

AMA Guides & PD

From a California Perspective

By: Colleen S. Casey
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Blackledge - Dr Determunes WPI

Doctors must EXPLAIN Rationale:

In *Blackledge v. Bank of America*, (2010) 75 CCC 613 (en banc) the WCAB at p.9 cites *People v. Bassett* (1968) 69 Cal.2d 122, 141, 144 and states, “the opinion of an expert is no better than the reasons upon which it is based.”



“Accordingly, when a physician evaluates an injured employee’s WPI(s), the physician must explain how he or she arrived at the WPI(s) so that the parties and the WCAB can determine whether the WPI(s) are consistent with the AMA Guides.

Blackledge – Dr Determines WPI

Hint: Review the entire medical record.



Make sure you read your doctor's ENTIRE report AND that you review all surgical reports and all PTP reports. Clarify all deficiencies **before** the MSC.

In the ***Blackledge*** case, the rater took it upon himself to zap the doctor's 2% WPI for knee pain based on the note to Table 17-31 at p. 544-545 of the Guides. The rater did this because the IW fell down the stairs and the rater did not see evidence of a direct trauma. However, the doctor **had** indicated this "direct trauma" in the ₃ "history" section of his report.

Table 17-31 Arthritis Impairments Based on Roentgenographically Determined Cartilage Intervals

Joint	Whole Person (Lower Extremity) [Foot] Impairment (%)			
	Cartilage Interval			
	3 mm	2 mm	1 mm	0 mm
Sacroiliac (3 mm)*	—	1 (2)	3 (7)	3 (7)
Hip (4 mm)	3 (7)	8 (20)	10 (25)	20 (50)
Knee (4 mm)	3 (7)	8 (20)	10 (25)	20 (50)
Patellofemoral†	—	4 (10)	6 (15)	8 (20)
Ankle (4 mm)	2 (5) [7]	6 (15) [21]	8 (20) [28]	12 (30) [43]
Subtalar (3 mm)	—	2 (5) [7]	6 (15) [21]	10 (25) [35]
Talonavicular (2-3 mm)	—	—	4 (10) [14]	8 (20) [28]
Calcaneocuboid	—	—	4 (10) [14]	8 (20) [28]
First metatarsophalangeal	—	—	2 (5) [7]	5 (12) [17]
Other metatarsophalangeal	—	—	1 (2) [3]	3 (7) [10]

* Normal cartilage intervals are given in parentheses.

† 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% whole person or 5% lower extremity impairment is given.

2nd Note>>

Paula McCartney's Story

Paula McCartney is a 29 year old lab technician for Abbey Road General Hospital. (She was also a paperback writer in her spare time.)

For several months she experienced numbness of bilateral digits 4 and 5, pain in her wrists and tight discomfort in her neck and bilateral posterior shoulders, while performing lab studies.

She requested an ergonomic microscope with articulating head for her work activities.

While the request was under consideration, her symptoms increased substantially.



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Paula McCartney's Story

On August 8, 2008, after an 8 hour shift of intensive lab work, Paula reached up to pull a box from a shelf several inches over her head.

She felt a sharp pain in her neck and arms, which did not resolve after treatment with ice packs and heat.

Paula hired an attorney and filed a workers' comp claim for a CT ending 8.8.08 to her bilateral upper extremities and neck.



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Paula McCartney's Story

Abbey Road GH denied the claim.

Paula had given birth to twin girls on May 24, 2008. The employer believed that the *real reason* Paula had filed a W.C. claim was so that she could stay at home and spend more time with her children.

This was confirmed by a statement Paula had made to one of her co-workers.



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Paula McCartney's Story

The employer also denied liability on the basis that they had already settled a prior industrial injury to Paula's back in 2001.

The employer believed that all of Paula's current symptoms were triggered by the following factors:

- The act of childbirth,
- Paula's extensive personal use of her home computer as a paperback writer; and
- Her prior 2001 industrial back injury.



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Dr. Zeus' Medical Report

In evaluating Paula, Dr. Zeus used the **“reasonable medical probability standard”** to determine all of the following issues:



- Causation of **Injury** (but forgot to designate a specific **body part** - **extremely** important in PD rating string)
- Impact of injury ADLs
- Work Status (RTW with or w/o modifications?)
- Diagnostic Tests & Diagnosis
- Additional Specialist Required
- **Whole Person Impairment** (both strict AMA Guide rating and Dr. Zeus' determination of “most accurate rating”)
- Causation of **Disability** & Apportionment

Dr. Zeus' Medical Report

Escobedo v. Marshall, (2005)

70 CCC 604 (en banc) set forth:

“The **reasonable medical probability**” standard.

See also, *E.L. Yeager Constr'n v. WCAB (Gatten)*, (2006), 71 CCC 1687



Dr. Zeus' Medical Report

Cause of Injury:



Dr. Zeus wrote,

“In Paula’s case, the fact that she worked 8 hours a day with a non-ergonomically correct work station, was definitely a primary cause of the injury to her bilateral extremities.”

(upper or lower extremities? And what about her neck?)

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Dr. Zeus' Medical Report

Cause of Injury:



“Her microscope did not have an articulating head to prevent prolonged neck flexion and the base platform was positioned in such a manner that forced her shoulders to be elevated in a very uncomfortable position.

Her injury is industrial.”

(But her injury to what? Her hands? Her wrists? Her shoulders? Her cervical spine?)

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Dr. Zeus' Medical Report



- Causation of injury affects MT
If cause of injury = 1% industrial, IW gets 100% MT needed to treat injury
(Analysis affects AOE/COE issues)
- Causation of disability affects PD
If cause of disability = 1% industrial, IW gets 1% of the PD rating payout.
(Affects apportionment issues)

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Dr. Zeus' Medical Report

In his report below, Dr. Zeus explained the impact of injury on Ms. McCartney's ADLs, which are easy to remember with: **CAN'T SSSSleep:**



- Communication
- Activity that's physical
- Non-specialized hand activities
- Travel

- Self-care, personal hygiene
- Sensory function
- Sexual function
- Sleep

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Dr. Zeus' Medical Report

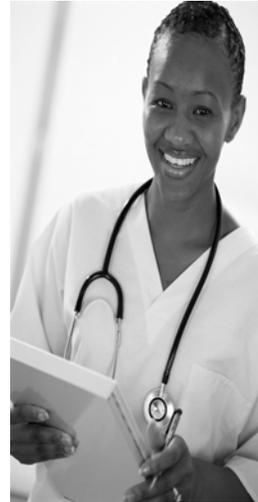
Dr. Zeus continues:

“ADLs & Work Status:

The **impact** of Paula's **injury on her ADLs** is as follows: -----

She is precluded from no prolonged neck flexion, no repetitive use of upper extremities, no firm gripping and no lifting of greater than 5 pounds.

She will not be able to return to her usual and customary work as a lab technician.”



