Washington Claims School

Presented by Reinisch Wilson Weier PC

June 14, 2017 Lake Oswego, Oregon

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Impairment Rating - How to begin to know, what you don't know, about the AMA Guides, 5th Edition

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Washington Claims School

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PANEL OF CONSULTANTS

How to Begin to know, what you Need to know, about the AMA Guides 5th Edition

An Introduction

Sponsor: Panel of Consultants
Speaker: Irene Suver

Our Objectives

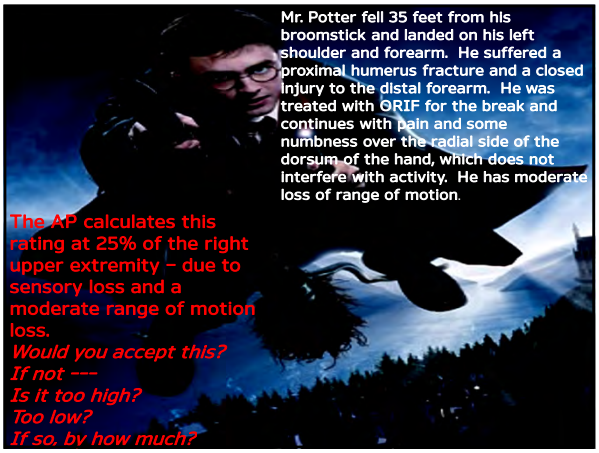
- *Understanding the stakes*
- *Demystifying the process*
- *Empowering you to act*
- *Encouraging you to learn*

"I can tell when a rating isn't right!"

Do you read a rating in a report and decide if it ***looks*** right?

How good do you think you are?

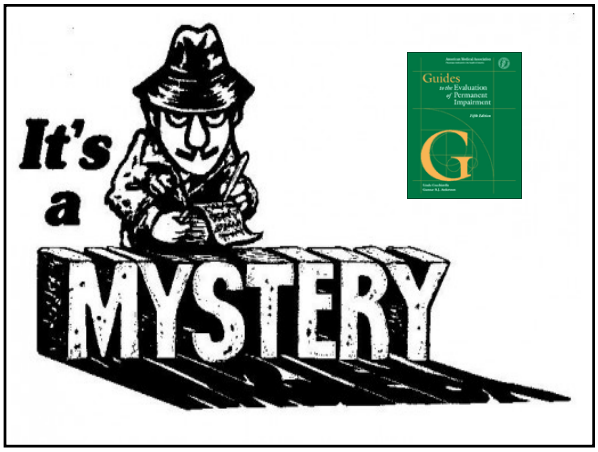
Let's find out.



Elbow

- Professor Dumbledore has developed elbow tendonitis in his wand (right) arm from excessive charm casting and horcrux destruction. He is six months from his report of injury and feels much better.

The AP calculates this rating at 7% of the right upper extremity.
Would you accept this?
If not ….
Is it too high?
Too low?
If so, by how much?



No.

It

Is

NOT.

- The AMA *Guides* are for *everyone,* **not just doctors**. "If the clinical findings are fully described, **any knowledgeable observer** (***this means YOU!!)*** may check the findings with the *Guides* criteria." (page 17)
- Therefore, **you** should always be able to "proof" a rating from the examination and report.
- Once **you** know how to use the *Guides,* **you** will **always** be able to tell if a rating is **correct** – ***and because it is correct, it is fair – to the worker, the employer and the insurer.***
- A ten minute proof can **make sure that happens**. (And isn't that worth it?)

WHAT's a "Proof"?

- A rating proof is:
  - Taking the **findings** of the physical examination
  - Follow the **step by step** instructions in the *Guides*
  - **Determine** the rating
  - **Compare** your rating against the impairment rating provided by the rating examiner(s).
  - This ensures that all the findings necessary to provide a rating are present AND that all the steps for correctly determining the rating (clinical and mathematical) were followed.
- ***You should always be able to "proof a rating".***
- **Always. No exceptions.**

WHEN should I proof a rating?

