AMA Guides 6th Edition

AADEP

ANNUAL COMPREHENSIVE COURSE

Sunday, April 10, 2010

Austin, TX

Marjorie Eskay-Auerbach MD, JD

James B. Talmage MD
Schedule

•  8 –  8:45 am  Introduction, Jim Talmage
•  8:45- 10:00 am  Spine, Margie Eskay-Auerbach
•  10:00 - 10:15 am  Break
•  10:15 - 12:15  Upper Extremity, Jim Talmage
•  12:15 - 1:15 pm  Lunch
•  1:15 - 2:30 pm  Lower Extremity Impairments*, Jim Talmage
•  2:30 - 2:45 pm  Pain, Margie Eskay-Auerbach
•  2:45 - 3:00 pm  Break
•  3:00 - 4:00 pm  Neurologic and Mental, Margie Eskay-Auerbach
•  4:00 - 5:00 pm  Case Presentations, Jim Talmage
Questions?

James B. Talmage MD,
Occupational Health Center,

315 N. Washington Ave, Suite 165
Cookeville, TN 38501
Phone 931-526-1604 (Fax 526-7378)
olddrt@frontiernet.net
olddrt@occhealth.md
James B. Talmage MD
Financial “Conflict of Interest” Disclosure

- “Reviewer”, *AMA Guides, 5th Edition*
- **Associate Editor**, the *Guides Newsletter*
  - PAID
- **Co-Editor & Co-Author**, the *Guides Casebook, 2nd Edition*
  - PAID
- **Co-Editor & Co-Author**, *A Physicians Guide to Return to Work*
  - PAID royalties
- **Consultant**: Guides Impairment Calculator software
  - PAID
James B. Talmage MD
Financial “Conflict of Interest” Disclosure

- **Co-Author**, *AMA Guides, 6\textsuperscript{th} Edition*
  - PAID
- **Member**, 6\textsuperscript{th} Edition Errata Committee
  - PAID consultant
- **Author**: Guides Sixth Impairment Training Workbooks:
  - Spine PAID
  - Lower Extremity PAID
  - CNS, Pain, Psych WILL BE PAID

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AMA Publications

Guides to the Evaluation of Permanent Impairment

• AMA Press: 1-800-621-8355 or
• www.amapress.com

The Guides Casebook

A Physician’s Guide to Return to Work

The Guides Newsletter

November/December 1996

Carpal Tunnel Syndrome: Challenges in Impairment Rating

by James B. Talmage, MD, FAADEP

Carpal tunnel syndrome is a common problem. This article discusses the impairment rating of CTS according to the Guides to the Evaluation of Permanent Impairment.
AMA Publications

Guides to the Evaluation of Permanent Impairment
Sixth Edition

Robert D. Rondinelli
Elizabeth Genovese • Richard T. Katz • Tom G. Mayer
Kathryn Mueller • Mohammed Ramesy
Christopher R. Brigham

Guides Sixth training workbooks and The Guides Casebook
Now available for pre-order!
The Medical Disability Advisor: Workplace Guidelines for Disability Durations, 5th Edition

Access the world's leading evidence-based disability duration information at the click of a mouse and provide the best case management possible.

See for yourself how MDA Internet streamlines workflow, increases communication among healthcare professionals, and provides the best in return-to-work guidance.

Sign Up for a FREE 30-DAY TRIAL

Effective case management increases workplace productivity by reducing lost time. Employers, employers, case managers and healthcare providers all benefit through use of evidence-based disability duration guidelines. Our disability guidelines are relevant to short-term disability (STD), long-term disability (LTD), workers compensation and other work-related absence management issues.

The Medical Disability Advisor: Evidence-Based Disability Duration Guidelines

- Data is derived from management disability cases that are coded at the time of diagnosis
- Clinical text is derived primarily from refereed sources rather than publications pulled indiscriminately from the Internet
- Strict process followed to obtain and interpret data in the context of expert medical judgement (Medical Advisory Board)
- The MDA is updated regularly with improved content, new conditions and valuable features
- The MDA review process includes an annual content and feature update, plus a 3

PAID CHAIR
Musculoskeletal Advisory Committee
3rd, 4th, & 5th Editions.
Paid Chair,
Medical Advisory Board,
ACOEM’s Practice Guidelines, 2nd Edition

Occupational Medicine Practice Guidelines
second edition

Evaluation and Management of Common Health Problems and Functional Recovery in Workers

AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE

NO ROLE
UNPAID CHAIR: Spine Committee

- Legally presumed correct treatment for workers’ compensation utilization review in California and Nevada.
  - 366 pages
  - 1320 articles reviewed and referenced.

- Neck chapter update underway.
The speaker is UNPAID Current President Elect of the American Academy of Disability Evaluating Physicians™ (AADEP).

"The premiere society for the prevention and management of disability"

For more information, contact AADEP @ 1-800-456-6095 or visit our website @ www.aadep.org
Peer Reviewer: UNPAID

- American Family Physician
- Archives of Physical Medicine and Rehabilitation
- The Spine Journal
Member

• Federal Motor Carrier Safety Administration Physician Work Group [PAID]

• **Tasked with:**
  
  – Suggesting revisions to the Medical Examination Form (paperwork)
  
  – Developing Communication Strategies to encourage providers to take the soon to be required training and test to be certified examiners.
  
  – Develop a Medical Examiner Resource Library
  
  – Suggest a format for publication of agency guidelines to Medical Examiners
Disability Evaluation
Earl D. McBride MD
1936.


Treatment Text.

Rated Disability
JAMA Feb 15, 1958
The Musculoskeletal System

12 other “Guides” published over the next 12 years in Issues of JAMA.
AMA Guides – Work in Progress
Gradual, Incremental Change
History of the AMA Guides

• 1956 - ad hoc committee
• 1958-1970 - 13 publications in JAMA
• 1971 - First Edition
• 1981 - established 12 expert panels
• 1984 - Second Edition
• 1988 - Third Edition
• 1990 - Third Edition-Revised
• 1993 - Fourth Edition (4 printings)
• 2007 (December) – Sixth Edition
  – Radical paradigm shift
Paradigm Shift
Paradigm Shift
Poll the Audience

• Use your device and answer:
• What percentage of treating physicians CURRENTLY USE the AMA Guides, 5th Edition correctly?

