



The Guides Newsletter

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Impairment Rating in California: Analysis of the Almaraz and Guzman Decision and Impact on the Use of the AMA *Guides*, Fifth Edition

by Christopher R. Brigham, MD and W. Frederick Uehlein, JD

The State of California Workers' Compensation Appeals Board (WCAB) February 3, 2009 decision in the consolidated cases of Almaraz vs SCIF et al. and Guzman vs Milpitas Unified School District (Almaraz/ Guzman) concluded that the AMA *Guides to the Evaluation of Permanent Impairment, Fifth Edition (Guides)* portion of the 2005 Permanent Disability Rating Schedule is rebuttable¹. Such decisions of the California Appeals Board are binding precedent on all California Appeals Board panels and workers' compensation judges unless overruled by the Appellate or State Supreme Courts of California.

The impact of this Decision is significant for California and it has the potential of being used as a catalyst for challenges on the use of the *Guides* in other jurisdictions. It exemplifies some of the challenges involved in rating impairment and rating disability and the role of the AMA *Guides* in workers' compensation. Unavoidable consequences of this Decision include more confusion in the assessment of permanent impairment and disability, far more litigation, increased medical-legal costs, and delayed case closure. The consequence of the WCAB's interpretation is significant financial costs, estimated by many experts to be in the billions of dollars, and human costs due to inaccurate expectations by employees as to the amount of benefits they may reasonably expect, delays in obtaining their benefits, and perception of being significantly permanently disabled.

Clearly, the Decision is inconsistent with legislative intent in State Bill 899 (SB 899). Furthermore, it references case law that is not applicable, confuses the concepts of "work impairment" and "disability" and presents misleading information about the *Guides* and its role in assessing impairment. The Decision compares "apples and oranges" when discussing impairment and work functionality when it fails to distinguish differences in California with the use of the Permanent Disability Rating Schedule (PDRS) versus other states that directly translate a permanent impairment rating into a disability rating.

The response by Gov. Arnold Schwarzenegger has been swift. In a letter to Insurance Commissioner Steve Poizner on March 17, 2009, he stated:



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Given our current economic environment, it is more important than ever that we protect the 2004 workers' compensation reforms, which reduced rates by more than 65 percent and have saved employers more than \$40 billion.

Recent Decisions by the Workers' Compensation Appeals Board, including the Almaraz/Guzman case, have contributed significantly to these costs. I am confident that these Decisions will not stand through the appellate process, based on their inconsistency with the law. The permanent disability rating schedule is supposed to promote consistency, uniformity and objectivity. The Board's Decision runs contrary to that mandate. My administration will support the effort to overturn these Decisions and protect the intent of the workers' compensation reforms.²

This WCAB Decision will be appealed to the Supreme Court, and it is quite likely that it will be overturned. Until that time, it is imperative that all stakeholders understand the significance of this Decision, take steps to assure that impairment ratings and resulting disability ratings are accurate, and counter efforts to rebut accurate ratings with evidence that is not based on learned studies or expert consensus and/or is based on individual not legislative opinion on "fairness".

In this article, we will review the Almaraz/Guzman Decision, the role of the *Guides* in defining permanent impairment, the legislative mandates for permanent disability assessment, and what we believe are problems associated with this Decision. We will discuss the practical implications on claims management and the reasons why it is imperative to assure all ratings in California are consistent with the process defined in the Fifth Edition.

Workers' Compensation Appeals Board (WCAB) Decision in the Consolidated Cases of Almaraz vs SCIF et al. and Guzman vs Milpitas Unified School District

The Workers' Compensation Appeals Board of the State of California granted reconsideration of the cases of Mario Almaraz vs Environmental Recovery Services and the State Compensation Insurance Fund and Joyce Guzman vs Milpitas Unified School District.

Mario Almaraz vs Environmental Recovery Services

The case of Mario Almaraz vs Environmental Recovery Services (also known as Enviroserve), insured by defendant, State Compensation Insurance Fund, involved an individual who had a low back injury claim involving resulting in lumbar radiculopathy and the performance of a laminectomy and discectomy at L4-L5. The evaluating physician correctly concluded that there was a 12% whole person permanent impairment based on a Diagnosis-related Estimates Category III rating. The parties stipulated that, before apportionment, applicant's injury would rate 17% under the 2005 Schedule and 58% under the 1997 Schedule. The Workers Compensation Judge (WCJ) found a 14% permanent disability, after apportionment and concluded he was not free to make a permanent disability finding based on the work preclusions set forth by the physician. The WCJ said that, in enacting Labor Code section 4660, the Legislature "mandated the use of the AMA Guide[s]."

Joyce Guzman vs Milpitas Unified School District

The case of Joyce Guzman vs Milpitas Unified School District (adjusted by Keenan & Associates) was for an admitted industrial injury to her bilateral upper extremities during a cumulative period ending on April 11, 2005, while employed as a secretary by defendant. The applicant (the claimant) was evaluated by an Agreed Medical Examiner (AME) who diagnosed bilateral carpal

tunnel syndrome, which was not yet permanent and stationary. The reports of this physician are not available for review; however the information presented in the Opinion and Decision After Reconsideration (En Banc) raises several questions relating to diagnosis, causation and apportionment analysis, impairment assessment, determining “preinjury capacity,” and permanent disability determination.

The Decision did not include a discussion of apportionment. From a medical point of view, it would be exceedingly difficult to attribute carpal tunnel syndrome (CTS) to the work activities of a secretary, since there are no empirical scientific studies that have demonstrated that the usual functional demands of this employment are associated with the development of CTS. Studies have demonstrated that keyboards are not an occupational risk for CTS; rather that the development of CTS is commonly associated with risk factors of female gender, obesity and age (41 to 60 years), genetics and with certain medical conditions.^{3, 4, 5, 6, 7, 8, 9, 10, 11, 12} This type of evidence should be offered in future cases involving this issue.

Later the physician declared Ms. Guzman to be permanent and stationary. He opined that applicant’s bilateral upper extremity injury caused “a 25% loss of her ... preinjury capacity for pushing, pulling, grasping, gripping, keyboarding [and] fine manipulation.” The Decision does not explain the basis provided for finding a “25% loss.” It was concluded that the applicant “could not go back to [her] former occupation,” because it would “caus[e] a gradual worsening of her condition”; scientific basis to support this risk analysis is not provided.

The physician issued a supplemental AME report that analyzed applicant’s permanent disability utilizing the *Guides*. He concluded that applicant’s injury caused 3% whole person impairment for each upper extremity, based upon applicant’s symptoms and her reported functional difficulties secondary to her symptoms. Carpal tunnel syndrome impairment assessment is discussed in the Fifth Edition in Section 16.5d, Entrapment/Compression Neuropathy (5th ed, 491-495) and specifically on page 495. One of the three scenarios presented for rating is having “Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a residual CTS is still present, and an impairment rating not to exceed 5% of the upper extremity may be justified.” Five percent upper extremity impairment converts to 3% whole person permanent impairment. If this was the basis for his rating, this would reflect an individual who has ongoing subjective complaints, however does not have any objective findings when evaluated for their previously electrodiagnostically confirmed CTS.

