Back To Chiropractic Continuing Education Seminars Med-Legal Report Writing for Chiropractors ~ 4 Hours

Revised 06/5/2025

This course is a 4 Hour mandatory requirement for QMEs for the California Department of Industrial Relations, Division of Worker's Compensation (DWC).

This course also counts as a 4 Hour CE Elective for the Board of Chiropractic Examiners for the state of California.

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Purpose of the Q.M.E.

- Qualified medical evaluators (QMEs) are qualified physicians who are <u>certified by the Division of Workers' Compensation Medical Unit</u> to examine injured workers to <u>evaluate disability</u> and write medical-legal reports.
- These Med-Legal reports are used to <u>determine an injured worker's eligibility</u> for workers' <u>compensation benefits</u>.
- QMEs include <u>medical doctors</u>, <u>doctors of osteopathy</u>, <u>doctors of chiropractic</u>, <u>dentists</u>, <u>optometrists</u>, <u>podiatrists</u>, <u>psychologists</u> and <u>acupuncturists</u>.

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

- Apportionment: Must be based on Substantial Evidence. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries.
- **Substantial Evidence:** Consists of the following essential elements within the Med-Legal report;
- 1. Opinion must be based on "reasonable medical probability."
- 2. The report must contain a legally compliant apportionment discussion pursuant to LC 4663.
- 3. A medical report cannot be "predicated on incorrect legal theory."
- <u>Proximate Cause</u>: Proximate Cause is the event that causes subsequent related events that result in injury. Proximate cause is referred to as the "cause and effect" of the industrial injury. Without a cause/action, there would not be a resulting injury.
- Overlap: Overlap refers to similar findings pertaining to the prior permanent disability and the current one. Defendants have the burden of proving overlap between the prior award and the new rating.
- <u>Duplication</u>: The determination if some or all factors of disability are the same or different. If the disability is the same, then duplication exists. If the factors of disability are different, then duplication does not exist. Duplication is relevant in situations where multiple body parts render similar disabilities (i.e. knee & back). The physician needs to explain why and how the disabilities are different. If not, the factors of disability will be found to be duplicative.

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

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

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

- Q. What is the difference between an AME and a QME?
- A. If you have an attorney, your attorney and the claims administrator may agree on a doctor without going through the state system used to pick a QME. The doctor your attorney and the claims administrator agree on is called an agreed medical evaluator (AME). A QME is picked from a list of state-certified doctors issued by the DWC Medical Unit. QME lists are generated randomly. An AME can only be used if you are represented by an attorney. Once you see an AME you are not entitled to see a QME. An AME may be used regardless of the year of injury. An AME physician may be a QME, but does not have to be one.
- Q. What is a panel QME?
- A. In this context, the word panel means a list. A panel QME is a randomly generated list of three QME physicians issued to you when there is a question about whether or not your injury is work related, or if there is a medical dispute that hasn't been resolved by the treating physician's report. Whoever fills out the form to request the panel QME chooses the specialty of the doctors on the panel.

- Q. I have two different problems from the same injury (for instance, a psychiatric and an orthopedic problem). <u>May I request two panels</u>, one psychiatric and one orthopedic?
- **A.** The <u>basic rule is that you get one</u>. The claims administrator is only required to pay for one QME evaluation. The <u>selected QME can get a consultation from another physician</u> if there is a need for input from more than one medical specialty.
- However, there are some circumstances where a workers' compensation administrative law judge, the Division of Workers' Compensation's executive medical director or a state information & assistance officer may request an additional panel. In those cases, a panel will be provided.
 - (Title 8, California Code of Regulations, section 32 (c), Labor Code sections 5703.5(a), 5703.5(b), 4063.3(i))

- Q. Can I get a new panel because the physicians on the panel are too far away?
- A. No. The Medical Unit cannot replace physicians based on distance from your address and cannot simply choose the physicians closest to you. By law, the QME panel process must be done randomly according to ZIP code. The claims administrator will pay your transportation costs to see the QME.
- Q. The QMEs on the panel you issued are close to my home. However, can you give me a panel closer to work?
- **A.** The <u>law requires the Medical Unit to issue panels close to your residence</u>. However, the DWC Medical Unit <u>can issue a panel of QMEs using the ZIP code of your workplace</u> if the claims administrator agrees to this request.
 - (Title 8, California Code of Regulations, section 31.5 (b) (2, Labor Code section 139.2 (h))

- Q. I was issued a panel of orthopedists at the claims administrator's request. However, I want to see a *chiropractor*. Will you issue a new panel?
- **A.** No. You had the first chance to send in the request form and to select the specialty of the QME. If you (the injured worker) failed to make the request within the **10-day deadline**, the claims administrator has the right to select the specialty of the panel.

- Q. My QME evaluation was yesterday. How long does the doctor have to issue the report?
- **A.** The QME has <u>30 calendar days</u> from the date of the commencement of the exam to issue the report. <u>There are three reasons a physician may request an extension:</u>
- 1. The physician requested you have <u>medical tests and is awaiting results</u>
- 2. The physician requested a <u>consultation and is awaiting the consultant's report</u>
- 3. The physician has a "good cause" for an extension. A good cause is a medical emergency of the evaluator or the evaluator's family, death in evaluator's family, natural disaster or other community catastrophes that interrupt the operation of the evaluator's office. The computer breaking down or a staff member quitting is not considered good cause. Extensions for good cause may not exceed 15 days from the date the report is required to be served.
- The physician <u>may not request an extension because the claims administrator failed to provide your medical records or past medical tests.</u> If the report is going to be late, the physician must file a time frame extension request with the DWC Medical Unit and send a copy to the claims administrator and to you. This must be filed five days before the report is due. (Title 8, California Code of Regulations, section 38)

- Q. I need another evaluation. Should the original QME do it? What if that physician is no longer performing QME evaluations?
- **A.** The second evaluation should be done by the same QME. The exceptions to this rule are:
- The physician is no longer available
- The physician became the treating physician after performing the QME evaluation
- A workers' compensation administrative law <u>judge decides you should have a new evaluation</u> with a <u>different QME</u>.
- If any exception applies, you may begin the QME request process again and you will receive a new panel.
 - (Labor Code sections 4062.3(j); 4067)

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

- Q. The QME evaluation is next week, but I have not received the medical records and neither has the QME. What should be done?
- A. <u>There are two options:</u>
- 1. You may <u>cancel the appointment</u>, call the claims administrator or treating doctor to obtain the records, and then reschedule the appointment
- 2. You may <u>keep the appointment</u> and have the claims administrator send the records to you and then to the QME after the evaluation. Some QMEs don't want to do an evaluation without the records, so check with the QME's office to see if the appointment should be rescheduled.

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

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

<u>Unrepresented Cases:</u>

• If either the <a href="employee or employer objects to a medical determination made by the treating physician concerning the existence or extent of permanent impairment and limitations or the need for future medical care, and if the employee is not represented by an attorney, the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators.

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

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

Represented Cases:

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

Labor Code Section 4610 Utilization Review

- The **UR process is governed by Labor Code section 4610 and regulations** written by the CA Division of Workers' Compensation (DWC), which lay out <u>timeframes and other rules for conducting UR.</u> The rules, contained in Title 8, California Code of Regulations, sections 9792.6 et seq, also require <u>UR plans to be filed</u> with the DWC administrative director.
- Additionally, the DWC has promulgated regulations that provide for <u>penalties to apply</u> <u>when claims administrators and UR companies don't follow UR rules.</u>
- The UR penalty regulations, found in Title 8, California Code of Regulations, sections 9792.11 9792.15, provide an **enforcement mechanism to ensure utilization reviews** are conducted in compliance with UR regulations.

