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Common Mistakes Doctors and Lawyers Make in WPI Ratings

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Workers' Compensation Law

- Does the medical report correctly follow the descriptions and measurements of the AMA *Guides* pursuant to Labor Code section 4660(b)(1) and 4660.1(b)?

- Does the medical report follow the California permanent disability rating schedule nuances?

- Does the medical report follow decisional case law? e.g. *Milpitas USD v. WCAB (Guzman)* (2010) 187 Cal. App. 4th 808.

Workers' Compensation Law

- *Milpitas USD v. WCAB (Guzman)* (2010) 187 Cal. App. 4th 808, 115 Cal. Rptr. 3d 112, 75 Cal. Comp. Cases 837 [Discussion is in Lawyer's Guide, Ch. 7, 7-41 through 7-49]
  - 1. What is the strict rating from the AMA Guides 5th Edition?
  - 2. Is the strict rating an accurate description of the IW's impairment and disability?
  - 3. If not, why is the strict rating inaccurate?
  - 4. What is the alternative rating under the AMA Guides 5th Edition?
  - 5. Why is the alternative rating more accurate than the strict rating?
  - 6. Are the physician's conclusions based on reasonable medical probability?
- Once the WPI is established, the physician has to make a determination of causation of permanent disability applying the principles of apportionment per LC 4663 or LC 4664.

CHAPTER 1 AMA *GUIDES*

Philosophy, Purpose and Appropriate Use of the *Guides*

- WCAB in AG-III and "Guzman III" quoted this chapter extensively to justify use of the four corners of the *Guides* to obtain the most accurate WPI ratings
- "A nationally accepted definition of impairment does not exist." Page 2
- Physicians determine the WPI ratings

CHAPTER 1 OF AMA *GUIDES*

"The *Guides* is not intended to be used for direct estimates of work disability. Impairment percentages derived according to the *Guides* criteria do not measure work disability. Therefore, it is inappropriate to use the *Guides'* criteria or ratings to make direct estimates of work disability."

AMA *GUIDES*, Section 1.2b, PAGE 9.

Chapter 1 of AMA *Guides*

- What are “permanent objective medical findings?”
  - Objectively confirmed by diagnostic testing, imaging and/or physical examination
  - Based on national medical standards that were peer reviewed and accepted
  - Without patient’s participation, reproducible
  - E.G. MRI, EMG/NCV, x-rays, troponin testing, echocardiograms; urine, blood testing

Chapter 1 of AMA *Guides*

- What is an objective diagnosis?”
  - Objectively confirmed by medical criteria accepted by national standards
    - E.g. plantar fasciitis, epicondylitis
  - *City of Sacramento vs. WCAB (Cannon), (2013) 222 Cal. App. 4th 1360, 167 Cal. Rptr. 3d 1,79 Cal. Comp. Cases 1*

Chapter 1 of AMA *Guides*

- WPI ratings are “consensus-derived.”
- “Disability” is different from “impairment”
  - Impairment is the loss of loss of use or derangement of any body part, organ system or organ function
  - Disability is “a person’s reduced ability to meet personal, social or occupational demands or statutory or regulatory requirements because of an impairment.”
- The Guides do not account for work disability because they don’t consider factors such as person’s knowledge, skills, abilities, experience, education and age

Chapter 1 of AMA *Guides*

- What does “consensus-derived” mean?
  - The WPI ratings are not based on clinical research
  - The WPI ratings are not based on any epidemiological studies
  - The WPI ratings are not scientifically based
    - E.G. Class 2 recurrent hernia is 19% WPI while a herniated lumbar disc is 13% WPI
  - Consensus derived means occupational medicine physicians were in charge of writing the book
  - The Guides are proprietary to the AMA and the senior editors
  - Congressional committee in 2010 recommended Institute of Medicine develop more scientifically based impairment rating system

Chapter 1 of AMA *Guides*

ACTIVITIES OF DAILY LIVING TABLE 1-2

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

Chapter 1 of AMA *Guides*

ACTIVITIES OF DAILY LIVING TABLE 1-2

"Table 1-2 can help to determine how significantly the impairment impacts those activities. Using the impairment criteria within a class and knowing the activities the individual can perform, the physician can estimate where the individual stands within that class." Pg. 5

Chapter 1 of AMA *Guides*

- ADL Functioning That Overlap With Work Activities:
  - Writing, typing, hearing, speaking
  - Standing, sitting, walking, climbing stairs
  - Grasping, lifting, reaching
  - Riding, driving
  - Sleeping?
- WPI = “WHOLE PERSON IMPAIRMENT”
  - UPPER EXTREMITY = 60% WPI
    - e.g. A 10% UE rating = 6% WPI
  - LOWER EXTREMITY = 40% WPI
    - e.g. A 10% LE rating = 4% WPI

Chapter 1 of AMA *Guides*

IMPAIRMENTS FALL UNDER ONE OF THREE CATEGORIES:

- ANATOMIC – amputations, limb length discrepancy
- DIAGNOSIS BASED – partial meniscus tear, resection arthroplasty of a joint (shoulder, elbow)
- FUNCTIONAL – loss of spinal motion, muscle strength, gait derangement, reduced lung or heart capacity

Chapter 1 of AMA *Guides*

- Why can't the *Guides* solely be used to determine disability?
  - Because there may not be a connection between an impairment and the ability to perform work activities
  - The *Guides* only describe impairment in ADL functioning
  - Someone with a 30% WPI may or may not be able to perform their job
  - "As a result, impairment ratings are not intended for use as direct determinants of work disability." Page 5
  - "When a physician is asked to evaluate work-related disability, it is appropriate for a physician knowledgeable about the work activities the worker can and cannot do, given the permanent impairment." Also page 5.

Chapter 1 of AMA *Guides*

- But then the authors say a physician CAN evaluate a person's disability:
  - "If the physician has the expertise and is well acquainted with the individual's activities and needs, the physician may also express an opinion about the presence or absence of a specific disability. For example, an occupational medicine physician who understands the job requirements in a particular workplace can provide insights on how the impairment could contribute to a workplace disability."
  - Notice that the authors do not say whether or how WPI ratings are affected by workplace disabilities.
  - The authors leave this issue to individual states or "regulatory agencies." Page 8.