In a later report the evaluator reiterated that applicant’s bilateral upper extremity injury caused WPI under the *Guides* of 3% for each side and also that her injury caused

a 25% loss of her pre-injury capacity for pushing, pulling, grasping, gripping, keyboarding and fine manipulation. The Decision does not explain the basis for the determination of a 25% loss. In his final report the evaluator stated that applicant’s bilateral upper extremity injury precludes her from “very forceful, prolonged repetitive and forceful repetitive work activities.” The scientific basis for this is not provided nor is information provided in regards to the physical demands of her job.

The Decision then quotes the evaluator stating “You are aware by now that there is often a discrepancy between the disability and the impairment. The type of problem [applicant] has is legitimate but does not rate very much (if anything) under the *AMA Guides*. Based on her ADL [(ie, activities of daily living)] losses, each upper extremity would have a 15% WPI This is not a method that is sanctioned by the *AMA Guides*.” No basis for the 15% WPI is provided, however it is noted that the maximum value for the upper extremity is 60% whole person permanent impairment and if multiplied by “25% loss” the result is 15% WPI.

The WCJ concluded “While the exact quantum of evidence required to rebut the [Schedule] has yet to be established by case law, I feel certain that a single paragraph in an AME report does not suffice. In particular, Dr. Feinberg provides no data or clinical observations in support of his opinion; his opinion seems to be, rather, that the *Guides* generally underrate this impairment. He may be correct; he is certainly a highly respected and qualified physician: but without a significant amount of objective data I am unwilling to accept his opinion, standing alone, against that of the Legislature.” In reversing the WCJ’s decision, it appears that the Board moved into the area of Judicial Legislations which is contrary to California law.

On reconsideration the applicant asserted that because a 15% WPI per upper extremity was found to be appropriate by the AME through the exercise of his clinical judgment, then applicant should be found to have 39% permanent disability, after adjustment for age and occupation.

In reviewing the information provided in the Decision, there is no reference to the critical issues of causation and apportionment. No basis is provided for how a “25% loss” was derived; rather it appears to have been the personal judgment of one physician. If there were no objective findings to support her complaints or that she continued to have the diagnosis of carpal tunnel syndrome, it could be concluded that there was no objective basis to support permanent partial disability.

Summary Conclusions of Court

The WCAB held in the *Almaraz v SCIF et al.* and *Guzman v Milpitas Unified School*, as noted on page 2 of the Decision, that:

1. The *Guides* portion of the 2005 Schedule is rebuttable;
2. The *Guides* portion of the 2005 Schedule is rebutted by showing that an impairment rating based on the *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; and
3. When an impairment rating based on the *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 *Guides*

Issues Not or Inadequately Addressed by the Court

What this Decision does not address, or addresses inadequately, is:

1. Who, when, and how is it determined that a Permanent Disability Award is inequitable or disproportionate?
2. Who, when, and how is a finding of "fairness" is made?
3. Upon a determination by someone of unfairness, what is an adequate standard of evidence for rebuttal of the *Guides*?
4. How does one alternatively calculate Permanent Disability?
5. How do the intervening findings of a higher court, the Court of Appeal, in the case of *Diane Benson v Workers Compensation Appeals Board and the Permanente Medical Group* (A120462, WCAB Case Nos. OAK 0297895, OAK 0326228) affect this Decision?

California Historical Perspective

The State of California is unique in having a sophisticated Permanent Disability Rating Schedule (PDRS) that translates an impairment rating into a permanent partial disability rating by modifying it for future earning capacity adjustment (based on research studies performed by the Rand Institute), impact on specific occupations, and age. Many other state jurisdictions directly link permanent impairment to permanent disability rates. Although the formula is not perfect it provides a more inclusive empirical approach to defining a permanent disability rating, avoiding subjectivity by using empirical data and other relevant factors to adjust an impairment rating under the *Guides* to reach a final disability rating. The final extent of loss then includes use of data involving groups of similarly situated people. The schedule itself is based on empirical evidence of a group of similarly situated employees and not one individual employee.

This is critical because, as we will discuss in more detail below, the impairment rating itself is only a measure of medical functionality and does not purport to measure the effect of that functionality on work. Rather the second step of the California disability determination process

deals with that issue. The impairment rating serves as a vehicle to create inter- and intrarater reliability amongst doctors that minimizes subjectivity and conflict.

Thus, the California Legislature, in passing Senate Bill 899 (SB 899) in 2004, put into place a system for determining loss of earning capacity benefits for permanently disabled workers that would be more consistent and would reduce time and friction costs. Under the new PDRS issued in January 2005, the degree of physical impairment must be evaluated in accordance with the Fifth Edition. The determination of physical loss is a physician assessment based on the use of a single standard, the *Guides*, which is based on a sophisticated consensus development process. The combined use of the California Permanent Disability Rating Schedule and the *Guides* should move the system toward one that promotes consistency, and hence fairness; thereby reducing the need for litigation and prolonged adjudication.

AMA Guides

The *AMA Guides to the Evaluation of Permanent Impairment*, Fifth Edition, is the international standard for impairment, the "loss, loss of use, or derangement of any body part, organ system, or organ function." (5th ed, 601). Disability is defined as "alteration of an individual's capacity to meet personal, social, or occupational demands or statutory or regulatory requirements because of an impairment." (5th ed, 600).

The Fifth Edition, published in 2000, is the edition used in the State of California; a more recent edition, the Sixth Edition, was published in December 2007. The development of the *Guides* is based upon a consensus among a large pool of expert doctors in the body systems and regions being rated; this is a process designed to provide accurate, reliable data. Consensus derived estimates for specific impairments provide a stronger basis for defining impairment than does the opinion of an individual physician. Chapter 2 of the Fifth Edition, Practical Application of the *Guides*, explains: "use the *Guides* for consistent and reliable acquisition, analysis, communication, and utilization of medical information through a single set of standards. Two physicians, following the methods of the *Guides* to evaluate the same patient, should report similar results and reach similar conclusions. Moreover, if the clinical findings are fully described, any knowledgeable observer may check the findings with the *Guides* criteria." (5th ed, 17)

The *Guides* are used in 40 of 51 United States jurisdictions; they are also used for certain Federal cases and internationally. Many jurisdictions directly equate impairment with disability and adjust for the effects of impair-

ment on work ability in the rate schedule it defines. California has a further second step process to reach a permanent disability rating by using empirical studies to determine the impact of specific impairments on future earning capacities and also adjusting for occupation and age. The *Guides* advise:

Impairment percentages derived from the *Guides* criteria should not be used as direct estimates of disability. Impairment percentages estimate the extent of the impairment on whole person functioning and account for basic activities of daily living, not including work. The complexity of work activities requires individual analyses. Impairment assessment is a necessary first step for determining disability. (5th ed, 13).

In California, impairment is not used as a direct estimate for disability; rather it is used as the impairment standard in the California Permanent Disability Rating Schedule and modified by other factors to reach a disability percentage. The permanent impairment rating serves only as the starting component to accurately define the loss as determined by the physician using a consistent approach; the California legislature chose to define a process based on statistics to consistently translate the impairment value into a disability rating using other factors.

One of the benefits of using the *Guides*, over allowing doctors to use their own anecdotal experience, is that it results in consistency of application of the assessment among doctors and by an individual doctor for various patients; hence it improves intra- and interrater reliability. The use of the *Guides*, therefore, furthers the legislature's goals.