  A. 0 - 25 %
  B. 26- 50 %
  C. 51- 75 %
  D. 76-100 %
Add slide from Chris’ data on Error rate

- Brigham and Associates
  - [www.impairment.com](http://www.impairment.com)
  - Review impairment rating reports for $$
  - June 2006 – June 2008, 2798 cases
  - 78% (2160) were incorrect.
    - Original report average rating was 20.4%
    - Correct rating average rating was 7.3%

- AMA Guides Newsletter, July – August 2008
Selection Bias

• A bias built into an experiment by the method used to select the subjects which are to undergo a test or treatment.

• Someone (insurer, employer, defense attorney, plaintiff attorney) knew enough about the Guides, and disliked the impairment report enough to be willing to pay “big bucks” to have experts check and correct the rating.
The Color: Purple

Enhance assessment and understanding with updated tools and resources from the AMA

Guides to the Evaluation of Permanent Impairment
SIXTH EDITION

Robert D. Rondinelli
Elizabeth Genovese • Richard T. Katz • Tom G. Mayer
Kathryn Mueller • Mohammed Rannavaya

New
Coming
December 2007

Date of publication
December 24, 2007
Merry Christmas
AMA 6th Edition

www.amapress.org

Click on “Guides Impairment Resources”

Guides to the Evaluation of Permanent Impairment, Sixth Edition
Hardcover, 630 pages, 8.5" x 11"
Item#: CP025407
Authors: American Medical Association
List Price: $189
AMA Member Price: $139

Price $ 189
AMA Members $ 139

Update: The newly revised Guides offers more current guidelines for correct impairment evaluation.

Standardized methodology is applied to each chapter to enhance the relevancy of impairment ratings, improve internal consistency and promote ease of application to the rating process. This ordered method enables busy physicians to become proficient with the ratings for multiple organ systems and anticipate how each chapter is organized and assimilates information.

Functionally based histories, physical findings and broadly accepted objective clinical test results are integrated wherever applicable to help physicians determine the grade within the impairment class. The result is a decision that is both transparent and reproducible.
There are Architects

• But I was **NOT an** architect.
I was a carpenter.

• Do **NOT** change the plans, just insert the boards.
There were many carpenters

• We altered what we could to improve the product.

**AADEP Fellows:**
Chris Brigham
Elizabeth Genovese
Mark Hyman
Mark Melhorn
Bill Nemeth
Mohammed Ranavaya
Jim Talmage
Russell Travis
Do NOT Shoot the Messenger

• We can tell you what’s in the book and how to use it.

Kindly Old Dr. Talmage

THE EDITOR
AMA *Guides* Growth in Size

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The Color: Purple

If you read 60 pages/hour, it requires 10.5 hours to read.

If you read complex technical material at 15-30 pages/hour, it should require 21.9 – 43.9 hours to read this book.
# Core Content for “Common Conditions” Rated in WC

<table>
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To “study” at perhaps 10 pages/hour, requires 38 hours for the “core content”.
Figure 1. Projected Use of the AMA Guides in State Workers’ Compensation Cases
Immediate Use of the 6th Edition

Many states require the use of the “most recent Edition” of the Guides either by statute or code; therefore, states that are expected to implement the Sixth Edition immediately include Alaska, Hawaii, Kentucky, Louisiana, Mississippi, Montana, New Hampshire, New Mexico, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Vermont and Wyoming.

AMA Guides Newsletter, Jan-Feb 2008
Impairment Rating Starts the Process That Compensates the Injured Worker
Example: Tennessee WC

- **Permanent impairment Award**
  - For injuries rated as “Whole person”
  - **DR** x WW ($/week) x 400 (weeks) = $ awarded
  - **DR** = Impairment rating as modified by the judge
    - If back at work at the same or higher wage, judge can choose a **DISABILITY MULTIPLIER 1.0-1.5** times the medical impairment rating.
    - If back at work at a lower wage, or if not back at work, the judge can choose a **DISABILITY MULTIPLIER 1-6** times the medical impairment rating.
  - (WW) Weekly wage is the employees average weekly wage, or the state average weekly wage (currently $ 784), whichever is less.
Impairment Rating Does NOT

• Determine Medical Care
• Comment on causation
• “Impairment evaluations are usually performed not to establish academic facts or to make treatment decisions but, rather, to establish the financial obligations of payers to individuals, or, conversely, the entitlement of individuals to monetary rewards.

• “… to translate objective clinical findings into a percentage of the whole person. Typically this number is used to measure the residual deficit, a loss – a number that is then converted to a monetary award to the injured party.” — page 20

• The Guides is not intended to be used for direct estimates of work participation restrictions. Impairment percentages derived according to the Guides criteria do NOT directly measure work participation restrictions.”
  – Page 6, 6th Edition
  – Page 13, 5th Edition
Chapter 1: Definitions

• **Impairment:**
  – Loss, loss of use, or derangement of any body part, organ system, or organ function. (unchanged)

• **Disability:**
  – Alteration of an individual’s capacity to meet **personal, social, or occupational** demands because of an impairment. (unchanged)
KEY POINT

• **Physicians** rate **impairment**
  – Medical determination
  – Medical training required (Anatomy, Physiology)

• **Judges** rate **disability**
  – Judge “factors in” **NON**-medical factors
  – In Workers’ Compensation, the philosophical basis for the Lump Sum **cash** settlement is the loss of earning ability, and NOT “pain and suffering”.

