evaluation when the medical condition is static and well stabilized (MMI).

Dr. Mohammed I. Ranavaya, in a seminar by the American Board of Independent Medical Examiners (ABIME), also affirms what continues to be the base of any P&S/MMI comprehensive report – the need of the physician to understand the regulatory demands of their respective systems.

In the closing remarks of his recent article, The Medical-Legal Evaluation Process under California Workers Compensation Law (After SB 899), David A. Kizer, Esq., said it best:

It is apparent that the AME/QME/IME currently exists in an atmosphere in which additional sweeping changes are about to be made. The IMC Physicians Guide and the evaluation guidelines of the California Code of Regulations [now the DWC Medical Unit Guides] are still viable resources in the preparation of a California P&S/MMI Report.

8 CCR WCAB § 10606 outlines what should be included in a medical evaluation. The codes, WCAB & California Courts decisions define what is considered a reliable medical legal expert opinion – substantial medical evidence. They provide guidance on what and how the information must be presented within the body of the medical report.

1.2(a) –MMI Report - What is New?

Evaluating physicians' responsibility is to understand and include in the comprehensive (MMI) Report:

History of Injury (Mechanism of Injury) (AOE/COE).

Objective/measurable factors of impairment.

The clinical findings at time of examination,

The Summarization of reviewed records including salient points considered in the opinion's formulation.

Explanation of both the testing and imaging results.

A description of the individual's subjective complaints.

Evaluator will focus the impairment evaluation criteria into the organ system where the problems (injury) originated or where the dysfunction is the greatest.

SB 899 - California Workers Compensation:

From Packard Thurber to The AMA Guides Transference of Evaluation Methodology

Evaluator will calculate the impairment rating and compare the medical findings with the impairment criteria, without separating subjective complaints from objective factors.

Evaluator will discuss impairment rating, criteria, prognosis, residual function and limitations.

Evaluator must discuss how the impairment rating was calculated.

1.2(b) – MMI Report is considered under-reported when:

The MMI report fails to clinically correlate the permanent disability to any measurable physical or clinical elements (**permanent impairment**).

It provides a **listing** of uncorrelated findings/diagnoses/clinical test or imaging results without a well-reasoned explanation and opinion. **The opinion must now include the rationale, logic, criteria and tables used in the determination of the impairment rating.**

It includes the review of prior clinical tests, conducts new provocative testing, includes anatomic measurable (objective) impairment factors & findings, pain & other individual complaint factors, but fails short in addressing the disproportion between the word descriptions of functional loss and the factual findings.

It disguises the lack of material (impairment) findings and creates a facade of ‘reasonable medical probability’ by creating both impairment and disability with:

Lists of findings, diagnostic terminology or diagnoses criteria uncorrelated to underlying pathological processes or to each other.

Minimal or ‘normal’ listing of evaluated measurable factors, conflicting with the described assertions of functional loss.

The use of pain & tenderness or other individual subjective complaints as objective findings.

Descriptions of individual pain factors at such extreme levels that not only would they be ‘work disabling’ **but also life disabling**.

Depiction of implausible, conflicting and puzzling descriptions of functional loss.

Failure to include a Factual history, medical history, medical examination and/or reasoned medical opinion.

Failure to identify the findings relied upon in the opinion’s formulation of the nature/extent and duration of both Impairment & Permanent Disability (Work) Functional Loss (if any).

Failure to identify the vocational accident and exposure factors and the cause of both the impairment and disability factors.

Fails to clearly state that: The employee must be placed on a preventative work restriction based on the **impairment** (objective) **findings** at the time of examination (regardless of whether the work restrictions are specifically relevant to the current occupation). No work restrictions are needed or that the residual disability is best expressed by the **(specific-regional-whole person) impairment percentage**.

There is no residual permanent disability.

Labor Code Section § 4620 – States that the Medical Legal Permanent & Stationary Medical Report must be capable of proving/disproving a disputed medical fact. In determining whether a report meets the requirements of the subdivision, a WCAB Judge shall give full consideration to the substance, as well as form of the report as required by applicable statutes and regulations.

