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Further Reflections on the Almaraz-Guzman WCAB En Banc Decision

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While the Almaraz-Guzman WCAB En Banc Decision remains under reconsideration, all of us continue to reflect on how to respond and report as an AME/QME/Treater. I have tried to collect and collate the thoughts of many physician colleagues in the following document.

I urge you to read the full Almaraz-Guzman WCAB En Banc Decision which can be obtained at <http://www.csims.net/pdf/Almaraz%20-%20Guzman%20en%20banc.pdf>.

The thoughts and ideas in this document are only some possible approaches and their inclusion does not constitute justification for use. Remember and note well that whatever method is chosen to provide an equitable, proportionate and fair impairment rating, the opinion must be medically reasonable (make sense) and it must be justified (explained) to the concerned parties. The physician only provides a medically reasonable opinion whereas the final arbiter is the finder-of-fact, the WCAB and the courts.

The WCAB held, in summary, that: (1) the AMA Guides portion of the 2005 Schedule is rebuttable; (2) the AMA Guides portion of the 2005 Schedule is rebutted by showing that an impairment rating based on the AMA Guides would result in a permanent disability award that would be inequitable, disproportionate, and not a fair and accurate measure of the employee's permanent disability (my underline); and (3) when an impairment rating based on the AMA Guides has been rebutted, the WCAB may make an impairment determination that considers medical opinions that are not based or are only partially based on the AMA Guides.

The WCAB expressly proclaimed that their holding does *not* open the door to impairment ratings directly or indirectly based upon any Schedule in effect prior to 2005, regardless of how "fair" such a rating might seem to a physician, litigant, or trier-of-fact (WCAB Judge).

A party may rebut a scheduled impairment rating based on the AMA Guides by showing that this impairment rating would result in a permanent disability award that would be inequitable and not commensurate with the disability the employee has suffered. Ordinarily, this showing would be accomplished through the opinions of treating or evaluating physicians who, using methodology in addition to and/or independent of the AMA Guides, conclude that the injured employee's impairment is greater than – or lesser than – the impairment rating called for by the Guides. In arriving at an impairment opinion that differs from the impairment rating called for by the AMA Guides, a physician may invoke his or her judgment based upon his or her experience, training, and skill.

As the evaluating physician, you can expect the applicant attorney to ask you if the impairment is equitable, fair and commensurate with the disability. The defense attorney / claims examiner will insist on your justification for rebutting the AMA Guides.

My personal current interpretation is that based on the Almaraz-Guzman Decision, we are not to go back to the “old” system; we are still supposed to use the AMA Guides 5th Edition, but the physician is now given more leeway to use other methods and to try to better match the impairment to the disability. It is critical that the physician provide justification to rebut a traditional, literal or standard AMA Guides impairment rating.

Therefore, a physician may depart from the specific recommendations of the AMA Guides and draw analogies to the Guides' other chapters, tables, or methods of assessing impairment. Also, in evaluating impairment in a manner outside of or in addition to that prescribed by the AMA Guides, the physician may consider other generally accepted medical literature or criteria. Such additional or alternative literature could include, but would not necessarily be limited to, other AMA publications or the publications of other established medical organizations. After chatting with many attorneys, my personal recommendation is that as physician evaluators that we stick with the legislatively mandated AMA Guides 5th Edition to the extent possible.

Moreover, in reaching an impairment opinion that is not based on a strict application of the AMA Guides, a physician may consider a wide variety of medical and non-medical information. For example, the AMA Guides analyzes whether an injured employee's injury impairs his or her ability to perform activities of daily living, *excluding work*. Therefore, when a physician believes that an impairment rating based on the AMA Guides would not provide a fair and accurate measure of the injured employee's degree of impairment, then the physician may assess how the permanent effects of the employee's injury impair his or her ability to perform *work* activities, as well as assess the medical consequences of performing certain work activities.

In addition, a physician may take into account pertinent diagnostic studies, such as functional capacity and rehabilitation evaluations. Finally, if the employee has been evaluated by a vocational rehabilitation expert, the physician may review and consider the vocational specialist's opinion regarding what jobs the employee might be able to perform and what effect the injury may have on his or her ability to earn.

The WCAB emphasizes that their decision does not permit physicians to deviate from the AMA Guides simply to achieve a more desirable result; (2) the reasons for such a deviation must be fully explained and the alternative methodology set forth in sufficient detail so as to allow a proper evaluation of its soundness and accuracy; and (3) therefore, within the report, an evaluating physician is expected to provide a full medical evaluation, analysis of the medical findings with respect to the patient's life activities, and comparison of the results of analysis with the impairment criteria.”

The WCAB does not suggest that this approach to evaluating impairment is perfect. The reality is that, at present, there is no simple method by which evidence regarding an employee's medical condition can be combined with other evidence to calculate the percentage to which an injured employee is occupationally impaired.

Nevertheless, just because there is no easy solution does not mean that when a rating called for by the AMA Guides does not provide a fair and accurate measure of the injured employee's impairment and does not truly and accurately reflect his or her loss, we may turn a blind eye to this fact and deny the employee his or her just compensation.

Approaches to Impairment Rating post Almaraz-Guzman

The physician evaluator must first evaluate using the AMA Guides and then must explain why he/she feels the (traditional or standard) Guides-based rating is inaccurate (either too low or too high, depending on the circumstances). Only after the Guides have been rebutted can the physician consider alternative evaluation approaches.