There was no compelling evidence presented in the Almaraz/Guzman Decision to suggest that the *Guides* method for achieving a rating of functionality is flawed or unfair, when used for the purpose intended by the California Legislature; such evidence would need to be based on statistics, studies, or consensus derived in a manner equal to or better than that used by the *Guides*. Anecdotal information, less formal consensus opinions, or inclusion of inadequately designed studies are factually inadequate to serve as basis for evidentiary "rebuttal" of a *Guides* rating. Such attempts to ignore the processes defined in the *Guides* could be seen as deliberate attempts to circumvent the legislative process and to recreate permanent disability values similar to those seen prior to the reform. One need only look at the process used by the American Medical Association and the Rand Institute, both parts of the 2004 reform, to see the Legislature's intent to substitute scientific empirical studies, and to provide accuracy and reliability to the process.

Problems with the Almaraz/Guzman Decision

Unfortunately, we believe there are several shortcomings to the Almaraz/Guzman Decision which resulted in flawed conclusions and recommendations. These include the following:

1. The Decision presented case law that was not relevant.
2. The Decision was contrary to legislative mandate.
3. The Decision incorrectly opined that the AMA *Guides* are rebuttable.
4. The Decision failed to reflect understanding of the concept of assessing impairment vs disability.
5. The Decision failed to demonstrate understanding of the impairment evaluation process.
6. The Decision failed to specify when and how to rebut an AMA *Guides* rating.
7. The Decision failed to specify standards for reasonable alternatives to an AMA *Guides* rating and left open the possibility that individual medical opinion might be allowed as rebuttal evidence.

Case Law Presented Not Relevant

Much of the case law referenced in the Decision and used in the court's Decision was not applicable, since much of the California case law was overturned by SB 899 and the case law from other states relates to jurisdictions where impairment is equated directly to disability (rather than having a formula as is used in California) or refers to earlier editions of the *Guides*.

Section "2. The Case Law of Other Jurisdictions Recognizes That the AMA *Guides* Need Not Always Be Followed" (Decision, page 20) refers to cases in other jurisdictions where impairment is used directly to define disability, as opposed to California which has a defined process for this conversion. Most of the references are to cases that predated the publication of the Fifth Edition, and consequently relied upon outdated editions of the AMA *Guides*; certain challenges were resolved in the more recent Fifth Edition used in the State of California. Therefore, much of the discussion is irrelevant. It is interesting that the footnote on page 20 states "some states strictly adhere to the AMA *Guides* and do not allow them to be rebutted under any circumstances. Because California law provides that its permanent disability schedule may be rebutted, the case law of those states is not useful to our discussion"; there was no discussion of the rationale for these states strictly adhering to the AMA *Guides*. It is probable that once the cases that the Decisions relied on are read, they are easily distinguishable to a point that renders the Decision based upon them erroneous and

Impairment Rating in California (continued)

reversible on appeal, if the right arguments are made, and the right record is established.

Decision Contrary to Legislative Mandate

In the recent Court of Appeal Decision of Diane Benson vs Workers Compensation Appeals Board and the Permanente Medical Group (A120462, WCAB Case Nos. OAK 0297895, OAK 0326228) it was specifically noted that “the workers’ compensation . . . reforms [of SB 899] were enacted as urgent legislation to drastically reduce the cost of workers’ compensation insurance” (*Brodie, supra*, 40 Cal. 4th at p. 1329; accord, Stats. 2004, ch. 34, Section 49). The intent of SB 899 included saving jobs, reducing costs for employers and improving care for injured workers; a major aspect of SB 899 was defining a process that would result in more accurate disability ratings which result in significant cost savings to the workers’ compensation system.

The advantages of the use of the California PDRS are best understood in the context of the results of other systems of linking medical functionality to a payment schedule upon reaching maximal medical improvement. In defining “fairness” it is important to distinguish the responsibilities of the legislature versus the courts. To substitute a courts’ interpretation of what is a “fair” process for that of a process defined by the legislature is not appropriate. Even worse, if we rely on each individual doctor’s interpretation, there is no uniformity, no fairness, and significantly increased costs to reach the result. The legislature determined a rate and a method presumably taking many factors into consideration, including what was fair to employers, taxpayers and employees in light of a crisis in the economy that has only gotten significantly worse since the passage of the legislation. Neither is there any data or evidence that a fairer or more reliable result will be reached if the legislature’s determination of fairness has been substituted by a judge’s or a doctor’s opinion.

The only goal of statutory interpretation by a court is to interpret ambiguities in a statute, in a manner that effectuates the legislative purpose. Therefore, it was erroneous to interpret the SB 899 in a manner that increases friction and litigation costs, and increases administrative expenses. This expression of the legislative intent as well as other aspects of the Decision in *Benson*, coming from a higher court, should be considered as controlling until other case law is developed.

The transition from the process of rating impairment prior to SB 899 to using the *Guides* and PDRS has been challenging for some physicians and other stakeholders. Using the *Guides* as the basis for defining the impairment standard as opposed to the pre-2005 schedule has resulted in

significant lowering of disability awards. In light of the legislative mandate, this may have been an intended consequence by the Legislature, but it is easy to understand and sympathize with a feeling amongst many stakeholders that it is “unfair.” If those stakeholders are right, and the legislature’s intent was unfair, is it not up to the stakeholders to press the legislature for change in rates under the schedule to make it fair? It is not a matter for the Courts to judicially legislate, a practice barred by California law. A significant flaw in the Decision’s approach is that it is not the use of the *AMA Guides* that results in the perceived “unfairness” or “inequity,” but rather the perceived unfairness would lie in the rating and award schedule.

Incorrectly Opined that the AMA Guides are Rebuttable

The Decision stated that since the new 2005 Schedule is prima facie evidence of an injured employee’s percentage of permanent disability, the schedule may be rebutted. Prima facie evidence suffices for the proof of a particular fact until contradicted and overcome by other evidence.

It was also concluded that the *Guides* portion of the 2005 Schedule is rebuttable, based on the reasoning that “because section 4660(c) still provides that the Schedule is rebuttable, then no portion of it – including the *AMA Guides* portion – is conclusive. Any contrary interpretation would nullify, at least in part, the language of section 4660(c). Moreover, had the Legislature intended that the *AMA Guides* portion of the Schedule be unrebuttable, it could have expressly so stated. It did not.” (Decision, p. 12 and 13)

There was no reason for the Legislature to say anything about the *Guides* in reference to section 4660 since that section made the “schedule” rebuttable. First, the *Guides* was not a part of the schedule when the language regarding the schedule being rebuttable was first enacted.

Second, section 4660 (b)(1) states that; “For purposes of this section, the ‘nature of the physical injury or disfigurement’ *shall incorporate* the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the American Medical Association (AMA) *Guides [to the Evaluation of Permanent Impairment (Fifth Edition)]*.” (Emphasis supplied.) There is no room for using anything else by rebuttal or otherwise for that component of the statutory formula.