- ***Every rating every time.***
- No one is perfect; even the best trained, most conscientious, physicians and QA departments make errors; we'd like to say were perfect, we're not.
- The more you do, the better you will become. This may take you 5-10 minutes each time you do it at first, but with practice, the simplest ones will be a matter of seconds.

WHY should *I* proof a rating?

Because …

On a more-probable-than-not basis ----

NO ONE ELSE HAS!

And…

NO ONE ELSE WILL!

But Doctors Know Best!

- ***Really? Sure of that, are you?***
- Physicians get **no training whatsoever** in medical school with the *Guides*.
- It's an expensive book; many physicians do not bother to buy it; or own an older edition – very few subscribe to the *Guides Newsletter,* or review and understand the extensive *errata*.
- Not only are the *Guides* expensive, it requires training to understand how to perform ratings; (some) panel examiners are trained (constantly) and still make errors. (We'd love to promise that we catch them ***all,*** but **no one is perfect!** – another reason for YOU to learn!)
- Even when trained, missing a step (adding instead of combining, for example) or making a simple math error can really throw the final rating off! **Everyone makes mistakes!**
- Given that many ratings are performed under the WAC Category system, where they get to "pick" a Category Rating (frequently with little rationale), physicians "pick a number" they *think is right or fair* based on the their "best clinical judgement".

$1,992.00(app) x (3) x 80 =

$478,080.00

- In California, it has been demonstrated that 80% of all PPD ratings contain an error.
- Let's assume that 80% of all Washington upper extremity ratings contain a 2-5% error *(our observed error rate – we picked 3 as a nice middle number).*
- Assume one hundred PPD cases; 80% gives you 80 cases.
- Ask yourself how much that is costing you.
- (Put your head down for a moment, you'll feel better).

Ok. Where do I Start?

- Buy your very own copy of the *Guides*

(Yes, Virginia, it's really worth it – about $189.00)

DON'T READ IT – (*really, don't!*)

It's a recipe book , not a novel!

- **Start by** reading **Chapter 1 and Chapter 2** (learn the cuisine) This gives you the principles of the Guides
- Read the **Introduction** to the Chapter you need like "Upper Extremities" (This will teach you how to read the recipes)

AND

- Read the section at the end of each chapter – "Summary Steps for Calculating Impairment --- often there are helpful forms there as well!

Everyone's SECOND Book!

- The State of Washington, Department of Labor & Industries *Medical Examiner's Handbook.*
- http://www.lni.wa.gov/IPUB/252-001-000.pdf

  Or Google "L&I Medical Examiner's Handbook"
- **This is a new edition as of November, 2015.**
- The handbook details the obligations of the IME examiner and what must be included in any rating report, no matter who does it. Pay particular attention to Chapter 12, Impairment Rating. There are invaluable tools for you to reference when confronted with a substandard rating report.
- **You should never order or read an IME without being familiar with the *Handbook.***

The Guides and its Authors

- Each chapter was written by a separate committee
- There are 18 chapters, 17 of which we use (the pain chapter is excluded in Washington)
- Chapters were added as they were submitted (really).
- Principles **DO NOT** "travel between chapters" – what's good for rating the upper extremities **DOES NOT APPLY** to any other body part. Upper and lower extremities are **NOT** the same. A good example of this is CRPS which is treated differently in the upper and lower extremity chapters AND in the neurology chapter!
- Each section has its own rules and instructions (different "recipes"); but each is grounded in basic concepts (or a combination of these concepts). These are introduced in Chapters 1 and 2.

Basic Concepts

Disability vs. Impairment

- The *Guides to the Evaluation of Permanent Impairment* reflect the degree to which a medical condition decreases an individual's ability to perform the **Activities of Daily Living**
  - **Excluding Work (page 4)**
- The Guides are **not intended** to be used for direct estimates of work disability. (page 9)
- The complexity of work activities requires **individual** analyses. Impairment assessment is a necessary ***first*** *step* for determining disability. (page 13).