More specifically, if you feel that the permanent disability award that would be inequitable, disproportionate, and not a fair and accurate measure of the employee's permanent disability, then you as a physician are tasked to offer an alternative impairment rating using good judgment based upon your experience, training, and skill (please see the above noted comments from the Almaraz-Guzman Decision from the WCAB).

Again, recognizing that the Almaraz-Guzman Decision is under reconsideration by the WCAB, the following are some possible approaches for consideration. Please understand that I am not personally advocating or promoting anything but rather I am sharing some possible approaches. These ideas have come from many individuals and I welcome other approaches via your input.

Functional Capacity Evaluations

Regarding Functional Capacity Evaluations (FCEs), Functional Capacity Assessments (FCAs), and work capacity Assessments (WCAs); they can be extremely valuable in determining an individual's loss of work and self care (ADLs) capacity and retained abilities; particularly when that individual gives a full effort during testing.

FCEs/FCAs/WCAs can still be useful but provide a different level of information with individuals who do not provide a full effort secondary to a conscious lack of effort or from a legitimate fear of reinjury, psychiatric comorbidity and chronic pain behavior other than to document inconsistency or lack of a full effort.

A high quality FCE can be educational to the injured worker in pointing out lack of full effort despite ability and thus can be used as a teaching and rehabilitation tool.

As with all things, FCEs have become a growth industry with widely varying costs and quality. The old saying "garbage in – garbage out" still holds so it is important to obtain a quality FCE to avoid wasting resources.

Injured Workers with a Chronic Pain Syndrome

At least in my practice, I see quite a number of very decent patients who have developed a chronic pain syndrome and frankly do not provide a “full effort” during examination or functional testing. Subjective complaints may be high while objective correlates may be low or at least not match the degree of complaints.

It is much harder with these individuals to match up disability and impairment. There may be legitimate psychiatric comorbidity that reasonably should be evaluated by a forensic AME/QME psychiatrist or psychologist.

Many evaluating physicians try to describe the true “physical” disability while noting that the patient has a chronic pain syndrome and stating that “non-physical” factors (psychiatric comorbidity) in concert with the “physical” factors may impede or prevent return to the open labor market and limit future earning capacity.

Rating by Analogy

An analogy is a similarity between two things. The *AMA Guides* tells us that when there is no clear impairment rating, consider other impairments that create a similar effect on ADLs. There is support for this approach in the *AMA Guides*.

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 (*AMA Guides, Chapter 1, page 11*).

As an example, for a knee meniscal tear without surgery (there would be 0% impairment by way of the *Guides*) you can rate by analogy as if there had been surgery (this is clearly supported by *AMA Guides* “Experts”).

As another example, for carpal tunnel syndrome, you could provide a 5% upper extremity Impairment rating (3% WPI) for someone with normal physical findings but abnormal electrodiagnostic testing (EMG/NCV) even without surgery (if you went by the book, there would be a 0% impairment rating in this situation absent surgery).

Upper Extremities

Describing disability or loss of work capacity is actually quite easy by listing work restrictions and/or loss of work capacity. As a physician you can describe a percentage loss of work capacity for the following tasks and others (Table 1). For instance, the patient has lost 25% of preinjury capacity for lifting, carrying, pushing, pulling, grasping, gripping or manipulation.

Table 1

Overhead work	Balancing
Work at or above shoulder level	Working at heights
Work below shoulder level	Climbing ladders
Torquing	Climbing stairs
Lifting	Walking on uneven terrain
Carrying	Standing / Walking
Reaching	Crouching
Pushing	Sitting
Pulling	Twisting
Grasping / Gripping	Bending
Feeling / Fingering	Squatting
Pinching	Kneeling
Handling / Holding	Stooping
Fine manipulation	Working around moving machinery
Keyboarding	Driving
	Spine flexing, extending, bending, and rotating

Likewise, when both upper extremities are affected, you could use Table 13-17 (see below), Criteria for Rating Impairment in Two Upper Extremities which is functionally based and if you look at each Class from 1 – 4, you could place the injured worker in the appropriate Class 1 – 4:

Table 13-17 Criteria for Rating Impairments of Two Upper Extremities

Class 1 1%-19% Impairment of the Whole Person	Class 2 20%-39% Impairment of the Whole Person	Class 3 40%-79% Impairment of the Whole Person	Class 4 80%+ Impairment of the Whole Person
Individual can use both upper extremities for self-care, grasping, and holding, but has difficulty with digital dexterity	Individual can use both upper extremities for self-care, can grasp and hold objects with difficulty, but has no digital dexterity	Individual can use both upper extremities but has difficulty with self-care activities	Individual cannot use upper extremities

Using this method does not exclude using the AMA Guides in a standard, traditional or literal fashion for the upper extremities for the various parts (amputation, shoulder, elbow, wrist, fingers, nerve compressions, etc.). In fact, based on Almaraz-Guzman, the evaluator should use the AMA Guides as per usual unless the physician believes that the impairment provided is not commensurate with the disability.

Remember you cannot go outside the AMA Guides just to get a higher impairment, it has to be justified and make clinical sense and it has to tie the disability to the impairment.

For the individual who has a shoulder, elbow or wrist disability (with or without surgery), the injured worker may have a good outcome from treatment or surgery and even return to work, but the individual may still have symptoms along with both work and ADL limitations. Consider other conditions that may present with a similar disability. For instance, for the shoulder, by analogy, consider using Table 16-27 for a distal clavicle excision (even if there wasn't one) which provides a 10% upper extremity impairment and a 6% WPI. This would be combined with any range of motion loss or other findings.