Third, under section 4660 (b) it is the “schedule [which]... without formal introduction in evidence, shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule.” When read as a whole it is clear that the statutory lan-

guage regarding rebuttal relates only to the PDRS reference in section 4660(b)(2) and not the *Guides* portion of the formula in section 4660(b)(1) whose use is mandated. If one allows it to be rebutted by something else, “shall” has no meaning. On the other hand, applying the right to rebuttal to the schedule preserves the rebuttal right concerning the schedule which predated the mandate that the *Guides* be used. There is nothing either in the plain language of the statute that requires that the pre-existing right to rebut the schedule somehow permits some other evidence to rebut the *Guides* portion of the Schedule, as doing so ignores the clear mandate of 4660(b)(1) that the ‘nature of the physical injury or disfigurement’ shall incorporate the descriptions and measurements of [the AMA *Guides*]. Any rebuttal would “incorporate” something other than the *Guides*. That result is directly contrary to an express legislative mandate.

Failed to Reflect Understanding of Concept of Assessing Impairment vs Disability

The Decision does not adequately define nor distinguish physical impairment (as determined by the *Guides*), “work impairment” (a term it uses, one not used in the *Guides*), and disability. The Decision also fails to adequately consider the unique difference in California by having a sophisticated schedule translating an impairment rating into a disability rating.

The Decision uses the term “work impairment” rather than the nomenclature used in the *Guides* and appears to confuse the concepts of what it refers to as “work impairment” with “disability.” The Decision notes whole person impairment ratings estimate the impact of an injury or condition on the individual’s overall ability to perform activities of daily living (ADLs), excluding work; however, it does not include or explain the rationale for this as provided on page 5 of the *Guides*:

“Work is not included in the clinical judgment for impairment percentages for several reasons: (1) work involves many simple and complex activities; (2) work is highly individualized, making generalizations inaccurate; (3) impairment percentages are unchanged for stable conditions, but work and occupations change; and (4) impairments interact with such other factors as the worker’s age, education, and prior work experience to determine the extent of work disability.” (5th ed, 5)

Therefore, to insist that the physician should assess “work impairment” is inappropriate. Rather, the issue of the permanent disability rating is based on the process defined in the PDRS. It is unclear why this critical discussion was not included and considered in the context of the PDRS.

The Decision seemed to confuse the fact that the *Guides* are only intended to enable the doctors to reach an opinion expressed as a percentage as to the physical loss of an injured worker at the point of maximal medical improvement and not an opinion of the ultimate issue - the employee’s disability (loss of earning capacity). Moreover, any opinion of permanent disability rating or loss of earning capacity addressed in the Schedule is outside of the expertise of a doctor. Therefore, discussion in the *Guides* that impairment and disability are not equivalent does not support the conclusion that the *Guides* are not to be followed for defining impairment (particularly in the context of having a disability formula). The *Guides* are simply the first necessary step, providing a well-defined role for doctors to play, within a broader formula for determination of loss of earning capacity.

The Decision incorrectly concludes that “the AMA *Guides* itself recognizes that, in least in some cases, it is appropriate to depart from an industrial impairment rating based strictly upon the *Guides*.” (Decision, p. 15) The *Guides* do not discuss the context of an impairment rating as being non-industrial or industrial; rather, it distinguishes among the concepts of impairment, and work ability or disability. Misuse of terms and apparent confusion in concepts is also reflected in the statement “the AMA *Guides* Recognizes That It Is Merely a First Step for Measuring Work Impairment; Therefore, Factors outside the *Guides* May Be Considered, Including the Impact of the Injury on the Employee’s Ability to Perform Work Activities.” (Decision, p. 15) A more correct interpretation is that that the *Guides* provide the process for defining impairment, the first step, and this information and other considerations are used to determine disability. There is no reference in the *Guides* that they are “merely a first step for measuring work impairment”.

Lack of differentiation between the terms used of “work impairment” and disability is also reflected in the statement “Because the AMA *Guides* does not actually measure work impairment, the AMA *Guides* also indicates it is but a component or tool for assessing such impairment. Accordingly, the *Guides* provide that when making a work impairment assessment, it is appropriate in some cases for a physician to consider factors outside the *Guides*, including the injured employee’s ability to perform work and his or her need for work restrictions or accommodations.” (Decision, p. 15) What the *Guides* actually states is “Impairment ratings are not intended for use as direct determinants of work disability. When a physician is asked to evaluate work-related disability, it is appropriate for a physician knowledgeable about the work activities of the patient to discuss the specific activities the worker can

and cannot do, given the permanent impairment.” (5th ed, 5)

The relationship between impairment and disability is highly complex, and the California PDRS provides a researched approach to provide a consistent methodology to translate the physical impairment to a disability by considering other key variables, eg, the impact of specific impairments on future capacity, occupational demands, and age. Therefore, this mechanism interfaces well with the process defined in the *Guides* to provide a reliable rating.

Failed to Demonstrate Understanding of Impairment Evaluation Process

The Decision does not adequately distinguish between the physician steps of assessing permanent impairment and the use of the PDRS to define the disability rating. It is likely that few physicians performing a permanent impairment rating fully understand how that rating is then specifically modified by the PDRS. To have physicians modify the rating initially to provide their personal estimate of “work impairment” will result in poor reliability of ratings and duplication of factors considered in the PDRS. This represents a “back door” method to remove the requirement of reliability and consistency that the legislature intended.

On page 18 of the Decision there is a misleading discussion entitled “The AMA *Guides* Allow an Evaluating Physician, Through the Exercise of His or Her Judgment, To Modify an Impairment Rating.” There are several quotations that are used out of context in an attempt to support of the position that “AMA *Guides* calls for the evaluating physician to draw on his or her judgment and experience in reaching a determination regarding impairment.” (Decision, p. 19) The degree and nature of the individual flexibility which is authorized by the Decision is not consistent with the rationale for use of clinical judgment that is called for by the *Guides*.

The Decision offers, starting on page 18, a series of quotes from the AMA *Guides*; however these are provided out of context and are therefore misleading in how they are used in the Decision:

- “A physician can often assess a person’s ability to perform ADLs based on knowledge of the patient’s medical condition and clinical judgment.” (5th ed, 5)

Comment: Assessment of activities of daily living (ADLs) is part of the evaluation process; however only in specific circumstances does it serve as the actual basis for defining impairment. Self-report of ADLs is often unreliable, particularly in the context of litigation. This issue is specifically removed from any consideration of ability to work; therefore, it is removed

from the Decision’s idiosyncratic concept of “work impairment.”

- “An individual can have a disability in performing a specific work activity but not have a disability in any other social role. Physicians have the education and training to evaluate a person’s health status and determine the presence or absence of impairment. If the physician has the expertise and is well acquainted with the individual’s activities and needs, the physician may also express an opinion about the presence or absence of a specific disability. For example, an occupational medicine physician who understands the job requirements in a particular workplace can provide insights on how the impairment could contribute to a workplace disability.” (5th ed, 8)

Comment: The role of the physician is to assess physical impairment; this impairment rating value is then used in the context of the PDRS process to define the rating. The goal of the *Guides* is not to directly provide a disability rating; rather it is a first step in a separate disability rating process. The *Guides* reference the involvement of occupational medicine physicians for their insight on how impairment could contribute to a workplace disability, especially when their work causes them to have regular exposure to certain workplaces; a relatively small percentage of Qualified Medical Examiner (QME) and Agreed Medical Examiner (AME) examinations are performed by board-certified occupational medicine physicians, or by physicians who have regular exposure to a specific applicant’s workplace. Additionally, the *Guides* specify that any such occupational medicine comment on disability is to be separated from the impairment rating (they are separate issues).