• **Doctor: Do NOT think about** the ability to do his/her job, availability of similar jobs in the local economy, etc., as that is the judge’s task, NOT your task.
Impairment DOES NOT equal Disability

• Example: both a lawyer and a pianist sustain an amputation of the non-dominant little finger.
  – Both have the same impairment
    • 100% of the digit, 10% of the hand, 9% of the upper extremity, 5% whole person
  – The lawyer has no disability
  – The pianist is unable to perform his occupation
    • Totally disabled for his occupation
    • Fully capable of many jobs

• Physician’s role: Determine IMPAIRMENT
Impairment is NOT Disability

“In disability evaluation, the impairment rating is ONE of several determinants of disablement. Impairment rating is the determinant most amenable to physician assessment; it must be further integrated with contextual information typically provided by nonphysician sources regarding psychological, social, vocational, and avocational issues.” — page 6

Unless otherwise specified page numbers refer to the Guides, 6th Edition
AMA Guides Philosophy

• Ratings reflect the severity and limitations of the organ/body system impairment and resulting functional limitations

• Ratings in whole person, or converted to whole person

• 0% whole person rating
  – No significant organ or body system functional consequences
  – Does not limit the performance of common activities of daily living

• 90% - 100% whole person rating
  – Very severe organ or body system impairment
  – Requires the individual to be fully dependent on others for self-care, approaching death (page 19)
AMA Guides, 6th Edition

Philosophy

• “Impairment rating: consensus derived percentage estimate of loss of activity reflecting severity for a given health condition, and the degree of associated limitations in ADLs.” – page 5
  – ADLs = Activities of Daily Living
  – DEFINITION for ADLs has CHANGED, but
    • No explanation why ??
    • No discussion.
Self-Care

Activities of Daily Living (ADLs):
• Bathing, showering
• Dressing
• Eating
• Feeding
• Functional mobility
• Personal device care
• Personal hygiene and grooming
• Sexual activity
• Sleep/rest
• Toilet hygiene
Self-Care

Instrumental Activities of Daily Living (IADLs)

• Care of others (including selecting and supervising caregivers)
• Care of pets
• Child rearing
• Communication device use
• Community mobility
• Financial management
• Health management and maintenance
• Home establishment and maintenance
• Meal preparation and cleanup
• Safety procedures and emergency responses
• Shopping
**Activities of Daily Living**

**5th Edition**

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<th>Activity</th>
<th>Example</th>
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<td>Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating</td>
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<tr>
<td>Communication</td>
<td>Writing, typing, seeing, hearing, speaking</td>
</tr>
<tr>
<td>Physical activity</td>
<td>Standing, sitting, reclining, walking, climbing stairs</td>
</tr>
<tr>
<td>Sensory function</td>
<td>Hearing, seeing, tactile feeling, tasting, smelling</td>
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<tr>
<td>Nonspecialized hand activities</td>
<td>Grasping, lifting, tactile discrimination</td>
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<tr>
<td>Travel</td>
<td>Riding, driving, flying</td>
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<td>Sexual function</td>
<td>Orgasm, ejaculation, lubrication, erection</td>
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<tr>
<td>Sleep</td>
<td>Restful, nocturnal sleep pattern</td>
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**6th Edition**

**Table 1-1**

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<th>Self-Care</th>
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<td><strong>Activities of Daily Living (ADLs)</strong></td>
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<td>Bathing, showering</td>
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**Instrumental Activities of Daily Living (IADLs)**

| Care of others (including selecting and supervising caregivers) |
| Care of pets                                                   |
| Child rearing                                                  |
| Communication device use                                       |
| Community mobility                                            |
| Financial management                                          |
| Health management and maintenance                             |
| Home establishment and maintenance                            |
| Meal preparation and cleanup                                   |
| Safety procedures and emergency responses                     |
| Shopping                                                       |

Source: Youngstrom.²⁴

**NOT in 5th Edition**

- Communication device use
- Community mobility
- Financial management
- Health management and maintenance
- Home establishment and maintenance
- Meal preparation and cleanup
- Safety procedures and emergency responses
- Shopping

**NOT in 6th Edition**

- Self-care, personal hygiene
- Physical activity
- Sensory function
- Nonspecialized hand activities
- Travel
- Sexual function
- Sleep
AMA Guides Editions 1 - 5

Model of Disablement

- Based upon *International Classification of Impairments, Disabilities and Handicaps (ICIDH)* (WHO 1980)
The Color: Purple

Enhance assessment and understanding with updated tools and resources from the AMA
ICF Model of Impairment

Pathology

Impairment

DISABILITY

Activity

No Activity Limitation

Complete Activity Limitation

No Participation Restriction

Complete Participation Restriction

HANDICAP

Environmental

Personal

Health Condition, Disorder or Disease

Body Functions and Structures

Normal Variation

Complete Impairment
International Classification of Functioning, Disability and Health (ICF)

The ICF is WHO's framework for measuring health and disability at both individual and population levels. The ICF was officially endorsed by 191 WHO Member States in the Fifty-fourth World Health Assembly on 22 May 2001 (resolution WHA 54.21). Unlike its predecessor, which was endorsed for use in Member States as the international standard to describe and measure health and disability.

The ICF puts the notions of 'health' and 'disability' in a new light. It acknowledges that every human being can experience a decrement in health and thereby experience some degree of disability. Disability is not something that only happens to a minority of humanity. The ICF thus 'mainstreams' the experience of disability and recognises it as a universal human experience. By shifting the focus from cause to impact it places all health conditions on an equal footing allowing them to be compared using a common metric - the ruler of health and disability. Furthermore ICF takes into account the social aspects of disability and does not see disability only as 'medical' or 'biological' dysfunction. By including Contextual Factors, in which environmental factors are listed, ICF allows to record the impact of the environment on the person's functioning.

DETAILED INFORMATION ON ICF

:: ICF Home Page
:: ICF Online

ICD REVISION
:: WHO revises the ICD

BUSINESS PLAN
:: More Information

EVENTS
:: WHOFIC Network Meeting 2007
:: Conference on Children Health, Disability and ICF-CY

ICD-10 ONLINE
:: Current Version (2007) Other materials

ICF ONLINE
:: International Classification of Functioning, Disability and Health
:: Online version

http://www.who.int/classifications/icf/en/

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We are all to some degree DISABLED?
1.2b Five New Axioms of the 6th Edition (page 2)

The vision embodied by this paradigm shift is articulated in terms of 5 specific new axioms. These axioms provide direction and define priorities.