If there is loss of range of motion, using a traditional approach, you could not also use a strength loss, but you might choose to do so if you felt that it was medically reasonable and doing so would make the impairment more closely commensurate with the disability. For example, if you listed a 5% (strength deficit) for each shoulder movement, it would bring the upper extremity impairment up to 12% and the WPI to 7%.

If the injured worker has had a poor (less than good) outcome from treatment or surgery, and the impairment is not commensurate with the disability, there are several possible approaches. You could consider several methods including the percent loss of work capacity noted above, use of one of the two Tables noted above (Table 13-17 or Table 13-22), or use of another AMA Guides Table that provides an impairment that is in keeping with the disability.

For an upper extremity amputee, the individual may have a concomitant neuropathic pain problem and be unable to wear a prosthesis. Such a disability is much greater than just having an amputation. Consider using not just the amputation impairment but also the neuropathic pain component using Table 13-22 (see above).

There are a number of areas that the AMA Guides does not recommend using grip loss. If you feel that grip loss is legitimate, you should consider using it.

Much to my surprise, a very astute and highly respected claims person told me that he would not have a problem with the following methodology if it resulted in an equitable impairment that could provide a basis for settling a claim. For an individual who has normal range of shoulder motion at rest but for whom

the physician describes a prophylactic limitation of no work over shoulder level, one could consider using that limitation (say 90 degrees for abduction and flexion) as the ROM limitation when calculating the impairment rating. This particular example is clearly outside the AMA Guides impairment rating system, so if used, the physician will have to cogently and clearly justify it as being reasonable and serving to better approximate the disability with the impairment.

Spine

There is considerable controversy as to when to use the ROM versus the DRE Method. Many physicians calculate impairment using both the ROM and the DRE Methods and then make a clinical judgment as to which provides the more accurate or “fair” impairment rating.

The DRE is the Method of choice per the AMA Guides 5th Edition, but the problem with the DRE Method (Table 15-3 Criteria for Rating Impairment Due to Lumbar Spine Injury - see below) has always been that if you don't have surgery and if you don't have a fusion/loss of motion segment integrity or a fracture, you cannot get up to the higher levels despite having a significant disability. Some evaluating physicians feel that you can now do so by analogy and per the instructions in Almaraz-Guzman.

For instance, the evaluating physician could move the impairment rating to a DRE IV or V if there is radiculopathy even without alteration of motion segment integrity when there is significant lower extremity impairment is present as indicated by atrophy or loss of reflex(es), pain, and/or sensory changes within an anatomic distribution (dermatomal), or electromyographic findings.

Assuming ADLs are negatively affected, and you chose a DRE V, that would give you 28%. These individuals may well deserve an additional 3% for chronic pain from Chapter 18, Pain. This would bring the total to 31% WPI. Taking this further, you can then combine by using Table 15-6 Rating Corticospinal Tract Impairment. The corticospinal tract is part of the spinal cord but, by analogy, the physician evaluator may feel that it is reasonable to use this for nerve root involvement. As you can see below in Table 15-6, this can legitimately provide significant additional impairment.

Table 15-3 Criteria for Rating Impairment Due to Lumbar Spine Injury

DRE Lumbar Category I 0% Impairment of the Whole Person	DRE Lumbar Category II 5%- 8% Impairment of the Whole Person	DRE Lumbar Category III 10%-13% Impairment of the Whole Person	DRE Lumbar Category IV 20%-23% Impairment of the Whole Person	DRE Lumbar Category V 25%-28% Impairment of the Whole Person
No significant clinical findings, no observed muscle guarding or spasm, no documentable neurologic impairment, no documented alteration in structural integrity, and no other indication of impairment related to injury or illness; no fractures	Clinical history and examination findings are compatible with a specific injury; findings may include significant muscle guarding or spasm observed at the time of the examination, asymmetric loss of range of motion, or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity and no significant radiculopathy or individual had a clinically significant radiculopathy and has an imaging study that demonstrates a herniated disk at the level and on the side that would be expected based on the previous radiculopathy, but no longer has the radiculopathy following conservative treatment or fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation (not developmental spondylolysis) that has healed without alteration of motion segment integrity; (3) a spinous or transverse process fracture with displacement without a vertebral body fracture, which does not disrupt the spinal canal	Significant signs of radiculopathy, such as dermatomal pain and/or in a dermatomal distribution, sensory loss, loss of relevant reflex(es), loss of muscle strength or measured unilateral atrophy above or below the knee compared to measurements on the contralateral side at the same location; impairment may be verified by electrodiagnostic findings or history of a herniated disk at the level and on the side that would be expected from objective clinical findings, associated with radiculopathy, or individuals who had surgery for radiculopathy but are now asymptomatic or fractures: (1) 25% to 50% compression of one vertebral body; (2) posterior element fracture with displacement disrupting the spinal canal; in both cases, the fracture has healed without alteration of structural integrity	Loss of motion segment integrity defined from flexion and extension radiographs as at least 4.5 mm of translation of one vertebra on another or angular motion greater than 15° at L1-2, L2-3, and L3-4, greater than 20° at L4-5, and greater than 25° at L5-S1 (Figure 15-3); may have complete or near complete loss of motion of a motion segment due to developmental fusion, or successful or unsuccessful attempt at surgical arthrodesis or fractures: (1) greater than 50% compression of one vertebral body without residual neurologic compromise	Meets the criteria of DRE lumbosacral categories III and IV; that is, both radiculopathy and alteration of motion segment integrity are present; significant lower extremity impairment is present as indicated by atrophy or loss of reflex(es), pain, and/or sensory changes within an anatomic distribution (dermatomal), or electromyographic findings as stated in lumbosacral category III and alteration of spine motion segment integrity as defined in lumbosacral category IV or fractures: (1) greater than 50% compression of one vertebral body with unilateral neurologic compromise

