Back To Chiropractic Continuing Education Seminars

QME Basics for Chiropractors: ~ 6 Hours

Welcome:

This course counts as 6 Hours of CE for the Chiropractic Board of Examiners for the state of California.

There is no time element to this course, take it at your leisure. If you read slow or fast or if you read it all at once or a little at a time it does not matter.

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Disclaimer

- The following course material contains the opinions of the author and does not reflect the opinions of the Division of Workers' Compensation, or associated entities. This course is intended to be used as a reference tool in assisting QMEs, and is not to be relied on as legal advice.

Purpose of the Q.M.E.

- Qualified medical evaluators (QMEs) are qualified physicians who are certified by the Division of Workers' Compensation - Medical Unit to examine injured workers to evaluate disability and write medical-legal reports.

- These Med-Legal reports are used to determine an injured worker's eligibility for workers' compensation benefits.

- QMEs include medical doctors, doctors of osteopathy, doctors of chiropractic, dentists, optometrists, podiatrists, psychologists and acupuncturists.

Definitions

- **Q.M.E.:** Qualified Medical Evaluator
- **P.Q.M.E.:** Panel Qualified Medical Evaluator; selected via a panel list of three QMEs based on residential zip code.
- **A.M.E.:** Agreed Medical Evaluator; Selected by agreement between the defense attorney/claims administrator & the applicant attorney, and may or may not be a QME.
- **I.D.E.:** Industrial Disability Evaluator; previous pre-requisite certification in report writing to become a Q.M.E. Consisted of a 44 hour Med-Legal/WC report writing course.

Definitions

- **Apportionment:** Must be based on Substantial Evidence. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries.

- **Substantial Evidence:** Consists of the following essential elements within the Med-Legal report;
- 1. Opinion must be based on "reasonable medical probability."
- 2. The report must contain a legally compliant apportionment discussion pursuant to LC 4663.
- 3. A medical report cannot be "predicated on incorrect legal theory."

- **Proximate Cause:** Proximate Cause is the event that causes subsequent related events that result in injury. Proximate cause is referred to as the "cause and effect" of the industrial injury. Without a cause/action, there would not be a resulting injury.

- **Overlap:** Overlap refers to similar findings pertaining to the prior permanent disability and the current one. Defendants have the burden of proving overlap between the prior award and the new rating.

- **Duplication:** The determination if some or all factors of disability are the same or different. If the disability is the same, then duplication exists. If the factors of disability are different, then duplication does not exist. Duplication is relevant in situations where multiple body parts render similar disabilities (i.e. knee & back). The physician needs to explain why and how the disabilities are different. If not, the factors of disability will be found to be duplicative.

Definitions

- **Medical Probability:** Reasonable medical probability refers to at least a 51% probability that something is true.
- **Section 4663:** Medical Apportionment. The employer should only be responsible for the injured worker's disability related to the industrial injury.
- **Section 4664:** Legal Apportionment. The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and in the course of employment.
- **Labor Code 4750:** Repealed in 2004. Previously, apportionment could be obtained under Labor Code section 4750 for a pre-existing permanent disability or physical impairment.
- **Labor Code 4750.5:** Allowed defendants to obtain apportionment to subsequent *non-compensable* injuries (i.e. multiple employers).

Definitions

- **California Evidence Code Section 140:** "Evidence" means testimony, writings, material objects, or other things presented to the senses that are offered to prove the existence or nonexistence of a fact.
- **SB 899:** Major workers' compensation reform in 2004
- **SB 863:** Major workers' compensation reform in 2013
- **Cumulative Trauma:** CT or Repetitive Stress Injuries (RSI) deal with micro trauma over an extended duration of time. CT/RSI cases often times require apportionment as the injured worker sustained the injury across multiple employers where overlap may have occurred.
- **Permanent Disability vs. Impairment:** For DOIs > 01/01/2005 use AMA Guides 5th edition for impairment ratings. For DOIs < 01/01/2005 use PDRS (Permanent Disability Rating Schedule).

QME DWC FAQs

- **Q. What is a QME?**

- **A.** A qualified medical evaluator (QME) is a physician who evaluates you when there are questions about what benefits you should receive. A physician must meet educational and licensing requirements to qualify as a QME. They must also pass a test and participate in ongoing education on the workers' compensation evaluation process. If you have an attorney, you and your claims administrator might agree on a doctor to resolve medical disputes. This doctor is called an agreed medical evaluator (AME). An AME or a panel QME will be used to resolve medical disputes in your workers' compensation case.

QME DWC FAQs

- **Q. What is the difference between an AME and a QME?**

- **A.** If you have an attorney, your attorney and the claims administrator may agree on a doctor without going through the state system used to pick a QME. The doctor your attorney and the claims administrator agree on is called an agreed medical evaluator (AME). A QME is picked from a list of state-certified doctors issued by the DWC Medical Unit. QME lists are generated randomly. An AME can only be used if you are represented by an attorney. Once you see an AME you are not entitled to see a QME. An AME may be used regardless of the year of injury. An AME physician may be a QME, but does not have to be one.

- **Q. What is a panel QME?**

- **A.** In this context, the word panel means a list. A panel QME is a randomly generated list of three QME physicians issued to you when there is a question about whether or not your injury is work related, or if there is a medical dispute that hasn't been resolved by the treating physician's report. Whoever fills out the form to request the panel QME chooses the specialty of the doctors on the panel.

QME DWC FAQs

- **Q. I have two different problems from the same injury (for instance, a psychiatric and an orthopedic problem). May I request two panels, one psychiatric and one orthopedic?**

- **A.** The basic rule is that you get one. The claims administrator is only required to pay for one QME evaluation. The selected QME can get a consultation from another physician if there is a need for input from more than one medical specialty.

- However, there are some circumstances where a workers' compensation administrative law judge, the Division of Workers' Compensation's executive medical director or a state information & assistance officer may request an additional panel. In those cases, a panel will be provided.
  (Title 8, California Code of Regulations, section 32 (c), Labor Code sections 5703.5(a), 5703.5(b), 4063.3(i))

QME DWC FAQs

- **Q. Can I get a new panel because the physicians on the panel are too far away?**

- **A.** No. The Medical Unit cannot replace physicians based on distance from your address and cannot simply choose the physicians closest to you. By law, the QME panel process must be done randomly according to ZIP code. The claims administrator will pay your transportation costs to see the QME.

- **Q. The QMEs on the panel you issued are close to my home. However, can you give me a panel closer to work?**

- **A.** The law requires the Medical Unit to issue panels close to your residence. However, the DWC Medical Unit can issue a panel of QMEs using the ZIP code of your workplace if the claims administrator agrees to this request.
  (Title 8, California Code of Regulations, section 31.5 (b) (2, Labor Code section 139.2 (h))

QME DWC FAQs

- **Q. I was issued a panel of orthopedists at the claims administrator's request. However, I want to see a *chiropractor*. Will you issue a new panel?**

- **A.** No. You had the first chance to send in the request form and to select the specialty of the QME. If you (the injured worker) failed to make the request within the **10-day deadline**, the claims administrator has the right to select the specialty of the panel.

QME DWC FAQs

- **Q. My QME evaluation was yesterday. How long does the doctor have to issue the report?**

- **A.** The QME has **30 calendar days** from the date of the commencement of the exam to issue the report. **There are three reasons a physician may request an extension:**

1. The physician requested you have **medical tests and is awaiting results**

2. The physician requested a **consultation and is awaiting the consultant's report**

3. The physician has a "**good cause**" for an extension. A good cause is a medical emergency of the evaluator or the evaluator's family, death in evaluator's family, natural disaster or other community catastrophes that interrupt the operation of the evaluator's office. The computer breaking down or a staff member quitting is not considered good cause. Extensions for good cause may not exceed 15 days from the date the report is required to be served.

- The physician may not request an extension because the claims administrator failed to provide your medical records or past medical tests. If the report is going to be late, the physician must file a time frame extension request with the DWC Medical Unit and send a copy to the claims administrator and to you. This must be filed five days before the report is due. (Title 8, California Code of Regulations, section 38)

QME DWC FAQs

- **Q. I need another evaluation. Should the original QME do it? What if that physician is no longer performing QME evaluations?**

- **A.** The second evaluation should be done by the same QME. The exceptions to this rule are:

- The physician is no longer available
- The physician became the treating physician after performing the QME evaluation
- A workers' compensation administrative law judge decides you should have a new evaluation with a **different** QME.

- If any exception applies, you may begin the QME request process again and you will receive a new panel.
  (Labor Code sections 4062.3(j); 4067)

QME DWC FAQs

- **Q. Why are my medical and non-medical records sent to the QME?**
- **A.** These records give the QME a history of your injury. The physician's records indicate the diagnosis and treatment received to date. Test results, such as MRIs, are forwarded so that the QME will not have to duplicate the tests. Medical records about treatment prior to the injury are often sent to help determine how much of the permanent disability is due to this injury and how much may be due to a prior injury or accident. Non-medical records, such as personnel records or films, are sent to provide information regarding the injury to the QME physician.
- Non-medical records may include personnel records or films.
- Once you make the QME appointment, the physician has five days to send the QME appointment notification form to the claims administrator advising them of the appointment. **The claims administrator is required to send you a copy of everything they plan to send to the QME physician 20 days prior to sending the records to the QME.**
- You are also required to send any information (letters from friends, personal records) you are planning to send to the QME to the claims administrator 20 days before you send it to the QME.
- Both you and the claims administrator (or your respective attorneys) have 10 days to object to any **non-medical** records being sent to the QME. There is no form for this objection. Whoever is objecting simply writes a letter to the other party.
- If either you or the claims administrator does not follow the 20-day rule, the wronged party has the right to cancel the evaluation.
(Title 8, California Code of Regulations, section 35, Labor Code section 4062.3 (b))

QME DWC FAQs

- **Q. The QME evaluation is next week, but I have not received the medical records and neither has the QME. What should be done?**

- **A.** <u>There are two options:</u>

1. You may **<u>cancel the appointment</u>**, call the claims administrator or treating doctor to obtain the records, and then reschedule the appointment
2. You may **<u>keep the appointment</u>** and have the claims administrator send the records to you and then to the QME after the evaluation. Some QMEs don't want to do an evaluation without the records, so check with the QME's office to see if the appointment should be rescheduled.

How to Become & be Selected as a QME
Labor Code Section 4061

- **Labor Code Section 4061:** Disputes over permanent disability (PD) and any need for future medical care. Labor Code section 4061 requires there be an objection to the medical determination made by the primary treating physician (PTP).

- **Unrepresented Cases:**
- If either the employee or employer objects to a medical determination made by the treating physician concerning the existence or extent of permanent impairment and limitations or the need for future medical care, and if the employee is not represented by an attorney, the **employer shall immediately provide the employee with a form** prescribed by the medical director with which to request assignment of a **panel of three qualified medical evaluators.**

How to Become & be Selected as a QME Labor Code Section 4061

- **Labor Code Section 4061:** Disputes over permanent disability (PD) and any need for future medical care. Labor Code section 4061 requires there be an objection to the medical determination made by the primary treating physician (PTP).

- **Represented Cases:**
- If either the employee or employer objects to a medical determination made by the treating physician concerning the existence or extent of permanent impairment and limitations or the need for future medical care, and the employee is represented by an attorney, a medical evaluation to determine permanent disability shall be obtained as provided in Section 4062.2.

Labor Code Section 4610 Utilization Review

- The **UR process is governed by Labor Code section 4610 and regulations** written by the CA Division of Workers' Compensation (DWC), which lay out timeframes and other rules for conducting UR. The rules, contained in Title 8, California Code of Regulations, sections 9792.6 et seq, also require UR plans to be filed with the DWC administrative director.

- Additionally, the DWC has promulgated regulations that provide for penalties to apply when claims administrators and UR companies don't follow UR rules.

- The UR penalty regulations, found in Title 8, California Code of Regulations, sections 9792.11 - 9792.15, provide an **enforcement mechanism to ensure utilization reviews are conducted in compliance with UR regulations**.

Labor Code 4604.5

- (a) The recommended guidelines set forth in the **medical treatment utilization schedule** adopted by the administrative director pursuant to Section 5307.27 **shall be presumptively correct** on the issue of extent and scope of medical treatment.

- The presumption is rebuttable and **may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines r**easonably is required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the **burden of proof.**

- (b) The recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices that are **evidence and scientifically based, nationally recognized, and peer reviewed.** The guidelines shall be designed to assist providers by offering an analytical framework for the evaluation and treatment of injured workers, and shall constitute care in accordance with Section 4600 for all injured workers diagnosed with industrial conditions.

Labor Code 4604.5

- (c) (1) Notwithstanding the medical treatment utilization schedule, for injuries occurring on and after January 1, 2004, an **employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury.** (2) (A) Paragraph (1) **shall not apply when an employer authorizes, in writing, additional visits to a health care practitioner for physical medicine services**.

- Payment or authorization for treatment beyond the limits set forth in paragraph (1) shall not be deemed a waiver of the limits set forth by paragraph (1) with respect to future requests for authorization. (B) The Legislature finds and declares that the amendments made to subparagraph (A) by the act adding this subparagraph are declaratory of existing law. (3) Paragraph (1) shall not apply to visits for postsurgical physical medicine and postsurgical rehabilitation services provided in compliance with a postsurgical treatment utilization schedule established by the administrative director pursuant to Section 5307.27.

- (d) **For all injuries not covered by the official utilization schedule adopted pursuant to Section 5307.27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are recognized generally by the national medical community and scientifically based.**

Title 8, California Code of Regulations, section 10606: Physicians' Reports as Evidence

- Chapter 4.5. Division of Workers' Compensation
  Subchapter 2. Workers' Compensation Appeals Board--Rules and Practice Procedure
  Article 9. Evidence and Reports

- (a) The Workers' Compensation Appeals Board favors the production of medical evidence in the form of written reports.

- **(b) Medical reports should include where applicable:**
- (1) the date of the examination;
- (2) the history of the injury;
- (3) the patient's complaints;
- (4) a listing of all information received in preparation of the report or relied upon for the formulation of the physician's opinion;
- (5) the patient's medical history, including injuries and conditions, and residuals thereof, if any;
- (6) findings on examination;
- (7) a diagnosis;
- (8) opinion as to the nature, extent, and duration of disability and work limitations, if any;
- (9) cause of the disability;
- (10) treatment indicated, including past, continuing, and future medical care;
- (11) opinion as to whether or not permanent disability has resulted from the injury and whether or not it is stationary. If stationary, a description of the disability with a complete evaluation;
- (12) apportionment of disability, if any;
- (13) a determination of the percent of the total causation resulting from actual events of employment, if the injury is alleged to be a psychiatric injury;
- (14) the reasons for the opinion; and,
- (15) the signature of the physician.

Pros & Cons of being a Chiropractic QME

- **Record Review:** LC 4628 requires review and provide medical record summary of all relevant records, and composing & drafting any conclusions.
- **Research:** Extra clinical research may be warranted. For example, if a condition is not clearly addressed, the evaluator may seek other sources that are considered evidence based medicine/peer reviewed literature.
- **Report Writing:** Address all issues at hand and correlate to physical examination findings, record review and patient history.
- **Preparation for Examination:** Prepare beforehand which physical examination procedures are required based on the body part(s) involved and associated with any impairment ratings that may apply.
- **Preparation for Depositions:** Review your prior Med-Legal report, which should include all of the record summaries and most current issues at hand. Reviewing prior to the deposition will help recall specific issues that pertain to the injured worker in question.

Pros & Cons of being a Chiropractic QME

- **Follow-Up process on referrals:** The QME should make all recommendations for further care such as but not limited to; diagnostics, labs, consults, etc.
- **Applicant Attorneys:** Legal representation for the injured worker.
- **Defense Attorneys:** Legal counsel for the employer/claims administrator.
- **Interpreters:** Required to translate during the Med-Legal examination. The claims administrator is responsible for paying for the interpretative services.
- Title 8. Section 34: (c) The QME shall include within the notification whether a Certified Interpreter, as defined by Labor Code Section 5811 and subject to the provisions of section 9795.3 of Title 8 of the California Code of Regulations, is required and specify the language. The interpreter shall be arranged by the party who is to pay the cost as provided for in Section 5811 of the Labor Code.

QME Referrals – Section 32

- **Q. Can a QME make referrals without first obtaining authorization from the employer/claims administrator?**

- **Section 32 of the QME Regulations** has changed since 2009 and **QMEs are prohibited from making referrals for the purpose of diagnostics and/or consultations without first obtaining prior authorization.** A Request For Authorization (RFA) **should be made using the DWC form RFA.**

- NOTE: The QME has never been granted permission to refer an injured worker out for treatment. Any further treatment should be outlined in your QME report, which explains in detail the need for such care. For example, the injured worker is not yet deemed permanent and stationary because of lack of appropriate treatment (i.e. surgery, medications, physical medicine, etc.), which may also include diagnostic studies.

- The QME is prohibited from referring the injured worker out for the purpose of obtaining the disability/impairment rating, which is the QME's responsibility to determine unless outside their scope of practice.

QME Referrals – Section 32

- If the QME is given authorization to make a referral for treatment, diagnostics and/or consultations, it is their responsibility to follow-up and arrange the referral.

- (d) Whenever an Agreed Panel QME or a QME determines that a consultation is necessary pursuant to this section and the physician selected for the consultation is not selected by the parties from a QME panel issued by the Medical Director, the referring QME must arrange the consultation appointment and advise the injured employee and the claims administrator, or if none the employer, and each party's attorney if any, in writing of the appointment date, time and place **by use of QME Form 110 (QME Appointment Notification Form)**(See, 8 Cal. Code Regs. § 110).

- The QME must include and annotate the results within their subsequent supplemental report **within 15 days of receipt of the results and copy all stakeholders**.

How to Become a QME

- **Q. How do I become a QME? How do I register for the test?**

- **A.** To become a QME, you must meet the requirements that are listed in Labor Code section 139.2. If you meet these requirements, you should submit a completed application form to the Division of Workers' Compensation Medical Unit. You also must submit a test registration form. Prior to becoming a QME you have to pass the QME competency exam. **Tests are scheduled twice a year in April and Oct.** Upon passing the test and paying the QME annual fee, you will be a certified QME. (Labor Code § 139.2(b) (n), 8 CCR § 10). Prior to appointment as a QME, a physician is **required to take a 12-hour course about writing medical legal reports.** (8 CCR § 11.5)

- **Q. What is the deadline for submitting my application and registration form?**

- **A.** A properly completed application for appointment and an exam registration form must be received, or postmarked, **45 calendar days prior to the date of the exam**. (8 CCR § 11(f)(4))

How to Become a QME

- **Q. Is there a fee to take the QME exam?**
- **A.** Yes. There is a $125 fee to take or retake the exam. (8 CCR § 11 (f) (2))

- **Q. What is the annual fee to be a QME?**
- **A.** The annual fee is $250 if you performed 25 or more comprehensive medical-legal evaluations in the year prior to assessment of the fee.
- If you performed 11-24 examinations, the annual fee is $125.
- If you performed 0-10, the fee is $110.
- This fee is for one office location.
- If you wish to have additional locations, the fee is $100 for each additional location. (Labor Code § 139.2 (n), 8 CCR § 17)

How to Become a QME

- https://www.dir.ca.gov/dwc/medicalunit/QME_page.html

Becoming a qualified medical examiner:

QME Exam

- Upcoming QME Exam
  - Exam packet
  - Exam application

QME Exam

- Upcoming QME Exam
  - Exam packet
  - Exam application

Online QME Form 106 Panel Request

For injuries on or after 1/1/05, online only as of Oct. 1, 2015.

QME EXAM

April 16, 2016

Study Guides:

- Competency examination study guide
- Competency examination booklet
- Competency examination for acupuncturists
- Physician guide - As a result of 2003 and 2004 legislative changes and 2009 regulatory changes, some portions of this Physician's Guide may be inconsistent with current law. Therefore, it must not be considered authoritative, and should only be consulted as an historical document.

QME competency examination results:

- Oct. 17, 2015 Exam
- April 25, 2015 Exam

PDRS (Permanent Disability Rating Schedule)

- https://www.dir.ca.gov/dwc/medicalunit/QME_page.html

Evaluation protocols:

For injuries rated under 1997 permanent disability rating schedule and prior

- Cardiac
- Foot and ankle
- Immunologic
- Neuromusculoskeletal
- Psychiatry
- Pulmonary

February 2016

PDRS (Permanent Disability Rating Schedule)

- https://www.dir.ca.gov/dwc/medicalunit/QME_page.html

N. FACTORS OF DISABILITY

Do not provide a "rating" but describe the medical information in such a way as to be used by raters, judges and other concerned parties. The evaluator will describe the subjective and objective components of disability. The following information shall be included:

1. Subjective Factors of Disability

Translate the injured worker's symptoms into ratable language using the terminology found in Appendix A.

DESCRIPTION OF ACTIVITIES

BALANCING:	Maintaining body equilibrium
BENDING:	Angulation from neutral position about a joint (e.g. elbow) or spine (e. g. forward)
CARRYING:	Transporting an object, usually holding it in the hands or arms or on the shoulder.
CLIMBING:	Ascending or descending ladders, stairs, scaffolding, ramps, poles, etc. . . using feet and legs and/or hands and arms.
CRAWLING:	Moving about on hands and knees and feet.
CROUCHING:	Bending body downward and forward by bending lower limbs, pelvis and spine.
FEELING:	Perceiving attributes of objects such as size, shape, temperature, or texture by means of receptors in the skin, particularly those of the finger tips.
FINGERING/ PINCHING:	Picking, pinching or otherwise working with fingers and thumb primarily (rather than with whole hand or arm as in handling).
GRASPING/ HANDLING:	Seizing, holding, grasping, turning or otherwise working with hand or hand (fingering not involved).
JUMPING:	Moving about suddenly by use of leg muscle, leaping from or onto the ground or from one object to another.
KNEELING:	Bending legs at knees to come to rest on knee or knees.
LIFTING:	Raising or lowering an object from one level to another (includes upward pulling)
OVERHEAD/ OVER SHOULDER:	Performing work activities with arm raised and held unsupported, at or above shoulder level.
PIVOTING:	Planting your foot and turning about that point.
PUSHING:	Exerting force upon an object so that the object moves away from the force (includes slapping, striking, kicking and treadle actions).

PULLING:	Exerting force upon an object so that the object moves towards the force (includes jerking).
REACHING:	Extending the hand(s) and arm(s) in any direction.
RUNNING:	Moving in a fast pace, moving the legs rapidly so that for a moment both legs are off the ground.
SITTING:	Remaining in the normal seated position.
SQUATING:	Crouching to sit on your heels, with knees bent and weight on the balls of your feet.
STANDING:	Remaining on one's feet in an upright position at a work station without moving about.
STOOPING:	Bending body downward and forward by bending spine at waist.
TURNING/ TWISTING:	Moving about a central axis, revolve or rotate.
USE OF HAND OR FOOT CONTROLS:	Required to control a machine by use of controls.
WALKING:	Moving about at a moderate pace over even or uneven ground.