Chapter 1 of AMA *Guides*

- Other issues mentioned in Chapter 1 that impact California cases:
  - Page 9: Authors state that some impairments can be expressed in terms of "regional impairment" that can be converted to WPI ratings such as fingers and the spine (See Figure 15-19, page 427 for Regional Spinal Impairments).
  - Page 11: There are 12 kinds of medical causation: constitutional, exciting, immediate, local, precipitating, predisposing, primary, proximate, remote, secondary, specific and ultimate.
  - Page 11: "Causation" means "an identifiable factor (like an injury or exposure to hazards of a disease) that results in a medically identifiable condition."
  - California adds: "contributing factor" as another form of causation. South Coast Framing v. WCAB (2015) 61 Cal. 4th 291, 349 P.3rd 141, 188 Cal. Rptr. 3d 46, 80 Cal. Comp. Cases 489

Chapter 1 of AMA *Guides*

- Other issues mentioned in Chapter 1 that impact California cases
  - Page 10: Combined Values Chart (page 604-608) is explained. Of importance to us is that impairment ratings from within the same region (cervical, lumbar spine or shoulder and wrist) are combined with each other and then the regional impairments are then combined.
  - The exceptions are the thumbs, ankles and ankle joints which are added.
  - The 2005 PDRS instructions take precedence over this instruction and some physicians will give one WPI rating for everything that means nothing.
  - There must be a pathophysiologic explanation for pain, fatigue and difficulty in concentration in order to justify an impairment rating for them.

Chapter 1 of AMA *Guides*

Use of the Combined Values Chart

- "A standard formula was used to ensure that regardless of the number of impairments, the summary value would not exceed 100% of the whole person. According to the formula listed in the CVC, multiple impairments are combined so that the WPI value is equal to or less than the sum of all the individual impairment values." AMA Guides, page 9.

Chapter 1 of AMA *Guides*

Use of the Combined Values Chart

- "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."

Chapter 1 of AMA *Guides*

Use of the Combined Values Chart

- "A combination of some impairments could decrease overall functioning more than suggested by just adding the impairment ratings for the separate impairments (e.g. blindness and inability to use both hands)."

- "When other multiple impairments are combined, a less than additive approach may be more appropriate…"
  "

Chapter 1 of AMA *Guides*

Use of the Combined Values Chart

- "Other options are to combine (add, subtract, or multiply) multiple impairments based upon the extent to which they affect an individual's ability to perform activities of daily living."

- "The current edition has retained the same CVC, since it has become the standard of practice in many jurisdictions. Other approaches, when published in scientific peer-reviewed literature will be evaluated for future editions." All above, page 10.
- See Athens Administrators v. WCAB (Kite) (2013) 78 Cal. Comp. Cases 213 (writ denied)

Chapter 1 of AMA *Guides*

- Other issues mentioned in Chapter 1 that impact California cases
  - The sections in the *Guides* on workers' compensation are useless in California.
  - Page 13: Formed the basis of the WCAB en banc decisions in A-G I, A-G II and "Guzman III":
    - "Impairment percentages derived from the *Guides* criteria should not be used as direct estimates of disability. Impairment percentages estimate the extent of the impairment on whole person functioning and account for basic activities of daily living, not including work. The complexity of work activities requires individual analyses. Impairment assessment is a necessary *first* step for determining disability."
    - "Physicians with the appropriate skills, training and knowledge may address some of the implications of the medical impairment toward work disability and future employment."

Chapter 1 of AMA *Guides*

Page 11 of the AMA *Guides 5th* Edition states:

> "In situations where impairment ratings are not provided, the *Guides* suggests that physicians use clinical judgment, comparing measurable impairment resulting from the unlisted condition to measurable impairment resulting from similar conditions with similar impairment of function in performing activities of daily living."

2005 PDRS, Page 1-4, second column, second paragraph states:

> "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. (AMA Guides page 11).

Chapter 1 of AMA *Guides*

- There are medical conditions we commonly see in our cases that are not listed in the AMA *Guides:*

Rotator cuff tears

Shoulder impingement

Chondromalacia patella

Recurrent back strains or sprains

Epicondylitis, bursitis

Labral tears (hips and shoulders)

Osteochondritis

Thoracic Outlet Syndrome

Fibromyalgia

Plantar fasciitis

Chapter 2 of the AMA *GUIDES*

PRACTICAL APPLICATION OF THE *GUIDES*

- Who performs the evaluation?
  - "Impairment evaluations are performed by a licensed physician. The physician may use information from other sources, such as hearing results obtained from audiometry by a certified technician. However, the physician is responsible for performing a medical evaluation that addresses medical impairment in the body or organ system and related systems." Pg 18.
  - Can a Chiropractor perform the measurements?
  - Physician must provide "independent, unbiased assessment of the individual's medical condition including its effect on function, and identify abilities and limitations to performing activities of daily living as listed in Table 1-2." Page 18.

- WPI ratings are performed when IW is MMI (Pg 19, also see AD Rules 9785, 10152) which means IW's ADL functioning will not change in a year with or without treatment

Chapter 2 of the AMA *GUIDES*

PRACTICAL APPLICATION OF THE *GUIDES*

- Physician must assess whether or not “measurements and test results are plausible and consistent with the impairment being evaluated…”
  - “If, in spite of an observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the physician may modify the impairment rating accordingly and then describe and explain the reason for the modification in writing.” Page 19
  - The authors imply this language is used to lower WPI ratings but the language also implies it can be used to raise WPI ratings.
  - E.G. Range of motion measurements of the spine, shoulder, wrist, hand etc.

Chapter 2 of the AMA *GUIDES*

- Two measurements by same examiner should fall within 10% of each other.
- Repeat measurements at different times will help verify the impairment ratings
- Three reliable measurements, use the highest of the three
- Assistive devices in evaluations?
  - Without use during evaluation
  - With use compared to without use
  - With use and consequences of use
  - E.G. How does routine use of a cane for a lower extremity condition affect upper extremity function?

- Physicians are failing to follow section 2.6 in the AMA *GUIDES*, pp. 21-22, and 8 Cal. Code Regulations 9785, 10682 and Labor Code section 4628.

Chapter 2 of the AMA *GUIDES*

- Side Effects of Medication: See section 1.5g, pages 20 and 600 (glossary).
  - Higher WPI rating within a class due to S/E Rx
  - Independent WPI rating due to S/E Rx
  - A WPI increase of 3% due to complex medical treatment
  - “The physician should use the appropriate parts of the Guides to evaluate impairment related to pharmaceutical effects. If information in the Guides is lacking, the physician may combine an estimated impairment percent based on the severity of the effect, with the primary organ system impairment by means of the combined values chart.”
  - E.G. Prednisone or other systemic steroid therapy that cause diabetes or osteoporosis; NSAIDS that cause GERD, ulcers or liver abnormalities; analgesic rebound

Required Elements for an AMA Compliant Medical Report

- Purpose of the exam (Tx MD, AME, PQME).
- History of present illness.
- Chief complaints.
- Pre-injury and post-injury ADLs (Table 1-2, page 4 OF AMA *Guides).*
- Past medical history.
- Job description.
- Review of submitted medical and legal records, list of items reviewed.
- Physical examination (includes who and what methods used), findings on exam.

