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California Workers Compensation Impairment & Disability Rating Specialists

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California Workers Compensation
Consistency of AMA Impairment Evaluation & Reporting:
Part I: Upper Extremities

A California Permanent Disability Rating starts with the evaluating physician's impairment rating in accordance with the medical evaluation protocols and rating procedures set forth in the 5th Edition of the AMA Guides. This initial component is then 'adjusted' into a permanent disability rating to account for diminished future earning capacity and the occupation and age of the injured employee at the time of the injury. These components of the rating formula are found on the Schedule for Rating Permanent Disabilities (PDRS).

Chapters 3 to 17 of the AMA Guides outline how imaging studies, signs and appropriate test results support the use of not only Diagnosis Related/Based Estimates (DRE) or (DBE) but of the distinct percentages for objective manifestations of impairment. Yes, the AMA Guides emphasize impairment ratings based on objective assessment but it also considers subjective symptoms within the diagnostic criteria and support of an impairment percentage. Chapter 18 specifically deals without situations above and beyond the effects of pain on Activities of Daily Living (ADL).

A whole person impairment rating based on the body or organ rating system of the AMA Guides (Chapters 3 through 17) may be increased by up to 03% WPI if the burden of the worker's condition increases by pain-related impairment in excess of the pain component already incorporated in the WPI rating in Chapters 3 to 17. AMA 5th Ed., page 573 & 2005 PDRS, page 1-12.

The fragmentation into 18 Chapters, of impairment calculating rating criteria, might lead some users to believe that there are no common rating principles applicable to any and all disabilities. Principles for determining impairment values for ROM, DRE, DBE and the avoidance of duplication appear recurrently from chapter to chapter. Rating principles previously found in the 97PDRS, i.e., interpolation, rounding, avoidance of duplication/pyramiding, combination of disabilities, etc. are first addressed in Chapters 1 and 2. Chapters 3 to 17 build on this foundation and expand these principles as related to the specific body parts or organ systems. For both the upper and lower extremities, the AMA Guides carries the concept of prior PD Schedules: that impairment manifestations cannot exceed the value of amputation. Section 7 of the 05PDRS provides examples and strengthens the concept in the description of the proper determination of California impairment-to-disability.

One thing is very clear by the requirements of both the AMA Guides & California Code of Regulations - Evaluating Physician must explain how the impairment was calculated. Attaching a computer generated report and/or worksheets does not replace the California requirements that determination of any impairment level must follow the AMA Guides established evaluation criterion and be explained by a well-reasoned/rational medical opinion.

Evaluating Physician must not fail to discuss how specific findings relate to and compare with the applicable rating criteria used to determine impairment - especially how impairment is determined with missing and/or limited data. AMA 5th Ed., Section 2.6b,page 22.

Imaging study findings and unsupported subjective complaints are worthless without a clinical correlation at the time of examination. Symptoms and complaints without integration to objective data (by the evaluating physician) should not serve as the sole criterion upon which decisions about impairment are made. General guidelines for the description and correlation of any imaging or diagnostic can be found on AMA 5th Ed., page 378.

AMA Guidance for addressing the issues of causation, aggravation and apportionment, which should be considered if the vocational causation is responsible for an aggravation of symptoms, are found in AMA pages 10, 11 and 12. (Physician must also be aware of SB 899 apportionment requirements.)

The report must show that the evaluating physician has considered avocational factors, findings and symptomatology independent of the permanent disability due to vocational causation. The evaluating physician provides a well-reasoned opinion based on the review of the medical records/history and considers pre-existing objective pathology, symptomatology, work limitations secondary to pre-existing disability, including time off from work or need for treatment.

In determining an overall level of impairment evaluating physician should always address the following question: *If it were not for the non-vocational factors or pre-existing conditions, would this level of impairment exist?*

Consistency is the key word when addressing impairment in a California P&S report. Consistency of imaging studies, to clinical findings on examination, to the medical/treatment histories, to the impairment rating criteria of the AMA Guides and to a reasoned medical opinion.