Labor Code 4604.5

- (a) The recommended guidelines set forth in the **medical treatment utilization schedule** adopted by the administrative director pursuant to Section 5307.27 **shall be presumptively correct** on the issue of extent and scope of medical treatment.
- The presumption is rebuttable and may be controverted by a
 preponderance of the scientific medical evidence establishing
 that a variance from the guidelines reasonably is required to cure or
 relieve the injured worker from the effects of his or her injury. The
 presumption created is one affecting the burden of proof.
- (b) The recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices that are **evidence and scientifically based**, **nationally recognized**, **and peer reviewed**. The guidelines shall be designed to assist providers by offering an analytical framework for the evaluation and treatment of injured workers, and shall constitute care in accordance with Section 4600 for all injured workers diagnosed with industrial conditions.

Labor Code 4604.5

- (c) (1) Notwithstanding the medical treatment utilization schedule, for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury. (2) (A) Paragraph (1) shall not apply when an employer authorizes, in writing, additional visits to a health care practitioner for physical medicine services.
- Payment or <u>authorization for treatment beyond the limits</u> set forth in paragraph (1) shall not be deemed a waiver of the limits set forth by paragraph (1) with respect to future requests for authorization. (B) The Legislature finds and declares that the amendments made to subparagraph (A) by the act adding this subparagraph are declaratory of existing law. (3) Paragraph (1) shall not apply to visits for postsurgical physical medicine and postsurgical rehabilitation services provided in compliance with a postsurgical treatment utilization schedule established by the administrative director pursuant to Section 5307.27.
- (d) For all injuries not covered by the official utilization schedule adopted pursuant to Section 5307.27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are recognized generally by the national medical community and scientifically based.

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

- Chapter 4.5. Division of Workers' Compensation Subchapter 2. Workers' Compensation Appeals Board--Rules and Practice Procedure Article 9. Evidence and Reports
- (a) The Workers' Compensation Appeals Board favors the production of medical evidence in the form of written reports.
- (b) Medical reports should include where applicable:
- (1) the date of the examination;
- (2) the history of the injury;
- (3) the patient's complaints;
- (4) a listing of all information received in preparation of the report or relied upon for the formulation of the physician's opinion;
- (5) the patient's medical history, including injuries and conditions, and residuals thereof, if any;
- (6) findings on examination;
- (7) a diagnosis;
- (8) opinion as to the nature, extent, and duration of disability and work limitations, if any;
- (9) cause of the disability;
- (10) treatment indicated, including past, continuing, and future medical care;
- (11) opinion as to whether or not permanent disability has resulted from the injury and whether or not it is stationary. If stationary, a description of the disability with a complete evaluation;
- (12) apportionment of disability, if any;
- (13) a determination of the percent of the total causation resulting from actual events of employment, if the injury is alleged to be a psychiatric injury;
- (14) the reasons for the opinion; and,
- (15) the signature of the physician.

Pros & Cons of being a Chiropractic QME

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

Pros & Cons of being a Chiropractic QME

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

QME Referrals – Section 32

- Q. Can a QME make referrals without first obtaining authorization from the employer/claims administrator?
- Section 32 of the QME Regulations has changed since 2009 and QMEs are prohibited from making referrals for the purpose of diagnostics and/or consultations without first obtaining prior authorization. A Request For Authorization (RFA) should be made using the <u>DWC form RFA</u>.
- NOTE: The QME has never been granted permission to refer an injured worker out for treatment. Any further treatment should be outlined in your QME report, which explains in detail the need for such care. For example, the injured worker is not yet deemed permanent and stationary because of lack of appropriate treatment (i.e. surgery, medications, physical medicine, etc.), which may also include diagnostic studies.
- The QME is prohibited from referring the injured worker out for the purpose of obtaining the disability/impairment rating, which is the QME's responsibility to determine unless outside their scope of practice.

QME Referrals – Section 32

- If the QME is given authorization to make a referral for treatment, diagnostics and/or consultations, it is their responsibility to follow-up and arrange the referral.
- (d) Whenever an Agreed Panel QME or a QME determines that a consultation is necessary pursuant to this section and the physician selected for the consultation is not selected by the parties from a QME panel issued by the Medical Director, the referring QME must arrange the consultation appointment and advise the injured employee and the claims administrator, or if none the employer, and each party's attorney if any, in writing of the appointment date, time and place by use of QME Form 110 (QME Appointment Notification Form)(See, 8 Cal. Code Regs. § 110).
- The QME must include and annotate the results within their subsequent supplemental report within 15 days of receipt of the results and copy all stakeholders.

How to Become a QME

- Q. How do I become a QME? How do I register for the test?
- A. To become a QME, you must meet the requirements that are listed in Labor Code section 139.2. If you meet these requirements, you should submit a completed application form to the Division of Workers' Compensation Medical Unit. You also must submit a test registration form. Prior to becoming a QME you have to pass the QME competency exam. Tests are scheduled twice a year in April and Oct. Upon passing the test and paying the QME annual fee, you will be a certified QME. (Labor Code § 139.2(b) (n), 8 CCR § 10). Prior to appointment as a QME, a physician is required to take a 12-hour course about writing medical legal reports. (8 CCR § 11.5)
- Q. What is the deadline for submitting my application and registration form?
- **A.** A properly completed application for appointment and an exam registration form must be received, or postmarked, **45 calendar days prior to the date of the exam**. (8 CCR § 11(f)(4))

How to Become a QME

- Q. Is there a fee to take the QME exam?
- **A.** Yes. There is a \$125 fee to take or retake the exam. (8 CCR § 11 (f) (2))
- Q. What is the annual fee to be a QME?
- **A.** The <u>annual fee is \$250</u> if you performed 25 or more comprehensive medical-legal evaluations in the year prior to assessment of the fee.
- If you performed <u>11-24 examinations</u>, the annual fee is \$125.
- If you performed <u>o-10</u>, the fee is \$110.
- This fee is for one office location.
- If you wish to have additional locations, the fee is \$100 for each additional location. (Labor Code § 139.2 (n), 8 CCR § 17)

How to Become a QME

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

Becoming a qualified medical examiner:

QME Exam

- . Upcoming QME Exam
 - Exam packet
 - Exam application

QME Exam

- Upcoming QME Exam
 - Exam packet
 - Exam application

Study Guides:

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

QME competency examination results:

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

Online QME Form 106 Panel Request

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

QME EXAM

April 16, 2016

PDRS (Permanent Disability Rating Schedule)

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

Evaluation protocols:

For injuries rated under 1997 permanent disability rating schedule and prior

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

February 2016

PDRS (Permanent Disability Rating Schedule)

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

N. FACTORS OF DISABILITY

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

1. Subjective Factors of Disability

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

DESCRIPTION OF ACTIVITIES

BALANCING: Maintaining body equilibrium

BENDING: Angulation from neutral position about a joint (e.g. elbow) or

spine (e. g. forward)

CARRYING: Transporting an object, usually holding it in the hands or arms

or on the shoulder

CLIMBING: Ascending or descending ladders, stairs, scaffolding, ramps,

poles, etc. . . using feet and legs and/or hands and arms.

CRAWLING: Moving about on hands and knees and feet.

CROUCHING: Bending body downward and forward by bending lower limbs,

pelvis and spine.