Required Elements for an AMA Compliant Medical Report

- Diagnostic and imaging study results
- Diagnosis and impressions
- Discussion and conclusions
  - Causation of the injury (specific, CT or both; compensable consequence?)
  - Has applicant reached MMI and is P&S?
  - Objective findings (loss of ROM, neurological deficits (sensory, pain, motor), diagnosis based
  - Discussion of negative or positive diagnostic tests or imaging studies.
  - Description of impairments for each separate part of body using specific chapters, tables and methods.

Required Elements for an AMA Compliant Medical Report

- Discussion and conclusions (continued)
  - Method of evaluating impairments (DRE, ROM, both; DBE, functional loss, anatomic loss; combining and adding where appropriate)
  - Are physician's conclusions consistent with 2005 PDRS and case law? Is impairment rating accurate? Is there an alternative rating method that is more accurate? How? Why?
  - How does the injury affect the applicant's current ADLs?
  - Physician's rationale for using a particular method of descriptions and measurements.
  - Causation of permanent impairments – how and why impairments are caused by the industrial injury and/or "other factors" (apportionment).

Required Elements for an AMA Compliant Medical Report

- Discussion and conclusions (continued)
  - Recommendations for further medical treatment.
  - Can applicant perform his/her usual and customary duties?
  - What are the applicant's residual functional capacities (listed in PR-4 form) and work restrictions?

Ref: Labor Code section 4628, 8 Cal. Code Regulations, section 10682, AMA *Guides*, section 2.6.

Chapter 2 of AMA *GUIDES*

- WPI ratings rate current impairment only
  - They do not account for future deterioration e.g. in a post-surgical knee or in a TKR
- Rate primary impairment first
  - “Generally, the organ system where the problems originate or where the dysfunction Is greatest is the chapter to be used for evaluating the impairment.” Page 19.
- The same medical conditions are rated in different chapters of the *Guides* and you use the highest WPI rating.

Chapter 2 of AMA *GUIDES*

Up to 3% pain add-ons

- See Page 1-12 of the 2005 PDRS instructions on up to 3% pain add-on
  - Supersedes anything in AMA *Guides* re Chapter 18
  - "Pursuant to Chapter 18 of the AMA *Guides*, a WPI rating based on the body or organ rating system of the AMA *Guides* (Chapters 3 through 17) may be increased by 0% up to 3% WPI if the burden of the workers' condition has been increased by pain-related impairment in excess of the pain component already incorporated in the WPI rating in Chapters 3-17. (AMA *Guides*, page 573).

Example #1: TKR

- 69 y/o elementary school teacher DOI 12/10/2018 sustained admitted injury to left knee resulting in total knee replacement.
- MMI report 8/28/2020 PTP indicates “occasional aches in left knee.”
- Range of motion measurements are normal
- “Surgical scar well healed. Range of motion 0-120 degrees of flexion. No evidence of any crepitation. Condition is P&S without any significant residual disability, occasional pain in left knee.”

Example #1 TKR – Use cm and not inches for measurements for atrophy

Lateral side

Medial Side

Example #1: TKR

Example #1: TKR

Example #1: TKR

- "According to AMA Guides 5th Ed., Table 17-33 the patient has a 15% impairment of the whole person.
- Apportionment: is not indicated
- Future medical treatment: No further treatment is indicated."
- If you need additional information, please contact me"
- Uh, duh!
  - Are conclusions based on RMP?
  - Where are the post-surgical measurements required under Table 17-36 for a TKR?
  - No FMTx? Are you kidding?
  - No mention of mechanism of injury

Example #1: Postscript on degenerative changes

- Apportionment of permanent disability when there is DDD or DJD
  - Many AAs do not allege the entire period of injurious exposure – they only allege the last year of injurious exposure as the “date of injury.”
    - This can be legally incorrect and mislead PTPs, QMEs and AMEs
    - The date of injury for a CT injury is a specific date – when there is a concurrence of disability and knowledge pursuant to LC 5412 and liability established under LC 5500.5.
    - The take away is to get an accurate history directly from the IW

Example #2: Burn Cases

- 69 year old bookkeeper on 10/08/2018 at 5:00 pm knocked over a thermos of hot water on to her lap at her desk burning her left thigh and less so on her right thigh

- She did not report the injury but went home and put herbal oil on her thighs

- The next day she went to the emergency room where they gave her a tetanus shot, cleaned the wounds and noticed her blood pressure was very high

Example #2: Burn Cases

- She went to her PMD who told her to file a WC claim which she did and was referred to a WC doctor.
- She was told to clean the wounds daily and she did but went to a dermatologist after two months.
- The wounds were blistering and sore, with thick scarring.
- The dermatologist gave her laser treatments to the burned scars on the left anterior and proximal thigh scars.
- She missed three days from work but actively treated for one year – MMI Sept. 2019.

Example #2: Burn Cases

- PQME exam 1/15/2020:
- She “complains of itching, violaceous coloring and hyperpigmentation in the burn area on her left lateral thigh that measures 20 cm from medial to lateral from the left medical thigh to the left lateral thigh and 30 cm from medial to distal from the left thigh inguinal crease down to around the distal mid thigh. The redness of the burn scar is redder now than it has been in the past month. The present appearance of the scar including the itchiness has been that way for the past six months.”

Example #2: Burn Cases

- PQME exam 1/15/2020:
  - “The patient suffered from a second degree burn on her left anterior thigh. Medically probable it became infected through the use of putting herbal medicine on the burn.
  - “She has a pigmented flat scar on her left thigh that is quite violaceous proximally in a band that is 7 cm from medial lateral x 4 cm proximal distal [RGR note: this is a little more than 4 square inches]. She has a patch approximately 30 cm from proximal to distal by 20 cm medial and lateral with the periphery of that patch is hyperpigmented and violaceous.”
  - “The claimant does not seem to care about the cosmetic appearance of the scar.”

Example #2: Burn Cases

- PQME exam 1/15/2020:
  - Come on, people, I did NOT make this up!
  - The PQME listed the above findings as Applicant's permanent objective findings and then stated:
  - "According to the fifth edition of the AMA Guides on page 178, table 8.2 she is in a category 1 with 0% impairment."
  - "Apportionment: is not indicated since there is no disability to apportion."
  - His future medical took half a page of recommendations including Pramosone lotion, hydroquinone, plus Retin-A plus hydrocortisone bleaching cream…on, and on, and on….

Example #2: Burn Cases

- PQME exam 1/15/2020:
  - He did not include any color photographs of her left or right thigh
  - He did not even mention her right thigh at all

- What does “violaceous” mean?

- How do you spell “OSA?”