Vocational Rehabilitation

To determine if the employee's need for job modifications are truly based on an objective clinical foundation, the evaluating physician must analyze vocational task and provide and explanation of the impact of the medical impairment on vocational activities. Any determination of need for job modifications or QIW status requires a demonstrable foundation of clinical signs or other independent measurable abnormalities.

Emphasizing residual capacity over activity limitations the physician determines the bases for any limitation of activities as supported by objective measurable and clinical information. Careful consideration must be given to the concepts of physical harm, current ability and perceived or actual tolerance for the inability to perform vocational activities. Physician should not lightly 'preclude' activities and functional loss not supported by an appropriate impairment level. Some questions to consider:

- **Risk (Harm):** ***Q:*** Do the work activities pose a 'substantial risk' of significant harm to self or others? Risk is not an increase in previously present symptoms like pain or fatigue.
- **Capacity – Current Ability:** ***Q:*** Is EE physically able to perform essential job functions? ***Q:*** Are current strength, flexibility & endurance levels up to capacity, or are current abilities reduced due to deconditioning?
- **Tolerance -** Ability to Endure sustained work activities. ***Q:*** Able to do specific tasks? Variable comfort level? ***Q:*** If any, what pychophysiological factors are affecting the individual's ability to tolerate greater levels of subjective symptomatology?

Job modifications or vocational rehabilitation must be substantiated by realistic facts and findings suitably identified in the formulation of the reasoned/logical medical opinion. The word 'prophylactic' can no longer be the proper support for job restrictions or modifications.

Its use is not objective evidence capable of proving/disproving impairment or disability. It only serves to disguise the lack of material findings and in turn create the facade of 'reasonable medical probability.' It's never been valid reason, as required by WCAB § 10606 (f) (f) (i) (k) (m) (n), for the support of impairment, disability or work modifications.

Upper Extremities

1. It is the physician's responsibility to: (1) include a relevant description of body habitus and any general observations such as a limp, obvious discomfort while sitting/standing, etc., (2) evaluate all joints on an injured extremity (if measurements or observations are normal physician should simply state "normal"), (3) include the voluntary active arc of motion of the injured over the un-injured and appropriate circumferential measurements of the involved muscle groups (evaluating physician should also record abnormal, excessive or limited range of motion, including ankylosis). AMA 5th Ed., Chapter 16, page 433.

1.1. Impairment is based on examiner's actual findings. (AMA pg. 435)

1.2. Impairment evaluation must address abnormal ROM, Ankylosis, Amputation, Peripheral Vascular & Nerve System and other disorders. (AMA pg. 435)

1.3. ROM Assessment requires that both extremities be compared and individual joints be evaluated separately. Active Motion measurements take precedent. (AMA pg. 451)

1.4. If an individual has previous measurements of function that were below or above average population values, physician may discuss the prior values and any subsequent loss for the individual based on the physician's estimate of the individual's pre-injury capacity.

1.5. If a contra lateral 'normal' joint has a less than average mobility, the impairment value(s) corresponding to the uninvolved joint can serve as a baseline and are subtracted rom the calculated impairment for the 'injured' joint. (AMA pg.453)

1.6. **Physician needs to validate the reasons for the restrictions of ROM and provide a complete a detailed examination of the upper extremities. (**AMA pg 435)

1.7. **Clearly state if the active motion recorded is 'normal' for the individual, even when less than 'estimated normals'.**

1.8. **If restriction of motion is present, evaluating physician must comment on the reason why; pain, muscle spasm, voluntary restriction, etc. Gentle passive range of motion may be performed in addition to active range of motion to determine whether the restriction is due to pain or mechanical block.**

2. **Peripheral Nerve Abnormalities** is based on the anatomic distribution and severity of loss of functions resulting from (1) sensory deficits or pain and (2) motor deficits and loss of power. Sharon (AMA pg. 481). **Without CRPS, abnormal ROM values are not added to peripheral nerve lesions.**

