

# Utah's 2002 IMPAIRMENT GUIDES



## Utah Labor Commission Division of Industrial Accidents

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## Utah's 2002 IMPAIRMENT GUIDES

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# Workers' Compensation Overview

## INTRODUCTION

The concept of compensating people for injuries received “on the job” has been present for many years. Even pirates who roamed and plundered in the 7th century had their own elaborate code of “compensation”<sup>1</sup>. It wasn't until the early 20th century that “workers' compensation” became a legislated right in the United States. Each jurisdiction has been designed to ensure the worker prompt, but limited benefits and to assign to the employer sure and predictable compulsory liability insurance with established parameters. The principal components that have received legislative expression in all systems include: (1) A statutory program. (2) Expeditious resolution of disputed issues. (3) Limited liability without fault: Since workers' compensation is a no-fault insurance program, determining negligence or blame is often irrelevant. (4) Automatic benefits which include: (a) Medical treatment coverage including: the medical care, services and supplies as necessary to cure or relieve the effects of an on the job injury. This means that the employee does not incur any deductible or out-of-pocket expense for the medical treatment of a work-related injury or illness. (b) Indemnity payments replacing wages while the injured employee recovers from an industrial injury and or reaches medical stability. All states have varying formulas for the calculation of these indemnity payments, which are often tax-free. (c) Death benefits, providing weekly payments to the surviving spouse and dependent children of a worker whose work-related injury result in death. Burial and funeral expenses are also paid. (d) An impairment settlement giving compensation to an injured worker for permanent physical loss from a work-related injury (i.e. scars, disfigurement, amputation, etc.), according to a defined compensation schedule. The most severely injured workers are those who are left with some permanent loss, qualifying for an impairment rating. Studies have shown that those who incur impairments have a significant impact on their future wage income.<sup>2 3 4</sup> As with the other benefits, there are significant differences between the states on the value of settlement amounts and the *methodology utilized* to calculate total disability benefits.<sup>5 6 7</sup>

By 1949, all 50 states had adopted some form of worker's' compensation legislation.<sup>8</sup> The scope and amount of payments for these agreed upon services are determined by the individual state and in some cases by federal law.

The inconsistencies inherent with current rating systems used to calculate injured worker's residual loss or impairment can be frustrating for patients, physicians, risk managers, state administrators and payers<sup>9</sup>. One of the major problems with impairment ratings and therefore a significant patient and administrative burden, is the lack of consistency between physician raters of impairments.<sup>10 11 12</sup> Unfortunately, this variability becomes a source of dispute, which is both costly to the employer and stressful to the employee.

## Impairment / Disability Relationship

An impairment rating is given for financial compensation for the residual deficits that remain because of the injury or event, after an injured worker reaches medical stability, (See Glossary). The standard impairment schedule considers percentage of loss on an arbitrary continuum with 0% reflecting no residual or loss and 100% equaling a state approaching death.<sup>13</sup> This would mean that complete amputation of the ring or little finger equals 6% Whole Person. For the complete loss of an eye, one is awarded 24% and for the complete loss of a leg at the hip, 40% is awarded.

In order to understand impairment ratings, it is also necessary to understand the relationship between impairment and disability. Although the impairment rating number is derived from a structured set of observations, it does not convey information about the impact of the impairment on the worker's capacity to meet personal, social, or occupational demands, referred to as *disability*. The Guides define disability as an alteration of an individual's capacity to meet personal, social, or occupational demands or statutory or regulatory requirements because of impairment.<sup>14</sup> Therefore, impairment percentages estimate the extent of the impairment of Whole Person functioning and account for basic activities of daily living, not including work disability. The complexity of work activities requires individual analysis. Impairment assessment is a necessary first step for determining disability.<sup>15</sup>

## AMA Impairment Guides

To calculate impairment ratings, 40 state workers' compensation systems require some utilization of the different editions of the *AMA Impairment Guides*.<sup>16 17</sup> California, the most populace state in the nation, nine other states and

the federal government's Social Security Administration disability program do not recognize the AMA impairment guides for rating impairment. Although not universally accepted by all disability programs, the AMA impairment guides attempts to provide a reasonable method by which to evaluate impairment and attempts to minimize inter-rater variability. Originally published as a series of articles in *JAMA*, the *Impairment Guides* have been revised periodically.<sup>18 19 20 21</sup> The AMA impairment Guides are a tool that can be used to convert medical information about permanent losses into numerical values. Each chapter in the Guides focuses on a single organ system and provides a description of the diagnostic and evaluative methods for assessing specified impairments. Each impairment is assigned a rating, expressed as a percentage of loss of function for that system. Organ-based ratings are then translated into impairment ratings for the Whole Person.

Those states that utilize the impairment *Guides* have noted difficulty and confusion in coming to a consistent rating between different raters for the same condition.<sup>22</sup> This lack of consistency has provoked calls for serious revisions of the impairment *Guides* to address this issue.<sup>23 24</sup> Some states have disallowed parts of the *4<sup>th</sup> Edition of the AMA Impairment Guides* in that it violated their state compensation laws.<sup>25</sup> A number of studies have demonstrated poor reliability of the *American Medical Association Guides'* spinal range of motion model to estimate impairment in the spinal chapter.<sup>26 27 28 29 30 31</sup> Further studies have shown that spinal range of motion is non reliable and dependent on the age<sup>32</sup> and sex of the patient,<sup>33 34</sup> osteoarthritis,<sup>35</sup> the time of the day the measurements were taken,<sup>36</sup> and has no relationship to disability.<sup>37</sup>

## The Utah Impairment Guides

In 1994, Utah noted that with the utilization of the *Third Edition of the AMA Impairment Guides*, there was unnecessary reporting variability in the impairment rating for what appeared to be the same physical loss. This variability facilitated unnecessary patient anger, suspicion, hostility, litigation and costs and was attributed to several non-medical factors, such as the rating process, the individual examining physicians and examiner training, medical reports and apportionment processes. It was believed that by improving the rating criteria physicians were required to utilize would reduce variability for the impairment ratings. It was also noted that experience and a certain skill level was necessary to accurately and consistently calculate impairment ratings.

For these reasons, the Utah Labor Commission, appointed a committee to review the rating process of the most common, costly and litigated impairments and to make recommendations on how to reduce physician-reporting variability. The committee understood that before inconsistencies could be corrected, it was necessary to standardize the rating process and provide training for physicians doing ratings of impairment. It was not the committee's purpose to be unduly critical of the existing impairment systems, as all attempt to classify and communicate about this rather complicated problem, fraught with difficulty. However, the inherent weaknesses necessitated the development of a system, which represented current medical science and was as objective as possible, given current technological limitations. In 1994, after reviewing different rating systems, utilizing examples and different unique models, the committee developed and the state of Utah adopted the American Medical Association's *4<sup>th</sup> Edition of the Guides*, with a completely new Utah impairment rating system to be used in place of the *AMA Guides* for spinal conditions, upper-extremity peripheral neuropathies, temporomandibular joint dysfunction, dental loss and painful upper extremity conditions.<sup>38</sup>

The 1994 and 1997 Utah rating systems were eventually developed and adopted in Utah, objectively described the rating process, report writing and defined standard methodology to be used in the calculation of impairments. **Since adopting these Utah 1994 and 1997 impairment guides, it is estimated that litigation over impairment ratings has reduced to less than 1%.**<sup>39</sup> This reduction of litigation has assisted in making Utah the least costly state in the nation for a manufacturer to obtain workers' compensation insurance,<sup>40</sup> while maintaining the medical fee schedule above the national average.<sup>41</sup>

# Utah's 2002 Impairment Guides

## Introduction

In January 1994, the Industrial Commission of Utah adopted the American Medical Association's Guides to the Evaluation of Permanent Impairment, Fourth Edition, with the 1994 Utah Modifications. These were to be used for impairment ratings that were calculated after March 3, 1994. Now in 2002, with the release of the AMA 's 5<sup>th</sup> edition, more medical input and experience, the Utah Impairment Committee has continued to expand on the previous efforts, culminating in the this new edition "Utah's 2002 Impairment Guides". Initiation of this expanded work was in response to a rather widely held belief that modifications could be made to improve reproducibility of impairment ratings in a more universal and equitable manner. The committees reviewed the guides with regard to its strengths and weaknesses and have made recommendations to the Labor Commission regarding the most effective way to facilitate reliability and consistency and to continue to provide fair ratings.

The committee's options were limited to the following:

1. Do nothing and continue using the 4<sup>th</sup> edition with the 1997 Utah Guides.
2. Adopt the 5<sup>th</sup> edition in place of the 4<sup>th</sup> and continue to use the current 1997 Utah Modifications.
3. Adopt parts of the 5<sup>th</sup> edition, with the current 1997 Utah modifications.
4. Adopt parts of the 5<sup>th</sup> edition and update the Utah 1997 Modifications.

After considerable discussion, study and work, including utilization of models, the Committee has recommended adopting parts of the AMA 5<sup>th</sup> edition and updating the Utah 1997 Modifications, replacing them with new 2002 edition of the Utah Modifications that further clarifies how impairment ratings are to be conducted in Utah.

We believe that what is now presented will quite clearly encompass all but some of the most unusual cases. As always, the Labor Commission is anxious to receive input regarding the methods of classification, methodology and specific impairment percentages.

## Rules for the Calculation of Impairment Ratings

R612-7. Impairment Ratings for Industrial Injuries and Diseases.

R612-7-1. Authority.

This rule is being enacted under the authority of Section 34A-1-104 and 34A-2-412.

R612-7-3 Method for Rating.

A. For rating all impairments, which are not expressly listed in Section 34A-2-412, the Commission adopts Utah's 2002 Impairment Guides as published by the Commission for all ratings of impairments on or after January 15, 2002. For those conditions or exclusions not found in Utah's 2002 Impairment Guides, the American Medical Association's "Guides to the Evaluation of Permanent Impairment, Fifth Edition" are to be used.

## Medical Evidence Needed in the Calculation of Impairment Ratings

As stated in Utah Code ' 34A-2-102(8), "impairment" is a purely medical condition reflecting any anatomical or functional abnormality or loss. Impairment may be temporary or permanent, industrial or non-industrial. Utah Administrative Rule R612-7-3. sets forth the method for rating and the Labor Commission has adopted the American Medical Association's Guides to the Evaluation of Permanent Impairment - 5th Edition (AMA Guides), as modified and supplemented by guidelines the Labor Commission may from time to time adopt and publish (Commission Guidelines).

According to Utah Code ' 34A-2-412 (C), in rating extremities, "permanent and complete loss of use shall be deemed equivalent to loss of the member. Partial loss or partial loss of use shall be a percentage of the complete loss or loss of use of the member." Physicians should express a rating as a Whole Person impairment, stating the specific derivations used in calculating the rating, i.e., % hand to % of upper extremity to % Whole Person. Physicians must report the impairment to the nearest whole number, rounding up or down, i.e., 12.3% = 12%; 12.5. % = 13%.

An impairment rating is a critical piece of medical evidence. Nevertheless, the final benefit award may reflect other factors, including settlement, adjudicatory decision, or statute, i.e., Utah Code ' 34A-2-412.

### **Impairment Ratings for Conditions not found in the Utah 2002 Edition or the AMA's 5<sup>th</sup> Edition**

As always, the physician should use the appropriate parts of the guides to evaluate impairment. If information in the guides is lacking, the physician may derive an impairment percent based on the severity of the effect and describe in detail their methodology for calculating an impairment rating. In certain instances, the treatment of an illness may result in apparently total remission of the person's signs and symptoms, yet it is debatable whether the worker has actually regained the previous status of normal good health. Such examples would be individuals with deep vein thrombosis requiring chronic anti-coagulants for more than a year, or organ transplant recipients who were treated with immunity suppressing pharmaceuticals. In these cases the physician may increase the impairment estimate by three percent.<sup>42</sup>

**A Patient Who Declines Surgical, Pharmacological, or Therapeutic Treatment of an Impairment.** If the patient declines recommended treatment for an injury or illness, that decision neither decreases nor increases the estimated percentage of the individual's impairment. However, the physician is to make a written comment in the medical evaluation report about the suitability of the therapeutic approach and describe the basis of the individual's refusal. The physician will need to address whether the patient is medically stable without treatment and the degree of anticipated improvement that could be expected with treatment.<sup>43</sup>

### **Reporting of Impairment Ratings**

The impairment rating should be based solely on the objective maximum condition achieved by the patient. The calculation of an impairment rating is considered reasonable and necessary for those workers who have residual loss secondary to an industrial event. The impairment rating is not considered a portion of any medical service previously rendered and is not included in the routine post-operative care. There are special code numbers for payment for this service. Unless treating physicians are uncomfortable with this process, they are encouraged to complete the case, declare the patient stable and if applicable, calculate an impairment rating.

If, for any reason, the attending physician prefers not to make this evaluation, they should notify the insurance carrier. The treating physician may then refer the patient to another physician, or request that the carrier refer the patient to a physician that has training and expertise with the patient's condition and Utah's impairment rating methodology. The physician needs to ensure that the examinee understands that the evaluation's purpose is medical assessment, not medical treatment. However, if new diagnoses are discovered, the physician has a medical obligation to inform the requesting party and individual about the condition and recommend further medical assessment.<sup>44</sup>

The attending physician is the person most knowledgeable regarding the condition, progress and final status of the injured employee. Therefore the treating physician is encouraged to render the final impairment rating.<sup>45</sup> When the physician is uncertain about which method to use in the calculation of an impairment rating, or if more than one method can be used, the physician should calculate the impairment rating using different alternatives and choose the method or combination of methods that gives the most clinically accurate and highest impairment rating.<sup>46</sup>

The history should be based primarily on the individual's own statements rather than secondhand information. The physician should consider information from sources, including medical records, however caution should be used in the interpretation of subjective information. It is not appropriate to question the individual's integrity. If information from the individual is inconsistent with what is known about the medical condition, circumstances, or written reports, the physician should simply comment on the inconsistencies.<sup>47</sup>

### **The Medical Report at Stability:**

The medical report at stability is a comprehensive report prepared after the injured worker is medical stable, sometimes referred to maximum medical improvement (MMI), or fixed state of recovery. (See definition below.<sup>48</sup>)



As this is an administrative document, the final disposition of the examiner should include the following information.

### **Diagnosis:**

The examiner needs to clearly state the diagnosis as substantiated from the medical record. The examiner should also define, as clearly as possible, the relationship of the diagnosis to the industrial event. It is recognized that, in many cases, specific pathologic diagnoses are not clearly evident. The examiner has the responsibility to provide a diagnostic impression that is as closely correlated to the clinical findings as possible.

### **Stability:**

Medical stability, (MMI), or fixed state of recovery,<sup>49</sup> refers to a date in which the period of healing has ended and the condition of the worker is not expected to materially improve or deteriorate by more than 3% Whole Person in the ensuing year.<sup>50 51 52 53 54</sup> It is important to note that medical stability may not be used to terminate necessary medical care. The date of medical stability and the date when the worker qualifies for an impairment rating can be two separate dates.

### **Calculation of Impairment:**

Using this rating criteria, the examiner should calculate the residual impairment, based on clinical findings established during the medical examination and information found in the medical records.

### **Apportionment:**

The examiner must identify and list any factors, occupational and non-occupational, which add to, or are a part of, the impairment, but are not directly resultant from the injury.(see apportionment section)

### **Capabilities Assessment:**

If requested, the physician should make a statement as to the current functional capacity of the patient. It is the physician's responsibility to determine if the impairment results in functional limitations and to inform the employer about an individual's ability and limitations. It is the employer's responsibility to identify and determine if reasonable accommodations are possible to enable the individual's performance of the essential job activities.<sup>55</sup> Not only does this clearly establish physical abilities, but also facilitates the patient/employer relationship for return to work. The Workplace Functional Ability Medical Guidelines,<sup>56 57</sup> published by the Utah Medical Association provides an excellent, comprehensive system review and report form. Functional ability evaluations should only be performed or requested if the carrier or self-insured employer makes a specific request for this service.

### **Future Medical Treatment:**

If requested, the examiner should be specific in identifying what medical treatment may be required in the future as a direct result of the industrial accident.

### **Time Periods for certain conditions to reach Medical Stability:**

Those who do impairment ratings must be aware, that for some conditions, there is a certain time period that must have passed before a condition is considered MMI. Some of these time periods are listed below:

#### **Soft Tissue Spinal Complaints**

The majority of patients with soft tissue spinal complaints resolve without any permanent residual, therefore, before considering any patient with residual soft tissue, developmental and degenerative spine complaints for an impairment, their symptoms **must have been present for a minimum of six continuous months.**

#### **Upper and Lower Extremity Painful Organic Syndromes:**

A musculoskeletal condition characterized by pain (and weakness) with use of the affected member, attributed to a lesion in the soft tissue (capsule, ligament, tendon, fascia, muscle) and documented by clinical findings that have been **present for longer than six months**.

### **Who are to do Impairment Ratings**

Only qualified physicians, who are licensed in the state of Utah and have attended advanced Utah specific training should perform impairment ratings as it relates to their specialty. When the treating physician is unable or uncomfortable in performing the impairment rating, it is recommended that the those involved with the impairment evaluations see that they are performed by physicians that have training and expertise with the patient's condition and Utah's impairment rating methodology.