- “The physician’s role in performing an impairment evaluation is to provide an independent, unbiased assessment of the individual’s medical condition, including its effect on function, and identify abilities and limitations to performing activities of daily living... Performing an impairment evaluation requires considerable medical expertise and judgment.” (5th ed, 18)
- Comment:** It is important to distinguish between the impairment evaluation process and the rating itself. Although this quote includes reference to the need of “independent” and “unbiased” assessment there is no discussion of how this relates to physicians then offering their own idiosyncratic opinions on rating. The baseless and individualized approach that is authorized by the Decision creates a wealth of opportunities for bias.
- “The physician must use the entire range of clinical skill and judgment when assessing whether or not the measurements or tests results are plausible and consistent with the impairment being evaluated. If, in spite of an observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the physician may modify the

impairment rating accordingly and then describe and explain the reason for the modification in writing.” (5th ed, 19)

Comment: This quote appears in a discussion of “consistency” in the *Guides*, explaining the need to base ratings on accurate information. It states if medical evidence is “insufficient” the physician may modify the rating; in all such circumstances this would decrease, not increase, a rating.

- “In situations where impairment ratings are not provided, the *Guides* suggest 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. The physician’s judgment, based upon experience, training, skill, thoroughness in clinical evaluation, and ability to apply the *Guides* criteria as intended, will enable an appropriate and reproducible assessment to be made of clinical impairment.” (5th ed, 11)

Comment: One of the primary purposes of the *Guides* is to facilitate interrater and intrarater reliability. Therefore, this quote emphasizes measurement, rather than simply opening a door to baseless clinical judgment. The *Guides* provide processes to rate the vast majority of conditions and it is very rare to encounter a clinical scenario that is not addressed. It is noted, however that certain “ambiguous or controversial syndromes,” such as “myofascial pain syndrome, fibromyalgia, and “disputed neurogenic” thoracic outlet syndrome” (5th ed, 569) are not specified as not being ratable, rather than being open to rating through baseless clinical judgment.

Failed to Specify When and How to Rebut an AMA Guides Rating

Section “D. Determining Whether An AMA *Guides* Impairment Rating Has Been Rebutted” (Decision, p. 38) attempts to address (1) what standards should be used in determining whether the *Guides* impairment rating has been rebutted; (2) what evidence may be presented to establish whether those standards have been met; and (3) if the standards have been met, how is impairment determined. They concluded that “an impairment rating strictly based on the *Guides* is rebutted by showing that such an impairment rating 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.” The *Guides* rating, standing alone, can only be determined to be fair or unfair in relation to the process of determining anatomic function or medical functionality, absent impact on work. To discern the appropriateness of an impairment rating and the resulting permanent disability award involves: (1) assessing the accuracy of the impairment rating itself and (2) assessing

the permanent disability award and associated benefit – most physician evaluators lack knowledge of the use of the PDRS and knowledge (even prescience) of the administrative outcome of a claim.

The Decision did not say specifically how one could rebut a *Guides* rating. The *Guides* impairment value, standing on its own, and the statements regarding inequitable or unfair results are misplaced as the *Guide’s* portion of the statutory formula is not determinative of the fairness of the ultimate result in terms of the amount of payment for loss of earning capacity. Therefore, even if rebuttal were proper under the statute, one can only rebut the *Guides* in reference to what it purports to do, which is to determine the functionality of the injured worker at maximum medical improvement. Rebut means to overcome the evidence. In the present context that means the evidence must be of greater quality than the prima facie evidence of the impairment value in the *Guides*. In that regard to be admissible, it is inconceivable how one doctor’s opinion is of greater quality than that of a consensus driven treatise such as the *Guides*.

Section “E. Evidence That May Be Presented To Demonstrate That The Standards For Rebutting The AMA *Guides* Impairment Rating Have Been Met” (Decision, p. 46) advises that the process of rebutting a scheduled impairment rating is “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*.” How is it possible for an individual physician to provide a personal opinion that would have greater weight than a widely accepted consensus driven process to defining impairment? Both a legal and factual record must be presented to demonstrate that the only way to “rebut” the *Guides* is a process which an expert can demonstrate is equally reliable and accurate. One doctor’s opinion does not meet that standard. Additionally, the Decision’s inclusion of treating doctors in this passage calls for a violation of the *Guides* principle of independent evaluation.

Failed to Specify Standards for Alternatives to AMA Guides Rating

The Decision states “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” (Decision, p. 46). What experience, training, or skill of a physician exceeds the carefully designed process presented in the *Guides*? Any such opinion should be backed up by a

scientific process designed to provide the same level of accuracy and reliability that the *Guides* are recognized as providing.

It is also advised that “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” (Decision, p. 47); yet no standards are defined for evaluating the quality or credibility of this literature or criteria. Presumably, the most supportable alternative would be the more current edition of the *Guides*, the Sixth Edition; however the Decision does not offer a single reference to the Sixth Edition which has been available since December 2007.

Physicians are then advised by the WCAB “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”; then provides examples of ability to perform work activities, job performance, functional capacity evaluations, and vocational rehabilitation information. Given the limits of every option mentioned in this passage, the passage fails to offer any credible direction.

Permanent medical impairment is that which the physician determines, however the Permanent Disability rating is based on this and other factors using the PDRS. The Legislature mandates use of the *Guides* for functionality without regard to work activities because work activities are addressed by the other factors specified in the statute. One is left wondering how a party can “rebut” the *Guides* on factors that are separate by definition from the purpose of the *Guides*.

Few physicians are qualified to assess work activities, and self-report on work activities and limitations are often unreliable. To be effective in assessing these issues physicians must be knowledgeable about risk, capacity, and tolerance. Multiple physicians often give contradictory answers to questions of work ability if tolerance of systems is what limits work performance. There is little good science on work risk assessment.¹³

Section “F. Determining Impairment Once The *AMA Guides* Portion Of The 2005 Schedule Has Been Rebutted” states that the “physician should state his or her best opinion regarding the employee’s percentage of impairment and explain how and why this impairment percentage was determined” (Decision, p. 49) and “a physician’s estimate of the percentage of the employee’s impairment may be accepted even though this estimate is not exact, provided

that the physician’s opinion is adequately explained and is based on the factors set forth in Section II-E, above – including the physician’s judgment, experience, training, and skill.” (Decision, p. 50) Calling upon a physician to offer “his or her best opinion” without following specific procedures and protocols will result in chaos.

In a March 2009 seminar on “Impairment Rating after Almaraz/Guzman” sponsored by the California Applicants’ Attorneys Association and held in Los Angeles, several examples of how to increase ratings were provided by their speakers. The following examples illustrate some of the creative approaches that are being used by physicians in California, yet are not supported by the *Guides*:

- Basing ratings on an estimate of reduction in percentage of pre-injury capacity for a body part and then translating that into an impairment percentage, as reflected in the Guzman case; eg, opining someone has lost 25% of their capacity of their upper extremity and therefore opining there is a 25% upper extremity impairment or 15% whole person permanent impairment. It is suggested that the percentage loss of capacity could be based on self-reports of percentage loss or use of activities of daily living scales. Another example is opining there is loss of 50% of the function of their lumbar spine and concluding that since Section 15.13, Criteria for Converting Whole Person Impairment to Regional Spine Impairment (5th ed, 427) specifies the conversion factor of a whole person impairment to a regional lumbar impairment is obtained by dividing 0.75 that the individual has a 50% x 75% whole person permanent impairment or a 38% whole person permanent impairment. It has been suggested that the percentage reduction could be based on reported decrease in function of the back based on self-reports, physician judgment or results on functional capacity evaluation. Another suggested approach is in assessing spinal fusions if there were five levels within a region (as in the lumbar spine) and two regions were fused one could conclude that there was loss of function of 2/5 or 40% of the lumbar spine.