3. **Entrapment/Compression Neuropathies** are rated when an objective verifiable diagnosis is present, supported by positive clinical findings and loss of function. Documentation requires Nerve Conduction Studies & EMG studies (AMA pg. 493). **Additional impairment values are not given for decreased grip strength.** (AMA pg. 494)

4. **Vascular Disorders** are only considered when objective testing establishes the presence of obstructive physiology. (AMA pg. 497)

5. **Bone & Joint Disorders**, resection or implant arthroplasty, musculo-tendinous disorders and loss of strength are used when the impairment criteria addressed on 1.13 to 1.16 have not adequately encompassed the extent of the impairment (AMA pg. 499). **Evaluating physician must be aware of the overlapping pathomechanics inherent among these conditions and closely follow the impairment evaluation criteria to avoid duplication of impairment.**

6. **Skin Disorders**, including disfigurement, scars and skin grafts, are evaluated using criteria in AMA Guides, Chapter 8.

7. **Grip/Pinch & Strength: Decreased strength cannot be rated in the presence of (1) decreased motion, (2) painful conditions, (3) deformities or (4) amputations, since they prevent effective application of maximal force in the region being evaluated.** AMA 5th Ed., pages 508 to 510

7.1. When the reduction of dynamometer readings is due to decreased motion, painful conditions, deformities or absence of parts, decreased strength is not a valid anatomic impairment factor in which to base any work capacity functional loss - other objective anatomic findings take precedent. (AMA 5th Ed., pg.508).

7.2. When dynamometer measurements are taken, if maximum effort is exerted, the data obtained will follow a bell curve. With maximum exertion/strength being greatest near the mid point. If upper extremity pain is present, strength may be decreased, but the bell curve pattern should be evident.

7.3. The use of dynamometer readings that have been affected by other disability factors such as pain, limitations of motion, muscle weakness, musculature atrophy, deconditioning, pain, lack of full effort or voluntary restriction, etc., creates an unrealistic result and produces a greater amount of Permanent Disability than actually exists.

7.4. **With the proper measurable/clinical finding and abiding to the AMA calculating criteria, physician can refer to Tables 16-31 & 16-32. The physician also must:**

7.4.1. Use unaffected or un-injured arm measurements, when rating a single extremity.

7.4.2. Repeat tests at least 3 times, at different points during the examination.

7.4.3. Validate that there is no a variance greater than 20% in the tests results.

7.4.4. Assess consistency of effort by plotting out the grip strength measurements at the five hand settings, or testing using the rapid exchange technique.

7.5. "Several syndromes involving the upper extremity are attributed to tendinitis, fasciitis or epicondylitis. The most common of these are the stubborn conditions of the origins of the flexor and extensor muscles of the forearm where they attach to the medial and lateral epicondyles or the humerus. **Although these conditions may be persistent for some time, they are not given a permanent impairment rating unless there is some other factor that must be considered."** (Objective measurable or clinical factor – not pain.) AMA 5th Ed., page 507

7.6. Impairment ratings considering <u>these syndromes</u> (tendinitis) are only given an impairment rating:

7.6.1. <u>If there is another objective impairment present</u>, i.e., ROM,

7.6.2. The Syndrome was treated surgically

7.6.3. The condition was caused by an <u>underlying</u> impairment such as tendon rupture.

7.7. <u>Manual Muscle Testing for Elbow/Shoulder Strength Deficits</u>

7.8. Addresses ability to move a joint through a full ROM against gravity, or move it against additional resistance applied by the examiner. AMA 5th Ed., 509. (Table 16-35, page 510).

Many of the AMA Guides concepts are not new to California Workers Compensation. Both the Labor Code, The California Code of Regulations and a multitude of cases have defined basic concepts, which continue to help us understand the standards of what constitutes substantial medical evidence on a California P&S medical report.
In a recent article at workcompcentral, the Honorable WCAB Judge Pamela W. Foust states:

California Evidence Code section 140 defines the term, evidence, as "testimony, writings, material objects, or other things presented to the senses that are offered to prove the existence or nonexistence of a fact." The phrase, substantial evidence, does not appear in the Evidence Code but definitions can be found in the case law. Probably the most widely accepted definition of substantial evidence is relevant evidence that a reasonable person might accept as adequate to support a conclusion.