FEELING: Perceiving attributes of objects such as size, shape, temperature,

or texture by means of receptors in the skin, particularly those

of the finger tips.

FINGERING/ Picking, pinching or otherwise working with fingers and PINCHING:

thumb primarily (rather than with whole hand or arm as in

handling).

GRASPING/ Seizing, holding, grasping, turning or otherwise working

HANDLING: with hand or hand (fingering not involved).

JUMPING: Moving about suddenly by use of leg muscle, leaping from or

onto the ground or from one object to another.

KNEELING: Bending legs at knees to come to rest on knee or knees.

Raising or lowering an object from one level to another LIFTING:

(includes upward pulling)

OVERHEAD/ Performing work activities with arm raised and held

OVER SHOULDER: unsupported, at or above shoulder level.

PIVOTING: Planting your foot and turning about that point.

PUSHING: Exerting force upon an object so that the object moves away

from the force (includes slapping, striking, kicking and treadle

actions).

PULLING: Exerting force upon an object so that the object moves towards

the force (includes jerking).

REACHING: Extending the hand(s) and arm(s) in any direction.

RUNNING: Moving in a fast pace, moving the legs rapidly so that for a

moment both legs are off the ground.

SITTING: Remaining in the normal seated position.

SQUATING: Crouching to sit on your heels, with knees bent and weight on

the balls of your feet.

STANDING: Remaining on one's feet in an upright position at a work station

without moving about.

STOOPING: Bending body downward and forward by bending spine at

waist.

TURNING/

TWISTING:

Moving about a central axis, revolve or rotate.

USE OF HAND OR Required to control a machine by use of controls.

FOOT CONTROLS:

WALKING: Moving about at a moderate pace over even or uneven ground.

PDRS (Permanent Disability Rating Schedule)

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

2. Objective Factors of Disability

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

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

3. Loss of Pre-Injury Capacity

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

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

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

4. Work Restrictions

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

Intensity vs. Frequency of Pain

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

• INTENSITY OF PAIN/SYMPTOMS:

SEVERE	Severe pain would preclude the activity precipitating the pain.
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• MODERATE Moderate pain can be tolerated, but would cause a marked handicap

in the performance of the activity precipitating the pain.

• **SLIGHT** Slight pain can be tolerated, but would cause some handicap in the

performance of the activity precipitating the pain.

MINIMAL Minimal (same as mild) pain would constitute an annoyance, but

would cause no handicap in the performance of the particular activity.

(Minimal pain is a non-ratable permanent disability)

Intensity vs. Frequency of Pain

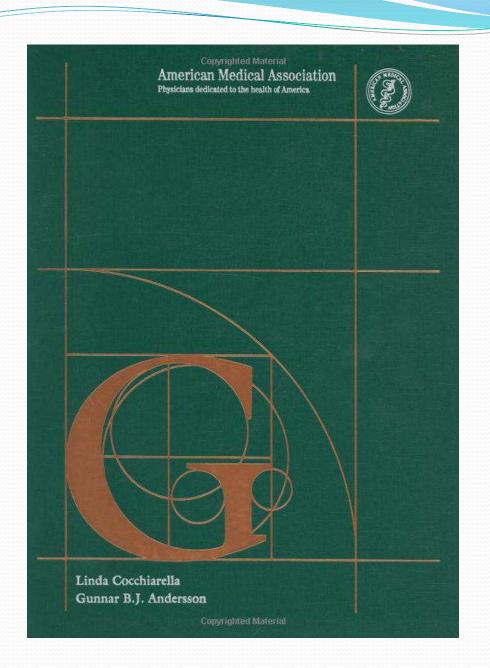
• FREQUENCY OF PAIN/SYMPTOMS:

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

QME CE

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



- ROM vs DRE Spine Example:
- DDX: Lumbar Disc Protrusion (L3-4 & L5-S1) (MRI Verified) & Intervertebral Disc Degeneration L3-4 (MRI Verified)
- Range of Motion (ROM) method to be used with lumbar spine.
- DRE not to be used for lumbar spine rating when multiple levels are identified objectively through MRI and clinical findings on exam.
- Table 15-8; Page 407; (Lumbar Flexion/Extension) Chapter 15
- Table 15-9; Page 409; (Lumbar Lateral Flexion) Chapter 15

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

• ROM vs DRE - Spine Example:

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

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

• ROM vs DRE - Spine Example:

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

- Sample Rating for D.O.I > 01/01/2005
- The AMA guides 5th edition is currently still used in California for dates of injury that extend beyond 1/1/2005.
- The AMA Guides require that the doctor utilize the textbook to determine an appropriate impairment rating based on the specific chapter(s), tables and figures as described and based on the injured body part(s).

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

- EXAMPLE:
- <u>D.O.I.:</u> 12/25/2008
- SUBJECTIVE COMPLAINT:
- Neck pain with radiculopathy into the left upper extremity.
- OBJECTIVE FINDINGS:
- All measurements met validity criteria
- (sets of three within 5 degrees of the mean or 10%, whichever is greater).
- The <u>mean</u> is calculated by taking the sum of the highest and lowest values and dividing by two.

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

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

• <u>Figure 15-18</u>; <u>Page 422</u>; (<u>Cervical Range of Motion (ROM)*</u>) <u>Chapter 15</u>

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

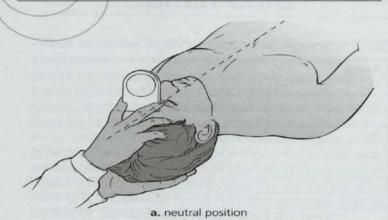
TOTAL Cervical ROM Impairment=???%

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

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

a.	Left Lateral Bend- ing From Neutral	Degree	s of I Motion	% Impairment of
	Position (0°) to (°):	Lost	Retained	the Whole Person
	0	45	0	4
	15	30	15	2
	30	15	30	1
	45	0	45	0
b.	Right Lateral Bend- ing From Neutral	Degrees of Cervical Motion		% Impairment of
	Position (0°) to (°):	Lost	Retained	the Whole Person
14	0	45	0	4
	15	30	15	2
	30	15	30	1
	45	0	45	0
c.	Ankylosis Region Ankylosed a	t (°):		
	0 (neutral position)	No second		8
	15			20
	30			30
	45 (full left or right i	rotation)		40

Figure 15-17 Measuring Cervical Rotation



b. right rotation

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

Abnormal Motion	
Average range of rotation is 1	60°;
the proportion of all cervical r	notion is 35%.

a.	Left Rotation From Neutral	Degree	s of Motion	% Impairment of
	Position (0°) to (°):	Lost	Retained	the Whole Person
	0	80	0	6
	20	60	20	4
	40	40	40	2
	60	20	60	1
	80	0	80+	0
b.	Right Rotation From Neutral	Degrees of Cervical Motion		% Impairment of
	Position (0°) to (°):	Lost	Retained	the Whole Person
	0	80	0	6
	20	60	20	4
	40	40	40	2
	60	20	60	1
	80	0	80+	0
c.	Ankylosis Region Ankylosed a	nt (°):		e e e e e e e e e e e e e e e e e e e
	0 (neutral position)	0 (neutral position)		
	20			20
	40			30
	60			40
	80 (full right or left i	rotation)		50
	A STATE OF THE PARTY OF THE PAR			AND RESIDENCE OF THE PARTY OF T