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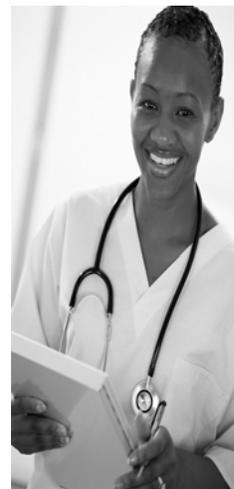
Dr. Zeus' Medical Report

Dr. Zeus Continues:

“Diagnostic Tests: Spurling's maneuver is negative, Tinel's test is positive. Phalen's maneuver is negative. Roo's test is positive. **I have requested an EMG, but it was denied.**

Diagnosis:

1. Carpal Tunnel Syndrome
2. Epicondylitis
3. Thoracic outlet syndrome”



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Dr. Zeus' Medical Report

"Impairment Rating:

Epicondylitis and shoulder strain is not rateable per p. 507 of the AMA Guides.

With regard to the CTS, per Table 16-10 & 16-11 of the AMA Guides, Paula has no sensory or motor deficit. In addition, the Guides on page 495, require an EMG to accurately rate this injury and that was denied.

In my opinion, the rating methods of the AMA Guides do not adequately describe or address Paula's impairment since the strict AMA Guide rating would be 0%. Although she is now trying to make a living as a singer, Paula is unable to return to her usual and customary occupation because of this work injury. Therefore a 0% WPI is not accurate."



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Rating CTS – p. 495 Guides

CTS is to be rated and not considered MMI until after optimum recovery, usually 1 year from DOI or date of surgery. (Surgery not necessary to rate CTS.)

1. Abnormal EMG + Abnormal sensory &/or motor deficits (A 3% pain add-on is permitted.)
2. Abnormal EMG + Normal sensory &/or motor deficits = 5% UE, (3% WPI, **6% WPI for bilateral**) (No pain add on allowed.)
3. Normal EMG + Normal sensory & motor deficits = 0% WPI



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Rating CTS

The warning bell should ring for any of the following. **Clarify record PRIOR to MSC:**

- The physician has not reviewed an EMG.
- The physician has not listed results of tests for sensory or motor deficit.
- The physician has not followed directions on p. 495 of the Guides (using Tables 16-10, 16-11 & 16-15.)
- A physician has selected 6% WPI because he was told the Guides provide that is the maximum for **bilateral** CTS.

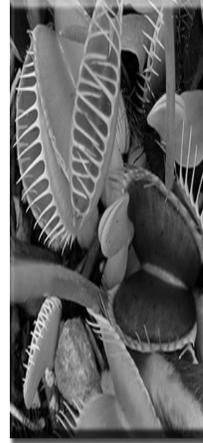


Table 16-10 Determining Impairment of the Upper
Extremity Due to Sensory Deficits or Pain
Resulting From Peripheral Nerve Disorders

a. Classification		
Grade	Description of Sensory Deficit or Pain	% Sensory Deficit
5	No loss of sensibility, abnormal sensation, or pain	0
4	Distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations or pain, that is forgotten during activity	1-25
3	Distorted superficial tactile sensibility (diminished light touch and two-point discrimination), with some abnormal sensations or slight pain, that interferes with some activities	26-60
2	Decreased superficial cutaneous pain and tactile sensibility (decreased protective sensibility), with abnormal sensations or moderate pain, that may prevent some activities	61-80
1	Deep cutaneous pain sensibility present; absent superficial pain and tactile sensibility (absent protective sensibility), with abnormal sensations or severe pain, that prevents most activity	81-99
0	Absent sensibility, abnormal sensations, or severe pain that prevents all activity	100

Table 16-11 Determining Impairment of the Upper Extremity Due to Motor and Loss-of-Power Deficits Resulting From Peripheral Nerve Disorders Based on Individual Muscle Rating

a. Classification		
Grade	Description of Muscle Function	% Motor Deficit
5	Complete active range of motion against gravity with full resistance	0
4	Complete active range of motion against gravity with some resistance	1- 25
3	Complete active range of motion against gravity only, without resistance	26- 50
2	Complete active range of motion with gravity eliminated	51- 75
1	Evidence of slight contractility; no joint movement	76- 99
0	No evidence of contractility	100

b. Procedure	
1	Identify the motion involved, such as flexion, extension, etc.
2	Identify the muscle(s) performing the motion and the motor nerve(s) involved.
3	Grade the severity of motor deficit of individual muscles according to the classification given above.
4	Find the maximum impairment of the upper extremity due to motor deficit for each nerve structure involved: spinal nerves (Table 16-13), brachial plexus (Table 16-14), and major peripheral nerves (Table 16-15).
5	Multiply the severity of the motor deficit by the maximum impairment value to obtain the upper extremity impairment for each structure involved.

Adapted from Lovett RW. From Omer GE Jr, Bell-Krotoski J. Evaluation of clinical results following peripheral nerve suture. In: Omer GE Jr, Spinner M, Van Beek AL, eds. *Management of Peripheral Nerve Problems*. 2nd ed. Philadelphia, Pa: WB Saunders Co; 1998:341; Seddon HJ. *Surgical Disorders of the Peripheral Nerves*. 2nd ed. Edinburgh, Scotland: Churchill Livingstone; 1975; Swanson AB, de Groot Swanson G. Evaluation of permanent impairment in the hand and upper extremity. In: Doege TC, ed. *Guides to the Evaluation of Permanent Impairment*. Fourth ed. Chicago, Ill: American Medical Association; 1993.

Table 16-15 Maximum Upper Extremity Impairment Due to Unilateral Sensory or Motor Deficits or to *Combined* 100% Deficits of the Major Peripheral Nerves

Nerve	Maximum % Upper Extremity Impairment Due to:		
	Sensory Deficit or Pain *	Motor Deficit†	Combined Motor and Sensory Deficits
Pectorals (medial and lateral)	0	5	5
Axillary	5	35	38
Dorsal scapular	0	5	5
Long thoracic	0	15	15
Medial antebrachial cutaneous	5	0	5
Medial brachial cutaneous	5	0	5
Median (above midforearm)	39	44	66
Median (anterior interosseous branch)	0	15	15
Median (below midforearm)	39	10	45
Radial palmar digital of thumb	7	0	7
Ulnar palmar digital of thumb	11	0	11
Radial palmar digital of index finger	5	0	5
Ulnar palmar digital of index finger	4	0	4
Radial palmar digital of middle finger	5	0	5
Ulnar palmar digital of middle finger	4	0	4
Radial palmar digital of ring finger	3	0	3
Musculocutaneous	5	25	29
Radial (upper arm with loss of triceps)	5	42	45
Radial (elbow with sparing of triceps)	5	35	38
Subscapulars (upper and lower)	0	5	5
Suprascapular	5	16	20
Thoracodorsal	0	10	10
Ulnar (above midforearm)	7	46	50
Ulnar (below midforearm)	7	35	40
Ulnar palmar digital of ring finger	2	0	2
Radial palmar digital of little finger	2	0	2
Ulnar palmar digital of little finger	3	0	3

* See Table 16-10a to grade sensory deficits or pain.

† See Table 16-11a to grade motor deficits.

* From Swanson AB, de Groot Swanson G. Evaluation of permanent impairment in the hand and upper extremity. In: Doegge TC, ed. *Guides to the Evaluation of Permanent Impairment*. Fourth ed. Chicago, Ill: American Medical Association; 1993.

