Complete QME

“Why, sometimes, I've believed as many as six impossible things before breakfast.”

— **Lewis Carroll, Through the Looking-Glass and What Alice Found There**

Before you begin:

1. Read the lawyers' letters
2. Verify identification
3. Establish communication

Use a Template

- RE: [patient]
- EMPLOYER: [name]
- JOB TITLE:
- CLAIM NO.:
- WCAB NO.:
- PANEL NO.:
- DATE OF INJURY:
-
    - PANEL QUALIFIED MEDICAL EVALUATION
-
- Dear [adjuster]: :
-
- The following is a Qualified Medical Evaluation related to the above-noted claim. Patient was referred to me by _____ as a _____. I have received letters from _____. I have been specifically asked _____[list body parts and specific questions]. I have been asked to evaluate possible industrial causation, permanent and stationary status, periods of temporary disability, permanent disability, necessary medical care, work restrictions and apportionment.
-
- I saw _____ on _____ at _____ and spent about ____ of face to face time with ____. In addition, I reviewed the medical records that were provided. Medical record summary was prepared by Doctus USA. I personally produced the report below. This report is submitted pursuant to 8 Cal. Code. Regs. Section 9795 (b) & (c) as an _____.

Identification

- Self-explanatory. Identify the name, age and chief complaint. Explain how you idenfied the patient.
    - Driver’s license
    - Photo

Job Description

- Describe the physical demands of the job. Use average hours/day of each activity.
  - Sitting
  - Standing
  - Walking (even or uneven ground)
  - Climbing (stairs, ladders, other)
  - Heavy gripping
  - Reaching (waist height or overhead)
  - Bending/Squatting/Kneeling
  - Push/pull
  - Typing
  - Lifting (maximum weight and average weight)
  - Keyboard/mouse use

Employment History

- First describe the job referenced in this claim (index job)
- Describe any side jobs the patient held while employed at the index job
- Describe the last couple of jobs the patient had prior to the index job
- Describe any jobs the patient has had since the index job

History of Injury

- Make this fairly detailed. PAY ATTENTION TO DATES!
  - What happened
  - What were the immediate symptoms (what body parts were affected)
  - What was the immediate treatment
  - What symptoms developed later and when (what body parts were affected)
  - What treatments were tried later
  - Which treatments worked and which didn’t
  - When was the last time patient was treated and with what
  - What treatments (including medications) are ongoing
  - What are the doses of current medications

Current Complaints

- Useful to run through the checklist for each body part
  - What is the primary symptoms (pain/weakness/paresthesias/other)
  - Is the symptom constant or intermittent (how frequent is it present)
  - What is the intensity and what is the range of intensity (scale of 1-10)
  - Does the symptom interfere with function and in what way

Past Medical History

- Standard medical history.
- Focus particularly on any conditions that might affect the same body parts that are mentioned in the industrial injury.

Review of Systems

- Standard review of systems
- Focus particularly on any conditions that might affect the same body parts that are mentioned in the industrial injury

Social History

I spend a little more than average time on this. While it may not, strictly, be related to the industrial injury, it does give me a sense of who the patient is and any hidden agendas related to their claim. I can't use this information directly, but it can color my decisions when I have to make judgements about impairment ratings, work restrictions and ongoing medical care.

- Marital status – include any stressors within the marriage
- Children – gender, ages and current level of connection
- Other family/close connections
- Financial stressors
- Vocational plans, if any

Activities of Daily Living

- Use a standard checklist and ask about any items that appear to be affected by the industrial injury
- This information is useful when deciding whether an additional pain award is warranted
    - What is the connection between the industrial injury and the reported limitation
    - How severe is the limitation
    - Was the patient able to perform that activity prior to the industrial injury

Medical Record Review

- This can be very tedious and many doctors use a service to summarize the record review. The review provided can then be copied into the final report for the insurance company.

HOWEVER

- The summary record review may be misleading or incomplete. ALWAYS make sure that you have the full records available and can check for details or accuracy if you need.

Physical Examination

This is a focused exam, looking at the claimed body parts. You may ultimately decide that one or another body part should not be accepted for that claim, but make sure you've examined it so you can defend your opinion.