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

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

a.	Flexion From Neutral Position (0°) to (°):	Degree Cervica Lost	es of al Motion Retained	% Impairment of the Whole Person		
	0	50	0	5		
	15	35	15	4		
	30	30	20	2		
	50	0	50	0		
b.	Extension From Neutral Position	THE STATE OF THE S	I Motion	% Impairment of		
	(0°) to (°):	Lost	Retained	the Whole Person		
	0	60	0	6		
	20	40	20	4		
	40	20	40	2		
	60	0	60+	0		
c.	Region Ankylosed a	t (°):				
	0 (neutral position)			12		
-	15	- Lane		20		
	30			30		
	50 (full flexion)			40		
d.	Region Ankylosed at (°):					
	0 (neutral position)	The same		12		
	20			20		
	40 ~			30		
	60 (full extension)			40		

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

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

Total cervical range of motion and ankylosis* impairment _______%

Position

Cervical ankylosis in

rotation

% Impairment

% Impairment

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

(Excludes any impairment for abnormal

rotation)

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

Table 15-15 Determining Impairment Due to Sensory Loss

a. Classification		
Grade	Description of Sensory Deficit	% Sensory Deficit
5	No loss of sensibility, abnormal sensation, or pain	0
4	Distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations or pain, that is forgotten during activity	1-25
3	Distorted superficial tactile sensibility (diminished light touch and two-point discrimination), with some abnormal sensations or slight pain, that interferes with some activities	26-60
2	Decreased superficial cutaneous pain and tactile sensibility (decreased protective sensibility), with abnormal sensations or moderate pain, that may prevent some activities	6 1-80
1	Deep cutaneous pain sensibility present; absent superficial pain and tactile sensibility (absent protective sensibility), with abnormal sensations or severe pain, that prevents most activity	81-99
0	Absent sensibility, abnormal sensations, or severe pain that prevents all activity	100

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

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

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

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

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

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

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

* Adapted from Medical Research Council.19

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

Nerve Root Impaired	Maximum % Loss of Function Due to Sensory Deficit or Pain	Maximum % Loss of Function Due to Strength
L3	5	20
L4	5	34
L5	. 5	37
51	5	20

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

15.15 Spine Evaluation Summary

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

ame	Soc. Sec	. No	Date
mpairment	Cervical	Thoracic	Lumbar
1. DRE Method (Tables 15-3 through 15-5)			
2. Range-of-Motion Method (and Table 15-8)	((I))) (I) (I) (I) (I) (I) (I) (I) (I)		
3. Nerve root: Loss of sensation with or without pain Loss of strength			
4. Other (From Section 15.14)			
 Regional impairment total (combine impairments in each column using the Combined Values Chart, p. 604) 			
5. Spine impairment total (combine all regional totals using the Combined Values Chart)			
7. Impairment(s) of other organ systems: for each impair	ment list condition, p	age number in Guides, and per	centage of impairment.
Impaired System		% Impairment	Guides Page Number
a.			
b.			
· с.			
d			
e.			

Sample AMA Rating

Impairment Guidelines

I C-SP DRE CARECOM III

(T-SP) DRE CATEGORY II

80% WP IMPARMENT

IMPAIRMENT RATING SUMMARY:

song passes	on, #	TOSE FIGURE H	wp% inarranin
C-SP	15-PG.392	DRE CATEGOY III	18%
T-SP	15-PG.389	ORE CHEWY II	8%
(BUE	16-16436-7	numple thouseless	20%
DUE	16-06-436-7	murine race fact	12%

TOTAL IMPARAMENT PATHUM IS 47% WHOLE PERSON, USING THE COMBINED VALUES CHOST ON PATHE 604, TO CONSIDE 20 & 18 TO OFT 34 AND THEN CONSIDE WITH 12 TO UET 42 AND PHATY COMBINE & 8.

Combined Values Chart

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2	48 49 50		42 43 44	37 38 39 40	32 33 34 35	27 28 29	23 24 25	18 19 20	13 14 15	9 10 11	4 5 6
3	49 50 51		43 44 45	38 39 40 41	33 34 35 36	28 29 30	23 24 25	19 19 20	14 15 16	11 12	6 7 8
4	49 50 51		43 44 45	40 40 41	34 35 36 37	30 31	24 25 26	19 20 21	16	11 12 13	8 9
5	49 50 51 52 53	48	44 45	39 40 41 42	35 36 37	29 30 31 32 33	24 25 26 27 28	19 20 21 22 23	15 16	12 13 14	10
6	50 51 52		45 45 46	40 41 42 43	35 36 37 38	30 31 32	26 27 28	21 22 23	17 18	14 14	
7	51 52 53		45 46 47	40 41 42 43	36 37 38 39	31 32 33	27 27 28	22 23 24	17 18 19	14 14 15	
8	51 52 53		46 47 48	41 42 43 44	37 37 38 39	32 33 34	27 28 29	23 24 25	18 19 20	15 16	
9	52 53 54		46 47 48	43 44 44	37 38 39 40	33 34 34	28 29 30	24 24 25	18 19 20 21 22	17	
10	52 53 54		47 48 49	42 43 44 45	38 39 40 41	33 34 35	29 30 31	24 25 26	20 21 22	- 10	
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ADL's

Play Role in Impairment

JAN 22, 2005

AMERICAN MEDICAL ASSOCIATION

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

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

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

In Activities of Daily Living Commonly Measured in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (JADL) Scales 67

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

Pain Add On - Example:

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

- Page 5 of the AMA Guides indicates..."The *Guides* refers to common ADLs, as listed in Table 1-2. The ADLs listed in this table correspond to the activities that physicians should consider when establishing a permanent impairment rating. *A physician can often assess a person's ability to perform ADLs based on knowledge of the patient's medical condition and clinical judgment."*
- A 3% whole person impairment for pain may be assigned. Please review figure 18-1, page 574 of the AMA Guides and also 18.3d part C on page 573.
- Step three states "If pain-related impairment appears to increase the burden of the individual's condition slightly, the examiner can increase the percentage found in step 1 by up to 3%. No formal assessment of pain-related impairment is required."

Determine which method to use: DRE or ROM

15.2 Determining the Appropriate Method for Assessment

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

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

The ROM method is used in several situations:

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

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

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

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

15.2a Summary of Specific Procedures and Directions

- 1. Take a careful history, perform a thorough medical examination, and review all pertinent records and studies. This is helpful in determining the presence or absence of structural abnormalities, nerve root or cord involvement, and motion segment integrity.
- 2. Consider the permanency of the impairment, referring to Guides Chapter 1 and the Glossary for definitions as needed. If the impairment is resolving, changing, unstable, or expected to change significantly with or without medical treatment within 12 months, it is not considered a permanent (stable) impairment and should not be rated under the Guides criteria.

- Select the region that is primarily involved (ie, the lumbar, cervical, or thoracic spine) and identify the individual's most serious objective findings.
- 4. Determine whether the individual has multilevel involvement or multiple recurrences/occasions within the same region of the spine. Use the ROM method if:
 - a. there are fractures at more than one level in a spinal region,
 - b. there is radiculopathy bilaterally or at multiple levels in the same spinal region,
 - c. there is multilevel motion segment alteration (such as a multilevel fusion) in the same spinal region, or
 - d. there is recurrent disk herniation or stenosis with radiculopathy at the same or a different level in the same spinal region; in this case, combine the ratings using the ROM method.

