



AMA Guides and Substantial Evidence

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DWC 16th Annual Educational Conference



AMA Guides & Substantial Evidence

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Part I: 10 Steps to an AMA Guide Compliant Medical Report

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1. Doctors should use clinical judgment per the AMA Guides



Doctor Won writes: In my best clinical judgment, this upper extremity impairment should be rated using grip loss rather than ROM as instructed by the AMA Guides.

1. Doctors should use clinical judgment per the AMA Guides

Page 11 of AMA Guides: “if an impairment based on an **objective medical condition is not addressed** by the AMA Guides, physicians should **use clinical judgment**, comparing measurable impairment... with similar impairment of function in performing activities of daily living.”



1. **Doctors should use clinical judgment per the AMA Guides**

The primary method for rating Upper Extremities (UE) is by:

- **Range of Motion (ROM) and**
- **Diagnostic based surgical procedures**

They are considered scientifically objective tools.

1. **Doctors should use clinical judgment per the AMA Guides**

There are exceptions:

- Tendon ruptures (p. 507)
- Severe muscle tear (p. 508)
- Impairment is based on unrelated etiologic or pathomechanical causes (p. 508)
- Permanent loss of strength one year after surgery (p.507 & 508)

1. **Doctors should use clinical judgment per the AMA Guides**



Since Dr. Won determined that the **grip loss** measurement should be used in this case, he must explain why.

He must explain how the IW's pain is not affecting the result.

1. **Doctors should use clinical judgment per the AMA Guides**

Hyatt Regency v. WCAB
(*Foote*), (2008) 73 CCC 524
WCJ used grip loss rather than
DEU rater for IW's UE injury of
epicondylitis.

(See also *Nielsen v. WCAB*,
(1974) 39 CCC 83.)



2. Doctor must follow Escobedo/Gatten on all issues



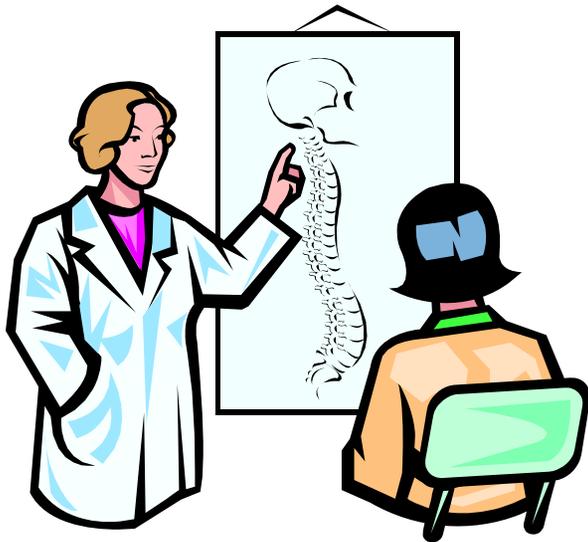
Dr. Tu writes: “It is medically possible, Mr.Mason’s anger towards his boss may have increased blood pressure, with the increased blood pressure then leading to the rupture of a presumed aneurysm.

However, there is no way I can say with reasonable medical probability that this chain of events caused his death.

I can only say this is a possible scenario, which cannot be proven or disproved.”

2. Doctor must follow *Escobedo/Gatten* on all issues

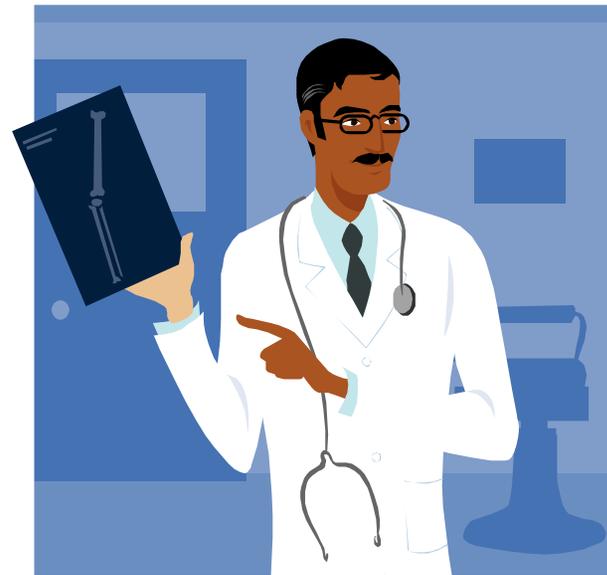
E.L. Yeager Constr'n v. WCAB (Gatten), (2006), 71 CCC 1687, the DCA held,



“Although the doctor does not state in his report that the apportionment is based on reasonable medical probability, he does do so in the deposition. This constitutes a sufficient basis for the apportionment.”

2. Doctor must follow **Escobedo/Gatten** on all issues

Gatten merely affirmed the **reasonable medical probability** standard set forth by the WCAB in *Escobedo v. Marshall*, (2005) 70 CCC 604 (en banc) in order for a medical report to constitute substantial evidence.



2. Doctor must follow Escobedo/Gatten on all issues

- (1) Analyze causation of disability;
- (2) Determine apportionment percentages (O.K. to indicate 100% to non-industrial, 0% to industrial or vice versa)
- (3) Applicant's burden = some percentage (%) of permanent disability (PD) caused by industrial factors
- (4) Defendant's burden = establish the % of PD caused by non-industrial factors;
- (5) Non-industrial factors may include pathology, asymptomatic prior conditions, retroactive prophylactic work restrictions; (not risk factors)
- (6) Medical report needs all necessary elements in order to constitute substantial evidence.

2. Doctor must follow **Escobedo/Gatten** on all issues

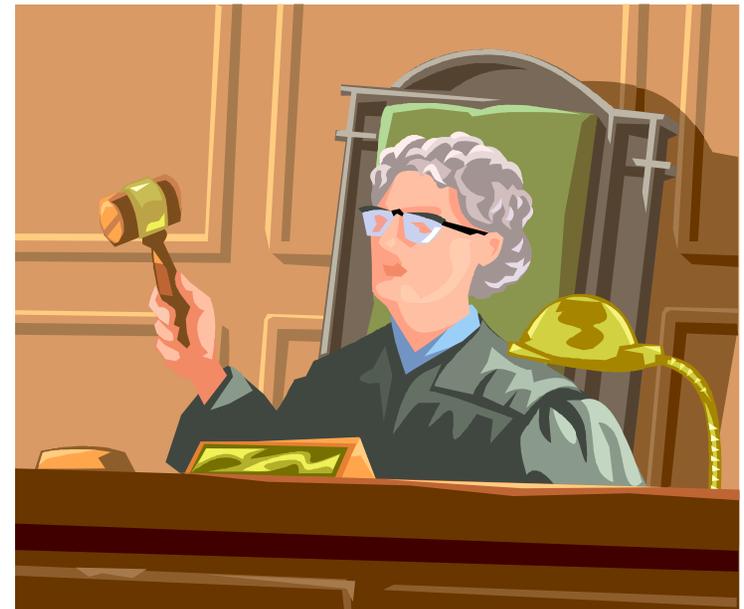


The how & why explanation standard of *Escobedo* and *Gatten* applies to all workers' compensation issues, not just apportionment.

If the doctor has not provided an explanation for her conclusion, the record must be developed through supplemental report or deposition in order to comply with this standard.

2. Doctor must follow Escobedo/Gatten on all issues

Dr. Tu's quote is taken from the case of *A. Teichert & Son v. WCAB (Barron)*, (2008) 73 CCC – (3rd DCA *unpublished case*) where the DCA overturned the WCJ & WCAB to determine that the doctor's report did not constitute substantial evidence.



3. Doctors must distinguish between causation of injury and causation of disability

Dr. Threa incorrectly explains causation of injury as follows:



"Mr. Reyes's injury was caused by a preexisting seizure activity, rather than by his 53 foot fall off the scaffold."

3. Doctors must distinguish between causation of injury and causation of disability

For causation of injury:

Doctors must discuss the **AOE/COE factors**.

AOE = arises out of employment.

COE = occurs in the course of employment.

3. **Doctors must distinguish between causation of injury and causation of disability**

Employers Mutual Liability Insurance Company of Wisconsin v. Industrial Accident Commission
(*Gideon*) (1953)
18 CCC 286.

The *Gideon* case is a 1953 Supreme Court decision. It is still good law today.



**3. Doctors must distinguish between
causation of injury and causation of
disability**

Reyes v. Hart Plastering, (2005)
70 CCC 223 (Significant Panel
Decision SPD)



Even though the IW had a
non-industrial seizure, the
injuries resulting from the
53 fall are industrial.

4. Dr. must correctly determine impairment

Doctor Fore writes:

“Mr. Wickham’s pericardial heart disease would be rated using Table 3-10 at page 52 of the *Guides*. He has recovered from surgery to remove the thickened pericardium, but continues to have symptoms, despite drug therapy. Therefore he would fall within Class 2.



4. Dr. must correctly determine impairment

Doctor Fore incorrectly continues,

“I tried to compare him to the examples in the Guides to see where he would fit in that Class 2 range. Since he is worse than the worst Class 2 example, which is Example 3-38, and since that example gives an impairment rating of 20% to 29%, I would also give Mr. Wickham an impairment rating of 20% to 29%.”

4. Dr. must correctly determine impairment

ADLs are easy to remember - **CAN'T SSSSleep**:

- Communication
- Activity that's physical
- Nonspecialized hand activities
- Travel

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

5. Dr. Must Provide Rationale for Conclusion



Dr. Pheiffer: writes, "Mr. Heffner had a failed back surgery.

He takes Vicodin to relieve the pain. He reports sexual dysfunction, since he and his wife are worried he might re-injury himself during fornication.

Mr. Heffner's injury can be rated using Table 7-5 at page 156. He would fall within Class I, with a 6% WPI."

5. Dr. Must Provide Rationale for Conclusion

Fear of re-injury or refraining from sex due to pain will not be adequate to rate an impairment per **Table 7-5** at page 156.

There are other ways to connect the dots, which Dr. Pfeiffer should have used in this case.

He should have focused on the Mr. Heffner's use of Vicodin from the back injury.



5. Dr. Must Provide Rationale for Conclusion

Other key data:

- Strength of medication,
- Amount of medication,
- Length of time IW would continue medication,
- How long would IW's sexual activity (and other ADLs) be impacted in a similar manner,
- **Identify medical literature that supports the theory that decreased libido may be caused by prolonged use of opiates**

6. Dr. Should designate Table & Page

From the Dead Sea Scrolls:

Woman without her man is nothing.

- **Woman without her man, is nothing.**

OR

- **Woman, without her, man is nothing**

6. Dr. Should designate Table & Page

Doctor Setts writes:



“Mr. Jones’ surgical hernia repair was successful, so I would place him in Class 1 at 2% WPI.”