Dr. Zeus' Medical Report

DOC MUST EXPLAIN REASONING:



At p. 19 of the AMA Guides, “If, in spite of an observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the physician may modify the impairment rating accordingly and then describe and **explain the reason** for the modification in writing.” (See also *Blackledge v. Bank of America*, (2010) 75 CCC 613 (en banc) .)

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Dr. Zeus' Medical Report

Dr. Zeus' Rating for Ms. McCartney:

“Since the strict AMA Guides rating is not accurate, I will provide what I consider to be the most accurate modified rating for this injury.”

“Using Table 15-5 page 392 of the AMA Guides, this patient has decreased cervical active range of motion for forward flexion due to muscle guarding and title palpable muscle spasms in the cervical paraspinal muscles, trapezius and rhomboid musculature.”



“Paula would fit in Class 3.”

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Table 15-5 Criteria for Rating Impairment Due to Cervical Disorders

DRE Cervical Category I 0% Impairment of the Whole Person	DRE Cervical Category II 5%-8% Impairment of the Whole Person	DRE Cervical Category III 15%-18% Impairment of the Whole Person
<p>No significant clinical findings, no muscular guarding, no documentable neurologic impairment, no significant loss of motion segment integrity, and no other indication of impairment related to injury or illness; no fractures</p>	<p>Clinical history and examination findings are compatible with a specific injury; findings may include muscle guarding or spasm observed at the time of the examination by a physician, asymmetric loss of range of motion or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity</p> <p>or</p> <p>individual had clinically significant radiculopathy and an imaging study that demonstrated a herniated disk at the level and on the side that would be expected based on the radiculopathy, but has improved following nonoperative treatment</p> <p>or</p> <p>fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation that has healed without loss of structural integrity or radiculopathy; (3) a spinous or transverse process fracture with displacement</p>	<p>Significant signs of radiculopathy, such as pain and/or sensory loss in a dermatomal distribution, loss of relevant reflex(es), loss of muscle strength, or unilateral atrophy compared with the unaffected side, measured at the same distance above or below the elbow; the neurologic impairment may be verified by electrodiagnostic findings</p> <p>or</p> <p>individual had clinically significant radiculopathy, verified by an imaging study that demonstrates a herniated disk at the level and on the side expected from objective clinical findings with radiculopathy or with improvement of radiculopathy following surgery</p> <p>or</p> <p>fractures: (1) 25% to 50% compression of one vertebral body; (2) posterior element fracture with displacement disrupting the spinal canal; in both cases the fracture is healed without loss of structural integrity; radiculopathy may or may not be present; differentiation from congenital and developmental conditions may be accomplished, if possible, by examining preinjury roentgenograms or a bone scan performed after the onset of the condition</p>

Dr. Zeus' Medical Report



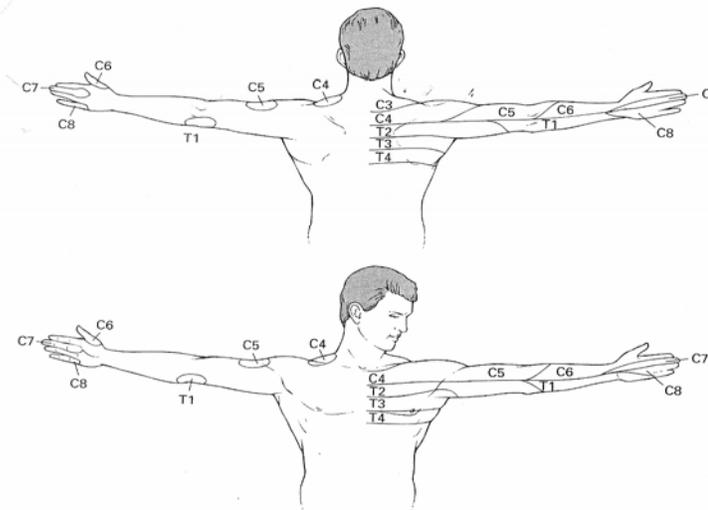
Dr. Zeus' Rating for Ms. McCartney:

"I am not able to verify her radiculopathy with an EMG, but I did do so, using Figure 15-2. As discussed above, since her ADLs have been severely impacted by this injury, 18% WPI at the top of the range would be the most accurate rating.

In addition, because of her persistent complaints of severe pain, she would be entitled to a 3% WPI add on to this rating, for a total rating of 21% WPI."

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Figure 15-2 Skin Area Innervated by the Cervical and Thoracic Nerve Roots Showing Autonomous Zones



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Dr. Zeus' Medical Report

Spinal injury cases are all about radiculopathy:

ROM v. DRE method?

Unilateral Radiculopathy = DRE

Bilateral Radiculopathy = ROM

DRE II or DRE III?

Unverified Radiculopathy = DRE II

Verified Radiculopathy = DRE III

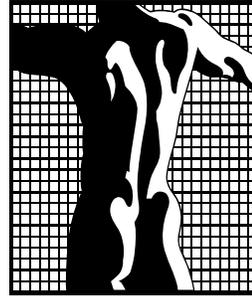


Fig. 15-1 or 15-2 or EMG can be used to verify radiculopathy.

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Rating String



16.04.02.00 – 21 - [4]26 – 220H – 31 – 28%

**Rating String for Paula's injury using modified WPI.
Dr. Zeus's determination affects 1st two components.
Judge determine remaining components of rating string.**

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Rating String



- 16.04.02.00 = Body part
- 21 = WPI
- [4] = DFEC
- 26 = Rating after adjusting for DFEC
- 220 = Occupational group
- H = Occupational variant
- 31 = Rating after adjusting for occupation
- 28% = Rating after adjusting for age = PD%

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Rating String



Body part/metric selected can effect FEC & occupational variant which can ultimate PD% payout.

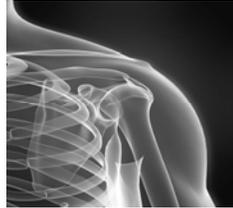
	Occupational Variant	DFEC Rank
• Neck	E (Reduces WPI%)	5
• Elbow	G (Increases WPI%)	2
• Shoulder	F (Same WPI%)	7
• Wrist	H (Increases WPI%)	4

The > the FEC rank, the > the WPI% will be.

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Rating String

Body part/metric selected
can effect FEC &
occupational variant
which can ultimate PD%.



<u>Neck</u>	15.01.01.00 – 21 – [5] 27– 220E – 25 – 22% = \$20,050
<u>Elbow</u>	16.03.02.00 – 21 – [2] 24 – 220G – 27 – 24% = \$22,050
<u>Shoulder</u>	16.02.02.00 – 21 – [7] 29 – 220F – 29 - 26% = \$24,300
<u>Wrist</u>	16.04.02.00 – 21 – [4] 26 – 220H – 31- 28% = \$26,700

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Rating String

If use, pain add on of 1-3%
must be designated to an
injured body part or parts.
If 3 body parts, wrist, ankle
and low back, you can add
1% to each part or 3% to
one part.