Table 15-6 Rating Corticospinal Tract Impairment

a. Impairment of One Upper Extremity Due to Corticospinal Tract Impairment							
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	
b. Criteria for Rating Impairments of Two Upper Extremities							
Class 1 1%-19% Impairment of the Whole Person		Class 2 20%-39% Impairment of the Whole Person		Class 3 40%-79% Impairment of the Whole Person		Class 4 80%+ Impairment of the Whole Person	
Individual can use both upper extremities for self-care, grasping, and holding, but has difficulty with digital dexterity		Individual can use both upper extremities for self-care, can grasp and hold objects with difficulty, but has no digital dexterity		Individual can use both upper extremities but has difficulty with self-care activities		Individual cannot use upper extremities	
c. Criteria for Rating Impairments Due to Station and Gait Disorders							
Class 1 1%-9% Impairment of the Whole Person		Class 2 10%-19% Impairment of the Whole Person		Class 3 20%-39% Impairment of the Whole Person		Class 4 40%-60% Impairment of the Whole Person	
Rises to standing position; walks, but has difficulty with elevations, grades, stairs, deep chairs, and long distances		Rises to standing position; walks some distance with difficulty and without assistance, but is limited to level surfaces		Rises and maintains standing position with difficulty; cannot walk without assistance		Cannot stand without help, mechanical support, and/or an assistive device	

d. Criteria for Rating Neurologic Impairment of the Bladder			
Class 1 1%-9% Impairment of the Whole Person	Class 2 10%-24% Impairment of the Whole Person	Class 3 25%-39% Impairment of the Whole Person	Class 4 40%-60% Impairment of the Whole Person
Individual has some degree of voluntary control but is impaired by urgency or intermittent incontinence	Individual has good bladder reflex activity, limited capacity, and intermittent emptying without voluntary control	Individual has poor bladder reflex activity, intermittent dribbling, and no voluntary control	Individual has no reflex or voluntary control of bladder
e. Criteria for Rating Neurologic Anorectal Impairment			
Class 1 1%-19% Impairment of the Whole Person	Class 2 20%-39% Impairment of the Whole Person	Class 3 40%-50% Impairment of the Whole Person	
Individual has reflex regulation but only limited voluntary control	Individual has reflex regulation but no voluntary control	Individual has no reflex regulation or voluntary control	
f. Criteria for Rating Neurologic Sexual Impairment			
Class 1 1%-9% Impairment of the Whole Person	Class 2 10%-19% Impairment of the Whole Person	Class 3 20% Impairment of the Whole Person	
Sexual functioning is possible, but with difficulty of erection or ejaculation in men or lack of awareness, excitement, or lubrication in either sex	Reflex sexual functioning is possible, but there is no awareness	No sexual functioning	
g. Criteria for Rating Neurologic Impairment of Respiration			
Class 1 5%-19% Impairment of the Whole Person	Class 2 20%-49% Impairment of the Whole Person	Class 3 50%-89% Impairment of the Whole Person	Class 4 90%+ Impairment of the Whole Person
Individual can breathe spontaneously but has difficulty performing activities of daily living that require exertion	Individual is capable of spontaneous respiration but is restricted to sitting, standing, or limited ambulation	Individual is capable of spontaneous respiration but to such a limited degree that he or she is confined to bed	Individual has no capacity for spontaneous respiration

The physician evaluator needs to focus on the impairment rating being commensurate with the disability. Given that the WCAB has clearly not directed use of the prior system of describing disability, the physician evaluator should avoid trying to connect the current impairment to prior descriptors in the old system but there is nothing wrong with using terms such as a loss of 50% of the preinjury lifting capacity or a limitation to sedentary work. These are universal terms that are accepted medically.

Another approach that I have seen promoted comes from The AMA Guides, Chapter 15, The Spine, page 427, 15.13 Criteria for Converting Whole Person Impairment to Regional Spine Impairment. The whole spine is divided into regions indicating the maximum whole person impairment represented by a total impairment of one region of the spine. The values are as follows: Lumbar 90%, Thoracic 40%, and Cervical 80%. If the evaluating physician felt that the injured worker had lost 50% of prior spine function for ADLS and work activities, then that percentage loss would be multiplied by the appropriate number of that region of the spine to give an impairment rating. For example, a 50% loss of lumbar spine function would provide a 45% WPI (50% X 90% = 45%).

Basically, the physician should describe the loss of ADL and loss of work capacity as part of the disability. The Table below is the Physical Demand Definitions from the Dictionary of Occupational Titles from the Department of Labor.

Physical Demand Definitions from the Dictionary of Occupational Titles (Department of Labor)

Sedentary Work – Exerting up to 10 pounds of force occasionally (Occasionally: activity or condition exists up to 1/3 of the time) and/or a negligible amount of force frequently (Frequently: activity or condition exists from 1/3 to 2/3 of the time) to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

Light Work - Exerting up to 20 pounds of force occasionally, and/or up to 10 pounds of force frequently, and/or a negligible amount of force constantly (Constantly: activity or condition exists 2/3 or more of the time) to move objects. Physical demand requirements are in excess of those for Sedentary Work. Even though the weight lifted may be only a negligible amount, a job should be rated Light Work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.

Medium Work - Exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects. Physical Demand requirements are in excess of those for Light Work.

