

**The Lawyer's Guide to the AMA *Guides* and California Workers' Compensation,
by Robert G. Rassp**

**Chapter 4
Substantial Medical Evidence in an AMA *Guides* Case**

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§ 4.01 Model Sequential Step Analysis

In a case that involves the *AMA Guides*, the WCAB and all of the workers' compensation judges should consider following a sequential step analysis to determine what medical reports constitute substantial medical evidence. How is the evidence in the record to be weighed in a case that involves the *AMA Guides* and where the post-SB 899 PDRS clearly applies? In an *AMA Guides* case, it is probable that the record as a whole will consist of the reports of the treating physicians, an AME or panel QME report, along with other documentary evidence and oral testimony from witnesses.

Model Sequential Step Analysis of Medical Evidence

1. What medical issues are in dispute between the applicant and defendant?

2. Which medical report(s) is/are each party relying on and why?
3. Are the relied upon reports substantial evidence [*see* § 4.02]?
4. Are the relied upon reports “AMA compliant” [*see* § 4.03]? Does each report follow the proper descriptions and measurements of the AMA *Guides* pursuant to Labor Code § 4660(b)(1), and are they consistent with the post-SB 899 PDRS?
5. Which report is more credible and persuasive on the disputed medical issues and why?

§ 4.02 Substantial Evidence Defined

What does “substantial medical evidence” mean? The analysis of what constitutes substantial medical evidence also has a sequential analysis and is best described in Part II.E. of the WCAB en banc decision *Escobedo v. Marshalls* [(2005) 70 Cal. Comp. Cases 604, 620-621]:

1. “. . . [I]n order to constitute substantial evidence, a medical opinion must be predicated on reasonable medical probability.” [*citing* *McAllister v. Workmen’s Comp. Appeals Bd.* (1968) 69 Cal.2d 408, 413, 416-417, 419, 445 P.2d 313, 71 Cal. Rptr. 697, 33 Cal. Comp. Cases 660]
2. “. . . [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.” [*citing* *Heggin v. Workmen’s Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169, 480 P.2d 967, 93 Cal. Rptr. 15, 36 Cal. Comp. Cases 93; *Place v. Workmen’s Comp. Appeals Bd.* (1970) 3 Cal.3d 372, 378-379, 475 P.2d 656, 90 Cal. Rptr. 424, 35 Cal. Comp. Cases 525; *Zemke v. Workmen’s Comp. Appeals Bd.* (1968) 68 Cal.2d 794, 798, 441 P.2d 928; 69 Cal. Rptr. 88, 33 Cal. Comp. Cases 358]
3. “. . . [A] medical report is not substantial evidence unless it sets forth the reasoning behind the physician’s opinion, not merely his or her conclusions.” [*citing* *Granado v. Workers’ Comp. Appeals Bd.* (1968) 69 Cal.2d 399, 407, 445 P.2d 294, 71 Cal. Rptr. 678, 33 Cal. Comp. Cases 647; *see also* *Zemke v. Workmen’s Comp. Appeals Bd.* (1968) 68 Cal.2d 794, 799-801, 441 P.2d 928; 69 Cal. Rptr. 88, 33 Cal. Comp. Cases 358]
4. “. . . [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.” [*Escobedo v. Marshalls* (2005) 70 Cal. Comp. Cases 604, 621 (Appeals Board en banc decision)]

In the context of a medical report that is based upon the *AMA Guides*, it is vital that the physician's conclusions are based upon an adequate examination of the applicant. The nature and type of physical examination of a person under the *AMA Guides* is much more involved and crucial to the physician's conclusions than a physical examination occurring under the pre-SB 899 PDRS.

For example, a physician's reliance on a technician to conduct range of motion testing is suspect. Likewise, a computer program that calculates impairment ratings or that records the range of motion angles is also suspect. The physical examination of the applicant must conform to the standards for the descriptions and measurements of the *AMA Guides*, including the requirement that the physician conduct the physical examination and measurements using active range of motion and not assisted or passive range of motion.

The rationale is that active range of motion is the only valid means to truly test the effect of an impairment on a person's activities of daily living. For example, in a shoulder injury, a physician may be able to force flexion and extension of an injured shoulder from 180 degrees flexion to 50 degrees extension and abduction from 0 degrees to 180 degrees with severe pain [*see AMA Guides*, Tables 16-38 and 16-41, pages 475 and 477, respectively]. However, if the active range of motion for flexion or abduction of the shoulder is only 90 degrees, the loss of motion in real life would affect the person's ability to perform overhead activities, such as combing hair or working above shoulder level [*see Ch. 3, § 3.17*].

NOTE: Part II.E. of the *Escobedo* decision does not refer solely to an analysis of apportionment of permanent disability, but to any disputed medical-legal issue that is addressed by a treating or evaluating physician. All medical issues addressed by a physician in a medical report must follow existing case law for substantiality that is well articulated by the WCAB in *Escobedo*. ■

NOTE: As noted in *Escobedo*, the seminal case on the quality or lack of quality of an expert witness's conclusions is *People v. Bassett* [(1968) 69 Cal.2d 122, 443 P.2d 777, 70 Cal. Rptr. 193], which states that "the chief value of an expert's testimony rests upon the material from which his or her opinion is fashioned and the reasoning by which he or she progresses from the material to the conclusion, and it does not lie in the mere expression of the conclusion; thus the opinion of an expert is no better than the reasons upon which it is based." ■

§ 4.03 AMA Compliant Reports

[1] Defined

What is an "AMA compliant" medical report? The term was coined for two purposes. The first is for the parties, raters, counsel, and judges to determine whether a

medical report in question correctly follows the descriptions and measurements of the *AMA Guides* as mandated by Labor Code § 4660(b)(1). The second purpose is to determine whether the medical report follows California law, including a reflection of the physician's understanding of the post-SB 899 PDRS, which modifies a literal application of the *AMA Guides* with certain nuances discussed in this guidebook and medical-legal issues that will ultimately be determined by decisional case law.