1. The *Guides* adopts the terminology and conceptual framework of disablement as put forward by the International Classification of Functioning, Disability and Health (ICF). (WHO, 2001)

2. The *Guides* becomes more diagnosis based with these diagnoses being evidence-based when possible.

3. **Simplicity, ease of application, and following precedent**, where applicable, are given high priority, with the goal of optimizing inter-rater and intra-rater reliability.

4. Rating percentages derived according to the *Guides* are **functionally-based**, to the fullest practical extent possible.

5. The *Guides* stresses conceptual and methodological congruity within and between organ system ratings.
# Examples in 6th Edition

Rated by the 5th and the 6th Edition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of examples</th>
<th>5th Edition Average Rating</th>
<th>6th Edition Average Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper Extremity</td>
<td>12</td>
<td>4% WPI</td>
<td>4% WPI</td>
</tr>
<tr>
<td>Lower Extremity</td>
<td>15</td>
<td>8% WPI</td>
<td>7% WPI</td>
</tr>
<tr>
<td>Spine (No fusion)</td>
<td>11</td>
<td>7% WPI</td>
<td>6% WPI</td>
</tr>
<tr>
<td>Spine Fusion</td>
<td>5</td>
<td>24% WPI</td>
<td>15% WPI</td>
</tr>
<tr>
<td>Example</td>
<td>Region</td>
<td>Class</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>---------</td>
<td>--------</td>
<td>-------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>15-1</td>
<td>Digit</td>
<td>0</td>
<td>Stenosing tenosynovitis, resolved with surgery</td>
</tr>
<tr>
<td>15-2</td>
<td>Digit</td>
<td>1</td>
<td>Fracture metacarpal</td>
</tr>
<tr>
<td>15-3</td>
<td>Digit</td>
<td>1</td>
<td>Stenosing tenosynovitis, symptomatic</td>
</tr>
<tr>
<td>15-4</td>
<td>Digit</td>
<td>2</td>
<td>Distal interphalangeal joint dislocation, reduced</td>
</tr>
<tr>
<td>15-5</td>
<td>Wrist</td>
<td>0</td>
<td>Contusion</td>
</tr>
<tr>
<td>15-6</td>
<td>Wrist</td>
<td>1</td>
<td>Ganglion cyst</td>
</tr>
<tr>
<td>15-7</td>
<td>Wrist</td>
<td>3</td>
<td>S/P Wrist Fusion</td>
</tr>
<tr>
<td>15-8</td>
<td>Elbow</td>
<td>0</td>
<td>Lateral epicondylitis</td>
</tr>
<tr>
<td>15-9</td>
<td>Elbow</td>
<td>1</td>
<td>Distal biceps tendon rupture</td>
</tr>
<tr>
<td>15-10</td>
<td>Shoulder</td>
<td>1</td>
<td>Nonspecific shoulder pain</td>
</tr>
<tr>
<td>15-11</td>
<td>Shoulder</td>
<td>1</td>
<td>Status post rotator cuff repair</td>
</tr>
<tr>
<td>15-12</td>
<td>Shoulder</td>
<td>2</td>
<td>Total shoulder arthroplasty</td>
</tr>
<tr>
<td>Average</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Example</td>
<td>Region</td>
<td>Class</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------</td>
<td>-------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>16-1</td>
<td>Foot and ankle</td>
<td>0</td>
<td>Contusion</td>
</tr>
<tr>
<td>16-2</td>
<td></td>
<td>1</td>
<td>Plantar fasciitis</td>
</tr>
<tr>
<td>16-3</td>
<td></td>
<td>1</td>
<td>Ankle instability</td>
</tr>
<tr>
<td>16-4</td>
<td></td>
<td>2</td>
<td>Bimalleolar fracture</td>
</tr>
<tr>
<td>16-5</td>
<td></td>
<td>3</td>
<td>Ankle arthritis</td>
</tr>
<tr>
<td>16-6</td>
<td></td>
<td>5</td>
<td>s/p Total ankle replacement with poor result</td>
</tr>
<tr>
<td>16-7</td>
<td>Knee</td>
<td>0</td>
<td>Knee strain, resolved</td>
</tr>
<tr>
<td>16-8</td>
<td></td>
<td>1</td>
<td>Meniscal tear</td>
</tr>
<tr>
<td>16-9</td>
<td></td>
<td>1</td>
<td>s/p Anterior cruciate reconstruction and medial meniscus repair</td>
</tr>
<tr>
<td>16-10</td>
<td></td>
<td>2</td>
<td>Subluxing patella</td>
</tr>
<tr>
<td>16-11</td>
<td></td>
<td>3</td>
<td>s/p Total knee replacement</td>
</tr>
<tr>
<td>16-12</td>
<td></td>
<td>4</td>
<td>Knee arthritis</td>
</tr>
<tr>
<td>16-13</td>
<td>Hip</td>
<td>0</td>
<td>Contusion</td>
</tr>
<tr>
<td>16-14</td>
<td></td>
<td>1</td>
<td>Hip dislocation and relocation</td>
</tr>
<tr>
<td>16-15</td>
<td></td>
<td>3</td>
<td>Hip fracture</td>
</tr>
<tr>
<td>Average</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Example</td>
<td>Region</td>
<td>Class</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>---------</td>
<td>--------</td>
<td>-------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17-1</td>
<td>Cervical</td>
<td>0</td>
<td>Cervical sprain/strain</td>
</tr>
<tr>
<td>17-2</td>
<td>Cervical</td>
<td>1</td>
<td>Intervertebral disc herniation (cervical disc herniation with resolved right-sided C6 radiculopathy)</td>
</tr>
<tr>
<td>17-3</td>
<td>Cervical</td>
<td>1</td>
<td>Intervertebral disc herniation or AOMSI at a single level (s/p nucleus pulposus and anterior cervical discectomy) and fusion at C5-6 with intermittent left arm pain</td>
</tr>
<tr>
<td>17-4</td>
<td>Cervical</td>
<td>2</td>
<td>Intervertebral disc herniation or AOMSI at a single level (cervical disc herniation with C8 radiculopathy)</td>
</tr>
<tr>
<td>17-5</td>
<td>Cervical</td>
<td>3</td>
<td>Intervertebral disc herniations and AOMSI at multiple levels (cervical disc herniations at 2 levels, with unresolved Radiculopathy at single level)</td>
</tr>
<tr>
<td>17-6</td>
<td>Cervical</td>
<td>4</td>
<td>Vertebral fractures at multiple levels (vertebral fracture with C4-7 fusion and unresolved radiculopathy at 2 levels)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Thoracic sprain / strain (postural discomfort)</td>
</tr>
<tr>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>17-8</td>
<td>Thoracic</td>
<td>1</td>
<td>Intervertebral disc herniation or AOMSI at one or more levels (HNP T1-2 with thoracic radiculopathy at T2)</td>
</tr>
<tr>
<td>17-9</td>
<td>Thoracic</td>
<td>3</td>
<td>Vertebral fractures at multiple levels (compression fractures of</td>
</tr>
</tbody>
</table>