PDRS (Permanent Disability Rating Schedule)

- https://www.dir.ca.gov/dwc/medicalunit/QME_page.html

2. Objective Factors of Disability

Note those finding which can be measured, observed or demonstrated on testing. They include, but are not limited to: range of motion, strength, sensation, reflexes, anatomical measurements, disfigurement, and radiographic or diagnostic results.

Note if assistive devices, prosthetics, or orthotics are required. Note if the device causes any limitation in motion.

3. Loss of Pre-Injury Capacity

Describe the loss of pre-injury capacity for activities. Report loss of pre-injury capacity for the work activities the injured worker was performing at the time of the injury and for potential activities in the open labor market.

The evaluator will estimate the total or partial loss of the injured worker's pre-injury capacity to lift, bend, stoop, push, pull, climb or other activities involving comparable physical strength. The best means is to describe the injured worker's loss of capacity, such as loss of one-quarter of his ability to lift.

Use of job history and/or description as well as other activities of daily living to estimate the pre-injury capacity, should be noted in the report to substantiate the evaluator's opinion on loss.

4. Work Restrictions

Describe all permanent work restrictions. Be as specific as possible, incorporating the injured worker's history, the RU-90, the DEU Form 100, and a formal job analysis, if it is available.

Intensity vs. Frequency of Pain

- It is important to understand and be able to properly describe frequency and intensity of pain within the workers' compensation system.

- **INTENSITY OF PAIN/SYMPTOMS:**

- **SEVERE** Severe pain would preclude the activity precipitating the pain.
- **MODERATE** Moderate pain can be tolerated, but would cause a marked handicap in the performance of the activity precipitating the pain.
- **SLIGHT** Slight pain can be tolerated, but would cause some handicap in the performance of the activity precipitating the pain.
- **MINIMAL** Minimal (same as mild) pain would constitute an annoyance, but would cause no handicap in the performance of the particular activity.
- (Minimal pain is a non-ratable permanent disability)

Intensity vs. Frequency of Pain

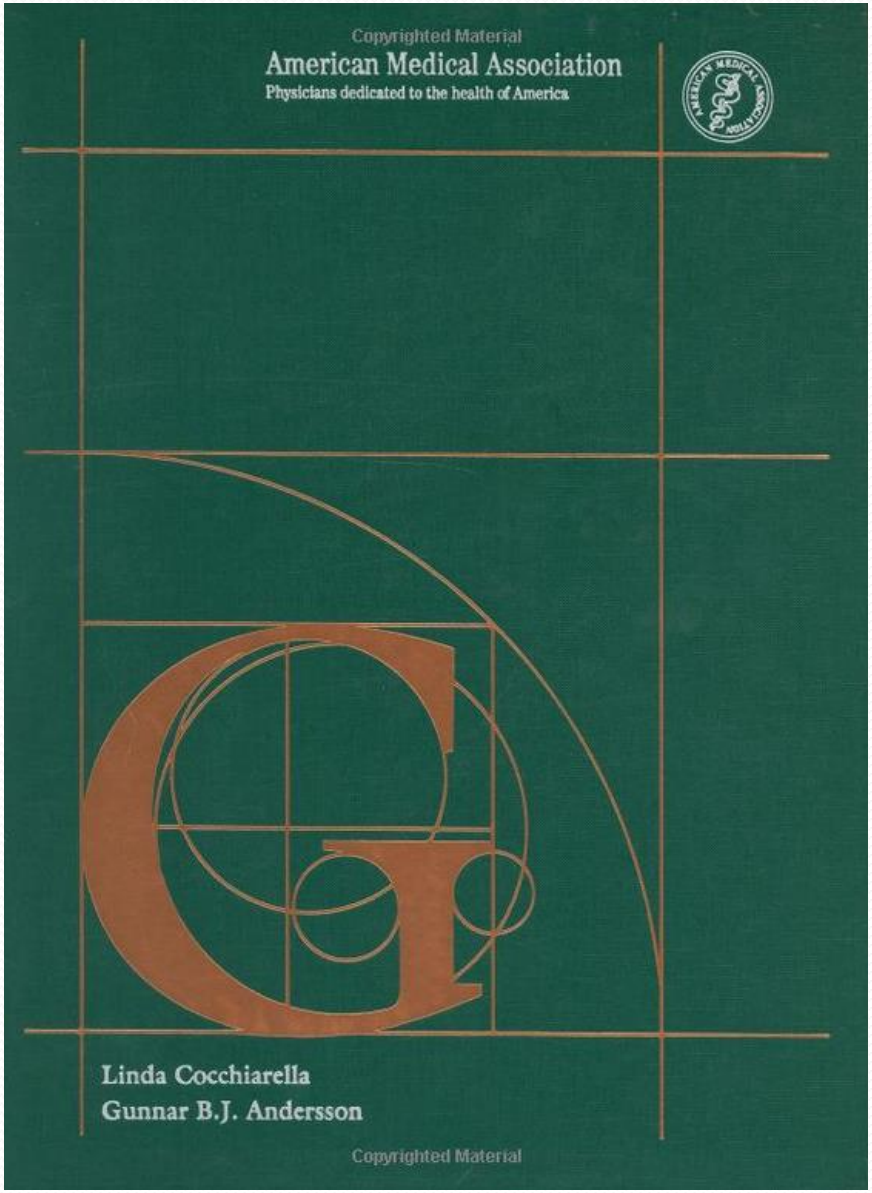
- **FREQUENCY OF PAIN/SYMPTOMS:**

CONSTANT	Occurring approximately 75-100% of the time
FREQUENT	Occurring approximately 50-75% of the time
INTERMITTENT	Occurring approximately 25-50% of the time
OCCASIONAL	Occurring approximately 0-25% of the time

QME CE

- **Q. How many years is my QME status valid?**

- **A.** QMEs who initially applied prior to July 17, 1993 were approved for a four-year term. QMEs who were approved on or after July 17, 1993, were approved for a two-year term. Once a QMEs initial term expires, he/she will be reappointed **every two years**. A QME must pay an annual fee in order to maintain his/her status and show **proof of having attended 12 hours of combined education in 24 months.** . For initial reappointment, the Medical Unit uses the QME exam passed as 6 hours of continuing education. The QME is only required to receive 6 hours of continuing education, in order to fulfill the 12 hour requirement.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AMA Guidelines

- **ROM vs DRE - Spine Example:**
- DDX: Lumbar Disc Protrusion (L3-4 & L5-S1) (MRI Verified) & Intervertebral Disc Degeneration L3-4 (MRI Verified)

- Range of Motion (ROM) method to be used with lumbar spine.
- DRE not to be used for lumbar spine rating when multiple levels are identified objectively through MRI and clinical findings on exam.

- Table 15-8; Page 407; (Lumbar Flexion/Extension) Chapter 15
- Table 15-9; Page 409; (Lumbar Lateral Flexion) Chapter 15

Lumbar Spine	**Normal (Degrees ◦)**	**Exam**	**Exam (Mean)**	**Maximum Angle (WPI%)**
Flexion	60	20, 25, 20	23	**4%**
Extension	25	10, 10, 12	11	**5%**
(L) Lateral Flexion	25	12, 12, 15	14	**2%**
(R) Lateral Flexion	25	15, 15, 15	15	**2%**

AMA Guidelines

- **ROM vs DRE - Spine Example:**

- Range of Motion Method as used for the lumbar spine does require combining the…
- 1.) Diagnosis-Based Impairment (table 15-7)
- 2.) Range of Motion Impairment and
- 3.) any Impairments due to Neurologic Deficits as described on pages 402-403 of the AMA Guides.
-
- 1) Figure 15-10; Page 410; (Lumbar Range of Motion (ROM)* Chapter 15
- TOTAL Lumbar ROM Impairment=**13%**
-
- 2) Diagnosis from table 15-7; Page 404; II. Part C.=(**5+2%)=7%**
-
- 3) Spinal nerve deficit from table 15-15 & 15-16 & 15-18=**1%**

AMA Guidelines

- **ROM vs DRE - Spine Example:**
- Sensory Deficit was determined using Table 15-15 in conjunction with Table 15-18 for "Maximum % Loss of Function Due to Sensory Deficit of Pain".
- Using Table 15-15, a Grade 4 was selected with a 25% *Sensory Deficit* pertaining to the lower extremities.
- L5 was chosen from Table 15-18 and correlates with a Maximum % Loss of Function due to Sensory Deficit or Pain of 5%.
- The AMA Guides states to multiply the severity of the sensory deficit (25%)/(Table 15-15) by the maximum impairment value(5%)/(Table 15-18) to obtain the extremity impairment for each spinal nerve involved. Therefore, multiplying 25% x 5% (.25x0.05x100%) resulted in 1%.
- Please be reminded that Table 15-16 was not used since there was no objective evidence of true motor weakness or loss of strength.

AMA Guidelines

- **ROM vs DRE - Spine Example:**
- The following will describe use of Table 15-7 to arrive at the Diagnosis-Based impairment rating.
- Pertaining to the lumbar spine, which included discogenic lesions between L3-4 and L5-S1, an impairment % of the whole person was given 5% based on the description in part II. Intervertebral Disk or Other Soft Tissue Lesion section B "Unoperated on, stable, with medically documented injury, pain, and rigidity associated with none to minimal degenerative changes on structural tests."
- Additionally, part F under the section II., states to add 1% per level for "Multiple levels, with or without operations and with or without residual signs or symptoms."
- MRI revealed disc pathology between L3-4 and L5-S1, or 2 levels in the lumbar spine. Therefore, an additional 2% should be assigned. With these final additions, the lumbar Diagnosis-Based Impairment was (5%+2%) 7%. This impairment rating will be combined with ROM and neurological deficit impairments.

AMA Guides to the Evaluation of Permanent Impairment (5th Edition)

- Sample Rating for D.O.I > 01/01/2005

- The AMA guides 5th edition is currently still used in California for dates of injury that extend beyond 1/1/2005.

- The AMA Guides require that the doctor utilize the text book to determine an appropriate impairment rating based on the specific chapter(s), tables and figures as described and based on the injured body part(s).

AMA Guides to the Evaluation of Permanent Impairment (5th Edition)

- Use the following tables and figures from the AMA Guides 5th Edition to determine the Whole Person Impairment Rating based on the information delineated below:

AMA Guides to the Evaluation of Permanent Impairment (5th Edition)

- **EXAMPLE:**
- **D.O.I.:** 12/25/2008
- **SUBJECTIVE COMPLAINT:**
- Neck pain with radiculopathy into the left upper extremity.
- **OBJECTIVE FINDINGS:**
- All measurements met validity criteria
- (sets of three within 5 degrees of the mean or 10%, whichever is greater).

- The mean is calculated by taking the sum of the highest and lowest values and dividing by two.

AMA Guides to the Evaluation of Permanent Impairment (5th Edition)

- **Spinal Measurements:**
- Table 15-12; Page 418; (Cervical Flexion/Extension) Chapter 15
- Table 15-13; Page 420; (Cervical Lateral Flexion) Chapter 15
- Table 15-14; Page 421; (Cervical Rotation) Chapter 15

AMA Guides to the Evaluation of Permanent Impairment (5th Edition)

Cervical Spine	Normal (Degrees ◦)	Exam	Exam (Mean)	Maximum Angle (WPI%)
Flexion	50	52, 52, 50		
Extension	60	60, 62, 65		
Right Rotation	80	65, 68, 68		
Left Rotation	80	65, 70, 68		
Right Lateral Flexion	45	30, 30, 32		
Left Lateral Flexion	45	37, 40, 38		

AMA Guides to the Evaluation of Permanent Impairment (5th Edition)

- Figure 15-18; Page 422; (Cervical Range of Motion (ROM)*) Chapter 15

- Use tables below to determine the WPI for the cervical spine based on the measurements in the previous slide.

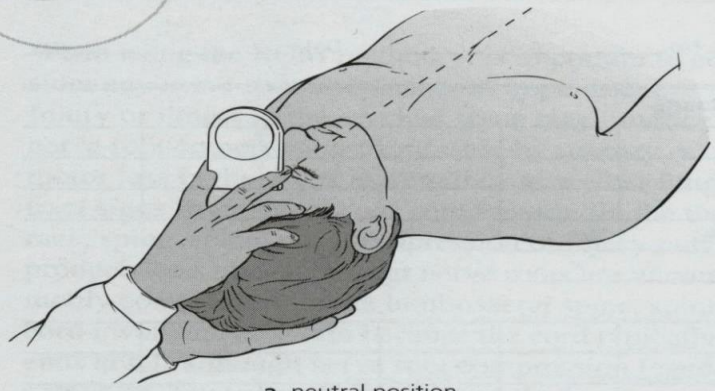
- TOTAL Cervical ROM Impairment=**???%**

Table 15-13 Impairment Due to Abnormal Motion and Ankylosis of the Cervical Region: Lateral Bending

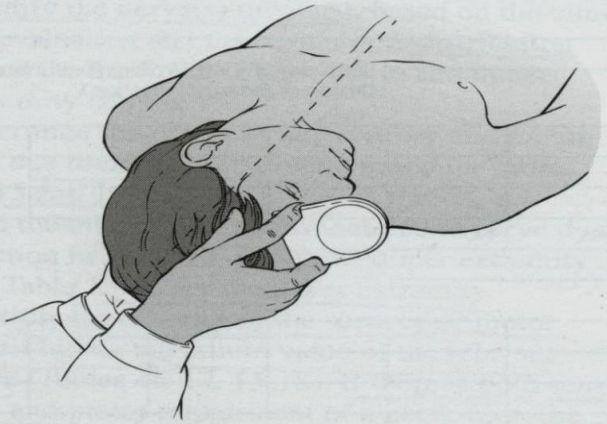
Abnormal Motion
The average range of lateral bending is 90°; the proportion of all cervical motions is 25%.

a.	Left Lateral Bending From Neutral Position (0°) to (°):	Degrees of Cervical Motion		% Impairment of the Whole Person
		Lost	Retained	
	0	45	0	4
	15	30	15	2
	30	15	30	1
	45	0	45	0
b.	**Right Lateral Bending From Neutral Position (0°) to (°):**	**Degrees of Cervical Motion**		**% Impairment of the Whole Person**
		Lost	**Retained**	
	0	45	0	4
	15	30	15	2
	30	15	30	1
	45	0	45	0
c.	**Ankylosis Region Ankylosed at (°):**			
	0 (neutral position)			8
	15			20
	30			30
	45 (full left or right rotation)			40

Figure 15-17 Measuring Cervical Rotation



a. neutral position



b. right rotation

Table 15-14 Impairment Due to Abnormal Motion and Ankylosis of the Cervical Region: Rotation

Abnormal Motion
Average range of rotation is 160°; the proportion of all cervical motion is 35%.

a.	Left Rotation From Neutral Position (0°) to (°):	Degrees of Cervical Motion		% Impairment of the Whole Person
		Lost	Retained	
	0	80	0	6
	20	60	20	4
	40	40	40	2
	60	20	60	1
	80	0	80+	0
b.	**Right Rotation From Neutral Position (0°) to (°):**	**Degrees of Cervical Motion**		**% Impairment of the Whole Person**
		Lost	**Retained**	
	0	80	0	6
	20	60	20	4
	40	40	40	2
	60	20	60	1
	80	0	80+	0
c.	**Ankylosis Region Ankylosed at (°):**			
	0 (neutral position)			12
	20			20
	40			30
	60			40
	80 (full right or left rotation)			50

Table 15-12 Cervical Region Impairment From Abnormal Flexion or Extension or Ankylosis

Abnormal Motion
Average range of flexion and extension is 110°; the proportion of all cervical motions is 40%.

a.	Flexion From Neutral Position (0°) to (°):	Degrees of Cervical Motion		% Impairment of the Whole Person
		Lost	Retained	
	0	50	0	5
	15	35	15	4
	30	30	20	2
	50	0	50	0
b.	**Extension From Neutral Position (0°) to (°):**	**Degrees of Cervical Motion**		**% Impairment of the Whole Person**
		Lost	**Retained**	
	0	60	0	6
	20	40	20	4
	40	20	40	2
	60	0	60+	0
c.	**Region Ankylosed at (°):**			
	0 (neutral position)			12
	15			20
	30			30
	50 (full flexion)			40
d.	**Region Ankylosed at (°):**			
	0 (neutral position)			12
	20			20
	40			30
	60 (full extension)			40

AMA Guides to the Evaluation of Permanent Impairment (5th Edition)

Cervical Spine	Normal (Degrees ◦)	Exam	Exam (Mean)	Maximum Angle (WPI%)
Flexion	50	52, 52, 50	51	0
Extension	60	60, 62, 65	63	0
Right Rotation	80	65, 68, 68	67	1
Left Rotation	80	65, 70, 68	68	1
Right Lateral Flexion	45	30, 30, 32	31	1
Left Lateral Flexion	45	37, 40, 38	39	1

- Add up the individual WPI per cervical ROM to total =
- 4% Cervical WPI (ROM)

Figure 15-18 Cervical Range of Motion (ROM)*

Name _____ Soc. Sec. No. _____ Date _____

Movement	Description	Range
Cervical flexion	Calvarium angle T1 ROM Cervical flexion angle ±10% or 5° Maximum cervical flexion angle % Impairment	Yes / No
Cervical extension	Calvarium angle T1 ROM Cervical extension angle ±10% or 5° Maximum cervical extension angle % Impairment	Yes / No
Cervical ankylosis in flexion/extension	Position % Impairment	(Excludes any impairment for abnormal flexion or extension motion)
Cervical left lateral bending	Calvarium angle T1 ROM Cervical left lateral flexion angle ±10% or 5° Maximum cervical right lateral flexion angle % Impairment	Yes / No
Cervical right lateral bending	Calvarium angle T1 ROM Cervical right lateral flexion angle ±10% or 5° Maximum cervical right lateral flexion angle % Impairment	Yes / No
Cervical ankylosis in lateral bending	Position % Impairment	(Excludes any impairment for abnormal lateral flexion or extension motion)
Cervical left rotation	Cervical left rotation angle ±10% or 5° Maximum cervical left rotation angle % Impairment	Yes / No
Cervical right rotation	Cervical right rotation angle ±10% or 5° Maximum cervical right rotation angle % Impairment	Yes / No
Cervical ankylosis in rotation	Position % Impairment	(Excludes any impairment for abnormal rotation)

Total cervical range of motion and ankylosis* impairment _____ %

Total cervical range of motion = % impairments of flexion + extension + left lateral bending + right lateral bending + left rotation + right rotation

* If ankylosis is present, combine the ankylosis impairment with the range-of-motion impairment (Combined Values Chart, p. 604). If ankyloses in several planes are present, combine the estimates (Combined Values Chart), then combine the result with the range-of-motion impairment.

Table 15-15 Determining Impairment Due to Sensory Loss

a. Classification

Grade	Description of Sensory Deficit	% Sensory Deficit
5	No loss of sensibility, abnormal sensation, or pain	0
4	Distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations or pain, that is forgotten during activity	1-25
3	Distorted superficial tactile sensibility (diminished light touch and two-point discrimination), with some abnormal sensations or slight pain, that interferes with some activities	26-60
2	Decreased superficial cutaneous pain and tactile sensibility (decreased protective sensibility), with abnormal sensations or moderate pain, that may prevent some activities	61-80
1	Deep cutaneous pain sensibility present; absent superficial pain and tactile sensibility (absent protective sensibility), with abnormal sensations or severe pain, that prevents most activity	81-99
0	Absent sensibility, abnormal sensations, or severe pain that prevents all activity	100

b. Procedure

1.	Identify the area of involvement using the dermatome charts (Figures 15-1 and 15-2).
2.	Identify the nerve(s) that innervate the area(s) (Table 16-12 and Figure 16-48).
3.	Grade the severity of the sensory deficit or pain according to the classification above.
4.	Find the maximum impairment of the extremity(ies) due to sensory deficit or pain for each: spinal nerves (Table 15-8) and brachial plexus (Table 16-14).
5.	Multiply the severity of the sensory deficit by the maximum impairment value to obtain the extremity impairment for each spinal nerve involved.

Table 15-16 Determining Impairment Due to Loss of Power and Motor Deficits

a. Classification

Grade	Description of Muscle Function	% Motor Deficit
5	Active movement against gravity with full resistance	0
4	Active movement against gravity with some resistance	1–25
3	Active movement against gravity only, without resistance	26–50
2	Active movement with gravity eliminated	51–75
1	Slight contraction and no movement	76–99
0	No contraction	100

b. Procedure

1.	Identify the motion involved, such as flexion, extension, etc.
2.	Identify the muscle(s) performing the motion and the spinal nerve(s) involved.
3.	Grade the severity of motor deficit of individual muscles according to the classification given above.
4.	Find the maximum impairment of the extremity due to motor deficit for each spinal nerve structure involved (Tables 15-18, 16-11, 16-13, and 17-37).
5.	Multiply the severity of the motor deficit by the maximum impairment value to obtain the extremity impairment for each spinal nerve involved.

* Adapted from Medical Research Council.[16]

Table 15-17 Unilateral Spinal Nerve Root Impairment Affecting the Upper Extremity*

Nerve Root Impaired	Maximum % Loss of Function Due to Sensory Deficit or Pain	Maximum % Loss of Function Due to Strength
C5	5	30
C6	8	35
C7	5	35
C8	5	45
T1	5	20

* For description of the process of determining impairment percent, see text.

Table 15-18 Unilateral Spinal Nerve Root Impairment Affecting the Lower Extremity*

Nerve Root Impaired	Maximum % Loss of Function Due to Sensory Deficit or Pain	Maximum % Loss of Function Due to Strength
L3	5	20
L4	5	34
L5	5	37
S1	5	20

* For description of the process of determining impairment percent, see text.

15.15 Spine Evaluation Summary

See Table 15-20 for a spine evaluation summary form.

Table 15-20 Spine Evaluation Summary

Name _____ Soc. Sec. No. _____ Date _____

Impairment	Cervical	Thoracic	Lumbar
1. DRE Method (Tables 15-3 through 15-5)			
2. Range-of-Motion Method (and Table 15-8)			
3. Nerve root: Loss of sensation with or without pain Loss of strength			
4. Other (From Section 15.14)			
5. Regional impairment total (combine impairments in each column using the Combined Values Chart, p. 604)			
6. Spine impairment total (combine all regional totals using the Combined Values Chart)			

7. Impairment(s) of other organ systems: for each impairment list condition, page number in *Guides,* and percentage of impairment.