“Where the physician addresses the disputed medical facts, applies the case facts, applies his expertise, and renders a rational opinion, then the expert medical opinion has ‘probative value’ to assist the court to resolve disputed issues.” - Honorable W. Ordas & N S Udkovick, WC Judges

“A worker’s compensation judge’s determination based on a medical report that is just a string of unsubstantiated conclusions is no better than judicial dart-throwing. For the medical report to be usable, it should clearly explain how the medical conclusions are reached and in a way that someone who is not a medical expert can understand.” – Honorable Alan Eskenazi, WC Judge.

SB 899 - California Workers Compensation:
From Packard Thurber to The AMA Guides Transference of Evaluation Methodology

Table 1.2 - Comparison Table of The Requirements for The Maximum Medical Improvement (MMI) Report				
<u>Comprehensive MMI Medical Report</u>	Packard Thurber & California Code of Regulations	<u>ACOEM 2nd Edition</u>	<u>AMA Guides 5th Edition</u>	<u>WCAB § 10606 Article 9 (Evidence & Reports) WCAB: Opinion as Evidence</u>
Purpose of Evaluation (Date of Examination)	X	X	X	(a)
Comprehensive History & Mechanism of Injury Work Related Factors	X	X	X	(b)(i)(j)(k)(l)
Current & Work Status Past Work History	X	See Chapter 7		(h)
Purpose of Evaluation (Date of Examination)	X	X	X	(a)
<u>Comprehensive MMI Medical Report</u>	Packard Thurber & California Code of Regulations	<u>ACOEM 2nd Edition</u>	<u>AMA Guides 5th Edition</u>	<u>WCAB § 10606 Article 9 (Evidence & Reports) WCAB: Opinion as Evidence</u>
Comprehensive History & Mechanism of Injury Work Related Factors	X	X	X	(b)(i)(j)(k)(l)
Current & Work Status Past Work History	X	See Chapter 7		(h)
Medical & Treatment History Past Illnesses/Disabilities	X	X	X	(e)(g)
Presenting Symptoms Pain & Other Factors Avocational Factors/Demands	X	X	X	(c)(f)
Impairment Examination (Normal/Abnormal Findings)	X	X	X	(d)(f)(n)
Imaging & Tests RED FLAGS		(See Algorithms) X	X	(d)(f)(n)
Records Reviewed Job Requirements Reviewed	x	x	X	(d) (n)(f)
Diagnosis (Avoid Non-specific Labels)	x	X	x	(g)(n)(f) "A Diagnosis"
Impairment Percentage (Specific Tables & Figures Used)	Specific Body Part	Specific Body Part	X	(h)(n)(f)
Diagnoses Related Estimate (Specific Criteria Required)		X	X	(h)(n)(f)
P&S/ MMI Maximum Medical Improvement	X	X	X	(k) (h)(n)(f)
Summary & Reasoned Opinion	X	X	X	(d)(h)(n)(f)
Work Functional Loss Opinion & Support	X	X		(h) (n) (k)(f)
Subjective Disability	X	X		(o) (h) (n)(f)
Causation of Disability (Exacerbations/Aggravations)		X	X	(i) (e) (n)(f)(d)
Prior Awards (Prior Disability) (Overlap)	x	X		(e) (l)(d)
Treatment Considerations Substantiation ?		X		(j)(e)
Job Modifications	X	X		
Compliance Statements	X	x	X	(a) To (o) + L.C.S. § 4628
Signature	x	X	X	(o)
For specific codes on Workers Compensation Regulations from a legal standpoint Refer Back to: The Medical-Legal Evaluation Process under California Workers Compensation Law (After SB 899) by DA Kizer, Esq. - Qualified Medical Examiner Article & Examination 17 - Elliott-Lopez Publications Current Decisions of the Workers Compensation Appeals Board: WCAB Cases.				

SB 899 - California Workers Compensation:

From Packard Thurber to The AMA Guides Transference of Evaluation Methodology

As pivotal members of the workers' compensation community, physicians have direction under Article 14 of The California Constitution, to discharge their responsibilities "irrespective of the fault of any party." The determination of **impairment & permanent disability** via the medical report should help accomplish substantial justice in all cases; expeditiously, inexpensively and without encumbrance. The medical report should help resolve disputes by providing reliable, comprehensible, prudent opinions based on substantial medical evidence, which in turn support non-confusing descriptions of work capacity functional loss.