Heavy Work - Exerting 50 to 100 pounds of force occasionally, and/or 25 to 50 pounds of force frequently, and/or 10 to 20 pounds of force constantly to move objects. Physical Demand requirements are in excess of those for Medium Work.

Very Heavy Work - Exerting in excess of 100 pounds of force occasionally, and/or in excess of 50 pounds of force frequently, and/or in excess of 20 pounds of force constantly to move objects. Physical Demand requirements are in excess of those for Heavy Work.

There may be another Table in a different Chapter that provides a reasonable and supportable impairment by analogy. For example, Chapter 6, The Digestive System. Table 6-9 (see below) Criteria for Rating Permanent Impairment Due to Herniation (hernias), Class 2 mentions “frequent discomfort, precluding heavy lifting but not hampering some activities of daily living.” There could be a scenario where an individual without a hernia has similar restriction and this could be used by analogy (see the Ferras vs. United Airlines Decision).

Class 1 0%-9% Impairment of the Whole Person	Class 2 10%-19% Impairment of the Whole Person	Class 3 20%-30% Impairment of the Whole Person
Palpable defect in supporting structures of abdominal wall <i>and</i> slight protrusion at site of defect with increased abdominal pressure; readily reducible <i>or</i> occasional mild discomfort at site of defect but not precluding most activities of daily living	Palpable defect in supporting structures of abdominal wall <i>and</i> frequent or persistent protrusion at site of defect with increased abdominal pressure; manually reducible <i>or</i> frequent discomfort, precluding heavy lifting but not hampering some activities of daily living	Palpable defect in supporting structures of abdominal wall <i>and</i> persistent, irreducible, or irreparable protrusion at site of defect <i>and</i> limitation in activities of daily living

Lower Extremities

Describing disability or loss of work capacity is actually quite easy by listing work restriction and/or loss of work capacity (see Table 1). Under the AMA Guides, the lower extremity impairment can be up to 40% WPI per limb.

If the individual had lost 25% of preinjury capacity in one lower extremity for work activities, the physician evaluator could note that taking into account the true impact on ADLs and the ability to function at work, the most accurate assessment would flow from the use of Table 17-3 (see below) where each lower extremity rates at 10% WPI (i.e., 25% of 40%). Per the Combined Values Chart, 10% WPI for the RLE combines with 10% WPI for the LLE as a 19% WPI.

Some evaluators feel that this approach is justified and fully supported by the Almaraz-Guzman Decision. The physician evaluator should not provide or accept this impairment rating carte blanche though – it has to be reasonable and justified clinically.

Table 17-3 Whole Person Impairment Values Calculated From Lower Extremity Impairment

% Impairment of Lower Extremity		% Impairment of Lower Extremity		% Impairment of Lower Extremity	
Whole Person	Lower Extremity	Whole Person	Lower Extremity	Whole Person	Lower Extremity
0 = 0	34 = 14	68 = 27			
1 = 0	35 = 14	69 = 28			
2 = 1	36 = 14	70 = 28			
3 = 1	37 = 15	71 = 28			
4 = 2	38 = 15	72 = 29			
5 = 2	39 = 16	73 = 29			
6 = 2	40 = 16	74 = 30			
7 = 3	41 = 16	75 = 30			
8 = 3	42 = 17	76 = 30			
9 = 4	43 = 17	77 = 31			
10 = 4	44 = 18	78 = 31			
11 = 4	45 = 18	79 = 32			
12 = 5	46 = 18	80 = 32			
13 = 5	47 = 19	81 = 32			
14 = 6	48 = 19	82 = 33			
15 = 6	49 = 20	83 = 33			
16 = 6	50 = 20	84 = 34			
17 = 7	51 = 20	85 = 34			
18 = 7	52 = 21	86 = 34			
19 = 8	53 = 21	87 = 35			
20 = 8	54 = 22	88 = 35			
21 = 8	55 = 22	89 = 36			
22 = 9	56 = 22	90 = 36			
23 = 9	57 = 23	91 = 36			
24 = 10	58 = 23	92 = 37			
25 = 10	59 = 24	93 = 37			
26 = 10	60 = 24	94 = 38			
27 = 11	61 = 24	95 = 38			
28 = 11	62 = 25	96 = 38			
29 = 12	63 = 25	97 = 39			
30 = 12	64 = 26	98 = 39			
31 = 12	65 = 26	99 = 40			
32 = 13	66 = 26	100 = 40			
33 = 13	67 = 27				

For the lower extremities, an alternative method by analogy is to use a functional approach as would be the case by using Table 13-15 Criteria for Rating Impairments Due to Station and Gait Disorders. This does not work in every situation but many lower extremity problems affect gait and station.

Table 13-15 Criteria for Rating Impairments Due to Station and Gait Disorders

Class 1 1%-9% Impairment of the Whole Person	Class 2 10%-19% Impairment of the Whole Person	Class 3 20%-39% Impairment of the Whole Person	Class 4 40%-60% Impairment of the Whole Person
Rises to standing position; walks, but has difficulty with elevations, grades, stairs, deep chairs, and long distances	Rises to standing position; walks some distance with difficulty and without assistance, but is limited to level surfaces	Rises and maintains standing position with difficulty; cannot walk without assistance	Cannot stand without help, mechanical support, and/or an assistive device

Using this alternate method by analogy does not exclude using the AMA Guides in a traditional or literal fashion for the lower extremities for the various parts (amputation, hip, knee, ankle, foot, nerve compressions, etc.). In fact, based on Almaraz-Guzman, we should use the AMA Guides as per usual unless the physician believes that the impairment provided is not commensurate with the disability.