	Impaired System	% Impairment	*Guides* Page Number
a.			
b.			
c.			
d.			
e.			

8. Impairment of the whole person: Use Combined Values Chart to combine spine impairment with the impairment(s) listed in 7 above. If several impairments are listed, combine spine impairments with the larger or largest value, then combine the resulting percentage with any other value(s), until all the listed impairments have been accounted for.

Total whole person impairment: _____

Sample AMA Rating

Impairment Guidelines

C-SP DRE CATEGORY III

18% WP IMPAIRMENT

T-SP DRE CATEGORY II

8% WP IMPAIRMENT.

IMPAIRMENT RATING SUMMARY:

BODY PARTS	CH. #	TABLE/FIGURE #	WP% IMPAIRMENT
C-SP	15-PG. 392	DRE CATEGORY III	18%
T-SP	15-PG. 389	DRE CATEGORY II	8%
(R) UE	16-PG 436-7	MULTIPLE TABLE/FIGS	20%
(L) UE	16-PG 436-7	MULTIPLE TABLE/FIGS	12%

TOTAL IMPAIRMENT RATING IS 47% WHOLE PERSON, USING THE COMBINED VALUES CHART ON PAGE 604, TO COMBINE 20 & 18 TO GET 34 AND THEN COMBINE WITH 12 TO GET 42 AND FINALLY COMBINE & 8.

Combined Values Chart

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
1	2																																																	
2	3	4																																																
3	4	5	6																																														
4	5	6	7	8																																													
5	6	7	8	9	10																																												
6	7	8	9	10	11	12																																										
7	8	9	10	11	12	13	14																																									
8	9	10	11	12	13	14	14	15																																							
9	10	11	12	13	14	14	15	16	17																																						
10	11	12	13	14	15	15	16	17	18	19																																					
11	12	13	14	15	15	16	17	18	19	20	21																																				
12	13	14	15	16	16	17	18	19	20	21	22	23																																			
13	14	15	16	16	17	18	19	20	21	22	23	23	24																																		
14	15	16	17	17	18	19	20	21	22	23	23	24	25	26																																	
15	16	17	18	18	19	20	21	22	23	24	24	25	26	27	28																																
16	17	18	19	19	20	21	22	23	24	24	25	26	27	28	29	29																															
17	18	19	19	20	21	22	23	24	24	25	26	27	28	29	29	30	31																														
18	19	20	20	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33																													
19	20	21	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	34																												
20	21	22	22	23	24	25	26	26	27	28	29	30	30	31	32	33	34	34	35	36																											
21	22	23	23	24	25	26	27	27	28	29	30	30	31	32	33	34	34	35	36	37	38																										
22	23	24	24	25	26	27	27	28	29	30	31	31	32	33	34	34	35	36	37	38	38	39																								
23	24	25	25	26	27	28	28	29	30	31	31	32	33	34	35	35	36	37	38	38	39	40	41																							
24	25	26	26	27	28	29	29	30	31	32	32	33	34	35	35	36	37	38	38	39	40	41	41	42																						
25	26	27	27	28	29	30	30	31	32	33	33	34	35	36	36	37	38	39	39	40	41	42	42	43	44																				
26	27	27	28	29	30	30	31	32	33	33	34	35	36	36	37	38	39	39	40	41	42	42	43	44	45	45																			
27	28	28	29	30	31	31	32	33	34	34	35	36	36	37	38	39	39	40	41	42	42	43	44	45	45	46	47																		
28	29	29	30	31	32	32	33	34	34	35	36	37	37	38	39	40	40	41	42	42	43	44	45	45	46	47	47	48																	
29	30	30	31	32	33	33	34	35	35	36	37	38	38	39	40	40	41	42	42	43	44	45	45	46	47	47	48	49	50																
30	31	31	32	33	34	34	35	36	36	37	38	38	39	40	41	41	42	43	43	44	45	45	46	47	48	48	49	50	50	51															
31	32	32	33	34	34	35	36	37	37	38	39	39	40	41	41	42	43	43	44	45	45	46	47	48	48	49	50	50	51	52	52														
32	33	33	34	35	35	36	37	37	38	39	39	40	41	42	42	43	44	44	45	46	46	47	48	48	49	50	50	51	52	52	53	54													
33	34	34	35	36	36	37	38	38	39	40	40	41	42	42	43	44	44	45	46	46	47	48	48	49	50	50	51	52	52	53	54	54	55												
34	35	35	36	37	37	38	39	39	40	41	41	42	43	43	44	45	45	46	47	47	48	49	49	50	51	51	52	52	53	54	54	55	56	56											
35	36	36	37	38	38	39	40	40	41	42	42	43	43	44	45	45	46	47	47	48	49	49	50	51	51	52	53	53	54	55	55	56	56	57	58										
36	37	37	38	39	39	40	40	41	42	42	43	44	44	45	46	46	47	48	48	49	49	50	51	51	52	53	53	54	55	55	56	56	57	58	58	59									
37	38	38	39	40	40	41	41	42	43	43	44	45	45	46	46	47	48	48	49	50	50	51	51	52	53	53	54	55	55	56	57	57	58	58	59	60	60								
38	39	39	40	40	41	42	42	43	44	44	45	45	46	47	47	48	49	49	50	50	51	52	52	53	54	54	55	55	56	57	57	58	58	59	60	60	61	62							
39	40	40	41	41	42	43	43	44	44	45	46	46	47	48	48	49	49	50	51	51	52	52	53	54	54	55	55	56	57	57	58	59	59	60	60	61	62	62	63						
40	41	41	42	42	43	44	44	45	45	46	47	47	48	48	49	50	50	51	51	52	53	53	54	54	55	56	56	57	57	58	59	59	60	60	61	62	62	63	63	64					
41	42	42	43	43	44	45	45	46	46	47	47	48	49	49	50	50	51	52	52	53	53	54	55	55	56	56	57	58	58	59	59	60	60	61	62	62	63	63	64	65	65				
42	43	43	44	44	45	45	46	47	47	48	48	49	50	50	51	51	52	52	53	54	54	55	55	56	57	57	58	58	59	59	60	61	61	62	62	63	63	64	65	65	66	66			
43	44	44	45	45	46	46	47	48	48	49	49	50	50	51	52	52	53	53	54	54	55	56	56	57	57	58	58	59	60	60	61	61	62	62	63	64	64	65	65	66	66	67	68		
44	45	45	46	46	47	47	48	48	49	50	50	51	51	52	52	53	54	54	55	55	56	56	57	57	58	59	59	60	60	61	61	62	62	63	64	64	65	65	66	66	67	68	68	69	
45	46	46	47	47	48	48	49	49	50	51	51	52	52	53	53	54	54	55	55	56	57	57	58	58	59	59	60	60	61	62	62	63	63	64	64	65	65	66	66	67	68	68	69	69	70
46	47	47	48	48	49	49	50	50	51	51	52	52	53	54	54	55	55	56	56	57	57	58	58	59	60	60	61	61	62	62	63	63	64	64	65	65	66	67	67	68	68	69	69	70	70
47	48	48	49	49	50	50	51	51	52	52	53	53	54	54	55	55	56	56	57	57	58	58	59	59	60	60	61	61	62	62	63	63	64	64	65	66	66	67	67	68	68	69	69	70	70
48	49	49	50	50	51	51	52	52	53	53	54	54	55	55	56	56	57	57	58	58	59	59	60	60	61	62	62	63	63	64	64	65	65	66	66	67	67	68	68	69	69	70	70	71	71
49	50	50	51	51	52	52	53	53	54	54	55	55	56	56	57	57	58	58	59	59	60	60	61	61	62	62	63	63	64	64	65	65	66	66	67	67	68	68	69	69	70	70	71	71	72
50	51	51	52	52	53	53	54	54	55	55	56	56	57	57	58	58	59	59	60	60	61	61	62	62	63	63	64	64	65	65	66	66	67	67	68	68	69	69	70	70	71	71	72	72	73

The values are derived from the formula A + B(1–A) = combined value of A and B, where A and B are the decimal equivalents of the impairment ratings. In the chart all values are expressed as percents. To combine any two impairment values, locate the larger of the values on the side of the chart and read along that row until you come to the column indicated by the smaller value at the bottom of the chart. At the intersection of the row and the column is the combined value.

For example, to combine 35% and 20%, read down the side of the chart until you come to the larger value, 35%. Then read across the 35% row until you come to the column indicated by 20% at the bottom of the chart. At the intersection of the row and column is the number 48. Therefore, 35% combined with 20% is 48%. Because of the construction of this chart, the larger impairment value must be identified at the side of the chart.

If three or more impairment values are to be combined, select any two and find their combined value as above. Then use that value and the third value to locate the combined value of all. This process can be repeated indefinitely, the final value in each instance being the combination of all the previous values. In each step of this process the larger impairment value must be identified at the side of the chart.

Note: If impairments from two or more organ systems are to be *combined* to express a whole person impairment, each must first be expressed as a whole person impairment percent.

ADL's

Play Role in Impairment

JAN 22, 2005

AMERICAN MEDICAL ASSOCIATION

'Guides to the Evaluation of Permanent Impairment', *Fifth Edition*

You Must Have The AMA Book to Perform Impairment Ratings
Call The AMA at 1-800-621-8335 to Order the Book Above

Page 4: "Impairment percentages or ratings developed by medical specialists are consensus-driven estimates that reflect the severity of the medical condition and the degree to which the impairment decreases an individual's ability, to perform common activities of daily living (ADL), *excluding work*. Impairment ratings were designed to reflect functional limitations and not disability. The whole person impairment percentages listed in the *Guide's* estimate the impact of the impairment on the individual's overall ability to perform activities of daily living, *excluding work, as listed in Table 1-2." (Below)*

Table 1-2 Activities of Daily Living Commonly Measured in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Scales [6,7]

Activity	Example
Self-care, personal hygiene	Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating
Communication	Writing, typing, seeing, hearing, speaking
Physical activity	Standing, sitting, reclining, walking, climbing stairs
Sensory function	Hearing, seeing, tactile feeling, tasting, smelling
Nonspecialized hand activities	Grasping, lifting, tactile discrimination
Travel	Riding, driving, flying
Sexual function	Orgasm, ejaculation, lubrication, erection
Sleep	Restful, nocturnal sleep pattern

AMA Guidelines

- **Pain Add On - Example:**

Body Parts	Chapter Number	Table/Figure Number
Pain Related Impairment (Slight)	18-Page 574	Figure 18-1

- Page 5 of the AMA Guides indicates…"The *Guides* refers to common ADLs, as listed in Table 1-2. The ADLs listed in this table correspond to the activities that physicians should consider when establishing a permanent impairment rating. *A physician can often assess a person's ability to perform ADLs based on knowledge of the patient's medical condition and clinical judgment.*"

- A 3% whole person impairment for pain may be assigned. Please review figure 18-1, page 574 of the AMA Guides and also 18.3d part C on page 573.

- Step three states "*If pain-related impairment appears to increase the burden of the individual's condition slightly, the examiner can increase the percentage found in step 1 by up to 3%. No formal assessment of pain-related impairment is required.*"

Determine which method to use:

DRE or ROM

DRE vs. ROM
AMA Guides, Pg. 379

15.2 Determining the Appropriate Method for Assessment

Spinal impairment rating is performed using one of two methods: the diagnosis-related estimate (DRE) or range-of-motion (ROM) method.

The DRE method is the principal methodology used to evaluate an individual who has had a distinct injury. When the cause of the impairment is not easily determined and if the impairment can be well characterized by the DRE method, the evaluator should use the DRE method.

The ROM method is used in several situations:

1. When an impairment is not caused by an injury, if the cause of the condition is uncertain and the DRE method does not apply, or an individual cannot be easily categorized in a DRE class. It is acknowledged that the cause of impairment (injury, illness, or aging) cannot always be determined. The reason for using the ROM method under these circumstances must be carefully supported in writing.

DRE vs. ROM
AMA Guides, Pg. 379

2. When there is multilevel involvement in the same spinal region (eg, fractures at multiple levels, disk herniations, or stenosis with radiculopathy at multiple levels or bilaterally).
3. Where there is alteration of motion segment integrity (eg, fusions) at multiple levels in the same spinal region, unless there is involvement of the corticospinal tract (then use the DRE method for corticospinal tract involvement).
4. Where there is recurrent radiculopathy caused by a new (recurrent) disk herniation or a recurrent injury in the same spinal region.
5. Where there are multiple episodes of other pathology producing alteration of motion segment integrity and/or radiculopathy.

The ROM method can also be used if statutorily mandated in a particular jurisdiction.

In the small number of instances in which the ROM and DRE methods can both be used, evaluate the individual with both methods and award the higher rating.

DRE vs. ROM
AMA Guides, Pg. 380

15.2a Summary of Specific Procedures and Directions

1. Take a careful history, perform a thorough medical examination, and review all pertinent records and studies. This is helpful in determining the presence or absence of structural abnormalities, nerve root or cord involvement, and motion segment integrity.
2. Consider the permanency of the impairment, referring to *Guides* Chapter 1 and the Glossary for definitions as needed. If the impairment is resolving, changing, unstable, or expected to change significantly with or without medical treatment within 12 months, it is not considered a permanent (stable) impairment and should not be rated under the *Guides* criteria.
3. Select the region that is primarily involved (ie, the lumbar, cervical, or thoracic spine) and identify the individual's most serious objective findings.
4. Determine whether the individual has multilevel involvement or multiple recurrences/occasions within the same region of the spine. Use the ROM method if:
   a. there are fractures at more than one level in a spinal region,
   b. there is radiculopathy bilaterally or at multiple levels in the same spinal region,
   c. there is multilevel motion segment alteration (such as a multilevel fusion) in the same spinal region, or
   d. there is recurrent disk herniation or stenosis with radiculopathy at the same or a different level in the same spinal region; in this case, combine the ratings using the ROM method.

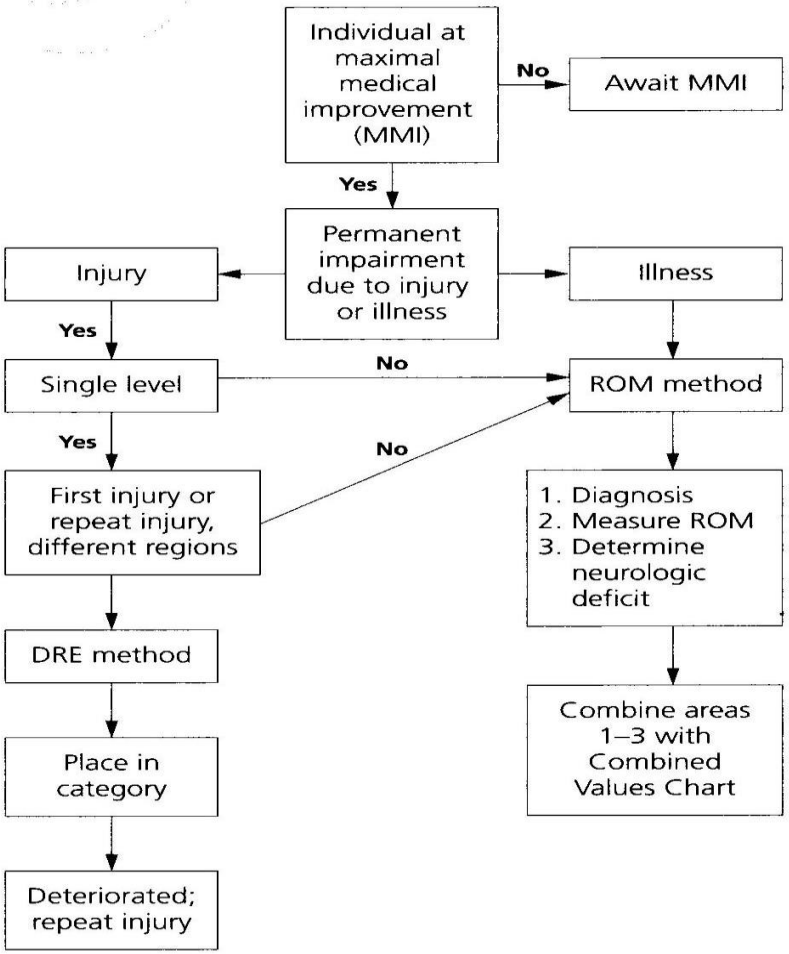
DRE vs. ROM
AMA Guides, Pg. 381

5. If the individual does not have multilevel involvement or multiple recurrences/occasions and an injury occurred, determine the proper DRE category. Most ratings will fall into categories I, II, or III. A corticospinal tract injury is evaluated according to Section 15.7.
6. If the individual has been treated with surgery or another modality, evaluate the results, extent of improvement, and impact on the ability to perform activities of daily living. If residual symptoms or objective findings impact the ability to perform ADL despite treatment, the higher percentage in each range should be assigned. If an individual had a prior condition, was asymptomatic, and now—at MMI—has symptoms that impact the ability to perform activities of daily living, the higher rating within a range may also be used. If ratings are increased, explicit documentation of the reasons for the increase should be included in the report.
7. If more than one spine region is impaired, determine the impairment of the other region(s) with the DRE method. Combine the regional impairments using the Combined Values Chart (p. 604) to express the individual's total spine impairment.
8. From historical information and previously compiled medical data, determine if there was a preexisting impairment. Congenital, developmental, and other preexisting conditions may be differentiated from those attributable to the injury or illness by examining preinjury roentgenograms or by performing a bone scan after the onset of the condition.
9. If requested, apportion findings to the current or prior condition, following jurisdiction practices and assuming adequate information is available on the prior condition. In some instances, to apportion ratings, the percent impairment due to previous findings can simply be subtracted from the percent based on the current findings. Ideally, use the same method to compare the individual's prior and present conditions. If the ROM method has been used previously, it must be used again. If the previous evaluation was based on the DRE method and the individual now is evaluated with the ROM method, and prior ROM measurements do not exist to calculate a ROM impairment rating, the previous DRE percent can be subtracted from the ROM ratings. Because there are two methods and complete data may not exist on an earlier assessment, the apportionment calculation may be a less than ideal estimate.
10. For individuals with corticospinal tract involvement, refer to Table 15-6 for the appropriate impairment rating.

Use Algorithm:

To determine impairment evaluation process

Figure 15-4 Spine Impairment Evaluation Process



The Spine

ROM

Range of Motion Method

(Inclinometry)

Examples of when to use ROM Method:

- DRE method does not apply; patient cannot be categorized
- If there is multi-level involvement in the same spinal region
- (i.e. Fx at multiple levels, disc herniations or stenosis with radiculopathy at multiple levels or bilaterally

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

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

a. neutral position

b. flexion

c. extension

d. straight leg raising (used for validation purposes)

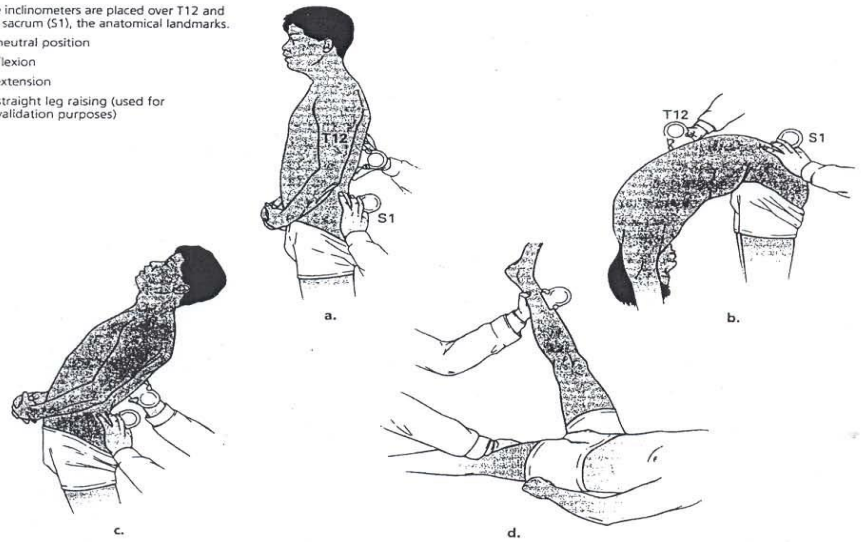


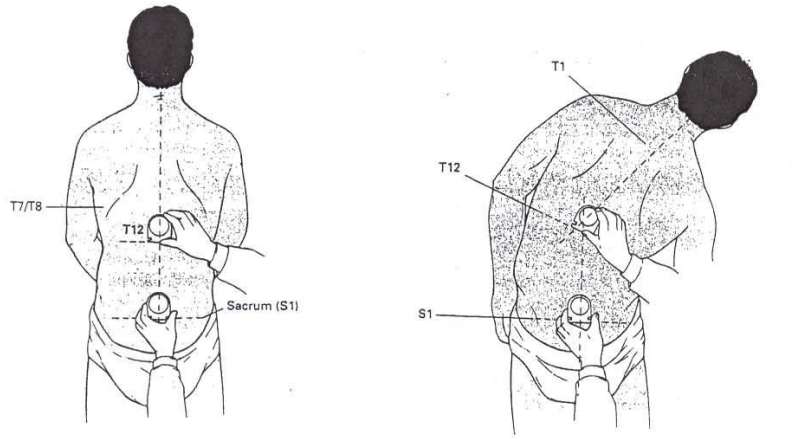
Table 15-8 Impairment Due to Abnormal Motion of the Lumbar Region: Flexion and Extension*

The proportion of flexion and extension of total lumbosacral motion is 75%.