The Labor Commission recommends that physicians doing impairment ratings attend specialty training on the 5<sup>th</sup> edition of the AMA guides. While such courses are designed to improve skills in the area of impairment ratings for the 5<sup>th</sup> edition, they all vary considerably in the length, scope and quality. Since not one of these certifications is universally recognized, the Utah Labor Commission does not accept certification from these or other courses and does not certify physicians as raters. In that Utah has it's own comprehensive rating guidelines, the listing of certifications by these or other agencies, such as "fellow", or "board certified impairment rater" is confusing to payers and employers and therefore it is recommended that these titles not be listed on Utah's injured workers' reports.

### **Billing for Impairment Ratings**

The physician is not entitled to reimbursement under the following codes if their report does not conform with the established criteria as outlined in these guides. It is however required that the physician list licensure after signature such as M.D., D.O., D.C., D.P.M., etc., so that payers are fully aware of the physicians licensure.

### **Billing for Impairment Ratings Done by the Treating Physician**

The following codes are used to report physician evaluation and management services when the treating physician provides an impairment rating to the insurance carrier and/or employer. This is an extension or continuation of the treatment process. Codes for impairment ratings *include the usual evaluation and management of this visit*, a review of the medical records and diagnostic studies when necessary, current physical findings on which the rating is based and the written report.

Codes 99461, 99462, 99466 and 99467 are to be used by physicians on the visit when stability is declared. These codes are to be used alone and *include the concurrent evaluation and management services on that day*.

**99461** Impairment rating by the treating physician that includes diagnosis, stability, calculation of impairment, apportionment, future medical treatment and may include, if requested, capabilities assessment.

Initial 30 minutes 2.15 Units x the medical conversion factor

**99462** each additional 30 minutes 1.77 Units x the medical conversion factor

### **Billing for Impairment Ratings Done by Someone other than the Treating Physician**

#### **A Rating Physician**

**99466** Impairment rating by the treating physician that includes diagnosis, stability, calculation of impairment, apportionment, future medical treatment and may include, if requested, capabilities assessment.

Initial 30 minutes 2.65 Units x the medical conversion factor

**99467** Each additional 30 minutes - 1.77 Units x the medical conversion factor

### **General Rules for Calculating Impairment Ratings:**

The following rules are provided in order for the evaluator to properly execute an impairment rating. These rules can be applied to all systems of the body.

1. The final impairment value, whether the result of a single or combined impairment, shall be rounded off to the nearest whole number percentile.
2. There is no difference between dominant or preferred side and the non-dominant extremity.

### **Rules for When to Combine and When to Add Impairment Values:**

Always combine all of the ratings of a region--digit, hand and upper extremity-- prior to converting to the next higher level, the hand-upper extremity-Whole Person. The same process is used in the lower extremity.

In other words, when there is more than one impairment of a member, such as abnormal motion, neurological loss and amputation, the impairments must be combined at the lowest level before conversion to the next larger unit.

Range of motion loss in the same joint is added.

Range of motion loss in multiple joints is combined:

Exception: CMC, MP and IP are added in the thumb because they are each a portion of a complex motion

Ankle and subtalar are also added for the same reason.

Impairment percentages for the thumb, index, middle, ring and the little fingers are added, not combined.

Ankylosis: If multiple ankyloses are present in the same joint or area, use the largest figure for the rating.

Spinal impairments for multiple regions are combined.

Everything else is combined.

### **PAIN**

As with the 3<sup>rd</sup> and 4<sup>th</sup> editions of the AMA Guides, the 5<sup>th</sup> edition continues with the traditional statement that, "The impairment ratings in the body organ system chapters make allowances for any accompanied pain." <sup>58</sup>

Unique to the 5<sup>th</sup> edition of the AMA guides, is a new and lengthy chapter on pain, along with the different methodology found in the neurological, upper and lower extremity and spine sections, which allows additional ratings for subjective pain. This new methodology provides the rating physician leeway to add up to an additional 3% Whole Person if the rater believes the individual to have a pain-related impairment that has "increased the burden of his or her condition slightly." <sup>59</sup>

The basic challenge for a system of rating pain related impairments is to incorporate the subjectivity associated with pain into an impairment rating system, whose fundamental premise is that impairment assessment should be based on objective findings. The inherent subjectivity of pain is incongruent with the guides attempts to assess impairment on the basis of objective measures of organ dysfunction, as it requires that determinations of pain intensity and the restrictions imposed by it must be largely based on subjective patients reports. <sup>60</sup> Yet subjective pain has been shown to be influenced by beliefs, expectations, rewards, attention and training. These markers reflect social and environmental factors as much as they reflect pain. <sup>61</sup> Prospective studies consistently show that the onset of disabling pain is highly associated with issues such as job dissatisfaction, lack of support at work, stress and perceived inadequacy of income. Once initiated, the progression of pain to chronicity is contingent upon similar factors. Financial compensation, receipt of work-related sickness payments and compensation related litigation are also associated with chronicity, as are social and economic factors as poor education, language problems and low income. Chronicity is also favored by individual tendencies to be preoccupied with one's body and symptoms. Even those individuals with clear-cut radicular pain from disk herniation, application for retirement at six months

was best predicted by depression and daily hassles at work. In the case of injured workers, performance on functional capacity evaluation is reduced if the worker is informed that the test results will be used to determine work classification. Industrial injuries and compensation situations appear to provide a disproportionate number of individuals with such issues.<sup>62</sup>

After reviewing the various philosophies, chapters and charts on pain, the Utah Impairment Rating committees expressed considerable concerns that this new subjective methodology for awarding percentages of impairment for pain related behaviors has not been used and tested on a widespread basis, as have other impairment ratings systems.<sup>63</sup> The committee felt that adopting this subjective methodology would increase interrater variability and secondary litigation. Therefore it was the committee's belief that the methodology found in the prior editions adequately considered pain and recommended that **no additional award will be allowed for pain under Chapters 13, 16, (except for CRPS, 16.5e), 17 and 18 of the AMA 5<sup>th</sup> edition of the Guides**, until advances in diagnostic technology and clinical experience make pain related impairment ratings feasible for individuals with pain syndromes.

### **Myofascial Pain Syndrome, Fibromyalgia and Chronic Fatigue Syndrome:**

The diagnoses of fibromyalgia, CFS, and myofascial pain syndromes are based on an individual's report of widespread subjective pain and reports of tenderness during physical examination. Despite extensive research, no specific underlying biological abnormality has been discovered to explain the reports of these people. In that the medical community has not achieved consensus on how to construe such conditions, these conditions are not to be rated.<sup>64</sup>

### **Deviations from Standard Impairment Procedures:**

The examining physician is responsible for the final rating. Reasons for deviations should be very unusual and supported by medical determination based on reasonable medical probability and supported by objective considerations that the guides (either Utah's or the AMA) have failed to properly consider.

Physicians are reminded that their report should be based on medical probability, (greater than 50%) rather than opinions based on surmise, speculation, conjecture, or unsubstantiated clinical methods.

### **Apportionment Overview**

To conform with the Utah Code, the terminology **PRIOR IMPAIRMENT** will be used and replaces various other descriptors, such as: pre-existing conditions, preexisting symptomatic conditions, previously existing conditions, previously existing symptomatic conditions.

It must be recalled that the awarding for permanent impairment and allocation to prior impairing conditions is not a precise and exact formulation. Various assumptions are made and included, based on reasonable medical probability, generally considered as greater than 50% chance. There will be varying responses of individuals who seemingly fit the same condition or category. No present method or knowledge is available to make differentiations, which may include a myriad of other factors. The average or usual person must be considered together with the results one anticipated from an accepted treatment program. Thus, ratings are considered a best estimate, based upon a complex study of all the factors involved. To arrive at the most valid conclusion, one must have available all of the applicable information that can be obtained. Assessing conclusions on incomplete data should be avoided, unless such data is unobtainable. If one believes additional data may alter the conclusions, it would be wise to so state.

### **When and How Impairment Benefits are Apportioned:**

When a permanent impairment results from the addition or combination of a prior impairment with the existing impairment from the industrial accident, then the permanent impairment is apportioned (or distributed) between the current injury and the prior impairment condition(s). Physicians must understand that apportionment generally applies only to permanent impairments. Apportionment of the final rating is necessary if there is objective medical documentation that a prior ratable impairment existed before the industrial event for the same anatomical area, structure or condition. In order to apportion any condition as a prior impairment, the condition would need to have been ratable by either the AMA Guides or Utah's 2002 Impairment Guides before the industrial event and must be

based on reasonable medical probability (i.e., greater than 50%). The total impairment is calculated and then the prior impairment is calculated and deducted. The remaining amount would then be due to the industrial accident.

Not all cases can be apportioned. If the physician cannot, with a reasonable degree of medical probability, estimate the level of impairment that would have existed, absent the injury, then the physician cannot apportion the final impairment.

Apportionment cannot be based solely on the existence of a disease, abnormality, or disorder. If a person has an occult disorder (spondylolysis, spondylolisthesis or significant degenerative changes, etc.) that would not have qualified for a rating before an event, then the final rating is not subject to apportionment. (Such a condition, while not clearly increasing the incidence of injury, does increase the morbidity, lessen the degree of recovery and increases the likelihood of surgery. Those issues that cannot be measured in any reasonable, objective way cannot qualify for an apportionment.)

**What Schedule to Use When Apportioning Pre-existing Conditions:**

If an individual has received a prior rating from the Utah’s 1994 Modification of the AMA Guides, the 4th Edition of the AMA Guides, the Utah 1997 Guides, or the New 2002 Impairment Guides, involving the same anatomical area as the industrial accident, then this prior rating would be subtracted from the new rating. If the person has received a prior rating for conditions from any other schedule than those listed above, the rater is to subtract the prior rating from the new rating, up to the amount *they would have received for the same condition under this schedule*. If the person has a preexisting condition that is listed in these guidelines and has not been rated for this problem, the rater should use these guidelines to document, as best they can, a rating for the preexisting conditions, which is then subtracted from the current rating. (See Spine Example 24)

If the person has preexisting conditions that are not found in these guidelines and has not been rated for these problems, the rater should use the Fifth Edition of the AMA Guidelines to document, as best they can, a rating for the pre-existing conditions, which is then subtracted from the current rating.

<b>Table 2</b>	
<b>What Schedule to Use When Apportioning Prior Ratable Conditions</b>	
<b>Patient has a prior ratable condition for the same body area being rated</b>	<b>What schedule to apply</b>
<b>Prior impairment was calculated from:</b> a. <i>The AMA’s 4<sup>th</sup> Edition Guides, or</i> b. <i>The 1994 or the 1997 Utah Modifications to the AMA’s 4<sup>th</sup> Edition, or</i> c. <i>This “2002 Utah’s Impairment Guides” or the accepted portions of the AMA’s 5<sup>th</sup> edition</i>	Subtract prior impairment directly for the new calculated impairment.
<b>Prior impairment was calculated from:</b> Any schedule other than the above:	Establish what the rating would have been under the schedule, "Utah’s 2002 Impairment Guides". If the condition to be rated is not included there, use the <i>AMA’s 5<sup>th</sup> Edition</i> . Subtract this % impairment from the total impairment %.
<b>A prior condition existed that was never rated, but contributes to the final rating.</b>	Establish what the rating would have been under this schedule, "Utah’s 2002 Impairment Guides". If the condition to be rated is not included here, use the <i>5<sup>th</sup> Edition</i> . Subtract this figure from the new calculated total impairment.

## Spine And Pelvis Conditions

### Utah's 2002 Impairment Guides:

Physicians are to use the following sections to rate patients with residual spinal problems from an industrial accident and not the AMA Editions. With this Utah's 2002 Impairment Guide, the patient is placed in the category that best describes their condition. The physician should never combine two impairments for the same spinal segment, except for completely different problems, which would be unusual. For example, if one has an L1 compression fracture and a herniated disc at L4, these would be regarded separately and combined. There will be unusual cases that do not fit these categories which should be rated in relationship to and utilizing these categories for guidelines. As with other sections of the Utah or AMA Guides, before an impairment rating is considered, the patient must be medically stable.

The majority of patients with soft tissue spinal complaints resolve without any permanent residual, therefore, before considering any patient with residual soft tissue, developmental and degenerative spine complaints for an impairment, their symptoms **must have been present for a minimum of six continuous months**.

It is recognized that all impairment ratings are a best estimate. Arriving at apportionment in the soft-tissue spine impairments has been extremely variable and unreliable. While **Schedule V, Severity Indexing For Apportionment of Schedule I**, may have some shortcomings, many variables have been considered and Schedule V appears to be a reasonable and logical approach to improve uniformity and reliability.

Each spinal area involved--the cervical-thoracic and thoracic-lumbar in Schedule I and the cervical, thoracic and lumbar in Schedule II is each considered a one-organ system. All numbers within Schedules I or II are to be added. When other organ systems are involved such as neurological loss, their values are combined with the spine.

### Spine Impairment Clarification Concepts:

- If a person has a disc herniation or excision, followed by a stabilized period and then later incurs a recurrent disc at the same level treated surgically, this new herniated disc would be rated according to Schedule II and the rating scheduled for the initial disc would be apportioned off the total. Whether it is the same lateralization makes no difference. This is true even though the circumstances that precipitated a recurrence may be minimal. There is no additional impairment for a recurrent disc treated conservatively, unless there is evidence of additional residual radiculopathy. [See Example 15]
- If a person has a disc herniation or excision followed by a stabilization period and then, later, incurs a herniation of a disc at a different level, the additional rating for the second herniation would be according to this schedule. If one includes the prior event in the rating, it would be apportioned off so the net result would be the same. [See Example 15, 16, 24, 25]
- Add-ons for additional levels II B, II D and II F can be applied only one time for the same level.
- If prior problems are not related, they must be deducted (apportioned), if it is required or requested that they be listed.
- Repeat explorations at the same level, or repeat fusions at the same level, only increase the impairment rating by 2%/per surgery. (See II-C)
- If a person only had degenerative changes, (no ratable conditions on Schedule V) and sustains a specific pathological condition, such as a herniated disc, no apportionment to the degeneration is made, as the specific injury is rated and the previous condition was not ratable.
- Two completely different spinal areas involved should be calculated separately and combined.

## SOFT TISSUE, DEVELOPMENTAL and DEGENERATIVE SPINE CONDITIONS SCHEDULE ONE

**Should only be used if no surgery has been performed**

SCHEDULE I. SOFT TISSUE, DEVELOPMENTAL and DEGENERATIVE SPINE CONDITIONS (Whole Person) Schedule I should only be used <b>if no surgery has been performed.</b> Schedule I requires a minimum of six months duration of symptoms from the time of the injury to the impairment rating. The rater is to use only one condition from 1A category through IE, one time.		
<i>Placement of a patient within one of these categories is dependent primarily on the history and physical findings. The examiner should also consider any "pain behaviors" that may be present.<sup>1</sup></i>	<b>CERVICAL- THORACIC</b>	<b>THORACIC- LUMBAR</b>
<b>I-A. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>relative minor injury event</b> . No evidence of acute changes on imaging and <b>none to minimal activity</b> modifications required.	0%	
<b>I-B. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>moderate injury event</b> . May have evidence of <b>mild degenerative changes</b> on imaging and <b>may- have permanent activity restrictions</b> .	3%	
<b>I-C. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>significant injury event</b> . May have imaging evidence of <b>moderate to severe degenerative changes</b> , including spondylolysis. <b>Should have permanent activity restrictions</b> .	5%	
<b>I-D. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>significant injury event</b> . This would include imaging evidence of objectifiable, disc herniation (s) that displaced nervous tissue <b>treated without surgery</b> , spondylolisthesis or segmental instability. <b>Should have permanent activity restrictions</b> .	7%	
<b>I-E. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>significant injury event</b> and a spondylolisthesis, Grade III or IV.	8%	
<b>ADD-ONS for above conditions in Schedule I. (Whole Person)</b>		
<b>I-F. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with continued pain, rigidity and <b>Imaging evidence</b> of objectifiable, disc herniation that displaces nervous tissue and has occurred from a <i>subsequent injury, at another level other than the first</i> and was treated without surgery.	3% per level	
<b>I-G. Neurological: Radiculopathy *</b> (If, after <b>one year</b> , the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 16-10,16-11,16-13,17-37,15-17,15-18 and <i>combine</i> the new radiculopathy rating, <i>in place</i> of the 3% listed here. [See <b>Radiculopathy Schedule V</b> ]*	3% for each involved nerve root (Combined)	