- From:
  - A Personal Perspective on the 6th Edition of the AMA Guides to the Evaluation of Permanent Impairment for the Musculoskeletal Chapters – J Mark Melhorn MD
    - *IAIABC Journal*, Fall 2008
  - Debunking Impairment Rating Myths -By Christopher R. Brigham, MD[1], W. Frederick Uehlein. JD[2], Craig Uejo, MD, MPH and Leslie Dilbeck, CIR
<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>17-10</td>
<td>Lumbar</td>
<td>0</td>
<td>Lumbar sprain/strain (non-specific low back pain, resolved)</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>17-11</td>
<td>Lumbar</td>
<td>1</td>
<td>Intervertebral disc herniation or AOMSI at a single level (herniated nucleus pulposus L5-S1, left, now asymptomatic)</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>17-12</td>
<td>Lumbar</td>
<td>1</td>
<td>Recurrent low back pain without objective findings (recurrent low back pain without objective findings on examination or clinical studies)</td>
<td>1%</td>
<td>5%</td>
</tr>
<tr>
<td>17-13</td>
<td>Lumbar</td>
<td>2</td>
<td>Intervertebral disc herniation or AOMSI at a single level (lumbar disc herniation, L4-5, left posterolateral, with left L5 radiculopathy)</td>
<td>12%</td>
<td>10%</td>
</tr>
<tr>
<td>17-14</td>
<td>Lumbar</td>
<td>2</td>
<td>Intervertebral disc herniation or AOMSI at a single level (s/p lumbar fusion at L4-5 with persistent L5 radiculopathy)</td>
<td>13%</td>
<td>25%</td>
</tr>
<tr>
<td>17-15</td>
<td>Lumbar</td>
<td>3</td>
<td>Intervertebral disc herniation or AOMSI at multiple levels (lumbar disc herniation L5-S1 with multiple level fusion)</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>Average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8%</td>
</tr>
</tbody>
</table>
Examples in $6^{\text{th}}$ Edition
Rated by the $5^{\text{th}}$ and the $6^{\text{th}}$ Edition

![Bar chart showing percentage of cases in different categories.](chart.png)

- Upper Extremity
- Lower Extremity
- Spine (except fusion)
- Spine Fusion

- Fifth
- Sixth
Paradigm shift: ICF Model

• “Historically, the numerical ratings applied for organ system impairment and whole person impairment throughout the Guides are based largely on consensus and expert opinion. Research has focused on reliability and reproducibility of ratings\textsuperscript{17} and functional validity of ratings\textsuperscript{15, 32,33}. The evidence basis for impairment percentages assignable to ICF functional levels must await further empirical testing\textsuperscript{19}…”

– 6\textsuperscript{th} Edition, page 9
References for quote on prior slide


AMA’s Rationalization

• If we apply to NIH for a grant to study whether the impairment ratings assigned by the Guides actually correlate with “real world” disability, NIH will reject our grant application, since it would use archaic (5th Edition) terminology. We must switch to the ICF model of disablement, as NIH now uses that model.
ICF Model of Impairment

Health Condition, Disorder or Disease

Body Functions and Structures

Activity

Participation

Normal Variation

Complete Impairment

No Activity Limitation

Complete Activity Limitation

No Participation Restriction

Complete Participation Restriction

Environmental

Personal
AMA Guides, 6th Edition
Section 1.3b

• **Definitions:**
  – **Body Functions**: physiologic functions of the body systems (including psychological functions)
  – **Body Structures**: anatomic parts of the body such as organs, limbs, and their components.
  – **Activity**: execution of a task or action by an individual
  – **Participation**: involvement in a life event
Definitions from ICF:

- **Impairments**: problems in body function or structure such as a significant deviation or loss.
- **Activity limitations**: difficulties an individual may have in executing activities.
  - Sounds like “Disability”
- **Participation restrictions**: problems an individual may experience in involvement in life situations.
  - Sounds like “Handicap”
AMA Guides
COMPARE 5TH & 6TH Editions

• “For purposes of the Guides” (6th Edition) the following operational definitions and disclaimers apply.” - page 5

  – 6th Edition: Impairment; a significant deviation, loss, or loss of use, of any body structure or body function in an individual with a health condition, disorder, or disease. – page 5

- 5th Edition: Impairment is “A loss, loss of use, or derangement of any body part, organ system, or organ function.”