Basic Concept

What are the "Activities of Daily Living"?

Table 1-2, page 7

1. **Self-care & personal hygiene**: Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating.
2. **Communication**: Writing, typing, seeing, hearing, speaking
3. **Physical Activity**: Standing, sitting, reclining, walking, climbing stairs
4. **Sensory Function**: hearing, seeing, tactile feeing, tasting, smelling
5. **Nonspecialized hand activities**: Grasping, lifting, tactile discrimination
6. **Travel**: Riding, driving, flying
7. **Sexual Function**: Orgasm, ejaculation, lubrication, erection
8. **Sleep**: Restful, nocturnal sleep pattern

What you sometimes (okay, usually) see …

- The current level of permanent impairment, regarding the right upper extremity, would be thirteen (13%) percent, and this is based on loss of range of motion of the right shoulder in various planes, and the Mumford procedure, as described above.

What's missing …

- *A statement of maximum medical improvement (**or** "fixed and stable") …. Something like this.*
- *(At the very LEAST.)*
- "The accepted conditions have reached maximum medical improvement."

Without a statement of MMI

The
Rating
Is
NOT
VALID.
Period.

Then … (REQUIRED)

Both the AMA *Guides* (all of them) and the *Medical Examiner's handbook* ***REQUIRE:***

- ***The Guides***
  - 2.6c. (page 22) **Discuss How the Impairment Rating was Calculated**
  - **2.6c.1** Include an explanation of each impairment value with reference to the applicable criteria of the Guides.
  - **2.6c.1** Include a summary list of impairments by percentage.
  - The "sample report" on page 24, specifically notes that Chapter and Table numbers **must be cited.**
- ***The Medical Examiner's Handbook***
  - **Rationale**: The rationale for the rating system is one of the most important parts of the rating report. The rationale must be supported by specific references to the clinical findings, especially objective findings and supporting documentation, **including the specific rating system, tables, figures and page numbers on which the rating was based.** The rationale must **restate all objective findings.** (WAC 296-20-2010 & WAC 296-23-377) **IMPORTANT NOTE: Be sure to attach worksheets used to formulate the rating so readers easily understand your methods. For example, the upper extremity worksheet on pages 436-437 of the AMA *Guides*, Fifth Edition is especially important.**

At the very, very least …

- The current level of permanent impairment, regarding the right upper extremity, would be thirteen (13%) percent, and this is based on loss of range of motion, per Figure 16-40 page 476; Figure 16-43 page 477, Figure 16-46 Table 479 and the Mumford procedure Table 16-27 page 506.
- This approach is ASS-U-MING you know how to use these tables and what do once you have the numbers.

There is a right way …

- *Per the AMA Guides to the Evaluation of Permanent Impairment, fifth edition, Chapter 16.4i, , there is a total of thirteen percent (13%) impairment of the right upper extremity calculated as follows:*

RIGHT	Best Measurement	Impairment	Figure & Page
Flexion	170°	1%	16-40 Page 476
Extension	50°	0%	16-40 Page 476
Adduction	40°	0%	16-43 Page 477
Abduction	170°	0%	16-43 Page 477
Internal Rotation	60°	2%	16-46 Page 479
External Rotation	70°	0%	16-46 Page 479

Per the instructions in Chapter 16.4i, Upper Extremities: Shoulder Motion Impairment: Flexion and Extension, page 475, these impairments are added as follows:

- Flexion and Extension: 1% + 0% = 1%

Per the instructions in Chapter 16.4i, Upper Extremities: Shoulder Motion Impairment: Abduction and Adduction, page 476, these impairments are added as follows:

- Abduction and Adduction: 0% + 0% = 0%

Per the instructions in Chapter 16.4i, Upper Extremities: Shoulder Motion Impairment: Internal and External Rotation, page 478, these impairments are added as follows:

- Internal Rotation and External Rotation 2% + 0% = 2%

Per the instructions in chapter 16.4i Upper Extremities: Determining Impairment Due to Abnormal Shoulder Motion, page 479, the regional impairment of the upper extremity due to loss of shoulder motion is obtained by adding the unit impairments as follows:

- 1% + 0% + 2% = 3%

There is, therefore, a total of three percent (3%) permanent impairment of the right upper extremity, per the AMA Guides to the Evaluation of Permanent Impairment, fifth edition, for loss of right shoulder range of motion.