<sup>1</sup> AMA 5<sup>TH</sup> edition

## SCHEDULE II. SURGICALLY TREATED SPINE CONDITIONS (Whole Person)

<b>SCHEDULE II. SURGICALLY TREATED SPINE CONDITIONS (Whole Person)</b> <b>For conditions found in Schedules II and III, no amount of time is required from the injury and the calculation of an impairment.</b> <b>Apportionment for conditions listed below is direct and Table V's methodology does not apply.</b> (See Examples)	
	<b>CERVICAL -THORACIC- LUMBAR</b>
<b>II-A. First spinal surgery at one level in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (Assigned one time per patient)	10% (one time per patient)
<b>ADD-ONS for Schedule II-A . (Whole Person)</b>	
<b>II-B.</b> Medically documented injury, with continued pain and rigidity <b>and imaging evidence</b> of objectifiable, disc herniation that displaces nervous tissue and has occurred from <i>the same or</i> subsequent injury, <i>at another level other than the first</i> and was treated either conservatively or surgically. This would also include <b>surgery</b> for severe degenerative or posttraumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (This is applied only one time per level per patient and not to be applied to levels explored.)	Add 3% (one time per level per patient)
<b>II-C. Second or subsequent spinal operation in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis.	Add 2% per operation
<b>II-D. Spinal Fusions</b> ( For the first level fused)	Add 3% for first level (use one time only)
<b>II-E. Fusions: Additional level (s)</b> (i.e. 3 segments = 2 levels)	Add 2% for each additional level. This is to be used only one time per level
<b>II-F. Neurological: Radiculopathy</b> * (If , after <b>one year</b> , the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 13-23 & 13-24 and <i>combine</i> the new radiculopathy rating, <i>in place</i> of the 3% listed here. [See Schedule Below]*)	Combine 3% for each involved nerve root
<b>II-G.</b> Minor procedures or operations, such as hardware removal	0%

- **Radiculopathy Schedule (see next page)**



**\* Radiculopathy Schedule**

(Must Have A Score Greater Than or Equal to 3 to Qualify)

Objective Testing	Documented Objective Findings at the Time of Rating	Score
<b>Imaging</b>	Significant Disc Protrusions <i>That Displace Nerve Tissue And Or Bony/Mechanical Encroachment On</i> The Imaging Which Correlates Anatomically With The Findings On The Neurological Examination	2
<b>Muscle Involvement</b>	Objective Myotomal Weakness And/Or Atrophy >2cm Compared To Uninvolved Limb	2
<b>EMG Changes</b>	Findings Of Fibrillation Potentials In The Distribution Of Myotome	2
<b>Sensory Involvement</b>	Objective Alteration Of Sensation (Sharp/Dull, Hot /Cold, Light Touch, ) Consistent With Specific Dermatomal Distribution	1
<b>Reflex Changes</b>	Loss Of/Or Diminished Deep Tendon Reflexes,( Biceps-Triceps-Brachioradialis-Patellar-Or Ankle Jerk ) As Compared To Non-Affected Side.	1
<b>Tension –Compression Signs</b>	Spurling's or Straight Leg Raise	1

**SCHEDULE III. VERTEBRAL FRACTURES (Whole Person)**

**SCHEDULE III. VERTEBRAL FRACTURES (Whole Person)**

The impairments listed below are the same with or without surgery.

If a fracture(s) is healed without functional impairment, there is no rating given.

Rater is to use only the highest ratings from either sections III-A or III-B or III-C.

Non-adjacent fractures at distinctly different areas may be rated separately and combined.

Accompanying impairments to other organ systems are calculated separately and combined with the fracture impairment.

**III-A: COMPRESSION FRACTURE(s), THAT REMAIN AT MEDICAL STABILITY**  
**THE BELOW LISTED IMPAIRMENTS ARE THE SAME WITH OR WITHOUT SURGERY.**  
 (Pre-existing compression fractures should be rated only when there has been aggravation by a new injury, shown by **objective radiological** findings. These values should be addressed as a pre-existing factor.)  
 If surgery is performed, the pre-operative compression percentage amount is used for the rating.

	Worst vertebra		
III-A:% Vertebral Compression Fracture	<i>CERVICAL</i>	<i>THORACIC</i>	<i>LUMBAR</i>
III-A-1: 10% or less	3%	2%	3%
III-A-2: 11% to 25%	6%	4%	4%
III-A-3: 26% to 50%	14%	6%	10%
III-A-4: Greater than 50% (Burst Fracture)	19%	9%	(Include T12 with Lumbar) 15%
III-A-5: Fusion- If it is required to extend the fusion over more than three vertebral segments, add			5% one time
III-A-6: For multiple fractures listed in III-A, with more than one level involved			Add 3% one time
III-A-7. Radiculopathy * (If , after one year, the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 16-10,16-11,16-13,17-37,15-17,15-18 and <i>combine</i> the new radiculopathy rating, <i>in place of</i> the 3% listed here. (See Below*))			Combine 3% one time
<p align="center"><b>III-B: X-RAY EVIDENCE OF VERTEBRAL FRACTURES WITH <u>AXIAL DISLOCATIONS</u> INVOLVING POSTERIOR ELEMENTS (REGARDLESS OF DEGREE OF VERTEBRAL COMPRESSION )</b>                      Including Those Fractures Which Involve the Pedicle, Lamina, or Articular Process</p>			
III-B-1 No Surgery is performed and reduction is Anormal			6%
III-B-2: Surgery performed and normal reduction (Includes fusion)			14%
III-B-3: No surgery performed and reduction is not normal			17%
III-B-4: Surgery performed with poor reductions (includes fusion)			20%
III-B-5: Fusion- If it is required to extend the fusion over more than three vertebral segments, add			5% one time
III-B-6: For multiple fractures listed in III-B, with more than two vertebrae involved			Add 3% one time
III-B-7: Radiculopathy * (If, after one year, the neurological deficits exceed 3% WP, then calculate the deficits as described from Tables 16-10,16-11,16-13,17-37,15-17,15-18 and <i>combine</i> the new radiculopathy rating, <i>in place of</i> the prior 3% awarded. [See Radiculopathy Schedule]*)			Combine 3% one time

<b>SCHEDULE III. VERTEBRAL FRACTURES</b> ( <i>Whole Person</i> ) The impairments listed below are the same with or without surgery. If a fracture(s) is healed without functional impairment, there is no rating given. Rater is to use only the highest ratings from either sections III-A or III-B or III-C. Non-adjacent fractures at distinctly different areas may be rated separately and combined. Accompanying impairments to other organ systems are calculated separately and combined with the fracture impairment.	
<b>III-C: OTHER FRACTURES NOT LISTED ABOVE</b> <b>THE BELOW LISTED IMPAIRMENTS ARE THE SAME WITH OR WITHOUT SURGERY.</b>	
<b>III-C-1. One or more transverse process or spinous process fracture healed without significant displacement or symptoms:</b>	0%
<b>III-C- 2. One transverse process or spinous process fracture healed with significant displacement and persistent symptoms remaining:</b>	3%
<b>III-C-3 More than one transverse process or spinous process fracture which have not healed with significant displacement and persistent symptoms remaining:</b>	5%
<b>III-C-4. Posterior elements healed without displacement or functional impairment.</b>	0%
<b>III-C-5. Posterior elements healed with or without displacement, but requiring spinal surgical intervention.</b>	10%
<b>III-C-6. Posterior elements healed with or without displacement requiring surgical fusion</b>	Add 3%
<b>III-C-7. Fusions over more than three segments add: (This is not to be used in conjunction with III-C-6)</b>	5% one time
<b>III-C-8. Radiculopathy * (If , after one year, the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 13-23 &amp; 13-24 and <i>combine</i> the new radiculopathy rating, <i>in place</i> of the 3% listed here. [*See Radiculopathy Schedule]</b>	Combine 3% one time

### Schedules for Calculating Neurological Loss

The methodology and schedules to be used in the calculation of neurological loss is contained in the Neurological section of the AMA 5<sup>th</sup> edition, page 482 – 484.

### Spine With Associated Severe Neurological Injuries

For consistency in evaluating spinal impairments with associated severe neurological involvement, the following should be used whenever possible, eliminating the need for multiple system evaluations. (These are best applied in more isolated circumstances or for other conditions) They are included by identification or implications in the categories as listed below. For spinal conditions with related impairments that clearly fall within the following classifications, use the *AMA Guides, 5th Edition*, Rating Corticospinal Tract Damage, (page 395) and the related text in the 2002 Utah Impairment Guides. The “Nerve Root and/or Spinal Cord Model”, found in the Spinal ROM section, on page 423, is not to be used.

## Pelvis

<b>SCHEDULE IV. THE PELVIS (Whole Person)</b>	
Healed Fracture without displacement or residual signs.....0% Healed fracture with displacement and without residual sign(s) involving: a. Single ramus..... 0% b. Rami, bilateral..... 0% c. Ilium.....0% d. Ischium.....0% e. Symphysis pubis, without separation.....5% f. Sacrum.....5% g. Coccyx.....0%	Healed fracture(s) with displacement, deformity, and <i>residuals problems</i> (s) involving: a. Single ramus.....2% b. Rami, bilateral .....5% c. Ilium .....2% d. Ischium, displaced 1 inch or more .....10% e. Symphysis pubis, displaced or separated .....15% f. Sacrum, into sacroiliac joint.....10% g. Coccyx, non union or excision..... 5% h. Coccyx, displacement.....3%* i. Fracture into acetabulum .....Evaluate according to hip

\*Residual problem of persistent sitting intolerance <20 min

## Schedule I Form for Computing Spinal Impairments

It is recommended that the following applicable form(s), along with supporting documentation, be submitted for spine impairments ratings.

Schedule I Form for Computing Spinal Impairments			
Use This Schedule if No Surgery has been Performed			
Patient's Name:	Date:		
<i>Placement of a patient within one of these categories is dependent primarily on the history and physical findings. The examiner should also consider any "pain behaviors" that may be present</i>		<b>CERVICAL-THORACIC</b>	<b>THORACIC-LUMBAR</b>
<b>I-A. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>relative minor injury event</b> . No evidence of acute changes on imaging and <b>none to minimal activity</b> modifications required.	0%		
<b>I-B. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>moderate injury event</b> . May have evidence of <b>mild degenerative changes</b> on imaging and <b>may have permanent activity restrictions</b> .	3%		
<b>I-C. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>significant injury event</b> . May have imaging evidence of <b>moderate to severe degenerative changes</b> , including spondylolysis. <b>Should have permanent activity restrictions</b> .	5%		
<b>I-D. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>significant injury event</b> . This would include imaging evidence of objectifiable, disc herniation (s) that displaced nervous tissue <b>treated without surgery</b> , spondylolisthesis or segmental instability. <b>Should have permanent activity restrictions</b> .	7%		
<b>I-E. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>significant injury event</b> and a spondylolisthesis, Grade III or IV.	8%		
<b>ADD-ONS for conditions in Schedule I-D. or I-E. (Whole Person)</b>			
<b>I-F. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with continued pain, rigidity and <b>Imaging evidence</b> of objectifiable, disc herniation that displaces nervous tissue and has occurred from a <i>subsequent injury, at another level other than the first</i> and was treated without surgery.	3%		
<b>Add Impairment (Total Amount for Spine)</b>			
<b>I-G. Neurological: Radiculopathy</b> * (If, after <b>one year</b> , the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 16-10,16-11,16-13,17-37,15-17,15-18 and <i>combine</i> the new radiculopathy rating, <i>in place</i> of the 3% listed here. (See Below*))	3% Combin ed		
<b>Total Impairment Value Without Apportionment</b>			
<b>Apportionment:</b>			
<b>Final Impairment Related to the Last Event:</b>			
Signature and Title of Physician doing Rating:			

**Schedule II Form for Computing Surgical Spinal Impairments**

**Schedule II Form for Computing Surgical Spinal Impairments**  
Use for Surgically Treated Spine Conditions

Patient's Name:		Date		
<b>Injury Events</b>		<i>Initial Event</i>	<i>Second Event</i>	<i>Third Event</i>
<b>II-A. First spinal surgery at one level in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (Assigned one time per patient.)		10% one time per patient		
<b>ADD-ONS for Schedule II-A . (Whole Person)</b>				
<b>II-B.</b> Medically documented injury, with continued pain and rigidity <b>and imaging evidence</b> of objectifiable, disc herniation that displaces nervous tissue and has occurred from <i>the same or</i> subsequent injury, <i>at another level other than the first</i> and was treated either conservatively or surgically. This would also include <b>surgery</b> for severe degenerative or posttraumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (This is applied only one time per level per patient and not to be applied to levels explored.)		Add 3% (one time per level per patient)		
<b>II-C. Second or subsequent spinal operation in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis.		Add 2% per operation		
<b>II-D. Spinal Fusions</b> ( For the first level fused)(use one time only)		3%		
<b>II-E. Fusions: Additional level (s)</b> / each additional level. This is to be used only one time per level		2%		
<b>II-G.</b> Minor procedures or operations, such as hardware removal		0%		
<b>Add Impairment (Total Amount for Spine)</b>				
<b>II-F. Neurological: Radiculopathy</b> * (If , after <b>one year</b> , the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 16-10,16-11,16-13,17-37,15-17,15-18 and <i>combine</i> the new radiculopathy rating, <i>in place</i> of the 3% listed here. (See Below*)		3% Combined		
<b>Total Impairment Value Without Apportionment</b>				
<b>Apportionment:</b>				
<b>Final Impairment Related to the Last Event:</b>				
<b>Signature and Title of Physician doing Rating:</b>				
*[See Radiculopathy Schedule]				

## SCHEDULE V-Severity Indexing Prior Conditions

It is recognized that all impairments are best estimates. Arriving at apportionment for LS spine impairments in the past has been extremely variable and unreliable. While Schedule V, Severity Indexing for apportionment of Schedule I, may have some shortcomings, many variables have been considered and it appears to be a reasonable and logical approach to improve uniformity and reliability.

<b>Schedule V. Severity Indexing for Apportionment of Schedule I.</b>			
(This applies only to the Impairment Process)			
<b>Schedule I requires a minimum of six months duration of symptoms, from the time of the injury and the impairment rating</b>			
Score	0	1pt.	2pts.
<b>V-A</b> Time Lost from Work in the Last 12 Months Because of Symptoms in the Same Spinal Region.	0	1-3 days	>3 days
<b>V- B</b> Number of Prior Episodes in the Same Spinal Region	0	1-3	>3
<b>V-C</b> Duration since Last Episode	>3 years	1-3 Years	<1year
<b>V- D</b> Prior Work Restrictions Because of Problems in the Same Spinal Region	No= 0	Temporary	Permanent
<b>V-E</b> Prior Objective Testing to the Same Spinal Region: EMG-NCV, X-ray, MRI-CT, Bone Scan	0	If taken prior to 2 years	If taken within the last 2 years
<b>V-F</b> Prior to latest claim, what ongoing Medical, Chiropractic Visits, Physical Therapy Visits were received for an injury to the Same Spinal Region.	0 -2 times in last 3 yrs	3-6 times in last 3 yrs	>6 in last 3 yrs
<b>V-G</b> Spondylolysis with Spondylolisthesis		<u>&lt;25% slip</u>	>25% Slip
<b>V-H</b> Radiculopathy (As objectified by Radiculopathy Schedule)	No History		<u><b>Prior History</b></u>

1-2 pts. = no Apportionment  
 3pts. = 10% may be apportioned off as a prior ratable condition  
 4pts. = 20% may be apportioned off as a prior ratable condition  
 5pts. = 30% may be apportioned off as a prior ratable condition  
 6pts. = 40% may be apportioned off as a prior ratable condition  
 7pts. = 50% may be apportioned off as a prior ratable condition  
 8pts. = 70% may be apportioned off as a prior ratable condition  
 9pts. = 90% may be apportioned off as a prior ratable condition  
 >10 pts. = 100% may be apportioned off as a prior ratable condition

### Summary of Basic Principles of Apportionment

- Apportionment applies only to permanent impairment.
- Impairment that directly results from the current injury being evaluated is not apportioned.
- Ratable impairment that existed prior to the injury is subject to apportionment.
- In all cases, the apportionment may not be speculative. Actual factors of prior impairments are to be discussed with sufficient reason in support of the apportionment.
- Spondylolysis with Spondylolisthesis are weighted, but no deduction without prior symptoms

## EXAMPLES - SPINE IMPAIRMENTS

### Contents:

- Example 1: Mechanical Back Pain, 0%
- Example 2: Mechanical Back Pain 3%
- Example 3: Mechanical Back Pain 5%
- Example 4: Mechanical Back Pain--with Referred Pain
- Example 5: Mechanical Back Pain--with Referred Pain and a Prior History
- Example 6: Cervical-Thoracic Pain Without Radiculopathy
- Example 7: Cervical-Thoracic Pain Without Radiculopathy and with Clinical Manifestations of Overt Pain Behaviors
- Example 8: Low Back Pain-with Radiculopathy--No Surgery
- Example 9: Low Back Pain--Post-Surgery
- Example 10: Low Back Pain, Post-Surgery and with Radiculopathy
- Example 11: Low Back Pain, Post-Surgery, with Foot Drop
- Example 12: Spondylolisthesis--Without History
- Example 13: Spondylolisthesis with Radiculopathy--Without History
- Example 14: Spondylolisthesis with Radiculopathy and Prior History
- Example 15: Prior History of Disc Problems Requiring Surgery; and now, with a Recurrent Disc Herniation, Needing Another Surgery
- Example 16: Second Disc Injury, Treated Non-operatively
- Example 17: First Industrial Disc Injury--Second Disc Herniation requiring a Second Surgery
- Example 18: Disc Injury--Undergoing 3 Surgeries, Including a Fusion
- Example 19: Degenerative Disc Disease--with Two-Level Decompression
- Example 20: Compression Fractures with Prior History and Rating
- Example 21: Burst Fracture Requiring Fusion
- Example 22: Coccygodynia
- Example 23: Prior Nonindustrial Injury with Two Industrial Injuries and Ratings.
- Example 24: Prior Industrial Rating with Another System, Now with a New Injury
- Example 25: Prior Industrial Rating with Another System, Now with a New Injury
- Example 26: Impairment Related to Two-Disc Operated on from One Event

### Example 1: Mechanical Back Pain

A thirty-four year old construction worker with a low-back injury claim over six months ago follows a relative minor event. He has had a course of physical therapy, medications and chiropractic physician's visits. Although he has continued to work, he still has subjective complaints of intermittent low back pain and over the counter medications are occasionally used. He has been declared medically stable and released to full duty. X-rays are normal.