6. Dr. Should designate Table & Page

Table 6-9 Criteria for Rating Permanent Impairment Due to Herniation

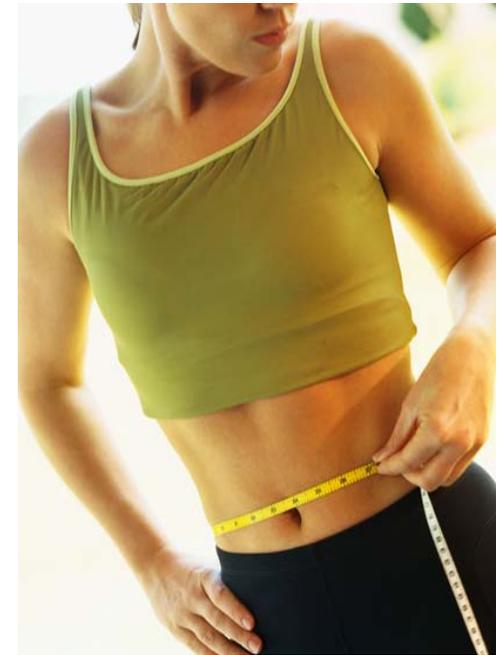
Class 1 0%-9% Impairment of the Whole Person	Class 2 10%-19% Impairment of the Whole Person
<p>Palpable defect in supporting structures of abdominal wall</p> <p><i>and</i></p> <p>slight protrusion at site of defect with increased abdominal pressure; readily reducible</p> <p><i>or</i></p> <p>occasional mild discomfort at site of defect but not precluding most activities of daily living</p>	<p>Palpable defect in supporting structures of abdominal wall</p> <p><i>and</i></p> <p>frequent or persistent protrusion at site of defect with increased abdominal pressure; manually reducible</p> <p><i>or</i></p> <p>frequent discomfort, precluding heavy lifting but not hampering some activities of daily living</p>

7. Doctors Must Adhere to AMA Guide Criteria

Dr. Sephen writes:

“Given the extent of NSAID use by Mr. Collins to control the pain from his industrial injury, he has developed GERD which would place him in Class 2 of Table 6-3 (page 121).

Mr. Collins’ impairment would be 10%, at the lowest end of the range, rather than at the high end of that range, because he has no weight loss, which would be typical for a Class 2 patient.”



7. Failure to Adhere to AMA Guide Criteria

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>

8. Dr. Must Rate Using Tests and Measurements

Dr. Ate's report states in part, "Ms. Elinor has a specific injury to the Lumbar Spine with unilateral dermatomal distribution sensory loss.

According to Table 15-3, page 384, she would fit into the DRE III of 10 – 13%.

I have requested an EMG to confirm the radiculopathy, but it has not been approved.

Because the patient has recovered sufficiently to return to work w/o serious work restrictions and has done well with conservative measures, I would rate this patient as 10% WPI."

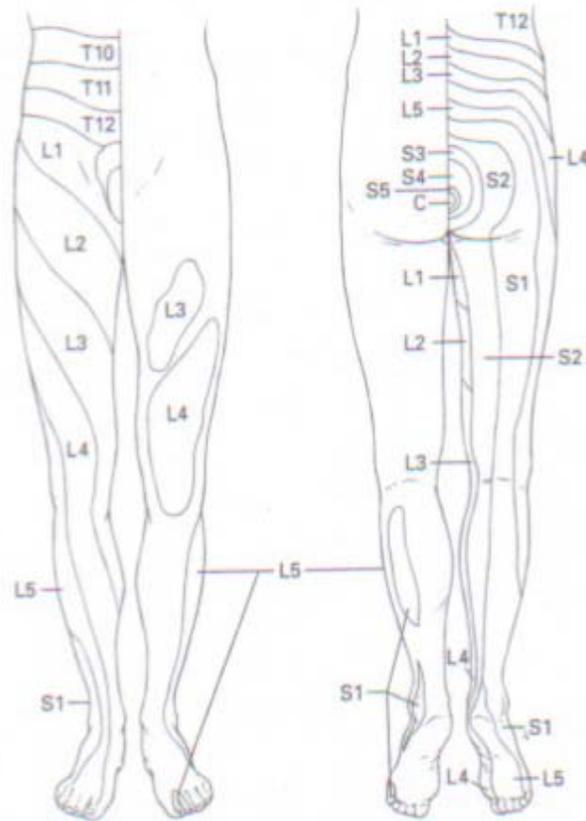
8. Dr. Must use Required Tests and Measurements

Table 15-3 Criteria for Rating Impairment Due to Lumbar Spine Injury

DRE Lumbar Category I 0% Impairment of the Whole Person	DRE Lumbar Category II 5%- 8% Impairment of the Whole Person	DRE Lumbar Category III 10%-13% Impairment of the Whole Person
<p>No significant clinical findings, no observed muscle guarding or spasm, no documentable neurologic impairment, no documented alteration in structural 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 significant muscle guarding or spasm observed at the time of the examination, 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 and no significant radiculopathy</p> <p>or</p> <p>individual had a clinically significant radiculopathy and has an imaging study that demonstrates a herniated disk at the level and on the side that would be expected based on the previous radiculopathy, but no longer has the radiculopathy following conservative treatment</p> <p>or</p> <p>fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation (not developmental spondylolysis) that has healed without alteration of motion segment integrity; (3) a spinous or transverse process fracture with displacement without a vertebral body fracture, which does not disrupt the spinal canal</p>	<p>Significant signs of radiculopathy, such as dermatomal pain and/or in a dermatomal distribution, sensory loss, loss of relevant reflex(es), loss of muscle strength or measured unilateral atrophy above or below the knee compared to measurements on the contralateral side at the same location; impairment may be verified by electrodiagnostic findings</p> <p>or</p> <p>history of a herniated disk at the level and on the side that would be expected from objective clinical findings, associated with radiculopathy, or individuals who had surgery for radiculopathy but are now asymptomatic</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 has healed without alteration of structural integrity</p>

8. Rating w/o Required Tests and Measurements

Figure 15-1 Skin Areas Innervated by the Thoracic and Lumbosacral Nerve Roots and Showing Autonomous Zones



8. Rating w/o Required Tests and Measurements

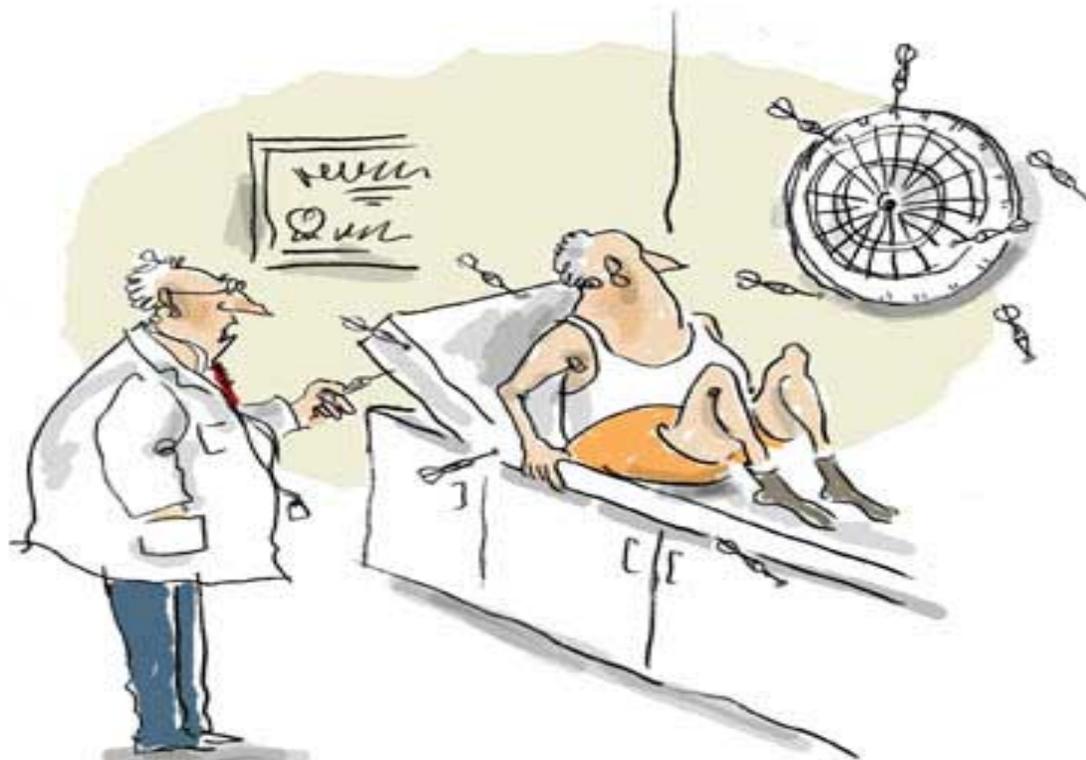
Dr. Ocho writes:

“Ms. Tensby suffered an industrial injury to her lumbar spine. Based on MRI scans, **I have repeatedly requested an EMG of the lower extremities to rule out radiculopathy** due to the disc protrusions and her complaints of big toe numbness. However, this request was denied.

I therefore rated Ms. Tensby’s impairment with the DRE method because there was a distinct injury. Ms. Tensby fits into DRE II, which = 5% WPI.



8. Warm up exercises are often forgotten.



**"I like to practice before
I start acupuncture treatment!"**

9. Incorrectly Rating “Brain - Pain” Headaches

Dr. Neinn, states, “Ms. Annesley suffered a concussion in her fall at work. She continues to present with symptoms of headaches, episodes of confusion and severe depression.

Dr. Neinn incorrectly concludes, “The concussion has fully resolved, therefore, Ms. Annesley does not have any rateable WPI%.”



9. Incorrectly Rating “Brain - Pain” Headaches

Chapter 18 acknowledges headaches as a well-established pain syndrome. (page 571 – **Table 18-1**)

Query: If 3% WPI is designated for headaches, can you add-on 1-3% for pain to leg?

The following is a sample string rating for headaches:

13.01.00.99 – 3 [6] – 4 – 322F – 4 – 4% WPI

9. Incorrectly Rating “Brain - Pain” Headaches



After Ms. Devon witnessed a co-worker being crushed to death at work. Dr. Nueve did a complete psych analysis of Ms. Devon and arrived at a GAF score of 46% WPI.

He then added, **“I understand 3% for brain pain can be added at this point. Ms. Devon has frequent headaches, which she didn’t have prior to her industrial injury. So an extra 3% for pain seems *fair*.”**

10. Doctor Must Determine Apportionment.

Dr. Tenn writes, "The IW, Mr. Gardener, had a cumulative trauma of cervical strain ending February 4, 2007. This work injury, of cervical strain lit up what I believe is a pre-existing, non-industrial. C6-7 disk herniation.

The mechanism of injury, which was general gardening duties for a local public park, (mowing, leaf blowing, pruning of bushes and trees, etc.) does not adequately explain the presence of a cervical disc extrusion.

Therefore, his cervical disc herniation is predominantly a non-industrial condition. I would apportion 100% of the disc herniation to a non-industrial cause. I would rate the cervical strain as a DRE Category I for 0%WPI."

10. Doctor Must Determine Apportionment.

- **Step One:** Dr. Tenn must properly analyze causation of injury.
- **Step Two:** Once Dr. Tenn has diagnosed the injury, and determined whether or not the cause of the injury is industrial, he must then correctly rate the impairment as we have discussed in this program.
- **Step Three:** Dr. Tenn then needs to make an apportionment determination, per LC 4663.