In order to follow the descriptions and measurements of the *AMA Guides*, the physician must comply with Section 2.6 of the *AMA Guides*, along with Administrative Director Rule 10606 [8 Cal. Code Reg. § 10606] [*see* Ch. 3, § 3.03]. A checklist of the elements required for a medical report to be "AMA compliant" is set forth in [2], *below*.

[2] Required Elements

The following checklist of the elements required for a medical report to be "AMA compliant" is a combination of Administrative Director Rule 10606 [8 Cal. Code Reg. § 10606] and Section 2.6 of the *AMA Guides*.

- Purpose of the examination (treating physician, AME, Panel QME, or QME)
- History of present illness
- Chief complaints
- Pre-injury and post-injury activities of daily living (Table 1-2 on page 4 of *AMA Guides*)
- Past medical history
- Job description
- Review of submitted medical and legal records, including a list of items reviewed
- Physical examination (includes who and what methods used) and findings on examination
- Diagnostic and imaging study results
- Diagnosis and impression
- Discussion and conclusions
 - Causation of the injury (specific injury, continuous trauma or both?)
 - Has applicant reached maximum medical improvement and is permanent and stationary?
 - Objective findings: loss of range of motion, neurological deficits by sensory deficits (pain, numbness, loss of tactile discrimination, tingling) and motor function deficits (muscle weakness, atrophy), spondylolysis, spondylolisthesis, herniated intervertebral disc, nerve impingement, etc.
 - Discussion of negative or positive diagnostic tests or imaging studies.
 - Description of impairments for each separate part of body using specific chapters, tables, and page numbers, and describing the method(s) of evaluation (DRE, ROM, both; DBE, functional loss, anatomic loss; combining and adding where appropriate).

- Are physician’s conclusions consistent with the post-SB 899 PDRS and relevant case law?
- How does the industrial injury currently affect the applicant’s ADLs?
- Physician’s rationale for using a particular method of descriptions and measurements from the *AMA Guides*.
- Causation of permanent impairments (apportionment), how and why other factors are causing permanent disability in addition to industrial factors.
- Recommendations for further medical treatment.
- Can the applicant perform his or her usual and customary job duties?
- What are the applicant’s residual functional capacities (listed in Form PR-4 “Primary Treating Physician’s Permanent and Stationary Report”; *see* 8 Cal. Code Reg. § 9785.4) and work restrictions?

§ 4.04 The Good, the Bad, and the Ugly: Examples of AMA Compliant and Non-AMA Complaint Medical Reports

[1] In General

The following seven examples are actual cases that were subject to the *AMA Guides* when a physician issued a permanent and stationary report that indicated the applicant reached maximum medical improvement. Some of the reports are substantial evidence and comply with Administrative Director Rule 10606 [8 Cal. Code Reg. § 10606] and Section 2.6 of the *AMA Guides*, and are consistent with the descriptions and measurements of the *AMA Guides* and the post-SB 899 PDRS. Other reports are not compliant with the *AMA Guides* and do not constitute substantial medical evidence. As you read the salient information about each case, see if you can tell what is wrong, if anything, with the report. You may want to consult with Ch. 3 of this guidebook and have the *AMA Guides* handy to check for specific instructions, tables, and figures that are referred to below.

[2] Example #1: Lumbar Spine Impairment Rating

Facts:

The applicant is a 17-year-old female grocery stock clerk who lifted a case of 24 bottles of beer and felt her low back “snap.” Two months after the incident, the treating physician declared her condition as permanent and stationary and MMI as follows:

MRI of the lumbar spine reveals L5-S1 disc degeneration with a 3-4 mm broad based central bulge encroaching on the anterior epidural fat without obvious nerve compression and without significant canal stenosis.

In the lumbar spine examination, the doctor stated:

Patient flexes so that the fingertips reach approximately 12 inches above the floor. The patient extends to 20% of normal and laterally rotates (sic) to 50% of normal.

All range of motion is limited by pain. There is tenderness to palpation throughout the lumbar spine from L1 to L5, but there is no obvious paraspinal muscle spasm.

Under impairment rating, the doctor opined:

[Patient] has severe symptoms in her low back and bilateral legs that do not correlate with her MRI findings. She has a mild disc bulge without impingement on the nerves although the films were not available today. All limitations of motion are due to pain only. The symptoms in her legs are in a non-dermatomal distribution. Therefore, according to *AMA Guides* . . . my recommendation is that the patient be assigned a DRE Category I, 0% impairment of the whole person.

Commentary:

This report is not AMA compliant and is not substantial evidence for the following reasons:

1. **No flexion-extension x-rays.** There are no flexion-extension x-rays to determine whether there is any intervertebral instability.
2. **No EMG/NCV study.** There is no EMG/NCV study to see if there is a verified lower extremity radiculopathy. The statement that the pain down the applicant's leg is "non-dermatomal" is speculative since the physician did not review any EMG or NCV and he never gave the applicant the benefit of the doubt that she has radicular symptoms.
3. **Correct ROM testing not performed.** The physician did not perform a correct range of motion testing. There is no evidence he used an inclinometer or other proper instrument. There is no such thing as "lateral rotation" in a lumbar spine range of motion test. Rotation is a hip function. The only valid planes to test range of motion for a lumbar spine is forward flexion, backwards extension, and right and left lateral flexion or bending [*see AMA Guides*, Tables 15-8 and 15-9, Figures 15-8 and 15-9, and text from pages 405 through 409 with the summary form, Figure 15-10 on page 410].
4. **MRI films not reviewed.** The physician cannot see how much space is in the spinal canal without an MRI. A 3-4 mm disc bulge could be clinically significant, and the applicant could have concordant pain with this MRI finding.

Afterword:

The applicant was later referred to an AME in orthopedic surgery who opined that the applicant has a DRE Category III whole person impairment rating of 13% because of the

severity of having a 3-4 mm disc bulge at age 17 with non-verified but credible radiculopathy and impingement of the bulge on the epidural fat.