Another way to approach spine and lower extremity disability if the injured worker is sedentary with the use of an assistive device, is by analogy using Table 17-7, Lower Limb Impairment due to Gait Derangement.

Table 17-5 Lower Limb Impairment Due to Gait Derangement

Severity	Individual's Signs	Whole Person Impairment
Mild	a. Antalgic limp with shortened stance phase and documented moderate to advanced arthritic changes of hip, knee, or ankle	7%
	b. Positive Trendelenburg sign and moderate to advanced osteoarthritis of hip	10%
	c. Same as category a or b above, but individual requires part-time use of cane or crutch for distance walking but not usually at home or in the workplace	15%
	d. Requires routine use of short leg brace (ankle-foot orthosis [AFO])	15%
Moderate	e. Requires routine use of cane, crutch, or long leg brace (knee-ankle-foot orthosis [KAFO])	20%
	f. Requires routine use of cane or crutch and a short leg brace (AFO)	30%
	g. Requires routine use of two canes or two crutches	40%
Severe	h. Requires routine use of two canes or two crutches and a short leg brace (AFO)	50%
	i. Requires routine use of two canes or two crutches and a long leg brace (KAFO)	60%
	j. Requires routine use of two canes or two crutches and two lower-extremity braces (either AFOs or KAFOs)	70%
	k. Wheelchair dependent	80%

For plantar fasciitis, the AMA Guides provides a 0% impairment rating. It seems that using Table 13-15 or Table 17-5 (above) would be a reasonable approach when this problem legitimately affects ADLs and work ability and causes disability.

For a hip or knee problem, there is Table 17-33, 17-34, & 17-35 which include total joint replacement that could be considered even when there has not been a joint replacement surgery.

Table 17-33 Impairment Estimates for Certain Lower Extremity Impairments (excerpts)

Region and Condition	Whole Person (Lower Extremity) [Foot] Impairment (%)
Hip	
Total hip replacement; includes endoprosthesis, unipolar or bipolar	
Good results, 85-100 pointst	15 (37)
Fair results, 50-84 pointst	20 (50)
Poor results, less than 50 pointst	30 (75)

Region and Condition	Whole Person (Lower Extremity) [Foot] Impairment (%)
Knee	
Total knee replacement including unicondylar replacement	
Good result, 85-100 pointst	15 (37)
Fair results, 50-84 pointst	20 (50)
Poor results, less than 50 pointst	30 (75)
Proximal tibial osteotomy	
Good result	10 (25)
Poor result	Estimate impairment according to examination and arthritic degeneration

Table 17-34 Rating Hip Replacement Results*

	Number of Points		Number of Points
a. Pain		d. Deformity	
None	44	Fixed adduction	
Slight	40	< 10°	1
Moderate, occasional	30	≥ 10°	0
Moderate	20	Fixed internal rotation	
Marked	10	< 10°	1
		≥ 10°	0
b. Function		Fixed external rotation	
Limp		< 10°	1
None	11	≥ 10°	0
Slight	8	Flexion contracture	
Moderate	5	< 15°	1
Severe	0	≥ 15°	0
Supportive device		Leg length discrepancy	
None	11	< 1.5 cm	1
Cane for long walks	7	≥ 1.5 cm	0
Cane	5		
One crutch	3	e. Range of Motion	
Two canes	2	Flexion	
Two crutches	0	> 90°	1
		≤ 90°	0
Distance walked		Abduction	
Unlimited	11	> 15°	1
Six blocks	8	≤ 15°	0
Three blocks	5	Adduction	
Indoors	2	> 15°	1
In bed or chair	0	≤ 15°	0
		External rotation	
c. Activities		> 30°	1
Stairs climbing		≤ 30°	0
Normal	4	Internal rotation	
Using railing	2	> 15°	1
Cannot climb readily	1	≤ 15°	0
Unable to climb	0		
Putting on shoes and socks			
With ease	4		
With difficulty	2		
Unable to do	0		
Sitting			
Any chair, 1 hour	4		
High chair	2		
Unable to sit comfortably	0		
Public transportation			
Able to use	1		
Unable to use	0		

* Add the points from categories a, b, c, d, and e to determine the total and characterize the result of replacement. Source: modified from Gross AE, McDermott AGP, Lavigne MV, et al. The use of alignment base in revision hip arthroplasty. In: Tinsell R, ed. *Proceeding of the Fourteenth Open Scientific Meeting of the Hip Society*. St Louis, Mo: CV Mosby Co; 1987:49. and Harris AH. Traumatic arthritis of the hip after dislocation and acetabular fractures: treatment by total arthroplasty. *J Bone Joint Surg Am*. 1969;51A:741-742.

Table 17-35 Rating Knee Replacement Results*

	Number of Points
a. Pain	
None	50
Mild or occasional	45
Stairs only	40
Walking and stairs	30
Moderate	20
Occasional	10
Continual	0
Severe	0
b. Range of Motion	
Add 1 point per 5°	25
c. Stability	
(maximum movement in any position)	
Anteroposterior	
< 5 mm	10
5-9 mm	5
> 9 mm	0
Mediolateral	
5°	15
6°-9°	10
10°-14°	5
≥ 15°	0
Subtotal	
Deductions (minus) d, e, f	
d. Flexion contracture	
5°-9°	2
10°-15°	5
16°-20°	10
> 20°	20
e. Extension lag	
< 10°	5
10°-20°	10
> 20°	15
f. Alignment	
0°- 4°	0
5°-10°	3 points per degree
11°-15°	3 points per degree
> 15°	20
Deductions subtotal	—

* The point total for estimating knee replacement results is the sum of the points in categories a, b, and c minus the sum of the points in categories d, e, and f. Modified from Insall JN, Dorr LD, Scott RD. Rationale of the Knee Society clinical rating system. *Clin Orthop*. 1989;248:14.