CHAPTER 8 – THE SKIN

Table 8-1 Structure, Functions, and Disorders of the Skin*

Structure or Component	Functions	Disorders
Epidermis		
Stratum corneum	Barrier against microorganisms, chemicals, and water loss	Infection; contact dermatitis; xerosis
Squamous and basal cells	Stratum corneum regeneration; wound repair	Squamous or basal cell carcinoma; ulceration
Melanocytes	Protection from ultraviolet radiation	Vitiligo; sunburn; hyperpigmentation; melanoma
Langerhans cells	Immune surveillance	Allergic contact dermatitis
Dermis		
Blood vessels and mast cells	Nutrition; thermoregulation; vasodilation	Ulceration; heat stroke; urticaria (contact, systemic); hand-arm vibration syndrome
Lymphatics	Immune surveillance; lymphatic circulation	Lymphedema
Nerve tissue	Sensory perception	Neuropathies; pain; itching; sensory changes
Connective tissue	Protection from trauma; wound repair	Hypertrophic and atrophic scars; scleroderma
Eccrine (sweat) glands	Thermoregulation	Heat intolerance
Sebaceous glands	Synthesis of skin surface lipids	Acne; chloracne; xerosis
Hair	Insulation; outward appearance	Folliculitis; alopecia
Nails	Manipulation of small objects	Paronychia; dystrophy; onycholysis; difficulty with grasping

*Modified from Mathias,[5] Table 10-7, p. 138.

CHAPTER 8 – THE SKIN

disorders are given in Table 8-2.

Table 8-2 Criteria for Rating Permanent Impairment Due to Skin Disorders*

Class 1 0%- 9% Impairment of the Whole Person	Class 2 10%-24% Impairment of the Whole Person	Class 3 25%-54% Impairment of the Whole Person	Class 4 55%-84% Impairment of the Whole Person	Class 5 85%-95% Impairment of the Whole Person
Skin disorder signs and symptoms present or intermittently present ***and*** no or few limitations in performance of activities of daily living; exposure to certain chemical or physical agents may temporarily increase limitation ***and*** requires no or intermittent treatment	Skin disorder signs and symptoms present or intermittently present ***and*** limited performance of some activities of daily living ***and*** may require intermittent to constant treatment	Skin disorder signs and symptoms present or intermittently present ***and*** limited performance of many activities of daily living ***and*** may require intermittent to constant treatment	Skin disorder signs and symptoms constantly present ***and*** limited performance of many activities of daily living, including intermittent confinement at home or other domicile ***and*** may require intermittent to constant treatment	Skin disorder signs and symptoms constantly present ***and*** limited performance of most activities of daily living, including occasional to constant confinement at home or other domicile ***and*** may require intermittent to constant treatment

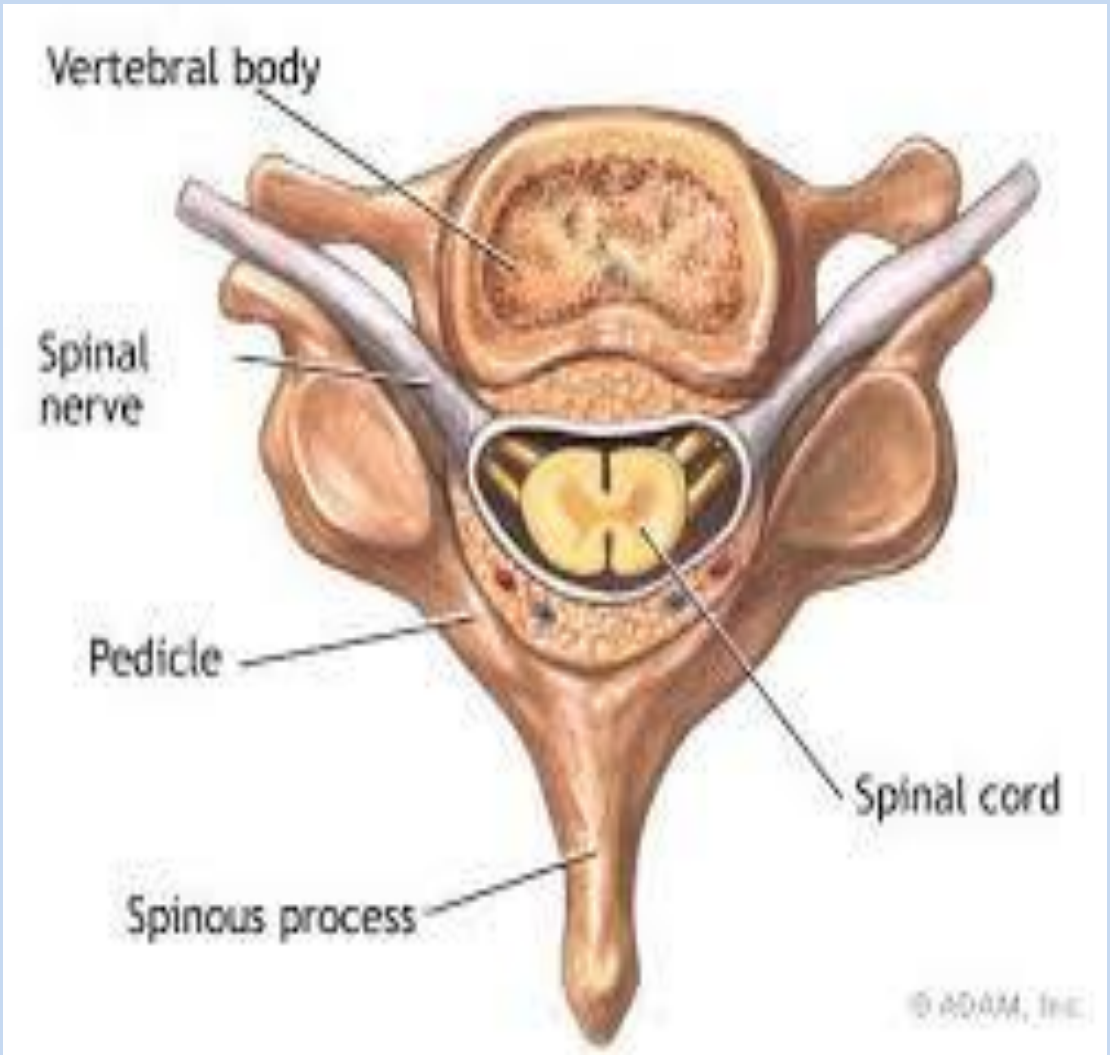
*The signs and symptoms of disorders in classes 1, 2, and 3 may be intermittent and not present at the time of examination. Consider the impact of the skin disorder on the ability to perform activities of daily living (see Table 1-2) in determining the class of impairment. Consider the frequency and intensity of signs and symptoms (ie, severity) and the frequency and complexity of medical treatment when selecting an appropriate impairment percentage and estimate within any class (see Introduction).