An excision of the acromioclavicular joint, was performed, rated as follows:
Per Table 16-27 Impairment of the Upper Extremity After Arthroplasty of Specific Bones or Joints, page 506:

- Total shoulder, Distal Clavicle, (isolated) Resection Arthroplasty, equates to 10% impairment

There is, therefore, ten percent (10%) impairment of the right upper extremity secondary to the July 26, 2016, distal clavicle excision.

Per the instructions in Chapter 16.9, Summary of Steps for Evaluating Impairments of the Upper Extremity, pages 511 and 512, Sections II, VI, and VII, these impairments are combined per the Combined Values Chart on page 604, as follows:

- 3% (loss of range of motion) combined with 10% (distal clavicle excision) equates to 13% impairment.

There is, therefore, thirteen percent (13%) impairment of the right upper extremity related to the injury under review.

However … usually…

- You won't get that kind of help.
- So you need to know how to take the, ahem, "short" approach **and check it**.
- First, let's look at the rules and tools the Guides give you.

Basic Concept
REPRODUCABILITY

- Two measurements made by the same examiner using the *Guides* .. **Would be consistent if they fall within 10% of each other**.
- **Two** physicians following the methods of the *Guides* to evaluate the same patient **should report similar results and reach similar conclusions.**

[page 20]

CRITICAL CONCEPT

Calculation Tools

- There are six tools for calculating impairment.
- To ***Add***, means simple addition.
- To ***Multiply***, means simple multiplication.
- To ***Average***, means mathematical average
- To ***Combine*** means to use the Combined Values Chart on **pages 604 & 605** of the Guides. "**combine**" and "**add**" are NOT the same!
- To ***Convert*** means to use a conversion table to convert the impairment for one body part(a finger) to another body part (the hand) in order to obtain the final rating, (the upper extremity).
- To ***Interpolate*** means to mathematically calculate values that fall between actual measurements.

WARNING!

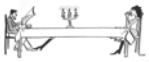
- *Adding, multiplying, averaging, combining, converting and interpolating are used as follows:*
  - ***READ** THE RECIPE (the instructions in the relevant chapter)*
  - ***UTILIZE** the Tables, Figures and Charts to determine values*
  - *Interpolate, Add, Multiply, Average, Combine and Convert AS INSTRUCTED in the recipe.*
- ***THE MOST COMMON MISTAKE IN RATING** is to "get lazy" and pick numbers out of tables and figures without CHECKING about HOW they are utilized to determine a rating. ALWAYS READ the Chapter and Check the Summary of Steps at the end of each chapter!*

CRITICAL CONCEPT

Tables, Figures and Charts

- You will be using the following tools:
  - Tables (no pictures)
  - Figures (with pictures, even just pictures with numbers)
  - Charts (Primarily the Combined Values Chart)
- Be sure you are utilizing the right tool; one of the easiest mistakes to make is fall into the error made by the physician; noting a table as a chart and vice-versa.

Tables



- Tables tend to work directly, that is, pick a number or diagnosis and select a percentage or conversion of a percentage directly from the table. (There are more Figures than Tables)
  - Surgical procedures
  - Conversion tables
  - Degree of Severity tables (mild, moderate, severe, etc.)
  - Ratings involving "Classes" of impairments

Table 16-27

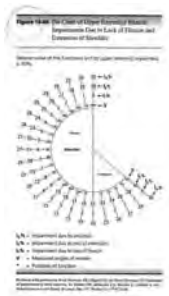
Impairment of the Upper Extremity After Arthroplasty of Specific Bones or Joints.