The AME opined that the 3-4 mm disc bulge is equivalent to a herniation in a patient this young. He indicated that he used the DRE method rather than the ROM method because the impairment was caused by a specific injury. For the record, the ROM method would have resulted in the same level of impairment in this case as the DRE method. The AME also stated that the injury has drastically affected the applicant's ADLs, including the fact that she cannot participate in any physical education activities while in her senior year in high school.

[3] Example #2: Upper Extremity (Left Wrist) Impairment Rating

Facts:

The applicant is a 63-year-old female librarian who slipped and fell and landed on her left major wrist, causing a closed left distal radius fracture. The fracture was reduced by a cast and removed after six weeks with intensive physical therapy. She was further diagnosed with post traumatic left carpal tunnel syndrome and referred for an EMG/NCV, which showed severe compression of the median nerve at the left carpal canal.

In his permanent and stationary MMI report, the treating physician stated: "In the patient's own words the following was described: 'I'm doing well and really have no problems and the problems I do have, I am learning to live with.'" The physician measured the applicant's range of motion to her left wrist as follows: Extension 45 degrees, flexion 60 degrees, radial deviation 15 degrees and ulnar deviation 25 degrees. (Normal range of motion for a wrist is flexion 60 degrees, extension 60 degrees, radial deviation 25 degrees, ulnar deviation is 30 degrees).

The physician used the correct upper extremity impairment rating chart [*see* AMA *Guides*, Figure 16-1a and 16-1b, pages 436 and 437) and assigned a 5% upper extremity impairment rating due to the loss of range of motion in the wrist. (He correctly used AMA *Guides*, Figure 16-26, page 466 for flexion and extension of the wrist, Figure 16-28 Pie Chart on page 467 for the rating, Figure 16-29 on page 468 for radial and ulnar deviation, and Figure 16-31 on page 469 Pie Chart for the rating). The 5% upper extremity rating converts to a 3% whole person impairment rating.

The defendant and applicant signed a Stipulation With Request for Award based upon the above for a 3% permanent disability, which was submitted to the WCJ for approval. The applicant was not represented by legal counsel at the time the settlement was submitted for approval.

Commentary:

NOTE: The WCJ expressed concern that “something was wrong” with the submitted settlement, and he consulted this guidebook and the *AMA Guides*. ■

This medical report is not AMA compliant and does not constitute substantial evidence for the following reasons:

1. **Nerve conduction study not included.** The physician failed to include a copy of the nerve conduction study with the permanent and stationary report.
2. **Proper grading system for sensory and motor function impairments not used.** The physician failed to evaluate the carpal tunnel syndrome using the grading system for sensory and motor function impairments in the *AMA Guides*, Chapter 16, peripheral nerve system impairment on the upper extremity chart on page 16-1b. He should have graded the sensory and motor function impairments using the severity of the EMG/NCV results, along with the applicant’s more detailed description of what she meant by saying she “has learned to live with it” concerning her carpal tunnel syndrome.
3. **ADLs not addressed.** The physician failed to specifically indicate how the left wrist injury has affected the applicant’s activities of daily living using the *AMA Guides*, Table 1-2 on page 4.
4. **Incorrect upper extremity rating.** The physician should have referred to *AMA Guides* Tables 16-10, 16-11, and 16-15 to determine the upper extremity rating for the sensory and motor impairments from the carpal tunnel syndrome.

Here, the applicant probably has at least a 25% loss (Grade 4) of median nerve sensory function (25% of 39 = 10% upper extremity rating) and a 25% loss (Grade 4) of motor function (25% of 10 = 3% upper extremity rating). The 10% sensory and 3% motor upper extremity rating is combined to equal 13% upper extremity rating = 8% whole person impairment rating for the carpal tunnel syndrome. This rating would then be combined with the wrist range of motion impairment of 3% whole person to rate 11% whole person impairment.

The 3% wrist loss of motion whole person impairment rating would then be rated for permanent disability adjusting for FEC, age, and occupation separately from the 8% whole person impairment rating adjusted to permanent disability for the carpal tunnel syndrome and then the final permanent disability ratings for each would then be combined for an overall permanent disability rating.

Note in this example that the applicant was *in pro per*, and the WCJ had the duty to determine whether the settlement was adequate. Even without the issue of whether the medical report was AMA compliant, the settlement submitted here was inadequate in the first place because the Stipulated Award was based upon the whole person impairment rating alone, without it having been rated out for FEC, age, and occupation, which would have been greater than the 3% submitted Stipulated Award.

Afterword:

The WCJ ordered the matter into an adequacy hearing, and the panel QME process will be initiated pursuant to Labor Code § 4062.1 if the parties cannot agree to a rating that correctly reflects this applicant's left wrist conditions. In the alternative, the WCJ may refer the matter back to the treating physician to develop the record, referring the physician to the proper sections in the *AMA Guides* Chapter 16 and the Tables and Figures mentioned above. See *McDuffie v. Los Angeles County Metropolitan Transit Authority* (2002) 67 Cal. Comp. Cases 138 (Appeals Board en banc decision). Otherwise, the WCJ could refer the matter out to a "regular physician" for an expert opinion from a board certified hand surgeon pursuant to Labor Code § 5701, also in compliance with *McDuffie*.

[4] Example #3: Multiple Orthopedic Impairment Ratings

Facts:

The *pro per* applicant, who is 50 years old, was a sixteen-year employee of a grocery store and performed stock work and cashiering. She developed multiple orthopedic injuries due to continuous trauma to her lumbar spine, thoracic spine, right knee, and both wrists, as well as stress incontinence, inability to engage in sexual relations, psychiatric depression, and medication dependency. A panel QME (who later became the applicant's primary treating physician) in April 2006 issued a permanent and stationary report, indicating the applicant's impairments with respect to her lumbar and thoracic spine, both wrists, and right knee as follows:

Lumbar spine: Using the DRE method, the lumbar and lumbosacral (sic) spine can be rated as follows: 5-8 percent for muscle spasms, 5-8 percent for asymmetry of the spinal motion, 5-8 percent for reflex abnormalities, 10-13 percent for weakness and/or sensory loss of the dermatome distribution by the S1 nerve root and 10-13 percent for atrophy of the spinal musculature, 10-13 percent for radiculopathy. Taking pain into consideration as well as the DRE, the lumbar spine rating should be 13 percent.