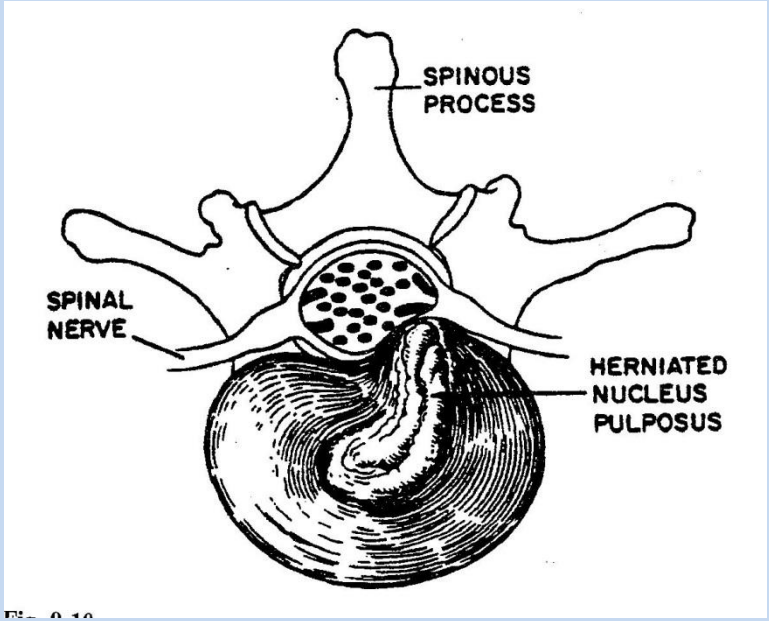
Example #3: Common Mistakes Re Spine

The Spine

- DRE vs. ROM (Pages 379-381)
  - Spondylosis
  - Spondylolysis
  - Spondylolisthesis
  - Herniated nucleus pulposus
  - Spinal canal or neural foramina stenosis
  - Zygoapophyseal pain (aka Facet Joint Syndrome)
  - Annular tears

Example #3 The Spine





Example #3: The Spine

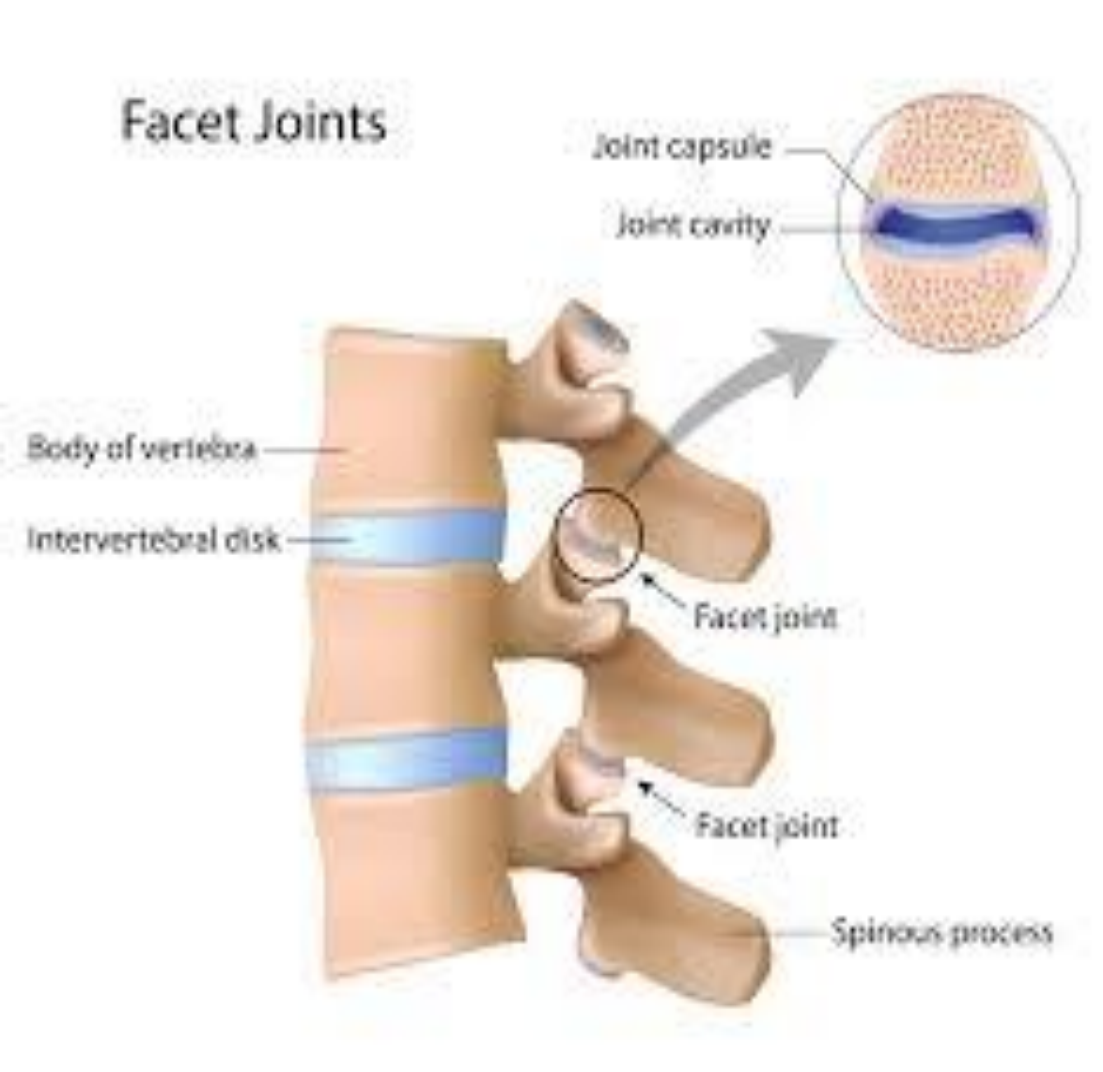
The Spine

- Spinal canal or neural foramina stenosis
  - “Stenosis” means narrowing
  - Lumbar spinal canal is >13 mm diameter
    - Stenosis is <12 mm
  - Cervical spine canal is 13-15 mm diameter
    - Stenosis is <10 mm
- Neural Foramina stenosis
  - A 2 mm disc bulge can cause it if the bulge is para-central 4:00 or 8:00 on the image previous slide

Example #3: The Spine

- Zygoapophyseal pain (aka Facet Joint Syndrome)
  - Facet Joints connect each vertebral body to the adjacent one
  - From coronal view, it looks like a butterfly
  - As we age, they become hypertrophic (they enlarge)
  - FJ injections are at a different location than most trans-foraminal or trans-laminar ESI procedures