Figures

- Figures tend to fall into two categories
  - Instructions to physicians, for example Figure 16-9, which shows the dermatomes of the upper limb (page 490)
  - Range of Motion Figures, which are "picture-wheels" of differing measured angles and their corresponding impairments.

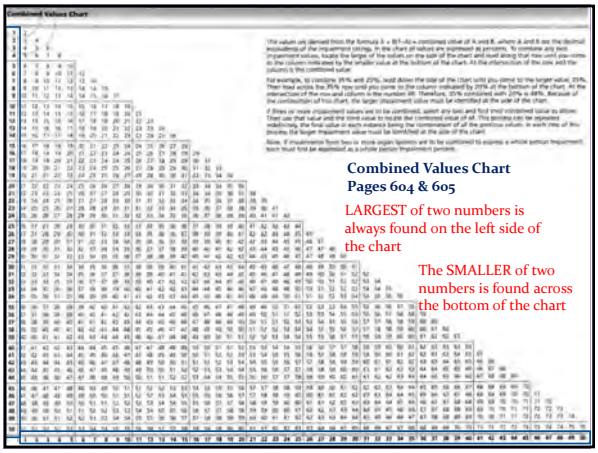
Range of Motion Figure 16-40

Pie Chart of Upper Extremity Motion Impairments Due to Lack of Flexion and Extension of Shoulder



The Combined Values Chart & "Combining"

- ALWAYS used when directions tell you to "combine"
- Pages 604 & 605
- Calculation of multiple impairments are made from the smallest to the largest (walk UP the stairs).
  - NOTE this is actually **WRONG**, in all other versions of the Guides AND on the worksheets, it is from largest to smallest; however, there has never been a correction in the *Guides Newsletter,* nor in the published errata, nor a correction in reprinting; therefore, since the book directs you to work from the smallest to largest, we recommend doing what is still in print. It must be noted that in multiple impairments this **CAN CHANGE** the impairment rating, not always, but occasionally.
  - See the Discussion of philosophy in Chapter 1.4, page 9



Three Types of Ratings

- **DBE (Diagnosis Based Estimates)** – Pick a diagnosis get a rating. (*This is actually the principle on which the entire sixth edition is based).*
- **ROM (Range of Motion)** This is for shoulders, elbows, wrists, hands, fingers, hips, knees, ankles, feet and toes. Basically, motion is measured and values derived from charts.
- **DRE (Diagnosis Related Estimates)** This is the remainder of ratings. The physician utilizes the physical examination findings and then calculates the rating based on a formula described in the chapter.

DIAGNOSIS BASED ESTIMATES

Page 506

Table 16-27

Find the level of arthroplasty

Find the Type of arthroplasty

The rating is at the intersection line of the two.

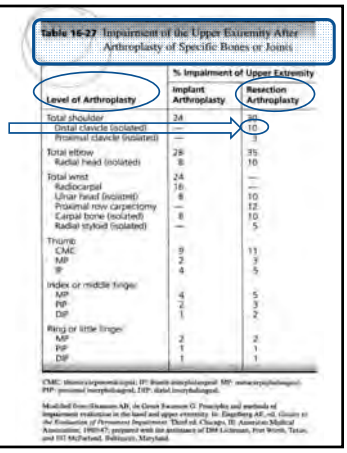


Table 16-27 Impairment of the Upper Extremity After Arthroplasty of Specific Bones or Joints

Level of Arthroplasty	% Impairment of Upper Extremity: Implant Arthroplasty	Resection Arthroplasty
Total shoulder	24	30
Distal clavicle (isolated)	—	10
Proximal clavicle (isolated)	—	3
Total elbow	28	35
Radial head (isolated)	8	10
Total wrist	24	—
Radiocarpal	16	—
Ulnar head (isolated)	8	10
Proximal row carpectomy	—	12
Carpal bone (isolated)	8	10
Radial styloid (isolated)	—	5
Thumb		
CMC	9	11
MP	2	3
IP	4	5
Index or middle finger		
MP	4	5
PIP	2	3
DIP	1	2
Ring or little finger		
MP	2	2
PIP	1	1
DIP	1	1

CMC: thumb carpometacarpal; IP: thumb interphalangeal; MP: metacarpophalangeal; PIP: proximal interphalangeal; DIP: distal interphalangeal.