Definitions are essentially the same
AMA Guides
COMPARE 5TH & 6th Editions

• “For purposes of the Guides” (6th Edition) the following operational definitions and disclaimers apply.” - page 5
  - 6th Edition: Disability; activity limitations and/or participation restrictions in an individual with a health condition, disorder, or disease. — page 5
  - 5th Edition: Disability; “An alteration of an individual’s capacity to meet personal, social, or occupational demands because of an impairment.”

Definitions are essentially the same
AMA Guides, 6th Edition

• **Definition:** Maximal Medical Improvement
  - “Maximum Medical Improvement (MMI) refers to a status where the person is as good as he/she is going to get from the medical and surgical treatment available to him/her. It can also be conceptualized as a date from which further recovery or deterioration is not anticipated, although over time (beyond twelve months) there may be some expected change.” – Chapter 2.5e, page 26

Words are somewhat different, but the concept is UNCHANGED.
AMA Guides, 6th Edition

- **Definition**: Maximal Medical Improvement
  - “MMI does not preclude the deterioration of a condition that is expected to occur with the passage of time or as a result of the normal aging process, nor does it preclude allowance for ongoing follow-up for optimal maintenance of the medical condition in question.”
  - Chapter 2.5e, page 26

Words are somewhat different, but the concept is UNCHANGED.
AMA Guides, 6th Edition

Adjustment for Treatment

• “In certain instances, the treatment of an illness may result in apparent total remission of the person’s signs and symptoms. … However, if the examiner concludes that with such permanent treatment based on objective findings, the patient has actually not regained his or her previous function, and if the Guides has not provided specific criteria to rate such impairment, the physician may choose to increase the impairment estimate by a small percentage (eg 1 – 3 %). Such a discretionary impairment is provided only once and is not to be duplicative of impairment provided by BOTC (Burden of Treatment Compliance).”

- Chapter 2.5e, page 26

Words are somewhat different.
Advantages of the ICF Model
Section 1.3b

• “The ICF model appears to be the best model for the Guides. It acknowledges the complex and dynamic interactions between an individual with a given health condition, the environment, and personal factors. The relationships between impairment, activity limitations, and participation are not assumed to be linear or unidirectional.”
  – Page 3
Advantages of the ICF Model
Section 1.3b

• “An individual may experience measurable impairment without significant activity limitations that do not produce restrictions to major life activities such as work or recreation. On the other hand, one can experience significant activity limitations and/or participation restrictions in the absence of demonstrable impairment”

– Page 3
Identical to Table 15-10 in the Upper Extremity
Similar to Table 17-10 in the Spine
Similar to Table 4-4 in the Cardiovascular System
Similar to Table 5-3 in the Pulmonary System
Similar to Table 6-3 in the Digestive System
Similar to Table 7-1 in the Urinary and Reproductive System
Etc.
HOW Does it Work ???????

• **5 Classes**: Class 0, 1, 2, 3, & 4
• Within each class there are
  – **5 grades of severity**: Grade A, B, C, D, & E
• **Diagnosis** usually establishes the Class.
• The “Default” severity grade is grade C
  – This will “most often” be the final impairment rating.
  – The final rating may be less than (grade A or B) or greater than (grade D or E) the default rating, depending on “MODIFIERS”.

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Steps:

1. Diagnosis determines Class

2. Adjust severity (determine Grade within the Class)

Summary of Diagnosis-based Impairment Estimate Process

1. Identify presumptive diagnosis and regions involved.
2. Perform history and examination (as defined in Section 16.1a)
   a. Obtain history and functional status.
   b. Perform physical examination; obtaining information used in defining the severity of the condition and for some diagnoses defining the class and range of impairments.
3. Review clinical studies (as defined in 16.1b); obtaining information used in defining the severity of the condition and for some diagnoses defining the class and range of impairments.
4. Determine Diagnosis-based Impairment Estimate and associated impairments (as defined in Section 16.2 and 16.3).
5. Adjust assigned default impairment, based on grading information and adjustment grids for functional history, physical examination and clinical studies. (Only adjust for reliable and related findings that are not used to define the Diagnosis-based Impairment Estimate.)
6. As applicable, consider alternatives to Diagnosis-based Impairment Estimates (i.e. peripheral nerve, complex regional pain syndrome, amputation, or range of motion impairment).
Diagnosis determines Class Adjust for severity (Grade)

<table>
<thead>
<tr>
<th>Specific Adjustment Grid</th>
<th>Grade Modifier 0</th>
<th>Grade Modifier 1</th>
<th>Grade Modifier 2</th>
<th>Grade Modifier 3</th>
<th>Grade Modifier 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>FUNCTIONAL HISTORY</td>
<td>No problem</td>
<td>Mild problem</td>
<td>Moderate problem</td>
<td>Severe problem</td>
<td>Very severe problem</td>
</tr>
<tr>
<td>PHYSICAL EXAMINATION</td>
<td>No problem</td>
<td>Mild problem</td>
<td>Moderate problem</td>
<td>Severe problem</td>
<td>Very severe problem</td>
</tr>
<tr>
<td>CLINICAL STUDIES</td>
<td>No problem</td>
<td>Mild problem</td>
<td>Moderate problem</td>
<td>Severe problem</td>
<td>Very severe problem</td>
</tr>
</tbody>
</table>

Concept: Each of these 3 factors can be described by degree of severity

Identical to Table 15-6, page 406 (The Upper Extremity)
Identical to Table 17-5, page 575 (The Spine and Pelvis)
Mathematical Explanation

For the mathematically inclined, net adjustment may be obtained by a mathematical formula and then using the resultant value to define the grade. The following abbreviations are used:

CDX = Class of Diagnosis (Regional Grid)
GMFH = Grade Modifier for Functional History
GMPE = Grade Modifier for Physical Examination
GMCS = Grade Modifier for Clinical Studies

Net Adjustment = (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX)

Example:

Class 2 impairment (by diagnosis)

FH = grade 1
PE = grade 2
CS = grade 3

NA = (1-2) + (2-2) + (3-2) = 0
OR
NA = minus 1 + 0 + 1 = 0

A Net adjustment of zero means The rating is grade C (the default rating)