For a lower extremity amputee, the individual may have a concomitant neuropathic pain problem and be unable to wear a prosthesis. For the lower extremity, this may leave the individual wheelchair bound. In this situation, consider using not just the amputation impairment but also the neuropathic pain component using Table 13-15 (see above).

For Chapter 17, The Lower Extremities, Table 17-2 (see below) Guide to the Appropriate Combination of Evaluation Methods, the AMA Guides tells us which Evaluation Methods can and cannot be combined. If this results in a permanent disability award that would be inequitable, disproportionate, and not a fair and accurate measure of the employee’s permanent disability, then the physician should consider combining all the Evaluation Methods that would provide a reasonable impairment result.

Table 17-2 Guide to the Appropriate Combination of Evaluation Methods

Open boxes indicate impairment ratings derived from these methods can be combined.

	Limb Length Discrepancy	Gait Derangement	Muscle Atrophy	Muscle Strength	ROM Ankylosis	Arthritis (DJD)	Amputation	Diagnosis-Based Estimates (DBE)	Skin Loss	Peripheral Nerve Injury	Complex Regional Pain Syndrome (CRPS)	Vascular
Limb Length Discrepancy		X					X					
Gait Derangement	X		X	X	X	X	X	X	X	X	X	X
Muscle Atrophy		X		X	X	X	X	X		X	X	
Muscle Strength		X	X		X	X		X		X	0	
ROM Ankylosis		X	X	X		X		X			0	
Arthritis (DJD)		X	X	X	X							
Amputation	X	X	X	X								
Diagnosis-Based Estimates (DBE)		X	X	X	X							
Skin Loss		X										
Peripheral Nerve Injury		X	X	X							X	
Complex Regional Pain Syndrome (CRPS)		X	X	0	0					X		X
Vascular		X									X	

X = Do not use these methods together for evaluating a single impairment.

0 = See specific instructions for CRPS of the lower extremity.

Brain Injury

In Chapter 13, The Central and Peripheral Nervous System, for a brain injury, according to the AMA Guides, when injury or illness affects the CNS, several areas of function may be impaired. There are four categories to be evaluated: (1) state of consciousness and level of awareness, whether permanent or episodic; (2) mental status evaluation and integrative functioning; (3) use and understanding of language; and (4) influence of behavior and mood. The motor and sensory systems, gait, and coordination are evaluated once the four categories of cerebral impairment have been determined.

According to the AMA Guides, the most severe of these four categories should be used to determine a cerebral impairment rating. With Almaraz-Guzman, there is an argument to be made that if this results in a permanent disability award that would be inequitable, disproportionate, and not a fair and accurate measure of the employee’s permanent disability, then the physician should consider using all of the four categories that would provide a reasonable impairment result. In other words, instead of taking only the most severe (highest impairment) of the four categories; combine them instead.

Remember, the physician evaluator should not provide or accept any impairment rating carte blanche – it has to be reasonable and justified clinically.

Headache

The AMA Guides 5th Edition is not helpful re: headaches and at best allows for 3% using Chapter 18, Pain. Headaches can be quite disabling and affect alertness, mood, concentration, being able to work under bright lights and thus effect one's ADLs and work ability.

The evaluating physician could consider using Table 13-2 or Table 13-4, or Tables 13-5 and 13-6. The same caveat holds here too, the physician evaluator should not provide or accept any impairment rating carte blanche – it has to be reasonable and justified clinically.

Table 13-2 Criteria for Rating Impairment of Consciousness and Awareness

Class 1 0%-14% Impairment of the Whole Person	Class 2 15%-39% Impairment of the Whole Person	Class 3 40%-69% Impairment of the Whole Person	Class 4 70%-90% Impairment of the Whole Person
Brief repetitive or persistent alteration of state of consciousness and minimal limitation in performance of ADL	Brief repetitive or persistent alteration of state of consciousness and moderate limitation in performance of ADL	Prolonged alteration of state of consciousness, which diminishes capabilities in personal care and ADL	State of semicoma with complete dependency and subsistence on nursing care and artificial medical means of support or irreversible coma requiring total medical support

Table 13-4 Criteria for Rating Impairment Due to Sleep and Arousal Disorders

Class 1 1%-9% Impairment of the Whole Person	Class 2 10%-29% Impairment of the Whole Person	Class 3 30%-69% Impairment of the Whole Person	Class 4 70%-90% Impairment of the Whole Person
Reduced daytime alertness; sleep pattern such that individual can perform most activities of daily living	Reduced daytime alertness; interferes with ability to perform some activities of daily living	Reduced daytime alertness; ability to perform activities of daily living significantly limited	Severe reduction of daytime alertness; individual unable to care for self in any situation or manner

Table 13-6 Criteria for Rating Impairment Related to Mental Status

Class 1 1%-14% Impairment of the Whole Person	Class 2 15%-29% Impairment of the Whole Person	Class 3 30%-49% Impairment of the Whole Person	Class 4 50%-70% Impairment of the Whole Person
Paroxysmal disorder with preimpairment exists, but is able to perform activities of daily living CDR = 0.5	Impairment requires direction of some activities of daily living CDR = 1.0	Impairment requires assistance and supervision for most activities of daily living CDR = 2.0	Unable to care for self and be safe in any situation without supervision CDR = 3.0