<u>Wrist</u>	16.04.02.00 – 21 – [4] 26 – 220H – 31- 28% = \$26,700
3% pain	16.04.02.00 – 24 - [4] 29 – 220H – 35 – 32% = <u>\$31,950</u>
<u>Wrist</u>	16.04.02.00 – 21 – [4] 26 – 220H – 31- 28% = \$26,700
1% pain	16.04.02.00 – 22 – [4] 27 – 220H – 33 – 30% = <u>\$29,150</u>

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Rating String



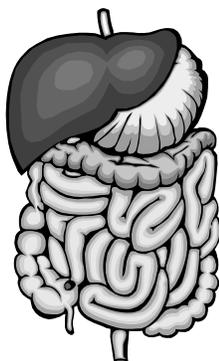
*But Dr. Zeus can **not** select a particular body part or a particular metric (like gait derangement over DBE) SOLELY because it results in a higher WPI% outcome for IW.*

Almaraz II, @ page 3:5

*“We emphasize that our decision does **not** permit a physician to utilize any chapter, table, or method in the AMA Guides simply to achieve a desired result.”*

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Dr. Pepper’s Medical Report



Additional Specialist Required:

Dr. Zeus writes:

“Paula has been taking NSAIDS for the past four years to relieve her symptoms. I believe that NSAID use may be connected to her recent diagnosis of GERD, and may be industrial as a compensable consequence.

However, I am not qualified to address this issue, and would recommend the parties immediately seek a Panel QME who specializes in this area to evaluate Paula.”

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Dr. Pepper's Medical Report

Dr. Pepper (2nd Panel QME) writes:

“Given the extent of NSAID use by Paula for relief of the symptoms of her industrial injury, she now has GERD which would place her in Class 2 of Table 6-3 (p. 121).

Paula's impairment would be 10%, at the lowest end of the range, rather than at the high end of that range, because she has no weight loss, which would be typical for a Class 2 patient.”



Dr. Pepper's Medical Report

Table 6-3 Criteria for Rating Permanent Impairment Due to Upper Digestive Tract (Esophagus, Stomach and Duodenum, Small Intestine, and Pancreas) Disease

Class 1 0%-9% Impairment of the Whole Person	Class 2 10%-24% Impairment of the Whole Person	Class 3 25%-49% Impairment of the Whole Person
<p>Symptoms or signs of upper digestive tract disease, or anatomic loss or alteration</p> <p>and</p> <p>continuous treatment not required</p> <p>** and **</p> <p>maintains weight at desirable level*</p> <p>or</p> <p>no sequelae after surgical procedures</p>	<p>Symptoms and signs of upper digestive tract disease, or anatomic loss or alteration</p> <p>and</p> <p>requires appropriate dietary restrictions and drugs for control of symptoms, signs, or nutritional deficiency</p> <p>** and **</p> <p>weight loss below desirable weight but does not exceed 10%*</p>	<p>Symptoms and signs of upper digestive tract disease, or anatomic loss or alteration</p> <p>and</p> <p>appropriate dietary restrictions and drugs do not completely control symptoms, signs, or nutritional state</p> <p>** or **</p> <p>10%-20% weight loss below desirable weight due to upper digestive tract disorder*</p>

Georgia Harrison's Story



Georgia Harrison is a yoga instructor with an accepted CT claim to her elbow. QME Dr. Eleanor Rigby writes,

“**Diagnosis:** Chronic Right Elbow Pain

WPI: Referring to page 472, Fig 16-34

Diminished ext 10 degrees = 1% UE

Diminished flex 130 degrees = 1% UE

1% + 1% = 2% UE = 1% WPI”

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Dr. Rigby's Medical Report



QME Dr. Eleanor Rigby writes:

“I note that Ms. Harrison complains of severe weakness in the right UE, her dominant arm. She has difficulties with digital dexterity and frequently drops objects weighing only a few ounces. She is no longer able to teach her yoga classes.

Per *Guzman*, I hereby refer to Table 15-6, p.396. Ms. Harrison's injury would fall within in the middle of Class I for an additional for a total WPI = 4%.” **(But why?)**

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Table 15-6 Rating Corticospinal Tract Impairment

a. Impairment of One Upper Extremity Due to Corticospinal Tract Impairment

Class 1		Class 2		Class 3		Class 4	
*** Dominant Extremity 1%-9% Impairment of the Whole Person	Nondominant Extremity 1%-4% Impairment of the Whole Person	Dominant Extremity 10%-24% Impairment of the Whole Person	Nondominant Extremity 5%-14% Impairment of the Whole Person	Dominant Extremity 25%-39% Impairment of the Whole Person	Nondominant Extremity 15%-29% Impairment of the Whole Person	Dominant Extremity 40%-60% Impairment of the Whole Person	Nondominant Extremity 30%-45% Impairment of the Whole Person
Individual can use the involved extremity for self-care, daily activities, and holding, but has difficulty with digital dexterity ***		Individual can use the involved extremity for self-care, can grasp and hold objects with difficulty, but has no digital dexterity		Individual can use the involved extremity but has difficulty with self-care activities		Individual cannot use the involved extremity for self-care or daily activities	

b. Criteria for Rating Impairments of Two Upper Extremities

Class 1 1%-19% Impairment of the Whole Person	Class 2 20%-39% Impairment of the Whole Person	Class 3 40%-79% Impairment of the Whole Person	Class 4 80%+ Impairment of the Whole Person
Individual can use both upper extremities for self-care, grasping, and holding, but has difficulty with digital dexterity	Individual can use both upper extremities for self-care, can grasp and hold objects with difficulty, but has no digital dexterity	Individual can use both upper extremities but has difficulty with self-care activities	Individual cannot use upper extremities

c. Criteria for Rating Impairments Due to Station and Gait Disorders

Class 1 1%-9% Impairment of the Whole Person	Class 2 10%-19% Impairment of the Whole Person	Class 3 20%-39% Impairment of the Whole Person	Class 4 40%-60% Impairment of the Whole Person
Rises to standing position; walks, but has difficulty with elevations, grades, stairs, deep chairs, and long distances	Rises to standing position; walks some distance with difficulty and without assistance, but is limited to level surfaces	Rises and maintains standing position with difficulty; cannot walk without assistance	Cannot stand without help, mechanical support, and/or an assistive device

Dr. Rigby's Medical Report

Dr. Eleanor Rigby continues,

“Alternatively, one could use Figure 16-2 to rate this impairment. The maximum value of the arm is 60% WPI. Ms. Georgia has a loss of function of 25% function, therefore her WPI% would be 15%.

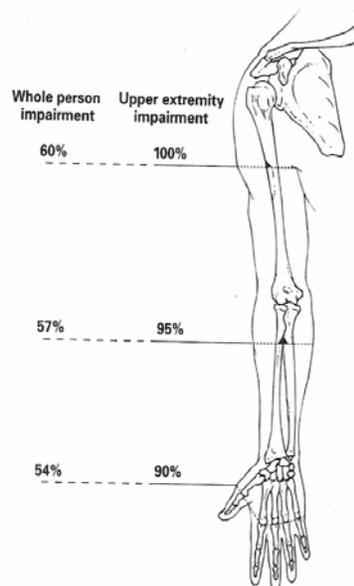
I can state with **reasonable medical probability** that the 15% WPI rating is a more accurate rating of Ms. Georgia's impairment than 4% or 0% would be.”

Again, doctor must explain why? Inquiring minds want to know.



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Figure 16-2 Impairment Estimates for Upper Extremity Amputation at Various Levels



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2011 Division of Workers' Compensation Conference

Substantial Evidence in *AMA Guides* Cases

By
Robert G. Rassp, Esq.