Thoracic spine: Using the DRE method, the thoracic spine DRE rating is 6 percent. Since both the extremities are also affected, the total DRE rating is 25 percent excluding the carpal tunnel syndrome and also the psychological depression.

Lower extremity: Thigh atrophy is 3 percent, mild calf atrophy is 3 percent, ACL laxity 7 percent, partial meniscectomy at 2 percent and DRE at 9 percent, combined at 7 percent and 2 percent. Converting the lower extremity rating to WPI is 9.04 percent equals 2.

Right knee: WPI is 4 percent as follows: right thigh atrophy is 3 percent, calf muscle atrophy is 3 percent, ACL laxity is 7 percent, partial meniscectomy is 2 percent and DRE is 9 percent (combination of 7 and 2 percent). Therefore, the right lower extremity is $.40 \times 9 = 4$ percent.

Bilateral hands: The patient still suffers from carpal tunnel syndrome of the bilateral hands. Even though the carpal tunnel syndrome is permanent and stationary, the patient still requires treatment in the form of surgery for this. Therefore, the whole disability rating for this is approximately 13 percent, taking the right and left hand into consideration.

Taking into account the above values, the total WPI disability is 38 percent. As for her work, she is still only able to do semi-sedentary work. Even if you take the psychiatric component into consideration, then she is only able to do sedentary work. Therefore, the final conclusion is sedentary type work with a total WPI disability is 38 percent.

Commentary:

This medical report is not AMA compliant and does not constitute substantial evidence. Unfortunately, the physician did not correctly apply any of the chapters in the *AMA Guides*. This report reflects what happens when a physician does not follow the instructions in the *AMA Guides* in each chapter for each body part:

1. **Unclear why DRE method used for lumbar spine evaluation.** The lumbar spine evaluation does not explain why the physician chose the DRE method instead of the ROM method. In fact, the ROM method would have been more appropriate here because the applicant has multiple pathologies within the same sub-region that are causing impairments.
2. **DRE category rating system erroneously applied.** The physician incorrectly used the DRE Category rating system by erroneously assigning a DRE category rating to each finding on examination, i.e., muscle weakness, asymmetry of spinal motion, sensory and motion abnormalities.
3. **Unclear why DRE method used for thoracic spine evaluation.** The thoracic spine rating of 6 percent may be correct, but the physician does not explain why he used the DRE method instead of the ROM method.
4. **Unclear why lower extremity evaluated separately from right knee.** The lower extremity section of the physician's report is also confusing and not in accordance with the *AMA Guides*. It is unknown why the physician evaluated the "lower extremity" separately from the right knee. The physician assigned DRE ratings to each lower extremity impairment, which ratings do not exist in Chapter 17 of the *AMA Guides*. DRE categories apply only in spinal impairments and not in lower extremity ratings. This physician may be confusing DRE spinal impairments

from Chapter 15 with Diagnosis Based Estimates (DBE) for lower extremity impairments in Chapter 17 of the *AMA Guides*.

5. **Improper evaluation of right knee condition.** The physician did not follow the *AMA Guides* instructions for evaluating the right knee condition, including the requirement that he start with Table 17-2 in the *AMA Guides*, which indicates what combination of factors are ratable for a lower extremity condition. Instead, he again assigns a separate “DRE rating” for each condition to the knee. It is a mystery where he got the DRE ratings from since they are not listed in Chapter 17, The Lower Extremities. That chapter uses Diagnosis Based Evaluation, Table 17-33, for lower extremity impairments that are combined with other ratable factors listed in Table 17-2 of the *AMA Guides*.
6. **Improper evaluation of bilateral hands and wrists.** For the bilateral hands and wrists, the physician failed to follow the instructions in *AMA Guides* Chapter 16, including measuring range of motion and sensory and motor function impairments using the grading system for nerve and motor function described in § 3.16 of this guidebook.
7. **Stress incontinence and psychiatry not addressed.** There were no QME reports on the stress incontinence or psychiatry, nor was there a referral for an opinion by this QME to any other specialist even though Labor Code § 4062.1 requires this PQME to refer the applicant to QMEs in other specialties.
8. **WPI rating purely speculative.** The conclusion that the applicant had a 38 percent WPI was completely wrong, and the report itself was not ratable under the *AMA Guides*. The main reason is that this physician, despite his being a licensed QME in good standing, did not correctly utilize any of the charts, tables, descriptions, or measurements in the *AMA Guides*. We have no measurements to determine the correct ratings for each body part, and using what the physician provided in his report would result in a purely speculative WPI rating.

Afterword:

This case never made it to the DEU for an advisory rating. If it had, the rater would have not been able to rate the report and would have had to indicate that the report was unratable. It is uncertain whether the physician can be trained in time to re-write this report with any meaningful evidentiary value. The parties will have to request new QMEs in orthopedic surgery, psychiatry, and urology. The applicant became represented by counsel, and the WCAB had to intervene to determine what course of action to take to develop the record.

[5] Example #4: Upper Extremity (Shoulders, Wrists, Elbow) Impairment Rating

Facts:

The applicant is a 53-year-old maintenance worker who worked five years for a city's public works department. He sustained three specific injuries and claimed a continuous trauma injury to both shoulders, both wrists, and left elbow. In July 2006, an AME concluded that the applicant reached maximum medical improvement as follows:

With respect to the right and left shoulders, the patient has undergone resection arthroplasties of both shoulders at the distal clavicle. Each of these corresponds to 10% upper extremity impairment. Using the Combined Values Chart on page 604, combining these two 10% impairments totals 19% upper extremity impairment.