<b>Example 1</b> <b>Schedule I Form for Computing Spinal Impairments</b>	<i>THORACIC -LUMBAR</i>
<b>I-A. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>relative minor injury event</b> . No evidence of acute changes on imaging and <b>none to minimal activity</b> modifications required.	0%
<b>Final Impairment Related to the Last Event:</b>	0%



### Example 2: Mechanical Back Pain

A twenty-three year old construction worker had a low-back injury claim six months ago following a slip on the ice wherein he landed on his buttocks. He had no known medical history of prior back pain. His x-rays have been read as normal and he has undergone a course of physical therapy and medications. Although he has continued to work, he still complains of intermittent low-back pain with referred pain into the back of the legs, that does not go into his feet. These symptoms have been consistent without any pain behaviors noted. He has primarily used over-the-counter medications, but occasionally requires a prescription anti-inflammatory. Occasionally he uses an L.S. brace to work in. He has been declared medically stable and released to full duty.

<b>Example 2</b> <b>Schedule I Form for Computing Spinal Impairments</b>	<i>THORACIC -LUMBAR</i>
<b>I-B. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>moderate injury event</b> . May have evidence of <b>mild degenerative changes</b> on imaging and <b>may have permanent activity restrictions</b> .	3%
<b>Add Impairments</b>	3%
<b>Apportionment: (The amount apportioned from Schedule I must agree with Schedules I &amp; V)</b>	
<b>Impairment Related to the Last Event:</b>	3%

### Example 3: Mechanical Back Pain

A forty-four year old female has a history of a low-back injury claim six months ago following a chair collapsing under her at work, wherein she landed on her buttocks. She has had no known history of prior back trouble. She has had a course of physical therapy and medications. Although she has continued to work, she still complains of intermittent low back pain with referred pain into the back of the legs, that does not go into her feet. She has missed some time at work and now mostly uses a prescription anti-inflammatory, a TENS unit and occasionally an L.S. brace to work in. Her physical examination does not demonstrate any neurological deficit, although she does have some "give-away" weakness. She has been declared medically stable and with a 30 lb infrequent lifting weight restriction. X-rays show minimal disc space narrowing.

<b>Example 3</b> <b>Schedule I Form for Computing Spinal Impairments</b>	<i>THORACIC -LUMBAR</i>
<b>I-C. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>significant injury event</b> . May have imaging evidence of <b>moderate to severe degenerative changes</b> , including spondylolysis. <b>Should have permanent activity restrictions</b> .	5%
<b>Add Impairments</b>	5%
<b>Apportionment: (The amount apportioned from Schedule I must agree with Schedules I &amp; V)</b>	
<b>Impairment Related to the Last Event:</b>	5%

### Example 4: Mechanical Back Pain-with Referred Pain

A forty-eight year old male had a low-back injury claim six months ago following lifting a 80 lb concrete panel. He has had a course of physical therapy, medications and chiropractic physician’s care. Although he has continued to work, he still complains of intermittent low back pain with referred pain into the back of the legs, that does go into the lateral aspect of his right leg. He does not have reflex changes, weakness, or dermatomal sensory changes. He now occasionally misses some time from work and mostly uses a prescription anti-inflammatory and a TENS unit and an L.S. brace at work. He has been declared medically stable and with a 50 lb infrequent weight restriction. X-rays show early degenerative disc disease, with a CAT scan showing a disc bulge at L4-L5 touching, but not displacing the nerve roots. He has no prior significant history of prior back injury and exhibits no pain behaviors.

<b>Example 4 Schedule I Form for Computing Spinal Impairments</b>	<i>THORACIC -LUMBAR</i>
<b>I-C. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>significant injury event</b> . May have imaging evidence of <b>moderate to severe degenerative changes</b> , including spondylosis. <b>Should have permanent activity restrictions.</b>	5%
<b>Add Impairments</b>	5%
<b>Apportionment: (The amount apportioned from Schedule I must agree with Schedules I &amp; V)</b>	
<b>Impairment Related to the Last Event:</b>	5%

Discussion: Although this patient has subjective referred pain into the lateral aspect of his right leg, this alone does not qualify as a radiculopathy.

### Example 5: Mechanical Back Pain-with Referred Pain and a Prior History

A forty-eight year old male who injured his back six months ago lifting a 80 lb concrete panel. He has had a course of physical therapy, medications and chiropractic physician’s care. Although he has continued to work, he still complains of intermittent low-back pain with referred pain into the back of the legs, that does go into the lateral aspect of his right foot. He does not have reflex changes, weakness, or dermatomal sensory changes or signs of pain behavior. He occasionally misses some time from work and mostly uses a prescription anti-inflammatory and a TENS unit and an L.S. brace at work. He has been declared medically stable with a 50 lb infrequent weight restriction. X-rays show early degenerative disc disease, with a CAT scan showing a disc bulge at L4-L5 touching, but not displacing the nerve roots. He has had two prior episodes of back pain, 5 years ago in which he had no lost time and again 2 years ago, with lost time of four days. He has had ten chiropractic physician visits 2 years, with a CT scan completed then. Prior to his latest injury, he had formally been given no permanent work restrictions.

<b>SCHEDULE V. SEVERITY INDEXING FOR APPORTIONMENT OF SCHEDULE I.</b> (This applies only to the Impairment Process)			
If the history was significant enough to automatically qualify for a rating in these Utah 2002 Guides-apportion directly			
Score	0	1pt.	2pts.
<b>V-A</b> Time Lost from Work in the Last 12 Months Because of Symptoms in the Same Spinal Region.	<u>0</u>	1-3 days	>3 days
<b>V- B</b> Number of Prior Episodes in the Same Spinal Region	0	<u>1-3</u>	>3
<b>V-C</b> Duration since Last Episode	0	<u>1-3 Years</u>	<1year
<b>V- D</b> Prior Work Restrictions Because of Problems in the Same Spinal Region	<u>No= 0</u>	Temporary	Permanent
<b>V-E</b> Prior Objective Testing to the Same Spinal Region: EMG-NCV, X-ray, MRI-CT, Bone Scan	0	If ever taken	<u>If taken within the last 2 years</u>
<b>V-F</b> Prior to latest claim, what ongoing Medical, Chiropractic Visits, Physical Therapy Visits were received for an injury to the Same Spinal Region.	0 -2 times in last 3 yrs	3-6 times in last 3 yrs	<u>&gt;6 in last 3 yrs</u>
<b>V-G</b> Spondylolysis with Spondylolisthesis		<u>&lt;25% slip</u>	>25% Slip
<b>V-H</b> Radiculopathy (As objectified by Radiculopathy Schedule)			<u>Prior History</u>

1-2 pts. = no Apportionment  
3pts. = 10% may be apportioned off as a prior rateable condition  
4pts. = 20% may be apportioned off as a prior rateable condition  
5pts. = 30% may be apportioned off as a prior rateable condition  
**6pts. = 40% may be apportioned off as a prior rateable condition**  
7pts. = 50% may be apportioned off as a prior rateable  
8pts. = 70% may be apportioned off as a prior rateable condition  
9pts. = 90% may be apportioned off as a prior rateable condition  
10 pts. = 100% may be apportioned off as a prior rateable condition

<b>Example 5</b> <b>Schedule I Form for Computing Spinal Impairments</b>	<b>THORACIC- LUMBAR</b>
<b>I-C. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>significant injury event</b> . May have imaging evidence of <b>moderate to severe degenerative changes</b> , including spondylolysis. <b>Should have permanent activity restrictions.</b>	5%
<b>Add Impairments</b>	5%
<b>Less Apportionment= 6 pts from table V = 40%, 40% of 5% (I-C.) = 2% WP</b>	- 2%
<b>Impairment Related to the Last Event:</b>	3%

### Example 6: Cervical-Thoracic Pain Without Radiculopathy

Six months ago while at work, a twenty-eight year old male was sitting in the driver's seat of the vehicle he was driving, waiting at a red light, when he was struck from behind by a pickup truck traveling approximately 20 miles per hour. His diagnostic workup has included plain x-rays and a MRI, which were found to be within normal limits. He has been treated with chiropractic manipulation, physical therapy, anti-inflammatories and muscle relaxers. Although these treatments have helped, he still complains of neck pain, mid scapular pain, with associated headaches. He still requires occasional medication and he has had to permanently modify his occupation to avoid extensive overhead work. His physical examinations have not disclosed any overt pain behaviors and he has had no prior history of cervical or thoracic injuries.

<b>Example 6 Schedule I Form for Computing Spinal Impairments</b>	<i>CERVICAL - THORACIC</i>
<b>I-C. Medically documented injury and subjective symptoms persisting for a minimum of six months with a clinical history of a significant injury event. May have imaging evidence of moderate to severe degenerative changes, including spondylolysis. Should have permanent activity restrictions.</b>	5%
<b>Add Impairments</b>	5%
<b>Apportionment: (The amount apportioned from Schedule I must agree with Schedules I &amp; V)</b>	
<b>Impairment Related to the Last Event:</b>	5%

Discussion: Although he continues to have pain in both the cervical and thoracic area, these are both considered under I-C and awarded 5% WP.

**Example 7: Cervical-Thoracic Pain Without Radiculopathy and with Clinical Manifestations of Overt Pain Behaviors**

Six months ago while at work, a thirty-two year old female has continual complaints of neck and thoracic problems from an accident that occurred while she was sitting in the driver's seat, waiting at a red light, when she was struck from behind by a pickup truck traveling approximately 20 miles per hour. Her diagnostic workup has included plain x-rays and an MRI, which were found to be within normal limits. She has been treated with chiropractic manipulation, physical therapy, anti-inflammatories and muscle relaxers. Although these treatments have helped, she still complains of neck and mid scapular pain, with associated headaches. She requires occasional medication and has had permanent activity restrictions given which is to avoid extensive overhead work. Her physical examinations have continued to demonstrate pain behavior of both verbal and non-verbal communication of distress and suffering, including embellishing her medical history, exaggerated pain drawings and providing responses on the physical examination inconsistent with known physiology. She denies any prior trauma or symptoms to this area.

<b>Example 7 Schedule I Form for Computing Spinal Impairments</b>	<i>CERVICAL - THORACIC</i>
<b>I-B. Medically documented injury and subjective symptoms persisting for a minimum of six months with a clinical history of a moderate injury event. May have evidence of mild degenerative changes on imaging and may have permanent activity restrictions.</b>	3%
<b>Add Impairments</b>	3%
<b>Apportionment: (The amount apportioned from Schedule I must agree with Schedules I &amp; V)</b>	
<b>Impairment Related to the Last Event:</b>	3%

Discussion: Residual symptoms in both the cervical and thoracic areas are both considered under I-B and awarded 3% WP. For ratings that fall between categories, pain behaviors maybe considered for placement in a lesser impairment percent.

**Example 8: Low-Back Pain-With Radiculopathy--No Surgery**

A fifty-three year old female dock worker, injured her lower back lifting a 80 lb box eight months ago. She initially had pain into her right leg, down to the ball of her foot, with associated numbness, tingling and weakness. She underwent an MRI which demonstrated an L5-S1 HNP with right S1 nerve root displacement. Treatment has included an epidural, physical therapy, medications and bracing. She now has been declared medically stable and released for work with permanent modified restrictions of infrequent lifts of 40 lbs. Her physical exam continues to show an absent right ankle jerk, straight leg lift at 40 degrees and leg atrophy of 2 cm comparing right to left. She has no significant history of back problems.

<b>Example 8 Schedule I Form for Computing Spinal Impairments</b>		<i>THORACIC -LUMBAR</i>
<b>I-D. Medically documented injury and subjective symptoms persisting for a minimum of six months with a clinical history of a significant injury event.</b> This would include imaging evidence of objectifiable, disc herniation (s) that displaced nervous tissue <b>treated without surgery</b> , spondylolisthesis or segmental instability. <b>Should have permanent activity restrictions.</b>	7%	7%
<b>Add Impairment (Total Amount for Spine)</b>		7%
<b>I-G. Neurological: Radiculopathy *</b> (If, after <b>one year</b> , the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 16-10,16-11,16-13,17-37,15-17,15-18 and <i>combine</i> the new radiculopathy rating, <i>in place</i> of the 3% listed here. [See Radiculopathy Schedule])	3% Com bined	3%
<b>Total Impairment Value Without Apportionment</b>		10%
<b>Apportionment: (The amount apportioned from Schedule I must agree with Schedules I &amp; V)</b>		
<b>Final Impairment Related to the Last Event:</b>		10%

### Example 9: Low-Back Pain--Post Surgery

A forty-eight year old female dockworker injured her low back lifting a 80 lb box nine months ago. She initially had pain into her right leg, down to the ball of her foot, with associated numbness, tingling and weakness. She underwent an MRI, which demonstrated an L5-S1 HNP with a right S1 nerve root displacement. Treatment included an epidural, physical therapy, medications, bracing and eventually an L5-S1 discectomy four months ago. She now has been declared medically stable and released for work with permanent restrictions of infrequent lifts of 40 lbs. Her physical exam has essentially returned to normal, with complaints of occasional back and leg pain, stopping at the knee. She has had no significant history of prior back pain.

Example 9 SCHEDULE II. Use for Surgically Treated Spine Conditions		Initial Event
II-A. First spinal surgery at one level in a given spinal region, including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (Assigned one time per patient.)	10% one time per patient	10%
<b>Add Impairments</b>		10%
<b>Apportionment:</b>		
<b>Final Impairment Related to the Last Event:</b>		10%

### Example 10: Low Back Pain, Post Surgery and with Radiculopathy

A thirty-five year old female warehouse worker injured her low back lifting a 50 lb box eight months ago. She initially had pain into her right leg, down to the ball of her foot, with associated numbness, tingling and weakness. She underwent an MRI, which demonstrated an L5-S1 HNP with a right S1 nerve root displacement. Treatment included an epidural, physical therapy, medications, bracing and **surgery** at L5-S1. She now has been declared medically stable and released for work with permanent modified restrictions of infrequent lifts of 40 lbs. Her physical exam continues to show an absent right ankle jerk, straight leg lift at 30 degrees and leg atrophy of 2 cm comparing right to left. She has had no significant history of prior back pain.

Example 10 SCHEDULE II. Use for Surgically Treated Spine Conditions		Initial Event
II-A. First spinal surgery at one level in a given spinal region, including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (Assigned one time per patient.)	10% one time per patient	10%
<b>Add Impairment (Total Amount for Spine)</b>		10%
II-F. Neurological: Radiculopathy * (If , after <b>one year</b> , the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 16-10,16-11,16-13,17-37,15-17,15-18 and <i>combine</i> the new radiculopathy rating, <i>in place</i> of the 3% listed here. [See Radiculopathy Schedule])	3% Combined	3%
<b>Add Impairments</b>		13%
<b>Apportionment:</b>		0
<b>Final Impairment Related to the Last Event:</b>		13%

### Example 11: Low Back Pain, Post Surgery, with Foot Drop

A thirty-five year old female warehouse worker injured her low back lifting a 50 lb box. She initially had pain into her right leg down to the lateral aspect of her leg, with associated numbness, tingling and the inability to dorsiflex her foot against gravity. She underwent an MRI which demonstrated an L4-L5 HNP with right L5 nerve root displacement. Treatment has included an epidural, physical therapy, medications, bracing and surgery at L4-L5. She was declared medically stable and released for work with permanent modified restrictions of infrequent lifts of 20 lbs. Her physical exam continues to demonstrate the inability to dorsiflex her right foot against gravity and needs to wear a AFO. She has leg atrophy of 2 cm comparing right to left. Her pain is minimal, but she does have 50% reduction of sensation at the L5 distribution. She has had no significant history of prior back pain and is now **one year** since surgery.