Example #3 The Spine



Example #3 The Spine

- DRE vs. ROM (Pages 379-381)
  - Conflict in Guides regarding use of ROM “only if there is radiculopathy”
  - But see Table 15-7, section II(C)
  - The *Guides* do NOT contemplate a cumulative trauma injury to the spine [or anything else!]
- The sacroiliac joint is not part of the lumbar spine – it can be rated separately

Example #3 The Spine

Figure 15-8 Two-Inclinometer Technique for Measuring Lumbar Flexion and Extension

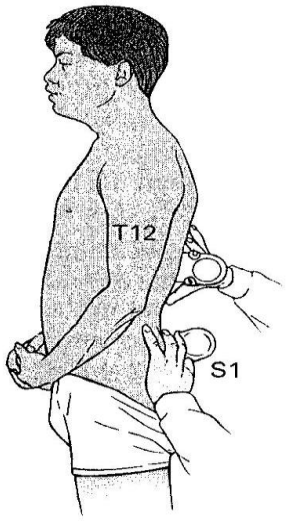
The inclinometers are placed over T12 and the sacrum (S1), the anatomical landmarks.

a. neutral position

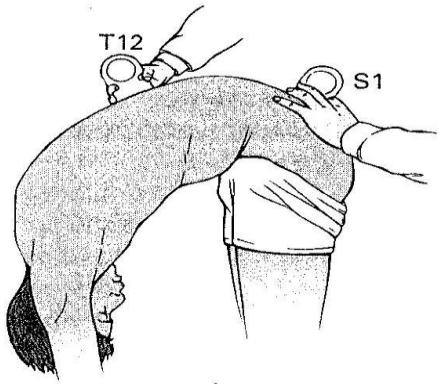
b. flexion

c. extension

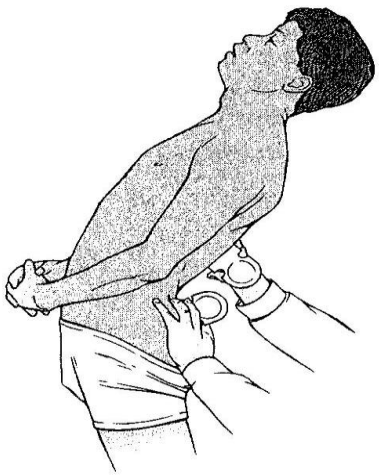
d. straight leg raising (used for validation purposes)



a.



b.

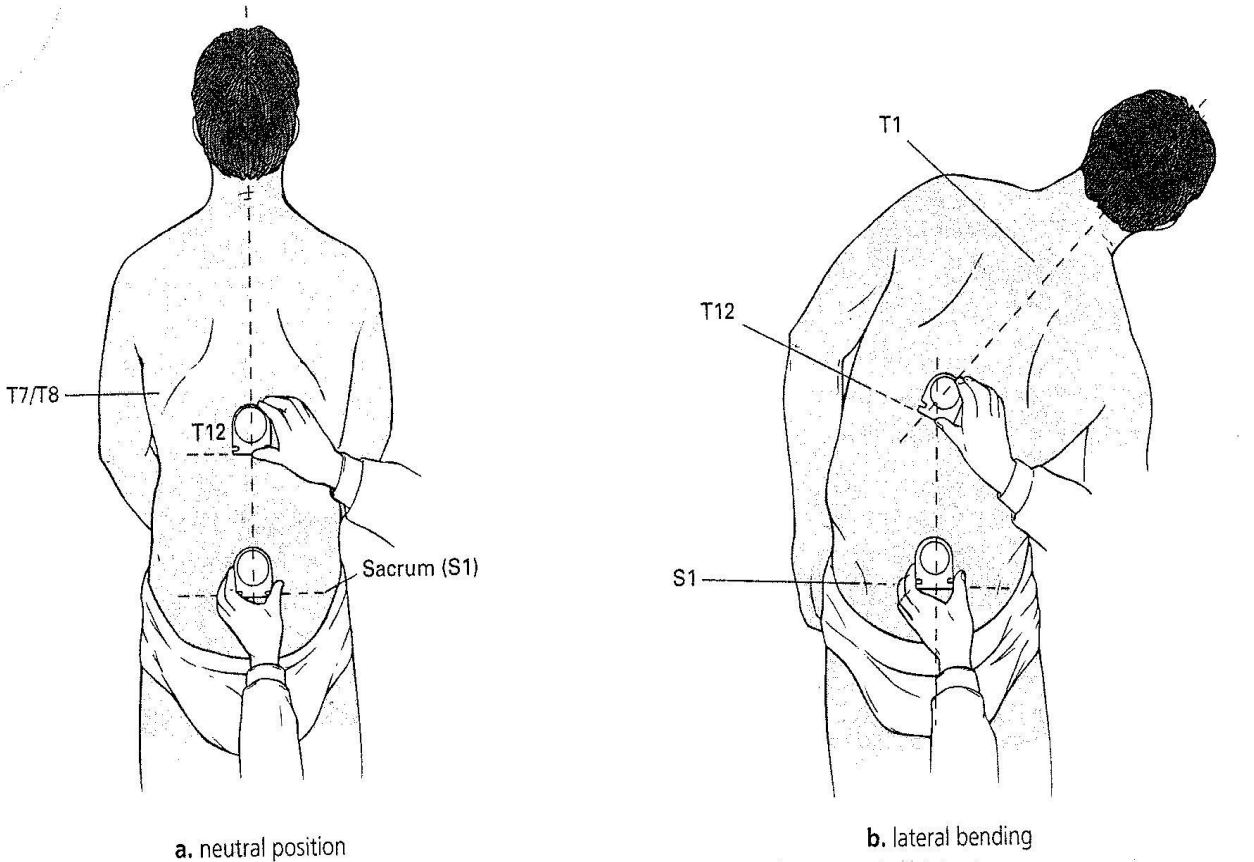


c.

d.