Sacral (Hip) Flexion Angle (°)	True Lumbar Spine Flexion Angle (°)	% Impairment of the Whole Person
45+	60+	0
	45	2
	30	4
	15	7
	0	10
30-45	40+	4
	20	7
	0	10
0-29	30+	5
	15	8
	0	11

True Lumbar Spine Extension From Neutral Position (0°) to:	Degrees of Lumbosacral Spine Motion		% Impairment of the Whole Person
	Lost	Retained	
0	25	0	7
10	15	10	5
15	10	15	3
20	5	20	2
25	0	25	0

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



a. neutral position

b. lateral bending

Table 15-9 Impairment Due to Abnormal Motion and Ankylosis of the Lumbar Region: Lateral Bending

Abnormal Motion
Average range of left and right lateral bending is 50°; the proportion of total lumbosacral motion is 40% of the total spine.

a.	Left Lateral Bending From Neutral Position (0°) to:	Degrees of Lumbosacral Motion		% Impairment of the Whole Person
		Lost	Retained	
	0	25	0	5
	10	15	10	3
	15	10	15	2
	20	5	20	1
	25	0	25	0
b.	**Right Lateral Bending From Neutral Position (°) to:**	**Degrees of Lumbosacral Motion**		**% Impairment of the Whole Person**
		Lost	**Retained**	
	0	25	0	5
	10	15	10	3
	15	10	15	2
	20	5	20	1
	25	0	25	0
c.	**Ankylosis / FUSION Region Ankylosed at (°):**			
	0 (neutral position)			10
	30			20
	45			30
	60			40
	75 (full flexion)			50

LATERAL BENDING

(MISTAKE) SIB IN FLEXION CHART

DRE Method

(Diagnosis Related Estimate)

Place patient into appropriate category

Table 15-5 Criteria for Rating Impairment Due to Cervical Disorders

DRE Cervical Category I 0% Impairment of the Whole Person	DRE Cervical Category II 5%-8% Impairment of the Whole Person	DRE Cervical Category III 15%-18% Impairment of the Whole Person	DRE Cervical Category IV 25%-28% Impairment of the Whole Person	DRE Cervical Category V 35%-38% Impairment of the Whole Person
No significant clinical findings, no muscular guarding, no documentable neurologic impairment, no significant loss of motion segment 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 muscle guarding or spasm observed at the time of the examination by a physician, 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 ***or*** individual had clinically significant radiculopathy and an imaging study that demonstrated a herniated disk at the level and on the side that would be expected based on the radiculopathy, but has improved following nonoperative treatment ***or*** fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation that has healed without loss of structural integrity or radiculopathy; (3) a spinous or transverse process fracture with displacement	Significant signs of radiculopathy, such as pain and/or sensory loss in a dermatomal distribution, loss of relevant reflex(es), loss of muscle strength, or unilateral atrophy compared with the unaffected side, measured at the same distance above or below the elbow; the neurologic impairment may be verified by electrodiagnostic findings ***or*** individual had clinically significant radiculopathy, verified by an imaging study that demonstrates a herniated disk at the level and on the side expected from objective clinical findings with radiculopathy or with improvement of radiculopathy following surgery ***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 is healed without loss of structural integrity; radiculopathy may or may not be present; differentiation from congenital and developmental conditions may be accomplished, if possible, by examining preinjury roentgenograms or a bone scan performed after the onset of the condition	Alteration of motion segment integrity or bilateral or multilevel radiculopathy; alteration of motion segment integrity is defined from flexion and extension radiographs as at least 3.5 mm of translation of one vertebra on another, or angular motion of more than 11° greater than at each adjacent level (Figures 15-3a and 15-3b); alternatively, the individual may have loss of motion of a motion segment due to a developmental fusion or successful or unsuccessful attempt at surgical arthrodesis; radiculopathy as defined in cervical category III need not be present if there is alteration of motion segment integrity ***or*** fractures: (1) more than 50% compression of one vertebral body without residual neural compromise	Significant upper extremity impairment requiring the use of upper extremity external functional or adaptive device(s); there may be total neurologic loss at a single level or severe, multilevel neurologic dysfunction ***or*** fractures: structural compromise of the spinal canal is present with severe upper extremity motor and sensory deficits but without lower extremity involvement

THE SPINE

Page 384

DRE (Diagnosis-Related Estimate)

Lumbar Spine

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

AMA Guidelines

- **Extremity Impairment - Example:**

- DDX: (B/L) Elbow-Lateral Epicondylitis & (B/L) De Quervain's Disease/Stenosing Tenosynovitis

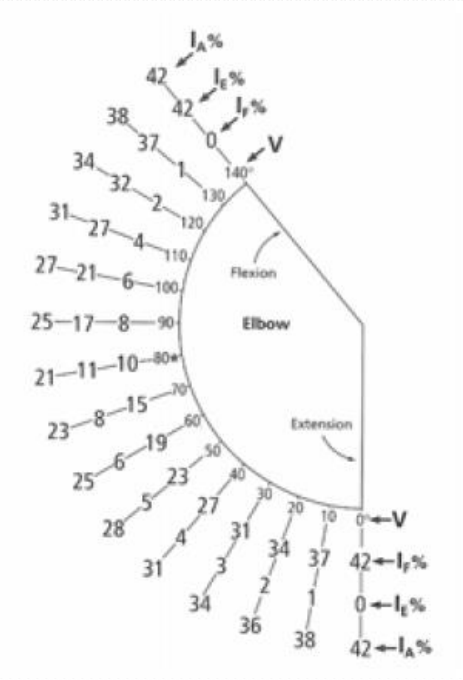
- Figure 16-34; Page 472; (Pie Chart Elbow Flexion/Extension) Chapter 16
- Figure 16-37; Page 474; (Pie Chart Elbow Supination/Pronation) Chapter 16

Right Elbow	Normal (Degrees ◦)	Exam	Exam (Mean)	Maximum Angle (WPI%)
Flexion	140	122, 125, 120	123	**2%**
Extension	0	0, 0, 0	0	**0%**
Supination	80	65, 65, 70	68	**0%**
Pronation	80	70, 72, 70	71	**1%**

AMA Guidelines

- **<u>Extremity Impairment - Example</u>:**

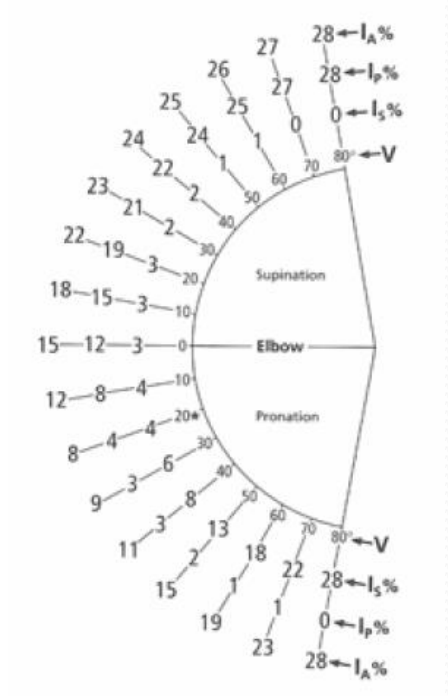
- DDX: (B/L) Elbow-Lateral Epicondylitis & (B/L) De Quervain's Disease/Stenosing Tenosynov
- <u>Figure 16-34; Page 472; (Pie Chart Elbow Flexion/Extension) Chapter 16</u>



AMA Guidelines

- **<u>Extremity Impairment - Example</u>:**

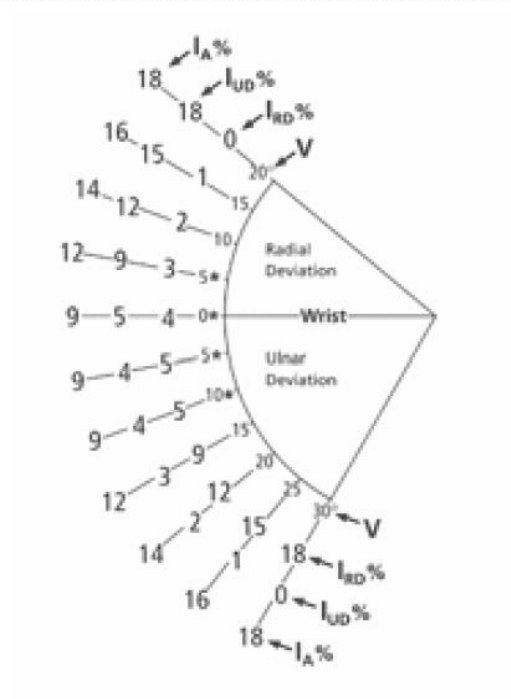
- DDX: (B/L) Elbow-Lateral Epicondylitis & (B/L) De Quervain's Disease/Stenosing Tenosynov
- <u>Figure 16-37; Page 474; (Pie Chart Elbow Supination/Pronation) Chapter 16</u>



AMA Guidelines

- **<u>Extremity Impairment - Example</u>:**

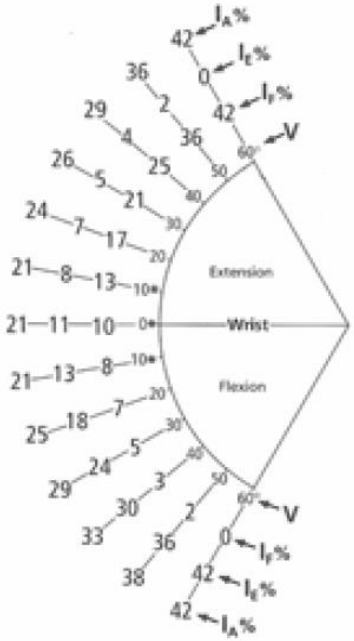
- DDX: (B/L) Elbow-Lateral Epicondylitis & (B/L) De Quervain's Disease/Stenosing Tenosynov
- <u>Figure 16-31; Page 469; (Pie Chart Wrist Radial/Ulnar Deviation) Chapter 16</u>



AMA Guidelines

- **<u>Extremity Impairment - Example</u>:**

- DDX: (B/L) Elbow-Lateral Epicondylitis & (B/L) De Quervain's Disease/Stenosing Tenosynovitis
- <u>Figure 16-28; Page 467; (Pie Chart Wrist Flexion/Extension) Chapter 16</u>



AMA Guidelines

- **Extremity Impairment - Example:**

- DDX: (B/L) Elbow-Lateral Epicondylitis & (B/L) De Quervain's Disease/Stenosing Tenosynovitis

- Figure 16-28; Page 467; (Pie Chart Wrist Flexion/Extension) Chapter 16
- Figure 16-31; Page 469; (Pie Chart Wrist Radial/Ulnar Deviation) Chapter 16

Right Wrist	Normal (Degrees ◦)	Exam	Exam (Mean)	Maximum Angle (WPI%)
Flexion	60	45, 44, 48	46	**3%**
Extension	60	47, 46, 45	46	**4%**
Radial Deviation	20	12, 14, 15	14	**1%**
Ulnar Deviation	30	17, 16, 19	18	**2%**

AMA Guidelines

- **Extremity Impairment - Example:**
- DDX: (B/L) Elbow-Lateral Epicondylitis & (B/L) De Quervain's Disease/Stenosing Tenosynovitis
- The following tables/figures are necessary to determine a rating for the upper extremities:
- Figure 16-1b; Page 437; Upper Extremity Impairment Evaluation Record (Wrist, Elbow, Shoulder); Chapter 16
- (Right Upper Extremity) Figure 16-1b yielded:
- 10% (Wrist) and 3% (Elbow) which combines to 13%
- Table 16-3 (Pg 439) was used to convert the Total Upper Extremity Impairment (13%) to Impairment of the Whole Person (12%)
- **(Right Upper Extremity) Impairment of the Whole Person = 12%**

Case Law

- **Escobedo v. Marshalls; CNA Insurance (2005):**

- The en banc panel decision of the WCAB determined that changes made to LC 4663, per SB 899 allows apportionment of a pre-existing asymptomatic arthritic pathologic condition to an accepted industrial injury.

- Background:
- Applicant sustained injury to her left knee on October 28, 2002, when she fell at her job as a sales associate with Marshalls, a retail clothing store. As a compensable consequence of that injury, she also developed right knee problems.

Case Law

- **Escobedo v. Marshalls; CNA Insurance (2005):**

- Applicant testified that, prior to her fall, she had never had any knee problems or limitations, and she had never consulted a doctor about her knees. Although her treating physician, Dr. Cronin, had diagnosed her as having arthritis about ten years earlier, he did not impose any work restrictions as a consequence of her arthritis.

- Applicant's Side:
- Applicant was treated for her industrial injury by Daniel Woods, M.D., who performed arthroscopic surgery on February 12, 2003, to repair the medial meniscus in the left knee. On June 5, 2003, Dr. Woods prepared a report declaring applicant to be permanent and stationary with bilateral knee disability resulting in a limitation to semi-sedentary work. He noted that applicant's job duties at Marshalls had required her to be on her feet, standing or walking, six to eight hours per day, and to kneel or squat up to three hours per day. He had attempted to have her return to work four hours per day, but she was unable to tolerate it because of right knee pain. With regard to the issue of apportionment, Dr. Woods noted that applicant had no history of any previous problems with her left knee, and thus he concluded that all of her disability was attributable to her industrial injury.

Case Law

- **Escobedo v. Marshalls; CNA Insurance (2005):**

- Applicant's Side:
- Applicant was treated for her industrial injury by Daniel Woods, M.D., who performed arthroscopic surgery on February 12, 2003, to repair the medial meniscus in the left knee. On June 5, 2003, Dr. Woods prepared a report declaring applicant to be permanent and stationary with bilateral knee disability resulting in a limitation to semi-sedentary work. He noted that applicant's job duties at Marshalls had required her to be on her feet, standing or walking, six to eight hours per day, and to kneel or squat up to three hours per day. He had attempted to have her return to work four hours per day, but she was unable to tolerate it because of right knee pain. With regard to the issue of apportionment, Dr. Woods noted that applicant had no history of any previous problems with her left knee, and thus he concluded that all of her disability was attributable to her industrial injury.

Case Law

- **Escobedo v. Marshalls; CNA Insurance (2005):**

- Defendant's Side:

- Defendant's qualified medical evaluator ("QME"), Daniel Ovadia, M.D., evaluated applicant on March 15, 2004 and prepared a report on that date. He noted that a pre-surgical MRI of applicant's left knee revealed degenerative changes, in addition to the medial meniscus tear, and that post-surgical x-rays showed osteoarthritis in both knees. Dr. Ovadia concluded, based on applicant's bilateral knee condition: that she was limited to four hours of weight bearing in an eight-hour day; that she should avoid very heavy work; that she should avoid more than occasional kneeling, squatting, or walking on uneven ground; that she should avoid stair, incline and ladder climbing; and that she is totally precluded from running or jumping. With regard to apportionment, Dr. Ovadia stated: "Ms. Escobedo's left knee residuals are directly related to the October 28, 2002 injury. The Applicant developed right knee problems as a derivative of the left knee and not as a result of any subsequent cumulative trauma. In my opinion, there is a medically reasonable basis for apportionment given the trivial nature of the injury that occurred on October 28, 2002 and the almost immediate onset of right knee symptoms that occurred shortly after the left knee injury.

Case Law

- **<u>Escobedo v. Marshalls; CNA Insurance (2005)</u>:**

- The Applicant has obvious, significant degenerative arthritis in both knees and essentially worked in a fairly congenial environment. Although denying any prior problems with her knees, it is medically probable that she would have had fifty percent of her current level of knee disability at the time of today's evaluation even in the absence of her employment at Marshalls. Dr. Woods did not take this into account when he discussed the issue of apportionment. Furthermore, when he saw the Applicant, he thought she had a lateral meniscus tear which was clearly not the case based on his operative findings (leading edge tears are of no clinical significance and would not have accounted for the Applicant's pathology and disability which relate to the medial and patellofemoral compartments)."

- Dr. Woods responded to Dr. Ovadia's conclusions on May 22, 2004, after he re-examined applicant. Dr. Woods found no basis for apportionment, stating:

- "The patient prior to her industrial injury of October 28, 2003, was not suffering from any disability relative to her knees. She indicates that she was able to walk in unlimited fashion and had been able to work. She clearly has disability at this time which I have, in the absence of previously documented disability, attributed to her industrial injury."

Case Law

- **<u>Escobedo v. Marshalls; CNA Insurance (2005)</u>:**

- Dr. Woods responded to Dr. Ovadia's conclusions on May 22, 2004, after he re-examined applicant. Dr. Woods found no basis for apportionment, stating:

- "The patient prior to her industrial injury of October 28, 2003, was not suffering from any disability relative to her knees. She indicates that she was able to walk in unlimited fashion and had been able to work. She clearly has disability at this time which I have, in the absence of previously documented disability, attributed to her industrial injury."

- The **WCJ determined** that, overall, applicant's bilateral knee disability rated 53%, based on the factors of disability outlined in Dr. Ovadia's March 14, 2004 report. The WCJ, however, also apportioned 50% of applicant's permanent disability to non-industrial causation under section 4663, relying on Dr. Ovadia's opinion that one-half of the disability was caused by her preexisting degenerative arthritis.

Case Law

- **<u>Escobedo v. Marshalls; CNA Insurance (2005)</u>:**

- DISCUSSION

- Address applicant's contention that new section 4663 does not apply to injuries sustained before the April 19, 2004 effective date of SB 899. This issue has been resolved by **Kleemann v. Workers' Comp. Appeals. Bd. (2005)** 127 Cal.App.4th 274 [70 Cal.Comp.Cases133], which held that the procedural and substantive aspects of new section 4663 **apply to all cases** that were pending as of the date of SB 899's enactment on April 19, 2004.

Case Law

- **Escobedo v. Marshalls; CNA Insurance (2005):**

- Section 4663 as amended by SB 899 provides:

- "(a) **Apportionment** of permanent disability shall be **based on causation**.
- "(b) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury **shall** in that report **address the issue of causation** of the permanent disability.
- "(c) In order for a physician's report **to be considered complete** on the issue of permanent disability, it **must include an apportionment determination**.

Case Law

- **<u>Escobedo v. Marshalls; CNA Insurance (2005)</u>:**

- A physician shall make an apportionment determination by finding what **approximate percentage of the permanent disability was caused by the direct result of injury** arising out of and occurring in the course of employment **and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries.**
- **If the physician is unable** to include an apportionment determination in his or her report, the physician **shall state the specific reasons why** the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician **shall then consult with other physicians or refer** the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division **in order to make the final determination**.
- "(d) An employee who claims an industrial injury shall, upon request, **disclose all previous permanent disabilities or physical impairments.**"

Case Law

- **Escobedo v. Marshalls; CNA Insurance (2005):**

- Section 4664(a) states:

- "The **employer shall only be liable for** the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment."

- **Summary:**
- The WCAB en banc panel affirmed the F&A, and as a result went against the previous precedent case law forbidding the apportionment of preexisting non-industrial asymptomatic pathology to an industrial injury.

- The Escobedo decision does not support the position that an employer takes the employee as he finds him at the time of injury. An employer takes the employee as he finds him and must compensate him, but the permanent disability may still be apportioned if some portion would have resulted even despite the subsequent industrial injury because of natural progression of the pre-existing disease.

Case Law

- **Escobedo v. Marshalls; CNA Insurance (2005):**

- **Summary:**
- "Other factors" include pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions, but there must be documented substantial medical evidence demonstrating the other factors resulted in permanent disability.

Case Law

- **<u>Key v. WCAB (2004)</u>:**
- Applicant sustained injuries in 1993 to his low back and right knee, and injuries in 1996 to his neck and back.
- In 1996, stipulations entered that the 1993 injury had resulted in 42.3% permanent partial disability, and entitled to other benefits.
- In 2003, applicant was found to be 100% disabled following the 1996 injury, and that 57.1% disability was apportionable to the 1996 injury.
- Both parties sought reconsideration, and both petitions were denied in 2004. Applicant sought review, contending that the first injury was not labor disabling at the time of the second injury.

Case Law

- **<u>Key v. WCAB (2004)</u>:**

- The Court found that **prior to April 19, 2004**, **apportionment** under Labor Code Section 4750 **was allowed for a pre-existing disability which was actually labor disabling at the time of the subsequent injury.**

- In this case the parties' agreed medical examiner (AME) had opined that the **prior disability from the 1993 injury remained at the time of the 1996 injury**. It noted evidence that applicant at the time of the 1996 injury was receiving treatment, using a leg brace, and using medical leave time due to the effects of the 1993 injury.

Case Law

- **<u>Key v. WCAB (2004)</u>:**

- Further, "Effective April 19, 2004, '**regardless of the date of injury**,' The legislature enacted a new, directly relevant conclusive presumption applicable to **apportioning [disability from] prior injuries**.

- Section 4664, subdivision (b) now provides: '**If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury**. This presumption is a presumption affecting the burden of proof.'

- Even if the record lacked substantial evidence to support [the finding that] Key was actually labor disabled at the time of his second injury, the WCAB would be bound to apportion."

Case Law

- **<u>Key v. WCAB (2004)</u>:**

- <u>Summary:</u>

- Section 4664, subdivision (b) now provides: '**If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury**. This presumption is a presumption affecting the burden of proof.'

- Even if the record lacked substantial evidence to support [the finding that] Key was actually labor disabled at the time of his second injury, the **WCAB would be bound to apportion**."

Case Law

- **<u>Pasquotto v. Hayward Lumber:</u>**

- Issue of apportionment under Labor Code sections 4663 and 4664,as enacted by Senate Bill 899 in situations where an employee suffers an industrial injury causing permanent disability and where there has been **a prior industrial injury that was settled by an approved compromise and release (C&R) agreement**.

- BACKGROUND

- This matter involves three industrial injuries sustained by (applicant)
- Applicant's first injury was settled by an approved compromise and release (C&R).
- His two subsequent injuries - involving a different employer with the parties disputing the issue of apportionment.

Case Law

- **Pasquotto v. Hayward Lumber:**

- A. The First Injury

- On May 9, 1998, applicant sustained an industrial injury to his low back while employed as a carpet layer , who was insured by State Compensation Insurance Fund (SCIF). Applicant received initial treatment for this injury from various physicians.
- An MRI of June 8, 1998 reflected that he had a disc herniation at L5-S1, as well as a disc protrusion at L4-5.
- In a July 1998 report, one physician suggested that applicant might benefit from an L5-S1 discectomy.
- On July 27, 1998, applicant was admitted to the hospital with severe back pain. There, he was treated with pain medications and kept on bed rest. He was discharged on July 30, 1998.

Case Law

- **Pasquotto v. Hayward Lumber:**

- A. The First Injury

- On July 31, 1998 (the next day), he was again admitted to the hospital, this time with pulmonary emboli. He was treated with anti-coagulants and discharged on August 4, 1998.
- On August 21, 1998, applicant started treatment for his back with an orthopedic surgeon. Diagnosed: moderate degenerative disc changes/disc desiccation at L4-5 and L5-S1; a moderate disc herniation at L5-S1, appearing to just touch the left S1 nerve root; a smaller herniation at L4-5; and a herniation at L3-4, which may contact the left L4 nerve root.
- On October 21, 1998, applicant had a CT scan of the lumbar spine. It showed disc bulges at all scanned levels (L2-S1), most prominent at L3-4 on the left . . . , but also prominent and calcified in the midline at L5-S1."
- A lumbar myelogram performed the same day indicated disc bulges at L3-4, L4-5, and L5-S1."

Case Law

- **Pasquotto v. Hayward Lumber:**
- A. The First Injury
- On October 29, 1998, applicant was seen by an agreed medical evaluator (AME) in internal medicine. A December 1, 1998 report opined that applicant's earlier pulmonary emboli were industrial, due to his July 1998 immobilization in the hospital because of his back injury. He opined that applicant had no residual respiratory problems, but he should be restricted from any work that would immobilize his lower extremities, preventing movement for greater than four hours.
- He said there was no basis for apportionment of this disability.