- 5. If the individual does not have multilevel involvement or multiple recurrences/occasions and an injury occurred, determine the proper DRE category. Most ratings will fall into categories I, II; or III. A corticospinal tract injury is evaluated according to Section 15.7.
- 6. If the individual has been treated with surgery or another modality, evaluate the results, extent of improvement, and impact on the ability to perform activities of daily living. If residual symptoms or objective findings impact the ability to perform ADL despite treatment, the higher percentage in each range should be assigned. If an individual had a prior condition, was asymptomatic, and now—at MMI—has symptoms that impact the ability to perform activities of daily living, the higher rating within a range may also be used. If ratings are increased, explicit documentation of the reasons for the increase should be included in the report.
- 7. If more than one spine region is impaired, determine the impairment of the other region(s) with the DRE method. Combine the regional impairments using the Combined Values Chart (p. 604) to express the individual's total spine impairment.
- 8. From historical information and previously compiled medical data, determine if there was a pre-existing impairment. Congenital, developmental, and other preexisting conditions may be differentiated from those attributable to the injury or illness by examining preinjury roentgenograms or by performing a bone scan after the onset of the condition.

- 9. If requested, apportion findings to the current or prior condition, following jurisdiction practices and assuming adequate information is available on the prior condition. In some instances, to apportion ratings, the percent impairment due to previous findings can simply be subtracted from the percent based on the current findings. Ideally, use the same method to compare the individual's prior and present conditions. If the ROM method has been used previously, it must be used again. If the previous evaluation was based on the DRE method and the individual now is evaluated with the ROM method, and prior ROM measurements do not exist to calculate a ROM impairment rating, the previous DRE percent can be subtracted from the ROM ratings. Because there are two methods and complete data may not exist on an earlier assessment, the apportionment calculation may be a less than ideal estimate.
- For individuals with corticospinal tract involvement, refer to Table 15-6 for the appropriate impairment rating.

Use Algorithm:

To determine impairment evaluation process

Figure 15-4 Spine Impairment Evaluation Process Individual at maximal No Await MMI medical improvement (MMI) Yes . Permanent impairment Illness Injury due to injury or illness Yes No ROM method Single level Yes No 1. Diagnosis First injury or 2. Measure ROM repeat injury, different regions 3. Determine neurologic deficit DRE method Combine areas 1-3 with Combined Place in Values Chart category Deteriorated; repeat injury e ar relevent proporties de la proportie de la completa de la completa de la completa de la completa de la com

The Spine

ROM
Range of Motion Method
(Inclinometry)

Examples of when to use ROM Method:

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

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

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

a. neutral position
b. flexion
d. straight leg raising (used for validation purposes)

S1

a.

b.

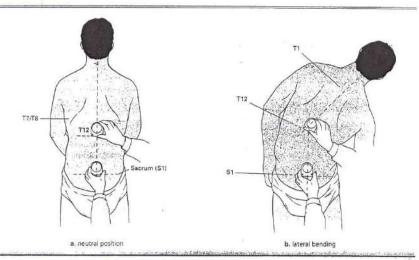
Table 15-8 Impairment Due to Aprormal Motion of the Lumbar Region: Flexion and Extension*

The proportion of flexion and extension of total

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

True Lumber Spine Extension From Neutral Position	Lumbo Spine #	sacral	% Impairment of the
(0°) to:	Lost	Retained	Whole Person
0	25	0	7
10	15	10	5
15	10	15	3
20	5	20	2
25	0	25	0

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



CHESCHIER CONTRACTOR OF THE CO and Ankylosis of the Lumbar Region: Lateral Bending

Abnormal Motion

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

a.	Left Lateral Bend- ing From Neutral Position (0°) to:		al Motion	% Impairment of			
		Lost	Retained	the Whole Person			
	0	25	0	5			
	10	15	10	3			
	15	10	15	2			
	20	5	20	1			
	25	0	25	0			
b.	Right Lateral Bend- Ing From Neutral	Degrees of Lum- bosacral Motion		% impairment of the Whole Person			
	Position (*) to:	Lost Retained					
	0	25	0	5			
	10	15	10	3			
	15	10	15	2			
	20	5	20	1			
	25	0	25	0			
с.	Ankylosis / FUSION Region Ankylosed at (*):						
	0 (neutral position)	10					
	30	30					
	45	45					
	60	40					
(Non-Call-	75 (full flexion)	50					

LATERAL preparedo

[WISTALLE) SIR IN FLEXION LHAPT

DRE Method

(Diagnosis Related Estimate)

Place patient into appropriate category

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

DRE Cervical Category I 0% Impairment of the Whole Person

No significant clinical findings, no muscular guarding, no documentable neurologic impairment, no significant loss of motion segment integrity, and no other indication of impairment related to injury or illness; no fractures

DRE Cervical Category II 5%-8% Impairment of the Whole Person

Clinical history and examination findings are compatible with a specific injury; findings may include muscle guarding or spasm observed at the time of the examination by a physician, asymmetric loss of range of motion or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity

or

individual had clinically significant radiculopathy and an imaging study that demonstrated a herniated disk at the level and on the side that would be expected based on the radiculopathy, but has improved following nonoperative treatment

or

fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation that has healed without loss of structural integrity or radiculopathy; (3) a spinous or transverse process fracture with displacement

DRE Cervical Category III 15%-18% Impairment of the Whole Person

Significant signs of radiculopathy, such as pain and/or sensory loss in a dermatomal distribution, loss of relevant reflex(es), loss of muscle strength, or unilateral atrophy compared with the unaffected side, measured at the same distance above or below the elbow; the neurologic impairment may be verified by electrodiagnostic findings

or

individual had clinically significant radiculopathy, verified by an imaging study that demonstrates a herniated disk at the level and on the side expected from objective clinical findings with radiculopathy or with improvement of radiculopathy following surgery

or

fractures: (1) 25% to 50% compression of one vertebral body; (2) posterior element fracture with displacement disrupting the spinal canal; in both cases the fracture is healed without loss of structural integrity; radiculopathy may or may not be present; differentiation from congenital and developmental conditions may be accomplished, if possible, by examining preinjury roentgenograms or a bone scan performed after the onset of the condition

DRE Cervical Category IV 25%-28% Impairment of the Whole Person

Alteration of motion segment integrity or bilateral or multilevel radiculopathy: alteration of motion segment integrity is defined from flexion and extension radiographs as at least 3.5 mm of translation of one vertebra on another, or angular motion of more than 11° greater than at each adjacent level (Figures 15-3a and 15-3b); alternatively, the individual may have loss of motion of a motion segment due to a developmental fusion or successful or unsuccessful attempt at surgical arthrodesis; radiculopathy as defined in cervical category III need not be present if there is alteration of motion segment integrity

0

fractures: (1) more than 50% compression of one vertebral body without residual neural compromise

DRE Cervical Category V 35%-38% Impairment of the Whole Person

Significant upper extremity impairment requiring the use of upper extremity external functional or adaptive device(s); there may be total neurologic loss at a single level or severe, multilevel neurologic dysfunction

or

fractures: structural compromise of the spinal canal is present with severe upper extremity motor and sensory deficits but without lower extremity involvement

THE SPINE Page 384

DRE (Diagnosis-Related Estimate)

(Lumbar Spine)

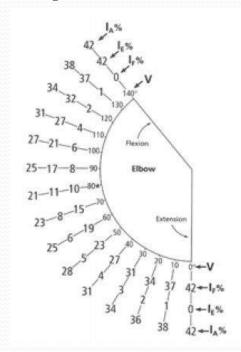
Table 1	5-3	Criteria	for Rat	ing Im	pairment	Due to	Lumbar	Spine	Injury	9
---------	-----	----------	---------	--------	----------	--------	--------	-------	--------	---