With respect to the left elbow cubital tunnel release, this actually was an ulnar nerve release. Page 492, Table 16-15, lists an ulnar nerve (above mid-forearm) as the appropriate nerve that is involved in this procedure. The maximum percentage of the upper extremity impairment due to sensory deficit or pain according to this table is 7% and the maximum impairment of motor deficit is 46%. The patient does not have a maximum deficit; and, in fact, has had a good surgical result but is left with some residual loss of muscle strength as evidenced by his slightly decreased grip strength compared to his previous examination and also some description of subjective pain. Therefore, I would assign using Table 16-10, page 482, and Table 16-11, page 484, a Grade IV classification for the sensory and motor function. The percentage of sensory deficit corresponding to Grade IV I would assign is 25% and the percentage of motor deficit using Grade IV I would assign is also 25%. These percentages of 25% are then used to multiply times the maximum percentage of deficit for the sensory and motor deficits listed in Table 16-15. Therefore, multiplying 25% times 7% for the sensory deficit of the ulnar nerve gives us a total of 2%. 25% times 46% for the motor deficit gives a total of 11.5% which is rounded off to 12%.

Using the Combined Values Chart on page 604, the combination of motor and sensory deficit for the left elbow of 12% and 2% gives a 14% upper extremity impairment.

For the bilateral carpal tunnel syndromes the patient has also had a good surgical result but is left with some minor sensory deficit and loss of motor strength as well. Using Table 16-15, page 492, and the median nerve (below mid-forearm) is utilized. The same grades of Grade IV are assigned to both the motor and sensory deficits and the same corresponding percentages of 25% deficits are used. The maximum sensory impairment for the median nerve is 39% and the motor is 10%. Therefore, 25% times 39% is 9.75%, rounded to 10%; and 25% of 10% is 3%. Using the Combined Values Chart on page 604, 10% and 3% are combined to 13% upper extremity impairment. The same impairment rationale is applied to the right side, and therefore, 10% sensory impairment combined with 3% motor impairment is a 13% upper extremity impairment for the right wrist.

Combining 13% for the left wrist and 13% for the right wrist for the bilateral carpal tunnel syndrome, as well as the 14% for the left elbow and 19% for the bilateral shoulders using the Combined Values Chart is as follows: 13% and 13% for the wrists is 24% upper extremity impairment; 24% combined with the 14% left elbow is 35%; 35% combined with the 19% bilateral shoulders is 47% upper extremity impairment.

Table 16-3, page 439 then converts 47% upper extremity impairment to 28% whole person impairment rating.

Commentary:

This report is AMA compliant, due in large part to the AME's 25 years of experience with performing evaluations under the AMA *Guides* for Longshore and Harbor Workers' Compensation Act cases:

1. **Ulnar nerve and median nerve deficits separately graded.** The AME used the correct tables in the AMA *Guides* and separately graded the ulnar nerve deficits (from the left elbow cubital tunnel syndrome) from the median nerve deficits (from the bilateral carpal tunnel syndrome wrist injuries).
2. **Sensory/pain and motor deficits separately graded.** The AME separately graded sensory/pain deficits from motor deficits.
3. **Rationale provided for each grade.** The AME explained his rationale for determining the grade given to each sensory and motor deficit.
4. **ADLs properly addressed.** Earlier in his report, the AME explained how the applicant's impairments affected his activities of daily living by stating that they were not that affected since he had a fairly good result from the shoulder and wrist surgeries.

The AME could have done a better job describing his reason for assigning a 10% upper extremity rating for each shoulder on the basis of the surgical procedure only. The applicant's shoulder ranges of motion were normal post surgically.

The AME did not use the upper extremity summary chart on pages 16-1a and 16-1b in the AMA *Guides*, which would have made the report easier to read and understand.

Afterword:

The point of this example is to show you the complexity of these reports and the details the physician must indicate in order for the report to be AMA compliant. In a similar case, the AME erroneously graded the sensory and motor impairments for carpal tunnel syndrome using Table 16-15 by grading the ulnar nerve rather than the median nerve.

The rating was 8% WPI higher than it should have been had the AME properly graded the median nerve sensory and motor deficits.

[6] Example #5: Lumbar Spine, Thoracic Spine, and Hip Impairment Ratings

Facts:

A 36-year-old bartender/food server sustained injuries to her thoracic and lumbar spine and right hip when she lifted a heavy tray of food and heard a “crunch” sound. MRI revealed focal annular tears at L4-5 and L5-S1 and 2-3 mm disc bulges at L3-4, L4-5, and L5-S1. Using computerized range of motion testing, the applicant had significant restricted ranges of motion in her lumbar and thoracic spine and both hips.

After declaring the applicant permanent and stationary and MMI, the evaluating QME gave work restrictions under the 1997 PDRS (no heavy work and no very prolonged weight bearing) and indicated the following:

The JTECH computerized range of motion system was utilized to gauge range of motion with the use of a computer for the thoracic spine, lumbar spine and hips. However, it should be noted that the JTECH system is not always applicable to the spine or lower extremities, as the DRE or other method of assessment may be used. The JTECH examination summary reveals that the Applicant has a 3% WPI of the thoracic spine, a 9% WPI of the lumbar spine and a 4% WPI of the right hip and a 4% WPI of the left hip.

Impairment ratings according to the AMA 5th Edition are as follows: With respect to the thoracic spine, there is a 0% WPI based upon a DRE Category I rating. With respect to the lumbar spine, there is spasm at rest and with motion on clinical examination. These findings fit the criteria for the DRE Category II method of impairment (Table 15-3, page 384). Given the degree of limitation of her activities of dialing living, she is assessed at 5% WPI (5% to 8% possible). With respect to the right hip, there is 0% WPI. (The contralateral, uninvolved left hip has 10% lower extremity impairment, as does the right hip, therefore, there is no remaining impairment on the right). She has a total of 5% WPI.

The QME was asked about the inconsistency between the JTECH range of motion ratings and his findings of a 5% WPI using the DRE method, and why he did not use the ROM method for the lumbar spine since there is more than one level of pathology within that sub-region. The QME responded as follows:

Since I used the DRE method of impairment, which will most often differ from the range of motion method, there is no true inconsistency in my findings. There

is an inconsistency between the AMA *Guides* WPI rating according to the range of motion method as compared to the DRE method of rating spinal impairment.