Substantial Evidence

Heart/Hypertension case Lung Transplant Case

- The Facts
- The Medicine
- Develop the record
- The ratings
- Blackledge
- Outcome

- The Facts
- The Medicine
- Develop the record
- The ratings
- Blackledge
- Outcome





Substantial Evidence

Heart/Hypertension case - The Facts

Applicant, 57, works for a major city as a supervisor for street maintenance. On July 2, 2008, he has a heated argument with another supervisor over who gets which employee on each crew.

At the conclusion of the argument, the IW has dyspnea, diaphoresis and chest pains. He drives himself to Kaiser where he is admitted for a possible heart attack.

He is in the hospital for a week and upon discharge, he is prescribed Plavix, aspirin and lopressor. He returns to work in his usual and customary occupation and has been working regularly for a year.



Substantial Evidence

Heart/Hypertension case - The Facts

- AME opines that the IW did not have a heart attack, has no evidence of hypertension and has a 0% WPI pending review of any records that exist in the year since his hospitalization. (There are no medical records since the hospitalization because the Applicant was asymptomatic and did not seek further treatment).

Heart/Hypertension case – The Medicine

- The terms “dyspnea” means shortness of breath; “diaphoresis” means profuse sweating and “chest pains” means severe crushing sub-sternal pain (“like an elephant was sitting on my chest”).





Substantial Evidence

Heart/Hypertension case – The Medicine

- The admitting KP records indicate a troponin of 2.0 (normal is < .19), with several repeat readings for 24 hours between 1.75-2.0.
- Echocardiogram shows inferior-posterior hypokinesis of the heart wall.
- The KP records over the year before the argument show 10 separate BP readings of $\geq 140/90$ mm Hg.
- Needless to say, the deposition of the AME was necessary



Substantial Evidence

Heart/Hypertension case – Developing the record

- What are the significance, if any, of the positive troponin tests, hypokinesis of the heart wall and the 10 BP readings historically?
 - Positive troponin test is enzyme of damaged heart muscle and is strong evidence of a myocardial infarction.
 - Hypokinesis of the heart wall means there is permanent damage to the heart muscle and it does not contract normally.
 - Only two separate high blood pressure readings of either the upper number or lower number mandates a diagnosis of hypertension





Substantial Evidence

Develop the record – Deposition of AME

- Establish the diagnosis (IW had a heart attack and has hypertension)
- Establish causation of diagnoses as industrial or non-industrial
- Determine WPI ratings for each diagnosis
- Is strict rating accurate?
- If not, Guzman III considerations?
- Apportionment?



Substantial Evidence

The WPI ratings:

- Q: “In this particular case, because of his history and because of his myocardial infarction, you would place him in Class II? At what level at a Class II?”
- A: “In regard to his myocardial infarction, the following ADLs are impacted: climbing stairs, lifting and therefore I would put him at the midrange of Class II at a 20% WPI. Because of the weakness of the heart muscle, I would add an additional 5% WPI which is really not considered in any of the WPI ratings under Table 3-6a but applies in this case.”



Substantial Evidence

Table 3-6a Criteria for Rating Permanent Impairment Due to Coronary Heart Disease

Class 1 0%-9% Impairment of the Whole Person	Class 2 10%-29% Impairment of the Whole Person	Class 3 30%-49% Impairment of the Whole Person	Class 4 50%-100% Impairment of the Whole Person
<p>Because of serious implications of reduced coronary blood flow, it is not reasonable to classify degree of impairment as 0% through 9% in anyone who has symptoms of CHD corroborated by physical examination or laboratory tests; this class of impairment should be reserved for individuals with equivocal histories of angina pectoris on whom coronary angiography is performed, or for those on whom coronary angiography is performed for other reasons and in whom less than 50% reduction in cross-sectional area of coronary artery is found with a normal EF; METS determination is not applicable</p>	<p>History of MI or angina pectoris documented by appropriate laboratory studies, but at time of evaluation, no symptoms while performing ordinary daily activities or even moderately heavy physical exertion (functional class I)</p> <p>and</p> <p>may require moderate dietary adjustment or medication to prevent angina or to remain free of signs and symptoms of CHF</p> <p>and</p> <p>able to walk on treadmill or bicycle ergometer and obtain HR of 90% of predicted maximum HR (see Table 3-6b) without developing significant ST-segment shift, VT, or hypotension; if uncooperative or unable to exercise because of disease affecting another organ system, this requirement may be omitted; METS >7</p> <p>or</p> <p>has recovered from coronary artery surgery or angioplasty, remains asymptomatic during ordinary daily activities, and able to exercise as outlined above; if taking a beta-adrenergic blocking agent, should be able to walk on treadmill to level estimated to cause energy expenditure of at least 7 METS as substitute for HR target</p>	<p>History of MI documented by appropriate laboratory studies, or angina pectoris documented by changes on resting or exercise ECG or radioisotope study suggestive of ischemia</p> <p>or</p> <p>either fixed or dynamic focal obstruction of at least 50% of coronary artery, angiography, and function testing</p> <p>and</p> <p>requires moderate dietary adjustment or drugs to prevent frequent angina or to remain free of symptoms and signs of CHF, but may develop angina pectoris after moderately heavy physical exertion (functional class II); METS >5 but <7</p> <p>or</p> <p>has recovered from coronary artery surgery or angioplasty, continues to require treatment, and has symptoms described above</p>	<p>History of MI documented by appropriate laboratory studies, or angina pectoris documented by changes on resting ECG or radioisotope study highly suggestive of myocardial ischemia</p> <p>or</p> <p>either fixed or dynamic focal obstruction of at least 50% of one or more coronary arteries, demonstrated by angiography and function testing</p> <p>and</p> <p>requires moderate dietary adjustments or drugs to prevent angina or to remain free of symptoms and signs of CHF, but continues to develop symptoms of angina pectoris or CHF during ordinary daily activities (functional class III or IV); METS <5</p> <p>or</p> <p>has recovered from coronary artery bypass surgery or angioplasty and continues to require treatment and have symptoms as described above</p>



Substantial Evidence

o Coronary Heart Disease

	Class 3 30%-49% Impairment of the Whole Person	Class 4 50%-100% Impairment of the Whole Person
	<p>History of MI documented by appropriate laboratory studies, or angina pectoris documented by changes on resting or exercise ECG or radioisotope study suggestive of ischemia</p> <p><i>or</i></p> <p>either fixed or dynamic focal obstruction of at least 50% of coronary artery, angiography, and function testing</p> <p><i>and</i></p> <p>requires moderate dietary adjustment or drugs to prevent frequent angina or to remain free of symptoms and signs of CHF, but may develop angina pectoris after moderately heavy physical exertion (functional class II); METS >5 but <7</p> <p><i>or</i></p> <p>has recovered from coronary artery surgery or angioplasty, continues to require treatment, and has symptoms described above</p>	<p>History of MI documented by appropriate laboratory studies, or angina pectoris documented by changes on resting ECG or radioisotope study highly suggestive of myocardial ischemia</p> <p><i>or</i></p> <p>either fixed or dynamic focal obstruction of at least 50% of one or more coronary arteries, demonstrated by angiography and function testing</p> <p><i>and</i></p> <p>requires moderate dietary adjustments or drugs to prevent angina or to remain free of symptoms and signs of CHF, but continues to develop symptoms of angina pectoris or CHF during ordinary daily activities (functional class III or IV); METS <5</p> <p><i>or</i></p> <p>has recovered from coronary artery bypass surgery or angioplasty and continues to require treatment and have symptoms as described above</p>



Substantial Evidence

The WPI ratings:

- Q: “As to the hypertension, the literature indicates that two separate blood pressure readings on two separate occasions where either the systolic or diastolic BP is elevated are the standard to establish the presence of hypertension?”
- A: “Yes, in Harrison’s Principles of Internal Medicine, 16th Edition and on page 66, section 4.1 of the *AMA Guides JNC-6* guidelines for the diagnosis of hypertension indicate two separate readings for either the top or bottom numbers justify the diagnosis.”



