Misconceptions in AMA Guides Rating

Presented by Disability Evaluation Unit
2019 DWC Conference

Misconception #1
Strength cannot be rated in the presence of pain or decreased motion

AMA Guides page 508

*Decreased strength cannot be rated in the presence of decreased motion, painful conditions...that prevent effective application of force in the region being evaluated*
**Misconception #1**

Strength cannot be rated in the presence of pain or decreased motion

Pain and decreased motion not an absolute preclusion from strength loss

Must contribute to the strength loss

Strength cannot be combined with other impairments unless due to different etiologic or patho-mechanical causes

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**Upper Extremity Strength loss**

If upper extremity strength loss used by physician

- Ask physician the cause of the strength loss
- Check to see if prohibited by AMA Guides page 508
- Check to see if strength loss has different cause if combined with other impairments
- Point out to physician
Occupation: Electrician
Age: 44 years

Right shoulder injury
Injured underwent rotator cuff repair.

Physician rated the following impairments:

25% strength deficit for all units of shoulder motion except internal and
external rotation which he gave a 10% strength deficit.

R Shoulder ROM
S: 20-0-120 F: 110-0-40 R: 50-0-30
Pain: 3 WP
Shoulder Motions

Flexion/Extension  
Abduction  
External/Internal Rotation

Shoulder Range of Motion

Extension 20 degrees
Flexion 120 degrees
Shoulder Range of Motion

Abduction 110 degrees

Adduction 40 degrees

Shoulder Range of Motion

External Rotation 50 degrees

Internal Rotation 30 degrees
Upper Extremity Strength Rating Example

Calculating shoulder ROM deficit

Flexion = 4 UE
Extension = 2 UE
Abduction = 3 UE
Adduction = 0 UE
Int Rotate = 4 UE
Ext Rotate = 1 UE
Total = 14 UE

<table>
<thead>
<tr>
<th>Joint Relative Value</th>
<th>Unit of Motion Relative Value</th>
<th>5%-25%*</th>
<th>30%-50%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder (60%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexion</td>
<td>24</td>
<td>1-6</td>
<td>7-12</td>
</tr>
<tr>
<td>Extension</td>
<td>6</td>
<td>0-2</td>
<td>2-3</td>
</tr>
<tr>
<td>Abduction</td>
<td>12</td>
<td>1-3</td>
<td>4-6</td>
</tr>
<tr>
<td>Adduction</td>
<td>6</td>
<td>0-2</td>
<td>2-3</td>
</tr>
<tr>
<td>Internal rotation</td>
<td>6</td>
<td>0-2</td>
<td>2-3</td>
</tr>
<tr>
<td>External rotation</td>
<td>6</td>
<td>0-2</td>
<td>2-3</td>
</tr>
<tr>
<td>Elbow (70%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexion</td>
<td>21</td>
<td>1-5</td>
<td>6-11</td>
</tr>
<tr>
<td>Extension</td>
<td>21</td>
<td>1-5</td>
<td>6-11</td>
</tr>
<tr>
<td>Pronation</td>
<td>14</td>
<td>1-4</td>
<td>4-7</td>
</tr>
<tr>
<td>Supination</td>
<td>14</td>
<td>1-4</td>
<td>4-7</td>
</tr>
</tbody>
</table>

* Use clinical judgment to select the appropriate percentage from the range of values shown for each severity grade.
* Complete range of motion against gravity only without resistance.
* Complete range of motion against gravity with some resistance.

Table 16-35 Impairment of the Upper Extremity Due to Strength Deficit From Musculoskeletal Disorders Based on Manual Muscle Testing of Individual Units of Motion of the Shoulder and Elbow

Derived from Sections 16-4 and Table 16-11 by G. deGroot Swanson, Grand Rapids, Michigan.
### Calculating shoulder strength deficit

<table>
<thead>
<tr>
<th>Movement</th>
<th>Max Value</th>
<th>Percentage</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexion</td>
<td>24</td>
<td>25%</td>
<td>6 UE</td>
</tr>
<tr>
<td>Extension</td>
<td>6</td>
<td>25%</td>
<td>2 UE</td>
</tr>
<tr>
<td>Abduction</td>
<td>12</td>
<td>25%</td>
<td>3 UE</td>
</tr>
<tr>
<td>Adduction</td>
<td>6</td>
<td>25%</td>
<td>2 UE</td>
</tr>
<tr>
<td>Int Rotate</td>
<td>6</td>
<td>10%</td>
<td>1 UE</td>
</tr>
<tr>
<td>Ext Rotate</td>
<td>6</td>
<td>10%</td>
<td>1 UE</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>15 UE</strong></td>
</tr>
</tbody>
</table>

**Upper Extremity Strength Rating Example**


Shoulder muscle strength: 15 UE

15 C 14 = 27 UE x .6 = 16 WP

DEU Consultative Rating Annotations

- Strength impairment cannot be rated in the presence of decreased motion or pain that prevents maximum application of force.

- Strength cannot be combined with other impairments unless due to different etiologic or pathomechanical cause.

When you receive the DEU consult rating what action do you take?