Example #3 The Spine

Figure 15-9 Two-Inclinometer Technique for Measuring Lumbosacral Lateral Bend



a. neutral position

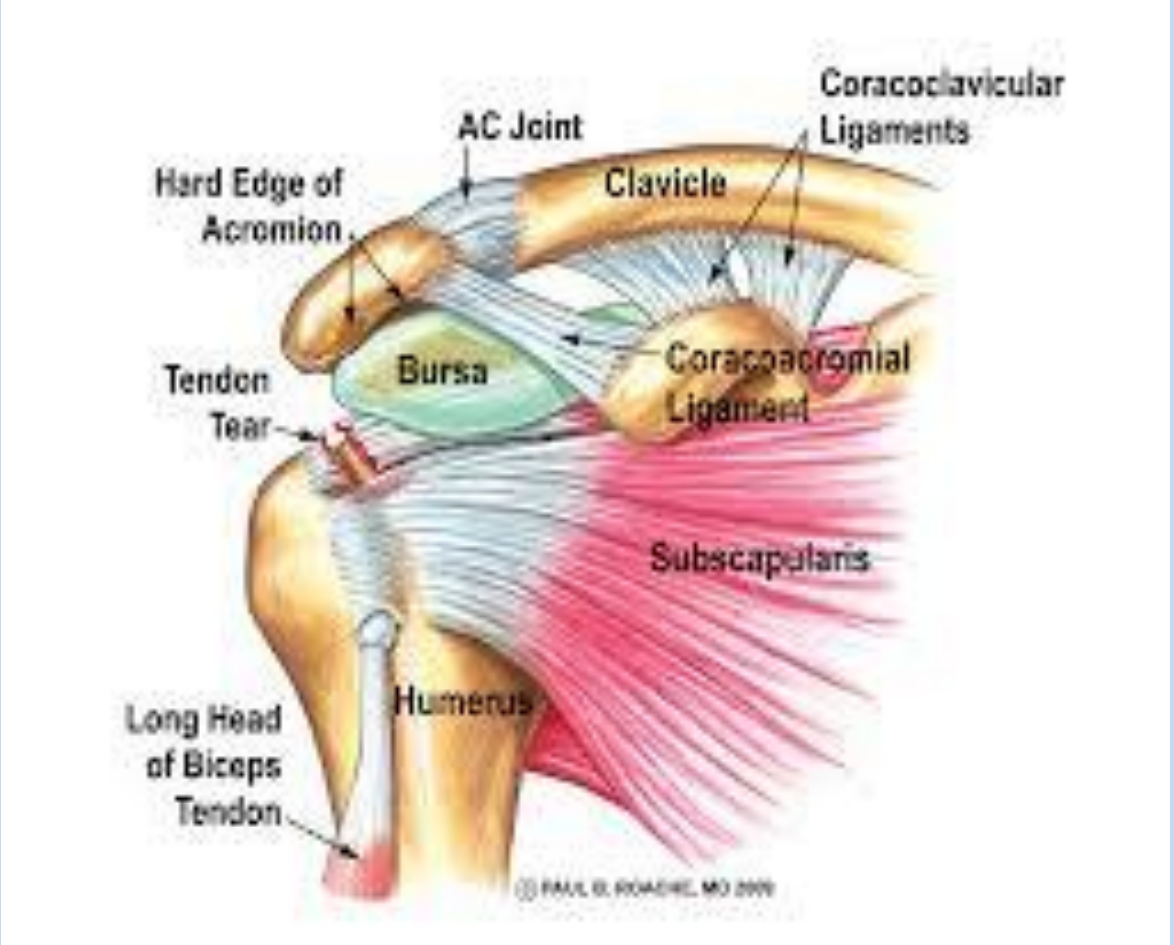
b. lateral bending

Example #4: The Shoulder

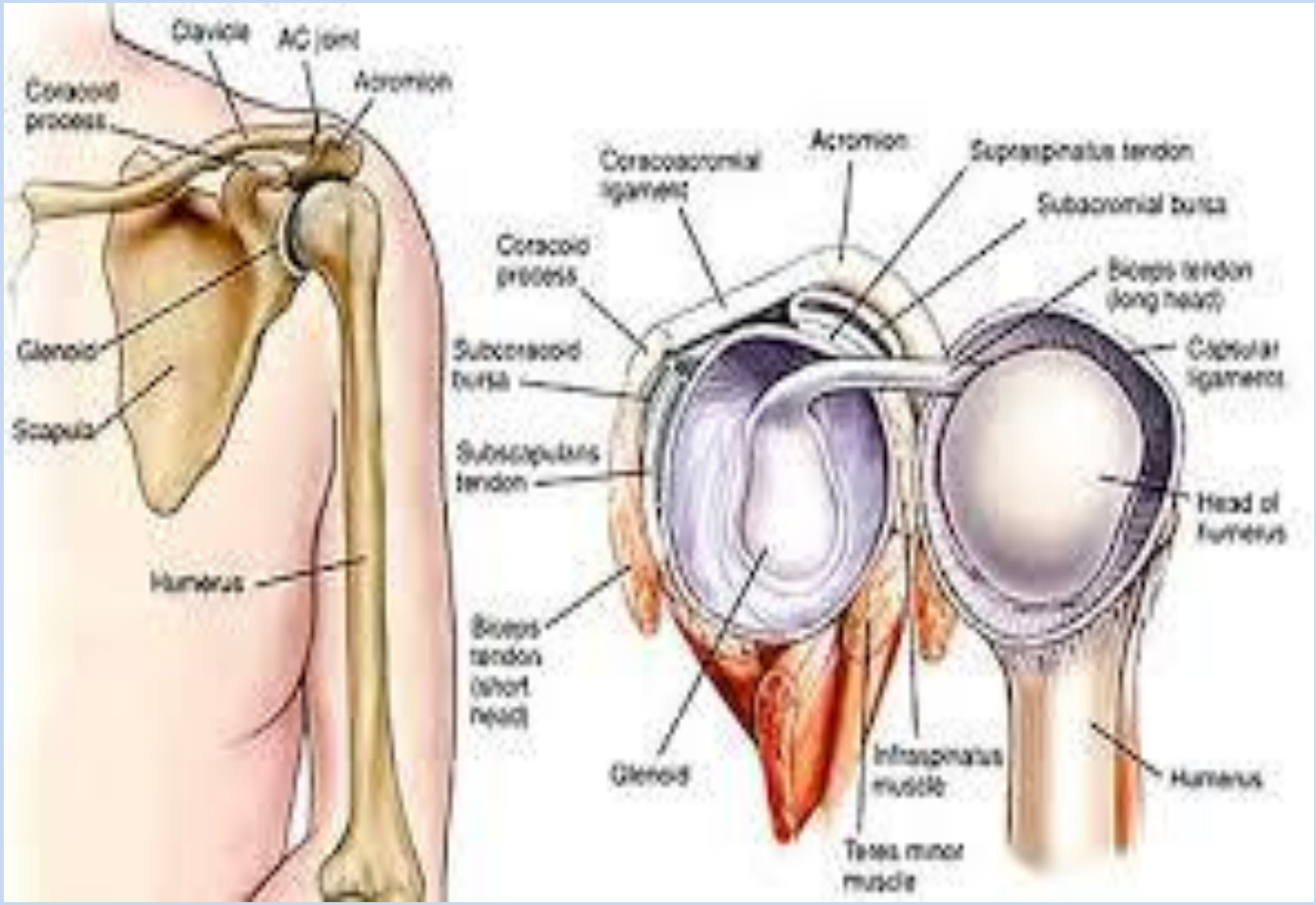
The Shoulder

- Shoulders – usually ROM (Figures 16-38 to 16-46) and muscle strength loss (Table 16-35)
  - Sub-acromial impingement
  - Rotator cuff or labral tears (SLAP lesions = Superior Labrum-Anterior-Posterior)
  - Mumford Procedure (distal clavicle resection arthroplasty)
  - Acromio-clavicular (AC) joint dysfunction
  - Table 16-27 vs. Table 16-18?