10. Doctor Must Determine Apportionment.



LC 4663 (c) ... "A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury AOE/COE and

What approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries.

(O.K. to indicate 100% to non-industrial factors, 0% to industrial factors or vice versa)

Enjoy the DWC Conference!





2009 DWC CONFERENCE

LOWER EXTREMITY INJURIES AND TABLE 17-33

APPORTIONMENT, DUPLICATION AND OVERLAP

By: ROBERT G. RASSP, ESQ.



CHAPTER 17 LOWER EXTREMITIES

- ➔ 13 WAYS TO EVALUATE LOWER EXTREMITY IMPAIRMENTS, 40% OF LE RATING = WPI RATING**
- ➔ TABLE 17-2 IS YOUR BIBLE FOR LOWER EXTREMITIES**
 - TO READ REPORTS AND SEE IF THEY COVER EVERYTHING**
 - TO USE TO CROSS EXAMINE PHYSICIANS**
 - TO USE FOR CROSS-USAGE – WHAT CAN BE COMBINED AND WHAT CANNOT BE COMBINED**



CHAPTER 17 - Lower Extremities

TABLE 17-2 REFERENCES

- **17-4 LIMB LENGTH DISCREPANCY**
- **17-5 GAIT DERANGEMENT**
- **17-6 MUSCLE ATROPHY**



CHAPTER 17 – LOWER EXTREMITIES

TABLE 17-2 REFERENCES

17-7, 8 MUSCLE STRENGTH

17-9 TO 17-30 ROM, ANKYLOSIS

**17-31 ARTHRITIS/DEGENERATIVE JOINT
DISEASE/PATELLOFEMORAL SYNDROME
(FOOTNOTE)**



CHAPTER 17 - Lower Extremities

TABLE 17-2 REFERENCES

- ⇒ **17-32** **AMPUTATION**

- ⇒ **17-33, 34 AND 35** **DIAGNOSIS BASED
ESTIMATES**

- ⇒ **17-36** **SKIN LOSS**



CHAPTER 17 - Lower Extremities

TABLE 17-2 REFERENCES

- ⇒ **17-37** **PERIPHERAL NERVE INJURY**

- ⇒ **13-15*** **CRPS**

- ⇒ **17-38** **VASCULAR**



CHAPTER 17 – TABLE 17-33 AND JOINT REPLACEMENTS

⇒ WHY DOES TABLE 17-33 (DBE) EXIT?

- FRACTURES, MENISCUS TEARS, LIGAMENT LAXITY, JOINT REPLACEMENTS**
- READ THE INSTRUCTIONS ON PAGE 545 AND 546! CERTAIN CONDITIONS CAN BE RATED BASED UPON THE DIAGNOSIS ALONE “WITHOUT A PHYSICAL EXAMINATION.”**
- E.G. PARTIALLY TORN ACL (“MILD” 3% WPI), COMPLETELY TORN ACL WITH REPAIR (“MODERATE” 7% WPI), COMPLETELY TORN ACL WITH REPLACEMENT (“SEVERE” 10% WPI)**
 - ANTERIOR DRAWER SIGN**
 - RATING IS BASED ON DIAGNOSIS AND TREATMENT BUT NOT ON PHYSICAL EXAMINATION**



CHAPTER 17 – TABLE 17-33 AND JOINT REPLACEMENTS

- ⇒ IW INJURES RIGHT KNEE AND HAS PARTIALLY TORN MEDIAL AND LATERAL MENISCI, COMPLETELY TORN ACL ALL SURGICALLY REPAIRED AND PATELLOFEMORAL CREPITUS. HOW IT IS RATED?**
- DBE RATINGS WITHIN ONE KNEE CAN BE COMBINED WITH EACH OTHER – TWO MENISCUS (4% WPI) COMBINED WITH ACL RATING (10% WPI)**
 - TABLE 17-31 FOOTNOTE FOR POST TRAUMATIC CREPITUS (2% WPI)**
 - ARTHRITIS CAN BE COMBINED WITH DBE RATINGS UNDER TABLE 17-2**
 - USE TABLE 17-2 AS A REFERENCE FOR OTHER RATINGS IN ALL LOWER EXTREMITY CASES**



CHAPTER 17 – TABLE 17-33 AND JOINT REPLACEMENTS

RATINGS FOR KNEE REPLACEMENTS

⇒ TWO PART PROCESS

- POINT SYSTEM FROM PHYSICAL EXAMINATION UNDER TABLE 17-35**
- DBE RATING BASED UPON “GOOD RESULT,” “FAIR RESULT” OR “POOR RESULT” OF KNEE REPLACEMENT.**

⇒ POINT SYSTEM:

- ADD POINTS FOR a. PAIN, b. ROM, c. STABILITY OF JOINT COMPONENTS**
- SUBTRACT POINTS FOR: d. FLEXION CONTRACTURE, e. EXTENSION LAG, f. ALIGNMENT**



CHAPTER 17 – TABLE 17-33 AND JOINT REPLACEMENTS

- ➔ **POINT SYSTEM (CONTINUED)**
- ➔ **THE FOOTNOTE BELOW TABLE 17-35 SAYS:**
“The point total for estimating knee replacement results is the sum of the points in categories a, b, c; minus the sum of the points in categories d, e and f.” **OR:**
$$(a + b + c) - (d + e + f) = \text{TOTAL POINTS}$$
- ➔ **TABLE 17-33 KNEE REPLACEMENTS:**
 - “GOOD RESULT” = 85-100 POINTS (15% WPI)
 - “FAIR RESULT” = 50-84 POINTS (20% WPI)
 - “POOR RESULT” = < 50 POINTS (30% WPI)
- ➔ **COMBINE WITH OTHER RATINGS IF ALLOWED UNDER TABLE 17-2**



PART VII – TABLE 17-33 AND JOINT REPLACEMENTS

KNEE REPLACEMENTS

WHAT ABOUT A PARTIAL KNEE REPLACEMENT?

- POINTS ARE DETERMINED BY: $\frac{1}{2}[(a + b + c) - (d + e + f)]$
- DIVIDE THE DBE RATING BY 2.

HIP REPLACEMENTS

⇒ TABLE 17-34 AND TABLE 17-33

- POINT SYSTEM IN FIVE CATEGORIES
- WPI RATING FROM DBE TABLE



CHAPTER 17 – TABLE 17-33 AND JOINT REPLACEMENTS

HIP REPLACEMENTS

➔ POINT SYSTEM

- ADD POINTS BASED UPON a. PAIN, b. FUNCTION (LIMP, SUPPORTIVE DEVICE, DISTANCE WALKED), c. ACTIVITIES (STAIRS, PUTTING ON SHOES AND SOCKS, SITTING, PUBLIC TRANSPORTATION), d. DEFORMITY, and e. RANGE OF MOTION
 - [(a) + (b) + (c) + (d) + (e)] = TOTAL POINTS

➔ TABLE 17-33 RATING

- “GOOD RESULT” = 85-100 POINTS (15% WPI)
- “FAIR RESULT” = 50-84 POINTS (20% WPI)
- “POOR RESULT” = < 50 POINTS (30% WPI)



CHAPTER 17 – TABLE 17-33 AND JOINT REPLACEMENTS

KNEE AND HIP REPLACEMENTS – NOTES

- ⇒ IF THERE IS A KNEE AND HIP REPLACEMENT ON THE SAME SIDE, IW GETS WPI RATINGS FOR EACH, CONVERT TO PD THEN COMBINE THEM.**
- ⇒ “ALIGNMENT” REFERS TO VARUS AND VALGUS OF LEG ON CENTER AXIS**
- ⇒ DON’T FORGET ABOUT TABLE 17-2 TO SEE IF THERE IS ANYTHING ELSE THAT CAN BE COMBINED WITH RATINGS UNDER 17-33 DBE IMPAIRMENTS**



APPORTIONMENT, DUPLICATION AND OVERLAP

GOALS OF THE PROGRAM

- ⇒ HOW TO DEVELOP THE RECORD FOR APPORTIONMENT, DUPLICATION AND OVERLAP IN CASES INVOLVING A PRIOR AWARD UNDER 1997 PDRS AND NEW INJURIES UNDER THE 2005 PDRS**
- ⇒ HOW TO APPLY APPORTIONMENT UNDER LABOR CODE SECTIONS 4663, 4664 AND CURRENT CASE LAW**



THE FACTS OF THE CASE

- ➔ **THE CASE: 54 Y/O PARK MAINTENANCE WORKER**
- ➔ **FEBRUARY 10, 2004 LOW BACK INJURY WITH MRI SHOWING 3-4mm CENTRAL PROTRUSION L5-S1 WITH POSITIVE EMG/NCV RIGHT LE RADICULOPATHY, POSITIVE SLR, TTD THRU 7/25/05**
- ➔ **AUGUST 29, 2005 LEFT SHOULDER INJURY WITH TORN ROTATOR CUFF WITH SURGICAL REPAIR**



THE FACTS OF THE CASE

- ➔ **APPLICANT HAS PRIOR AWARD FOR 36% PD TO NECK, LEFT SHOULDER AND LEFT ELBOW DUE TO MVA ON MAY 12, 1998 SAME EMPLOYER.**
- ➔ **PRIOR STIPULATION SAYS AWARD IS BASED ON PTP'S P&S REPORT.**
- ➔ **IW FILES A CT FROM 1/96-10/28/05; 2/10/04 LUMBAR SPINE, 8/29/05 LEFT SHOULDER CASES.**



TREATING PHYSICIAN'S 1999 REPORT

- ✓ **“The cervical spine disability precludes heavy lifting or repetitive motions of the neck.”**
- ✓ **“The left shoulder disability precludes him from heavy lifting, working above shoulder level, or torquing. This contemplates the individual has lost 25% of his pre-injury capacity for lifting, above shoulder level work, torquing or other activities of comparable physical effort.”**
- ✓ **(Diagnosis was “Chronic left shoulder tendinosis with +1 palpable tenderness and intermittent slight to moderate pain.”)**



1999 TREATING PHYSICIAN REPORT

✓ LEFT SHOULDER ROM (LEFT HAND DOMINANT):

“Normal”

Measured on left

Forward Flexion:	170 deg.	170 deg.
Extension:	30 deg.	30 deg.
Abduction:	170 deg.	170 deg.
Adduction:	30 deg.	30 deg.
Internal rotation:	60 deg.	60 deg.
External rotation:	80 deg.	80 deg.

“RIGHT SHOULDER ROM IS NORMAL.”



AME REPORT 1/3/2007

- ✓ **LUMBAR SPINE: DRE III 10% WPI TABLE 15-3, PAGE 384-388 MRI FINDINGS, POSITIVE EMG/NCV FOR VERIFIABLE RADICULOPATHY UNOPERATED.**
- ✓ **LEFT SHOULDER: ROM 9% UE OR 5% WPI FIGURES 16-38 THROUGH 16-46, pp. 450-454, 474-479.**
- ✓ **1 cm ATROPHY LEFT UPPER ARM (RGR NOTE: ATROPHY IS NOT IN AMA *GUIDES* FOR UPPER EXTREMITIES)**



AME REPORT 1/3/2007

LEFT SHOULDER ROM:

AMA NORMAL

MEASUREMENTS

		R	L
Flexion:	180 deg.	180	120
Extension:	50 deg.	50	40
Abduction:	180 deg.	180	130
Ext. Rot.:	90 deg.	90	80
Int. Rot.:	80 deg.	80	70
Adduction:	40 deg.	40	30



APPORTIONMENT 4664 OR 4663?