Misconception #2
Grip is a prescribed method for rating CTS

AMA Guides page 494

*In compression neuropathies, additional impairment values are not given for decreased grip strength*

AMA Guides page 508

*Motor weakness associated with disorders of the peripheral nerve system....are evaluated according to Section 16.5*
Rating Carpal Tunnel Syndrome

• AMA Tables 16-10, 16-11 and 16-15

• Physician identifies injured nerve and grades sensory and motor nerve deficit

• Maximum sensory and motor nerve values are multiplied by percentage nerve deficit

Carpal Tunnel Rating Example

• Secretary, 52 years old with carpal tunnel syndrome in right hand. Physician states 25% sensory deficit and 20% motor deficit of the median nerve.
Identify the Nerve and maximum sensory/motor impairments

<table>
<thead>
<tr>
<th>Nerve</th>
<th>Sensory Deficit or Pain</th>
<th>Motor Deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pectoralis (medial and lateral)</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Axillary</td>
<td>5</td>
<td>35</td>
</tr>
<tr>
<td>Dorsal scapular</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Long thoracic</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Medial antebrachial cutaneous</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Medial brachial cutaneous</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Median (above midforearm)</td>
<td>39</td>
<td>44</td>
</tr>
<tr>
<td>Median (anterior interosseous branch)</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Median (below midforearm)</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>Radial palmar digital of thumb</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Ulnar palmar digital of thumb</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Radial palmar digital of index finger</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Ulnar palmar digital of index finger</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Radial palmar digital of middle finger</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Ulnar palmar digital of middle finger</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Radial palmar digital of ring finger</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Musculocutaneous</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Radial upper arm with loss of triceps</td>
<td>5</td>
<td>42</td>
</tr>
<tr>
<td>Radial elbow with sparing of triceps</td>
<td>5</td>
<td>35</td>
</tr>
</tbody>
</table>

Grade the Nerve using Tables 16-10 and 16-11

25%  
20%
Carpal Tunnel Rating Example

Multiply maximum nerve values by nerve deficit
Combine sensory and motor impairments and convert to WP

- Sensory, Grade 4 – 25% deficit
  \[39 \text{ UE} \times 25\% = 10 \text{ UE}\]
- Motor, Grade 4 – 20% deficit
  \[10 \text{ UE} \times 20\% = 2 \text{ UE}\]

Combine sensory and motor impairments and convert to WP
\[10 \text{ C 2} = 12 \text{ UE} \times 0.6 = 7 \text{ WP}\]
\[16.01.02.02 – 7 – [1.4]10 – 112H – 13 – 16 \text{ Final PD}\]

Misconception #3
The existence of pain qualifies for a pain add-on

AMA Guides page 10
*Impairment ratings in the Guides already have accounted for commonly associated pain*

PDRS 1-12
*Impairment rating based on AMA Guides chapters 3-17 may be increased up to 3% WPI if the burden of the worker’s condition has been increased by pain-related impairment in excess of the pain component already incorporated in the WPI rating.*
Pain add-on

- Must have excess pain
- Pain must increased the burden of the injured worker’s condition
- WPI reflects difficulty with ADL so the burden of IW condition likely related to ADL difficulty
- Physician determines normal of expected pain (AMA Guides page 566)
- Remember: Maximum 3 WP pain add-on per injury and no pain add-on to 0 WPI in a strict AMA Guides rating.

Misconception #4

The Combined Values Chart is used to eliminate overlap

- The AMA Guides handles overlap between two impairments by not rating one of the impairments

- Examples
  - Lower extremity combining Table 17-5
  - When both DRE and Rom spine impairments apply – rate the highest
  - If strength caused by pain or decreased motion, it is not rated
  - Arthroplasty not combined with instability or subluxation
Misconception #5
The sole purpose of the Combined Values Chart is to assure that values do not exceed 100%

AMA Guides page 9

*A standard formula was used to ensure that regardless of the number impairments, the summary value would not exceed 100% of the whole person*

This is one purpose of the CVC, but not the whole story

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The Combined Values Chart

- \[ A + (100 - A) \times B \]

- Combined Values Chart applies compaction

AMA Guides page 438

*The method for combining various impairments is based on the principle that a second and each succeeding impairment do not apply to the unit as a whole, but only to the part that remains.*
Combined Values Chart

Three Fold Purpose

1) To obtain a summary value for multiple impairments/disabilities
2) To ensure values do not go over 100%
3) To apply compaction

Misconception #6
It is impossible to obtain a 100% value using the Combined Values Chart

- There are 104 combined values of 100 on the CVC
- It is not impossible, but it is very difficult

Examples
50 C 50 = 75
97 C 71 = 99
Misconception #7
No need to obtain a standard AMA Guides rating with Almaraz/Guzman

- Almaraz/Guzman states strict AMA guides rating is rebuttable
- Allows physician to provide an accurate rating by using the four corners of the AMA Guides
- Without obtaining a standard AMA Guides rating, how does one know if it is not accurate?
- At very least, not providing a standard AMA guides rating weakens the rationale for the Almaraz/Guzman rating