"A medical-legal report that does not contain the reasoning behind the medical opinions reached is worthless in the workers' compensation system."

2.1: - Evaluating Impairment Ratings – What is new?

Chapter 2 – Practical Application of the AMA Guides, provides the roadmap on how to present impairment information based on the Guides criteria.

When the clinical findings indicate that the medical condition is permanent/static and well stabilized – change can still occur, but no further recovery or worsening is expected. You can then determine this date to be the date of maximal medical improvement. Now you are ready to prepare an MMI Report [Old P&S Report].

Impairments often involve more than one body/organ system. The Evaluator can use the Chapter where the problem originated. Or since the same condition may be discussed in more than one chapter, it is recommended that the evaluator address the impairment factors causing greatest area of dysfunction.

The evaluating physician must address the occupational factors that contributed or played a significant role in producing the disability. **The evaluating physician must give a reasoned, well-supported opinion authenticating the level of permanent impairment that is due to both vocational and avocational factors.** The physician's reasoning should be reflected within the medical report with proper substantiation of all medical opinions.

For Workers Compensation purposes, neurological and musculoskeletal impairments due to an industrial injury for the spine or extremities should first be evaluated under:

Chapter 15 – The Spine [Cervical, Thoracic, Lumbar & Pelvis]

Chapter 16 – The Upper Extremities [Shoulders to Hand Digits]

Chapter 17 – The Lower Extremities [Hip to Toes]

When evaluating impairment **due to documented dysfunction** of the brain, cranial nerves, spinal cord, nerve roots and or peripheral nerves and muscles, **then and only then** is **Chapter 13 the Brain and Nervous System Chapter** to be used.

Determine first the individual's most significant (primary) impairment and evaluate all other impairments in relationship to it.

Related but separate conditions are rated independently from the primary impairment - when there is no impairment duplication.

For example, an individual with an injury causing neurologic and muscular impairment to the upper extremity would be evaluated under the upper extremity criteria in Chapter 16. Any skin impairment due to significant scarring is rated separately under the criteria of Chapter 08 – The Skin. [Example from AMA Guides Section 2.5b.]

SB 899 - California Workers Compensation:

From Packard Thurber to The AMA Guides Transference of Evaluation Methodology

.1(a): What is New?

The impairment criteria and ratings in the various body organ system chapters make s allowance for any accompanying pain and other subjective residuals.

When there are objective findings present from a recognized or well-accepted biological cause, a description of Pain can be considered.

Impairment percentages based on diagnoses related methods or functional losses cannot be adjusted by the pain factors (adding on 01 to 03%).

Example 1: Based on the symptoms, signs and appropriate tests results, physician places an individual in Category II of Table 15-4 – Criteria for Rating Impairment due to Thoracic Spine Injury. Evaluator states that the individual has a 08% impairment.

The range for Category II: 05-08%.

The range for Category III: 15-18%

Adding Subjective factors range of 01-03% will create a new category 09-11% which is not part of the accepted criteria.

The permanent impairment determinations to different parts [upper extremity, spine, lower extremity] or systems [digestive, visual, respiratory, cardiovascular] of the body are described separately. References to the independent explanations of the rationale, logic and criteria used in their determinations must be part of the MMI Report. **The evaluating physician should also provide a written opinion when a level of impairment is unsupported.**

Example 2: Based on the symptoms, signs and appropriate tests results, physician places an individual in Category I of Table 15-5 – Criteria for Rating Impairment due to Cervical Disorders, which is a 00% impairment percentage. **According to the level and frequency of subjective pain factors, physician could use the 01 to 03% impairment range.** [Chapter 18 of the AMA Guides.] **But if the cervical, thoracic or lumbar spines were injured, you can only use the pain add-on once.** **The same concept is applicable when there are different body parts of organ systems being considered – the subjective add-on can only be used once.**

2.2 – Consistency of Evaluation Methodology: Range of Motion (ROM)

The Practical Guide to Range of Motion Assessment is a companion book to the AMA Guides. It provides standardized guidelines and key principles in the evaluation of range of motion (ROM). **For the upper and lower extremities ROM is the foremost tool in measuring and assessing musculoskeletal function.**

The book provides the physician with recommendations in how to avoid and limit the potential of errors, achieve consistent measurements, provides suitable warm-up exercises and accurate recording of measurements.