EFFECTS OF 1998 INJURY ON APP'S ADL FUNCTIONING?

LOSS OF 25% ABILITY TO DO HEAVY LIFTING, OVER LEFT SHOULDER WORK AND OR TORQUING; INTERMITTENT SLIGHT PAIN.

EFFECTS OF 2005 LEFT SHOULDER INJURY ON ADL FUNCTIONING?

CAN'T LIFT OVER 50-60 LBS. TROUBLE SLEEPING DUE TO LEFT SHOULDER PAIN, "WEAKNESS" IN USE OF ARM.

(ADLs BECAUSE OF LUMBAR SPINE NOT LISTED HERE).



AME REPORT 1/3/2007 ON APPORTIONMENT

✓ **“The patient did receive a prior stipulated award for 36% PD with regard to the 1998 industrial injuries to his left shoulder, cervical spine and left elbow. Under Labor Code Section 4664 therefore, it is felt the subtraction method needs to be used for the patient’s current level of permanent left shoulder disability as compared to the level of disability already awarded. With regard to the increased level of left shoulder disability, it is felt that 10% would be attributable to non-industrial underlying degenerative disease with the remaining portion attributable to industrial causation.”**



AME 1/3/2007 REPORT ON APPORTIONMENT

- ✓ “As to the lumbar spine impairment, 100% of the cause of the patient’s disability is caused by the specific industrial injury of 2/4/2004. He has mild spurring which I do not feel is a causative factor in his impairment or disability.”
- ✓ SHOULDER: 16.02.01.00 – 5 – [7] 7 – 480H –10 – 12%
- ✓ LUMBAR: 15.03.01.00 – 10 – [5] 13 – 480I – 18 – 20%
- ✓ 20% COMBINED WITH 9% = 28% PD
- ✓ COMBINE AFTER CONVERTING WPI TO PD!!!!
- ✓ BUT WHAT ABOUT APPORTIONMENT?????



AME ON APPORTIONMENT

- ✓ **ARE THE AME'S CONCLUSIONS SUBSTANTIAL EVIDENCE?**
- ✓ **CAN THE "SUBTRACTION METHOD" APPLY UNDER LABOR CODE SECTION 4664? IF SO, HOW? IF NOT, WHY NOT?**
- ✓ **CAN YOU DETERMINE A RETROACTIVE WPI RATING IN THE PRIOR AWARD?**
- ✓ **CAN YOU SUBTRACT APPLES FROM ORANGES?**
- ✓ **DOES LABOR CODE SECTION 4663 APPLY?**



COMPARE REPORTS AND NORMALS

✓ LEFT SHOULDER ROM (LEFT HAND DOMINANT):

	<u>AMA</u> <u>NORMAL</u>	<u>AME</u>	<u>1999</u> <u>PTP</u>
Flexion:	180	120	170 deg.
Extension:	50	40 deg.	30 deg.
Abduction:	180	130 deg.	170 deg.
Adduction:	50	30 deg.	30 deg.
Internal rot.	90	70 deg.	60 deg.
External rot.:	90	80 deg.	80 deg.

- PTP DID NOT MEASURE ARM OR FOREARM GIRTH, AME DID: 1 CM LESS ON LEFT UPPER ARM THAN ON RIGHT UNINJURED ARM



CROSS EXAMINATION OF AME

- ✓ **ARE IMPAIRMENT RATINGS CORRECT?**
 - ✓ **DRE vs. ROM, WHAT WPI WITHIN A CLASS?**
 - ✓ **ARE SHOULDER RATINGS CORRECT? OTHER DISORDERS?**
- ✓ **“SUBTRACTION METHOD” LABOR CODE SEC. 4664?**
- ✓ **LABOR CODE SEC. 4663 METHOD?**
- ✓ **WHERE DID 1 CM ATROPHY COME FROM?**
- ✓ **WHAT ABOUT OVERLAP BETWEEN PRIOR AWARD FOR CERVICAL SPINE AND CURRENT DISABILITY FOR LUMBAR SPINE?**



LABOR CODE SECTION 4664

- ✓ **4664(a): “THE EMPLOYER SHALL ONLY BE LIABLE FOR THE PERCENTAGE OF PERMANENT DISABILITY DIRECTLY CAUSED BY THE INJURY ARISING OUT OF AND OCCURRING IN THE COURSE AND SCOPE OF THE EMPLOYMENT.”**

- ✓ **4664(b): “IF THE APPLICANT HAS RECEIVED A PRIOR AWARD OF PERMANENT DISABILITY, IT SHALL BE CONCLUSIVELY PRESUMED THAT THE PRIOR PERMANENT DISABILITY EXISTS AT THE TIME OF ANY SUBSEQUENT INDUSTRIAL INJURY. THIS PRESUMPTION IS A PRESUMPTION AFFECTING THE BURDEN OF PROOF.”**



4663 AND 4664 APPORTIONMENT FORMULA

STEP 1: CAN YOU CONVERT PRIOR MEDICAL EVIDENCE INTO WPI RETROACTIVELY?

STEP 2: IF YES, IS THERE OVERLAP BETWEEN CURRENT WPI AND PRIOR “WPI” OR DISABILITY? (See, *Kopping vs. WCAB* (2006) 71 Cal. Comp. Cases 1229).

STEP 3: IF “YES” USE THE SUBTRACTION METHOD AND PRESUMPTION OF SECTION 4664 APPLIES.

STEP 4: IF THERE IS NO OVERLAP AND NEW IMPAIRMENT IS INDEPENDENT OF PRIOR ONE THEN APPLY 4663.

STEP 5: IF STEP #1 ABOVE IS “NO” THEN APPLY 4663.



SUBTRACTION METHOD UNDER L.C. SECTION 4664

✓ HOW CAN A PHYSICIAN DETERMINE RETROACTIVE WPI?

- ✓ NOT FROM THE PRIOR AWARD**
- ✓ WAS ACTIVE ROM MEASUREMENTS TAKEN BY PREVIOUS PHYSICIAN?**
- ✓ DID PREVIOUS PHYSICIAN USE AMA *GUIDES* NORMALS OR COMPARE INJURED TO NON-INJURED SIDE?**
- ✓ DID PREVIOUS INJURY INVOLVE A RATABLE CONDITION REGARDLESS OF TX OUTCOME? (E.G. PARTIAL MENISCECTOMY, PRIOR ONE LEVEL DISCECTOMY)**



SUBTRACTION METHOD UNDER L.C. SECTION 4664

- ✓ **ONCE YOU ESTABLISH PRIOR WPI RATING BASED UPON REASONABLE MEDICAL PROBABILITY, CAN YOU SUBTRACT “OLD” WPI RATING FROM NEW ONE?**
- ✓ **DOES THE SUBTRACTION METHOD OF CURRENT WPI MINUS PRIOR WPI COVER OVERLAP? (E.G. PRIOR SHOULDER WAS ROTATOR CUFF REPAIR, NEW INJURY IS DISTAL CLAVICLE RESECTION)**
- ✓ **ALWAYS CONSIDER OVERLAP AND MAKE A COMMENT ON IT**



APPORTIONMENT 4664 OR 4663?

**NOTE: PRIOR LEFT SHOULDER DX WAS “TENDINOSIS” AND
“NORMAL” ROM**

**CURRENT LEFT SHOULDER DX IS TORN ROTATOR CUFF
WITH DECREASED ROM.**

**WHAT IF PRIOR DX WAS “TENDINOSIS” AND CURRENT
ONE IS “DISTAL CLAVICLE RESECTION
ARTHROPLASTY?”**

**WHAT IF PRIOR DX WAS ROTATOR CUFF TEAR WITH
LOSS OF ROM AND CURRENT IS DCR WITH LOSS OF
ROM?**



FINAL RATINGS AFTER APPORTIONMENT

SHOULDER:

2/3[16.02.01.00 – 5 – [7] 7 – 480H – 10 – 12%] 9% LESS
10% = 8% PD

LUMBAR: 15.03.01.00 – 10 – [5] 13 – 480I – 18 – 20% PD
NO APPORTIONMENT.

20% PD COMBINED WITH 8% PD = 26% PD

WHAT ABOUT *BENSON*?



MORE ON APPORTIONMENT

SUPPOSE THERE WAS AN HNP OF L5-S1 IN 1998 INCIDENT AND APPLICANT'S 2/10/04 LUMBAR INJURY RESULTS IN A ONE LEVEL FUSION OF L5-S1?

1998 INJURY: DRE CATEGORY III 10% WPI?

**2005 INJURY: ROM REQUIRED RECURRENT DISC
18% WPI (Table 15-7 IV. (D) COMB.
WITH DECREASED ROM COMB.
WITH SENSORY/MOTOR DEFICITS.**



LABOR CODE SECTION 4663

- ✓ **IF YOU CANNOT SUBTRACT A PRIOR AWARD UNDER L.C. SECTION 4664 THEN DEFAULT TO APPLYING SECTION 4663:**
- ✓ **“APPROXIMATELY HOW MUCH IMPAIRMENT IS DIRECTLY CAUSED BY THE NEW INJURY AND HOW MUCH IS CAUSED BY OTHER FACTORS, INCLUDING THE PRIOR INDUSTRIAL INJURY?”**
- ✓ **DO YOU STILL CONSIDER OVERLAP USING LABOR CODE SECTION 4663? YES AND NO!**



RISK FACTORS AND APPORTIONMENT

- ✓ **RISK FACTORS ARE STATISTICAL PROBABILITIES**
- ✓ **A RISK FACTOR IS NOT A PATHOLOGY**
- ✓ **YOU CAN ONLY APPORTION PATHOLOGY (L.C. SECTION 4663)**
- ✓ **GENETIC PREDISPOSITION IS A RISK FACTOR UNLESS YOU CAN PROVE A DIRECT GENETIC LINK TO ILLNESS OR MEDICAL CONDITION**
- ✓ ***UNITED AIRLINES vs. WCAB (MILIVOJEVICH) (2007)* 72 Cal. Comp. Cases 1415 (W/D) YOU CANNOT APPORTION RISK FACTOR OF HYPERLIPIDEMIA TO HEART IMPAIRMENT RATING.**
- ✓ **OBESITY, GENDER, AGE, RACE ARE ALL RISK FACTORS BUT SOME MAY BE A PART OF CAUSATION OF AN IMPAIRMENT**



RISK FACTORS AND APPORTIONMENT

- ✓ **VAIRA vs. WCAB (2007) 72 Cal. Comp. Cases 1586 (not certified for publication but here it is anyways)**
- ✓ **A PRIOR NON-INDUSTRIAL CONDITION CAN BE “LIT UP” BY AN INDUSTRIAL INJURY.**
- ✓ **BUT APPORTIONMENT MUST BE BASED UPON WHAT CAUSED THE DISABILITY, NOT WHAT CAUSED THE INJURY. WCAB CANNOT USE RISK FACTORS OF INJURY IN APPORTIONING PERMANENT DISABILITY.**
- ✓ **THE LENGTH OF TIME A PRE-EXISTING CONDITION (OSTEOPOROSIS) EXISTS MAY BE A FACTOR FOR APPORTIONMENT BUT NOT THE APPLICANT’S AGE ALONE. APPLICANT’S GENDER MAY NOT BE A FACTOR (IW WAS 73 YEARS OLD BENT OVER TO PICK UP PAPERS T12 FX – 40% NON-INDUSTRIAL. AME FAILED TO SAY HOW AND WHY)**

APPORTIONMENT, DUPLICATION AND OVERLAP



Enjoy
The
Rest
Of
The
PROGRAM!