There are other reasons for inconsistencies between actual ratings in reports and the JTECH examination summary findings. The JTECH examination system which I use does not recognize interpolating between ratings on for example, wrist pie charts. That must be done manually. The JTECH examination system measures and adds impairment for both sides, when in fact, there are times when this should not be done, as according to the *Guides* on page 453, "If a contralateral 'normal' joint has less than average mobility, the impairment value(s) corresponding to the uninvolved joint can serve as a baseline and are subtracted from the calculated impairment for the involved joint." In those cases, the contralateral side is *subtracted* in my actual report and a wide variance may be seen between my rating and the JTECH "rating," however, that does not imply in any way lack of credibility of the system. It is in fact, if I understand correctly, the JTECH system is the only licensed computerized system for evaluation of WPI by the American Medical Association. The JTECH is merely recording range of motion measurements for either subtraction, adding or combining. I verify all impairment ratings cited by the JTECH system with the *Guides*. When there is a conflict, the information contained in the *Guides* apply.

. . . [W]hat is actually wrong with the patient may not be represented accurately with the AMA *Guides*. For example, an injured worker with soft tissue injuries, which may be credibly very long standing, may ultimately receive a 0% WPI ratings according to the AMA *Guides* 5th Edition. The medical literature supports this notion, although long-lasting soft tissue injuries are not the norm, however, these types of injuries occur regularly.

In this case, the Applicant has annular tears at two levels of the lumbar spine and receives only a 5% WPI rating, assigned the lowest rating as a result of her stated lack of degree of limitation of her ADLs. However, these tears do represent compromise of the spine and the ROM method would be considered given the interpretation of Labor Code Section 3202 which gives an injured worker the benefit of the doubt under liberal construction of the law in favor of granting benefits, so that this Applicant's WPI rating is more in line with her findings.

So that the parties have a choice of ratings, I will amend my permanent and stationary report dated 5/24/06 to include range of motion methods for the thoracic spine and lumbar spine. The ratings are clear from the JTECH examination summary; a 9% WPI for the lumbar spine rating is applied and a 3% WPI rating for the thoracic spine is applied for a combined total of 12% spine WPI.

The right hip, as stated in my permanent and stationary report, has the exact impairment rating of the left hip, which results in 0% WPI for the injured right hip. There is no historical or medical record evidence or other impairing

condition for the left hip and the *Guides* do read, as noted above, that one must use as a baseline the contralateral, uninjured joint. If the patient did not disclose to me a prior injury to the left hip, or has a condition of which I was not aware or if the patient has had pain complaints to the left hip of unknown etiology, then the left hip would not be considered an uninjured, uninvolved joint and the 10% lower extremity impairment which converts to 4% WPI (Table 17-3, page 527) would also apply. Should the right hip rating apply, it, combined with the spine rating would equate to 16% WPI.

Commentary:

These two medical reports constitute substantial medical evidence and are AMA compliant:

1. **DRE method applicable for medical condition caused by an injury.** The QME originally used the DRE method because the *AMA Guides* Chapter 15, The Spine, literally says to use the DRE method if the condition is caused by an “injury.” This case involved a specific injury.
2. **WPI rating for lumbar spine using ROM method was correct.** The QME’s WPI ratings using the ROM method were correct based upon the measurements compared with normal spinal range of motion (normal range of motion for lumbar spine: +60 degrees for flexion, 25 degrees for extension, 25 degrees each for right and left lateral flexion).
3. **Applicability of ROM method for lumbar spine noted.** However, the QME also indicated that the ROM method may apply since the applicant had annular tears at two levels within the lumbar spine. Note that the QME stated that the *AMA Guides* do not list “annular tears” as any kind of condition within Table 15-7 for the ROM spinal disorders. A WCJ could interpret an annular tear as a “soft tissue lesion” under that description since the *AMA Guides* indicates no definition of that condition and requires an analysis of the condition by analogy. This QME is agreeing with such an analysis.
4. **Computerized ROM systems addressed.** The QME explained the use of computerized range of motion measuring systems and their limitations. What is important here is that the physician ultimately decided the actual WPI rating that should fit this case (*see #5, below*).

NOTE: The point the QME makes about the limitations of the JTECH or any other kind of computerized measurement system is that no one can cross-examine the computer or its software. The QME or treating physician who uses one of these systems had better be prepared to independently justify the measurements, descriptions, and conclusions with respect to an injured worker’s WPI. Do the computerized systems truly reflect the applicant’s impairments and the effect of those impairments on the applicant’s ADLs? Do these systems substitute for the

physician's own intuition and knowledge of the *AMA Guides* and how they apply to California workers' compensation cases?

5. **Rationale provided for lumbar spine WPI rating.** Note how the QME justified why he assigned a rating within a DRE category based upon the effect of the injury on the applicant's ADLs. He stated his rationale for the lower level of a 5% WPI. However, the ROM method resulted in a 9% WPI. Which one applied? The QME suggested that the WCJ apply Labor Code § 3202 and use the higher rating because it was more fair to this applicant, who has two levels within the lumbar spine that have annular tears. Most orthopedic surgeons will tell you that annular tears are the first step towards a herniated nucleus pulposus.

NOTE: This case calls for judicial interpretation of the criteria used in the *AMA Guides* for determining whether the DRE or ROM method applies in a case where there is a significant discrepancy between the ratings. The applicant will argue Labor Code § 3202 and the pathology at two levels within a sub-region of the spine to justify use of the ROM method for the lumbar spine, while the defendant will argue for use of the DRE method since the lumbar condition was caused by a specific "injury." ■

NOTE: The case also illustrates how you can have a case in which the ROM method applies to one sub-region of the spine (here, lumbar spine) and the DRE method applies to another sub-region (here, thoracic spine). ■

6. **Rationale provided for right hip WPI rating.** The QME gave a WPI for the right hip even though he deferred to the WCJ to determine whether the rating of 4% WPI would hold up based upon the applicant's history with respect to her "uninjured" left hip. It is probable that the loss of range of motion in both hips are anatomical and not related to this injury, but the QME is allowing development of facts to see if there is a link between the condition on the right side and the injury.
7. **Thoracic spine rating was correct.** The thoracic spine rating (DRE) was correct since there is no pathology at multiple levels within the thoracic sub-region like there is in the lumbar spine, which, arguably as stated above, should be ROM and not DRE.