Modified from Chamay AR, de Groot Swanson G: Principles and methods of impairment evaluation in the hand and upper extremity. In: Engelberg AF, ed. Guides to the Evaluation of Permanent Impairment. Third ed. Chicago, IL: American Medical Association, 1993:47; prepared with the assistance of Dirk Lichtman, Fort Worth, Texas, and Hil McFarland, Baltimore, Maryland.

RANGE OF MOTION

How to Read a Range of Motion Pie Chart

Shoulder Flexion & Extension
Figure 16-40, Page 476.

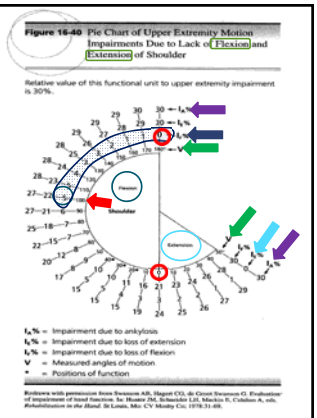
The range of motion pie charts are easy to read. First, be sure you know what the pie chart measures.

Flexion & **Extension**
You will note there are four rings on the wheel from inside out they are:

- V (Measured angle of Motion) (What the doctor measures)
- I_F (Impairment due to loss of flexion)
- I_E (Impairment due to loss of extension)
- I_A (Impairment due to Ankylosis (fusion)

To find an impairment, first find the motion you are looking for. Then, the measured angle of motion. In this case, 100° of flexion.

The impairment is the intersection on the I_F line where 100° of flexion bisects the chart.



Startling Fact !

Every Human has …

TWO Sides!

CRITICAL CONCEPT

Contralateral Baseline

- *"If a contralateral 'normal' joint has less than average mobility,* the impairment value(s) corresponding to the uninvolved joint **can serve** as a baseline ***and are subtracted*** from the calculated impairment for the involved joint." (page 453, column 2, paragraph 2; see also page 451 column 11, second sentence)

DIAGNOSIS RELATED ESTIMATES

Diagnosis Related Estimates

- **Sensory & Motor (Neurology Impairments)** These are DRE or "diagnosis related estimates"
- Nervous system impairments are calculated from a formula:
  - **(maximum percentage impairment for the nerve times the percentage of sensory deficit within the selected grade equals total impairment).**
    - **x% x y% = z%**
- There is physician judgement in the entirety of the neurology sections of the Guides, but this judgement still must be supported by the **objective findings.**

NEUROLOGY
What YOU must KNOW

- What is the NERVE STRUCTURE INVOLVED
- What is the MAXIMUM IMPAIRMENT VALUE for that nerve?
- How **SEVERE** is the impairment (Description of Sensory Deficit or Pain)

*You must know these three things before you start – if you don't – don't even **BEGIN**.*

BASIC CONCEPTS

- You must be able, from the examination, to identify **the nerve involved** (Table 16-35) **AND**
- The severity of that involvement (Table 16-10, Sensory & Table 16-11 Motor).
- This is then **MATHEMATICALLY CALCULATED** AS FOLLOWS:
- (maximum value of the nerve%) x (severity of involvement%) = rating%
- 5% x 25% = 1.25% or 1% **NOT** five percent (which is what happens when you "pick" the full value of the nerve!)

MY PERSONAL PET PEEVES

"I have some pet peeves we need to discuss."