Notwithstanding these considerations, substantial evidence is simply evidence that is believable. At the extreme ends of the spectrum, the concept will be easy to apply. If any reasonable person could read a medical report and find the doctor's conclusion to be persuasive, that's substantial evidence, assuming the report is based on accurate facts. On the other hand, if the doctor's opinion would insult the intelligence of any reasonable person or elicit the reaction that it could only happen this way on a cold day in hell, the report is not substantial evidence.

- <u>LC§ 4620</u> – Medical Legal 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 statues and regulations.

  "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.

the disputed issues). ***"Where the physician addresses the disputed medical facts, applies the case facts, applies his expertise, and renders a <u>rational opinion</u>, then the expert medical opinion has 'probative value' to assist the court to resolve disputed issues."*** *- Honorable W. Ordas & N S Udkovick, WC Judges*

<u>8 CCR § 10606</u> - The medical report must be clear as to any loss of work capacity, be it objective physical findings, disabling effects of pain, work restrictions or a percentage of pre-injury capacity functional loss. <u>If there is no residual impairment (disability) the report should state so.</u>

- <u>8 CCR § 9793</u> (c) – "<u>Comprehensive Medical-Legal Evaluation</u>" means an evaluation of an employee which {a} results in the preparation of a narrative medical report prepared <u>and attested</u> to in accordance with LC§ 4628, any <u>applicable procedures promulgated under LC§ 139.2</u> <u>and the requirements of 8 CCR § 10606</u>, and {b} is either performed by a (QME), (AME), or (PTP).

- ***<u>'Pass Through' Reports</u> - " The physician has not bothered to perform any reasoned analysis at all. There are merely unsupported conclusions with no basis. In this type of report usually one or two sentences of 'conclusions' [reasoned medical opinion?] are usually hallmarked by having no factual or medical reasons expressed for the conclusion."*** *-- Honorable W. Ordas & N S Udkovick, WC Judges*

Upper Extremities Guide to Appropriate Combination of "Other" Evaluation Methods
Open Boxes Indicate Impairment Ratings Derived from Theses methods Can Be Combined
X - Do Not Use These Methods Together for Evaluating a Single Impairment

	Synovial Hypertrophy 16.7 (T)16-19	Digital Deviation 16.7 (T)16-20	Rotational Deformity 16.7 (T)16-21	Sublaxation or Dislocation 16.7 (T) 16-22	Joint Mediolateral Instability 16.7 (T)16-23	Joint Mediolateral Deviation 16.7 (T)16-24	Carpal Instability 16.7 (T)16-25	Decreased ROM 16.4	Arthroplasty 16.7b	Musculo-Tendinious 16.7 c&d	Strength Evaluation / Muscle Testing 16.8	Shoulder Instability 16.7 (T) 16-26-&16-27
Synovial Hypertrophy 16.7 (T)16-19		X	X	X	X	X	X	X	X	X	X	
Digital Deviation 16.7 (T)16-20	X		X	X					X		X	
Rotational Deformity 16.7 (T)16-21	X	X		X					X		X	
Sublaxation or Dislocation 16.7 (T) 16-22	X	X	X					X	X		X	
Joint Mediolateral Instability 16.7 (T)16-23	X								X		X	
Joint Mediolateral Deviation 16.7 (T)16-24	X								X		X	
Carpal Instability 16.7 (T)16-25	X	X	X	X	X	X			X	X	X	
Decreased ROM 16.4	X			X						X	**See AMA Page 508**	
Arthroplasty 16.7b		X	X	X	X	X	X					X
Musculo-Tendinious 16.7 c&d								X				
Strength Evaluation / Muscle Testing 16.8		X	X	X	X	X	X	**See AMA Page 508**				
Shoulder Instability 16.7 (T) 16-26-& 16-27	X			X	X	X			X	X	X	

From An original by Linda Cocchiarella, MD- Master the AMA Guides-2001 AMA 5th Ed.

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