Comparing Apples with Oranges APPORTIONMENT, DUPLICATION AND OVERLAP

By: ROBERT G. RASSP, ESQ.

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This subject has been and will continue to be a highly litigated and controversial issue, even in *AMA Guides* cases. The *AMA Guides* in fact make our cases ripe for litigation and controversy on the issue of apportionment. Apportionment in the *Guides* looks somewhat like Labor Code Section 4663. See *AMA Guides*, Chapter 1, pages 11-12. However, it appears that the authors of Chapter 1 of the *Guides* confuse causation of an injury with causation of an impairment. California law requires that we distinguish between causation of an injury [See *Reyes vs. Hart Plastering*, (2005) 70 Cal. Comp. Cases 223], and causation of permanent disability at the time the Applicant is permanent and stationary or has reached maximum medical improvement. See *Marlene Escobedo vs. Marshalls*, (2005) 70 Cal. Comp. Cases 604; *E.L. Yeager Construction vs. WCAB (Gatten)* (2007) 72 Cal. Comp. Cases 1687.

The important point here is that even the authors of the *AMA Guides* mandate the individualization of each person's impairment rating. Labor Code Section 4660 mandates that the state utilize a uniform, objective and consistent method of rating industrial injuries. What is clear from reading Chapters 1 and 2 of the *AMA Guides* is that the only thing that is "uniform, objective and consistent" as mandated by the Labor Code is the actual use of the *AMA Guides*. But once you open the *Guides* and use its pages in a given case for a given applicant, any uniformity, objectivity or consistency are discarded in favor of both individualizing a person's impairment rating based in part on the effects of the impairment on that person's ADLs and individualizing apportionment of impairments to "other factors" if appropriate.

How do we deal with a prior award under Labor Code Sections 4663 and 4664 when there is a new injury that occurs after January 1, 2005 and is rated under the *AMA Guides*? Suppose

there is a 39 year old nurse who sustains a low back injury in 1995 that resulted in a no heavy work restriction. That case would rate 30% permanent disability after adjustment for age and occupation. Now, in 2005, the same nurse has another lumbar spine injury. How would apportionment work in this case?

Can you subtract apples from oranges? The 1995 permanent disability was based upon work restrictions. The 2005 permanent disability is based upon a spinal impairment under Chapter 15, *The Spine*, in the *AMA Guides*. So the 1997 PDRS is based upon loss of ability to compete in the open labor market while the 2005 PDRS is based upon the *AMA Guides* and the DFEC adjustment. Cases under the 1997 PDRS are the apples and cases rated under the 2005 PDRS are the oranges

One preliminary note: since there is a reoccurrence of an injury to the nurse's lumbar spine, the ROM method would apply for rating the 2005 spinal injury. See pages 379-381 of the *AMA Guides*. One other note is that the following analysis applies regardless of whether the prior injury was industrially related or not – the analysis applies under both Labor Code Section 4664 for a prior award and Section 4663 for a prior non-industrial injury with the same surgical results.

Can the WCJ subtract the prior percentage of permanent disability from the current permanent disability that was rated from permanent impairment to PD using the 2005 PDRS? No. There is no way you can use the direct subtraction of percentages now mandated by Labor Code Section 4664 and current case law. [See *Welcher/Brodie vs. WCAB* (2007) 40 Cal.4th 1313, 72 Cal. Comp. Cases 565]. This is because the percentages of permanent disability derived from impairment ratings are totally different from the ratings based upon work restrictions. Another way to put it is that you would be subtracting apples from oranges, which you cannot do. Therefore, there would be only two ways apportionment can occur in this type of case, both under Labor Code Section 4663:

- I. Have the treating or evaluating physician determine what impairment rating under the *AMA Guides* the prior injury would have been and subtract that impairment rating from the current one.

OR

- II. Default to analyzing apportionment under Labor Code Section 4663 – what approximate percentage of permanent disability is directly caused by the 2005 lumbar spine injury and approximately what percentage of permanent disability is caused by other factors, including the prior 1995 industrial lumbar spine injury?

Chapter 1 of the *AMA Guides* permit the first method mentioned above if the physician can rate the prior injury using the *AMA Guides* retrospectively. For example, if the nurse had suffered a one level lumbar disc herniation resulting in a laminectomy from the 1995 injury then a physician today using the *AMA Guides* could reasonably conclude that the nurse had a DRE Category III lumbar spine impairment rating (between 10% and 13% WPI) if the physician can discover through review of records, reviewing the Applicant's deposition etc. that the nurse had surgery and determine his or her quality of life afterwards.

The physician could then pinpoint approximately where within the DRE III category the nurse was when declared permanent and stationary from the 1995 injury based upon how well the nurse felt or functioned after being released from care for the first injury. Since the ROM method would be used due to the new injury to the lumbar spine in 2005, the physician would then subtract the DRE III rating from the current ROM rating, which would be consistent with both Labor Code Section 4664 and 4663.

Applicant's counsel may object to the first method on the grounds that a retroactive DRE rating under the *AMA Guides* is too speculative. Defense counsel may object since this method does not take into account "other factors" besides the prior ratable injury. However, it is reasonable from an evidentiary standpoint that this method could pass scrutiny by the WCAB as to whether the physician's opinion that gives a retroactive impairment rating constitutes substantial medical evidence. Again, the physician would have to state how and why he or she came to his or her conclusions about a retroactive impairment rating and the rationale for doing so.

We are also faced with the issue under Labor Code Section 4663 about whether the nurse could argue that her lumbar spine condition improved and she rehabilitated from the prior injury since the presumption of Labor Code Section 4664 cannot apply (remember, you cannot subtract apples from oranges). See *Kopping vs. WCAB* (2006) 71 Cal. Comp. Cases 1229.

The decision in *Kopping* reiterates existing law that the Defendant has the burden of proving the existence of a prior award in order for the presumption that permanent disability exists under Labor Code Section 4664 applies. However, the Defendant also has an additional burden of proving that there is overlap between the prior permanent disability award and any current impairment from the new industrial injury before any total or partial subtraction of a prior award can occur from a new award.

But what if the nurse injures her neck instead of her lumbar spine in 2005? How does apportionment work where the prior spinal award or injury was to the lumbar spine and the new industrial injury is to the cervical spine? Is there consideration for overlap? Is there such a thing as overlap and duplication in *AMA Guides* cases?

If the nurse has a prior lumbar spine award of 30% permanent disability based upon the 1995 injury and now she has a DRE Category IV 25% cervical spine impairment, is there any adjustment to the cervical spine rating on account of the prior award to the lumbar spine? Maybe not, even though the impairments are within the same region, i.e. the spine. Remember, Labor Code Sections 4664(c)(1) and (c)(2) mandate that an impairment rating cannot exceed 100% in a person's life time for any single body region, including the spine. In this case, it is arguable that a cervical spine injury results in separate impairments than a lumbar spine injury.

If the nurse had both cervical and lumbar spine injury in 2005, each impairment rating would be combined using the Combined Values Chart and then rated for permanent disability with any "overlap" being covered by the Combined Values Chart. See the 2005 PDRS, page 1-11.

However, the 2005 PDRS at page 1-5 states:

“It is not always appropriate to combine all impairment standards resulting from a single injury, since two or more impairments may have a duplicative effect on the function of the injured body part. The *AMA Guides* provide some direction on what impairments can be used in combination. Lacking such guidance, it is necessary for the evaluating physician to exercise his or her judgment in avoiding duplication.”

One example would involve a single injury to the elbow and shoulder of the same arm resulting in muscle strength deficits – reduced strength of the elbow would probably overlap with reduced muscle strength in the shoulder. Notice here, that the 2005 PDRS refers to multiple impairments resulting from a single injury to the same region. It is doubtful that this rule in the 2005 PDRS would apply to impairments to different regions of the body from the same injury.

Therefore, it is an open question about whether duplication and overlap occur in *AMA Guides* cases. Defendants may want to make the medical-legal argument that there is overlap and duplication for impairments that occur within the same region like in spinal injury cases involving impairments to the cervical and lumbar spine caused by the same injury. Applicant’s counsel may argue that Labor Code Section 4664(c)(1) and (c)(2) already account for overlap and duplication as does the application of the Combined Values Chart.

However, in the example above involving the nurse, since the lumbar spinal injury and the cervical spinal injury occurred separately, ten years apart, there probably is no overlap or duplication unless it can be proven that the effects on the Applicant’s ADL functioning for each injury overlap in some manner. One can argue that ADL functioning is affected differently for a lumbar impairment than they are affected by a cervical spinal impairment.

GENETICS, RISK FACTORS AND APPORTIONMENT

By: Robert G. Rassp, Esq.

October 15, 2008

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In late May 2008, Congress passed and the President signed into law the landmark H.R. 493 Genetic Information Nondiscrimination Act of 2008 (nicknamed "GINA"). This act amends federal law including the Americans With Disabilities Act, Employment Retirement and Income Security Act of 1974, the Public Health Service Act, Internal Revenue Code of 1986 and the Social Security Act and prohibits discrimination on the basis of genetic information with respect to health insurance and employment.

Section 202(a) of GINA states, in relevant part as follows:

"Discrimination Based on Genetic Information – It shall be unlawful employment practice for an employer-

- (1) to fail or refuse to hire, or to discharge, any employee, or otherwise to discriminate against any employee with respect to the compensation, terms, conditions, or privileges of employment of the employee, because of genetic information with respect to the employee; or**
- (2) to limit, segregate, or classify the employees of the employer in any way that would deprive or tend to deprive any employee of employment opportunities or otherwise adversely affect the status of the employee, because of genetic information with respect to the employee.**

Section 202(b) of GINA states. in relevant part, as follows:

"Acquisition of Genetic Information – It shall be an unlawful employment practice for an employer to request, require, or purchase genetic information with respect to an employee or a family member of an employee, except..."

The exceptions pertain to inadvertent genetic information disclosed by the employee to the employer, genetic monitoring for hazardous exposures where required by federal or state occupational safety laws or for an employee's compliance with certification under the Family Medical Leave Act of 1993 (29 U.S.C. 2613) or state family and medical leave acts.

Genetic information is now protected health information under both federal and state laws and is strictly protected against disclosure for insurability, insurance premium calculations and for employment.