Substantial Evidence

The WPI ratings:

- Q: “So how would you rate his hypertension?”
- A: “Since he had normal blood pressure on the date of my evaluation and since I did not find evidence of end organ injury but he did have significantly abnormal blood pressure readings in the KP records and I can see he was treated then for it, I would put him in the midrange of 5% WPI in Table 4-2.”



Substantial Evidence

Table 4-1 Classification of Hypertension in Adults

Blood Pressure	Blood Pressure Categories			Hypertension Categories		
	Optimal	Normal	High-Normal	Stage 1	Stage 2	Stage 3
Systolic	<120	<130	130-139	140-159	160-179	≥180
Diastolic	<80	<85	85-89	90-99	100-109	≥110
	and	and	or	or	or	or

¹ Adapted from the sixth report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med.* 1997;157:2413-2446.

vascular disease. Because patients with hypertensive cardiovascular disease do not become symptomatic until the very late stages, the impairment classification requires information on the end-organ damage that may occur even in the absence of symptoms.

Table 4-2 Criteria for Rating Permanent Impairment Due to Hypertensive Cardiovascular Disease

Class 1 0%-9% Impairment of the Whole Person	Class 2 10%-29% Impairment of the Whole Person	Class 3 30%-49% Impairment of the Whole Person	Class 4 50%-100% Impairment of the Whole Person
Asymptomatic; stage 1 or 2 hypertension without medications <i>or</i> normal blood pressure on anti-hypertensive medication <i>and</i> no evidence of end-organ damage	Asymptomatic; stage 1 or 2 hypertension despite multiple medications <i>or</i> antihypertensive medication with any of the following: (1) proteinuria, urinary sediment abnormalities, no renal function impairment as measured by the blood urea nitrogen (BUN) and serum creatinine; (2) definite hypertensive changes on fundoscopic examination in arterioles, eg, "copper" or "silver wiring," or arteriovenous crossing changes with or without hemorrhages and exudates; either abnormality suggests end-organ damage	Asymptomatic; stage 3 hypertension despite multiple medications <i>or</i> antihypertensive medication with any of the following: (1) proteinuria, urinary sediment abnormalities, renal function impairment as measured by the BUN and serum creatinine, and a decreased creatinine clearance of 20% to 50% normal; (2) LV hypertrophy by ECG or echocardiography but no symptoms of HF; either abnormality suggests more extensive end-organ damage	Antihypertensive medication with stages 1-3 and any of the following abnormalities: (1) proteinuria, urinary sediment abnormalities, renal function impairment as measured by the BUN and serum creatinine, and a creatinine clearance < 20% normal; (2) hypertensive cerebrovascular damage or episodic hypertensive encephalopathy; (3) LV hypertrophy, systolic dysfunction, and/or signs and symptoms of HF due to hypertension



Substantial Evidence

The WPI ratings:

- Q: “Is it true that the treating physicians have prescribed Plavix, aspirin and Lopressor for the patient upon his discharge from Kaiser?”
- A: “Yes.”
- Q: “And Plavix is a blood thinner, isn’t it? Along with aspirin?”
- A: “Yes, both aspirin and Plavix are blood thinners.”
- Q: “Is it reasonably probable that the Applicant will need to take Plavix and aspirin for the rest of his life?”



Substantial Evidence

The WPI ratings:

- A: “Yes, the Applicant will need to take Plavix and aspirin for the rest of his life.”
- Q: “Are you familiar with Chapter 9 in the *AMA Guides* that allow up to a 10% WPI because a patient has to take an anti-coagulant medication?”
- A: “No.”
- Q: “Please take a look at page 203, section 9.5 where it says ‘Individuals with venous or arterial thromboembolic disease who receive anticoagulant therapy...should avoid activities that might lead to trauma. Impairment of the who person with acquired blood-clotting defects is estimated at 0% to 10%.’”



Substantial Evidence

Page 203 of *AMA Guides*, second column:

Acquired blood-clotting defects are usually secondary to severe underlying conditions, such as chronic liver disease. Individuals with venous or arterial thromboembolic disease who receive anticoagulant therapy with a vitamin K antagonist (eg, warfarin sodium) should avoid activities that might lead to trauma. Impairment of the whole person with acquired blood-clotting defects is estimated at 0% to 10%.



Substantial Evidence

The WPI ratings:

– Q: “Doesn’t Plavix and aspirin have the same increased bleeding risk that low molecular weight heparin and warfarin have?”

– A: “Yes, I don’t think Plavix existed when the 5th edition of the *Guides* was published. I would assign an additional 10% WPI due to this patient having to take the Plavix and aspirin.”

– Q: “So you are changing your mind from your conclusions in this case as written in your reports?”

– A: “Yes, I did not closely review this case because I thought there were more records.”





Substantial Evidence

The WPI ratings:

- Q: “So your final conclusion in this case is that the Applicant has a 25% WPI from Table 3-6a, Class II for the heart attack and heart wall damage; an additional 5% WPI for the Class I hypertension from Table 4-2; and an additional 10% WPI for his Plavix and aspirin?”
- A: “Yes, that’s correct.”
- Q: “And your conclusions today are based on reasonable medical probability?”

– A: “Yes.”



Substantial Evidence

The WPI ratings:

- Q: “On the issue of apportionment, is it your conclusion that there is no apportionment to non-industrial factors?”
- A: “Yes, that’s correct. There is no apportionment because this patient did not have any significant risk factors for heart disease or hypertension. He worked there for 22 years. He has no family history of heart disease or high blood pressure. He has no systemic illness such as diabetes, or thyroid problems. He is not obese, he never smoked cigarettes and he is not an alcohol abuser. Age is a risk factor but at 57 he is otherwise healthy.”



Substantial Evidence

The WPI ratings:

– A (continued): “I don’t think there is sufficient evidence to justify apportionment to non-industrial factors – age alone is not enough. I think risk factors have to be cumulative or established for significant time in order to justify apportionment to causation and those do not exist in this case. Therefore, there is no apportionment here. One hundred percent of this patient’s disability and impairment is caused by work stress and the argument, on a continuous trauma basis.”



Substantial Evidence

The Outcome

- Case was stipulated at 53% PD for heart and cardiovascular hypertensive disease.
- Applicant is still working full time, supervising crews that fill potholes from the rains in December 2010.
- They filled 350,000 potholes in 2010 and hope to fill in 250,000 in 2011 due to budget cut-backs.
- The 10% WPI for the blood thinner was thrown in from another case. In this case, the Applicant refuses to take anything except a 325 mg aspirin per day.