Case Law

- **Pasquotto v. Hayward Lumber:**

- A. The First Injury

- On December 17, 1998, applicant had a left lateral microdiscectomy at L3-4.
- On May 10, 1999, a report was issued finding applicant to be permanent and stationary.
- He said that applicant had slight sacroiliac pain that increases to moderate with heavy lifting and repetitive bending. He also said that applicant was precluded from heavy work and should not lift more than 30 pounds. He found no basis for apportionment.
- On approximately June 14, 1999, applicant commenced vocational rehabilitation, apparently with the goal of becoming a truck driver.

Case Law

- **Pasquotto v. Hayward Lumber:**
- B. The Current Injuries
- On October 8, 1999, applicant was seen for a pre-employment physical examination for the truck driving job with Hayward Lumber. In an October 15, 1999 report on that examination, it revealed a history from applicant: that he had "low back surgery done in 1997;" that he had been released in 1998 "to do heavy work;" that "he has had no recent low back pain whatsoever;" and that he has been working out at the YMCA lifting weights five times a week with no pain or symptoms." The doctor concluded that applicant was medically qualified to perform the job of truck driver "without restrictions."

Case Law

- **Pasquotto v. Hayward Lumber:**

- B. The Current Injuries

- On or about October 19, 1999, applicant was hired as a driver by Hayward Lumber. There, he had to unload doors, windows, molding and specialty lumber by hand.
- In December 2001, applicant sustained an admitted industrial injury while delivering a prefabricated 10'x 4' "strong wall," which was "very, very, very heavy."
- He and a co-worker were carrying it, but the co-worker tripped and the strong wall fell onto applicant, causing a back injury.
- On August 2, 2002, applicant sustained another admitted injury when, while he was bending to move some lumber, he reaggravated his back.
- Eventually, applicant had a left L5-S1 microdiscectomy.

Case Law

- **Pasquotto v. Hayward Lumber:**
- B. The Current Injuries
- Defendant had applicant evaluated by Daniel N. Ovadia, M.D., as its qualified medical evaluator (QME) in orthopedic surgery.
- In a September 15, 2003 report Dr. Ovadia concluded that applicant was permanent and stationary, with intermittent slight lumbar spine pain and with a preclusion from heavy work.

Case Law

- **Pasquotto v. Hayward Lumber:**
- B. The Current Injuries
- With respect to **apportionment**, Dr. Ovadia stated:
- "It is my feeling that there is a reasonable basis for apportionment given that Mr. Pasquotto has been diagnosed with an L5-S1 disc herniation following an injury that he sustained in 1998. The Applicant also had disc herniation at L3-4 for which surgery was undertaken. Permanent work restrictions were imposed on the Applicant who received an award.

Case Law

- **Pasquotto v. Hayward Lumber:**
- B. The Current Injuries
- Based on this information, I would apportionment fifty percent (50%) of Mr. Pasquotto's lumbar spine residuals to factors predating his employment with Hayward Lumber and the specific injuries that he sustained in December of 2001 and August of 2002. Furthermore, I believe the combined effects of the applicant' previous injury in 1998 that resulted in disc herniations at L5-S1 and at L3-4 (the latter requiring surgery) combined with the injuries at Hayward Lumber led to the need for Mr. Pasquotto's recent lumbar spine surgery.
- As such, I believe Mr. Pasquotto would have had fifty percent of his current level of lumbar spine disability even in the absence of his employment at Hayward Lumber. The remaining fifty percent of lumbar spine disability is directly related to the Applicant's employment and injuries at Hayward Lumber."

Case Law

- **Pasquotto v. Hayward Lumber:**

- On May 17, 2004 (i.e., about a month after SB 899), Dr. Kahmann examined applicant and issued a report. The report declared him to be permanent and stationary (P&S), with subjective disability of frequent slight low back pain increasing to moderate with heavy lifting and repetitive bending. Dr. Kahmann also stated that applicant was precluded from heavy work, that he has a 30-pound lifting limitation, and that he should avoid repetitive bending.

- Under the heading "**Apportionment**," Dr. Kahmann said:
- "Not indicated. He did have **previous surgery at the L3-4 level, recovered** from that surgery and **was back to work full-time in a very heavy work capacity without symptoms**. On a 1998 CT scan/myelogram, it was noted that he had a disc herniation on the left at L5-S1. This herniated disc was **completely asymptomatic** and **did not become symptomatic until his present injury**.
- Therefore, in my opinion this is a **pre-existing asymptomatic abnormality** that did not cause any disability whatsoever until the industrial injury. Therefore, in my opinion, there are **no grounds for apportionment to pre-existing industrial or non-industrial factors**."

Case Law

- **Pasquotto v. Hayward Lumber:**
- On October 6, 2004, the WCJ issued rating instructions for applicant's **December 2001** and **August 2002** back injuries with Hayward Lumber.
- The WCJ asked the disability evaluation specialist (rater) to consider that these two injuries resulted in a preclusion from heavy work, a thirty-pound lifting limitation, and a need to avoid repetitive bending.
- The WCJ further asked the rater to "consider apportionment where applicant had a prior low back disability [from the **May 1998** injury] precluding heavy work (Category E); should not lift greater than thirty pounds."
- The **rater found** that applicant's December 2001 and August 2, 2002 injuries caused **0% (zero percent) permanent disability, after apportionment** –
- i.e., the rater concluded that both applicant's current back disability and his prior back disability rated 30% standard (and 36% after adjustment for age and occupation), resulting in a **net 0% rating**.

Case Law

- **Pasquotto v. Hayward Lumber:**

- The WCJ determined that "applicant is not entitled to a permanent disability award" for his December 2001 and August 2, 2002 back injuries because "there is a legal basis for apportionment under Labor Code § 4663 ."

- In the accompanying Opinion on Decision, the WCJ stated that he "does not believe [section] 4663 is relevant." The WCJ further said, "the crux of this case revolves around Labor Code § 4664 and more specifically subparagraph (b)." His Opinion then indicated, in essence, that **he found a legal basis for apportionment because defendant had established the existence of a "prior award of permanent disability**" within the meaning of section 4664(b) - i.e., the OACR for the May 9, 1998 injury - and that, under section 4664(b), this "prior award is conclusively presumed to [still] exist."

Case Law

- **<u>Pasquotto v. Hayward Lumber:</u>**
- DISCUSSION
- Section 4664(b) provides: "If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury." (Emphasis added.)
- The fact that **an approved compromise and release agreement generally constitutes an "award" does not mean that it is an "award of permanent disability"** under section 4664(b), even if the compromise and release agreement resolved the issue of permanent disability.
- The 1999 compromise and release (C&R) agreement did not stipulate to or otherwise specify the percentage of permanent disability – or the factors of disability - attributable to applicant's May 9, 1998 back injury.

Case Law

- **Pasquotto v. Hayward Lumber:**
- DISCUSSION
- The compromise and release agreement contained neither any stipulation regarding applicant's percentage of permanent disability nor any language specifying the nature of his back disability. Moreover, while it might be fair to assume that some of the $35,000 in settlement money was for applicant's back, there is no way to determine - at least on this record - how much of this consideration was for his back permanent disability - particularly given:
- (1) the compromise and release specified there was an "issue" regarding the "nature and extent of permanent disability," which implies there was a dispute regarding applicant's back permanent disability;
- (2) we do not know whether, absent the settlement, either party would have obtained supplemental medical reports on the issue of applicant's back permanent disability; and
- (3) we cannot determine how much of the settlement money was in consideration for releasing issues other than applicant's back permanent disability.
- This last point is of no small significance, given that applicant had a post-surgical back; yet, he settled his right to any further medical treatment. Moreover, in addition to applicant's back, there apparently also were issues regarding pulmonary disability and/or treatment.

Case Law

- **Pasquotto v. Hayward Lumber:**
- Summary
- Labor Code §4664 is 1 of 2 of California's two apportionment statutes:
- "If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury."
- Pasquotto raises issue if an Order Approving a Compromise and Release (OACR) is the same as a "prior award of permanent disability." The WCAB unanimously held that it is not, "without more."
- The WCAB was hesitant to apply Labor Code §4664, because it would be speculative for the WCJ to determine how much, if any, permanent disability paid in the prior C&R pertained to various body parts that were currently an issue in determining current apportionment and rating.
- Despite employers potential preclusion from Labor Code §4664 apportionment in such scenarios, the use of Labor Code **§4663 remains**. That statute requires that a physician determine the "**approximate percentage**" of permanent disability due to the industrial injury and the "**approximate percentage**" of permanent disability to apportion based on other factors.

Case Law

- **Sanchez v. County of LA (2005):**
- Summary:
- Apportionment under **Labor Code section 4664** as enacted by SB 899 in situations where an employee suffers an industrial injury causing permanent disability, and where there has been a prior industrial injury resulting in an award of Permanent Disability relating to the SAME body region.
- The defendant has the burden of proving the existence of any PRIOR permanent disability award(s) relating to the SAME body region.
- The PD underlying any such award(s) is conclusively presumed to STILL EXIST (i.e. the applicant is not permitted to show medical rehabilitation from disabling effects of earlier industrial injuries)

Case Law

- **Sanchez v. County of LA (2005):**
- When the defendant has established the existence of any prior PD award(s) relating to the SAME BODY region, the percentage (%) of PD from PRIOR AWARD(S) will be SUBTRACTED from the current overall percentage of PD…
- …UNLESS the applicant disproves overlap (i.e. the applicant demonstrates that the prior PD and the current PD affect different abilities to compete and earn, either in whole or in part.
- The issue of whether the prior PD for the SAME region of the body overlaps the current disability is determined using substantially the same principles that were applied prior to section 4664
- The **SUM of PD awards for any one body region** **CANNOT exceed 100%**, even where the PD caused by the applicant's new injury does not overlap the PD underlying the prior award(s)

Case Law

- **Sanchez v. County of LA (2005):**
- Background:
- Sanchez (applicant) sustained an industrial injury to her left foot in 2002 while employed as a deputy sheriff.
- Parties stipulated her left foot injury resulted in PD of 7%
- The 7% PD was based on an orthopedic AME 2004 report by J. Greenfield, MD
- Previously the applicant received a stipulated 22% PD award for a 1997 B/L knee injury, sustained also as a deputy sheriff

Case Law

- **Sanchez v. County of LA (2005):**
- Background:
- In 2004 the WCJ issued a decision that the 2002 left foot injury resulted in 7% PD without apportionment.
- The defendant filed petition for reconsideration and **contended that apportionment is required** and that no new PD should have been awarded because:
- (1) the factors of disability resulting from applicant's left foot injury are **completely overlapped** by the factors of disability from her prior bilateral knee injury for which she received a 22% PD award.
- (2) section 4664(b) enacted by SB 899 provides that if the applicant has received a prior award of PD, it shall be conclusively presumed that the prior PD exists at the time of any subsequent industrial injury.

Case Law

- **Sanchez v. County of LA (2005):**
- Background:
- Applicant filed an answer to the petition for reconsideration.
- The WCJ issued a Report and Recommendation on Petition for Reconsideration, recommending that the petition be denied because there is no overlap between applicant's current left foot disability, which is based solely on subjective complaints, **and** her prior bilateral knee disability, which was based solely on work restrictions.

Case Law

- **Sanchez v. County of LA (2005):**
- Discussion:
- *Does section 4664 as enacted by SB 899 require apportionment of OVERLAPPING disability when an employee suffers an industrial injury causing PD to one region of the body, but there has been a PRIOR PD award for the SAME body region?*
- **The original Workmen's Compensation Safety Act of 1917 stated:**
- "The percentage of permanent disability caused by any injury shall be so computed as to cover the permanent disability caused by that particular injury without reference to any injury previously suffered or any permanent disability caused thereby."

Case Law

- **Sanchez v. County of LA (2005):**
- Discussion: Former section 4750
- If all of the factors of permanent disability attributable to the subsequent industrial injury already existed as a result of the prior injury or condition, then there was "**total**" overlap, and the employee was not entitled to any additional permanent disability;
- If the subsequent industrial injury caused some new factors of permanent disability that were not pre-existing, then there was "**partial**" overlap, and the employee was entitled to permanent disability to the extent the subsequent industrial injury further restricted his or her earning capacity or ability to compete. (i.e. Back vs. Heart PD)

Case Law

- **Sanchez v. County of LA (2005):**
- Discussion:
- It was not the part of the body involved in the subsequent industrial injury that was important; rather, it was the nature of the disability resulting from the new injury in relation to the pre-existing disability that was determinative.
- The fact that the pre-existing disability and the new disability involved two different anatomical parts of the body, while relevant, did not in itself preclude apportionment.
- The **issue of apportionment** would be resolved by determining the percentage of combined disability after the new injury, and **then subtracting** the percentage of disability due to the prior injury which overlapped – either partially or totally – the disability resulting from the new injury.
- If, however, successive injuries produced separate and independent disabilities – i.e., if the disabilities did not fully or partially overlap because they did not affect the same abilities to compete and earn – then each was rated separately.

Case Law

- **Sanchez v. County of LA (2005):**
- The Determination Of Overlapping Disabilities After SB 899
- SB 899 repealed former section 4750 (Stats. 2004, ch. 34, §37) and, as relevant here, added current section 4664. (Stats. 2004, ch. 34, §35.)

Case Law

- **Sanchez v. County of LA (2005):**
- New section 4664 provides:
- "(a) The **employer shall only be liable for the percentage of permanent disability directly caused by the injury** arising out of and occurring in the course of employment.
- "(b) If the applicant has **received a prior award** of permanent disability, it shall be conclusively **presumed that the prior permanent disability exists at the time of any subsequent industrial injury.** This presumption is a presumption affecting the burden of proof.
- "(c)(1) The **accumulation of all permanent disability awards** issued with respect to any one region of the body in favor of one individual employee **shall not exceed 100 percent over the employee's lifetime** unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662.

Case Law

- **Sanchez v. County of LA (2005):**

- New section 4664 provides:
- As used in this section, the regions of the body are the following:
- (A) Hearing.
- (B) Vision.
- (C) Mental and behavioral disorders.
- (D) The spine.
- (E) The upper extremities, including the shoulders.
- (F) The lower extremities, including the hip joints.
- (G) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs (A) to (F), inclusive.

- "(2) Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100 percent."

Case Law

- **Sanchez v. County of LA (2005):**

- Section 4664(a) states:
- "The employer shall only be liable for the **percentage of permanent disability** directly caused by the injury arising out of and occurring in the course of employment."

- Lab. Code, §4663:
- The employer is liable only for "the **permanent disability … caused by the direct result of the injury**" and it is not liable for "the permanent disability … caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries"

- Thus, we conclude that, as was true before the repeal of former section 4750 and continuing with the enactment of new section 4664, **an employee is not entitled to be compensated for permanent disability resulting from a new industrial injury to the extent that this permanent disability is overlapped by prior permanent disability involving the same region of the body.**

Case Law

- **Sanchez v. County of LA (2005):**
- If an employee is entitled to receive compensation for any **new non-overlapping** permanent disability caused by the new industrial injury, then it is possible that the sum of the employee's successive permanent disability can reach a total of 100%, but the **employee will not be compensated twice for the same disability**.
- Section 4664(b) **states only that any prior permanent disability shall be conclusively presumed to "exist" at the time of the subsequent injury. It does not require that the prior permanent disability be subtracted, but also it does not preclude subtraction.**
- The language of section 4664(b) also supports that a determination must be made regarding the consequences of the previously "existing" permanent disability
- – i.e., if the pre-existing permanent disability and the current permanent disability **overlap**, **there will be subtraction** to the extent of that overlap, **but, otherwise if no overlap, then there will be no subtraction.**

Case Law

- **<u>Sanchez v. County of LA (2005):</u>**
- **The Defendant Has The Burden Of Proving The Existence Of Any Prior Permanent Disability Award(s) Relating To The Same Region Of The Body**
- It is the defendant's burden to prove that applicant had a prior permanent disability award relating to the same region of the body.
- Placing this burden on defendant is also consistent with the longstanding principle that, because **it is the defendant that benefits from a finding of apportionment**, it bears the burden of demonstrating that apportionment is appropriate.

Case Law

- **Sanchez v. County of LA (2005):**
- **When The Defendant Has Established The Existence Of Any Prior Permanent Disability Award(s) Relating To The Same Body Region, The Permanent Disability Underlying Any Such Award(s) Is Conclusively Presumed To Still Exist**
- i.e., The Applicant Is Not Permitted To Show Medical Rehabilitation From The Disabling Effects Of The Earlier Industrial Injury Or Injuries
- **When The Defendant Has Established The Existence Of Any Prior Permanent Disability Award(s) Relating To The Same Region Of The Body, The Percentage Of Permanent Disability From The Prior Award(s) Will Be Subtracted From The Current Overall Percentage Of Permanent Disability, Unless The Applicant Disproves Overlap**
- i.e., The Applicant Demonstrates That The Prior Permanent Disability And The Current Permanent Disability Affect *Different Abilities* To Compete And Earn, Either In Whole Or In Part

Case Law

- **Sanchez v. County of LA (2005):**
- The WCJ correctly determined that applicant's December 18, 2002 left foot injury caused 7% permanent disability, with no apportionment.
- To claim apportionment under section 4664(b), defendant had the burden of proving the existence of any prior permanent disability award(s). Defendant satisfied this burden by presenting a copy of the May 6, 2002 stipulated Findings and Award, which established that applicant's October 10, 1997 bilateral knee injury caused 22% permanent disability.
- Under section 4664(b), applicant was not entitled to assert that she had medically rehabilitated from her bilateral knee disability. She was, however, entitled to disprove apportionment by demonstrating that her conclusively existing bilateral knee disability does not overlap the permanent disability caused by her December 18, 2002 left foot injury, either in whole or in part.

Case Law

- **Sanchez v. County of LA (2005):**

- Applicant succeeded in carrying her burden of proof. The 2002 stipulated Findings and Award shows that applicant's bilateral knee disability consisted of a 35% loss of her pre-injury capacity for kneeling, squatting, climbing, heavy lifting, pushing and pulling.

- Thus, applicant's pre-existing knee disability resulted solely in a diminished capacity to perform specified work activities. This partial loss of work capacity with respect to applicant's knees **does not overlap** her current disability of intermittent slight left foot pain – becoming moderate with cold weather and rain – because the prior and current disabilities affect her abilities to compete and earn in separate and independent ways. Therefore, applicant has demonstrated that there is no overlap between her prior permanent disability, which conclusively still exists, and her current permanent disability.

- Although both applicant's current and prior injuries involved the same region of the body, i.e., the lower extremities under section 4664(c)(1)(F), the sum of her current 7% permanent disability award and her prior 22% permanent disability award does not exceed 100%.

Case Law

- **Sanchez v. County of LA (2005):**

- For purposes of section 4664(c)(1), applicant now has a total of 29% permanent disability (i.e., 22% plus 7%) for the lower extremities region.

- We affirm the WCJ's 2004 decision finding that applicant's 2002 left foot injury resulted in 7% permanent disability, without apportionment.

Case Law

- **Strong v. City and County of San Francisco (2005):**

- Reconsideration to further study the issue of apportionment under Labor Code section 4664, as enacted by Senate Bill 899 (SB 899), in situations where an employee suffers an industrial injury causing permanent disability to one region of the body, and where there has been a prior industrial injury resulting in an award of permanent disability involving and/or including different regions of the body.

- Applicant sustained a series of industrial injuries while employed as a stationary engineer by the City and County of San Francisco (defendant).

- Applicant initially sustained a 1995 injury to his left knee. On December 8, 1999, a stipulated award issued, which found that this left knee injury caused permanent disability of 34-½%.

- That report found that applicant "has a disability corresponding to Category C of the Guidelines for Work Capacity," i.e., a preclusion from heavy lifting. The report also found that applicant had objective and subjective disability.

Case Law

- **Strong v. City and County of San Francisco (2005):**

- Applicant had another industrial injury on February 12, 1999, to his left shoulder, left knee, left ankle, and right wrist.

- A stipulated award issued on March 28, 2003, finding that this injury caused permanent disability of 42%.

- Based on the summary rating determination admitted in evidence at trial, this 42% rating was based on a limitation to light work, after apportionment to applicant's prior preclusion from heavy lifting. Both the light work limitation and the apportionment to the prior no heavy lifting restriction were consistent with the June 6, 2001, February 28, 2001, December 13, 2001, and May 9, 2002 reports. Those reports also set forth various objective and subjective factors of disability, as well as some additional work restrictions.

Case Law

- **Strong v. City and County of San Francisco (2005):**
- The back injury in the case now before us occurred on May 8, 2002.
- The parties also stipulated that applicant's overall permanent disability is 70%, after adjustment for age and occupation. The parties raised the issue of the application of section 4664 and the issue of apportionment (overlap) for determination.
- The WCJ issued rating instructions to the Disability Evaluation Unit (DEU), as follows:
- "Please consider whether there is overlap between the following disabilities:
- "Applicant has an overall disability of 70% after adjustment of for age and occupation based on a limitation to semi-sedentary work because of a back injury of 5/08/02 and previous injuries to the left shoulder, left knee, left ankle and right wrist.
- "Prior to the 5/08/02 injury, applicant was limited to light work for an injury to the left shoulder, left knee, left ankle and right wrist limiting the applicant to light work."

Case Law

- **Strong v. City and County of San Francisco (2005):**
- On March 29, 2005, a disability evaluation specialist (rater) of the DEU issued a 10% recommended permanent disability rating opining:
- (1) that applicant's pre-existing light work limitation rated 60%, after adjustment for his current occupation; and
- (2) that applicant's May 8, 2002 caused 10% permanent disability, after apportionment (**i.e., the stipulated 70% overall disability minus the 60% pre-existing disability**).
- On May 31, 2005, the WCJ issued a Findings and Award determining that applicant's May 8, 2002 back injury caused 10% permanent disability.
- Thereafter, applicant filed a timely petition for reconsideration.

Case Law

- **Strong v. City and County of San Francisco (2005):**
- The petition contends:
- (1) that, under section 4664(a), the **employer is liable for the "percentage of permanent disability directly caused by the injury**" and, here, applicant's May 8, 2002 back **injury has directly caused permanent disability of 70%**
- (2) that, because the 70% permanent disability caused by the May 8, 2002 **injury is all in the region of the back**, then under section 4664(c)(1) there **cannot be any apportionment to pre-existing disability in other regions of the body**; and
- (3) that, if apportionment is to apply, it is limited to **subtracting the monetary equivalent of the pre-existing disability from the monetary equivalent of the current** overall disability.