Musculotendinous Impairments & Tendinitis --16.7c & d Pages 506-7

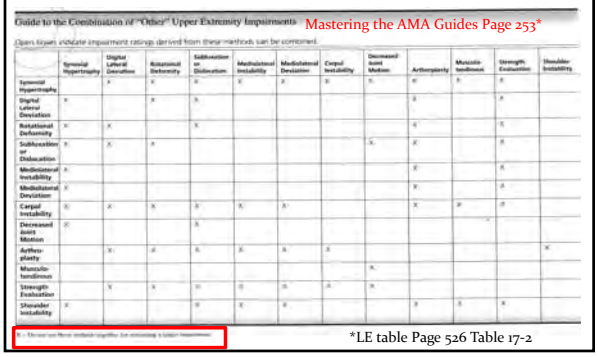
- Chapter **16.7c** deals with Intrinsic Tightness, Constrictive Tenosynovitis and Extensor Tendon Subluxation; these are measured by mild, moderate or severe range of motion impairment. In all these tables **READ THE RECIPE AND THE TABLES** carefully!
- Chapter **16.7d** discusses **tendinitis**. It notes specifically "***medial and lateral epicondylitis are not given a permanent impairment rating unless there is some other factor that must be considered***". *(Like Surgery) (Page 507, 16.7d)*

Impairment Due to Other Disorders Chapter 16.8 - Strength

- Strength testing is fundamentally a **functional test**. (For that matter so is ROM)
- Review 16.8a, "principles" regarding the rare instances in which a loss of strength represents an impairing factor. (i.e. a severe muscle tear that healed leaving a **palpable** muscle defect.)
- Loss of Strength can be combined **with** other impairments ***only if based on unrelated etiology***.*(16.8a, first paragraph, Principles, page 508)* Otherwise, impairment ratings are based on objective anatomic findings only.

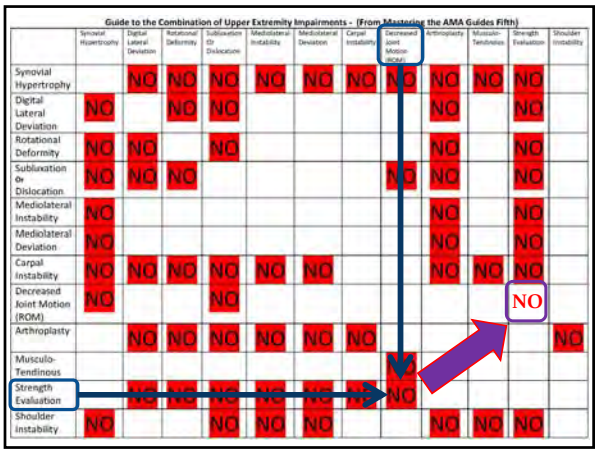
CRITICAL CONCEPT

Those things don't go Together!



Guide to the Combination of "Other" Upper Extremity Impairments Mastering the AMA Guides Page 253*

*LE table Page 526 Table 17-2


Guide to the Combination of Upper Extremity Impairments - (From Mastering the AMA Guides Fifth)
Synovial Hypertrophy
Digital Lateral Deviation
Rotational Deformity
Subluxation Or Dislocation
Mediolateral Instability
Mediolateral Deviation
Carpal Instability
Decreased Joint Motion (ROM)
Arthroplasty
Musculo-Tendinous
Strength Evaluation
Shoulder Instability
NO

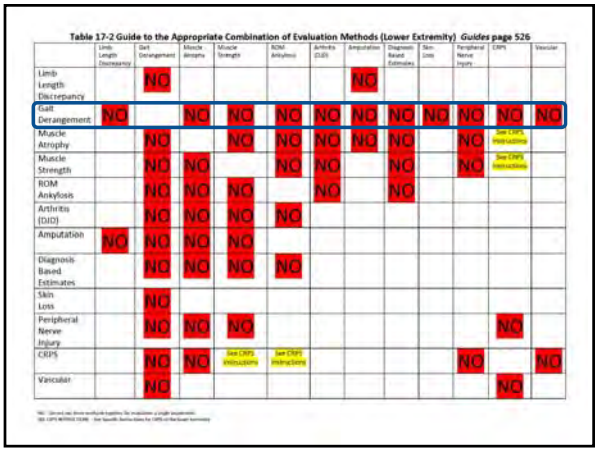


Table 17-2 Guide to the Appropriate Combination of Evaluation Methods (Lower Extremity) Guides page 526
Limb Length Discrepancy
Gait Derangement
Muscle Atrophy
Muscle Strength
ROM Ankylosis
Arthritis (DJD)
Amputation
Diagnosis Based Estimates
Skin Loss
Peripheral Nerve Injury
CRPS
Vascular
NO