Table 13-5 Clinical Dementia Rating (CDR)

	Impairment Level and CDR Score		
	None 0	Questionable 0.5	Mild 1.0
Memory (M)	No memory loss or slight inconsistent forgetfulness	Consistent slight forgetfulness; partial recollection of events; "benign" forgetfulness	Moderate memory loss; more marked for recent events; defect interferes with everyday activities
Orientation (O)	Fully oriented	Fully oriented except for slight difficulty with time relationships	Moderate difficulty with time relationships; oriented for place at examination; may have geographic disorientation elsewhere
Judgment and Problem Solving (JPS)	Solves everyday problems and handles business and financial affairs well; judgment good in relation to past performance	Slight impairment in solving problems, similarities, and differences	Moderate difficulty in handling problems, similarities, and differences; social judgment usually maintained
Community Affairs (CA)	Independent function at usual level in job, shopping, volunteer and social groups	Slight impairment in these activities	Unable to function independently at these activities although may still be engaged in some; appears normal to casual inspection
Home and Hobbies (HH)	Life at home, hobbies, and intellectual interests well maintained	Life at home, hobbies, and intellectual interests slightly impaired	Mild but definite impairment of function at home; more difficult chores abandoned; more complicated hobbies and interests abandoned
Personal Care (PC)	Fully capable of self-care	Fully capable of self-care	Needs prompting

Myofascial Pain Syndrome & Fibromyalgia

The AMA Guides considers these conditions as without objective correlates and provides a 0% impairment rating. These conditions can result in fatigue and decreased alertness and can have an effect on ADLS and work capacity. When clinically appropriate, consider the use of Table 13-4 Criteria for Rating Impairment to Sleep and Arousal Disorders.

Table 13-4 Criteria for Rating Impairment Due to Sleep and Arousal Disorders

Class 1 1%-9% Impairment of the Whole Person	Class 2 10%-29% Impairment of the Whole Person	Class 3 30%-69% Impairment of the Whole Person	Class 4 70%-90% Impairment of the Whole Person
Reduced daytime alertness; sleep pattern such that individual can perform most activities of daily living	Reduced daytime alertness; interferes with ability to perform some activities of daily living	Reduced daytime alertness; ability to perform activities of daily living significantly limited	Severe reduction of daytime alertness; individual unable to care for self in any situation or manner

Strength

Because strength measurements are functional tests influenced by subjective factors that are difficult to control and the *Guides* for the most part is based on anatomic impairment, the *Guides* does not assign a large role to such measurements (16.8 Strength Evaluation, page 507) but it does not say no role!

In a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods in the *Guides*, the loss of strength may be rated separately (16.8a Principles, page 508). The physician determines what constitutes a "rare" case and when strength should be used!

While decreased strength *cannot* be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts (e.g., thumb amputation) that prevent effective application of maximal force in the region being evaluated (16.8a Principles, page 508), the physician could choose to alternatively rate by loss of strength if clinically there is application of maximal force.

If an individual has had tendon rupture or has undergone surgical release of the flexor or extensor origins or medial or lateral epicondylitis, or has had excision of the epicondyle, there may be some permanent weakness of grip as a result of the tendon rupture or the surgery. In this case, impairment can be given on the basis of weakness of grip strength (16.8 Strength Evaluation, page 507). Grip strength can be used when there is a "loss of strength due to a severe muscle tear that healed leaving a palpable muscle defect (16.8a Principles, page 508). By analogy, the physician could rate based on consistent weakness due to an injury. It is critical that the physician clearly and unequivocally state that the injured worker is credible and the testing results are reliable.

Combining and Adding

The AMA Guides does not allow combining certain impairments, i.e., you cannot use strength when there is a range of motion (ROM) loss or a compression neuropathy. There is an argument to be made that Almaraz-Guzman gives the physician latitude to consider combining different impairments (i.e., a loss of strength even with a loss of ROM or with a compression neuropathy) that provide a fair, equitable and commensurate impairment to the disability even when the standard, traditional or literal approach to the AMA Guides says you cannot combine the impairment values.

In general, the AMA concept and use of combining lowers the impairment rating (15% + 15% = 28%) prevents getting over a 100% impairment and even makes it hard to get to 100%. There is probably an

argument (which has already been made by applicant attorneys) that combining may unfairly lower the impairment such that it is not fair, equitable or commensurate with the disability. The evaluating physician can consider the argument that various impairments should not be combined but rather added.

When this situation is the case, it will be necessary to justify such opinions by showing that adding rather than combining results in the impairment being fair, equitable and commensurate with the disability when doing so.

Summary

Physician evaluators find themselves in a precarious position with the controversial Almaraz-Guzman Decision which is currently under reconsideration by the WCAB. My personal recommendation is to remember that the finder of fact (workers' compensation judge) and the WCAB are the final arbiters. It the task of the evaluating physician to provide reasonable medical opinions.

After providing an impairment rating using a traditional or literal approach to the AMA Guides, it is reasonable to provide a careful and thoughtful opinion about whether the impairment is commensurate with the disability. The next step according to Almaraz-Guzman is to "draw analogies to the Guides other chapters, tables, or methods of assessing impairment."

This document is a work in progress. I am not recommending or promoting any of the above ideas and concepts but provide them for consideration and discussion.

I have shared these ideas with you so I would ask in return that you write back to me via email (stevenf@stanford.edu) with your thoughts, additions, criticisms, ideas, etc.

Sincerely,

A handwritten signature in black ink that reads "Steven Feinberg MD". The signature is written in a cursive, flowing style.

Steven D. Feinberg, M.D.

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