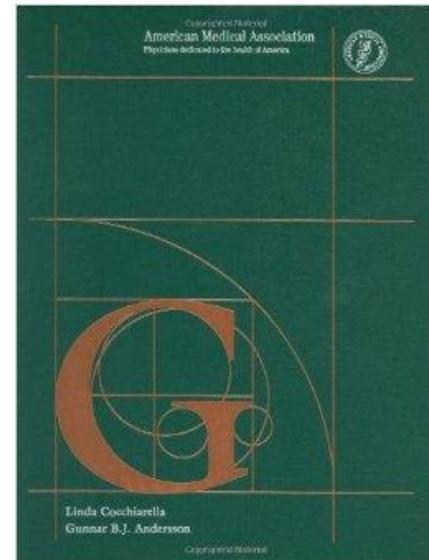


Using the Four Corners of the AMA Guides

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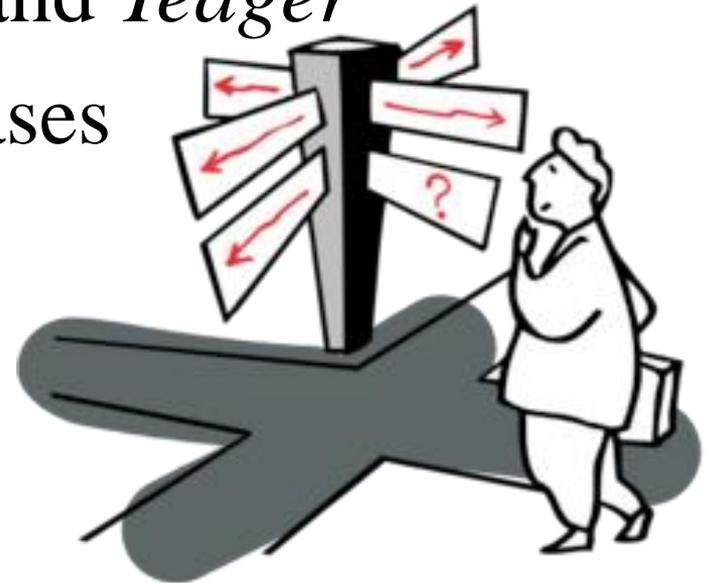
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OUTLINE

- 1) Physician's role according to *Blackledge*
- 2) *Almaraz/Guzman* and *Cannon*
- 3) *AMA Guides* Chapter 1 & 2
- 4) Apportionment: *Escobedo* and *Yeager*
- 5) Sorting through complex cases



Blackledge v. Bank of America (en banc)

- The WCAB's holding:

“the physician’s role is to assess the injured employee’s whole person impairment percentage(s) by a report that sets forth facts and reasoning to support its conclusions and that comports with the AMA Guides and case law;”

Full decision: <http://www.dir.ca.gov/wcab/EnBancdecisions2010/Blackledge.pdf>



Blackledge v. Bank of America

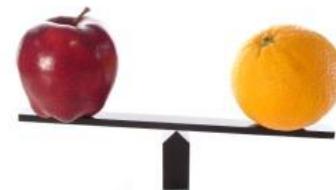
(en banc)

- Impairment typically is assessed in a comprehensive medical-legal report (see Reg. 10606)
- Under AMA Guides, physician performs an evaluation to determine the whole person impairment (“WPI”) expressed as a percentage.
 - Impairment evaluation includes: a discussion of the employee’s history and symptoms, results of the physical examination, results of tests and diagnostic procedures, the diagnosis, the anticipated clinical course, the need for further treatment, and the residual functional capacity and ability to perform activities of daily living.
 - Physician compares the medical findings for each condition with the impairment criteria listed within the Guides and then calculates the appropriate impairment rating(s) for the condition.
 - The report should include a summary list of the impairments and impairment ratings by percentage, together with a calculation of the final WPI, and a statement of the rationale underlying the WPI opinion.



Blackledge v. Bank of America (en banc)

- If a condition is **not covered by the Guides**, the physician compares measurable impairment results from the non-covered condition to the measurable impairment results from other conditions with similar impairment of function in performing ADLs.



- To constitute substantial medical evidence, regarding WPI, a physician's opinion must comport with the AMA Guides, including as applied and interpreted in published appellate opinions and en banc decisions.