DRE Lumbar Category I	DRE Lumbar Category II	DRE Lumbar Category III	DRE Lumbar Category IV	DRE Lumbar Category V
0% Impairment of	5%-8% Impairment of	10%-13% Impairment of	20%-23% Impairment of	25%-28% Impairment of
the Whole Person	the Whole Person	the Whole Person	the Whole Person	the Whole Person
No significant clinical findings, no observed muscle guarding or spasm, no documentable neurologic impairment, no documented alteration in structural integrity, and no other indication of impairment related to injury or illness; no fractures	Clinical history and examination findings are compatible with a specific injury; findings may include significant muscle guarding or spasm observed at the time of the examination, asymmetric loss of range of motion, or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity and no significant radiculopathy or individual had a clinically significant radiculopathy and has an imaging study that demonstrates a herniated disk at the level and on the side that would be expected based on the previous radiculopathy, but no longer has the radiculopathy following conservative treatment or fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation (not developmental spondyloysis) that has healed without alteration of motion segment integrity; (3) a spinous or transverse process fracture without a vertebral body fracture, which does not disrupt the spinal canal	Significant signs of radiculopathy, such as dermatomal pain and/or in a dermatomal pain and/or in a dermatomal pain and/or in a dermatomal distribution, sensory loss, loss of relevant reflex(es), loss of muscle strength or measured unilateral atrophy above or below the knee compared to measurements on the contralateral side at the same location; impairment may be verified by electrodiagnostic findings or history of a herniated disk at the level and on the side that would be expected from objective clinical findings, associated with radiculopathy, or individuals who had surgery for radiculopathy but are now asymptomatic or fractures: (1) 25% to 50% compression of one vertebral body; (2) posterior element fracture with displacement disrupting the spinal canal; in both cases, the fracture has healed without alteration of structural integrity	Loss of motion segment integrity defined from flexion and extension radiographs as at least 4.5 mm of translation of one vertebra on another or angular motion greater than 15° at 1.1-2, 1.2-3, and 1.3-4, greater than 20° at 1.4-5, and greater than 25° at 1.5-51 (Figure 15-3); may have complete or near complete loss of motion of a motion segment due to developmental fusion, or successful or unsuccessful attempt at surgical arrhrodesis or fractures: (1) greater than 50% compression of one vertebral body without residual neurologic compromise	Meets the criteria of DRE lumbosacral categories III and IV; that is, both radiculopathy and alteration of motion segment integrity are present; significant lower extremity impairment is present as indicated by atrophy or loss of reflex(es), pain, and/or sensory changes within an anatomic distribution (dermatomal), or electromyographic findings as stated in lumbosacral category III and alteration of spine motion segment integrity as defined in lumbosacral category IV or fractures: (1) greater than 50% compression of one vertebral body with unilateral neurologic compromis

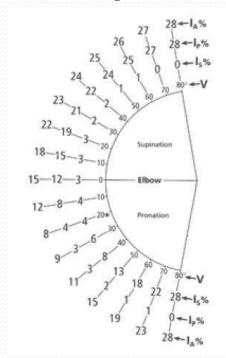
- Extremity Impairment Example:
- DDX: (B/L) Elbow-Lateral Epicondylitis & (B/L) De Quervain's Disease/Stenosing Tenosynovitis
- Figure 16-34; Page 472; (Pie Chart Elbow Flexion/Extension) Chapter 16
- Figure 16-37; Page 474; (Pie Chart Elbow Supination/Pronation) Chapter 16

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

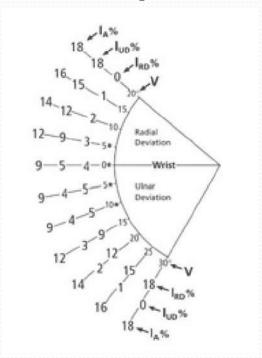
- Extremity Impairment Example:
- DDX: (B/L) Elbow-Lateral Epicondylitis & (B/L) De Quervain's Disease/Stenosing Tenosynov
- Figure 16-34; Page 472; (Pie Chart Elbow Flexion/Extension) Chapter 16



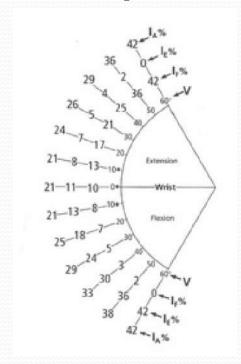
- Extremity Impairment Example:
- DDX: (B/L) Elbow-Lateral Epicondylitis & (B/L) De Quervain's Disease/Stenosing Tenosynov
- Figure 16-37; Page 474; (Pie Chart Elbow Supination/Pronation) Chapter 16



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



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



- Extremity Impairment Example:
- DDX: (B/L) Elbow-Lateral Epicondylitis & (B/L) De Quervain's Disease/Stenosing Tenosynovitis
- Figure 16-28; Page 467; (Pie Chart Wrist Flexion/Extension) Chapter 16
- Figure 16-31; Page 469; (Pie Chart Wrist Radial/Ulnar Deviation) Chapter 16

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

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

Depositions

- TITLE 8. INDUSTRIAL RELATIONS
 DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
 CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR
- Article 3. Assignment of Qualified Medical Evaluators, Evaluation Procedure
- §35.5. Compliance by AMEs and QMEs with Administrative Director Evaluation and Reporting Guidelines.
- (f) Unless the Appeals Board or a Workers' Compensation Administrative Law Judge orders otherwise or the parties agree otherwise, whenever a party is legally entitled to depose the evaluator, the <u>evaluator shall make himself or herself available for deposition within at least one hundred twenty (120) days of the notice of deposition and, upon the request of the unrepresented injured worker and whenever consistent with Labor Code section 5710, the <u>deposition shall be held at the location at which the evaluation examination was performed</u>, **or** at a facility or office chosen by the deposing party that is not more than 20 miles from the location of the evaluation examination.</u>

Supplemental Reports

- QME Supplemental Reports:
- Q. What is the time frame for supplemental reports?
- A. You have <u>60 days</u> from the date of the written request for a supplemental report. The time frame <u>may be extended up to 30 additional days</u> if the parties agree without the need to request an extension from the medical director. (8 CCR § <u>38(h)</u>)

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

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

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

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

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

Stipulated Award vs. Compromise & Release

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

Stipulated Findings and Award

ADVANTAGES:

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

DISADVANTAGES:

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

Compromise and Release (C&R)

ADVANTAGES:

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

DISADVANTAGES:

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

Medical Report Checklist

- Below is a list of components generally incorporated into a medical legal report, which are utilized for rating disability/impairment.
- This should be considered as an overall guideline.
- Date
- 2. Insurer/Attorney Address
- Patient Information
- 4. Record Review
- 5. History of the Injury
- 6. History of Treatment
- 7. History of other Injuries
- 8. Current Symptoms
- Job Description
- 10. Work History

Medical Report Checklist

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

Medical Report Checklist

- 21. Causation
- 22. Apportionment
- 23. Vocational Rehabilitation
- 24. Subjective Factors of Disability
- 25. Objective Factors of Disability
- 26. Work Preclusion
- **27.** Future Medical
- 28. Reasons for Opinion
- 29. Rating Statement
- 30. Compliance Statement
- 31. Signature
- NOTE: If writing a P&S report under the new (AMA) System (DOI > 01/01/2005), then items 24-26 are not necessary.
- The older disability rating system (PDRS) (DOI < 01/01/2005) is based on four factors; items 24-26 and Loss of Functional Capacity/pre-injury status (The inability to compete in the open labor market)

HISTORY OF THE INJURY:

Document the mechanism of the industrial injury.