Sensory Deficits Classification for Determining Impairment Due to Resulting from Nerve Disorders (Upper or Lower Extremity Value)		
Class	Description of sensory loss or pain	% Sensory
1	No loss of sensation , abnormal sensation, or pain	0
2	Normal sensation except for pain, or decreased sensation with or without pain, forgotten during activity	1-25
<b>3</b>	<b>Decreased sensation with or without pain, interfering with activity</b>	<b>26-60</b>
4	Decreased sensation with or without pain or minor causalgia that may prevent activity	61-80
5	Decreased sensation with severe pain or major causalgia that prevents activity	81-95%

**Sensory component, = 50% of nerve multiplied by the L5 Sensory Nerve Root value , 5%, = 3% Lower Extremity**

Motor Deficits Classification for Determining Impairment Due to Loss of Function Resulting From Nerve or Mechanical Disorders (Upper or Lower Extremity Value)		
Class	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
<b>2</b>	<b>Active movement with gravity eliminated</b>	<b>51 - 75</b>
1	Slight contraction and no movement	76 - 99
1	No contractions	100

**Motor Deficit, = 70% of nerve value multiplied by the L5 Motor nerve value 37%, =26% Lower Extremity  
26% for the motor value combined with 3% for the sensory value = 28% Lower Extremity  
28% Lower Extremity = 11% Whole Person (100% Lower Extremity = 40% Whole Person)**



<b>Example 11</b>		<i>Initial Event</i>
<b>SCHEDULE II. Use for Surgically Treated Spine Conditions</b>		
<b>II-A. First spinal surgery at one level in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (Assigned one time per patient)	10% one time per patient	10%
<b>Add Impairment (Total Amount for Spine)</b>		10%
<b>II-F. Neurological: Radiculopathy</b> * (If , after <b>one year</b> , the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 16-10,16-11,16-13,17-37,15-17,15-18 and <i>combine</i> the new radiculopathy rating, <i>in place</i> of the 3% listed here. [See Radiculopathy Schedule]		11%
<b>Final Impairment Related to the Last Event:</b>		20%

### Example 12: Spondylolisthesis without History

A forty-five year old male slipped and fell four feet, landing flat on his back six months ago. An x-ray demonstrated an L5 spondylolysis with a grade one spondylolisthesis. He was treated with a course of physical therapy, medication and uses a brace occasionally. He continues to have back pain and occasional leg pain to the back of his legs, but no reflex changes, atrophy, or dermatomal changes. He has been released to work with permanent restrictions-- not to lift over 40 lbs. He has had no significant history of back pain.

<b>Example 12</b>		<i>THORACIC-LUMBAR</i>
<b>Schedule I Form for Computing Spinal Impairments</b>		
<b>I-D. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>significant injury event</b> . This would include imaging evidence of objectifiable, disc herniation (s) that displaced nervous tissue <b>treated without surgery</b> , spondylolisthesis or segmental instability. <b>Should have permanent activity restrictions.</b>	7%	7%
<b>Add Impairments</b>		7%
<b>Apportionment:</b>		0%
<b>Impairment Related to the Last Event:</b>		7%

No apportionment is calculated, in that prior to his fall, he would not have qualified for an impairment rating.

**Example 13: Spondylolisthesis with Radiculopathy- without prior history**

A forty-five year old male slipped and fell four feet, landing flat on his back seven months ago. An X-ray demonstrated an L5 spondylolysis with a grade one spondylolisthesis and L5 bilateral foraminal narrowing. He was treated with a course of physical therapy, medication and uses a brace occasionally. He continues to have back pain and moderate right leg pain to the outside of his foot. His physical exam demonstrates a positive straight leg raise at 30 degrees, with sensory loss in the L5 distribution. A EMG demonstrated fibrillations, consistent with a right L5 radiculopathy. A CAT scan demonstrated a bilateral pars defect at L5, old in nature with severe foraminal stenosis. He has declined surgery and has been released to work, not to lift over 30 lbs, with occasional medications and bracing. Prior to his industrial accident, **he has had no history of back pain or leg pain.**

<b>Example 13 Schedule I Form for Computing Spinal Impairments</b>		<i>THORACIC -LUMBAR</i>
<b>I-D. Medically documented injury and subjective symptoms persisting for a minimum of six months with a clinical history of a significant injury event.</b> This would include imaging evidence of objectifiable, disc herniation (s) that displaced nervous tissue <b>treated without surgery</b> , spondylolisthesis or segmental instability. <b>Should have permanent activity restrictions.</b>	7%	7%
<b>Add Impairment (Total Amount for Spine)</b>		7%
<b>I-G. Neurological: Radiculopathy</b> * (If , after <b>one year</b> , the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 16-10,16-11,16-13,17-37,15-17,15-18 and <i>combine</i> the new radiculopathy rating, <i>in place</i> of the 3% listed here. *[See Radiculopathy Schedule]	3% Combined	3%
<b>Total Impairment Value Without Apportionment</b>		10%

No apportionment is calculated, in that prior to his fall, he would not have qualified for an impairment rating.

### Example 14: Spondylolisthesis with Radiculopathy and Prior History

A forty-five year old male slipped and fell four feet, landing flat on his back seven months ago. An X-ray demonstrated an L5 spondylolysis with a grade one spondylolisthesis and L5 bilateral foraminal narrowing. He was treated with a course of physical therapy, medication and uses a brace occasionally. He continues to have back pain and moderate right leg pain radiating to the outside of his leg and to the top of his foot. His physical exam demonstrates a positive straight leg raise at 30 degrees on the right, with sensory loss in the L5 distribution. A EMG demonstrated fibrillations, consistent with a L5 radiculopathy. A CAT scan demonstrated a bilateral pars defect at L5, old in nature. He has been released to work, not to lift over 50 lbs, with occasional medications and bracing. He has a prior history of back pain 11 months ago, where he hurt himself taking out the garbage. With that episode he had x-rays taken, missed three days work, saw his personal physician two times and had a positive EMG. Between his first and second episode, he continued to use a brace and NSAIDS intermittently.

Schedule V. Severity Indexing for Apportionment of Schedule I. (This applies only to the Impairment Process)			
If the history was significant enough to automatically qualify for a rating in these 2002 Guides--apportion directly			
Score	0	1pt.	2pts.
<b>V-A</b> Time Lost from Work in the Last 12 Months Because of Symptoms in the Same Spinal Region.	0	<u>1-3 days</u>	>3 days
<b>V- B</b> Number of Prior Episodes in the Same Spinal Region	0	<u>1-3</u>	>3
<b>V-C</b> Duration since Last Episode	0	1-3 Years	<u>&lt;1year</u>
<b>V- D</b> Prior Work Restrictions because of Problems in the Same Spinal Region	<u>No= 0</u>	Temporary	Permanent
<b>V-E</b> Prior Objective Testing to the Same Spinal Region: EMG-NCV, X-ray, MRI-CT, Bone Scan	0	If ever taken	<u>If taken within the last 2 years</u>
<b>V-F</b> Prior to latest claim, what ongoing Medical, Chiropractic Visit, Physical Therapy Visits were received for an injury to the Same Spinal Region.	<u>0-2 times in last 3 yrs</u>	3-6 times in last 3 yrs	>6 in last 3 yrs
<b>V-G</b> Spondylolysis with Spondylolisthesis		<u>&lt;25% slip</u>	>25% Slip
<b>V-H</b> Radiculopathy (As objectified by Radiculopathy Schedule)			<u>Prior History</u>

**9pts. = 90% may be apportioned off as a prior rateable condition**

<b>Example 14</b>		<i>THORACIC-LUMBAR</i>
<b>Schedule I Form for Computing Spinal Impairments</b>		
<b>I-D. Medically documented injury and subjective symptoms persisting for a minimum of six months</b> with a clinical history of a <b>significant injury event</b> . This would include imaging evidence of objectifiable, disc herniation (s) that displaced nervous tissue <b>treated without surgery</b> , spondylolisthesis or segmental instability. <b>Should have permanent activity restrictions.</b>	7%	7%
<b>Add Impairment (Total Amount for Spine)</b>		7%
<b>I-G. Neurological: Radiculopathy</b> * (If, after <b>one year</b> , the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 16-10,16-11,16-13,17-37,15-17,15-18 and <i>combine</i> the new radiculopathy rating, <i>in place</i> of the 3% listed here. [See <b>Radiculopathy Schedule</b> ]	3% Com bined	3%
<b>Total Impairment Value Without Apportionment</b>		10%
<b>Apportionment: (The amount apportioned from Schedule I must agree with Schedules I &amp; V)</b>		-9%
<b>Final Impairment Related to the Last Event:</b>		1%

If there was no radiculopathy before his industrial lifting episode, it could not be apportioned. This radiculopathy would be subject to apportionment because it existed prior to his industrial lifting event.

### **Example 15: Prior History of Disc Problems Requiring Surgery and Now with a Recurrent Disc Herniation, Needing Another Surgery**

Four months ago, a thirty-year-old secretary falls from her roller stool and injures her back and was found to have a recurrent L4-L5 disc herniation. Two years earlier she had a non-work related L4-L5 disc surgical excision with moderate remaining symptoms but no radiculopathy or activity modification. She has now undergone repeat surgery for the recurrent L4-L5 disc. She has done well, with occasional back and leg pain, but no radicular symptoms.

<b>Example 15</b>		<i>Initial Event</i>	<i>Second Event</i>
<b>SCHEDULE II. Use for Surgically Treated Spine Conditions</b>			
<b>II-A. First spinal surgery at one level in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (Assigned one time per patient.)	10% one time per patient	10%	
<b>II-C. Second or subsequent spinal operation in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis.	2%		2%
<b>Add Impairments</b>			12%
<b>Apportionment:</b>		10%	
<b>Final Impairment Related to the Last Event:</b>			2%

There is no rating given for the first disc excision, but she would be entitled to a 2% rating for the second operation because of the recurrent disc excision at the same level. There is no additional impairment for a recurrent disc treated conservatively, unless there is evidence of residual radiculopathy

### Example 16: Second Disc Injury, Treated Non-operatively

A forty-year old female, slipped and fell at work, leaving her with pain into her right quadriceps area, with numbness and weakness on standing. Her healing was protracted and therefore an MRI was completed, demonstrating an L4-L5 far lateral disc bulge, displacing the right L4 nerve root. She underwent a conservative program and eventually was declared stable with residual problems and no radiculopathy. Her history is significant in that she has had a prior non-industrial problem at L5-S1, with a herniation and surgery five years before.

<b>Example 16</b>		<i>THORACIC-LUMBAR</i>
<b>Schedule I Form for Computing Spinal Impairments</b>		
<b>II-B. Medically documented injury</b> , with continued pain and rigidity <b>and Imaging evidence</b> of objectifiable, disc herniation that displaces nervous tissue and has occurred from <i>the same or subsequent</i> injury, <i>at another level other than the first</i> and was treated either conservatively or surgically. This would also include <b>surgery</b> for severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (This is applied only one time per level per patient and not to be applied to levels explored.)	Add 3%	3%
<b>Add Impairments</b>		3%
<b>Apportionment:</b>		
<b>Impairment Related to the Last Event:</b>		3%

(This is a different disc and receives the rating for a subsequent disc. The prior surgery is unrelated to the L4-5 level. If one were to include the rating for the prior disc, it would be deducted as preexisting, so the net result is the same. If one is asked to include all of the prior ratable condition impairment rating, then report the 10% and deduct it under apportionment.)

### Example 17: First Industrial Disc Injury-Second Disc Herniation requiring a Second Surgery

A thirty-two-year-old secretary falls from her roller stool and injures her back. Two years earlier she had a non-work related L4-L5 disc excision with moderate remaining symptoms and permanent activity modifications. She has now incurred an occupational low back injury, causing an L5-S1 herniated disc. This eventually required surgery and she is left with no radiculopathy; however, her results are not quite as good a recovery as she had before.

<b>Example 17</b>		<i>Second Event</i>
<b>SCHEDULE II. Use for Surgically Treated Spine Conditions</b>		
<b>II-C. Second or subsequent spinal operation in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis.	2%	2%
<b>II-B. Medically documented injury</b> , with continued pain and rigidity <b>and imaging evidence</b> of objectifiable, disc herniation that displaces nervous tissue and has occurred from <i>the same or</i> subsequent injury, <i>at another level other than the first</i> and was treated either conservatively or surgically. This would also include <i>surgery</i> for severe degenerative or posttraumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (This is applied only one time per level per patient and not to be applied to levels explored.)	Add 3%	3%
<b>Add Impairments</b>		5%
<b>Apportionment:</b>		
<b>Final Impairment Related to the Last Event:</b>		5%

This is a different disc and receives the rating for the second operation and level. No rating is given for the prior surgery. [See explanation above.]

### Example 18: Disc Injury-Undergoing Three Surgeries, Including a Fusion

A forty year old office worker lifts and twists with a computer monitor, causing sudden pain in the back and down the leg. He eventually undergoes an L5-S1 disc excision. He returned to work, only to have recurrent back pain and eventually has a second surgical procedure with a disc excision at the L4-L5 level. He returned to work, but unfortunately, one year later, without an intervening injury, began to develop progressive worsening with no radiculopathy. He undergoes his third surgical procedure, of an L4-L5 and an L5-S1 disc. excision and fusion with hardware. His fusion is solid at twelve months, with continued leg pain to his foot, 2 cm atrophy and EMG changes consistent with radiculopathy. He continued to have back pain and so two months ago had his hardware removed, without an appreciable change in his condition. Prior to lifting the monitor, he had no significant history of back pain.

<b>Example 18</b>				
<b>Schedule II Form for Computing Spinal Impairments For Individual Areas</b>				
SCHEDULE II. Use for Surgically Treated Spine Conditions		<i>Initial Event</i>	<i>Second Event</i>	<i>Third Event</i>
<b>II-A. First spinal surgery at one level in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (Assigned one time per patient.)	10% one time per patient	10%		
<b>II-B. Medically documented injury</b> , with continued pain and rigidity <b>and imaging evidence</b> of objectifiable, disc herniation that displaces nervous tissue and has occurred from <i>the same or</i> subsequent injury, <i>at another level other than the first</i> and was treated either conservatively or surgically. This would also include <b>surgery</b> for severe degenerative or posttraumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (This is applied only one time per level per patient and not to be applied to levels explored.)	Add 3%		3%	
<b>II-C. Second or subsequent spinal operation in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (L4-5 and Fusion)	2%		2%	2%
<b>II-E. Fusions: Additional level (s) / each additional level.</b> This is to be used only one time per level	2%			2%
<b>II-D. Spinal Fusions ( For the first level fused)(use one time only)</b>	3%			3%
<b>Add Impairment (Total Amount for Spine)</b>		10%	5%	7%
<b>II-F. Neurological: Radiculopathy *</b> (If , after <b>one year</b> , the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 16-10,16-11,16-13,17-37,15-17,15-18 and <i>combine</i> the new radiculopathy rating, <i>in place</i> of the 3% listed here. [*See Radiculopathy Schedule]	3% Combined			3%
<b>Total Impairment Value Without Apportionment</b>		25%		
<b>Apportionment:</b>				
<b>Final Impairment Related to the Last Event:</b>		10%	5%	10%

(These impairments are listed separately for clarity though all are due to the same event.)  
No impairment is given for hardware removal.

### Example 19: Degenerative Disc Disease--with Two-Level Decompression

A fifty-year old man who does moderately heavy work, has had a history of a fall at home. This has left him with LBP with episodes ten years, six years and two years ago. X-rays showed moderate to severe degenerative changes. A chiropractic physician treated him each time with his last visit two months before his industrial claim. For all of his prior episodes, he has missed a total of approximately ten days of work, seven of which have been in the last 12 months. He has had no prior MRIs or CT scans. Eight months ago, while lifting a tongue of a trailer, he had a severe onset of back pain with development of a radiculopathy. After two months of conservative care, he eventually underwent an L4-L5 and an L5-S1 discectomy. He obtained moderately good results, with no residual radiculopathy, but is unable to be as active in his work as he did before lifting the trailer. He has been released to infrequent lifting of 20-30 lbs, frequent lifting.

<b>Schedule V. Severity Indexing for Apportionment of Schedule I. (This applies only to the Impairment Process)</b>			
<b>Schedule I requires a minimum of six months duration of symptoms, from the time of the injury and the impairment rating</b>			
Score	0	1pt.	2pts.
<b>V-A</b> Time Lost from Work in the Last 12 Months Because of Symptoms in the Same Spinal Region.	0	1-3 days	<u>&gt;3 days</u>
<b>V-B</b> Number of Prior Episodes in the Same Spinal Region	0	<u>1-3</u>	>3
<b>V-C</b> Duration since Last Episode	0	1-3 Years	<u>&lt;1year</u>
<b>V-D</b> Prior Work Restrictions Because of Problems in the Same Spinal Region	No= 0	Temporary	Permanent
<b>V-E</b> Prior Objective Testing to the Same Spinal Region: EMG-NCV, X-ray, MRI-CT, Bone Scan	0	<u>If taken prior to 2 years</u>	If taken within the last 2 years
<b>V-F</b> Prior to latest claim, what ongoing Medical, Chiropractic visit, Physical Therapy Visits were received for an injury to the Same Spinal Region.	0 -2 times in last 3 yrs	3-6 times in last 3 yrs	<u>&gt;6 in last 3 yrs</u>
<b>V-G</b> Spondylolysis with Spondylolisthesis		<25% slip	>25% Slip
<b>V-H</b> Radiculopathy (As objectified by Radiculopathy Schedule)	None		<u><b>Prior History</b></u>

8pts. = 70% of his maximal soft tissue award would be apportioned off as a prior ratable condition



<b>Example 19</b>		<i>Initial Event</i>	<i>Second Event</i>
<b>SCHEDULE II. Use for Surgically Treated Spine Conditions</b>			
<b>II-A. First spinal surgery at one level in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (Assigned one time per patient)	10% one time per patient		10%
<b>II-B. Medically documented injury</b> , with continued pain and rigidity <b>and imaging evidence</b> of objectifiable, disc herniation that displaces nervous tissue and has occurred from <i>the same or</i> subsequent injury, <i>at another level other than the first</i> and was treated either conservatively or surgically. This would also include <i>surgery</i> for severe degenerative or posttraumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (This is applied only one time per level per patient and not to be applied to levels explored.)	Add 3%		3%
<b>Add Impairments</b>			13%
<b>Apportionment1- **</b> <b>Apportionment: = 8 pts. =70% I-C = 5%, 5% X 70% severity index = 4%</b>		-4%	
<b>Final Impairment Related to the Last Event:</b>			9%

(He does not have apportionment due to degenerative changes alone, but rather to the symptomatic prior ratable status of those changes)

## Fractures

### Example 20: Compression Fractures with Prior History and Rating

Eight months ago a thirty-three year old roofer fell 18 feet landing on his feet. He had immediate back pain and was taken to the hospital where x-rays demonstrated acute compression fractures of T11(20%), T12 (30%) and L1(10%). He has been treated surgically with a three-level fusion (four vertebral segments) and has now been declared stable. His complaints continue to be back pain with referral into the back of his legs. He has no objective radicular signs or neurological sequelae. He did have a history of an industrial back claim from a lifting injury three years ago, for which he received a 5% rating and was given permanent lifting restrictions of 30 lbs.