Blackledge v. Bank of America (en banc)

- The physician must explain how he or she arrived at the WPI so that the parties and the WCAB can determine whether the WPI(s) are consistent with the AMA Guides.



Almaraz/Guzman II (en banc)

- WCAB held that:
 - 1) the Permanent Disability Rating Schedule is rebuttable.
 - 2) the burden of rebutting a scheduled permanent disability rating rests with the party disputing the rating.
 - 3) one method of rebutting a scheduled rating is to successfully challenge one of the component elements of that rating (e.g. WPI)
 - 4) when determining an injured employee's WPI, it is not permissible to go outside the four corners of the AMA Guides.

Almaraz/Guzman II (en banc)

Remember that Labor Code 4660(b)(1) and 4660.1(b)(1) state:

-the nature of the physical injury or disfigurement shall incorporate the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the AMA Guides 5th Edition.

Almaraz/Guzman II (en banc)

- A physician may utilize any chapter, table, or method in the AMA Guides that most accurately reflects the injured employee's impairment....the AMA Guides contemplates that a physician will use judgement, experience, training, and skill in assessing WPI.
- WCAB emphasized a physician may not use any chapter simply to achieve a desired result....the opinion must set forth the facts and reasoning which justify the impairment.
- A physician's WPI opinion that is not based on the Guides does not constitute substantial medical evidence.
- An injured employee's permanent disability rating and each component of that rating are questions of fact to be resolved by the WCAB.

Guzman III

Court of Appeal upheld the WCAB decision in *Almaraz/Guzman*.

- The Court noted that they agreed with defendant that the Guides must be applied as intended and written, but took a broader view.
- The Court stated that LC 4660(b)(1) recognizes the variety and unpredictability of medical situations by requiring *incorporation* of the descriptions, measurements, and corresponding percentages in the Guides for each impairment, not their mechanical application without regard to how accurately and completely they reflect the actual impairment sustained by the patient.
- The Court of Appeal denied the writ in *Almaraz*.



City of Sacramento v. WCAB (Cannon)



- The Court of Appeal rejected defendant's argument that it is improper to rate a condition by analogy under A/G where there are no objective findings and the rating is based solely on subjective complaints.
- The Court also dismissed defendant's argument that a variation from the strict application of the Guides may only occur in those cases that are complex and extraordinary.

AMA Guides 5th Edition

- **Chapter 1**

- 1.1 History
- 1.2 Impairment, Disability, and Handicap
- 1.3 Organ System and Whole Person Approach to Impairment
- 1.4 Philosophy and use of CVC
- 1.5 Incorporating science with clinical judgement
- 1.6 Causation, Apportionment Analysis, and Aggravation
- 1.7 Use of the Guides
- 1.8 Impairment Evaluations in W/C
- 1.9 Employability Determinations
- 1.10 Railroad and Maritime Workers
- 1.11 The Physician's role based on ADA
- 1.12 Summary

- **Chapter 2**

- 2.1 Impairment Evaluation
- 2.2 Who performs...
- 2.3 Examiners' roles and responsibilities
- 2.4 When are impairment ratings performed
- 2.5 Rules for Evaluation
- 2.6 Preparing reports

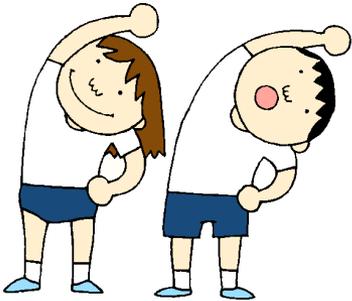


AMA Guides, 5th Edition – Chapter 1

- Chapter 1.2 Impairment, disability, and handicap
 - “*Impairment*” is defined by the Guides as “*a loss, loss of use, or derangement of any body system, organ system, or organ function*”.
 - An impairment can be manifested objectively and/or subjectively.
 - Although the Guides emphasize objective assessments, subjective symptoms are included within the diagnostic criteria.
 - An impairment may lead to functional impairment or the inability to perform activities of daily living.

AMA Guides, 5th Edition – Chapter 1

- Loss, loss of use, or derangement implies a change from a *normal or preexisting state*.
 - A normal value can be defined from an individual or population perspective.
 - **Two options** (Guides use both approaches):
 - » Consider the individual's healthy preinjury or preillness state or the condition of the unaffected side as "normal"
 - OR
 - » Compare that individual to a normal value defined by population averages of health people (Recommend when applicable values in the Guides are available).
- Impairment percentages or ratings developed by medical specialists are consensus-derived estimates that reflect the severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common ADLs, excluding work.
 - Impairment ratings were designed to reflect functional limitations and not disability.