A Net Adjustment of + 1 would mean grade D, while a Net Adjustment of – 1 would mean Grade B is the final rating.
## Diagnosed-Based Impairments and Adjustment Factors

<table>
<thead>
<tr>
<th>Diagnostic Criteria</th>
<th>Class 0</th>
<th>Class 1</th>
<th>Class 2</th>
<th>Class 3</th>
<th>Class 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>RANGES</td>
<td>0%</td>
<td>1% - 13%</td>
<td>14%-25%</td>
<td>26%-49%</td>
<td>50%-100%</td>
</tr>
<tr>
<td>GRADE</td>
<td>A B C D E</td>
<td>A B C D E</td>
<td>A B C D E</td>
<td>A B C D E</td>
<td></td>
</tr>
<tr>
<td></td>
<td># # # # #</td>
<td># # # # #</td>
<td># # # # #</td>
<td># # # # #</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Default</td>
<td>Default</td>
<td>Default</td>
<td>Default</td>
<td></td>
</tr>
</tbody>
</table>

## Adjustments Non-Key Factor

<table>
<thead>
<tr>
<th>Non-Key Factor</th>
<th>Grade Modifier 0</th>
<th>Grade Modifier 1</th>
<th>Grade Modifier 2</th>
<th>Grade Modifier 3</th>
<th>Grade Modifier 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional History</td>
<td>No Problem</td>
<td>Mild Problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Exam</td>
<td>No Problem</td>
<td>Mild Problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Studies</td>
<td>No Problem</td>
<td>Mild Problem</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1-1=0
### Diagnosed-Based Impairments and Adjustment Factors

<table>
<thead>
<tr>
<th>Diagnostic Criteria</th>
<th>Class 0</th>
<th>Class 1</th>
<th>Class 2</th>
<th>Class 3</th>
<th>Class 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>RANGES</td>
<td>0%</td>
<td>1% - 13%</td>
<td>14%-25%</td>
<td>26%-49%</td>
<td>50%-100%</td>
</tr>
<tr>
<td>GRADE</td>
<td>A B C D E</td>
<td>A B C D E</td>
<td>A B C D E</td>
<td>A B C D E</td>
<td>A B C D E</td>
</tr>
<tr>
<td></td>
<td>Default</td>
<td>Default</td>
<td>Default</td>
<td>Default</td>
<td>Default</td>
</tr>
</tbody>
</table>

### Adjustments Non-Key Factor

<table>
<thead>
<tr>
<th>Non-Key Factor</th>
<th>Grade Modifier 0</th>
<th>Grade Modifier 1</th>
<th>Grade Modifier 2</th>
<th>Grade Modifier 3</th>
<th>Grade Modifier 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional History</td>
<td>No Problem</td>
<td>Mild Problem</td>
<td>1-2= minus 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Exam</td>
<td>No Problem</td>
<td>Mild Problem</td>
<td>1-2= minus 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Studies</td>
<td>No Problem</td>
<td>Mild Problem</td>
<td>1-2= minus 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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## Net Adjustment Formula

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>-2</th>
<th>-1</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
</tbody>
</table>

Modifiers permit moving Up or Down within a Class to a different severity Grade.

Modifiers do **NOT** permit changing to a different Class.
Lower Limb Chapter

# Table 16-9: Methodology for Determining the Grade in an Impairment Class

<table>
<thead>
<tr>
<th>Diagnostic Criteria (Key Factor)</th>
<th>Class 0</th>
<th>Class 1</th>
<th>Class 2</th>
<th>Class 3</th>
<th>Class 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairment Ranges</td>
<td>0% LE</td>
<td>1%–13% LE</td>
<td>14%–25% LE</td>
<td>26%–49% LE</td>
<td>50%–100% LE</td>
</tr>
<tr>
<td>Grade</td>
<td>A B C D E</td>
<td>A B C D E</td>
<td>A B C D E</td>
<td>A B C D E</td>
<td>A B C D E</td>
</tr>
<tr>
<td>Example Rating</td>
<td>3 4 5 6 7</td>
<td>16 18 20 22 24</td>
<td>26 28 30 32 34</td>
<td>50 52 54 56 58</td>
<td></td>
</tr>
</tbody>
</table>

*LE indicates lower extremity.

Identical to Table 15-10 in the Upper Extremity
Similar to Table 17-10 in the Spine
Similar to Table 4-4 in the Cardiovascular System
Similar to Table 5-3 in the Pulmonary System
Similar to Table 6-3 in the Digestive System
Similar to Table 7-1 in the Urinary and Reproductive System
Etc.
LIVE BY

Chapters 1 & 2
True
Table 2-1: Fundamental Principles of the *Guides* [ The “Constitution” ]

1. Concepts and philosophy in this chapter are the fundamental rules of the *Guides*; they shall preempt anything in subsequent chapters that conflicts with or compromises the principles.

2. No impairment may exceed 100% whole person permanent impairment. No impairment arising from a member or organ of the body may exceed the amputation value of that member.

3. All regional impairments in the same organ or body system shall be combined as prescribed by the rule, at the same level first and further combined with other regional impairments at the whole person level.

4. Impairments must be rated per the chapter relevant to the organ or system where the injury primarily arose or where the greatest dysfunction consistent with objectively documented pathology remains.
Table 2-1: Fundamental Principles of the *Guides* [The “Constitution”]

5. Only permanent impairment may be rated according to the *Guides* and only after maximum medical improvement (MMI) status is certified.

6. Impairment evaluation requires medical knowledge. Physicians duly recognized by an appropriate jurisdiction should perform such assessments within their applicable scope of practice and field of expertise.

7. A valid impairment evaluation report based on the *Guides* must contain the 3-step approach described in Section 2.7. (clinical evaluation, analysis of findings, and discussion of how the impairment rating was calculated).