Comment: Such approaches are markedly inconsistent with the methodology in the *Guides* and are fraught with problems. Furthermore, physicians lack the ability to independently define current injury capacity for body part, nor is there any reasonable basis to define a preinjury status. It has been clearly demonstrated that self-reported history in the context of litigation is very unreliable.¹⁴ Therefore, physician opinions of reduction in pre-injury capacity are speculative.

- For spine injuries, encouraging routinely rating by range of motion (ROM) method which often results in higher impairment than the diagnosis-related estimates (DRE) method (with the exception of single level spinal fusion).

Comment: This approach ignores subsequent recognition that ROM is an unreliable measure of spinal impairment. The Sixth Edition states “Range of motion is no longer used as a basis for defining impairment, since current evidence does not support this as a reliable indicator of specific pathology or permanent functional status.” (6th ed, 558).

- For spine impairments recommending when rating by the range for motion method to rate for multiple diagnoses within a spinal region and combine or add them.

Comment: This is inconsistent with specific guidance in Section 15.8d, Estimating Whole Person Impairment Using the ROM Method that “If there are two or more diagnoses within a spinal region, use that which is most significant.” (5th ed, 402) In the Sixth Edition typically operative interventions do not result in additional impairment; in fact, it should be the goal of any treatment (medical or surgical) to improve function and reduce impairment.

- For spinal pain with antalgic gait also encouraging rating for gait disturbance per Chapter 17, The Lower Extremities.

Comment: This ignores specific instructions not to do this per Section 17.2c, Gait Derangement (5th ed, 529); ie, “Section 17.2c does not apply to abnormalities based only on subjective factors, such as pain or sudden giving-way, as with, for example, an individual with low-back discomfort who chooses to use a cane to assist in walking.” (5th ed, 529)

- For extremity disorders, encouraging the rating of strength deficits for both upper and lower extremities, despite specific directives in the *Guides* against this approach.

Comment: Rating for strength deficit is often duplicative and measurements are often unreliable, particularly in the context of litigation. In the Fifth Edition, for upper extremity impairment assessment, Section 16.8, Strength Evaluation and Section 16.8a, Principles (5th ed, 508) explains that this is used in a “rare case,” “could be combined with the other impairments only if based on unrelated etiologic or pathomechanical causes” and “cannot be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts (eg, thumb amputation) that prevent effective application of the maximal force in the region being evaluated”. For lower extremity assessment Section 17.2e, Manual Muscle Testing explains the limitations on this approach and notes “individuals whose performance is inhibited by pain or the fear of pain are not good candidates.” (5th ed, 531). In the Sixth Edition strength loss is not used for rating.

- For lower extremity ratings, recommending rating for all applicable approaches and then combining them.

Comment: This ignores the guidance provided in the Fifth Edition that “typically, one method will adequately characterize the impairment and its impact on

the ability to perform ADL.” (5th ed, 527) and ignores the use of Table 17-2, Guide to the Appropriate Combination of Evaluation Methods (5th ed, 526).

- Providing ratings for “deconditioning” associated with musculoskeletal and other disorders by utilizing Table 5-12, Impairment Classification for Respiratory Disorders, Using Pulmonary Function and Exercise Test Results. (5th ed, 107). The suggestion is rate for exercise test results based on demonstrated metabolic equivalent of tasks (METs) or reported equivalents on self-reports. For example, if a patient can walk only 2.5 miles per hour this corresponds with 3.0 – 3.5 METs and a Class 4 rating associated with 51% to 100% whole person permanent impairment.

Comment: Table 5-12 lists criteria for permanent impairment rating of respiratory disorders and is not designed to assess impairment due to reported deconditioning. The etiology of deconditioning is multifactorial and the baseline for a patient is typically not known. In Chapter 4, The Cardiovascular System: Heart and Aorta, in Section 3.1, Principles of Assessment, it is noted that “a major problem with the use of any exercise-testing technique to attempt to quantify an individual’s functional capacity is the marked variability in the people’s efforts and abilities. . . some will continue longer than they should, while others will stop after minimal effort because they feel fatigued. (5th ed, 28).

Each of these recommended approaches are inconsistent with the processes defined in the *Guides* and inconsistent with the goal to have a process that results in reproducible ratings; simply stated, ignoring or misapplying the *Guides* is not rebuttal of the *Guides*.

Functional capacity evaluations (FCE) are of no value in rating permanent impairment or permanent disability within the context of workers’ compensation litigation; the results of these assessments are often unreliable. FCE protocols vary in quality and in the context of determination of benefits and litigation it is common for examinees to under-demonstrate their capabilities.^{15, 16} Studies have conclusively shown that FCE performance does not predict sustained return to work in claimants with chronic back pain.¹⁷ Scientific scrutiny has additionally demonstrated that work-restrictions which are based on FCEs are harmful to the health of examinees.¹⁸ FCE are not a comparable method of evaluation of impairment and therefore do not rebut the *Guides*.

The Decision states “the method for evaluating impairment described above does not mean that an impairment rating can be directly or indirectly based on what the employee’s work preclusions would have rated under the old Schedule, had it been applicable”; yet, the process

outlined in the Decision is as subjective and problematic as that previously provided rating on the basis of work preclusion.

Therefore, at this time there are no practical alternatives to defining impairment other than the *Guides* standard, with the only notable exception to the Fifth Edition being the more current Sixth Edition.

This Decision is going to result in confusion among examining physicians who are left without a well-defined process to assessing permanent impairment. Some examiners in California are concluding that whenever an impairment rating is requested based on the *Guides*, a physician may invoke his or her judgment based upon his or her experience. This defeats both the intent of State Bill 899 and the *AMA Guides*, ie, to have a method such that “two physicians, following the methods of the *Guides* to evaluate the same patient, should report similar results and reach similar conclusions.” (5th ed, p 17) Lacking a consistent standard, we open the impairment assessment process to subjectivity and variability and the result is unreliable and inconsistent. Lack of inter- and intrarater reliability results in conflict, friction costs, delays, and substantial costs.

Physicians are put into a position that is not supportable by their skill set if they are asked to judge whether or not a final disability rating is fair and then modify or base an impairment rating on his or her personal judgment. The issue for the doctor should be, was the impairment rating correctly arrived at under the *Guides* or, if one accepted the premise of the court that the *Guides* are subject to rebuttal, is there another consensus or evidenced based treatise of equal to or better standard that may be utilized? It may be appropriate to acknowledge that the newer Sixth Edition is a more appropriate treatise. Absent reliance on such a treatise based on widely accepted evidence or consensus equivalent to the *Guides* such an opinion might not be supportable (would not meet standards of substantial evidence) and would not be supportable within a Daubert type challenge.