<b>Example 20</b>	
<b>Spine Impairment Example</b>	
<b>Compression Fractures with Prior History</b>	
<b>Pathology</b>	<b>Impairment</b>
<b>III-A-3:</b> 26% to 50% T12 (30%) Worst	6%
<b>III-A-6</b> Multiple fractures:(Second, T11(20% Compression) and Third, L1(10% Compression)	3%
<b>III-A-5:</b> Fusion- If it is required to extend the fusion over more than three vertebral segments, add	5% one time
<b>Final Impairment Related to the Last Event: (Added)</b>	14%
<b>(Prior rating not related) Apportionment:</b>	0
<b>Impairment Industrial is responsible for:</b>	14%

(The 5% prior rating is not considered for apportionment, as it bears no relationship to the current injury or impairment)

### Example 21: Burst Fracture requiring Fusion

Eighteen months ago, a forty-year old male fell twenty-five feet, incurring a burst fracture at L1 of 60%, with partial neurological loss. He eventually underwent a fusion that extended from T10 to L3. He is now medically stable of and with complete restoration of his neurological deficit. He has had no prior spinal pain.

<b>Example 21 Spine Impairment Example Burst Fractures with Fusion</b>	
<b>Pathology</b>	<b>Impairment</b>
<b>III-A-4:</b> Burst Fractures-Compression of 60%	15%
<b>III-A-6:</b> Fusion- If it is required to extend the fusion over more than three vertebral segments	5%
<b>Impairment: ( added)</b>	20%
<b>(Prior rating not related) Apportionment:</b>	0
<b>Impairment Industrial is responsible for:</b>	<b>20%</b>

### Example 22: Coccygodynia

Twelve months ago, a thirty-three year old female slipped and fell on the ice, landing on her buttocks. She had x-rays taken, showing a deviated coccyx. No prior films were available for comparison and she denies having any significant history of problems prior to the fall. She has had conservative treatment and continues to have intermittent pain, with trouble sitting. A rectal examination is significant for a palpable step off of the sacral-coccygeal joint and reproduction of her usual and typical pain with provocative motion. (Radiographic diagnosis of coccyx fractures is notoriously unreliable).

<b>Example 22 Spine Impairment Coccygodynia</b>	
<b>Pathology</b>	<b>Impairment</b>
IV. H - Healed fracture(s) with displacement, deformity and <i>residuals signs</i> (s) involving: h. Coccyx, displacement	3%
<b>Impairment:</b>	3%
<b>Apportionment:</b>	0%
<b>Impairment Industrial is responsible for:</b>	<b>3%</b>

### Example 23: Prior Nonindustrial Injury with two Industrial Injuries and Ratings.

An eighteen-year old male injured his L4-L5 disc while playing high school football in 1985. He subsequently reinjured this same area doing summer construction work in 1987. His treatment only consisted of physical therapy following both incidents. In 1996, while working on an oil rig, he injured his L4-L5 area again, resulting in lumbar surgery. Following his 1987 work-related accident, he was rated in accordance with the *Third Edition (Revised) of the AMA Guides* and was awarded a 10% (Whole Person) impairment with 5% due to the 1985 football injury and 5% due to the 1987 construction industrial accident. What would be his current impairment following his 1996 discectomy?

<b>Example 23 Spine Impairment Prior Nonindustrial Injury with two Industrial Injuries and Ratings.</b>		
Date	Pathology	Impairment
1996	<b>II-A. First spinal surgery at one level in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (Assigned one time per patient.)	10% one time per patient
<b>Impairment:</b>		10%
<b>1985 &amp; 1987 Injuries</b> Apportionment of his prior rating by current Physical Impairment Guides I-C. Medically documented injury and subjective symptoms persisting for a minimum of six months with a clinical history of a significant injury event. May have imaging evidence of moderate to severe degenerative changes, including spondylolysis. Should have permanent activity restrictions.		-5%
<b>Additional Impairment Industrial is responsible for: related to 1996</b>		<b>5%</b>

**Discussion:** He has incurred another separate injury in 1996, requiring surgery. Therefore for consistency=s sake, it is recommended that the impairment *he would have been awarded* for his 1985 and 1987 injuries be deducted calculated using these current Utah 2002 Guides. In this case it would have been 5% WP, which is apportioned off of his new total award.

### Example 24: Prior Industrial Rating With Another System, now with a new injury

A thirty-year old male injured his back at work in 1991 and was diagnosed with mechanical back pain and an impairment of 14% Whole Person was calculated using the 3rd edition of the AMA Guides and restrictions of not lifting over 50 lbs was given. Three year later, in 1994, while working for another employer, he reinjured his back, which later required surgery, including a two-level discectomy and fusion. He has now returned to work and has been declared medically stable.

<b>Example 24</b>		<i>Initial Event</i>	<i>Second Event</i>
<b>SCHEDULE II. Use for Surgically Treated Spine Conditions</b>			
<b>II-A. First spinal surgery at one level in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (Assigned one time per patient.)	10% one time per patient		10%
<b>II-B. Medically documented injury</b> , with continued pain and rigidity <b>and imaging evidence</b> of objectifiable, disc herniation that displaces nervous tissue and has occurred from <i>the same or</i> subsequent injury, <i>at another level other than the first</i> and was treated either conservatively or surgically. This would also include <b>surgery</b> for severe degenerative or posttraumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (This is applied only one time per level per patient and not to be applied to levels explored.)	Add 3%		3%
<b>II-D. Spinal Fusions</b> ( For the first level fused)(use one time only)	3%		3%
<b>II-E. Fusions: Additional level (s)</b> / each additional level. This is to be used only one time per level	2%		2%
<b>Add Impairments</b>			18%
<b>Apportionment:</b>		5%	
<b>Final Impairment Related to the Last Event:</b>			13%

**Discussion:** In 1991, he incurred an injury, which probably began the degenerative cascade, predisposing him later for the problems he incurred in 1994, therefore, apportionment is indicated. The 14% awarded prior for soft tissue complaints is inflated. He has incurred another separate injury, therefore, for consistency=s sake, it is recommended that the maximum impairment *he would have been awarded* under these current AUtah 2002 Guides (5%), rather than the 14% be used. In this case it would have been 5% WP, which is apportioned off of his new total award.

### Example 25: Prior Industrial Rating With Another System, now with a new injury

A forty-year old male incurred an industrial accident in 1985. He underwent an L5-S1 discectomy and was declared medically stable and given a 5% impairment. In 1988, he herniated another disc at L4-L5 and in 1989, underwent an L4-L5 discectomy, was declared stable and was given another 5% impairment rating. In 1994, while working for another employer, he fell off a ladder, causing pain in his quadriceps area. He was later diagnosed with a L3-L4 disc and it was decided that he would have to have another discectomy--this time with a fusion from L3-S1. This was carried out in 1995 and he was declared medically stable. He has continued to have pain in the quadriceps area, with a loss-of -strength reflex and positive EMG changes in the L4 nerve root distribution. His fusion is solid. What would be his total current impairment and what would be related to his 1994 industrial accident?

<b>Example 25</b>				
<b>Schedule II Form for Computing Spinal Impairments For Individual Areas</b>				
SCHEDULE II. Use for Surgically Treated Spine Conditions		<i>Initial Event</i>	<i>Second Event</i>	<i>Third Event</i>
<b>II-A. First spinal surgery at one level in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (Assigned one time per patient.)	10% one time per patient	10%		
<b>II-B. Medically documented injury</b> , with continued pain and rigidity <b>and imaging evidence</b> of objectifiable, disc herniation that displaces nervous tissue and has occurred from <i>the same or</i> subsequent injury, <i>at another level other than the first</i> and was treated either conservatively or surgically. This would also include <i>surgery</i> for severe degenerative or posttraumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (This is applied only one time per level per patient and not to be applied to levels explored.)	Add 3%		*3%	3%
<b>II-C. Second or subsequent spinal operation in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis.	2%		*2%	2%
<b>II-D. Spinal Fusions</b> ( For the first level fused)(use one time only)	3%			3%
<b>II-E. Fusions: Additional level (s) / each additional level.</b> This is to be used only one-time per level.	2%	*2%	2% *	
<b>Add Impairment (Total Amount for Spine)</b>		12%	7%	8%
<b>II-F. Neurological: Radiculopathy</b> * (If , after <b>one year</b> , the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 16-10,16-11,16-13,17-37,15-17,15-18 and <i>combine</i> the new radiculopathy rating, <i>in place</i> of the 3% listed here. [*See Radiculopathy Schedule]	3% Combined			3%
<b>Total Impairment Value Without Apportionment</b>		30%		
<b>Apportionment:</b>		12	7	11%

The percentage for fusions at each level is apportioned off because the need for those fusions was more of a direct result of the 85 and 88 herniations and not the 94 injury.

### Example 26: Impairment Related to Two Discs Operated on from One Event

A thirty-five year old male is picking up a 100 lb container and falls, hurting his back, giving him pain into his right leg, into his foot. He has sensory changes, reflex changes, muscle weakness, are all consistent with a S1 radiculopathy. An MRI demonstrated an L5-S1 HNP displacing his right S1 nerve root and a broad based L4-L5 disc, giving relative moderate spinal stenosis. Conservative treatment of six weeks does not give him acceptable relief, therefore he undergoes an L5-S1 and an L4-L5 discectomy. He is now four months out and is left with occasional low back pain--without radiculopathy. Prior to his industrial event, he has had no significant history of back pain.

<b>Example 26</b>		<i>Initial Event</i>
<b>SCHEDULE II. Use for Surgically Treated Spine Conditions</b>		
<b>II-A. First spinal surgery at one level in a given spinal region</b> , including herniated discs, severe degenerative or post traumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (Assigned one time per patient.)	10% one time per patient	10%
<b>II-B. Medically documented injury</b> , with continued pain and rigidity <b>and imaging evidence</b> of objectifiable, disc herniation that displaces nervous tissue and has occurred from <i>the same or</i> subsequent injury, <i>at another level other than the first</i> and was treated either conservatively or surgically. This would also include <i>surgery</i> for severe degenerative or posttraumatic changes, foraminal stenosis, spondylolysis, spondylolisthesis, segmental instability and spinal stenosis. (This is applied only one time per level per patient and not to be applied to levels explored.)	Add 3%	
<b>Add Impairments</b>		13%
<b>Apportionment:</b>		
<b>Final Impairment Related to the Last Event:</b>		13%

If the second disc was operated at an later time, there would be another 2%, II-C, added.

## Upper Extremity: AMA 5<sup>th</sup> Edition Chapter 16

The 5<sup>th</sup> edition of the AMA guides provides a number of methods that can be utilized in the calculation of the impairment rating in the upper extremity. To provide rating methodology that facilitates consistency, the impairment committee has reviewed and simplified the upper extremity rating process as listed below. As with other sections of the *Impairment Guides*, the rater is reminded that the rating of a part should never be greater than that which is allowed for the whole part. This would mean that the maximum rating a physician could award for the upper extremity would be equal to 100%, (amputation of the upper extremity or shoulder disarticulation) which is equal to 60% Whole Person. Impairment ratings for the upper extremity have not been adjusted for hand dominance, therefore hand dominance should not be considered in the determination of disability.<sup>65</sup>

The following methods from the 5<sup>th</sup> edition of the AMA guides have been approved for rating impairments of the upper extremity. Physicians are reminded that these individual sections are to be combined:

<b>2002 Utah's Labor Commission's UPPER EXTREMITY Rating Guidelines Worksheet</b>			
<i>Name:</i> _____ <i>Age</i> _____ <i>Sex</i> _____ <i>Date</i> _____ <i>Side</i> <b>R L</b>			
<i>Diagnosis</i>			
Schedules to use for Impairments of Utah's Injured Workers		Section (Page)	% UE Current Event 2
<b>Anatomic</b>	Finger and Hand Impairment Methodology	16-1a (436)	
	Amputation	16-2 (441)	
	Peripheral Nerve Disorders	16-5 (480-495)	
	Entrapment Neuropathies	Page * Utah's 2002 Guides	
	CRPS type 1 or 2	16-5e (495)	
	Dermatological	18 (173)	
	Vascular	16-6 (497)	
<b>Functional</b>	Range of Motion including Ankylosis	16-4 (450)	
<b>Diagnosis Based</b>	Impairments Due to Other Disorders (Specify)	16-7a (499)	
	Arthroplasty	16-7b, (505)	
	Musculotendinous Impairment 3	16-7c (506)	
	Utah's Specific Upper Extremity Neuro-Muscular Impairments	Page * Utah's 2002 Guides	
	Upper Extremity Rotator Cuff Impairments	Page * Utah's 2002 Guides	
<b>Stand Alone: Utah's Specific Upper Extremity Painful Organic Syndromes</b> (Page #, Utah's 2002 Impairment Guides) Not to be Combined with Other Ratings		Page * Utah's 2002 Guides	
<b>Total Upper Extremity Impairment:</b>			

If more than one method can be used to calculate a rating, the physician should calculate the impairment rating using different alternatives and choose the method or combination of methods that gives the most clinically accurate and highest impairment rating.<sup>66</sup>

<sup>2</sup> That event which precipitated the need for care as compared to those findings that are present, absent the new findings from the current event

<sup>3</sup> Constrictive tenosynovitis is a condition that is readily corrected by surgery, therefore the Impairment Committee recommends that Chart 16-29 found on page 507, only be applied to post-operative patients.

**Schedules in AMA 5<sup>th</sup> not to be used for Upper Extremity Ratings in Utah**

- Carpal Tunnel Syndrome (495) Use Utah’s Upper Extremity Entrapment Neuropathies
- Strength Testing for Grip and Pinch, (507) except as found under Utah's Upper Extremity Neuro-Muscular Impairments<sup>67</sup>
- Tendonitis 16-7d (507) Use Utah Painful Upper Extremity Painful Disorders
- Manual Muscle Testing 16-8c (509) 4 (Must have true neurological weakness and use 16-10, 16-11)
- Criteria for Rating Impairment of One Upper Extremity 13-16 p 338
- Criteria for Rating Impairments Related to Chronic Pain in One Upper Extremity Table 13-22 p 343

**Upper Extremity Rotator Cuff Impairments**

Table VI is to be used for individuals who incur rotator cuff injuries related to work. These are to be combined with other ratings as indicated.

<b>Schedule VI</b> <b>Upper Extremity Rotator Cuff Impairments</b> <b>Recommend Pictures Be Taken, Confirming Findings</b>	
Conservative Treatment for a MRI or Arthroscopically Demonstratable Tendonitis and/or Tear, Not Requiring Surgical Repair	2% UE
Partial Thickness Tear or a Full Thickness Tear, <1cm Repaired Surgically	3% UE
Full Thickness Tear, 1-3 cm Repaired Surgically	4% UE
Full Thickness Tear, 3-5 cm Repaired Surgically	5% UE
Full Thickness Tear, >5 cm Repaired Surgically	6% UE

**Distal Clavicle Resection**

The award for the distal clavicle resection found in table 16-27 (page 506) is only to be applied when the surgical treatment is primarily for acromioclavicular dysfunction and is not to exceed 5% upper extremity.

**Utah's Upper Extremity Neuro-Muscular Impairments**

Upper Extremity Impairments Due to Entrapment Neuropathies should be severity indexed according to table VII with impairment assigned to the category in which the majority of symptoms and findings occur. It should be noted that healed entrapment neuropathies might have no impairment.