Case Law

- **Strong v. City and County of San Francisco (2005):**
- The WCJ correctly determined that applicant's May 8, 2002 back injury caused 10% permanent disability, after apportionment.
- At trial, the parties stipulated that applicant's overall permanent disability is 70%, after adjustment for age and occupation. The parties then placed the questions of the application of section 4664 and of apportionment (overlap) in issue.
- To claim apportionment under section 4664(b), defendant had the burden of proving the existence of any prior permanent disability award(s) including or involving different regions of the body. Defendant satisfied this burden by offering in evidence:
- (1) a December 8, 1999 stipulated award finding that applicant's November 27, 1995 left knee injury caused 34-½% permanent disability; and
- (2) a March 28, 2003 stipulated award finding that applicant's February 12, 1999 left shoulder, left knee, left ankle, and right wrist injury caused 42% permanent disability.

Case Law

- **Strong v. City and County of San Francisco (2005):**

- Under section 4664(b), applicant was not entitled to assert that he had medically rehabilitated from the permanent disability caused by his two prior injuries. **However, he was entitled to disprove apportionment by demonstrating** that his conclusively existing permanent disability, upon which the December 8, 1999 and March 28, 2003 awards were based, **does not overlap** the permanent disability caused by his May 8, 2002 back injury, either in whole or in part.

- On this record, **applicant succeeded in disproving total overlap**, i.e., he established there is only partial overlap between his current disability and the disability upon which his prior permanent disability awards were based.

Case Law

- **Strong v. City and County of San Francisco (2005):**
- The evidence establishes:
- (1) that the stipulated 34-½% permanent disability rating for applicant's November 27, 1995 left knee injury was based on a preclusion from heavy lifting, in accordance with the August 13, 1998 report; and
- (2) that that the stipulated 42% permanent disability rating for applicant's February 12, 1999 left shoulder, left knee, left ankle, and right wrist injury was based on a limitation to light work, after apportionment to applicant's prior preclusion from heavy lifting, in accordance with the provider's June 6, 2001, February 28, 2001, December 13, 2001, and May 9, 2002 reports.
- Accordingly, applicant had pre-existing overall disability consisting of a limitation to light work, from which he cannot assert medical rehabilitation.

Case Law

- **Strong v. City and County of San Francisco (2005):**
- The evidence also establishes that the parties' stipulation that applicant's overall disability following his May 8, 2002 back injury is 70%, after adjustment for age and occupation, is based on an overall a limitation to semi-sedentary work, in accordance with the provider's November 3, 2002, November 30, 2002, February 17, 2003, and January 26, 2004 reports.
- Finally, these four reports state that the increase in disability from a limitation to light work to a limitation to semi-sedentary work is a result of applicant's May 8, 2002 back injury.
- The **pre-existing light work limitation only partially overlaps the current semi-sedentary**
- **work limitation.**
- Therefore, applicant is entitled to be compensated for the difference.
- This is what the WCJ did. Specifically, he found that applicant's May 8, 2002 back injury caused 10% permanent disability, after apportionment. He arrived at this 10% rating by deducting the pre-existing 60% disability (which was based on applicant's pre-existing light work limitation, as adjusted by the DEU for applicant's current age) from the stipulated 70% overall disability (which was based on applicant's current overall limitation to semi-sedentary work, as adjusted for his current age and occupation).

Case Law

- **Strong v. City and County of San Francisco (2005):**

- Accordingly, the WCJ followed the correct procedure. On this record, with the evidentiary basis for the prior permanent disability awards having been established, it would not have been appropriate for the WCJ to utilize a methodology of simply adding the percentages of permanent disability from the prior awards and then subtracting that total from the current overall percentage of permanent disability.

- Accordingly, we affirm the WCJ's May 31, 2005 decision finding that applicant's May 8, 2002 back injury caused 10% permanent disability, after apportionment.

Case Law

- **E.L Yeager Constr'n v WCAB (Gatten) :**

- Petitioner contends that the Board erred by not correctly applying the newly enacted apportionment statutes and in rejecting the independent medical examiner's (IME) opinion on apportionment.

- Applicant sustained an admitted injury to his lower back in 1996 while working for petitioner. The injury occurred when he fell from a five-and-one-half-foot wall, landing on his buttocks. At the time of the injury, he was diagnosed with a lumbar strain/sprain with a compression fracture at L2.

- Prior to this injury, applicant had occasional back pain and had received two to three chiropractic adjustments for the pain in the preceding 10-year period.
- Following his injury, applicant saw various physicians and eventually the workers' compensation administrative law judge (WCJ) appointed Dr. Akmakjian as the IME.

Case Law

- **E.L Yeager Constr'n v WCAB (Gatten) :**

- Dr. Akmakjian apportioned 20 percent of applicant's present disability to chronic degenerative disease of his lumbar spine. He testified that applicant's magnetic resonance imaging (MRI) taken in 1997 showed dehydration, indicating early degenerative change at almost every disc in his back. He noted that this is a naturally occurring process that everyone gets, but it bothers some people and others it does not.

- Although Dr. Akmakjian could not tell when this process started, he opined that the MRI taken within a year of the injury date showed the degenerative changes had already begun. "If you go back to your MRI from 1997, it says you have disc dehydration, indicating early degenerative change at almost every disc in your back, and that was within a year of your injury date, so, you know, all that stuff was there, it's bottom line. The arthritic changes, beginning degeneration, it was there."

Case Law

- **E.L Yeager Constr'n v WCAB (Gatten) :**

- When he was asked if he could find it, "medically probable that [applicant] had some back problems that you can apportion to prior to his injury of 1996," Dr. Akmakjian replied, "That, plus the MRI findings, yes."

- The WCJ found applicant's industrial back injury caused a 74 percent permanent disability with no basis for apportionment. The WCJ rejected Dr. Akmakjian's opinion regarding apportionment as not supported by substantial evidence. Petitioner now seeks review of this finding of no apportionment.

Case Law

- **E.L Yeager Constr'n v WCAB (Gatten) :**

- **Discussion**
- In 2004, the Legislature made a diametrical change in the law with respect to apportionment to an employee's preexisting injury by enacting (**Senate Bill 899**).
-
- Prior to their repeal by this bill, apportionment under Labor Code **former section 4663** was limited to circumstances where the apportioned disability was the result of the natural progression of a preexisting, nonindustrial condition and such nonindustrial disability would have occurred in the absence of the industrial injury.

Case Law

- **E.L Yeager Constr'n v WCAB (Gatten) :**

- Apportionment based on causation was prohibited. **Thus, "[p]rior to 2004, apportionment could never be made on the basis of pathology, either in a case of preexisting disability or in a case of an aggravation of an existing condition; it had to be made on the basis of causation of permanent disability.**

- "The rule under the law prior to [Senate Bill] 899 was 'an employer takes the employee as he finds him at the time of the employment.

Case Law

- **E.L Yeager Constr'n v WCAB (Gatten) :**

- "[Senate Bill] 899 repealed former section 4663. [Senate Bill] 899 added a new section 4663 and section 4664 affirmatively requiring apportionment of permanent disability based on causation and limiting the employer's liability under certain circumstances. The new section 4663 also requires that a reporting physician address the apportionment issue in a specific manner.

Case Law

- **E.L Yeager Constr'n v WCAB (Gatten) :**

- The WCJ and the Board, in its answer to this petition, acknowledge that the new law governing apportionment applies to this case, and that, consequently, **apportionment may be based on pathology and asymptomatic prior conditions.** The Board asserts, however, that petitioner has not carried its burden of proof in establishing the percentage of disability caused by nonindustrial factors. More specifically, it contends that Dr. Akmakjian's opinion attributing 20 percent of applicant's disability to nonindustrial factors does not constitute substantial evidence on this issue.

- **In order to constitute substantial evidence, a medical opinion must be predicated on reasonable medical probability.**

Case Law

- **E.L Yeager Constr'n v WCAB (Gatten) :**

- A medical opinion is **not substantial evidence** if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess.

- Further, a medical report is **not substantial evidence** unless it sets forth the reasoning behind the physician's opinion, not merely his or her conclusions.

Case Law

- **E.L Yeager Constr'n v WCAB (Gatten) :**

- The Board has taken the position "**to be substantial evidence on the issue of the approximate percentages of permanent disability due to the direct results of the injury and the approximate percentage of permanent disability due to other factors, a medical opinion must be framed in terms of reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and it must set forth reasoning in support of its conclusions**."

- Degenerative disease can be **asymptomatic and still apportionable** under the new law.

Case Law

- **Kleeman v. WCAB:**

- Petitioner claimed industrial injuries from work as a special agent for respondent, State of California. After his claim was tried and submitted to the workers' compensation administrative law judge (WCJ) for a decision, the Legislature enacted Senate Bill No. 899 (2003-2004 Reg. Sess.) (Bill 899) and required apportionment based on causation under new Labor Code sections 4663 and 4664.

- Petitioned Workers' Compensation Appeals Board (WCAB) for a ruling that new Labor Code sections 4663 and 4664 did not apply.

Case Law

- **Kleeman v. WCAB:**

- Kleemann contends before this court that new Labor Code sections 4663 and 4664 are inapplicable, since his injuries preceded enactment of S.B. 899 and the Legislature did not intend, and could not legally require, retroactive application of those provisions. We conclude that the Legislature intended new Labor Code sections 4663 and 4664 to apply to pending cases such as Kleemann's, prospectively from the date of enactment of S.B. 899, regardless of the date of injury. Accordingly, the decision of the WCAB is annulled and the matter is remanded for further proceedings consistent with this opinion.

Case Law

- **Kleeman v. WCAB:**
- FACTUAL AND PROCEDURAL BACKGROUND
- Kleemann, a special agent and investigator for the Department of Justice of the State of California (State), claimed injury to his cardiovascular system due to stress during employment from 1996 to April 30, 2000.
- Kleemann also claimed injuries to his right knee from work on April 14, 1999, and on August 14, 2001.
- Kleemann had previously worked as a police officer for the City of Los Angeles, and in that capacity had injured his back and right knee on May 27, 1986, for which he had received 16-1/2 percent permanent disability indemnity.

Case Law

- **Kleeman v. WCAB:**

- On March 22, 2000, Kleemann and the State entered into "Stipulations with Request for Award" (Stipulations), agreeing that the April 14, 1999, right knee injury did not result in permanent disability. On October 11, 2002, Kleemann petitioned **to reopen the April 14, 1999, right knee injury claim for new and further disability.**

- Kleemann also obtained a medical-legal report dated January 2, 2003, from Dennis Ainbinder, M.D. Dr. Ainbinder recommended work restrictions for the right knee, and **apportioned 40 percent of the right knee disability to the injury of April 14, 1999, and 60 percent to the injury of August 14, 2001.** Dr. Ainbinder further concluded that the **right knee disability was not apportioned to the 1986 right knee injury, because Kleemann's pain from that injury had "fully resolved" and "Kleemann did rehabilitate himself".**

Case Law

- **Kleeman v. WCAB:**

- Kleemann's internist reported his cardiovascular and hypertensive disease precluded heavy work and unduly stressful environments, without apportionment to nonindustrial factors.

- The State's internist reported that Kleemann had no permanent disability, and his coronary and hypertensive condition requiring treatment was caused by multiple factors, including hereditary predisposition, abnormal lipids and work stress.

- Kleemann and the State appeared at a mandatory settlement conference and documented issues and exhibits. On March 24, 2004, trial commenced and Kleemann testified regarding his industrial injuries, treatment and disability. Kleemann also testified that he did not have disability when he was hired by the State and passed a physical exam in 1996.

Case Law

- **Kleeman v. WCAB:**

- Kleemann petitioned the WCAB for removal, alleging that the WCJ's retroactive application of apportionment under new sections 4663 and 4664 would cause irreparable harm. In the report on removal, the WCJ explained that new sections 4663 and 4664 became applicable to Kleemann's case upon enactment of S.B. 899 under Section 47.3

Depositions

- **TITLE 8. INDUSTRIAL RELATIONS**
  DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
  CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR
- Article 3. Assignment of Qualified Medical Evaluators, Evaluation Procedure
- **§35.5. Compliance by AMEs and QMEs with Administrative Director Evaluation and Reporting Guidelines.**

- (f) Unless the Appeals Board or a Workers' Compensation Administrative Law Judge orders otherwise or the parties agree otherwise, whenever a party is legally entitled to depose the evaluator, the evaluator shall make himself or herself available for deposition within at least one hundred twenty (**120**) days of the notice of deposition and, upon the request of the unrepresented injured worker and whenever consistent with Labor Code section 5710, the deposition shall be held at the location at which the evaluation examination was performed, **or** at a facility or office chosen by the deposing party that is not more than 20 miles from the location of the evaluation examination.

Supplemental Reports

- **QME Supplemental Reports:**

- **Q. What is the time frame for supplemental reports?**

- A. You have **60 days** from the date of the written request for a supplemental report. The time frame may be extended up to 30 additional days if the parties agree without the need to request an extension from the medical director. (8 CCR § 38(h))

Permanent & Stationary Status (P&S)

- A workers' medical condition is considered permanent and stationary after it has medically stabilized, which is also termed "Maximum Medical Improvement".
- It is possible that some slight improvement may be anticipated in the near future, or when the condition has been stationary for a "reasonable period of time".
- Permanent and stationary is when a worker's condition has NOT reached PRE-INJURY STATUS, but the patient has reached maximum medical improvement (MMI).
- The injured worker is considered to be P&S after all reasonable treatment and/or diagnostics have been considered.

Permanent & Stationary Status (P&S)

- Permanent and stationary assumes that there will no appreciable improvement or decline in the foreseeable future.
- The condition is considered stable and has been so for a period of time.
- The amount of time is subjective and is best determined by the primary treating physician (PTP).
- It is not unusual to see fluctuations in the patient's condition over a period of several weeks.

Permanent & Stationary Status (P&S)

- According to the AMA Impairment Guidelines, "An impairment is considered permanent and stationary when it has reached maximum medical improvement (MMI), meaning it is well stabilized and unlikely to change substantially in the next year with or without treatment"
- Note that if **more than one injury exists**; give **P&S dates for each condition**.
- If the patient has not yet reached P&S status, the physician should give an opinion as to when P&S will be achieved, the extent of treatment necessary to do so and any continued total/partial temporary disability.

Permanent & Stationary Status (P&S)

- Opinions should be deferred on issues that require additional time and which cannot be concluded until the condition has stabilized or plateaued.
- Such considerations may include permanent impairment and possibly vocational rehabilitation.
- If the worker's condition continues to improve or deteriorate, it is likely that their condition has not yet reached P&S or MMI.

Permanent & Stationary Status (P&S)

- If the treating physician believes that the patient has received appropriate care, but may benefit from additional treatment (i.e. surgery, consultation, injections), <u>but the patient will not consider trying these forms of treatment, the patient is then to be considered P&S even though additional treatment would more than likely improve their condition.</u>
- However, such procedures should be indicated for future medical if the patient reconsiders these treatment options at a later time or if their condition deteriorates.

- **<u>NOTE:</u>** P&S does not mean that the workers' condition cannot <u>IMPROVE</u> or <u>DETERIORATE</u> over time.

- **<u>NOTE:</u>** P&S means that the condition is currently stable and ready to be evaluated.

Stipulated Award
vs.
Compromise & Release

- Once permanent disability has been determined, the injured worker faces two options with regard to settling their case.
- The worker may either choose between a **stipulated award** or a **compromise & release**.
- Both settlements face advantages as well as disadvantages.

Stipulated Findings and Award

- **ADVANTAGES:**

1. Future medical care is provided to cure or relieve them of the effects of the injury.
2. A quick and easy method of settling their case and protecting their rights.
3. A court hearing is not necessary if not represented by an attorney.
4. The settlement will be reviewed by the Division of Workers' Compensation to protect the worker's rights.
5. Should the patient's condition worsen, they can apply for additional payments and/or benefits anytime within 5 years from the D.O.I.
6. The injured worker may request a lump sum payment of all or part of their PD if they can show a financial need or hardship. This is more difficult since a workers' compensation judge must first be convinced.

- **DISADVANTAGES:**

1. Payments are made every 2 weeks (Not a lump sum payment)

Compromise and Release (C&R)

- **ADVANTAGES:**

1. Settlement is usually for more money because the employer/insurance carrier is buying the patient's future medical care.
2. The worker will receive the settlement payment in one lump sum.
3. If the employer/insurer disputes the PD rating, the patient is assured that they will receive an agreed sum of money rather than risk getting a lesser amount or nothing later.

- **DISADVANTAGES:**

1. Releases the employer/insurer of future liability for medical care or other benefits if their condition or disability becomes worse.
2. Once the judge has approved the C&R, the settlement is final.
3. If a worker dies due to their injury, their dependents are not entitled to death benefits.

Medical Report Checklist

- Below is a list of components generally incorporated into a medical legal report, which are utilized for rating disability/impairment.
- This should be considered as an overall guideline.

1. Date
2. Insurer/Attorney Address
3. Patient Information
4. Record Review
5. History of the Injury
6. History of Treatment
7. History of other Injuries
8. Current Symptoms
9. Job Description
10. Work History

Medical Report Checklist

11. Past Medical History
12. Family History
13. Review of Systems
14. Off Work Activities
15. Social History
16. Physical Exam
17. Studies (X-ray, MRI, NCV, etc.)
18. Discussion
19. Diagnosis
20. P&S Status

Medical Report Checklist

21. Causation
22. Apportionment
23. Vocational Rehabilitation
24. Subjective Factors of Disability
25. Objective Factors of Disability
26. Work Preclusion
27. Future Medical
28. Reasons for Opinion
29. Rating Statement
30. Compliance Statement
31. Signature

- **NOTE:** If writing a P&S report under the new (AMA) System (DOI > 01/01/2005), then items 24-26 are not necessary.

- The older disability rating system (PDRS) (DOI < 01/01/2005) is based on four factors; items 24-26 and Loss of Functional Capacity/pre-injury status (The inability to compete in the open labor market)

HISTORY OF THE INJURY:

Document the mechanism of the industrial injury.

HISTORY OF TREATMENT:

Utilize this section of the report to document the industrial injury from date of injury to most current treatment received by the injured worker. Identify injured body parts and treatment rendered, including but not limited to any special imaging or referrals to specialists.

HISTORY OF OTHER INJURIES:

Indicate any other injuries sustained by the patient including any previous work related injuries or personal injuries.

CURRENT SYMPTOMS:

Describe the patient's symptoms at time of Permanent & Stationary evaluation. Remember to describe their symptoms for each complaint using proper terminology as described in these notes on page 2.

JOB DESCRIPTION:

Note the patient's job title at the time of the injury. Also state when they began working for the employer where the injury was sustained. A RU-91/Description of Employee's Job Duties may be available for your review and comment.

WORK HISTORY:

Report all available work history, which includes each employer pre and post injury and the related work duties for each job. Be sure to reference dates of employment in case apportionment becomes an issue.

PAST MEDICAL HISTORY:

List relevant past medical history, which may include injuries to the same body region.

FAMILY HISTORY:

Identify any health related issues within the family that may be congenital or a tendency for predisposition for certain disorders and/or pathology.

REVIEW OF SYSTEMS:

As related by the patient on the Review of Systems. This includes gastro-intestinal, respiratory, cardio-vascular, muscle & joints, EENT, genitor-urinary, etc.

OFF WORK ACTIVITIES:

List the patient's activities outside of work. Report any sports they participate in or extracurricular activities they are involved with. This may be pertinent to the injury so be sure to investigate outside activities in detail with your patient

SOCIAL HISTORY:

State if the patient is married and if they use alcohol, tobacco and/or recreational drugs.

PHYSICAL EXAM:

Physical examination findings should be revealed in this section. List any positive exam findings, which may include orthopedic testing, neurological exam, myotomal testing, palpatory findings, restricted ranges of motion, posture analysis and any other relevant findings.

RADIOGRAPHIC EXAM:

Report any radiographic findings and where the imaging was performed along with the date of service.

MRI:

Report any MRI findings and where the imaging was performed along with the date of service.

DIAGNOSTIC TESTING:

Report any diagnostic tests performed, which may include but is not limited to NCV and EMG testing.

DISCUSSION:

This section should be used to discuss the injury in depth and provide your professional opinion regarding this case. You should discuss the nature and extent of the injury and the consistency with the mechanism of injury. As the primary treating physician you should comment on the appropriateness of care rendered, not just in your office but as a whole. Has the patient received all of the appropriate measures to cure or relieve the symptoms of their industrial injury? Were medically warranted referrals not authorized by the insurance adjustor? This is the section to comment on such topics. State if the patient has responded to care and which modalities were most beneficial in relieving their symptom complex.

DIAGNOSES:

List all diagnoses with a written description along with the ICD-

<SAMPLE>

1. (R) Wrist Degenerative Joint Disease (Capitohamate Joint)
2. (R) Wrist Cyst (Intraosseous Ganglion)
3. (R) Wrist Tenosynovitis
4. (R) Wrist Inflammation
5. (R) Wrist Segmental Dysfunction

PERMANENT AND STATIONARY STATUS:

State if it is your opinion that the patient's condition is permanent and stationary. If so, provide a date at which time the patient became permanent and stationary.

CAUSATION:

Identify if the mechanism of injury is consistent with the subjective complaints and the objective findings. Essentially, is this injury due to a work related incident?

APPORTIONMENT:

This section identifies the liability of the injury. Apportionment is only a factor if the injury was not 100% related to the employer where the injury occurred. Identify if the patient denies any pre-existing symptoms and/or disability relative to the injured body part(s). Also, state if there were any new reported injuries to the injured region(s).

VOCATIONAL REHABILITATION:

If the patient was unable to return to their regular job duties due to the injury and they were placed on modified work restriction, but the employer was not able to offer any alternative work at equivalent pay, then they would be classified as a Qualified Injured Worker (QIW). This means that they are eligible for re-training in another job classification at similar pay rate. The employer is responsible for paying for the re-training. The patient must be assigned a VR counselor to assist in choosing an alternative and appropriate job to re-trained in. If the employer is able to offer an alternative job at equivalent pay for one year they have satisfied the requirement and are not responsible for paying for Vocational Rehabilitation.

SUBJECTIVE FACTORS OF DISABILITY:

State your opinion regarding what the patient's pain relative to the injury would be graded at and best described using the terminology from page 2. Indicate any factors that exacerbate the condition, such as forceful gripping and fine manipulation with grasping maneuvers.

OBJECTIVE FACTORS/FINDINGS OF DISABILITY:

- Objective findings include positive orthopedic testing, painful range of motion, decrease in grip strength, positive neurological findings/deficits, etc
- Positive MRI findings
- Pain and tenderness/Palpatory findings

Apportionment

- **(Medical Separation of Industrial vs. Non-Industrial Disability)**
- Apportionment as related to workers' compensation may be defined as separating or determining the employer's liability due to a specific industrial injury. This requires the physician to separate out the disability or condition that has resulted from a work injury from the other parts of disability that are the result of non-industrial conditions or diseases.