HISTORY OF TREATMENT:

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

HISTORY OF OTHER INJURIES:

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

CURRENT SYMPTOMS:

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

JOB DESCRIPTION:

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

WORK HISTORY:

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

PAST MEDICAL HISTORY:

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

FAMILY HISTORY:

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

REVIEW OF SYSTEMS:

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

OFF WORK ACTIVITIES:

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

SOCIAL HISTORY:

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

PHYSICAL EXAM:

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

RADIOGRAPHIC EXAM:

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

MRI:

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

DIAGNOSTIC TESTING:

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

DISCUSSION:

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

DIAGNOSES:

List all diagnoses with a written description along with the ICD-<SAMPLE>

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

PERMANENT AND STATIONARY STATUS:

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

CAUSATION:

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

APPORTIONMENT:

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

VOCATIONAL REHABILITATION:

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

SUBJECTIVE FACTORS OF DISABILITY:

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

OBJECTIVE FACTORS/FINDINGS OF DISABILITY:

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

Apportionment

- (Medical Separation of Industrial vs. Non-Industrial Disability)
- Apportionment as related to workers' compensation may be defined as separating or determining the employer's liability due to a specific industrial injury. This requires the physician to separate out the disability or condition that has resulted from a work injury from the other parts of disability that are the result of non-industrial conditions or diseases.
- Apportionment is usually upheld by the WCAB as long as the physician's opinions are based on substantial medical evidence. The doctor's opinion should be based on physical evaluation of the patient and complete review of the medical records.

Apportionment

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

Labor Code 4663

• The physician must determine in their opinion what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment

and

- what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the work injury, which also includes prior work injuries.
- The physician should indicate specific reasons why they came to said conclusion.

Apportionment

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

Required QME Forms (Unrepresented Cases)

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

Who is Billed for the QME Report?

- Always send your QME bill with Proof of Service (POS) to the <u>Claims Administrator</u>.
- Do not bill the attorney...
- either the Applicant (AA) or the Defense attorney (DA)

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

Action	Unrepresented QME Labor Code § 4060	Represented QME Labor Code § 4060	Unrepresented QME Labor Code § 4061	Represented QME Labor Code § 4061	Unrepresented QME Labor Code § 4062	Represented QME Labor Code § 4062
Who gets served ?	Applicant	Applicant and Applicant's attorney	Applicant	Applicant and Applicant's attorney	Applicant	Applicant and Applicant's attorney
	Claims Administrator or the defense attorney	Claims Administrator or the defense attorney	Claims Administrator or the defense attorney	Claims Administrator or the defense attorney	Claims Administrator or the defense attorney	Claims Administrator or the defense attorney
ls DEU served?	No	No	Yes	No	No	No
What is served?	Medical Report	Medical Report	Doument Coversheet	Medical Report	Medical Report	Medical Report
	QME Form 111-QME Findings Summary Form	QME Form 122-AME or QME Declaration of Service of Medical-Legal Report Form	Doucment Seprator sheet- DWC-CA form 10232.2	QME Form 122-AME or QME Declaration of Service of Medical-Legal Report Form	QME Form 111-QME Findings Summary Form	QME Form 122-AME or QME Declaration of Service of Medical-Legal Report Form
			Medical Report			
			Doucment Seprator sheet- DWC-CA form 10232.2			
			QME Form 111-QME Findings Summary Form			
			Doucment Seprator sheet- DWC-GA form 10232 2			
			DWC-AD Form 100-Employee's Disability Questionnaire			
			Doucment Seprator sheet- DWC-CA form 10232 2			
			DWC-AD Form 101-Request for Summary Rating Determination of Qualified Medical Evaluator's Report			

- TITLE 8. INDUSTRIAL RELATIONS
- DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
- CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR
- §34. Appointment Notification and Cancellation
- (a) Whenever an appointment for a comprehensive medical evaluation is made with a QME, the QME <u>shall complete an appointment notification form</u> by submitting the form in Section 110 (QME Appointment Notification Form) (8 Cal. Code Regs. § 110)
- The completed form shall be postmarked or sent by facsimile to the <u>employee and</u> <u>the claims administrator</u>, or if none the employer, within 5 business days of the date the appointment was made.
- In a <u>represented case</u>, a copy of the completed form shall also be sent to the attorney who represents each party, if known.
- Failure to comply with this requirement shall constitute grounds for <u>denial of</u> reappointment under section 51 of Title 8 of the California Code of Regulations.

- TITLE 8. INDUSTRIAL RELATIONS
- DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
- CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR
- §34. Appointment Notification and Cancellation
- (b) The QME shall schedule an appointment for a comprehensive medical-legal examination which shall be conducted only at the medical office listed on the panel selection form.
- However, upon written request by the injured worker and only for his or her convenience, the evaluation appointment may be moved to another medical office of the selected QME if it is listed with the Medical Director as an additional office location.

- TITLE 8. INDUSTRIAL RELATIONS
- DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
- CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR
- §34. Appointment Notification and Cancellation
- (c) The QME shall include within the notification whether a Certified Interpreter is required and specify the language.
- The interpreter shall be arranged by the party who is to pay the cost as provided for in Section 5811 of the Labor Code.

- TITLE 8. INDUSTRIAL RELATIONS
- DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
- CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR
- §34. Appointment Notification and Cancellation
- (d) An evaluator, whether an AME, Agreed Panel QME or QME, <u>shall not cancel</u> a scheduled appointment <u>less than six (6) business days prior to the appointment</u> date, except for good cause.
- Whenever an evaluator cancels a scheduled appointment, the evaluator shall advise the parties in writing of the reason for the cancellation. The Appeals Board shall retain jurisdiction to resolve disputes among the parties regarding whether an appointment cancellation pursuant to this subdivision was for good cause.
- The Administrative Director shall retain jurisdiction to take appropriate disciplinary action against any Agreed Panel QME or QME for violations of this section.

- TITLE 8. INDUSTRIAL RELATIONS
- DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
- CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR
- §34. Appointment Notification and Cancellation
- (e) An Agreed Panel QME or a <u>QME who cancels a scheduled appointment</u> shall reschedule the appointment to a date within thirty (30) calendar days of the date of cancellation.
- The re-scheduled appointment date may not be more than sixty (60) calendar days from the date of the initial request for an appointment, unless the parties agree in writing to accept the date beyond the sixty (60) day limit.

- TITLE 8. INDUSTRIAL RELATIONS
- DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
- CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR
- §34. Appointment Notification and Cancellation
- (g) Failure to receive relevant medical records, as provided in section 35 of Title 8 of the California Code of Regulations and section 4062.3 of the Labor Code, prior to a scheduled appointment shall not constitute good cause under this section for the evaluator to cancel the appointment, unless the evaluator is a psychiatrist or psychologist.

Document Separator Sheet

https://www.dir.ca.gov/dwc/FORMS/EAMS%2oForms/ADJ/DWCCAform10232_2.pdf

In Adobe Reader, a list of document titles and types may be viewed by double clicking the paper clip icon on the left.				
DOCUMENT SEPARATOR SHEET				
Product Delivery Unit		·		
Document Type		•		
Document Title		•		
Document Date	MM/DD/YYY			
Author				
Office Use Only Received Date MM/DD/YYYY				
 DWC-CA form 10232.2 Rev. 9/2014 Page 1				

Document Separator Sheet

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

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How to complete a document separator sheet

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

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

- 1. A document cover sheet
- 2. A document separator sheet
- 3. The form you need to file

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

You may complete the attached separator sheet using a typewriter or with block printing. This form can also be completed online at www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCCAform10232 2.pdf.