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<sup>4</sup> Strength evaluation: voluntary muscles strength testing remains somewhat subjective until a precise way of measuring muscle contraction is generally debatable. It should also be noted that the correlation of strength with performance of activities of daily living is poor and that increased strength does not necessarily equate with increased function. Page 507



## Upper Extremity Entrapment Neuropathies

### Schedule VIIa. Guidelines For Placement Of Patients Within Schedule VII

Signs-Symptoms	Minimum	Mild	Moderate	Severe
Nocturnal paresthesia	+	+	+	+
Paresthesia with Activity	+	+	+	+
2 pt discrimination	< 6mm	6mm	7-15mm	>15mm
Symptoms are within the anatomical distribution of the involved nerve	+	+	+	+
Atrophy	0	0	+/-	+
% of Strength loss Index 1.	<10	10-30	31-60	>61
Phelan's test positive	+	+	+	N/A
Tinnel's test positive	+	+	+	+
Nerve Conduction Studies Positive 2.	-	+	+	+
Electromyographic changes present	-	+/-	+	+

$$1. \text{ Normal Strength - Abnormal Strength} \div \text{Normal Strength} = \% \text{ of Strength loss Index}$$

These tests should be done with validation of effort as described on page 508 of the *AMA Guides-5th Edition*.

2. For nerve conduction testing, the Impairment Committee recommends uniform adoption of the AAE M Criteria

Schedule VII-b. Utah's Specific Upper Extremity Impairments Due to Entrapment Neuropathy						
ENTRAPPED NERVE	ENTRAPMENT SITE	Minimum	Mild	Moderate	Severe	Complete Motor and Sensory Loss
Median	Elbow	7	15	35	50	65
Median	Wrist	5	10	20	30	44
Ulnar	Elbow	3	10	30	40	50
Ulnar	Wrist	3	10	30	35	40

## Utah's Upper Extremity Strength Evaluations

Upper extremity strength evaluations, (grip and pinch strength) should only be used as described here in Table VIIb. The rater is not to award grip strength alone or in combination with other ratings.

### Constrictive Tenosynovitis

Constrictive tenosynovitis is a condition that is readily corrected by surgery, therefore table 16-29 only be applied to post-operative patients.

## Utah's Specific Upper Extremity Painful Organic Syndromes

### Upper Extremity Painful Organic Syndromes That Are Not Otherwise Accounted for Within These Guides or the *AMA Guides -5th Edition*

A musculoskeletal condition characterized by pain (and weakness) with use of the affected member, attributed to a lesion in the soft tissue (capsule, ligament, tendon, fascia, muscle) and documented by clinical findings that have been present for longer than six months. Medical stability, (MMI) and the date someone qualifies for an impairment rating can be two separate dates.

<b>Schedule VIII for Upper Extremityxxxx</b>				
<b>Utah's Specific Upper Extremity Painful Organic Syndromes (Upper Extremity% is 60% whole person)</b>				
<b>Residual Symptoms</b>	<b>Minimum</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
Shoulder and or Elbow and or Wrist and or Hand	0%	1%	3%	5%

## Example of Upper Extremity Impairment Ratings

### Example of Rotator Cuff Repair, 1#

45-year-old postman is seen for shoulder pain after a fall at work 2 weeks earlier, wherein he slipped on some ice, landed on his outstretched arm. He was found to be unable to abduct his arm past 60 degrees with considerable pain. He was suspected of having a rotator cuff tear and was taken to surgery, where he was found to have a complete, full thickness (>5cm) tear of the rotator cuff. This was surgically repaired with an open procedure with a distal clavicle resection. He under went a course of physical therapy and has been declared medically stable. He has been left with weakness and associated loss of motion in his shoulder.

His ROM findings are listed below:

<b>ROM Shoulder Impairment</b> (Upper Extremity) Figures 16-40, 43, 46. p. 466 AMA Guides					
<b>Flexion (180°)</b>	<b>Extension (50°)</b>	<b>Abduction (170°)</b>	<b>Adduct (40°)</b>	<b>Internal Rotation (80°)</b>	<b>External Rotation (60°)</b>
100/5%	30/1%	100/4%	30/1%	60/2%	60/0%
<b>Total Shoulder Range of Motion Impairment</b>					<b>13%</b>

His impairment for his rotator cuff:

Schedule VI Upper Extremity Rotator Cuff Impairments For Distal Clavicle Resection to be awarded (p.506), at least 2 cms of the complete clavicle must be Removed Recommend Pictures Be Taken, Confirming Findings	
Conservative Treatment for a MRI or Arthroscopically Demonstratable Tendonitis and/or Tear, Not Requiring Surgical Repair	2% UE
Partial Thickness Tear or a Full Thickness Tear, <1cm Repaired Surgically	3% UE
Full Thickness Tear, 1-3 cm Repaired Surgically	4% UE
Full Thickness Tear, 3-5 cm Repaired Surgically	5% UE
Full Thickness Tear, >5 cm Repaired Surgically	6% UE
Full Thickness Tear, Global, Unrepairable.	

His impairment is 6% for his rotator cuff repair. 6% combined with 13% is 18% upper extremity or 11% whole person.

2002 Utah's Labor Commission's UPPER EXTREMITY Rating Guidelines Worksheet			
Schedules to use for Impairments of Utah's Injured Workers		Section (Page)	% Upper Ext
			Current Event 5
<b>Functional</b>	Range of Motion including Ankylosis	16-4 (450)	13%
	Upper Extremity Rotator Cuff Impairments	Page * Utah's 2002 Guides	6%
<b>Total Upper Extremity Impairment:</b>			<b>18%</b>

5 That event which precipitated the need for care as compared to those findings that are present, absent the new findings from the current event.

**Upper Extremity Example 2#**

One year ago, a 58-year-old male incurred a fracture to his right shoulder after a fall at work. He has undergone therapy and has been left with a weak, stiff and painful upper extremity with associated numbness secondary to a partial neuropathy of the radial nerve. After undergoing physical therapy, he has been declared medically stable. An impairment is calculated using the Utah’s 2002 Impairment Guides and the AMA 5<sup>th</sup> edition.

For his neurological loss, the radial nerve is weighted at 45% UE.

<b>Table 16-16 Maximum Upper Extremity Impairment due to Unilateral Sensory or Motor Deficits (AMA Guides p.492)</b>			
Nerve	Sensory Deficits	Motor Deficits	Combined Motor and Sensory deficits
Radial (upper arm) with Loss of Triceps	5	42	45

He qualifies for 30% of the radial nerve.

<b>Table 16-11 Determining Impairment Of The Upper Extremity Due To Motor And Loss Of Power Deficits Resulting From Peripheral Nerve Disorders Based On Individual Muscle Rating. (Upper or Lower Extremity Value) (AMA Guides p.484)</b>		
Class	Description of Muscle Function	% Motor Deficit
3	Active movement against gravity only without resistance	26 - 50

30% for the total value of the radial nerve x 45% equals 14% upper extremity for motor and sensory loss.

**Loss of Motion**

Xxx hand domance needs to be clarified roger

<b>ROM Shoulder Impairment (Upper Extremity) Figures 40, 43,44, 46. p. 466 AMA Guides</b>					
Flexion (180°)	Extension (50°)	Abduction (170°)	Adduct (40°)	Internal Rotation (80°)	External Rotation (60°)
130/3%	30/1%	120/3%	30/1%	40/3%	70/0%
<b>Total Shoulder Range of Motion Impairment</b>					<b>11%</b>

For his loss of motion he would have 11% Upper extremity.

<b>Scheduled tables to be use for Impairments for Utah’s Injured Workers</b>			<b>Page</b>	<b>% Upper Ext</b>
				Recent
	Peripheral Nerve Damage		16-5 (480-495)	14%
<b>Functional</b>	Range of Motion including Ankylosis		16-4	11%
<b>Total Upper Extremity Impairment:</b>				<b>23%</b>

**These combine to equal 23% upper extremity or 14% whole person.**

## **Lower Extremity: AMA 5<sup>th</sup> Edition Chapter 17**

The 5<sup>th</sup> edition of the AMA guides provides a number of methods that can be utilized in the calculation of the impairment rating in the lower extremity. To provide a rating methodology that facilitates consistency, the impairment committee has reviewed and simplified the lower extremity rating methodology as listed below. As with other sections of the Impairment Guides, the rater is reminded that the total rating of a part of an extremity should never be greater than that which is allowed for the whole extremity. This would mean that the maximum rating that a physician can award would be equal to 100% amputation of the lower extremity (hip disarticulation), which is awarded 40% whole person

The following methods from the 5<sup>th</sup> edition of the AMA guides have been approved for rating impairments of the lower extremity for injured workers in Utah. Physicians are reminded that these are to be combined:

Gait derangement 336 and pager 529 exclude gait derangementxxx

**2002 Utah's Labor Commission's  
LOWER EXTREMITY  
Rating Guidelines Worksheet**

Name: \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date \_\_\_\_\_

Side R L Diagnosis \_\_\_\_\_

Schedules to use for a rating of the Lower Extremity in Utah		Section No# (Page)	% Lower Ext
			Current <sup>6</sup>
<b>Anatomic</b>	Limb Length Discrepancy	17.2b (528)	
	Amputation	17-2i (545)	
	Skin Loss	17-2k (550)	
	Peripheral Nerve Injury	17.2l (550) 16-5 (480-495)	
	CRPS type 1 or 2	16-5e (495)	
	Vascular	17-38 (553)	
	These are Mutually Exclusive: Arthroscopic findings take Precedent.	Arthritis of Joints , p 544 **Acute Arthroscopic Osteochondral Lesions: Chart IX	17-2.h (544) Page * Utah's 2002 Guides
<b>Functional</b>	Range of Motion including Ankylosis	17.2f (533)	
<b>Diagnosis Based ( 545)</b>	Fractures	17.2j(546)	
	Ligament Injuries	17.2j (546)	
	Partial Meniscectomies (2% L.E. Per Partial Meniscectomy, up to a max of 7% L.E. For each meniscus)	17.2j (546)	
	Foot Deformities	17.2j (546)	
	Hip and Bursitis	17.2j (546)	
	Lower Extremity Joint Replacements	17.2j (546)	
<b>Stand Alone:</b> Lower Extremity Painful Organic Syndromes That Are Not Otherwise Accounted for Within These Guides or the AMA Guides - 5th Edition (Page #, Utah's 2002 Impairment Guides) Not to be Combined with Other Ratings		Page 56 xxxUtah's 2002 Guides	
<b>Stand Alone:</b> Patellofemoral pain and crepitation with a history of direct trauma		17-31 (544)	
<b>Total Lower Extremity Impairment Value Without Apportionment:</b>			
<b>Final Impairment Related to the Last Event:</b>			
<b>Signature and Professional Title of Physician doing Rating:</b>			

If more than one method can be used to calculate a rating, the physician should calculate the impairment rating using different alternatives and choose the method or combination of methods that gives the most clinically accurate and highest impairment rating.<sup>68</sup>

<sup>6</sup> That which precipitated the need for care as compared to those findings that are present, absent the new findings from the current event

**Schedules in AMA 5<sup>th</sup> not to be used for rating impairments in the Lower Extremity**

Atrophy 17.2d (530)

Causalgia/Reflex Sympathetic Dystrophy 17.2m (553) Use methodology as found in the upper extremity section describing CRPS type 1 or 2, 16-5e (495)

Gait Derangement 17.2c

Manual Muscle Testing, 17-2e 7 (Must have true neurological weakness and use 16-10, 16-11)

Chart 13-15 Gait in neurological section p 336

**Lower Extremity Arthroscopic Cartilaginous Impairments**

It is readily recognized that arthroscopic findings are the most accurate in identifying a joint's current condition and prognosis, including findings expected from recent events compared to long standing or degenerative conditions. Table XI allows the impairment rater to outline what findings are present, the severity of the findings and why they are there, based on the arthroscopic findings.

Schedule IX Acute Arthroscopic Osteochondral Lesions Impairments Lower Extremity Recommend Pictures Be Taken, Confirming Findings Calculate the lower extremity impairment by adding Size% + Stage % + Location = Total %LE			
Total Area of lesions (Greatest Diameter of Lesion)	Stages of Acute Articular Cartilage Separation (Not Award for Successful Re implantation or Transplantation)	Location Weight Bearing Surface = 2% Non-weight bearing Surface = 0% (Patella femoral Joint is Considered a Weight Bearing Joint)	Current Event <sup>8</sup>
< 1cm = 2%  1-1.5 cm = 4%  >1.5 cm = 6%	Partial Thickness Cartilage Loss 3%  Full Thickness Cartilage loss, Bone Exposed 6%	Knee	
		Medial	
		Lateral	
		Patella femoral	
		Subtalar	
<b>Lower Extremity Cartilage Impairment</b>			

**Lower Extremity Painful Organic Syndromes That Are Not Otherwise Accounted for Within These Guides or the AMA Guides - 5th Edition**

A musculoskeletal condition characterized by pain (and weakness) with use of the affected member, attributed to a lesion in the soft tissue (capsule, ligament, tendon, fascia, muscle) and documented by clinical findings that have been present for longer than six months. Medical stability, (MMI) and the date someone qualifies for an impairment rating can be two separate dates

Schedule Xxxxx lower ext and do example roger Lower Extremity Painful Organic Syndromes (Lower Extremity% is 40% whole person)				
Residual Symptoms	Minimum	Mild	Moderate	Severe
Hip, Knee, Ankle, Foot	0%	1%	3%	5%

7 Strength evaluation: voluntary muscles strength testing remains somewhat subjective until a precise way of measuring muscle contraction is generally debatable. It should also be noted that the correlation of strength with performance of activities of daily living is poor and that increased strength does not necessarily equate with increased function. Page 507

8 That event which precipitated the need for care as compared to those findings that are present, absent the new findings from the current event. Xxx rating from new injury

## Example of Lower Extremity Impairment Rating

33 year old male who is seen today for an impairment rating for the residual loss that he has of his left knee. He states that he was in his usual state of health until February 5, 1999. At that time he was driving freight and in the process of doing his job, he slipped off the freight truck trailer approximately, four feet straight down, putting full weight on the left knee and as a result it buckled underneath him. He eventually saw Dr. Scott, who recommended an MRI. The MRI showed that he had an ACL tear and a partial lateral meniscus tear. He was taken into surgery, where he was found to have a complete tear of the anterior cruciate ligament of the left knee and a longitudinal tear of the posterior horn of the lateral meniscus of his left knee. He was also found to have an acute osteochondral defect, with it's greatest diameter of 1.6mm, full thickness to bone on the weight bearing surface of the lateral femoral condyle left knee.

<b>Schedule IX</b> <b>Acute Arthroscopic Osteochondral Lesions</b> <b>Impairments Lower Extremity</b> <b>Recommend Pictures Be Taken, Confirming Findings</b> Calculate the lower extremity impairment by adding Size% + Stage % + Location = Total %LE			
Total Area of lesions (Greatest Diameter of Lesion)	Stages of Acute Articular Cartilage Separation (Not Award for Successful Re implantation or Transplantation)	Location Weight Bearing Surface = 2% Non-weight bearing Surface = 0% (Patella femoral Joint is Considered a Weight Bearing Joint)	Current Event <sup>9</sup>
< 1cm = 2%  1-1.5 cm = 4%  >1.5 cm = 6%	Partial Thickness Cartilage Loss 3%	Knee	
		Medial	
	Lateral	14	
	Patella femoral		
	Subtalar		
<b>Lower Extremity Cartilage Impairment</b>			14%

<b>2002 Utah's Labor Commission's</b> <b>LOWER EXTREMITIY</b> <b>Rating Guidelines Worksheet</b>			
Schedules to use for a rating of the Lower Extremity in Utah using chart 17-2, 526 for Guidance of which can be combined		Section No# (Page)	% Lower Ext
<b>Functional</b>	Range of Motion including Ankylosis	17.2f (533)	20%
	Ligament Injuries	17.2j (546)	17%
	Partial Meniscectomies (2% L.E. Per Partial Meniscectomy, up to a max of 7% L.E. For each meniscus)	17.2j (546)	2%
	*Acute Arthroscopic Osteochondral Lesions: Chart IX	Page 56 Utah's 2002 Guides	14%
<b>Final Impairment Related to the Last Event:</b>			18% WP 44% (LE)

<sup>9</sup> That event which precipitated the need for care as compared to those findings that are present, absent the new findings from the current event.



## Loss of Teeth Secondary to an Industrial Event

Maximum of 10% WP to Be Awarded

### Impairment in Whole Person

Upper Incisors.....1% (Each)  
All other Teeth.....1/2% (Each)

## TEMPOROMANDIBULAR JOINT

### Impairment in Whole Person

The tempromandibular joint is unique in that it is a bilateral joint, but functions in relationship to only a single bone, the mandible, which moves as a unit with complex motions. This joint is not comparable to the situation of bilateral joints of the extremities that are independent from each other. The following schedule should be used in reporting impairment related to the tempromandibular joint.