Practical Implications

This Decision will result in confusion among many stakeholders (physicians, attorneys, fact-finders, and injured workers); it removes a well-defined process to assessing permanent impairment, the first step in ultimately rating disability.

It is probable that certain stakeholders will assert that an impairment rating based on the *Guides* is not fair, equitable, proportionate, or a fair and accurate measure of the

employee's permanent disability. Yet, how are each of these factors determined? It is likely that applicant attorneys will continue to instruct their colleagues, including physicians, on new ways to assess impairment and develop methods to determine permanent disability that will artificially inflate ratings. The response to this must be insisting that the impairment standard be based on a correct rating per the *Guides* not speculation by the physician.

It is highly recommended that an expert on the *Guides* carefully review all ratings to determine if they are reliable and to assess any deviations from the processes defined in the *Guides*. The experts reviewing these ratings must have extensive experience in the use of the *Guides* and either be clinicians or work in conjunction with clinicians who can interpret medical findings and physician opinions on impairment and disability. Any rating not correctly based on the *Guides* should be challenged, both to drive an accurate rating for that case and to reduce the likelihood of similar errors in the future. It will also be imperative to collect data on each rating reviewed to profile physician performance and to provide more insight to impairment issues associated with specific diagnoses.

Physicians must provide high quality and reliable impairment ratings. The ability to accomplish this has been demonstrated in other jurisdictions and can occur in California if all stakeholders shared the same goal of having accurate, unbiased ratings.

Conclusions

The State of California Workers' Compensation Appeals Board (WCAB) February 3, 2009 decision in the consolidated cases of *Almaraz v SCIF et al.* and *Guzman v Milpitas Unified School District (Almaraz / Guzman)* was flawed and should be retried on remand with the best possible record and arguments, and, if necessary, appealed, with all interested parties weighing in to insure that their interests are protected.

Particularly at this time of general economic crisis which is more severe than the economic crisis under which the legislation was passed, it is imperative that all stakeholders work together to assure a reliable process in assessing permanent impairment and then using these findings in consideration of other factors to determine permanent partial disability. California, as opposed to other jurisdictions, has a well-defined process to accomplish this, eg, the California Permanent Disability Rating Schedule, with the starting point being the accurate assessment of impairment using the *Guides to the Evaluation of Permanent Impairment*, Fifth Edition.

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Use of the AMA Guides in State Workers' Compensation Systems: 2009 Update

by Christopher R. Brigham, MD and Jenny Walker

The *AMA Guides to the Evaluation of Permanent Impairment* is the most widely used basis for determining impairment. The *Guides* are used in state workers' compensation systems, federal systems, automobile casualty, and personal injury. They are used in the majority of state workers' compensation jurisdictions. Table 1 summarizes their use and Table 2 provides information by state.¹

The Fifth Edition (published in 2000) is the most commonly used edition. Sixteen states make use of the Fifth Edition (California, Delaware, Georgia, Hawaii, Kentucky, New Hampshire, Idaho, Indiana, Iowa, Kentucky, Massachusetts, Nevada, North Dakota, Ohio, Vermont and Washington).

Eleven states use the Sixth Edition which was released at the end of 2007: Alaska, Arizona, Louisiana, Mississippi, Montana, New Mexico, Oklahoma, Pennsylvania, Rhode Island, Tennessee and Wyoming.

Eight states still commonly make use of the Fourth Edition (published in 1993): Alabama, Arkansas, Kansas, Maine, Maryland, South Dakota, Texas, and West Virginia.

Two states use the Third Edition, Revised (published in 1990): Colorado and Oregon. Connecticut does not stipulate which edition of the *Guides* to use.

Six states use their own state specific guidelines (Florida, Illinois, Minnesota, New York, North Carolina, and Wisconsin) and six states do not specify a specific guideline (Michigan, Missouri, Nebraska, New Jersey, South Carolina, and Virginia).

Statutes may or may not specify which edition of the *Guides* to use and how the *Guides* are to be utilized. Some states may use their own guidelines for specific problems and use the *Guides* for other problems. Many states use a statutory schedule for amputations, hearing loss, visual

Use of the *AMA Guides* (continued)

loss, hernias, and disfigurement. Some states may use a statutory schedule and use the *Guides* for nonscheduled injuries and others do not specify the use of any specific guidelines.

A map illustrating the current use of the *AMA Guides* by edition is available at http://www.impairment.com/PDFFiles/Map_of_AMA_Guides_by_State2009.pdf

1. www.impairment.com/use_of_ama_guides.htm
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Table 1. Summary of *AMA Guides* Usage in State Workers Compensation Systems

AMA <i>Guides</i> Edition or Other Guidelines	Number of States	Percentage
Third Ed., Revised	2	4%
Fourth Edition	8	16%
Fifth Edition	16	32%
Sixth Edition	11	22%
Any Edition	1	2%
State Specific	6	12%
Not Specified	6	12%

Table 2. Use of *AMA Guides* and Other Impairment Guidelines by State*

State	Edition most commonly used	Statute/Code	Comment
Alabama	Fourth Edition	AL § 480-5-5-.35	The Fourth Edition is the “recommended guide” to be used by physicians.
Alaska	Sixth Edition	AK S. §. 23.30.190(d)	Statutes state new edition to be adopted by board within 90 days of the last day of the month when the new edition is published. The use of the Sixth Edition required as of March 31, 2008.
Arizona	Sixth Edition	AZ Rev. S. Ann. § 23-1044; § 23-1065; Rule R20-5-113(B) of the Workers’ Compensation Practice and Procedure	Edition not specified by statute. The <i>Guides</i> are used to support medical opinion and in supplementing Arizona’s statutory disability schedule.
Arkansas	Fourth Edition	Workers’ Compensation Rule 34	Excludes any sections that refer to pain and exclusive of straight leg raising tests or range of motion tests when making physical or anatomical impairment ratings to the spine.
California	Fifth Edition	CA Code of Reg. Title 8, Ch. 4.5 Sub Ch. 1 Art. 7	Schedule for Rating Permanent Disability, an impairment-based rating system which is based on the Fifth Edition and modifies ratings based on adjustments for Future Earning Capacity, occupational demands and age. Fifth Edition adopted as of January 1, 2005. California Workers’ Compensation Appeals Board issued a decision February 2009 in the consolidated cases of <i>Almaraz v. SCIF, et al.</i> , and <i>Guzman v Milpitas Unified School District</i> that the <i>AMA Guides</i> were rebuttable.
Colorado	Third Edition, revised	Colo. Rev. Stat. § 8-42-101	Legislation maintains the use of the 3rd Edition, Revised.
Connecticut	Fourth, Fifth Edition, and Sixth Edition		The physician who is doing a rating must use an “objective” standard. The state recommends use of the <i>AMA Guides</i> but specifically does not require use of a specific edition.
Delaware	Fifth Edition	Title 19, Ch. 23	Not required by statute but are strongly favored including in case law.
Florida	State specific	1996 Florida Uniform Permanent Impairment Rating Schedule Title XXXI, Chapter 440 69L-7.604	State specific guide, however incorporated some principles from the Fourth. Not anticipating use of <i>AMA Guides</i> .
Georgia	Fifth Edition	GA Code Ann. § 34-9-263(d)	Fifth Edition adopted as of July 1, 2001.
Hawaii	Fifth Edition		Uses latest edition but has not moved to Sixth Edition at this time.
Idaho	Fifth Edition		Uses the Fifth Edition as medical evidence, neither regulation nor state require it
Illinois	State specific	820 ILCS § 305/1	State schedule used for certain cases, no reference in statutes or regulations to the <i>Guides</i> .
Indiana	Fifth Edition	IN Code 22-3-3-10	The <i>Guides</i> use not required, however latest edition of the <i>Guides</i> often used to evaluate nonscheduled impairment.