California law already has significant statutory protections against disclosure of genetic information for insurability, housing and employability. See especially California Civil Code Section 56.17 (penalties for unauthorized disclosure of genetic information); Government Code Sections 12926(h)(2)(A) and (B) and Section 12940(o) which are part of the Fair Employment and Housing Act, Government Code Section 6276.22 which is part of the Public Records Act; Insurance Code Sections 10123.35, 10140.1 and Health and Safety Code Section 1374.7(d) which all prohibit discrimination due to genetic information for the purpose of granting or denying group or individual health insurance coverage or establishing insurance premium rates.

Typical language in California law that defines "genetic information" or "genetic characteristics" that is prohibited from unauthorized disclosure is as follows:

"Any scientifically or medically identifiable gene or Chromosome or combination of alteration thereof, that is known to be a cause of a disease or disorder in a person or his or her offspring, or that is determined to be associated with a statistically increased risk of development of a disease or disorder, and that is presently not associated with any symptoms of any disease or disorder. Or

"Inherited characteristics that may derive from the individual or family member, that are known to be a cause of a disease or disorder in a person or his or her offspring, or that are determined to be associated with a statistically

increased risk of development of a disease or disorder, and that are presently not associated with any symptoms of any disease or disorder." See Health and Safety Code Section 1374.7.

An interesting aspect of the Federal GINA is the protections against discrimination on the basis of genetic information are applicable for individuals through the fourth degree of relatives while the protections under California law apply only to "offspring" which is to the first degree.

Current research is leading towards discovery of potential genetic links to many disorders and disease processes. The Human Genome Project (Human Genome Research Institute of the National Institutes of Health www.nih.gov.) is in the process of investigating many common medical conditions to search for genetic causes. However, there is a difference between a genetic characteristic or genetic information being a "risk factor" and being a direct cause of an medical condition or impairment.

Remember, a risk factor for anything is based upon a statistical probability and has nothing to do with predicting whether any given individual will develop a medical condition, disease process or pathology. A risk factor is not pathology and does not cause permanent impairment. See *American Airlines vs. WCAB (Milivojevich)* (2007) 72 Cal. Comp. Cases 1415 (W/D) (high cholesterol is a risk factor for stroke and heart disease but many people who have high cholesterol never develop heart disease or have a stroke; therefore apportionment to high cholesterol in a stroke case was not valid apportionment under the *Escobedo* case). For example, we know that the African American population has a higher incidence of hypertension than other racial groups. But that does not mean that a given person will in fact develop hypertension simply because his or her genetic characteristics include being African American.

There is some evidence that opioid addiction (heroin, vicodin, oxycontin, Davocet, Percocet, morphine, Methadone, hydrocodone etc.) or some people with alcohol dependency or addiction may have a genetic link because there seems to be increased probabilities that these conditions run in families along blood lines. Some mental illnesses such as some forms

of schizophrenia or depression also may have a genetic link. Science is able to identify some genetic abnormalities or “genetic markers” (called single nucleotide polymorphisms or “SNAPS”) or mutations in DNA that lead to a disease process or medical condition. If an industrial injury triggers or lights up a medical condition due to a genetic pre-disposition for that medical condition then causation of the injury may be in part due to genetic factors.

The slippery slope occurs when the legal analysis gets to the question of causation of any permanent impairment from that medical condition and whether an alleged genetic pre-disposition can cause part or all of an impairment rating if environmental factors such as a work injury lights up or causes that medical condition to manifest itself. Counsel is only too familiar with the legal argument that “but for the industrial injury the medical condition would not have developed as and when it did.” But science and medicine do not think that simplistically – remember, Chapter 2 of the *AMA Guides* advises that there are 12 different kinds of medical causation.

So the questions remain, can an employer contend in a workers’ compensation claim that an injured worker’s genetic characteristics or genetic information is a factor that causes the injury itself or contributes to a permanent impairment? Can an employer compel a genetic test to determine whether an employee who is claiming an industrial injury would have developed a medical condition anyways regardless of industrial exposures due to his or her genetic information or characteristics? Can an injured worker be compelled to disclose his or her family history of heart disease, hypertension or diabetes? Does such disclosure violate GINA or California law?

The answers to these questions depend upon the reliability of the evidence submitted to support a request to compel disclosure of such information and the reliability and validity that a particular medical condition even has a genetic factor causing the condition or the consequences of that condition. It is safe to say that there is reasonable discovery for a treating or evaluating physician to determine a person’s family history of disease or disability to rule in or rule out genetic information as a contributing factor to the cause of a disorder or

impairment from one. But it appears that actual genetic testing is out of the question unless and until a judge orders it.

However, answers to these questions get murkier when you deal with a specific medical condition for which there is a genetic pre-disposition but an industrial injury lights up that medical condition and but for the industrial exposure, the medical condition would not have occurred as and when it did. Case law will have to determine resolution of these issues. But a cautionary note is needed here - we know from our legal history that advances in science and medicine occur far quicker than advances in law. The law takes time to catch up with advances in science and medicine and how to deal with the legal consequences of scientific study and discovery. The courts have gradually come to realize the necessity of having advances in science and medicine correspond with advances in the law with legal standards changing as the scientific advances occur. See, for example, *Daubert vs. Merrill Dow Pharmaceuticals* (1993) 509 U.S. 579, 113 S. Ct. 2786, 125 L. Ed. 2d 469.

One of the first cases that addresses these issues is the recent Court of Appeal case *Vaira vs. WCAB* (2008) 72 Cal. Comp. Cases 1586 wherein the Court concluded that the WCAB cannot use risk factors of injury or age per se (osteoporosis in a 73 year old employee) in apportioning causation of disability or impairments. We look forward to further guidance from the courts as science and medicine also progresses.

Top 10 Mistakes in Medical Reports (and how to fix them):

By: Colleen S. Casey
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1. Misunderstanding Chapters 1 & 2 of the AMA Guides

Report Impairments from Entire Book:

Doctors must report ALL rateable impairments, even those beyond their specialty. Many physicians are unsure as to what authority they have to suggest that the IW has rateable impairments other than those they were assigned to rate. For instance, an orthopedic surgeon might recognize that an injured worker has a psychiatric compensable consequence to an industrial orthopedic injury. The physician should state this fact in his report and rate the additional impairment. If he is not qualified to rate the additional impairment, he should state that as well, so that the parties will be put on notice of this issue, and can make the necessary arrangements to have the impairment rated.

Page 18 of the AMA Guides directs the physicians to do this. "...if new diagnoses are discovered, the physician has a medical obligation to inform the requesting party and individual about the condition and recommend further medical treatment."

The most common "missed" industrial impairments are:

- Impairment of respiration
- Skin disorders & surgical scars
- Psych issues
- Eating disorders
- General deconditioning (weight gain or loss, decreased stamina/METS, hypertension, diabetes)
- Effects of medication (gastrointestinal injury, sexual dysfunction, sleep disorders)
- Heart & cardiovascular disease

Dr. Peau writes, "In terms of the left knee, he has a surgical scar with keloid formation. This scar is quite large and hypertrophic. It measures 1 cm wide and has an elevation of a few millimeters. It extends throughout the entire incision. Per Table 8-2, @ p.178, this scar should be classified as class 1, with a 5%WPI."

Whole Person Impairment (WPI) versus Permanent Disability (PD):

The AMA Guides defines “**whole person impairment**” (WPI) at page 603 as “Percentages that estimate the impact of the impairment on the individual’s overall ability to perform activities of daily living (ADLs), excluding work.” WPI is a **MEDICAL** determination that is made by the physician.

Once the physician has made a determination as to the “impairment standard” or WPI, that number is “then adjusted to account for diminished future earning capacity (DFEC), occupation and age at the time of injury to obtain a final permanent disability (PD) rating.” (2005 PDRS, Page 1-2) The determination of PD is a **LEGAL** determination, that is made by the trier of fact.

The following is an example of a rating formula can be found on page 1-9 of the 2005 PDRS:

15.01.02.02 – **8** – [5]10 – 470H – 13 – 11%

The bold number “**8**” is the WPI that is the medical determination by the physician. The other components of the rating formula are:

15.01.02.02	= Impairment # for cervical spine
[5]	= Future Earning Capacity (FEC) adjustment
10	= Rating after FEC adjustment
470	= Occupational group for furniture assembler
H	= Occupational variant
13	= Rating after occupational adjustment
11%	= Total WPI rating after adjustment for the worker at age 30

Use and Misuse of Clinical Judgment

Doctor Darcy writes, “**According to LC §4662(b), the loss of both hands or the use thereof shall be conclusively presumed to be 100% PD (permanent disability). Ms. Bennet’s injury to her cervical spine has caused debilitating bilateral radiculopathy to both upper extremities. Therefore, based on my clinical judgment, I would determine that she has essentially lost the use of both hands. Therefore by analogy to the condition which is presumed 100% under LC §4662(b), which is loss of use of both hands, Ms. Bennet should be considered 100% PD.**”

Physicians are instructed by the Guides to analogize to similar conditions when a particular impairment is not listed in the AMA Guides. In this case, Ms. Bennet’s injury is listed in the Guides, so the analogy by Dr. Darcy may not be accepted by the trier of fact, even though his use of clinical judgment is permitted under certain circumstances.

See the discussion of use of clinical judgment found at Page 1-4 of 2005 PDRS and page 11 of AMA Guides: “if an impairment based on an **objective medical condition is not addressed** by the AMA Guides, physicians should use clinical judgment, comparing measurable impairment resulting from the **unlisted** objective medical condition to measurable impairment resulting from similar objective medical conditions, with similar impairment of function in performing activities of daily living.” (Emphasis added.)

In Dr. Darcy’s case, since the Guides have already listed the rating for this upper extremity impairment, Dr. Darcy must follow the specified chart for that impairment, rather than relying on his own clinical judgment as to what rating he thinks would best fit this injured worker (IW).

2. **Doctor’s Rationale is Essential for Substantial Evidence**

EXAMPLE 1: Doctor Elijah writes, “Mr. Jones’ surgical hernia repair was successful, so I would place him in Class 1 at 2% WPI.”

It is essential for physicians to provide a basis and rationale for their conclusion. This is particularly true for sections of the AMA Guides that are subject to various interpretations. One example of this, is when punctuation is missing, such as from Table 6-9, at page 136. This table sets forth the criteria for rating hernias. However, the table is missing some commas. The table groups the criteria into three different classes of hernias, each with a different range of WPI as follows:

Class 1 - 0-9% WPI

Class 2 – 10-19% WPI

Class 3 – 20-30% WPI

There are 3 criteria for each class.

- a. Palpable defect
- b. Slight protrusion
- c. Level of discomfort affecting Activities of Daily Living (ADLs)

For the first 2 classes, the formula is a + b or c. Because of the missing punctuation, that formula is subject to 2 different interpretations:

1st way: (a + b) or c

2nd way: (a + b) or (a + c)

Some physicians follow the 1st approach. They find that in order to qualify for a Class 2 hernia rating 10-19% WPI, you need “a + b” (a palpable defect + a persistent

protrusion) **OR** you need **only** a “c” (frequent discomfort, precluding heavy lifting, but not hampering some activities of daily living).

Other physicians follow the 2nd interpretation and would require (a + b) or (a + c) to qualify for Class 1 (0-9%) or Class 2 (10-19%). Under this 2nd interpretation, the level of WPI rating would depend on the definition of "palpable defect."