<b>Schedule XI. Tempromandibular Joint Impairment (Whole Person)</b>	
Use either the <u>Range of Motion</u> or the <u>Structural Change</u> Model, <i>Whichever is Greater</i> *	
Range of Motion Model	Structural Change Model
<p><b>Range of Motion in Millimeters</b></p> <p>(Only the vertical opening from incisal edge of maxillary teeth to incisal edge of mandibular teeth measured in mm)</p> <p>0 -10....(Traumatic Microstomia).....10%</p> <p>11-20.....8%</p> <p>21-30.....6%</p> <p>31-40<sup>69</sup>.....3%</p>	<p><b>Recurrent Subluxating or dislocating disc</b></p> <p>Unilateral.....1%</p> <p>Bilateral.....2%</p> <p><b>Recurrent Subluxating or dislocating joint</b></p> <p>Unilateral.....3%</p> <p>Bilateral.....4%</p> <p><b>Meniscal Repair or Meniscectomy</b></p> <p>Unilateral.....3%</p> <p>Bilateral.....4%</p> <p><b>Meniscectomy and implant alloplastic or soft tissue</b></p> <p>Unilateral.....7%</p> <p>Bilateral.....10%</p> <p><b>Arthroplasty (Total Joint) reconstruction, resection</b></p> <p>Unilateral.....7%</p> <p>Bilateral.....10%</p> <p><b>Arthroscopic surgical debridement/synovectomy</b></p> <p>Unilateral.....2%</p> <p>Bilateral.....3%</p>

\* In severe cases, the range of motion model or the structural change model may be combined with weight loss<sup>70</sup>, speech impediment<sup>71</sup>, or disfigurement<sup>72</sup> as defined in the *AMA Guides, 5th Edition*.

# AMA 5<sup>th</sup> Edition Review Utah's Clarification of the AMA Guides to the Evaluation of Permanent Impairment 5<sup>th</sup> Edition

## **The relative scale of 0 to 100% is inconsistent through out the different chapters.**

Definitions established in chapters 1 and 13, establish the entire relative scale of the rating process:

### **Chapter 1**

90 percent to 100 percent whole person impairment indicates a very severe organ or body system impairment requiring the individual to be fully dependent on others for self-care, approaching death. (P. 5)

### **Chapter 13**

90 Percent, persistent vegetative state due to cerebral contusion and intracranial hemorrhage. 90 percent of the whole person. Persistent vegetative state is defined as a clinical condition of complete unawareness of the self and the environment. Page 311, Exp 13-4,

## **Location and Inconsistencies**

### **These chapter's relative scale is inconsistent with the prior defined definitions:**

#### **Page 30, 3.2 a, table 3-5**

Signs of physical examination valvular heart disease and symptoms at rest or in performance of less than ordinary activities **50 percent-100 percent impairment of the whole person** Out of line with impairment relative scale.

#### **Page 34, Exp 3-8**

Unable to do most activities of daily living without assistance. **90 to 100 percent impairment of the whole person.** Out of line with impairment relative scale.

#### **Page 46, 3-25 Exp 3-25**

Comfortable during exertion for short periods: weak and breathless on more moderate exertion. **80 to 90 percent impairment of the whole person.** Out of line with impairment relative scale

#### **Page 46, Exp 3-26**

Recent activity markedly limited because of fatigue with minimal exertion. **95 to 100 percent of whole person.** Out of line with impairment relative scale.

#### **Page 51, Exp 3-34**

Dyspnea on exertion with one flight of stairs or ambulation over 25 feet. **80 to 89 percent of whole person.** Out of line with impairment relative scale.

#### **Page 54, Exp 3-41**

Able to walk on a level surface and do activities of living. **80 to 89 percent impairment of whole person.** Out of line with impairment relative scale.

#### **Page 59, Exp 3-49 3-50**

**70 to 90 percent impairment of the whole person.** Out of line with impairment relative scale.

#### **Page 69, Exp 4-8**

Marked tiredness and breathlessness with ordinary activities. **80 percent whole person.** Out of line with impairment relative scale.

**Page 110, Exp 5-7**

Increasing dyspnea for 5 years: difficulty keeping up with others the same age. Unable to walk upstairs past second flight. **26 to 50 percent whole person.** Out of line with impairment relative scale.

**Page 111, Exp 5-10.**

Severe dyspnea: unable to perform activities of daily living, try pain to and from work, walking on little ground, said dress. **51 to 100 percent whole person.** Out of line with impairment relative scale.

**Page 344 Exp 13-44:**

Routine venipuncture causing post traumatic neuralgia of the superficial radial nerve secondary to injury. **25% percent of the whole person.** Out of line with impairment relative scale.

### **Utah Clarification**

Utah will adopt the scale of 0% represents a complete and independent individual with 90 percent to 100 percent whole person impairment indicating a very severe organ or body system impairment requiring the individual to be fully dependent on others for self-care, approaching death. *Page 5.* Raters are to use this relative scale in interpreting all ratings throughout the Guides in Utah

## **Chapter 7 Gynecological Impairments are out of line with accepted scales.**

**Page 167, Exp 7-46,**

A symptomatic female with radical hysterectomy and pelvic lymphadenectomy, ovaries conserved. **30% whole person.** Out of line with impairment relative scale.

**Page 168, Exp 7-48**

Pelvic pain secondary to recurrent endometriosis, **20 percent whole person.** Out of line with impairment relative scale.

**Page 169, Exp 7-49,**

Bilateral salpingectomy, **30 percent whole person.** Out of line with impairment relative scale

**Page 169, Exp 7-50,**

Infertility due to primary ovarian failure. **30% whole person.** Out of line with impairment relative scale

### **Utah Clarification**

Utah raters are to calculate their ratings as specific as possible with written justification of their derivations Utah will maintain the methodology that, “ In certain instances, the treatment of an illness may result in apparently total remission of the person’s signs and symptoms. Examples include individuals with deep vein thrombosis with chronic anti-coagulants for more than a year. Yet it is debatable whether, with treatment, the patient has actually regained the previous status of normal good health. In these instances, the physician may choose to increase the impairment estimate by **three percent.**”

## **Inconsistencies exists for the defining, diagnosing and rating RSD, Causalgia and C. R. P. S. 1 & 2**

The Guides states in Chapter 13,Page 343, 13.8, not to use the terminology C. R. P. S. 1 & 2, and to only use the terms RSD, Causalgia.

Yet Chapter 16 states that RSD and Causalgia terms are not to be used, but a very comprehensive review is given for C. R. P. S. 1 & 2.

### **Utah Clarification**

Utah raters are to calculate their ratings for these conditions using the methodology found in chapter 16.5e, p.495, for both the upper and lower extremity.

## **Dominant Extremity Inconsistencies**

Controversy exists as to whether allow an increased of 5-10% impairment for the dominant extremity.

### **Chapter 13 Table 13-22:**

Page 338, 13.6, table 13-16, Chapter 15, Table 15-6, Page 396, awarded five to ten percent more for dominant upper extremity.

### **Chapter 16 16.1 B. page 435**

Impairment ratings in this chapter have not been adjusted for hand dominance.

## **Utah Clarification**

Utah raters are not to consider hand dominance, except as specified for corticospinal tract impairment (page 396).

## **Rating Subjective Complaints**

Instructions for the ratings of subjective complaints of pain..

## **Utah Clarification**

It is believed that the methodology found in the prior editions of the Guides adequately considered pain. Utah raters are **not to award additional percentages for pain under Chapters 13, 16,17 and 18, of the AMA 5<sup>th</sup> edition of the Guides**, until advances in diagnostic technology and clinical experience make pain related impairment ratings feasible.

## **Spinal Chapter, Chapter 15**

Remains very confusing. Two separate ways are described to calculate a rating, with little or no consideration for current published literature. How one selects which method to use remains unnecessarily complicated and confusing.

## **Utah Clarification**

In Utah, Chapter 15 for spinal rating is not to be used, except as specified in the Utah 2002 Impairment Guides.

## **Strength Testing**

Chapters 16 and 17

Strength evaluation: those who have contributed to the guides believe that further research is needed before loss of grip & strength is given a larger role in impairment evaluation page 507

## **Utah Clarification**

In Utah, strength testing is not to be utilized, except as specified in these Utah Guides.

## **Atrophy Chapter 16**

## **Utah Clarification**

In Utah, atrophy is not to be used.

## **Combining Range of Motion in upper extremities and lower extremities.**

5<sup>th</sup> edition is confusing, allowing ROM to be combined in fingers with nerve loss and in lower extremity with nerve loss, but not in upper extremity.

## **Utah Clarification**

In Utah, ROM may be combined with upper and lower extremities as specified

## Errors Identified in the Calculation Process of the 5<sup>th</sup> Edition

### **Error in calculation of impairment for the same example found in two different chapters.**

Page 75, Exp 4-19, Exp is the same case that is found on page 498 16-62. The impairment of 49 percent of whole person is calculated wrong, the Exp. of page 498 calculates a rating of 44 percent whole person and appears correct.

### **Error: The Skin chapter. Impairment exceeds total amount that can be awarded (amputation)**

Page 185, Exp 8-17, post thrombophlebitis syndrome with stasis dermatitis and ulceration; scar formation secondary to chemical burn. 55% percent whole person. The maximum award for complete leg amputation is 40 percent whole person.

### **Error: Award for whole person instead of upper extremity**

Table 13-22: rating for chronic pain in one upper extremity.

Uses dominant and nondominant extremity with ranges of 5 to 10 percent whole person difference. Is awarded as the whole person, not upper extremity.

### **Error: Reference made that is not found**

Page 346 a reference is made to a section 13.8 B. that does not appear to be in the book.

### **Error: Award for whole person instead of lower extremity**

Page 348, Exp 13-46 Exp calculates the impairment as a whole person first and not as a lower extremity and then converting to a whole person.

### **Error: In Calculation**

Page 349, Exp 13-47, Exp. is calculated entirely wrong, concluding with a 31% whole person rating. The correct calculation is 15 percent whole person. (Not only is the methodology incorrect, but the numbers utilized to calculate the rating are also incorrect.)

### **Error: Award for whole person instead of upper extremity**

Page 424 to 15-17 and table 15-18 should be for upper extremity rather than whole person. Refer to page 346 and is inconsistent refer to page 489

### **Error: Award for whole person instead of lower extremity**

Example 425 Should be 1% and 5% lower extremity or 6% lower extremity, not whole person.(See page 489)

### **Error: Wrong calculation process**

Page 438 wrong calculation process, to begin with the biggest number and combine

### **Error: Wrong calculation process**

Page 346 nerve pain, the sensory and motor impairments are first combined to upper extremity and then converted to a whole person impairment page 347

### **Error: Inconsistent: Ratings of conditions that become asymptomatic should be 3%**

Page 218, Exp 10-5, Hashimoto's thyroiditis. Five percent whole person. Inconsistent: Ratings of conditions that become asymptomatic should be 3%.

### **Inconsistency: Vestibular system:**

Chart 11-4, p 253 demonstrates 95% WP for dysequilibrium where as table 13-13, p 334 is 70% for same condition. In Utah, chapter 13 is to be used for dysequilibrium.

## Glossary of Terms

### Definitions of clinical findings accepted by the Utah Labor Commission Glossary of Terms:

#### Medical stability:

Medical Stability sometimes referred to maximum medical improvement (MMI), or fixed state of recovery,<sup>73</sup> refers to a date in which the period of healing has ended and the condition of the worker is not expected to materially improve or deteriorate by more than 3% Whole Person in the ensuing year.<sup>74 75 76 7778</sup> It is important to note that medical stability may not be used to terminate necessary medical care. The date of medical stability and the date when the worker qualifies for an impairment rating can be two separate dates.

#### Causation:

Causation means an identifiable factor, e.g., accident or exposure to hazards of the disease that brought on and worsened a medically identifiable condition, Medical or scientifically based causation requires a detailed analysis of whether the factor, **based on a reasonable probability, greater than 50 percent likelihood**, could have caused the condition, or temporarily-permanently aggravated the condition, based upon scientific evidence and specifically experienced judgment as to whether the alleged factor in the existing environment did cause the permanent impairment.<sup>79</sup>

#### Apportionment of Permanent Impairment Ratings

Apportionment represents a distribution or allocation of causation among multiple factors that caused or significantly contributed to the injury or disease and resulting impairment. The factor could be a pre-existing injury, illness, or impairment. Before determining apportionment, the physician needs to verify that all the following information is true for an individual. No. 1 there is documentation of a prior factor. No. 2 the current permanent impairment is greater as a result of the prior factor, by impairment, the injury, or illness. No. 3 there is evidence indicating the prior factor caused or contributed to the impairment, based on a reasonable probability, greater than 50 percent likelihood.<sup>80</sup>

The apportionment analysis must consider the nature of the impairment and its possible relationship to each alleged factor and must provide an explanation of the medical basis for all conclusions and opinions.<sup>81</sup>

#### Aggravation: Temporary

Temporary aggravation refers to a factor, e.g., physical, chemical, biological, or medical condition, that temporarily alters the course or progression of the medical condition, without a new added dimension of medical impairment.

#### Aggravation: Permanent

Permanent Aggravation refers to a factor, e.g., physical, chemical, biological, or medical condition, that alters the course or progression of the medical condition, with a new added dimension of impairment expected.<sup>82</sup>

#### Muscle Spasm

Muscle spasm is a sudden, involuntary contraction of a muscle or group of muscles, Paravertebral muscle spasm is common after acute spinal injury but is rare in chronic back pain. It is occasionally visible as a contracted paraspinous muscle but is more often diagnosed by palpation (a hard muscle). To differentiate true muscle spasm from voluntary muscle contraction, the individual should not be able to relax the contractions. The spasm should be present standing as well as in the supine position and frequently causes a scoliosis. The physician can sometimes differentiate spasm from voluntary contraction by asking the individual to place all his or her weight first on one foot and then the other while the physician gently palpates the paraspinous muscles. With this maneuver, the individual normally relaxes the paraspinous muscles on the weight bearing side. If the examiner witnesses this relaxation, it usually means that true muscle spasm is not present.

## **Muscle Guarding**

Guarding is a contraction of muscle to minimize motion or agitation of the injured or diseased tissue. It is not true muscle spasm because the contraction can be relaxed. In the lumbar spine, the contraction frequently results in loss of the normal lumbar lordosis and it may be associated with reproducible loss of spinal motion.

## **Asymmetry of Spinal Motion**

Asymmetric motion of the spine in one of the three principal planes is sometimes caused by muscle spasm or guarding. That is, if an individual attempts to flex the spine, he or she is unable to do so moving symmetrically; rather, the head or trunk leans to one side. To qualify as true asymmetric motion, the finding must be reproducible and consistent and the examiner must be convinced that the individual is cooperative and giving full effort.

## **Nonverifiable Radicular Root Pain**

Nonverifiable pain is pain that is in the distribution of a nerve root but has no identifiable origin; i.e., there are no objective physical, imaging, or electromyographic findings. For dermatomal distributions, see Figures 15-1 and 15-2

## **Reflexes**

Reflexes may be normal, increased, reduced, or valid, the involved and normal limb(s) should show marked asymmetry between arms or legs repeated testing. Once lost because of previous radiculopathy, a reflex rarely returns. Abnormal reflexes such as Babinski signs or clonus may be signs of corticospinal tract involvement.

## **Weakness and Loss of Sensation**

To be valid, the sensory findings must be in a strict anatomic distribution, i.e., follow dermatomal patterns (see Figures 15-1 and 15-2). Motor findings should also be consistent with the affected nerve structure(s). Significant, long-standing weakness is usually accompanied by atrophy.

## **Atrophy**

Atrophy is measured with a tape measure at identical levels on both limbs. For reasons of reproducibility, the difference in circumference should be 2 cm or greater in the thigh and 1 cm or greater in the arm, forearm, or leg. The evaluator can address asymmetry due to extremity dominance in the report.

## **Radiculopathy (As defined in the Radiculopathy Schedule, V)**

Radiculopathy for the purposes of the Guides is defined as significant alteration in the function of a nerve root or nerve roots and is usually caused by pressure on one or several nerve roots. The diagnosis requires a dermatomal distribution of pain, numbness and/or paresthesias in a dermatomal distribution. A root tension sign is usually positive. The diagnosis of herniated disk must be substantiated by an appropriate finding on an imaging study. The presence of findings on an imaging study in and of itself does not make the diagnosis of radiculopathy. There must also be clinical evidence as described above.

## **Electrodiagnostic Verification of Radiculopathy**

Unequivocal electrodiagnostic evidence of acute nerve root pathology includes the presence of multiple positive sharp waves or fibrillation potentials in muscles innervated by one nerve root. However, the quality of the person performing and interpreting the study is critical. Electromyography should be performed only by a licensed physician performed only by a licensed physician qualified by reason of education, training and experience in these procedures. Electromyography does not detect all compressive radiculopathies and cannot determine the cause of the nerve root pathology. On the other hand, electromyography can detect non-compressive radiculopathies, which are not identified by imaging studies.

### **Cauda Equina Syndrome**

Cauda equina syndrome is manifested by bowel or bladder dysfunction, saddle anesthesia and variable loss of motor and sensory function in the lower extremities. Individuals with cauda equina syndrome usually have loss of sphincter tone on rectal examination and diminished or absent bladder, bowel and lower limb reflexes.

### **Urodynamic Tests**

Cystometrograms are useful in individuals where a cauda equina syndrome is possible but not certain. A normal cystometrogram makes the presence of a nerve-related bladder dysfunction unlikely. Occasionally, more extensive urodynamic testing is necessary.



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