- Apportionment is usually upheld by the WCAB as long as the physician's opinions are based on substantial medical evidence. The doctor's opinion should be based on physical evaluation of the patient and complete review of the medical records.

Apportionment

- **Labor Code Section 4663**
- Pursuant to SB 899, Labor Code section 4663 was amended.
- Section 4663 may be termed "**Medical Apportionment**"
- Section 4663 is based on the idea that the employer should only be responsible for the injured worker's disability related to the industrial injury.
- All physicians must address the issue of apportionment in their final permanent and stationary report.

Labor Code 4663

- The physician must determine in their opinion what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment
  - *and*
- what approximate percentage of the permanent disability was caused by other factors **both before and subsequent** to the work injury, which also includes prior work injuries.

- The physician should indicate specific reasons why they came to said conclusion.

Apportionment

- **<u>Labor Code Section 4664</u>**
- Labor Code section 4664 is termed "**Legal apportionment.**"
- Section 4664 states that the **employer shall only be liable for the percentage of permanent disability directly caused by the injury** arising out of and in the course of employment.
- The WCAB ruled in the ***Escobedo case*** that apportionment may now include:
- Pathology, Retroactive Work Preclusions and Asymptomatic Prior Conditions.

Required QME Forms (Unrepresented Cases)

- DWC-AD 100 Employee's Permanent Disability Questionnaire
- DWC-AD 101 Request for Summary Rating Determination
- QME 111 QME's Findings Summary Form
- NOTE: No forms required in "Represented" cases!

Who is Billed for the QME Report?

- Always send your QME bill with Proof of Service (POS) to the Claims Administrator.

- Do not bill the attorney…
- either the Applicant (AA) or the Defense attorney (DA)

Q. To whom do I send copies of the QME or AME report?

Action	Unrepresented QME Labor Code § 4060	Represented QME Labor Code § 4060	Unrepresented QME Labor Code § 4061	Represented QME Labor Code § 4061	Unrepresented QME Labor Code § 4062	Represented QME Labor Code § 4062
Who gets served ?	Applicant	Applicant and Applicant's attorney	Applicant	Applicant and Applicant's attorney	Applicant	Applicant and Applicant's attorney
	Claims Administrator or the defense attorney	Claims Administrator or the defense attorney	Claims Administrator or the defense attorney	Claims Administrator or the defense attorney	Claims Administrator or the defense attorney	Claims Administrator or the defense attorney
Is DEU served?	No	No	Yes	No	No	No
What is served?	Medical Report	Medical Report	Doument Coversheet	Medical Report	Medical Report	Medical Report
	QME Form 111-QME Findings Summary Form	QME Form 122-AME or QME Declaration of Service of Medical-Legal Report Form	Doucment Seprator sheet-DWC-CA form 10232.2	QME Form 122-AME or QME Declaration of Service of Medical-Legal Report Form	QME Form 111-QME Findings Summary Form	QME Form 122-AME or QME Declaration of Service of Medical-Legal Report Form
			Medical Report			
			Doucment Seprator sheet-DWC-CA form 10232.2			
			QME Form 111-QME Findings Summary Form			
			Doucment Seprator sheet-DWC-CA form 10232.2			
			DWC-AD Form 100-Employee's Disability Questionnaire			
			Doucment Seprator sheet-DWC-CA form 10232.2			
			DWC-AD Form 101-Request for Summary Rating Determination of Qualified Medical Evaluator's Report			

How to Bill for the QME Report?

- **ML 100 Missed Appointment**
- Not a guarantee for payment, but the QME should notify the claims administrator of their cancellation fee at time of the appointment notification.

- **ML 101 Follow Up Med-Legal Evaluation**
- Completed within 9 months & requires examination
- $250 per hour; $62.50 per ¼ hour
- <u>Billing includes:</u>
- Face to Face time
- Record Review
- Medical Research
- Report Preparation Time

How to Bill for the QME Report?

- **ML 102 Basic Med-Legal Evaluation**
- $625.00 Flat Rate

- **ML 103 Comprehensive Med-Legal Evaluation**
- Includes 3 complexity factors
- $937.50 Flat Rate

- **ML 104 Comprehensive Med-Legal Evaluation**
- Includes 4 complexity factors
- $250 per hour; $62.50 per ¼ hour

Med-Legal Complexity Factors

- **Complex Comprehensive Medical-Legal Evaluation. Includes evaluations which require three of the complexity factors set forth below.**
- **In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon:**
- **(1) Two or more hours of face-to-face time by the physician with the injured worker;**
- **(2) Two or more hours of record review by the physician;**
- **(3) Two or more hours of medical research by the physician;**
- **(4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor;**
- **(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors;**
- **(6) Addressing the issue of medical causation, upon written request of the party or parties requesting the report;**
- **(7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), or two or more or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.**
- **(8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.**
- **(9) Where the evaluation is performed for injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before June 30 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.**

How to Bill for the QME Report?

- **ML 105 Med-Legal Testimony**
- Minimum 1 hour, reasonable preparation, travel
- $62.50 per ¼ hour

- **ML 106 Supplemental Med-Legal Evaluation**
- Written when test results and/or records not available at time of initial evaluation
- $250 per hour; $62.50 per ¼ hour

Med-Legal Modifiers

- **-92**
- Med-Legal report done by PTP (Primary Treating Physician)

- **-93**
- Med-Legal report done with interpreter present

- **-94**
- Med-Legal done by AME (Agreed Medical Evaluator)
- Increase by 25%

- **-95**
- Med-Legal done by PQME (Panel Qualified Medical Evaluator)

Billing 10% Interpreter Surcharges

- When billing for ML-101 or ML-104 DO NOT add 10% surcharge for using an interpreter because these billing codes are billed at an hourly rate ($250.00/hour), which already includes your time spent. You should not bill an additional 10% for the interpreter.

- You may bill the 10% surcharge when billing ML-102 ($625.00) and ML-103 ($937.50) because these reports are billed at a flat rate.

- -93 Interpreter needed at time of examination, or other circumstances which impair communication between the physician and the injured worker and significantly increase the time needed to conduct the examination. Requires a description of the circumstance and the increased time required for the examination as a result. This modifier shall only be applicable to ML 102 and ML 103.

- http://www.dir.ca.gov/t8/9795.html

Rules to Scheduling QME Appointment

- TITLE 8. INDUSTRIAL RELATIONS
- DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
- CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR
- **§34. Appointment Notification and Cancellation**

- (a) Whenever an appointment for a comprehensive medical evaluation is made with a QME, the QME shall complete an appointment notification form by submitting the form in Section 110 (**QME Appointment Notification Form**) (8 Cal. Code Regs. § 110)

- The completed form shall be postmarked or sent by facsimile to the employee and the claims administrator, or if none the employer, within 5 business days of the date the appointment was made.

- In a represented case, a copy of the completed form shall also be sent to the attorney who represents each party, if known.

- Failure to comply with this requirement shall constitute grounds for denial of reappointment under section 51 of Title 8 of the California Code of Regulations.

Rules to Scheduling QME Appointment

- TITLE 8. INDUSTRIAL RELATIONS
- DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
- CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR
- **§34. Appointment Notification and Cancellation**

- (b) The QME shall schedule an appointment for a comprehensive medical-legal examination which shall be conducted only at the medical office listed on the panel selection form.

- However, upon written request by the injured worker and only for his or her convenience, the evaluation appointment may be moved to another medical office of the selected QME if it is listed with the Medical Director as an additional office location.

Rules to Scheduling QME Appointment

- TITLE 8. INDUSTRIAL RELATIONS
- DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
- CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR
- **§34. Appointment Notification and Cancellation**

- (c) The QME shall include within the notification whether a Certified Interpreter is required and specify the language.

- The interpreter shall be arranged by the party who is to pay the cost as provided for in Section 5811 of the Labor Code.

Rules to Scheduling QME Appointment

- TITLE 8. INDUSTRIAL RELATIONS
- DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
- CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR
- **§34. Appointment Notification and Cancellation**

- (d) An evaluator, whether an AME, Agreed Panel QME or QME, shall not cancel a scheduled appointment less than six (6) business days prior to the appointment date, except for good cause.

- Whenever an evaluator cancels a scheduled appointment, the evaluator shall advise the parties in writing of the reason for the cancellation. The Appeals Board shall retain jurisdiction to resolve disputes among the parties regarding whether an appointment cancellation pursuant to this subdivision was for good cause.

- The Administrative Director shall retain jurisdiction to take appropriate disciplinary action against any Agreed Panel QME or QME for violations of this section.

Rules to Scheduling QME Appointment

- TITLE 8. INDUSTRIAL RELATIONS
- DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
- CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR
- **§34. Appointment Notification and Cancellation**

- (e) An Agreed Panel QME or a QME who cancels a scheduled appointment **shall reschedule** the appointment to a date **within thirty (30) calendar days of the date of cancellation**.

- The re-scheduled appointment date may not be more than sixty (60) calendar days from the date of the initial request for an appointment, unless the parties agree in writing to accept the date beyond the sixty (60) day limit.

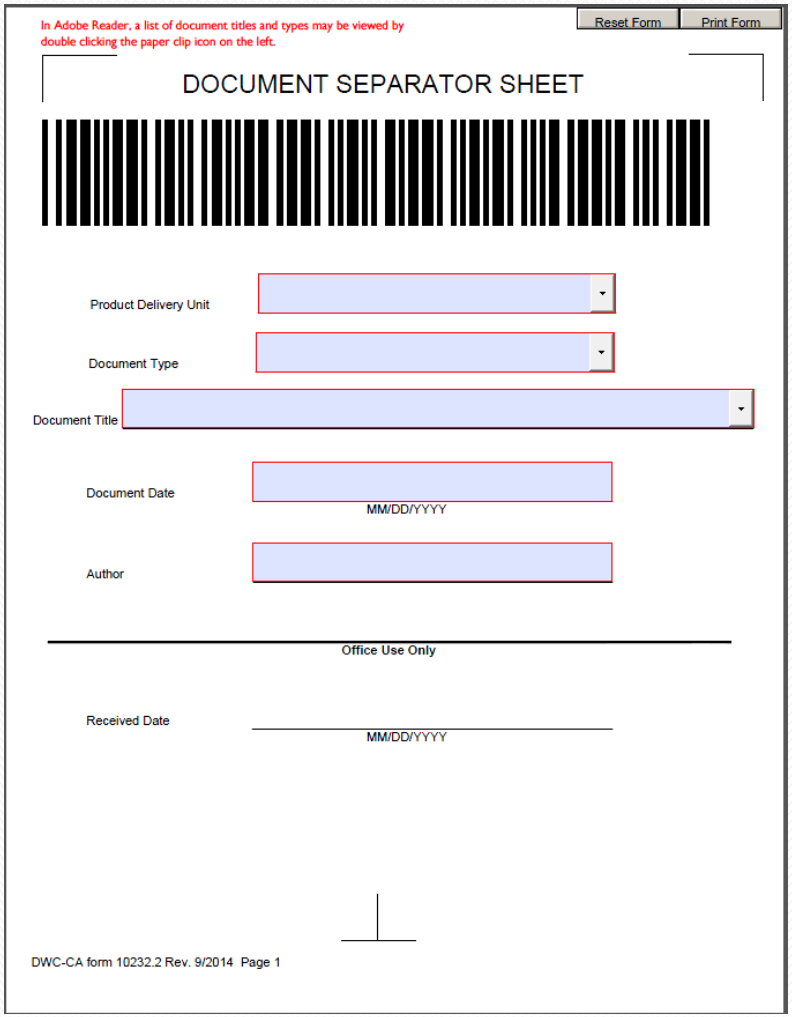
Rules to Scheduling QME Appointment

- TITLE 8. INDUSTRIAL RELATIONS
- DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
- CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR
- **§34. Appointment Notification and Cancellation**

- (g) Failure to receive relevant medical records, as provided in section 35 of Title 8 of the California Code of Regulations and section 4062.3 of the Labor Code, prior to a scheduled appointment shall not constitute good cause under this section for the evaluator to cancel the appointment, unless the evaluator is a psychiatrist or psychologist.

Document Separator Sheet

https://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCCAform10232_2.pdf



In Adobe Reader, a list of document titles and types may be viewed by double clicking the paper clip icon on the left.

Reset Form | Print Form

DOCUMENT SEPARATOR SHEET

Product Delivery Unit

Document Type

Document Title

Document Date

MM/DD/YYYY

Author

Office Use Only

Received Date

MM/DD/YYYY

DWC-CA form 10232.2 Rev. 9/2014 Page 1

Document Separator Sheet

https://www.dir.ca.gov/dwc/iwguides/IWGuide18.pdf

Information & Assistance Unit guide 18

How to complete a document separator sheet

In addition to the document cover sheet (see guide 17), forms filed with your local Workers' Compensation Appeals Board (WCAB) district office need a *"document separator sheet."* We need the separator sheet so information in the form that follows it can be read by our Electronic Adjudication Management System (EAMS).

The separator sheet is required even if you are only filing one document. This means you will be submitting at least three documents, in the following order, with anything you file at the WCAB:
1. A document cover sheet
2. A document separator sheet
3. The form you need to file

If you are filing supporting documents with your form you will need separator sheets to identify them.

You may complete the attached separator sheet using a typewriter or with block printing. This form can also be completed online at www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCCAform10232_2.pdf.

Use the attached sample form as a guide.

Keep in mind the separator sheet provides information about the document that follows it. To fill out the separator sheet:

- Select the correct *"product delivery unit"* (the unit that will receive your form or document). You must select ADJ, DEU, RSU, VOC, or INT. Please see the appendix and sample form for more information
- Select the *"document type"* for the product delivery unit chosen. See the appendix for the document types available under each product delivery unit. For example, under ADJ, the only four document types are: legal document, liens and bills, medical document and miscellaneous. Use ONLY the options provided. Do not write in a document type that doesn't exist for the unit. If you are filling out the separator sheet on the Web site, the available options are in a drop down menu on the form
- Select the *"document title"* from the appendix. Again, use ONLY the options provided. Do not write in a document title that doesn't exist for the unit and document type you selected. If you are filling the separator sheet out on the Web site, the available options are in a drop down menu on the form
- Fill in the *"document date"* (such as the date of medical report or date of a letter) using two-digit months and dates, and four digit years. The month, date, and year should be separated by a slash, like this: 02/15/2008

Document Separator Sheet

https://www.dir.ca.gov/dwc/iwguides/IWGuide18.pdf

Information & Assistance Unit guide 18

- Put the name of the person or organization who wrote the document in the *"author"* box. For example, if the document following the separator sheet is a form you filled out, you are the author. If the document following the separator sheet is a doctor's report, the doctor is the author. If your claims administrator is the author you need to know the "uniform assigned name" of that company and put that in the box. You can find the uniform assigned name of your claims administrator on the Web site at http://www.dir.ca.gov/DWC/EAMS/EAMS-LC/EAMSClaimsAdmins.asp.

Send the completed filing packet to the correct local WCAB district office. WCAB district office addresses and phone numbers are attached to this guide.

Additional instructions for filing forms in EAMS can be found on line in the "EAMS OCR forms handbook" at http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS_OCR%20handbook.pdf.

If you need help, call an Information and Assistance (I&A) office, or attend a workshop for injured workers. The local I&A phone numbers are attached to this guide. You can get information on a local workshop from the I&A office or on the Web at www.dwc.ca.gov.

The information contained in this guide is general in nature and is not intended as a substitute for legal advice. Changes in the law or the specific facts of your case may result in legal interpretations different than those present here.

When sending documents to a district office, please make sure they are not folded or stapled. Send them in a large manila envelope. Please see the EAMS OCR forms handbook for further instructions.

DOCUMENT SEPARATOR SHEET *SAMPLE*

Product Delivery Unit: SELECT UNIT

Document Type: SELECT DOCUMENT TYPE, REFER TO LIST

Document Title: SELECT DOCUMENT TITLE, REFER TO LIST

Document Date: DATE YOU FILLED ATTACHED DOCUMENT
MM/DD/YYYY

Author: YOUR NAME

Office Use Only

Received Date: _____
MM/DD/YYYY

DEU Forms

- Remember to use the Document Separator Sheet when submitting correspondence to the DEU:
- Select DEU Forms & appropriate document title from list.
- <u>Example:</u>
- Product Delivery Unit= **DEU**
- Document Type = **DEU FORMS**
- Document Title= **Request for Summary Rating Determination – QME Report (DWC 101)**

Product Delivery	Document type	Document Title
ADJ	MISC	SUMMARY RATING
ADJ	MISC	TRANSMITTAL LETTER
ADJ	MISC	TYPED OR WRITTEN LETTER
DEU	DEU DOCS - OTHER	EARNINGS INFORMATION
DEU	DEU DOCS - OTHER	JOB DESCRIPTION
DEU	DEU DOCS - OTHER	PHOTOGRAPHS
DEU	DEU DOCS - OTHER	RESPONSE TO REQUEST FOR FACTUAL CORRECTION
DEU	DEU FORMS	COMMUTATION REQUEST
DEU	DEU FORMS	EMPLOYEES PERMANENT DISABILITY QUESTIONAIRE
DEU	DEU FORMS	REQUEST FOR CONSULTATIVE RATING
DEU	DEU FORMS	REQUEST FOR FACTUAL CORRECTION
DEU	DEU FORMS	REQUEST FOR INFORMAL RATING BY INSURANCE CARRIER OR SELF-INSURER
DEU	DEU FORMS	REQUEST FOR RECONSIDERATION OF SUMMARY RATING BY THE AD
DEU	DEU FORMS	REQUEST FOR SUMMARY RATING DETERMINATION - QME REPORT
DEU	DEU FORMS	REQUEST FOR SUMMARY RATING DETERMINATION – TREATING PHYSICIAN
DEU	MEDICAL REPORTS	AME
DEU	MEDICAL REPORTS	DEFAULT QME (REPRESENTED WITH DOI ON/AFTER 1-1-05)
DEU	MEDICAL REPORTS	PANEL QME (NON-REPRESENTED ALL DOI)
DEU	MEDICAL REPORTS	REPRESENTED QME (REPRESENTED WITH DOI BEFORE 1-1-05)
DEU	MEDICAL REPORTS	TREATING PHYSICIAN
DEU	MISC	PROOF OF SERVICE

DEU Forms

- Remember to use the Document Separator Sheet when submitting correspondence to the DEU:
- Select DEU Forms & appropriate document title from list.
- <u>Example:</u>
- Product Delivery Unit= **DEU**
- Document Type = **DEU FORMS**
- Document Title= **Employees Permanent Disability Questionnaire (DWC 100)**

Product Delivery	Document type	Document Title
ADJ	MISC	SUMMARY RATING
ADJ	MISC	TRANSMITTAL LETTER
ADJ	MISC	TYPED OR WRITTEN LETTER
DEU	DEU DOCS - OTHER	EARNINGS INFORMATION
DEU	DEU DOCS - OTHER	JOB DESCRIPTION
DEU	DEU DOCS - OTHER	PHOTOGRAPHS
DEU	DEU DOCS - OTHER	RESPONSE TO REQUEST FOR FACTUAL CORRECTION
DEU	DEU FORMS	COMMUTATION REQUEST
DEU	DEU FORMS	EMPLOYEES PERMANENT DISABILITY QUESTIONAIRE
DEU	DEU FORMS	REQUEST FOR CONSULTATIVE RATING
DEU	DEU FORMS	REQUEST FOR FACTUAL CORRECTION
DEU	DEU FORMS	REQUEST FOR INFORMAL RATING BY INSURANCE CARRIER OR SELF-INSURER
DEU	DEU FORMS	REQUEST FOR RECONSIDERATION OF SUMMARY RATING BY THE AD
DEU	DEU FORMS	REQUEST FOR SUMMARY RATING DETERMINATION - QME REPORT
DEU	DEU FORMS	REQUEST FOR SUMMARY RATING DETERMINATION – TREATING PHYSICIAN
DEU	MEDICAL REPORTS	AME
DEU	MEDICAL REPORTS	DEFAULT QME (REPRESENTED WITH DOI ON/AFTER 1-1-05)
DEU	MEDICAL REPORTS	PANEL QME (NON-REPRESENTED ALL DOI)
DEU	MEDICAL REPORTS	REPRESENTED QME (REPRESENTED WITH DOI BEFORE 1-1-05)
DEU	MEDICAL REPORTS	TREATING PHYSICIAN
DEU	MISC	PROOF OF SERVICE

DEU Forms

- Remember to use the Document Separator Sheet when submitting correspondence to the DEU:
- Select Medical Docs & appropriate document title from list.
- Example:
- Product Delivery Unit= **ADJ**
- Document Type = **Medical Docs**
- Document Title= **QME Reports (& QME 111 form)**

ADJ	MEDICAL DOCS	ALL MEDICAL REPORTS
ADJ	MEDICAL DOCS	AME REPORTS
ADJ	MEDICAL DOCS	P & S REPORT
ADJ	MEDICAL DOCS	QME REPORTS

WORKERS' COMPENSATION APPEALS BOARD
DISTRICT OFFICES

ANAHEIM, 92806-2131
1065 N PacifiCenter Drive, Suite 170
Information & Assistance Unit **(714) 414-1800**

BAKERSFIELD, 93301-1929
1800 30th Street, Suite 100
Information & Assistance Unit **(661) 395-2514**

EUREKA, 95501-0481 * **Satellite office** *
100 "H" Street, Suite 202
Information & Assistance Unit **(707) 441-5723**

FRESNO, 93721-2219
2550 Mariposa Street, Suite 4078
Information & Assistance Unit **(559) 445-5355**

LONG BEACH, 90802-4339
300 Oceangate Street, Suite 200
Information & Assistance Unit **(562) 590-5240**

LOS ANGELES, 90013-1105
320 W 4th Street, 9th Floor
Information & Assistance Unit **(213) 576-7389**

MARINA DEL REY, 90292-6902
4720 Lincoln Boulevard, 2nd and 3rd floors
Information & Assistance Unit **(310) 482-3858**

OAKLAND, 94612-1499
1515 Clay Street, 6th Floor
Information & Assistance Unit **(510) 622-2861**

OXNARD, 93030-7912
1901 N Rice Avenue, Suite 100
Information & Assistance Unit **(805) 485-3528**

POMONA, 91768-1653
732 Corporate Center Drive
Information & Assistance Unit **(909) 623-8568**

REDDING, 96002-0940
250 Hemsted Drive, 2nd Fl, Ste. B
Information & Assistance Unit **(530) 225-2047**

RIVERSIDE, 92501-3337
3737 Main Street, Suite 300
Information & Assistance Unit **(951) 782-4347**

SACRAMENTO, 95834-2962
160 Promenade Circle, Suite 300
Information & Assistance Unit **(916) 928-3158**

SALINAS, 93906-2204
1880 N Main Street, Suites 100 & 200
Information & Assistance **(831) 443-3058**

SAN BERNARDINO, 92401-1411
464 W Fourth Street, Suite 239
Information & Assistance Unit **(909) 383-4522**

SAN DIEGO, 92108-4424
7575 Metropolitan Drive, Suite 202
Information & Assistance Unit **(619) 767-2082**

SAN FRANCISCO, 94102-7014
455 Golden Gate Avenue, 2nd Floor
Information & Assistance Unit **(415) 703-5020**

SAN JOSE, 95113-1402
100 Paseo de San Antonio, Suite 241
Information & Assistance Unit **(408) 277-1292**

SAN LUIS OBISPO, 93401-8736
4740 Allene Way, Suite 100
Information & Assistance Unit **(805) 596-4159**

SANTA ANA, 92701-4070
605 W Santa Ana Boulevard, Bldg 28, Suite 451
Information & Assistance Unit **(714) 558-4597**

SANTA BARBARA, 93101-7538 * **Satellite office** *
411 E Canon Perdido Street, Suite 2
Information & Assistance Unit **(805) 884-1988**

SANTA ROSA, 95404-4771
50 "D" Street, Suite 420
Information & Assistance Unit **(707) 576-2452**

STOCKTON, 95202-2314
31 E Channel Street, Suite 344
Information & Assistance Unit **(209) 948-7980**

VAN NUYS, 91401-337
6150 Van Nuys Boulevard, Suite 105
Information & Assistance Unit **(818) 901-5374**

Rev. 4/15

Minimum Time Guidelines

- Neuro-musculo-skeletal 20 Minutes
- Cardiovascular 30 Minutes
- Pulmonary 30 Minutes
- Psychiatric 60 Minutes
- All Others 30 Minutes

- Face to Face Time = The actual time the evaluator spent with the injured worker regarding direct face to face contact, which includes history taking, physical examination, and other related discussions in completing the evaluation.