It will be up to the trier of fact to determine which of the 2 interpretations is correct. Dr. Elijah only selected a WPI number from the chart. He did not address whether the injured worker had a palpable defect or slight protrusion. In addition, he did not state whether he considered those criteria in selecting that WPI number. Therefore, it will be impossible for the WCJ to determine whether the doctor has followed the selection criteria appropriately. On that basis, Dr. Elijah’s report cannot be considered substantial evidence.

EXAMPLE 2: Dr. Lucas writes, “**Mr. Fitzwilliam had an industrial injury resulting in a protruding disc at L5-S1 and takes Vicodin to relieve the pain. He reports sexual dysfunction, since both he and his wife are concerned with the possibility of re-injury in the course of fornication. Mr. Fitzwilliam has morning erections and nocturnal ejaculations, so the primary impediment here is the concern about re-injury. Decreased libido may also be a result of opiate use and is well documented in medical literature. Mr. Fitzwilliam’s injury can be rated using Table 7-5 at page 156. He would fall within Class I, with a 6% WPI.**”

Fear of re-injury or refraining from sex due to pain will not be adequate to rate an impairment per **Table 7-5** at page 156. But there are other ways to connect the dots, which Dr. Lucas should have used in this case. He should have focused on the IW’s use of Vicodin from the back injury, and other key data including:

- strength of the medication,
- the amount of medication used each day,
- that Mr. Fitzwilliam would have to continue this medicine therapy at least as far as the near future,
- that it was reasonably foreseeable that his sexual activity (and other ADLs) would be impacted in a similar manner for a considerable period of time, and
- He should have identified the medical literature that supports the theory that decreased libido may be caused by prolonged use of opiates

It would also be helpful to provide fact specific information such as, “prior to his industrial injury, Mr. Fitzwilliam and his wife had sex three times a week, now they are lucky if they have it once every few months or so.” Then, perhaps the 6% WPI in Class I may work with that explanation.

3. **Failing to Select the Correct # in a Class Range**

EXAMPLE 1: Doctor Lydia writes, "Mr. Wickham's pericardial heart disease would be rated using Table 3-10 at page 52 of the Guides. He has recovered from surgery to remove the thickened pericardium, but continues to have symptoms, despite drug therapy. Therefore he would fall within Class 2. I tried to compare him to the examples in the Guides to see where he would fit in that Class 2 range. Since he is worse than the worst Class 2 example, which is Example 3-38, and since that example gives an impairment rating of 20% to 29%, I would also give Mr. Wickham an impairment rating of 20% to 29%."

Physician must select a specific Whole Person Impairment (WPI), not a range, within a class. In this case, Dr Lydia must analyze the impact of the injury on Mr. Wickham's ADLs, and then determine where in the range of 20% to 29% his WPI would fall. For instance, if all of the ADLs are severely affected by the injury, the doctor may determine Mr. Wickham's injury to be at the top – 29% WPI.

ADLs are easy to remember with the acronym - CAN'T SSSSsleep:

- Communication
- Activity that's physical
- Nonspecialized hand activities
- Travel

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

EXAMPLE 2: Dr. Chris writes, "Mr. Michaels is a composite chemist. After recurrent skin rashes, itching and swelling, that were only symptomatic during the work week, he was tested for exposures to various chemicals at work. Patch testing with hydroxyl ethyl methacrylate showed a significant reaction at 48 hours. Although he does have a history of non-industrial eczema, it is clear that his exposure to chemicals at work is the cause of his current skin conditions. Therefore his impairment would fall in the middle of the Class 1 range per Table 8-2 at page 178 of the Guides, for a rating of 5%WPI."

Dr. Chris only provided a conclusion of 5% WPI, but no rationale for his conclusion. It would be helpful for him to explain his determination in more detail, using the criteria from **Table 8-2**. Dr. Chris should discuss the following criteria of the Class 1 range between 0-9% as it applies to Mr. Michael's impairment:

- Skin disorder signs and symptoms present or intermittently present
- Impact on activities of daily living
- May require treatment

4. Doctors must refer to Page or Table in the AMA Guides

EXAMPLE 1: Dr. Cutamin writes, "Officer Glen has an industrial heart condition which requires various medication including Coumadin. This condition should be rated at 10%WPI and is to be considered as a hematopoietic system impairment separate and in addition to his heart condition."

Or perhaps Dr. Cutamin is relying on the following passage at page 203 of the Guides, "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 (e.g. 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%."

Table 9-4 at page 203 may also be appropriate to use under the facts of this case.

EXAMPLE 2: Dr. de Bourgh states, "Ms. Hurst has no measurable hearing loss per Table 11-3 on page 250. However, she has complained of Tinnitus, (an unwanted sound, not based on external stimuli,) so I would give her 5% WPI for that."

Dr. de Bourgh is referring to page 246 of the Guides which state, "Tinnitus in the presence of unilateral or bilateral hearing impairment may impair speech discrimination. Therefore, add up to 5% for tinnitus in the presence of measurable hearing loss if the tinnitus impacts the ability to perform activities of daily living."

It's not clear if tinnitus may be rated as a stand-alone impairment, or if it must be ADDED to an existing impairment, such as is mandated for a pain add-on.

Dr. de Bourgh should clarify that Ms. Hurst **has an industrial injury** of hearing loss, but that the hearing impairment is not great enough at this point to be measurable per AMA Guides, **Table 11-3**. That way, the IW will be eligible for all medical treatment such as hearing aids to cure or relieve from the effects of the industrial injury, even though the impairment is not rateable under the AMA Guides.

EXAMPLE 3: Doctor Ishmael writes, "The difference in Ms. Smith's thigh circumference is 1.9 cm and therefore his injury would be a 2% whole person impairment(WPI)."

It is important for the doctor to designate the table, chart and page number from which they are selecting the Whole Person Impairment% (WPI%), so that the trier of fact is able to confirm that the doctor has interpreted the AMA Guides accurately.

Some doctors confuse **WPI%**, which is the rating for the **whole body**, with a Lower Extremity% (**LE**) rating or an Upper Extremity% (**UE**) rating, which is a rating for only **part** of the body.

A LE% must be multiplied by 40% to equal a WPI%.

An UE% must be multiplied by 60% to equal a WPI%.

The AMA Guides have provided conversion "Cheat Sheets" as follows:

Table 16-3 page 439 – Conversion chart for Upper Extremity% to WPI%

Table 17-3 page 527 – Conversion chart for Lower Extremity% to WPI%

Some tables, like **Table 17-5** at page 529 provide the WPI %, but other tables just give the UE% or LE%, and the doctors must do the WPI% calculation themselves. So it's easy to see why people might get confused, and forget to convert an UE% or a LE% to WPI%. In addition, still other tables give both ratings. The first number is the WPI% and next to the WPI%, the table provides the UE% or LE % in brackets.

Still **other** tables, like **Table 17-6** at page 530 give the correct LE%, but next to it, they have the **INCORRECT** WPI%. (There are over 300 clerical errors in the AMA Guides.) In the last column of **Table 17-6**, the Guides state for Leg Muscle Atrophy:

Impairment Degree	WPI% (LE%)
Mild (1-1.9cm)	1-2 (3-8)
Moderate (2-2.9cm)	3-4 (8-13)

It should read:

Impairment Degree	WPI% (LE%)
Mild (1-1.9cm)	1- <u>3</u> (3-8)
Moderate (2-2.9cm)	3- <u>5</u> (8-13)

If the doctor has not specified the Table used for the selection criteria, there is no way for the trier of fact to confirm whether the doctor has selected an incorrect WPI% from **Table 17-6** or the correct LE%.

In the case of Doctor Ishmael above, he has indicated that the difference in circumference is 1.9cm which would equal 8% LE impairment per **Table 17-6**, but the WPI% for that would equal 3% ($8\% \times 40\% = 3.2\%$). It would not equal 2% which is incorrectly indicated in **Table 17-6** and which Dr. Ishmael copied and incorrectly indicated in his report. Also, since he did not designate which table (and page number) he used, the trier of fact would have a very difficult time tracking down these items to determine whether the doctor's rating was correct.

5. Failing to adhere to AMA Guide criteria

Doctor Bingley writes, **“Given the extent of NSAID use by Mr. Collins to control the pain from his industrial injury, he has developed gastro esophageal reflux disease (GERD) which would place him in Class 2 of Table 6-3 (page 121). Mr. Collins' impairment would be 10%, at the lowest end of the range, rather than at the high end of that range, because he has no weight loss, which would be typical for a Class 2 patient. However, his symptoms severely impact his ADLs as explained on page 3 of this report, and medication is not entirely helpful in this regard.”**

Dr. Bingley is using **Table 6-3** at page 121 of the Guides to determine Mr. Collins impairment rating. **Table 6-3** sets forth the criteria for rating the upper digestive tract. This **Table 6-3** groups the criteria into four classes of digestive disease, each with a different range of WPI% as follows:

- Class 1 - 0-9% WPI
- Class 2 – 10-24% WPI
- Class 3 – 25- 49% WPI
- Class 4 – 50-75% WPI

In this case, the Injured worker (IW) takes NSAIDs to control pain for industrial orthopedic condition, which resulted in a compensable consequence of an ulcer, which would be rated per Table 6-3 as indicated by Dr. Bingley. However, according to **Table**

6-3, at page 121, the patient must have **three** criteria to be placed in Class 2 (10% - 24% WPI). In this case, Mr. Collins is missing criteria **#3**, “weight loss below desirable weight.” Doctor Bingley merely glosses over that missing criteria, and could result in his report not constituting substantial evidence.

6. Rating Without the Required Tests and Measurements

EXAMPLE 1:

Dr. Templeton’s report states in part, “**Ms. Elinor has a specific injury to the Lumbar Spine with unilateral dermatomal distribution sensory loss. According to Table 15-3, page 384, she would fit into the DRE III of 10 - 13%. I have requested an EMG to confirm the radiculopathy, but it has not been approved. Because the patient has recovered sufficiently to return to work w/o serious work restrictions and has done well with conservative measures, I would rate this patient as 10% WPI.**”

If we pull up Table 15-3, we see that Dr. Templeton has placed Ms. Elinor at the bottom of the DRE III Class for a 10% WPI. How did he get there?

First, he determined whether to use ROM method or the DRE method to measure her spinal impairment. Basically his decision was based on the IW’s radiculopathy. If it had been bilateral, he would have used ROM. But since it is unilateral, he used the DRE method.

Next, Dr. Templeton had to select whether the IW fell in DRE Class II or DRE Class III. Again, Dr. Templeton based his determination on radiculopathy. Since the IW has verified radiculopathy, (the IW’s radiculopathy follows the dermatomal nerve root pattern of Fig. 15.1 & 15.2 @ page 377,) he placed the IW in DRE class III. Dr. Templeton wanted to confirm that Ms. Elinor’s radiculopathy was verified with an EMG. But that request was denied. Regardless, the trier of fact most likely would find Dr. Templeton’s report to constitute substantial evidence, even without the EMG, since Dr. Templeton found verified radiculopathy based on a reasonable medical probability.

