Today's Presentation

CMRS is independent of the AMA and American College of Occupational and Environmental Medicine. This presentation is neither endorsed nor sponsored by the AMA.

Introduction

Use of the AMA Guides

The 5th Edition is the edition used by the State of California for workers' compensation cases. This is mandated by SB899. Adoption of the 6th Edition will require action by the legislature.

Use of the AMA Guides

• The 6th Edition of the Guides is occasionally used by the US Department of Labor. Its use is not mandated by the US Department of Labor; however, many divisions are requesting physicians rate impairment on the basis of this edition.

• CMRS recommends that physicians rate impairments utilizing the 6th Edition only when specifically requested to do so by an adjuster or attorney.

Chapters 1 & 2

• Like the 5th Edition, Chapters 1 & 2 address the basic tenets regarding application of the Guides.

6th Edition

The 6th Edition employs a paradigm shift in the method for rating, with significantly greater emphasis placed on key factors that are used for a default rating which is then modified on the basis of non-key factors that may include examination findings, function, and objective diagnostic results. There is greater consistency throughout the chapters. The basic concepts are applied throughout this edition.
Basics!!

Note Key Factor for Condition based on Chapter Guidelines. Look up appropriate Grid in Chapter Identify class and default rating Assess non-key factors for modifying the default rating Final Rating

Key Factor

Identifying the key factor for rating allows the physician to utilize the grids and identify a default impairment rating.

For most organ systems or disease processes this will be the "History of Clinical Presentation." For the spine and extremities, initial placement in the grid is based upon the diagnosis alone.

Key Factor

For cardiac, pulmonary, and renal systems, "objective test results" are used as the key factor for rating.

For the endocrine system, the key factor is the BOTC (Burden of Treatment Compliance).

Default Rating

- Within each class, there is a range of A-E. A is the lowest rating a patient with that condition in that class may receive with E being the highest rating. The default rating for each patient prior to adjustment for non-key factors is C.
What you take home

Basic Rating:
Key factor identifies an initial class or default rating that can be modified by physical examination, function, clinical studies.
GM – Grade Modifier
GMFH – Grade Modifier Functional History
GMPE – Grade Modifier Physical Exam
GMCS – Grade Modifier Clinical Studies

QuickDASH

For the upper extremities, the QuickDASH score indicating impact on function is provided for ease in identifying the functional grid modifier.
The QuickDASH is an abbreviated version of the DASH Outcome Measure.
DASH: Disabilities of the Arm, Shoulder, and Hand

QuickDASH

The QuickDASH is a Questionnaire that asks patient’s questions about their symptoms as well as their ability to perform certain activities. The QuickDASH and the full DASH questionnaires can be downloaded for use by a clinician at www.dash.iwh.on.ca

Example

Using the elbow grid:
Under Soft Tissue:
Elbow Pain*
Nonspecific elbow pain following injury or occupational exposure

Only Class 0 and Class 1 are available. The greatest impairment for this condition is 1%. A-B are 0% and C-E are 1%

What is the Default Impairment?

Recall that the default impairment is C. Therefore, in this example, the default impairment for a patient with this key factor is 1%.
Modifying an Impairment

The next step would be to modify the impairment rating or default rating based on non-key factors which may include function, objective test results, and examination findings.

Remember!

Once a patient’s impairment has been assigned to a Class on the basis of the Key factor (for musculoskeletal injuries this is generally the diagnosis) the modifications cannot change the class of the rating, only move the impairment up or down in the range provided of A-E. If there is any question, a physician should re-evaluate the original placement in the Class.

Modifier Grid

<table>
<thead>
<tr>
<th>Grade</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional History</td>
<td>No problem</td>
<td>Mild problem</td>
<td>Moderate problem</td>
<td>Severe problem</td>
<td>Very severe problem</td>
</tr>
<tr>
<td>Examination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective Tests</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Grade Modifiers

Our patient, who is a Class 2 on the basis of his diagnosis, has a GMFH of 3, a GMPE of 2, and a GMCS of 2.

Net adjustment: GMFH – CDX = 3-2=1

For examination and test results the grade and class are the same and result in no change in the impairment.