Afterword:

This case was settled by way of a Compromise and Release based upon an underlying compromise rating of 9% WPI rating for the lumbar spine, a DRE Category I, 0% WPI for the thoracic spine, and 2% WPI rating for the right hip. As was true in our old cases, and is still true in our new ones, everything is negotiable.

[7] Example #6: Lower Extremity (Patella Fracture) Impairment Rating

Facts:

The applicant, 58 years old, while employed as a janitor at a hospital, slipped on some plastic wrap and sustained a 5 mm displaced fracture of his left patella. After open reduction and internal fixation with two pins, and post surgical physical therapy, the applicant was declared permanent and stationary and MMI by his treating physician.

The patella fracture was reduced to its anatomical position by the surgery with thigh circumference 41 cm on the left injured versus 44 cm on the right uninjured. Calf circumference is 31 cm on the left, 32 cm on the right. Therefore, there is a 3 cm atrophy on the left thigh and 1 cm atrophy on the left calf. Flexion and extension of the left knee is normal 0-135 degrees.

There is mild quad atrophy and very mild calf atrophy with a minimal loss of flexion and minimal loss of strength. The patient continues to work, stand, squat, and climb up and down stairs with “some occasional pain with extremes of standing” [*sic*]. The motor examination is 5/5 for the quadriceps. The physician states as follows:

According to the *AMA Guides* and utilizing the anticipated impairment, utilizing Table 17-33, the patient’s impairment currently is commensurate with a displaced patella fracture, healed. Accordingly, his lower extremity impairment is 7%, WPI is 3%. Accordingly, based on his mild subjective complaints and his current objective findings, I believe this is a fair representation of his current impairment. Given the fact that the patient did have a patella fracture he is at risk for patella problems in the future including patellofemoral syndrome and patella arthritis.

Commentary:

This medical report is AMA compliant. However, it is on the conservative side, and as stated below, did pass scrutiny as substantial evidence in this case. The steps to confirm the physician’s findings are as follows:

1. **Review Table 17-2 of the *AMA Guides*.** This table indicates what combination of the 13 ways [*see* Table 17-1] to rate lower extremity impairments applies in this case.

NOTE: Attorneys, judges, and claims adjusters must become familiar with the 13 ways to evaluate lower extremity ratings and learn to recognize from medical reports whether all of the information has been provided by the physician to properly and fairly evaluate a lower extremity case. ■

2. **Review Table 17-6 of the *AMA Guides*.** This table indicates that the atrophy for the thigh is 3 cm, which is a 5% WPI, along with the 1 cm atrophy for the calf, which is a 1% WPI, which combines to a 6% WPI rating. After adjustment for FEC, age, and occupation, the permanent disability rating would be 10%.

3. **Determine if muscle weakness of knee joint was measured by physician.** If muscle weakness of the knee joint existed, it would be 25%, grade 4 (5% WPI) for flexion, and 25%, grade 4 (5% WPI) for extension, which combined would be a 10% WPI based upon Tables 17-7 and 17-8 of the *AMA Guides*.

NOTE: An applicant's attorney would argue that if this physician failed to test for muscle weakness, the report may not be substantial evidence since muscle weakness is a common result from fractures, disuse, and/or atrophy. ■

NOTE: This case was similar to Example 17-5, on page 532 of the *AMA Guides*, which happens to be the same page as Table 17-8 for impairments to the lower extremity because of muscle weakness. ■

4. **Review Table 17-33 of the *AMA Guides*.** This physician believed that the DBE (Diagnosis Based Estimate) is the best way to evaluate this case. According to Table 17-33, the DBE method cannot be combined with any rating for muscle strength or atrophy, so the result of 7% lower extremity rating stands alone. The 7% lower extremity rating is converted to a 3% WPI rating, which results in a 5% permanent disability rating after adjustment for FEC, age, and occupation.

Afterword:

This case involved an applicant who was not represented by legal counsel. The case was informally rated by the DEU prior to submission of the case to the WCJ. The DEU rater used the WPI rating based upon the thigh and calf atrophy as the basis for the final rating of 10% permanent disability, since it was greater than the DBE method of rating. The WCJ approved a submitted Stipulation With Request for Award for a 10% permanent disability.

Since the treating physician warned about post traumatic arthritis, it may have been reasonable to test the applicant for that condition, as well as muscle weakness on knee flexion, extension, and atrophy, before any settlement was approved. The arthritic condition could be separately rated and combined with the DBE rating, according to Table 17-2 of the *AMA Guides*. In fact, Table 17-31 is the arthritis impairment reference, which can be combined with the DBE rating method, but cannot be combined with muscle strength loss or atrophy. In Table 17-31, the following asterisked statement appears: "In an individual with a history of direct trauma, a complaint of patellofemoral pain, and crepitation on physical examination but without joint space narrowing on x-rays, a 2% WPI or 5% lower extremity impairment is given."

This case reflects how the WCJ, with some advice from a DEU rater, can choose which method(s) to rate a lower extremity impairment case. The more familiar everyone is with Table 17-2 of the *AMA Guides* and the different methods of evaluating lower extremity impairments, the more fair the ratings for these injuries will be. The rater here chose the middle ground rating since the physician did not comment too much on muscle weakness.

Besides, the atrophy was much more dramatic a result from this injury than the DBE listed “displaced patella” method of rating.