EXAMPLE 2:

Dr. Anders writes: “**Ms. Tensby suffered a slip and fall work-related injury to her lumbar spine. Based on Ms. Tensby’s MRI scan results, I have repeatedly requested an EMG study of the lower extremities to rule out any radiculopathy due to the disc protrusions and her complaints of left big toe numbness, however, this request was denied. I therefore rated Ms. Tensby’s impairment with the DRE method because there was a distinct injury and the injury can be well characterized by the DRE**

method. Ms. Tensby fits into DRE Category II, at Table 15-3, page 384, which equates to 5% WPI."

In the first example with Dr. Templeton, the fact that there was no EMG authorized will probably not cause Dr. Templeton report to be tossed as lacking substantial evidence, because Dr. Templeton found verified radiculopathy based on a reasonable medical probability. However, the same is not true in this case. Dr. Anders made it clear that he needed the EMG in order to make a determination on radiculopathy. Without the EMG, Dr. Anders was not able to make a determination of either verified or non-verified radiculopathy based on a reasonable medical probability. Since the selection of DRE category in this case is completely based on verification of the IW's radiculopathy, Dr. Anders report most likely would not be considered substantial evidence because there is no EMG. This is especially true, since Dr. Anders failed to explain why he chose Category II, and how the impact of the injury on the IW's ADLs placed Ms. Tensby at the bottom of the 5-8% WPI range.

EXAMPLE 3:

Doctor Orca writes,

<u>Lumbar Range of Motion (ROM)</u>	<u>Observed</u>	<u>Normal</u>
Flexion	60	60
Extension	60	60

Doctors must use **objective measurements, tests AND tools** as instructed by the Guides. Doctors in the past simply watched the patient's movements and "observed" Range of Motion (ROM). They did not use any **objective** tool of measurement to evaluate range of motion, except their eyes. This is the case with Dr. Orca in the above example. The Guides now prohibit "eyeballing" ROM. The Guides state on page 400, "...an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical, and inexpensive way." In any event, under the Guides, some form of accurate measurement device, aside from the physician's eyes, must be used for ROM testing.

Measuring Range of Motion (ROM) for spinal injuries is very complicated, but detailed instructions are provided on pages 402 to 403 of the Guides. The most common mistake made by doctors is that they take the average of three readings that they perform as the measurement to determine the impairment rating. Although the instructions indicate that doctors must **average three readings**, this is for reliability purposes only. If all three measurements do not fall within the larger of 5 degrees or 10% of the average, then the results must be disregarded as unreliable. (See #6 on page 403.) However, once the measurements are deemed to be credible and reliable, the instructions then state that the **maximum** motion is the one the doctor should select to determine the impairment rating. (See #7 on page 403.)

Also, many doctors **forget to ask the patient to warm up prior to ROM testing** which is required for a valid measurement. These warm up exercises are set forth in the last paragraph of page 399.

EXAMPLE 4:

Doctor Moby writes, "Finally, the carpal tunnel condition translates to 3% whole person impairment for each wrist, since I understand that's the maximum that can be given for carpal tunnel syndrome under the AMA Guides. I felt this qualifies for impairment because of the documented slowing of median nerve conduction on electrodiagnostic testing."

Doctor Moby's conclusion that there is a ratable impairment here is correct, because of the positive findings from the EMG. But under the AMA Guides, there is not a 3% WPI maximum stated for each wrist. In addition, the EMG is just one of the criteria necessary in order to rate a Carpal Tunnel Syndrome (CTS) condition. Doctor Moby also needs to perform motor (**Table 16-11**) deficit and sensory (**Table 16-10**) deficit testing. He needs to then specify what those measurements are in his report. Next, he must go through the selection process from the AMA Guides as set forth below, before he can arrive at an accurate rating of the injured worker.

There are three categories of CTS impairments stated on page 495 of the Guides.

1. Abnormal EMG + Sensory Deficit &/or Motor Deficits – This would indicate Median Nerve Damage. (A 1-3% pain add-on is permitted.)
2. Abnormal EMG + No Sensory Deficit &/or No motor deficits = 5% UE, (3% WPI) (No pain add on is allowed for this category.)
3. Normal EMG + Normal sensory &/or motor deficits = 0% WPI

Many doctors fail to perform the sensory and motor deficits tests because they do not realize they exist. They do not realize that they can rate the Median Nerve Damage, for CTS cases, so they still use grip loss, which is barred on page 508 (with exceptions on page 507 & 508). Grip loss is thought to be less accurate than other types of measurements. The rationale for this is that the injured workers' pain most likely would prevent maximum effort during the grip strength test.

Attorneys will most likely request a supplemental report from the physician if:

- A physician has not reviewed an EMG
- A physician has not performed appropriate testing for sensory or motor deficit
- A physician has selected 6% WPI because he was told the Guides state that is the maximum for bilateral CTS.

7. **Selecting measurement based on the outcome rather than the instructions of the Guides**

Dr. Austen states, "I'm using gait derangement to measure Mr. Darcy's knee impairment, because I understand that measurement gets a substantially higher earnings rating in the rating string, than if I used the AMA Charts for either arthritis or DBE."

Dr. Austen has a point. Under the 2005 PDRS, the FEC (future earning capacity adjustment) for the knee = 2 and for gait derangement, the FEC = 5 and would rate out as follows:

Knee 17.05.06.00 – 37 – [2] 42 – 214F – 42 = \$47,300

Gait 17.01.07.00 – 37 – [5] 47 – 214F – 47 = \$55,000

Under the proposed 2009 PDRS, the gap between the two FECs will be even wider, knee = 1, and gait derangement = 8 as follows:

Knee 17.05.06.00 – 37 – [1] 41 – 214F – 41 = \$45,760

Gait 17.01.07.00 – 37 – [8] 52 – 214F – 52 = \$63,195

However, this rating is obviously not based on empirical scientific measurements or the instructions of the AMA Guides. Therefore it would not constitute substantial evidence, and a trier of fact would not be able to rely on this rationale in an opinion on decision.

8. **Incorrectly Using Pain Add – on.**

Doctor Tashtego wrote, "Therefore, he would have 8% WPI for the right knee, but none for the left. However, the patient does have some discomfort with the left knee, and in my opinion a 3% impairment for pain on the left side would be considered reasonable."

The 1-3% pain "add on" may *only* be added to a body part that already has a ratable impairment. In this case, the only body part with a ratable impairment is the right knee. Therefore, that's the only body part eligible for a pain add-on. The doctor's 3% pain add on to the left knee with no impairment would not be valid.

Applicant's attorney might possibly take the deposition of Doctor Tashtego in this case, explain these rules, and then ask, "Didn't you really mean to add the 3% to the right knee?" IF the doctor says yes, the Defense attorney will then ask the doctor if that is true, then where in the IW's medical chart does he find the support for that. That is, where does the doctor note in any of his records or reports that the IW told him that his right LE is giving him more pain than would normally be expected with an injury like this.

In order to add on up to 3% for pain you need the following:

- Pain more severe than would be normal for this injury
- Pain is impacting Activities of Daily Living (ADL) severely
- Applicant is credible with regard to his/her claim of pain

9. **Incorrectly Rating “Brain Pain” - Headaches**

EXAMPLE 1:

Dr. Pemberley, a neurologist states, **“Ms. Annesley suffered a concussion, as well as injury to her left shoulder in her fall at work. She continues to present with symptoms of headaches, episodes of confusion, insomnia, chronic shoulder & neck pain and severe depression. The concussion has fully resolved, therefore, Ms. Annesley does not have any rateable WPI%.”**

The basis for rating muscle tension headaches as well as migraines can be found in Chapter 18, since headaches are acknowledged as a “well-established pain syndrome.” (page 571 – **Table 18-1**) However, if a 3% is allowed for muscle tension headaches, then you can not use an additional 1-3% add-on for other body parts for that same date of injury. The DEU would utilize a chapter 13 impairment number of 13.01.00.99 in the rating formula to rate headaches in this manner. For example, the following rating formula would be used to calculate a doctor’s impairment finding of 3% for headaches of a 40 year old pantry worker:

13.01.00.99 – 3 [6] – 4 – 322F – 4 – 4% WPI

Doctors have also been using **Table 13-11** at page 331 of the AMA Guides to rate headaches that are based on organic migraine symptoms, rather than simple muscle tension headaches. Depending on the level of the pain experienced by the IW and the impact of the headaches on the IW’s ADLs, the IW could get up to 35% WPI.

Dr. Pemberley should re-examine the IW to determine if her headaches would be considered a rateable impairment. She may also have some other rateable impairments as well.

EXAMPLE 2:

After Ms. Devonshire witnessed a co-worker being crushed to death by a toppled crane at work. Dr. Willoughby did a complete psych analysis of Ms. Devonshire and arrived at a GAF score of 46% WPI. He then added, **“I understand 3% for brain pain can be added at this point, so I would go ahead and do that. Ms. Devonshire**

now has frequent headaches, which she didn't have prior to her industrial injury. Because of acute bouts of depression, she has no interest in exercising and has gained a considerable amount of weight. So an extra 3% for pain seems *fair*."

Instead of using Chapter 14 of the AMA Guides, the PDRS instructs physicians to rate IW's psych impairment based on their GAF score. (See 2005 PDRS page 1-12.) So Dr. Willoughby did that part of the rating correctly. However, a pain add-on of 3% may only be added to a body part or organ. (See 2005 PDRS page 1-12.) So it's not clear that it is appropriate to add 3% to a psych injury. It should be noted, however, that the 3% WPI may be appropriate for headaches as a stand alone impairment as discussed above.

10. Misunderstanding How to Rate Side Affects from Medications

Dr Stubb writes, "**Relying on my clinical judgment, I have assigned this patient a 1%WPI add-on to his 8% WPI for the spine, based on the side affects from his meds.**"

In order to constitute substantial evidence on this issue, Dr Stubb should state the specific medication this patient is taking and how the medication is adversely affecting the patient's activities of daily living (ADLs). Dr. Stubb should also state where in the Guides he finds authority for his rating. (This impairment rating is to be distinguished from the 1-3% WPI add on for pain, which is discussed above.)

There are 3 types of ratings for side effects of medications:

- **WPI% for Getting Better:**

The first type can be found in Chapter 2 at page 20 of the Guides, where medication may cause a total remission of the injured worker's (IW's) condition. In those circumstances, the doctor may assign an impairment of between 1 to 3%... sort of a token prize for getting better. For instance, a physician might write, "IW has an UE injury and takes motrin & Norflex which allows him to return to work and function at his current level, so per page 20 of the Guides, I'd assign the IW a 3% WPI."

- **Impact on ADLs:**

The second type can be found at page 600 of the AMA Guides, which states, "Medication may impact the individual's signs, symptoms, and ability to function. The physician may choose to increase the impairment estimate by a small percentage (1% to 3%) to account for effects of treatment." **This condition appears to be the type of medication impact that Dr. Stubb is referencing.** Query as to whether this may constitute a stand-alone impairment?

- **Compensable Consequence:**

The third type is when medication taken for the industrial injury CAUSES a separate ratable industrial condition, such as liver disease, ulceration, GERD, brain dysfunction or kidney disease. In this type of situation, the underlying condition should be rated separately from the compensable injury caused by the medication.