SHOULDER
Mr. Potter fell 35 feet from his broomstick and landed on his left shoulder and forearm. He suffered a proximal humerus fracture and a closed injury to the distal forearm. He was treated with ORIF for the break but continues with pain and some numbness over the radial side of the dorsum of the hand, which does not interfere with activity.
Examination reveals the following:
Hypesthesia in the distribution of the superficial dorsal branch of the radial nerve
Positive percussion test over the point of nerve injury
External Rotation of fifty degrees
Internal Rotation of fifty degrees
Abduction of 130 degrees
Adduction ten degrees
Flexion of 140 degrees
Extension of twenty degrees

Shoulder Rating – The AP

Range of motion impairment:

- Extension of twenty degrees – 2%
- Flexion of 140 degrees – 3%
- Adduction of ten degrees – 1%
- Abduction of 130 degrees – 3%
- Internal Rotation of fifty degrees – 2%
- External Rotation of fifty degrees – 9%

ROM impairment is calculated as (2+3+1+3+2+9) = 20% Upper extremity impairment for ROM

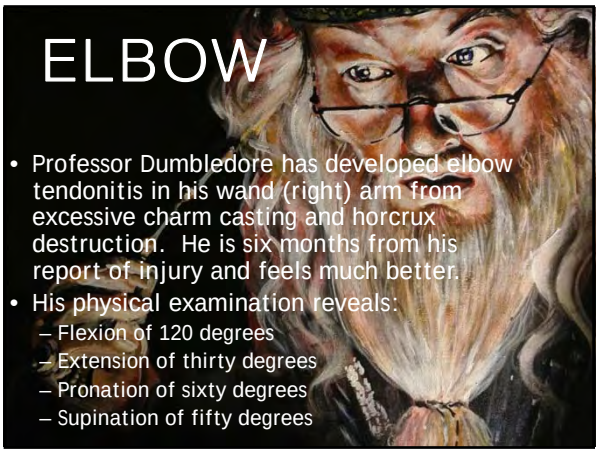
- For the nerve impairment, an additional 5% impairment for impairment of the superficial dorsal branch of the radial nerve.

The AP calculates this rating at 25% of the left upper extremity. Is this correct? If so, why? If not, why not?

Shoulder Rating – YOU

ROM Impairment

Shoulder Rating – You



Elbow Rating – AP

- Dr. Pomfrey determines Professor Dumbledore is at MMI and calculates the impairment as follows:
  - For flexion of 120 degrees – 2% impairment
  - For extension of thirty degrees – 3%
  - For pronation of sixty degrees – 1%
  - For supination of fifty degrees – 1%

  These impairments were added (2+3+1+1) = 7% impairment.

  The AP calculates this rating at 7% of the right upper extremity. Is this correct? If so, why? If not, why not?

Elbow Rating – YOU

JOIN THE MISSION !

- Please, keep learning!
  - This course is an introduction, not an end in itself.
  - There is more to know, skills to acquire!
    - (The Best) Phil Walker http://philwalker.do/training/
    - Take our advanced course, AMA *Guides 5th Edition Practicum*
    - IAIME (formerly AADEP) and SEAK (L&I sponsors courses in Washington they teach)
    - Online training is available at Impairment.com http://www.impairment.com/online-training.html they also have a resource called "impairment check" (this is cost-based service)
    - Brigham & Associates https://www.cbrigham.com/ (also a cost-based service)

www.rwwcomplaw.com