Net Adjustment

The +1 for Functional Modification, however, moves the impairment from the default of C up one to D.

In returning to the Elbow Regional Grid, C (1%) is = to D(1%) and results in no change in impairment.

Summary

Impairment classes are determined by a patient’s key factor for the organ system injured (spine and extremities is diagnosis).

A default impairment of C is assessed and then may be modified to reflect adjustments for non-key factors.
Upper Extremities

Most impairment values for the upper extremity are calculated using the Diagnosis-Based Impairment (DBI) method. Grade modifiers or non-key factors may include functional history, physical examination, and relevant clinical studies.

See Handouts

1) Table 15-7 Functional History Adjustment: Upper extremities
2) Table 15-8 Physical Examination Adjustment: Upper extremities
3) Table 15-9 Clinical Studies Adjustment: Upper extremities

Diagnosis Based Impairment

The physician should select the most accurate diagnosis and identify the class containing that diagnosis. Choose the diagnosis that is the most impairing and causally related.

In the rare case when there are multiple DBI's, the values are combined. These impairments should not be overlapping or duplicative.

Upper Extremity Grids

Digital Regional Grid: Digit Impairments
Wrist Regional Grid: Upper Extremity Impairments
Elbow Regional Grid: Upper Extremity Impairments
Shoulder Regional Grid: Upper Extremity Impairments

Elbow Example

Using the grid on Slide 34:

The patient has a diagnosis of Elbow contusion or crush injury* with healed minor soft tissue or skin injury
Impairments A-E are 1 2 2 2 3
Default impairment is 2
Modifiers
Function: QuickDASH of 21
Examination: Grade Modifier 0
Clinical Studies: 1 Imaging studies confirm diagnosis, mild pathology

Modifiers, Contd.
CDX – 1
(Class based on diagnosis)
GMFH 1 – 1 = 0 Remains default impairment C
(Grade modifier for functional history)
GMPE 0 – 1 + -1 Moves to B
(Grade modifier for physical examination)
GMCS 1-1 + 0 No change, remains B
(Grade modifier for clinical studies)
Impairment: B, 2% UE impairment

Remember the Rules
- The modifiers do not change a class. Once selected the class does not change. If the modifiers are not consistent with the class, reconsider how you placed a patient in the class in the first place.
- If the functional score is 2 or more grades described by the PE or clinical studies, it should be considered unreliable and not used.

Peripheral Nerve Injuries
Peripheral nerve injuries have their own grid.
For traumatic nerve injuries, including CRPS II, use Table 15-21, P. 436
For brachial plexus injuries, use Table 15-20, P. 434
For entrapment nerve injuries, such as carpal tunnel syndrome, use Table 15-23, P. 449

Alternate UE ratings
On the diagnosis grid for the upper extremities, you may see an asterisk next to the diagnosis. This indicates you can also use the range of motion method for rating the patient. The range of motion method is a stand alone rating and should only be used in rare cases when it is not possible to otherwise do so.

BOTC
Burden of Treatment Compliance
The BOTC is added in selected chapters when compliance with treatment minimizes the objective evidence of dysfunction but results in a significant compromise in ADL’s.
BOTC

In most chapters, specifically spine (Chapter 17) and the other musculoskeletal chapters (Chapter 15 and 16) the BOTC is already considered as part of the History of Clinical Presentation and is not separately added.

In the endocrine chapter (Chapter 10) BOTC is so significant as to be the key factor driving the impairment. The importance of the BOTC varies from chapter to chapter and is addressed in the system chapter introduction.

Pain

As in the 5th Edition, impairment related to pain that is typically associated with a condition has been considered and included in the impairment rating provided.

Impairment on the basis of PRI

PRI – Pain related impairment

In the 6th Edition, pain is rated only if “the patient’s condition cannot be rated according to the principles described in Chapters 4-17.” This is a stand-alone impairment of 1-3% and requires use of a Pain Disability Questionnaire (PDQ).

PDQ

The PDQ is also used when determining impairment related to the pelvis. Specifically, the PDQ score is referenced when assessing the functional modification to the default impairment rating.

Thank you!