AMA Guides, 5th Edition – Chapter 1

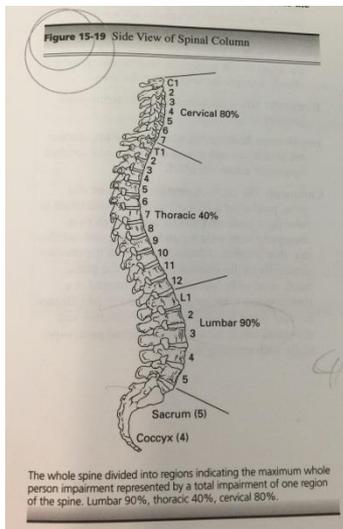
- The ADLs listed in Table 1-2 should be considered by the physicians when establishing a permanent impairment rating:
 - Help determine where in a class an individual may fall.

Table 1-2 Activities of Daily Living Commonly Measured in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Scales ^{6,7}

Activity	Example
Self-care, personal hygiene	Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating
Communication	Writing, typing, seeing, hearing, speaking
Physical activity	Standing, sitting, reclining, walking, climbing stairs
Sensory function	Hearing, seeing, tactile feeling, tasting, smelling
Nonspecialized hand activities	Grasping, lifting, tactile discrimination
Travel	Riding, driving, flying
Sexual function	Orgasm, ejaculation, lubrication, erection
Sleep	Restful, nocturnal sleep pattern

AMA Guides, 5th Edition – Chapter 1

- Chapter 1.3 The organ system and whole body approach to impairment
 - The Guides impairment ratings reflect the severity and limitations of the organ/body system impairment and resulting functional limitations.
 - Most chapters provide whole person impairment
 - Musculoskeletal chapters provide regional impairments which are then converted to whole person impairment.
 - With some musculoskeletal regions, a consensus group developed weights to reflect the relative importance of certain regions (e.g. different fingers or different regions of the spine).
 - » The different weights represent the unique and relative importance to the regions overall function.
 - Ex. Figure 15-19



AMA Guides, 5th Edition – Chapter 1

- Chapter 1.4 Philosophy and use of combined values chart (CVC):
 - The CVC was designed to enable the physician to account for the effects of the multiple impairments with a summary value.
 - A standard formula was used to ensure that regardless of the number of impairments, the summary value would not exceed 100%: $A+B(1-A)= CV$ of A and B
 - *“A scientific formula has not been established to indicate the best way to combine multiple impairments”*
 - Given the diversity of impairments and great variability inherent in combining multiple impairments, it is difficult to establish a formula that accounts for all situations.
 - Adding impairments instead of combining due to “synergistic effect” (Almaraz/Guzman???)
 - see LA County Metro Trans Authority v. WCAB (La Count) 80 CCC 470
 - see East Bay Municipal Utility Dist. V. WCAB (Kite) 78 CCC 213



AMA Guides, 5th Edition – Chapter 1

- **Chapter 1.5 Incorporating Science with Clinical Judgement:**
 - The Guides uses objective and scientific based data when available.
 - When objective data have not been identified, estimates of the degree of impairment are used, based on clinical experience and consensus.
 - Subjective concerns when not accompanied by demonstrable clinical signs or independent, measurable abnormalities, generally are not given separate impairment ratings.
 - The Guides do not deny the existence or importance of subjective complaints to the individual or their functional impact.
 - *Because the presence and severity of subjective concerns varies among individuals with the same condition, the Guides have yet to identify an accepted method within the scientific literature to ascertain how these concerns consistently affect organ or body system function.*
 - The Guides recommend the physician ascertain and document subjective concerns and the physician is encouraged to discuss these concerns in the impairment evaluation.

AMA Guides, 5th Edition – Chapter 1

- Chapter 1.5 Incorporating Science with Clinical Judgement (cont.):
 - Given the range, evolution, and discovery of new medical conditions, *the Guides cannot provide an impairment rating for all impairments*.
 - Also since some medical conditions are poorly understood and are manifested only by subjective symptoms, impairment ratings are not provided for these conditions.
 - *When ratings are not provided...*
 - The Guides suggest that the physician use **clinical judgement**, comparing measurable impairment resulting from the unlisted condition to measurable impairment resulting from similar conditions with similar impairment of function in performing ADLs.