Substantial Evidence

The WPI ratings: Apportionment in internal medicine cases, non-industrial causation of impairment:

- Positive family history of heart disease or high blood pressure.
- History of systemic illness such as diabetes, or thyroid problems.
- Obesity
- Substance abuse (smoked cigarettes, heavy alcohol use, cocaine, meth.
- Age is a risk factor.
- Lifestyle choices (does not exercise, lots of red meat and too many "Happy Meals").



Substantial Evidence

The WPI ratings: Apportionment in internal medicine cases, "industrial risk factors" for causation of impairment:

- Long term employment with lots of perceived stress
- Severe work related physical injury
- Chronic pain syndrome
- Acute episodes of stress with or without 40% to 60% of an occluded coronary artery.
- No family history of heart disease, strokes, hypertension
- No personal history of systemic illnesses, substance abuse (smoking, drug use)



Substantial Evidence

The WPI ratings: Apportionment in internal medicine cases for causation of impairment:

- The more non-industrial risk factors exist, the more likely those risk factors are causative of illness and injury and therefore of impairment.
- The longer non-industrial risk factors exist, the more likely those risk factors are causative of illness or injury and therefore of impairment.
- The more significant industrially related risk factors exist or their length of time of existence will create more industrial causation.



Substantial Evidence

The WPI ratings: Apportionment in internal medicine cases for causation of impairment:

- Industrial risk factors can directly cause, aggravate or accelerate internal medical conditions such as heart disease, hypertension, lung/pulmonary conditions
- Once there is impairment from those conditions, the physician has to sort out what is the direct cause of the impairment (Labor Code section 4664(a).
- There is no case law yet on internal medicine cases that defines what "direct cause" means. Legally, "direct cause" has meant "but for the industrial exposure, there would not have been impairment as and when it occurred." But that standard may not apply in internal medicine cases because of the complexity of medical causation of the underlying condition.





Substantial Evidence

Blackledge – Formal Rating Instructions

Rule 10602 states in part: “The WCAB [or a WCJ] may request the DEU to prepare a formal rating determination...The request may refer to an accompanying medical report or chart for the sole purpose of describing measurable physical elements of the condition that are clearly and exactly identifiable. In every instance, the request shall describe the factors of disability in full.”



Substantial Evidence

Blackledge – Formal Rating Instructions

– Please rate this patient’s impairment as follows:

Applicant has a 25% WPI from Table 3-6a, Class II for the heart attack and heart wall damage; an additional 5% WPI for the Class I hypertension from Table 4-2; and an additional 10% WPI for his Plavix and aspirin therapy based on the instructions on Page 207 of the *AMA Guides*.

Substantial Evidence

“OBJECTIVE MEDICAL CONDITIONS” MEAN:

- Any medical condition that is recognized by physicians within a given medical specialty.

“PERMANENT OBJECTIVE MEDICAL FINDINGS” MEAN:

- Any objective medical finding that is permanent and can be diagnosed and assessed by any physician utilizing standardized methods of diagnosis and assessment.
 - Confirmed by diagnostic imaging studies
 - Confirmed by operative reports
 - Confirmed by physical examination
 - Confirmed by standard tests, lab studies
 - Does not involve direct patient participation

Substantial Evidence

Lung case – The Facts

- Applicant is a 43 year old food “compounder” who worked in a flavoring company from 1997 through 2005. In 2001 she started having a chronic cough, x-rays were taken and she was diagnosed with interstitial lung disease (ILD).
- By the end of 2005, she had to stop working due to severe coughing, shortness of breath, wheezing and increasing pulmonary difficulties.
- She was exposed to powder dust and fumes from flavorings including diacetyl (popcorn butter), vanilla flavoring, acetone powder, mustard oil, butyric acid, benzaldehyde and others.

Substantial Evidence

Lung case – The Medicine

- In June 2006, the Applicant has a lung biopsy at UCLA that shows glass-like formations in her lungs. She is diagnosed with bronchiolitis obliterans pneumoniae (aka hypersensitivity pneumonitis) secondary to diacetyl exposure.
- Her PFT in January 2008 shows FVC is 61% predicted, her FEV1 is 19% predicted and a 31% ratio FEV1 to FVC.
- In July 2009, she is placed on a bilateral lung transplant list at UCLA.

Substantial Evidence

Lung case – The Medicine

- AME in internal medicine with an emphasis in toxicology opines that the Applicant's lung condition is caused by exposure to diacetyl.
- She is MMI in June 2006 with the following impairment rating:
 - “AMA Guides, page 107, Table 5-12, is a Class IV, Pulmonary Disability with an FEV1 of 19% (table <40) at 90% impairment of the whole person...I have considered apportionment under L.C. 4663/64 and there is no apportionment to occupational factors.”

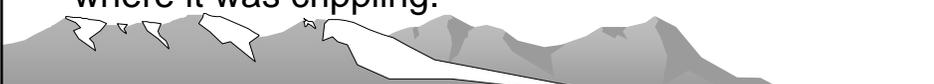
Substantial Evidence

Lung case – Developing the Record – AME depo

- Q: “How do you physically describe this bronchiolitis obliterans?”
 - A: “It involves a permanent change in the ability of the alveoli, which are the most distal parts of the lung, to transfer gas, that is, oxygen and carbon dioxide, therefore making the person who has it chronically short of breath and with symptoms that essentially are like an asthma.”
 - Q: “And so you feel her condition, this bronchiolitis obliterans, is due to exposure to diacetyl?”
 - A: “Yes.”
- 

Substantial Evidence

Lung case – Developing the Record – AME depo

- Q: “Why?”
 - A: “Well, she’s a typical case in the sense that she was unaware of having any lung problems even as she worked there for several years and then ultimately evolves with an increasingly serious degree of lung disease for no apparent reason. Her smoking history that ended long before her employment here was not an apparent reason for her lung problem and then it progressed to a point where it was crippling.”
- 

Substantial Evidence

Lung case – Developing the Record – AME depo

- Q: “So how did you arrive at the 90% WPI from Table 5-12?”
- A: “In the left handed column FEV1, if you follow that across for Class 4, it says ‘less than 40 percent of predicted.’ In her case, it was 19%. I think she is half way between 51% and 100% she is 75% WPI. However, you have to remember that her FVC which is the first column across was at the level of a Class 2 which is an additional 15% WPI. So now you have a decreased FVC and a decreased FEV1.