Use the attached sample form as a guide.

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

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

Document Separator Sheet

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

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

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

Additional instructions for filing forms in EAMS can be found on line in the "EAMS OCR forms handbook" at

http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS_OCR%20handbook.pdf.

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

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

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

DOC	UMENT SEPARATOR SHEET SAMPLE				
Product Delivery Unit	SELECT UNIT				
Document Type	SELECT DOCUMENT TYPE, REFER TO LIST				
Occument Title SELECT DOCUMENT TITLE, REFER TO LIST					
Document Date	DATE YOU FILLED ATTACHED DOCUMENT MM/DD/YYYY				
Author	YOUR NAME				
	Office Use Only				
Received Date	MM/DD/YYYY				

DEU Forms

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

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

DEU Forms

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

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

DEU Forms

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

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

WORKERS' COMPENSATION APPEALS BOARD DISTRICT OFFICES

ANAHEIM, 92806-2131

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

BAKERSFIELD, 93301-1929

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

EUREKA, 95501-0481 * Satellite office *

100 "H" Street, Suite 202 Information & Assistance Unit (707) 441-5723

FRESNO, 93721-2219

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

LONG BEACH, 90802-4339

300 Oceangate Street, Suite 200 Information & Assistance Unit (562) 590-5240

LOS ANGELES, 90013-1105

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

MARINA DEL REY, 90292-6902

4720 Lincoln Boulevard, 2nd and 3nd floors Information & Assistance Unit (310) 482-3858

OAKLAND, 94612-1499

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

OXNARD, 93030-7912

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

POMONA, 91768-1653

732 Corporate Center Drive Information & Assistance Unit (909) 623-8568

REDDING, 96002-0940

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

RIVERSIDE, 92501-3337

3737 Main Street, Suite 300 Information & Assistance Unit (951) 782-4347 SACRAMENTO, 95834-2962

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

SALINAS, 93906-2204

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

SAN BERNARDINO, 92401-1411

464 W Fourth Street, Suite 239
Information & Assistance Unit (909) 383-4522

SAN DIEGO, 92108-4424

7575 Metropolitan Drive, Suite 202 Information & Assistance Unit (619) 767-2082

SAN FRANCISCO, 94102-7014

455 Golden Gate Avenue, 2nd Floor Information & Assistance Unit (415) 703-5020

SAN JOSE, 95113-1402

100 Paseo de San Antonio, Suite 241 Information & Assistance Unit (408) 277-1292

SAN LUIS OBISPO, 93401-8736

4740 Allene Way, Suite 100 Information & Assistance Unit (805) 596-4159

SANTA ANA, 92701-4070

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

SANTA BARBARA, 93101-7538 * Satellite office *

411 E Canon Perdido Street, Suite 2 Information & Assistance Unit (805) 884-1988

SANTA ROSA, 95404-4771

50 "D" Street, Suite 420 Information & Assistance Unit (707) 576-2452

STOCKTON, 95202-2314

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

VAN NUYS, 91401-337

6150 Van Nuys Boulevard, Suite 105 Information & Assistance Unit (818) 901-5374

Minimum Time Guidelines

Neuro-musculo-skeletal 20 Minutes

Cardiovascular 30 Minutes

Pulmonary 30 Minutes

Psychiatric
 60 Minutes

All Others
 30 Minutes

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

Required Guidelines

- For accepted claims, The California Division of Workers' Compensation (DWC) requires that any treatment not authorized by the claims administrator, be sent to Utilization Review.
- Utilization Review must use mandated guidelines in rendering a medical necessity determination.
- The reviewer may only deviate from the mandated guidelines if they are "silent," or do not address the treatment being requested.
- MTUS http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS/MTUS_Regulations.htm
- ACOEM 2004, 2nd edition
- Official Disability Guidelines

Guidelines

CALIFORNIA MANDATED TREATMENT GUIDELIENS

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

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

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

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

If UR denies treatment, can a QME still help?

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

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

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

- Summarized below are some of the reasons a replacement QME panel may be requested per 8 CCR 31.5(a):
- 1. QME does not practice in specialty requested.
- 2. QME cannot examine the applicant within 60-90 days.
- 3. Injured worker changed residences.
- 4. Panel QME is a member of same practice group as another member of the panel.
- 5. QME not available.
- 6. Panel QME is the treating physician for the disputed injury. (See also 8 CCR 41(a)(4))

- Summarized below are some of the reasons a replacement QME panel may be requested per 8 CCR 31.5(a):
- 7. Parties agree to QME within region of applicant's workplace, and original QME panel is outside this region.
- 8. Medical documentation indicates different specialty required.
- 9. Panel QME did not send out appointment notification.
- 10. QME issued a late report.
- 11. QME had a conflict of interest.
- 12. Panel QME does not provide complete medical evaluation, or QME is not medically qualified to address disputed issues.
- 13. Panel issued over 24 months ago, and no QME from that panel was used.

- Summarized below are some of the reasons a replacement QME panel may be requested per 8 CCR 31.5(a):
- In addition, LC 4062.3 and 8 CCR 35(k) allow for replacement of the QME panel when there has been an **ex parte communication violation**.
- A replacement QME Panel may also be warranted when the initial panel QME produces a report that does not constitute substantial evidence.

- Ex parte communications and violation of LC Section 4062.3(g) which provides:
- "(g) Ex parte communication with an agreed medical evaluator or a qualified medical evaluator selected from a panel <u>is prohibited</u>. If a party communicates with the agreed medical evaluator or the qualified medical evaluator in violation of subdivision (e), the aggrieved party <u>may elect to terminate</u> the medical evaluation and <u>seek a new evaluation</u> from <u>another qualified medical evaluator</u> to be selected according to Section 4062.1 or 4062.2, as applicable, or proceed with the initial evaluation."
- Rule 35(k) also prohibits ex parte communication with QMEs as follows:
- "If any party communicates with an evaluator in violation of Labor Code section 4062.3, the Medical Director shall provide the aggrieved party with a new panel in which to select a new QME or the aggrieved party may elect to proceed with the original evaluator. Oral or written communications by the employee, or if the employee is deceased by the employee's dependent, made in the course of the examination or made at the request of the evaluator in connection with the examination shall not provide grounds for a new evaluator unless the Appeals Board has made a specific finding of an impermissible ex parte communication."

Proof of Service

How can you prove you sent your treatment request?

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

Resources

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



"Luck favors the prepared."

- Edna Mode

Questions?

COURSE EVALUATION FOR ADMINISTRATIVE DIRECTOR

As a part of the Administrative Director's ongoing efforts to ensure that courses for Qualified Medical Evaluators offer valuable information on California's Workers' Compensation-related medical evaluation issues, we are asking attendees of the courses approved by the Administrative Director (including distance learning programs) to complete the following Course Evaluation.

COURSE EVALUATION LINK (click here)

TO ALL ATTENDEES: PLEASE RETURN THIS FORM TO THE DWC

DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT PO BOX 71010 OAKLAND, CA 94612

OR

AOGarcia@dir.ca.gov

Thanks So Much!



Hope To See You Soon

Back To Chiropractic CE Seminars!

backtochiropractic.net