Misconception #8
A half value is given for a partial knee replacement

- Knee replacements rated per Table 17-33
- Points assigned per table 17-35 to determine good, fair or poor result
- No provision to give lessor value for partial knee replacement
- Physician should determine result and assign impairment per AMA guides
- Could consider reduced impairment value per Almaraz/Guzman
Misconception #9
Spine imaging studies alone establish impairment

- Imaging Studies – MRI, CT scan, x-rays
- AMA Guides page 378

An imaging test alone is insufficient to qualify for a DRE category

To be of diagnostic value, clinical symptoms and signs must agree with the imaging findings

Verification of radiculopathy requires both radicular symptoms and a positive imaging study (or EMG)

An imaging study can verify radiculopathy which affects an impairment rating

An imaging study that verified multiple levels of radicular symptoms or multiple levels of fracture could qualify case for spine ROM method
Spine Rating Example #1

- Lumbar injury
- No radicular symptoms, muscle guarding or fracture
- Imaging studies show disc bulge at L4-5
- What is the impairment rating?
  DRE I -0 WP

Misconception #10
Spine ROM measurements alone can be used to rate impairment

- Spine ROM impairment is one of three components of the spine ROM method
- ROM method includes diagnostic, ROM and spinal nerve root impairments
- The criteria for ROM method must be met or the DRE method would be applicable
Spine Rating Example #2

• Physician finds degenerative disk bulging at L2-3, L3-4, L4-5 and L5-S1 following lumbar injury

• On physical examination IW has muscle guarding and significant reduced motion

• Physician determines that the ROM method applies based on multiple levels of positive imaging finding

• Physician assigns a 14 WP impairment based on the lumbar ROM for flexion, extension, left and right lateral bending

Is the ROM method applicable?

No, there is no multi-level radiculopathy, surgery, and fracture to qualify to ROM method

What appears to be the correct impairment rating?

Lumbar DRE II 5-8 WP impairment based on muscle guarding
Misconception #11
An effects of medication can be given for just taking medication

• Use when “Pharmaceuticals themselves may lead to an impairment” – AMA Guides page 20

• Side effects of medication may be given a 1-3 WPI

• Sides effects of medication may also be rated using the appropriate AMA Guides table

• Example: Anti-inflammatories that cause an upper digestive impairment

Effects of Anti-Coagulants

• Impairment with acquired blood clotting defects is 0-10 WP – AMA Guides page 203

• Long-term anti-coagulation with warfarin increases bleeding risk and constitutes impairment in the 10% range – AMA Guides page 207
Effects of Anti-Coagulants

- Police Officer Age 55
- Coronary Heart Disease Class 3: 35 WP

\[03.02.00.00 - 35 - [1.4]49 - 490I - 58 - 64 PD\]

Place on warfarin, could rate:

\[09.01.00.00 - 10 - [1.4]14 - 490F - 14 - 16 PD\]

Misconception #12

Gait impairment is only rated when there are no other impairments

*Whenever possible, the evaluator should use a more specific method*

-AMA Guides page 529

However Example 17-2 allows gait to accurately rate the condition even though a more specific impairment was available.
Gait Impairment Limitations

- Should not apply to subjective factors
- Shoulder be supported by pathologic finding such as x-rays
- Table 17-5 lists moderate to advanced arthritis as documentation for a mild gait impairment

Misconception #13
It is easy to get LC 4664 Apportionment

- Conclusive presumption of prior disability award
- Per Kopping appellate decision
  1) Must prove existence of award
  2) Must prove existence overlap between current disability and disability from prior award
LC4664 Limitations

• Cannot obtain LC4664 apportionment when different schedules are used

• The same metric must be used in determining disability from prior award and current disability

Apportioning DRE from ROM Impairment

Hom Panel Decision ADJ10658104

• Prior award of 20 PD based on DRE III 10 WP impairment

• Current disability of 30 PD based on spine ROM method impairment rating

• Apportionment disallowed since based on different metrics
LC 4664 Apportionment

• Check to see if metrics the same

• Is not, is it possible for rating on prior award to be derived based on metrics for current impairment?

• Make sure the physician applies LC4663 apportionment

Misconception #14

It is always a good strategy to cross examine the DEU rater

• Raters are cross examined from formal rating instructions

• Formal ratings take place after trials

• Raters are just following the formal instructions

• Judges pull instructions from medical reports

• WP impairments originate from physicians
Misconception #14

It is always a good strategy to cross examine the DEU rater

• Most rating issues are with the instructions

• Rating issues often relate to how physician addressed impairment

A better strategy

1) Obtain consult rating from DEU to obtain disability level and identify rating issues

2) Follow up with physician to clarify rating issues

Misconception #15

It is impossible to get a rating from DEU

• Use correct forms
  ➢ DEU 100, 101 and coversheets for summary QME rating
  ➢ DEU 102 and coversheets for summary treating physician rating
  ➢ DEU 104 and coversheets for consultative rating
  ➢ Commutation request form for commutations (do not efile)

• DEU backlogs are down

• Let me know if there is a problem in your area
Questions???