AMA Guides, 5th Edition – Chapter 1

- Chapter 1.6 Causation, Apportionment Analysis, and Aggravation:
 - For the Guides, *causation* means an identifiable factor that results in a medically identifiable condition.
 - Apportionment Analysis:
 - Before determining apportionment the physician needs to verify that all of the following information is true for the individual:
 - There is documentation of a prior factor.
 - The current permanent impairment is greater as a result of the prior factor.
 - There is evidence indicating the prior factor caused or contributed to the impairment, based on reasonable medical probability.

AMA Guides, 5th Edition – Chapter 1

- Chapter 1.6 Causation, Apportionment Analysis, and Aggravation (cont.)
 - The apportionment analysis must consider the nature of the impairment and its possible relationship to each alleged factor, and it must provide an explanation of the medical basis for all conclusions and opinions.
 - Example: In apportioning a spinal impairment rating for an individual with a history of a spine condition, one should calculate the current spine condition. Then calculate the impairment from any preexisting spine problem. The preexisting impairment is then subtracted from the present impairment rating.

AMA Guides, 5th Edition – Chapter 2

- An **impairment evaluation** is a medical evaluation using a standard method as outlined in the Guides to determine permanent impairment associated with the medical condition.
 - Physician's role is to provide an independent, unbiased assessment of the individual's medical condition, including its effects on function, and identify abilities and limitations to performing ADLs.
 - **Thorough documentation will ensure that reporting is fair and consistent and that individuals have the information needed to pursue any benefits to which they are entitled.**
 - Impairment rating performed when injured worker reached maximal medical improvement (MMI).

AMA Guides, 5th Edition – Chapter 2

- Chapter 2.5 Rules for Evaluation
 - Confidentiality
 - Combining impairment ratings
 - Consistency
 - If in spite of an observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, **the physician may modify the impairment rating accordingly and then describe and explain the reason for the modification.**
 - Interpolating, Measuring, and Round Off
 - Pain
 - Using Assistive Devices in Evaluations
 - Adjusting for Effects of Treatment or Lack of Treatment (e.g. 1% to 3%; see Glossary “Effects of Medication”)
 - Changes in impairment from prior ratings.

Escobedo v. Marshalls (en banc)

- The WCAB held:
 - LC 4663(a)'s statement **that apportionment of permanent disability shall be based on causation refers to the causation of the permanent disability, not causation of injury**, and the analysis of the causal factors of PD for apportionment may be different from the analysis of the causal factors of the injury itself.
 - LC 4663(c) not only prescribes what determinations a reporting physician must make, it also prescribes what standard the WCAB must use in deciding apportionment...that is both a reporting physician and the WCAB must make a determination of what percentage of the PD was directly caused by the industrial injury and what percentage was caused by other factors.
 - Applicant has the burden of establishing percentage of PD caused by the injury and defendant has burden of establishing percentage caused by other factors.
 - **Apportionment of PD caused by other factors may include pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions, provided there is substantial medical evidence that these other factors have caused permanent disability.**
 - The report and apportionment opinions still needs to constitute substantial evidence.

Escobedo v. Marshalls (en banc)

- In order to constitute substantial evidence, a medical opinion must be predicated on reasonable medical probability.
- The physician should set forth the reasoning behind the opinion, not merely the conclusions.
- The medical opinion must disclose familiarity with the concept of apportionment, **describe in detail the exact nature of the apportionable disability**, and set forth the basis for the opinion.
- The physician must explain **how and why** the disability is causally related to the industrial injury and **how and why** the injury is responsible for a percentage of the disability.

E.L. Yeager Construction v. WCAB (Gatton)

- The Court of Appeal stated that:
 - “...prior disability or evidence of modified work is no longer a prerequisite to apportionment.”
 - “An asymptomatic prior condition would not involve a ratable disability, so that the fact that applicant here did not have a history of medical treatment or lost time due to his degenerative back condition is not significant under the new apportionment standards and does not serve a basis to disregard Dr. Akmakjian’s opinion.”
 - Apportioned 20% of permanent disability to chronic degenerative disease in the lumbar spine.
 - Rated on 1997 PDRS
- Could the case have been different if the permanent disability was rated under the AMA Guides?

The End