State	Edition most commonly used	Statute/Code	Comment
Iowa	Fifth Edition	IA Code, §876-2.4(85); IA Code §§ 85.34(2) “a” to “s”	Adopted for determining permanent partial disabilities under Iowa Code section 85.34(2) “a” to “s”. “Nothing in this rule shall be construed to prevent the presentations of other medical opinions or guides or other material evidence for the purpose of establishing that the degree of permanent disability to which the claimant would be entitled would be more or less than the entitlement indicated in the AMA guide.”
Kansas	Fourth Edition	KS Stat. § 44-510d, KS Stat. § 44-510e	Not known if more recent edition will be considered.
Kentucky	Fifth Edition	KY Rev. Stat. § 342.0011 (35); House Bill 333	Previously stated latest available edition; however, House Bill 333 passed February 12, 2009 remove a requirement for use of the latest edition.
Louisiana	Sixth Edition	LA Rev. Stat. Ann. § 23:1221.(4)(q)	Statute mandates that most recent version of the <i>Guides</i> should be utilized.
Maine	Fourth Edition	ME Title 39-A, 153 § 8	Fourth Edition specified. No plans to use more recent edition at this time.
Maryland	Fourth Edition	MD Title 14.09.04.01	Change to the more recent edition is not planned at this time.
Massachusetts	Fifth Edition	MA Gen. Law Title XXI Ch. 152, § 36	Edition not specified. Incorporates <i>Guides</i> by statute, requiring its use when certain criteria are met for permanent conditions.
Michigan	Not Specified	Worker’s Disability Compensation Act of 1969 §418.361	Scheduled amputations and total permanent disabilities are listed in law.
Minnesota	State specific	Stat. Ch. 176.101	State specific schedule of permanent partial disabilities used.
Mississippi	Sixth Edition	Fee Schedule: IV Impairment Rating ‘A’	“In determining the extent of permanent impairment attributable to a compensable injury, the provider shall base this determination on the most current edition of the <i>Guides</i> ... which is in effect at the time the service is rendered.”
Missouri	Not Specified	Ch. 287 Rev. Stat.	No guide for nonscheduled injuries, but ratings from the <i>Guides</i> may be used.
Montana	Sixth Edition	MT Code Ann. §39-71-711(b)	Current edition specified.
Nebraska	Not Specified	NE Stat. § 48-121	The <i>Guides</i> not specified, however commonly used as a predicate for disability..
Nevada	Fifth Edition (Sixth Edition as of June 2009)	NV Rev. Stat. 616C.110	Fifth Edition used as of October 2003 and Sixth Edition will be used as of June 2009.
New Hampshire	Fifth Edition (Sixth Edition for MMI 1/1/08-6/25/08)	NH Rev. Stat. Ann. § 281-A:32; Labor rules 508.01(d)	Most recent edition was previously specified, however legislation in July 2008 removed this requirement and specified ratings are to be performed by the Fifth Edition with the exception of workers who achieved MMI between January 1 and June 25, 2008 who will be evaluated by the Sixth Edition.
New Jersey	Not Specified	NJ Stat. Ann. § 34:15-12	Permanent disability is based upon the objective medical evidence of a disability as well as the injured worker’s testimony.
New Mexico	Sixth Edition	NM Stat. Ann. § 52-1-24	Most recent edition specified.
New York	State specific	Medical Guidelines	Uses own Medical Guidelines, not anticipating use of <i>Guides</i> .
North Carolina	State specific	NC Stat. 97, WCA 97-31	Use on guides presented in the NC Workers Compensation Rating Guide.
North Dakota	Fifth Edition	ND Cent Code § 65-05-12-2	<i>Guides</i> are modified to be consistent with ND law, to resolve issues of practice and interpretation, and to address areas not sufficiently covered by the guides. Subject to rules adopted under this subsection, Fifth Edition of the <i>Guides</i> .
Ohio	Fifth Edition	OH Rev. Code § 4123	Statute specifies most current edition - not moved to Sixth Edition.
Oklahoma	Sixth Edition	OK Stat. Title 85-22-3	Specifies “latest publication”. “Paragraph 3 of Section 22 of this title, relating to scheduled member injury or loss; and impairment, including pain or loss of strength, may be awarded with respect to those injuries or areas of the body not specifically covered by said guides.”
Oregon	Third Edition, Revised	OR Admin. Rules Ch. 436, Div. 035	Utilizes Third Edition, Revised, re-affirmed 1/1/06. The DRE model does not fit their concept of impairment.
Pennsylvania	Sixth Edition	34 Pa. Code § 123.105.	Most recent edition specified.
Rhode Island	Sixth Edition	RI Gen. Laws § 28-29-2	Most recent edition specified



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Use of the AMA Guides (continued)

State	Edition most commonly used	Statute/Code	Comment
South Carolina	Not Specified	SC Reg. Sec. 67-1101	Use of the AMA Guides is required per executive order of Gov. Mark Sanford in September 2007.
South Dakota	Fourth Edition	SD Codified Law 62-1-1.2	Fourth Edition required by statute.
Tennessee	Sixth Edition	TN Code Ann. §50-6-102 and 50-6-204	Most recent edition specified - Sixth Edition adopted January 1, 2008 - or "in cases not covered by the AMA Guides an impairment rating by any appropriate method used and accepted by the medical community."
Texas	Fourth Edition	TX Lab. Code Ann. § 408.124	Fourth Edition required. No plans to use more recent edition at this time.
Utah	State specific	Rule 612-7-3 Method for Rating Utah's Impairment Guides	For rating all impairments, which are not expressly listed in Section 34A-2-412, the Commission adopts Utah's 2006 Impairment Guides as published by the Commission for all ratings of impairments on or after January 1, 2006. For those conditions or exclusions not found in Utah's 2006 Impairment Guides, the Guides are to be used.
Vermont	Fifth Edition	VT Stat. Ann. Tit. 21, § 648	Recent legislation specifies use of Fifth Edition.
Virginia	Not Specified	VI § 65.2-503	The Guides most often used as source of impairment rating. No specific guide mentioned in statute or regulation.
Washington	Fifth Edition/ State Specific	WAC 296-23-381 WAC 296-20-220	State specific guidelines for certain conditions, Fifth Edition used for loss of function of extremities, partial loss of vision or hearing.
West Virginia	Fourth Edition	WV Title §85-20-3	Code specifies Fourth Edition.
Wisconsin	State specific	WI Adm. Code 80.32, 80.33; WI Stat. Ch. 102	Not anticipating use of the Guides. State specific schedules provided for rating.
Wyoming	Sixth Edition	WY Stat § 27-14-405(g)	Most recent edition specified

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