Example #4: The Shoulder



Example #4: The Shoulder



Example #4: The Shoulder

Table 16-18 Maximum Impairment Values for the Digits, Hand, Wrist, Elbow, and Shoulder Due to Disorders of Specific Joints or Units*

Units and Joints	% Impairment of			
	Unit	Hand	Upper Extremity	Whole Person
Shoulder				
Glenohumeral	—	—	60	36
Acromioclavicular	—	—	25	15
Sternoclavicular	—	—	5	3
Elbow				
Entire elbow	—	—	70	42
Ulnohumeral	—	—	50	30
Proximal radioulnar	—	—	20	12
Wrist				
Entire wrist	—	—	60	36
Radiocarpal	—	—	40	24
Distal radioulnar	—	—	20	12
Proximal carpal row	—	—	30	18
Entire hand	—	100	90	54
Thumb				
Entire thumb	100	40	36	22
CMC	60	24	22	13
MP	15	6	5	3
IP	25	10	9	5
Index and middle				
Entire finger	100	20	18	11
MP	50	10	9	5
PIP	30	6	5	3
DIP	20	4	4	2
Ring or little				
Entire finger	100	10	9	5
MP	50	5	5	3
PIP	30	3	3	2
DIP	20	2	2	1

* Each value is related to the next larger units and the whole person

Example #4: The Shoulder

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

Example #5: Peripheral UE Nerve Entrapments

- Carpal Tunnel Syndrome
- Cubital Tunnel Syndrome
- Epicondylitis (lateral, medial)
- Ulnar entrapment
- Median entrapment
- Radial entrapment

Example #5: Peripheral UE Nerve Entrapments

- For strict WPI ratings, use Tables 16-10, 16-11, and 16-15

- Sensory Deficits or Pain:
  - Median: Max value: 39 UE
  - Ulnar: Max Value: 7 UE
- Motor Deficits
  - Median: Max value: 10 UE
  - Ulnar: Max value: 35 UE

- Carpal Tunnel Syndrome
  Page 495
  5% UE = 3% WPI

If, after an *optimal recovery time* following surgical decompression, an individual continues to complain of pain, paresthesias, and/or difficulties in performing certain activities, three possible scenarios can be present:

1. Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual CTS is rated according to the sensory and/or motor deficits as described earlier.
2. Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a residual CTS is still present, and an impairment rating not to exceed 5% of the upper extremity may be justified.
3. Normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength, and nerve conduction studies: there is no objective basis for an impairment rating.

Example #5: Peripheral UE Nerve Entrapments

Table 13-16 Criteria for Rating Impairment of One Upper Extremity

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

Example #5: Peripheral UE Nerve Entrapments

- Grip Loss: Tables 16-30 through 16-34
- Use it sparingly - AMA Guides say to use it only if no other method of rating exists
- Since AG-III, it is used all the time

Apportionment of PD

- Compare Escobedo with Benson with Barbara Justice cases*
  - All depended on the analysis by the doctor in discussing degenerative changes.
  - In Escobedo and Justice, both doctors felt the DJD was long-standing: DOI v. Date of MRI/X-rays
  - Benson: Dr. Ito could have easily said the day Ms. Benson reached for the medical records file on the shelf was the last day of a long CT and found no specific injury to her cervical spine.
  - *Marlene Escobedo v. Marshall's (2005) 70 Cal. Comp. Cases 604 (WCAB en banc decision); Diane Benson v. WCAB (2009) 170 Cal. App. 4th 1535, 89 Cal. Rptr. 3d 166, 74 Cal. Comp. Cases 113; Co. of Santa Clara v. WCAB (Justice) (2020) 49 Cal. App.5th 605; 85 Cal. Comp. Cases 467

Depositions of Doctors

- Always understand the mechanism of injury (specific, CT, multiple)
- Causation of injury is separate analysis from causation of disability (WPI ratings)
- Hypothetical questions have to be based on facts the proponent of the questions can prove at trial
- Your conclusions need to be objectively reasonable
- It is ok to say apportionment is “approximately” such and such percent due to work injury and “approximately” such and such percent due to non-industrial factors
- Your conclusions are based on reasonable medical probability

Apportionment of PD

- Compare Escobedo with Benson with Barbara Justice cases*
  - All depended on the analysis by the doctor in discussing degenerative changes.
  - In Escobedo and Justice, both doctors felt the DJD was long-standing: DOI v. Date of MRI/X-rays
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Substantial Medical Evidence: What if it is not?

Labor Code Section 139.2(d): A QME upon request shall be reappointed if they meet the criteria under (b) and meets all of the following criteria:

- (d)(1): Is in compliance with all applicable regulations and evaluation guidelines adopted by the administrative director;
- (d)(2): Has not had more than five of his or her evaluations that were considered by a [workers' compensation judge] at a contested hearing rejected by the [judge] or [Appeals Board] pursuant to this section during the most recent two-year period during which the physician served as a [QME]. If the [judge or Appeals Board] rejects the [QME's] report on the basis that it fails to meet the minimum standards for those reports established by the [AD],[the Appeals Board], or [a judge],as the case may be, shall make a finding to that effect, and shall give notice to the medical evaluator, and to the [AD]. Any rejection shall not be counted as one of the five qualifying rejections until the specific finding has become final and time for appeal has expired.

Substantial Medical Evidence: What if it is not?

Title 8 Cal. Code of Regulations Section 10683: Where a QME's report has been considered and rejected pursuant to LC Section 139.2(d)(2), the [judge] or [Appeals Board] shall make and serve a specific finding on the QME and the [DWC] at the time of decision on the regular workers' compensation issues. The specific finding may be included in the decision.

If the Appeals Board, on reconsideration, affirms or sets aside the specific finding of fact filed by a [judge], it shall advise the QME and the DWC at the time of service of its decision on the petition for reconsideration. If the [judge] does not make a specific finding and the Appeals Board, on reconsideration makes a specific finding of rejection pursuant to LC 139.2(d)(2), it shall serve its specific finding on the QME and the DWC at the time it serves its decision after reconsideration.

Rejection of a QME's report pursuant to LC 139.2(d)(2) shall occur where the QME's report does not meet the minimal standards prescribed by the provisions of Rule 10682 and the regulations of the DWC.