8. The evaluating physician must use knowledge, skill, and ability generally accepted by the medical scientific community when evaluating an individual, to arrive at the correct impairment rating according to the *Guides*.
Table 2-1: Fundamental Principles of the Guides [The “Constitution”]

9. The Guides is based on objective criteria. The physician must use all clinical knowledge, skill, and abilities in determining whether the measurements, test results, or written historical information are consistent and concordant with the pathology being evaluated. If such findings, or an impairment estimate based on these findings, conflict with established medical principles, they cannot be used to justify an impairment rating.

10. Range of motion and strength measurement techniques should be assessed carefully in the presence of apparent self-inhibition secondary to pain or fear.

11. The Guides does not permit the rating of future impairment.

12. If the Guides provide more than one method to rate a particular impairment or condition, the method producing the higher rating must be used.

13. Subjective complaints alone are generally not ratable under the Guides (see Chapter 3, Pain for potential exceptions).

14. Round all fractional impairment ratings, whether intermediate of final, to the nearest whole number. Unless otherwise specified.
A clear, accurate, and complete report must be provided to support a rating of permanent impairment.
The following 3-step process is required by the examiner to estimate impairment according to the Guides:

- Clinical evaluation
- Analysis of the findings
- Discussion of how the impairment rating was calculated.

2. Practical Application of the Guides
Clinical Evaluation

• Relevant history
  – Review of medical records reflecting past medical history
  – Patient’s presentation of the current history
Clinical Evaluation

It is important to review medical records before performing an impairment rating, as this will enable the examiner, among other things to:

• **Clarify or at least document** inconsistencies, if any, between the history provided by the patient and the history contained in the medical records.

• **Reconcile** any inconsistencies, if any, between the patient’s history during the examination and other previous medical records. It is necessary to clarify historical inconsistencies because several issues, including causation, are primarily determined by the history.

• **Focus on the portions of the history pertinent to the impairment rating.**
Analysis of the Findings

- Discuss how specific findings relate to the conclusion of diagnoses and MMI status.
- Refer to the current abilities of ADLs and any validated deficiencies.
- Explain the absence of any pertinent data and how the physician determined the impairment rating with limited data.
Discussion of How the Impairment Rating was Calculated

• **Discussion** of how the *Guides*’ criteria were applied to medical information that generated the specific rating is required for an impairment evaluation to be consistent with the *Guides*.

• **Compare** the appropriate information obtained on history and objective findings with the criteria described in the applicable chapter of the *Guides*.

• **Include an explanation** of each impairment value with reference, including pages and table number, to the applicable criteria of the *Guides*.

2. Practical Application of the *Guides*
Discussion of How the Impairment Rating was Calculated

• Combine multiple impairments for a final composite whole person impairment number, unless otherwise directed by jurisdictional application.

• Discuss how individual ratings were combined or added to create a final number; explain why certain ratings were disregarded in the final analysis due to invalid measurements and test results; and perform apportionment, where applicable.

• Include a summary list of impairments and impairment ratings by percentage, including calculation of the whole person impairment, as appropriate.

2. Practical Application of the Guides
• Using Assistive Devices in Evaluations
  – If an individual must regularly an assistive device, the physician should test and evaluate the organ system with the device.
  – If device is easily removable, the examiner may choose to test without the assistive device in place and then report both sets of results.
  – Physician may also choose to report alterations in organ function with and without use of device, as well as challenges, if any, that are posed by using the device.
  – If the assistive device is not easily removable, (implanted lens) evaluate the organ system’s functioning with the device in place.
  – Test the visual system with and without the patient’s glasses or contact lenses in place, if they are used, and report both findings.
Concepts Important to the Independent Medical Examiner

- Legal vs Medical Possibility and Probability
- Causality, Exacerbation, and Aggravation
- Apportionment
- Changes in Impairment from Prior Ratings
- Maximum Medical Improvement
- Permanency
- Cultural Differences

2. Practical Application of the Guides
“Apportionment is an allocation of causation among multiple factors that caused or significantly contributed to the injury or disease and resulting impairment. Apportionment requires a determination of percentage of impairment directly attributable to preexisting as compared with resulting conditions and directly contributing to the total impairment rating derived. In such cases the rating physician may estimate these contributions by first developing the following contingent ratings as based on earlier work.”
1. “A “total” impairment rating (A) (an all-inclusive current rating) is derived irrespective of preexisting and resulting conditions.

2. A second “baseline” rating (B) is derived that accounts solely for preexisting conditions without associated or aggravating reinjury.

3. The final rating (C) is derived in which preexisting conditions are discounted by subtracting the second from the first rating (A – B).”
• Changes in Impairment from Prior Ratings

“The physician should assess the current state of the impairment according to the criteria in the Guides. If an individual received an impairment rating from an earlier edition and needs to be reevaluated because of a change in the medical condition, the individual is evaluated according to the latest information pertaining to the condition in the current edition of the Guides.”
Concepts Important to the Independent Medical Examiner

• Changes in Impairment from Prior Ratings
  • “If a prior impairment evaluation was not performed, but sufficiently well documented information is available to currently estimate the prior impairment, the assessment would be performed based on the most recent Guides’ criteria.”
Concepts Important to the Independent Medical Examiner

• Changes in Impairment from Prior Ratings
  • “However, if the information is insufficient to accurately document the change, the physician must explain the basis of a prior determination and should not estimate the change.”
TRANSLATION:

- Joe had a **prior rotator cuff repair**, and received an **18% UEI** rating.
- Joe **re-injures** his shoulder.
  - He says he is worse.
  - ROM is about the same.
- **6th Edition** says he has a **9% UEI**.
- "**However,** if the information is insufficient to accurately document the change, **the physician** must explain the basis of a prior determination and **should not estimate the change.**"

- In deposition: "**I can not** estimate how much his impairment changed." — page 26
Do whatever Workers’ Comp Bureau or the Lawyers say
Better to read the rules, than to “drive blind”.
Thanks For Your Attention

SAY SOMETHING NICE TO EVERYONE YOU MEET TODAY! IT’LL DRIVE ’EM CRAZY!