Substantial Evidence

Lung case – Developing the Record – AME depo

tion-listed values, the examiner may depart from

Table 5-12 Impairment Classification for Respiratory Disorders, Using Pulmonary Function and Exercise Test Results*

Pulmonary Function Test	Class 1 0% Impairment of the Whole Person	Class 2 10%-25% Impairment of the Whole Person	Class 3 26%-50% Impairment of the Whole Person	Class 4 51%-100% Impairment of the Whole Person
FVC	Measured FVC \geq lower limit of normal (see Tables 5-2b and 5-3b) and	$\geq 60\%$ of predicted and $<$ lower limit of normal or	$\geq 51\%$ and $\leq 59\%$ of predicted or	$\leq 50\%$ of predicted or
FEV ₁	Measured FEV ₁ \geq lower limit of normal (see Tables 5-4b and 5-5b) and	$\geq 60\%$ of predicted and $<$ lower limit of normal or	$\geq 41\%$ and $\leq 59\%$ of predicted or	$\leq 40\%$ of predicted or
FEV ₁ /FVC	FEV ₁ /FVC \geq lower limit of normal† and			
Dco	Dco \geq lower limit of normal (see Tables 5-6b and 5-7b) or	$\geq 60\%$ of predicted and $<$ lower limit of normal or	$\geq 41\%$ and $\leq 59\%$ of predicted or	$\leq 40\%$ of predicted or
Vo ₂ max	Vo ₂ max ≥ 25 mL/(kg·min) or > 7.1 METS	≥ 20 and < 25 mL/(kg·min) or 5.7-7.1 METS	≥ 15 and < 20 mL/(kg·min) or 4.3 to < 5.7 METS	< 15 mL/(kg·min) or < 1.05 L/min or < 4.3 METS

*FVC indicates forced vital capacity; FEV₁, forced expiratory volume in the first second; Dco, diffusing capacity for carbon monoxide; Vo₂max, maximum oxygen consumption; and METS, metabolic equivalents (multiples of resting oxygen uptake). Dco is primarily of value for persons with restrictive lung disease. In classes 2 and 3, if FVC, FEV₁, and FEV₁/FVC are normal and Dco is between 41% and 79%, then an exercise test is required to determine level of impairment.

†Refer to Crapo RO, Morris AH, Gardner RM for the lower limit of normal for FEV₁/FVC.²

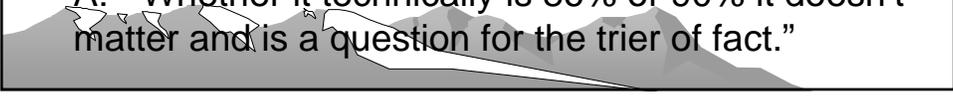
Substantial Evidence

Lung case – Developing the Record – AME depo

- Q: “But Table 5-12 and the instructions for its use does not say you can add or combine impairments for FEV1, FVC or any other of the 5 components?”
 - A: “Counsel, medically, as far as I’m concerned, they should be added together because they’re two separate measurements.”
 - Q: “So if you use her PFT for the FEV1 she has a 75% WPI. If you utilize the PFT for FVC she has an 15% WPI?”
 - A: “My impression would be that they would be cumulative because they measure different parameters of lung function that in cases like this lady with hypersensitivity pneumonitis are really inseparable.”
- 

Substantial Evidence

Lung case – Developing the Record – AME depo

- Q: “Assume that since the instructions on page 107 and Table 5-12 and its footnotes do not describe with specificity of adding the WPI ratings for FVC, FEV1 and the three other factors listed there but instead require the physician to look at the patient as a whole in addition to the objective measurements here in the Table with her in a Class 4, are you still comfortable with a 90% WPI rating in this case?”
 - A: “Whether it technically is 86% or 90% it doesn’t matter and is a question for the trier of fact.”
- 

Substantial Evidence

Lung case – Developing the Record – AME depo

5.10 Permanent Impairment Due to Respiratory Disorders

Table 5-12 lists criteria for estimating the permanent impairment rating due to respiratory disorders, using pulmonary function and exercise test results. Perform spirometry and Dco on each person being evaluated.³ $\dot{V}O_2$ max may provide additional information in selected individuals when indicated. Determine the predicted values for FVC, FEV₁, and Dco using Tables 5-2a through 5-7a, and calculate the percent predicted (observed/predicted value). Determine the lower limit of normal for FVC, FEV₁, and Dco using Tables 5-2b through 5-7b. The person must meet all of the listed criteria except for $\dot{V}O_2$ max in order to be considered nonimpaired. At least one of the listed criteria must be fulfilled to place an individual in any class with an impairment rating. As discussed in Chapter 1, in individuals where the preinjury or preillness values differ from the population-listed values, the examiner may depart from the

population-listed normal values for determining an impairment rating, using the preinjury and preillness “normal” value, and explain the reason for the departure.

The classification system in Table 5-12 considers only pulmonary function measurements for an impairment rating. It is recognized that pulmonary impairment can occur that does not significantly impact pulmonary function and exercise test results but that does impact the ability to perform activities of daily living, such as with bronchiectasis.

In these limited cases, the physician may assign an impairment rating based on the extent and severity of pulmonary dysfunction and the inability to perform activities of daily living (see Table 1-2). Measured losses of pulmonary function, and corresponding impairment classes, result in a loss in the ability to perform some activities of daily living. The physician can use these associations as a reference. A detailed description with supporting, objective documentation of the type of pulmonary impairment and its impact on the ability to perform activities of daily living is required.

Substantial Evidence

Lung case – Developing the Record – AME depo

- Q: “Do you consider the 12 years smoking history to be significant?”
 - A: “Well, the fact that she had discontinued smoking 12 years previously and her description of having smoked only a couple cigarettes a day probably doesn’t qualify as a disabling level of smoking history.”
 - Q: “So 12 years of smoking two cigarettes per day is it medically probably that would cause some type of impairment?”
 - A: “No.”
- 

Substantial Evidence

Lung case – Developing the Record – AME depo

- Q: “Why not?”
 - A: “The general rule of thumb for smoking is it takes approximately 20 pack years which is a pack a day for 20 years or two packs a day for 10 years to produce a measurable amount of decreased function. Two cigarettes a day is kind of a spit in the ocean.”
 - Q: “And after reviewing this case today with your deposition testimony, it is still your opinion there is no apportionment to non-industrial factors, is that correct?”
 - A: “That’s correct.”
- 

Substantial Evidence

Lung case – Blackledge Rating Instructions:

- Applicant's proposed instructions:
 - “Please rate 90% WPI based on the factors set forth in AME deposition, page 14, lines 3 through 15 – ‘Page 107, Table 5-12, Class IV FEV1 19% predicted, 75% WPI added to Class 2 FVC 61% predicted, 15% WPI added together (and taking into account a 31% FEV1 to FVC ratio of 31%, normal 70%), to constitute 90% WPI.’”
- Defendant's proposed instructions:
 - “Please rate 75% WPI based on the factors set forth on page 5 of the AME report dated 1/29/08, Class IV FEV1 19% predicted only.”

Substantial Evidence

Lung case – The outcome

- Formal rating instructions were for 90% WPI and case rated 100% PTD.
- Cross-examination of rater indicated that she only could follow WCJ's instructions. She was not allowed to answer if Table 5-12 allows adding impairments for separate PFT abnormalities.
- An Award of 100% PTD issued and was upheld on Def's Petition for Recon.
- Applicant is still waiting for a new set of lungs and is not yet O2 dependent.

Substantial Evidence

Summary of Program

- Diagnosis by physician
- WPI ratings by physician
- Develop the record – diagnosis, permanent objective medical findings, effect of industrial injury on ADLs and work ADLs.
- Apportionment issues: “direct causation”
- Blackledge formal rating instructions
- Cross-examination of DEU rater is limited to WCJ instructions



Substantial Evidence in AMA Cases

The End - Enjoy the Conference!