[8] Example #7: Head Injury Impairment Rating

Facts:

On April 22, 2005, the applicant, a 59-year-old “barista” at a coffee house, was mopping the floor when he slipped and fell backwards striking the back of his head on the floor. He had a brief loss of consciousness and was taken to the emergency room in which he was diagnosed as having a contracoup injury to the frontal lobe of his cortex. CT and MRI scans were negative, and the applicant was released after a few hours of observation.

While employed part time as a barista, the applicant was also enrolled in a university’s student teaching program. After release from the emergency room, the applicant was stable, but suffered from episodic headaches, dizziness, and nausea. His wife noticed he had some short term memory problems and was depressed and more irritable than usual. On June 6, 2005, the applicant was walking down stairs at home to go to school when he felt “funny.” He sat on the bottom stair, and the next thing he remembered was four days later when he “woke up” in the hospital. He was diagnosed with a subdural hematoma and hygroma that occurred in the left frontal cortex as diagnosed by CT and MRI scans.

The applicant was initially placed on Depakote (an anti seizure medication), which his stomach did not tolerate, and then Keppra, on which he maintains. The applicant continued to have unpredictable episodes of dizziness, headaches, short term memory loss, depression, and irritability. While his college grades and studies kept up, he was ejected from two separate student teaching assignments because of inappropriate behavior towards the students. He was compliant with taking his medication.

In January 2006, the applicant was examined by an AME in neurology. In his report, the AME opined that the applicant was permanent and stationary and also stated:

The applicant has no permanent disability, no work restrictions and he is 90% better . . . the applicant needs future medical treatment by taking Keppra but the episodic headaches, dizziness and short term memory problems will resolve within the next year. The formal diagnosis is post-traumatic epilepsy due to subdural hematoma or hygroma and post concussion head syndrome. The subdural hematoma/hygroma was caused by the original slip and fall injury at work.

Commentary:

The report is not AMA compliant and does not constitute substantial evidence. This case illustrates how attorneys need to develop the record in *AMA Guides* cases in order to obtain substantial medical evidence when the record is inadequate.

1. **Cross-examination of AME indicated problems with his report.** At the AME's deposition, it was established that:
 - a. The applicant was not permanent and stationary, and any future improvement of symptoms was speculative.
 - b. There should have been neuropsychological testing at the time of permanent and stationary/MMI status to see if there were any cognitive deficits.
 - c. Applicant's behavior, which led to his dismissals from student teaching assignments, may have been due to "disinhibition" caused by the original head injury.
 - d. The AME did not have any formal training on the *AMA Guides* except for a three-hour, brief overview of SB 899 that occurred a year ago.
 - e. The AME was unaware of an incident involving the applicant that occurred after he wrote his report. On March 6, 2006, the applicant had taken a shower at home and while cleaning the inside shower door with a squeegee, the applicant bent down, became extremely dizzy, straightened up, and fell backwards, striking the back of his head against the shower wall and lacerating his scalp. Paramedics were called, but he declined to be transported to the hospital. His neurologist examined him the next day and told him to stay on his Keppra. After informing the AME about the shower incident, the AME opined that there needed to be a repeat MRI scan of the brain to assess the hygroma, along with an EEG to see if there was any sub-clinical seizures. In addition, neuropsychological testing would be essential to determine any cognitive deficits.
2. **AME was not familiar with *AMA Guides* sections on vestibular disorders.** The AME was not familiar with *AMA Guides*, Chapter 11, Section 11.2b and Table 11-4, vestibular disorders, and that the applicant may have a post concussion head syndrome that includes positional station deficits.

Afterword:

The applicant was subsequently referred to an AME in neuropsychology, who tested the applicant and opined that he had a slight post concussion head syndrome, post traumatic epilepsy, and major depression with a probable personality disorder (due to a spotty and inconsistent work history since 1994). According to this AME in neuropsychology, the applicant had reached MMI and had a residual GAF score of 50, which corresponded to a WPI rating of 30% (based upon the post-SB 899 PDRS, pages 1-12 through 1-16). He

opined that 40% of the WPI was directly caused by the industrial head trauma and that 60% was caused by a pre-existing personality disorder and a previous well documented history of depression. Therefore, the applicant had a 12% WPI rating for the cognitive disorder caused by the head trauma after apportionment. This rating did not include any rating from Chapter 13 of the *AMA Guides*, which rating needs to be independently determined by the AME in neurology as to any permanent impairment due to the subdural hematoma/hygroma conditions.

NOTE: The AME in neurology needs to follow the step-by-step analysis in the *AMA Guides*, Chapter 13, Section 13.2, as well as Tables 13-3, 13-4, 13-5, 13-6, 13-7, and 13-8, for each of the components of a central nervous system injury like this one. Those tables cover which conditions can be combined with a central nervous system impairment after choosing the highest WPI ratings from: (1) Table 13-2, criteria for rating impairment due to consciousness and awareness; (2) Table 13-3, criteria for rating impairment due to episodic loss of consciousness or awareness; (3) Table 13-4, sleep and arousal disorders; (4) Table 13-5, clinical dementia rating with Table 13-6, mental status impairment; (5) Table 13-7, aphasia or dysphasia; and (6) Table 13-8, emotional or behavioral disorders. ■

The subsequent brain MRI and EEG showed no changes from the prior neurological examinations, and it was agreed that, as a result of the industrial head trauma, the applicant had a Class I, 14% WPI rating for Impairment Due to Episodic Loss of Consciousness or Awareness, Table 13-3, page 312 of the *AMA Guides* (“Paroxysmal disorder with predictable characteristics and unpredictable occurrence that does not limit usual activities but is a *risk* to the individual or limits daily activities”). The rationale for this rating on the high end of Category I (0%-14% WPI) was that this applicant had recurrent seizure activity even while compliant with his medication schedule, but with some minor effects on his ADLs.

The cognitive rating of 12% WPI (from the psychiatric component) was rated separately for FEC, occupation, and age from the 14% WPI rating for the brain injury, which was also rated for FEC, occupation, and age. The final calculated permanent disability rating for each was then combined for a final permanent disability rating, which resulted in a 31% permanent disability award.