Required Guidelines

- For accepted claims, The California Division of Workers' Compensation (DWC) requires that any treatment not authorized by the claims administrator, be sent to Utilization Review.
- Utilization Review must use mandated guidelines in rendering a medical necessity determination.
- The reviewer may only deviate from the mandated guidelines if they are "silent," or do not address the treatment being requested.

- MTUS - http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS/MTUS_Regulations.htm
- ACOEM – 2004, 2nd edition
- Official Disability Guidelines

Guidelines

CALIFORNIA MANDATED TREATMENT GUIDELIENS

The current state of the treatment guidelines is that MTUS is presumptively correct and must be used first before going to ODG.

MTUS has incorporated parts of ACOEM & ODG. Collectively it is referred to as MTUS.

If MTUS is silent on a treatment, then other guidelines can be used.

If MTUS is not update and other guidelines suggest a more advanced and better treatment, then the other guidelines can be used, but the reasoning must be given in the report to override MTUS.

If UR denies treatment, can a QME still help?

Q: How does SB 863 change an injured worker's ability to appeal a UR denial or modification?

A: SB 863 ultimately will require all treatment disputes resulting from utilization review to go through the IMR (Independent Medical Review) process. A QME may no longer address treatment disputes.

- **After 07/01/2013 all DOIs will have treatment disputes handled by**
    1. The IMR Process
    2. The URO's Internal Voluntary Appeal Process
    3. Both appeal routes may occur concurrently

Reasons to Remove a QME

- **Summarized below are some of the reasons a replacement QME panel may be requested per 8 CCR 31.5(a):**

- 1. QME does not practice in specialty requested.
- 2. QME cannot examine the applicant within 60-90 days.
- 3. Injured worker changed residences.
- 4. Panel QME is a member of same practice group as another member of the panel.
- 5. QME not available.
- 6. Panel QME is the treating physician for the disputed injury. (See also 8 CCR 41(a)(4))

Reasons to Remove a QME

- **Summarized below are some of the reasons a replacement QME panel may be requested per 8 CCR 31.5(a):**

- 7. Parties agree to QME within region of applicant's workplace, and original QME panel is outside this region.
- 8. Medical documentation indicates different specialty required.
- 9. Panel QME did not send out appointment notification.
- 10. QME issued a late report.
- 11. QME had a conflict of interest.
- 12. Panel QME does not provide complete medical evaluation, or QME is not medically qualified to address disputed issues.
- 13. Panel issued over 24 months ago, and no QME from that panel was used.

Reasons to Remove a QME

- **Summarized below are some of the reasons a replacement QME panel may be requested per 8 CCR 31.5(a):**

- In addition, LC 4062.3 and 8 CCR 35(k) allow for replacement of the QME panel when there has been an **ex parte communication violation**.

- A replacement QME Panel may also be warranted when the initial panel QME produces a report that **does not constitute substantial evidence**.

Reasons to Remove a QME

- Ex parte communications and violation of LC Section 4062.3(g) which provides:

- "(g) Ex parte communication with an agreed medical evaluator or a qualified medical evaluator selected from a panel is prohibited. If a party communicates with the agreed medical evaluator or the qualified medical evaluator in violation of subdivision (e), the aggrieved party may elect to terminate the medical evaluation and seek a new evaluation from another qualified medical evaluator to be selected according to Section 4062.1 or 4062.2, as applicable, or proceed with the initial evaluation."

- Rule 35(k) also prohibits ex parte communication with QMEs as follows:

- "If any party communicates with an evaluator in violation of Labor Code section 4062.3, the Medical Director shall provide the aggrieved party with a new panel in which to select a new QME or the aggrieved party may elect to proceed with the original evaluator. Oral or written communications by the employee, or if the employee is deceased by the employee's dependent, made in the course of the examination or made at the request of the evaluator in connection with the examination shall not provide grounds for a new evaluator unless the Appeals Board has made a specific finding of an impermissible ex parte communication."

The Wall Street Journal; Business & Tech – ICD-10 (09/28/2015)

70,000 Ways to Classify Ailments

Enormous expansion of codes doctors use will change paperwork, insurance, monitoring

By Melinda Beck

Doctors, hospitals and insurers are bracing for possible disruptions on Oct. 1 when the U.S. health-care system switches to a massive new set of codes for describing illnesses and injuries.

Under the new system, cardiologists will have not one but 845 codes for angioplasty. Dermatologists will need to specify which of eight kinds of acne a patient has. Gastroenterologists who don't know what's causing a patient's stomachache will be asked to specify where the pain is and what other symptoms are present—gas? eructation (belching)?—since there is a separate code for each.

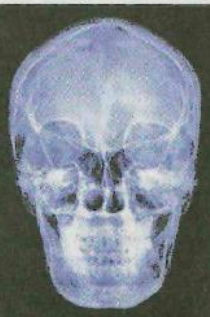
In all, the number of diagnostic codes doctors must use to get paid is expanding from 14,000 to 70,000 in the latest version of the International Classification of Diseases, or ICD-10. A separate set of ICD-10 procedure codes for hospitals is also expanding, from 4,000 to 72,000.

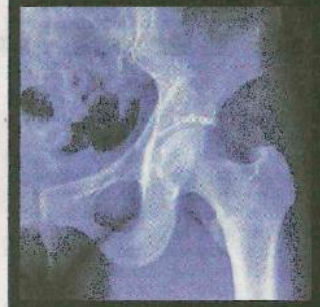
Hospitals and physician practices have spent billions of dollars on training programs, boot camps, apps, flashcards and practice drills to prepare for the conversion, which has been postponed three times since the original date in 2011.

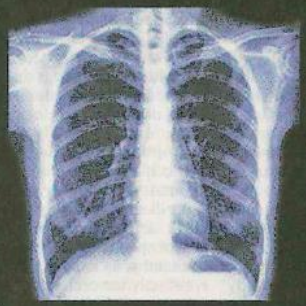
Some coding experts warn that claims denials could double as providers and payers get

Please see CODES page B2

GETTY IMAGES/ISTOCKPHOTO





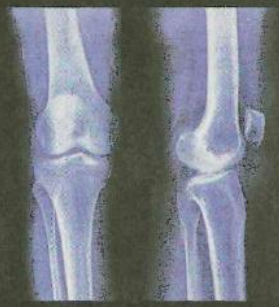


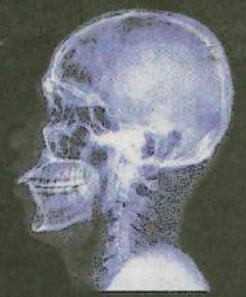
Break the Code

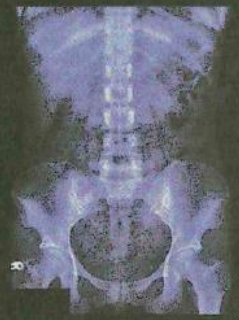
The following are all actual diagnostic codes in the new ICD-10 system:

1. Injured using a hand-held interactive electronic device
2. Underdosing of caffeine
3. Forced landing of spacecraft, injuring occupant
4. Inadequate social skills, not elsewhere classified
5. Problems in relationship with in-laws
6. Fall from (out of) a grocery cart
7. Other contact with a squirrel
8. Personal history of in-utero procedure while a fetus
9. Parental overprotection

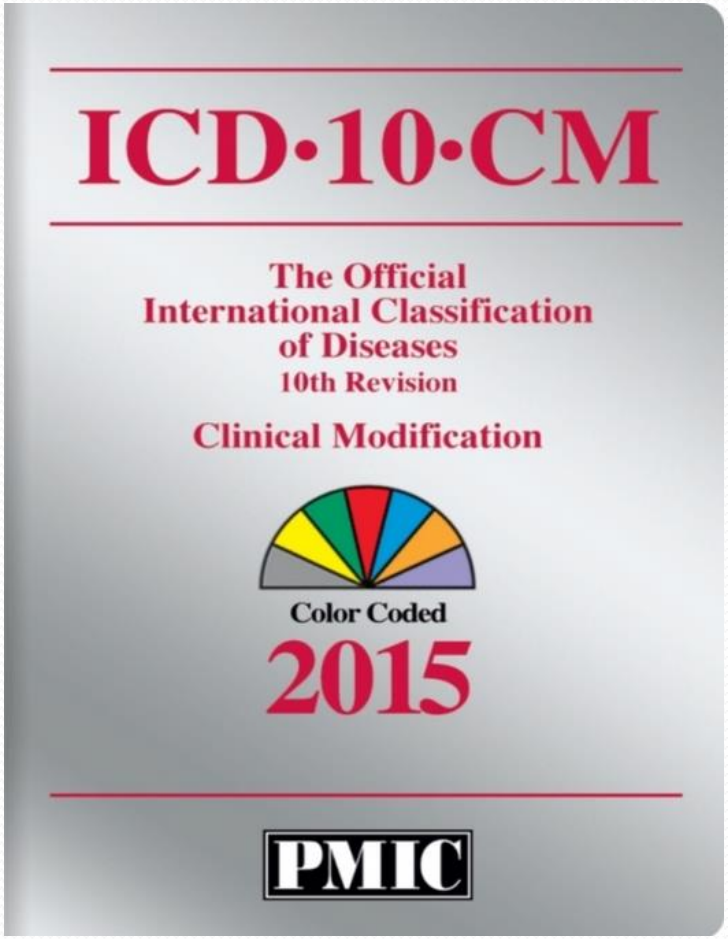
Check out an interactive database with the new diagnosis codes, at WSJ.com/Business.







- ICD-9 ~ 14,000 Codes
- ICD-10 ~ 70,000 Codes



ICD-10-CM

International Classification of Diseases, Clinical Modification

- ICD-10 (uses 3 to 7 digits) vs. ICD-9 (uses 3 to 5 digits)
- Coding format is similar
- ICD-10 captures laterality, fractures, subsequent encounters…
- ICD-10 offers improved metric tracking

- Digits 1-3: Category
- Digits 4-6: Etiology, Anatomical Site, Severity
- Digit 7: Extension (Injuries & External causes)

- Digit 1: Alpha (Not U)
- Digit 2: Numeric
- Digit 3, 4, 5, 6, 7: Any combination of Alpha or Numeric values (case sensitive)
- A decimal is placed after the 3rd digit

- A: Initial encounter
- D: Subsequent encounter
- S: Sequela
- X: Dummy placeholder for future coding expansion

ICD-10-CM (GEM)

- **General Equivalency Mapping (GEM):**
- Bidirectional conversions between ICD-9 vs. ICD-10
- Not intended to be crosswalks.
- A tool to help map/code accurately
- Clinical judgement & decision making is still critical
- Read the coding instructions

- ICD10Data.com
- CMS.gov/icd10
- ICD10CODEsearch.com
- http://www.acatoday.org/icd-10-code-conversion/

ICD-9 to ICD-10 Crosswalk

Diagnosis	ICD-9	ICD-10
Cervicalgia	723.1	M54.2
Thoracic Myofascial Pain	724.1	M54.6
Lumbago	724.2	M54.5
Cervical Sprain of ligaments, initial encounter	847.0	S13.4XXA
Cervical Sprain of joints and ligaments of other parts, initial encounter	847.0	S13.8XXA
Thoracic Sprain of ligaments, initial encounter	847.1	S23.3XXA
Thoracic Sprain of other specified parts, initial encounter	847.1	S23.8XXA
Lumbar Sprain of ligaments, initial encounter	847.2	S33.5XXA
Carpal Tunnel Syndrome	354.0	G56.00
Ankle Sprain of unspecified ligament, initial encounter (unspecified ankle)	845.00	S93.409A
Ankle strain of unspecified muscle and tendon and foot, initial encounter (unspecified ankle)	845.00	S96.919A
Ankle Sprain of unspecified ligament (Right Ankle), initial encounter	845.00	S93.401A
Ankle Sprain of unspecified ligament (Left Ankle), initial encounter	845.00	S93.402A
Spasmodic Torticollis	723.5	M43.6
Cervicogenic Headache	784.0	R51
Headache Vascular, not elsewhere classified	784.0	G44.1
Concussion without LOC	850.0	S06.0X0A
De Quervain - Radial Styloid tenosynovitis	727.04	M65.4
Thoracic, Thoracolumbar, Lumbosacral intervertebral disc disorder unspecified	722.2	M51.9
Wrist pain unspecified	719.4	M25.539
Elbow - Lateral Epicondylitis, unspecified elbow	726.32	M77.10
Elbow - Medial Epicondylitis, unspecified elbow	726.31	M77.00
Headache - Post-Traumatic, unspecified	339.20	G44.309
MVA - Driver	E812.0	V49.88XA
MVA - Passenger	E812.1	V49.59XA

ICD-10 (Commonly Used by Chiropractors)

- **Chapter 13**
- Diseases of the musculoskeletal system and connective tissue (**M00-M99**)

This chapter contains the following blocks:

M00-M02	Infectious arthropathies
M05-M14	Inflammatory polyarthropathies
M15-M19	Osteoarthritis
M20-M25	Other joint disorders
M26-M27	Dentofacial anomalies [including malocclusion] and other disorders of jaw
M30-M36	Systemic connective tissue disorders
M40-M43	Deforming dorsopathies
M45-M49	Spondylopathies
M50-M54	Other dorsopathies
M60-M63	Disorders of muscles
M65-M67	Disorders of synovium and tendon
M70-M79	Other soft tissue disorders
M80-M85	Disorders of bone density and structure
M86-M90	Other osteopathies
M91-M94	Chondropathies
M95	Other disorders of the musculoskeletal system and connective tissue
M96	Intraoperative and postprocedural complications and disorders of musculoskeletal system, not elsewhere classified
M99	Biomechanical lesions, not elsewhere classified

ICD-10 (Commonly Used by Chiropractors)

- **Other dorsopathies (M50-M54)**

M54.1 Radiculopathy
Brachial neuritis or radiculitis NOS
Lumbar neuritis or radiculitis NOS
Lumbosacral neuritis or radiculitis NOS
Thoracic neuritis or radiculitis NOS
Radiculitis NOS

Excludes1: neuralgia and neuritis NOS (M79.2)
radiculopathy with cervical disc disorder (M50.1)
radiculopathy with lumbar and other intervertebral disc disorder (M51.1-)
radiculopathy with spondylosis (M47.2-)

M54.10 Radiculopathy, site unspecified

M54.11 Radiculopathy, occipito-atlanto-axial region

M54.12 Radiculopathy, cervical region

M54.13 Radiculopathy, cervicothoracic region

M54.14 Radiculopathy, thoracic region

M54.15 Radiculopathy, thoracolumbar region

M54.16 Radiculopathy, lumbar region

M54.17 Radiculopathy, lumbosacral region

M54.18 Radiculopathy, sacral and sacrococcygeal region

ICD-10 (Commonly Used by Chiropractors)

- **Other dorsopathies (M50-M54)**

M54.2 Cervicalgia

Excludes1: cervicalgia due to intervertebral cervical disc disorder (M50.-)

M50.0 Cervical disc disorder with myelopathy

M50.00 Cervical disc disorder with myelopathy, unspecified cervical region

M50.01 Cervical disc disorder with myelopathy, high cervical region
C2-C3 disc disorder with myelopathy
C3-C4 disc disorder with myelopathy

M50.02 Cervical disc disorder with myelopathy, mid-cervical region
C4-C5 disc disorder with myelopathy
C5-C6 disc disorder with myelopathy
C6-C7 disc disorder with myelopathy

M50.03 Cervical disc disorder with myelopathy, cervicothoracic region
C7-T1 disc disorder with myelopathy

ICD-10 (Commonly Used by Chiropractors)

- **Other dorsopathies (M50-M54)**

M54.3 Sciatica

Excludes1: lesion of sciatic nerve (G57.0)
sciatica due to intervertebral disc disorder (M51.1-)
sciatica with lumbago (M54.4-)

M54.30 Sciatica, unspecified side

M54.31 Sciatica, right side

M54.32 Sciatica, left side

M54.4 Lumbago with sciatica

Excludes1: lumbago with sciatica due to intervertebral disc disorder (M51.1-)

M54.40 Lumbago with sciatica, unspecified side

M54.41 Lumbago with sciatica, right side

M54.42 Lumbago with sciatica, left side

M54.5 Low back pain
Loin pain
Lumbago NOS

Excludes1: low back strain (S39.012)

lumbago due to intervertebral disc displacement (M51.2-)
lumbago with sciatica (M54.4-)

ICD-10 (Commonly Used by Chiropractors)

- **Soft tissue disorders (M60-M79)**
- **Disorders of muscles (M60-M63)**

M62.83	**Muscle spasm**	
	M62.830	**Muscle spasm of back**
	M62.831	**Muscle spasm of calf** Charley-horse
	M62.838	**Other muscle spasm**

ICD-10 (Commonly Used by Chiropractors)

- **Chapter 20**
- **External causes of morbidity (V00-Y99)**

This chapter contains the following blocks:

V00-X58	Accidents
V00-V99	Transport accidents
V00-V09	Pedestrian injured in transport accident
V10-V19	Pedal cycle rider injured in transport accident
V20-V29	Motorcycle rider injured in transport accident
V30-V39	Occupant of three-wheeled motor vehicle injured in transport accident
V40-V49	Car occupant injured in transport accident
V50-V59	Occupant of pick-up truck or van injured in transport accident
V60-V69	Occupant of heavy transport vehicle injured in transport accident
V70-V79	Bus occupant injured in transport accident
V80-V89	Other land transport accidents
V90-V94	Water transport accidents
V95-V97	Air and space transport accidents
V98-V99	Other and unspecified transport accidents
W00-X58	Other external causes of accidental injury
W00-W19	Slipping, tripping, stumbling and falls

ICD-10 (Commonly Used by Chiropractors)

- **Chapter 20**
- **External causes of morbidity (V00-Y99)**

V49 Car occupant injured in other and unspecified transport accidents

The appropriate 7th character is to be added to each code from category V49
A - initial encounter
D - subsequent encounter
S - sequela

V53 Occupant of pick-up truck or van injured in collision with car, pick-up truck or van

The appropriate 7th character is to be added to each code from category V53
A - initial encounter
D - subsequent encounter
S - sequela

V00.15 Heelies accident
Rolling shoe
Wheeled shoe
Wheelies accident

V00.151 Fall from heelies

V00.152 Heelies colliding with stationary object

V00.158 Other heelies accident

ICD-9 to ICD-10 Crosswalk

Head Segmental Dysfunction	739.0	M99.00
Cervical Segmental Dysfunction	739.1	M99.01
Thoracic Segmental Dysfunction	739.2	M99.02
Lumbar Segmental Dysfunction	739.3	M99.03
Sacral Segmental Dysfunction	739.4	M99.04
Pelvic Segmental Dysfunction	739.5	M99.05
Lower Extremity Segmental Dysfunction	739.6	M99.06
Upper Extremity Segmental Dysfunction	739.7	M99.07
Rib Cage Segmental Dysfunction	739.8	M99.08

Sprain vs. Strain
S13 vs. S16

- **S13 Codes (Sprain)**
- Dislocation and Sprain of joints & ligaments @ Neck
- Includes:
- Avulsion, Laceration, Sprain, Traumatic Tear
- **Excludes2**: Strain of muscle or tendon @ Neck

- **S16 Codes (Strain)**
- Injury of muscle, fascia, tendon @ Neck
- **Excludes2**: Sprain of joint or ligament @ Neck

W-9

- Always include a completed W-9 form when billing an insurance company for the first time.
- The insurance carrier will need to add the provider as a new vendor of services.
- Usually, if the insurance carrier does not have your completed W-9 on the initial billing, it will delay payment until they have it.

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C–C corporation, S–S corporation, P–partnership) ►
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
___ – ___ – ____

or

Employer identification number
___ – _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person** ► | **Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Proof of Service

How can you prove you sent your treatment request?

- Proof of Service
- Email confirmation
- Fax proof/confirmation of delivery

Resources

- State of California Dept. of Insurance – *www.insurance.ca.gov*
- UR and Causation section of FAQs: *http://www.dir.ca.gov/dwc/UtilizationReview/UR_FAQ.htm*
- Division of Workers' Compensation Dept. of Industrial Relations - *http://www.dir.ca.gov/DWC*
- URAC – *www.urac.org*
- MTUS Regulations: *http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS_Regulations/MTUS_Regulations.htm*.
- ACOEM-Occupational Medicine Practice Guidelines 2nd Edition 2004
- CWCI
- LexisNexis
- ICD-10 CM PMIC 2015
- CPT Plus PMIC 2012
- https://www.dir.ca.gov/t8/9795.html
- AMA Guides, 5th Edition 2005

"Luck favors the prepared."

– Edna Mode

Questions?

Thanks So Much For Being Here Today!

Hope To See You Soon

Back To Chiropractic CE Seminars!

backtochiropractic.net