SB 899 - California Workers Compensation:

From Packard Thurber to The AMA Guides Transference of Evaluation Methodology

Key Features

Presents the **Modified Neutral Zero Measuring Method**.

Neutral –0- method defines the starting positions from the so-called anatomical position of the body.

AMA Guides recommends multiple measurements of active motion.

Discusses instrumentation and standardized features, including positioning and stabilization of the body.

Details the standardized warm-up exercises prior to taking measurements.

Provides anatomical landmarks, terminology, and gravity related starting-0- positions.

2.2(a) – Range of Motion for Cervical, Thoracic, Lumbar Spine

AMA Guides Chapter 15 – The Spine provides physician with two distinct methods of assessment for the 3 main regions of the spine. The most commonly used method to evaluate an individual who has had a distinct injury is the Diagnosis-Related Estimates Method (DRE). Section 15.2(a) summarizes the specific procedures and directions to take when determining the impairment methodology to be followed.

When following the Range of Motion Method, Section 15.8 provides the criteria and elements that must be included. Evidence-based impairment ratings based on the ROM of the various segments of the spine can be used when:

An individual cannot be easily categorized in a (DRE) Class and/or there is no verifiable injury.

There is multilevel involvement:

Fractures, herniation, stenosis with radiculopathy at multiple levels. Fusion at multiple levels (without corticospinal involvement). Alteration of motion segment integrity.

Recurrent injury, recurrent radiculopathy or a new herniation with radiculopathy.

It rates higher than the (DRE) method in the small number of instances in which both can be used.

The three components to be assessed and combined are:

The range of motion of the impaired spinal region.

Table 15.9 – ROM of the Lumbar Spine, page 405.

Table 15-10 – ROM of the Thoracic Spine, page 411

Table 15.11 - ROM of the Cervical Spine, page 417.

Accompanying Diagnoses with specific references to Table 15.7 on page 404.

Spinal Nerve Deficit either described in Chapter 15 Section 15.12 or Chapter 13, Central and Peripheral Nervous System. Review of the diagnostic criteria in Chapter 13, can help physician determine which of the two Chapters should be used.

On page 423 the Guides provide the physician with specific criteria for the identification of the nerves involved based on the clinical evaluation and the dermatome charts for either the upper extremities [**Figure15.2**] or the lower extremities. [**Figure15.1**]. It advises physician how to determine the extent of sensory and motor loss (due to nerve impairment) and the 'maximum impairment' due to nerve dysfunction.

SB 899 - California Workers Compensation:

From Packard Thurber to The AMA Guides Transference of Evaluation Methodology

Chapter 15 – The Spine Table 15-20 - Spine evaluation Summary Form			
Impairment	Cervical	Thoracic	Lumbar
DRE Method (Tables 15-3 through 15-5)			
Range-of-Motion Method (& Table 15-8)			
Nerve root: Loss of sensation with or without pain Loss of strength			
4. Pelvis (From Section 15.14)			
5. Regional impairment total (combine impairments in each column using the Combined Values Chart, p. 604)			
6. Spine impairment total (combine all regional totals using the Combined Values Chart)			
7. Impairments) of other organ systems: for each impairment list condition, page number in Guides, and percentage of impairment. <u>Requires Specific Evidenced Based Criteria.</u>			
Impaired System	% Impairment	Tables/ Charts	Guides Page #
8. Impairment of the whole person: Use Combined Values Chart to combine spine impairment with the impairments listed in 7 above. If several impairments are listed, combine spine impairments with the larger or largest value, then combine the resulting percentage with any other value(s), until all the listed impairments have been accounted for.			
Total whole person impairment: _____			