For range of motion testing, use the forms that are provided in the AMA Guides:

Spine	Table A-2, pg. 597
Upper extremities	Table A-1, pg. 596
Lower extremities	Table A-3, pg. 598

SPINE RANGE OF MOTION

AMA GUIDES, Table A-2, pg. 597

SPINAL AREA	PLANE	ROM – 0 – ROM	TEXT DESCRIPTION	SFTR RECORDING
Cervical	Sagittal	Extension – 0 – Flexion	Extend: Flex:	S:
Cervical	Frontal	Left lateral – 0 – Right Lateral	Bend left: Bend right:	F:
Cervical	Rotation	Left rotation – 0 – Right rotation	Left: Right:	R:
Thoracic	Sagittal	Extension – 0 – Flexion	Extend: Flex:	S:
Thoracic	Frontal	Left lateral – 0 – Right lateral	Left: Right:	F:
Thoracic	Rotation	Left rotation – 0 – Right rotation	Left: Right:	R:
Lumbar	Sagittal	Extension – 0 – Flexion Sacral flexion:	Extend: Flex:	S:
Lumbar	Frontal	Left lateral – 0 – Right lateral	Left: Right:	F:
Lumbar	SLR Left	± 10% or 5 deg Max SLR right		F:
Lumbar	SLR Right	± 10% or 5 deg Max SLR left		F:

UPPER EXTREMITY RANGE OF MOTION

AMA GUIDES, Table A-1, pg. 596

Joint	Plane	Normal Active ROM	Text description	SFTR Recording
Shoulder				
Left	Sagittal	S: ext - 0 - flex 40 - 0 - 150	Ext: Flex:	
Right	Sagittal	S: ext - 0 - flex 40 - 0 - 150	Ext: Flex:	
Shoulder				
Left	Frontal	F: abd - 0 - add 150 - 0 - 30	Abd: Add:	
Right	Frontal	F: abd - 0 - add 150 - 0 – 30	Abd: Add:	
Shoulder				
Left	Rotation	R: ext - 0 - int 90 - 0 - 80	Ext: Int:	
Right	Rotation	R: ext - 0 - int 90 - 0 - 80	Ext: Int:	
Elbow				
Left	Sagittal	S: ext - 0 - flex 0 - 0 - 150	Ext: Flex:	
Right	Sagittal	S: ext - 0 - flex 0 - 0 - 150	Ext: Flex:	
Forearm		R: sup - 0 - pron 80 - 0 - 80		
Left	Rotation	R: sup - 0 - pron 80 - 0 - 80	Sup: Pron:	
Right	Rotation	R: sup - 0 - pron 80 - 0 - 80	Sup: Pron:	
Wrist				
Left	Sagittal	S: ext - 0 - flex 60 - 0 - 60	Ext: Flex:	
Right	Sagittal	S: ext - 0 - flex 60 - 0 - 60	Ext: Flex:	
Wrist				
Left	Frontal	F: Rad - 0 - Uln 20 - 0 - 30	Rad: Ulnar:	
Right	Frontal	F: Rad - 0 - Ulnar 20 - 0 - 30	Rad: Ulnar:	

LOWER EXTREMITY RANGE OF MOTION

AMA GUIDES, Table A-3, pg. 598

JOINT	PLANE	ROM – 0 – ROM (deg)	TEXT DESCRIPTION	SFTR RECORDING
Hip	Sagittal	Extension – 0 – Flexion	Left: Extend: Flex: Right: Extend: Flex:	Left S: Right S:
Hip	Frontal	Abduction – 0 – Adduction	Left: Abduct: Adduct: Right: Abduct: Adduct:	Left F: Right F:
Hip	Rotation	Left rotation – 0 – Right rotation	Left: External: Internal: Right: External: Internal:	Left R: Right R:
Knee	Sagittal	Extension – 0 – Flexion	Left: Extend: Flex: Right: Extend: Flex:	Left S: Right S:
Ankle talocrural	Sagittal	Extension (dorsiflexion) – 0 – Flexion (plantar flexion)	Left: Dorsiflexion: Plantar flexion: Right: Dorsiflexion: Plantar flexion:	Left S: Right S:
Ankle subtalar	Frontal	Eversion – 0 – Inversion	Left: Eversion: Inversion: Right: Eversion: Inversion:	Left F: Right F:

A Word About Spine

Much has been made about the decision to use DRE (Diagnosis Related Estimates) vs. Range of Motion Method.

85-90% of the time you will use the DRE method (see page 398 of the ***AMA Guides***)

If using the Range of Motion Method, include

Range of motion

Diagnosis (Table 15-7, pg. 404)

Spinal nerve deficit (dermatomal sensory and motor losses; Tables 15-15 to 15-18, pg. 424)

When rating with the Range of Motion Method, the whole person impairment rating is obtained by combining ratings from all three components, using the Combined Values Chart (p. 604).

Assessment

This can be very brief. Include:

Patient reports [symptoms] due to [diagnoses] that (s)he attributes to [industrial injury].

Patient has received [treatment] with/without significant benefit.

Subjective Complaints

This is just a summary of section “current complaints” earlier in your report. You are not analyzing or editorializing yet. Just report the subjectives.

Causation

FINALLY ... Dr. Adjudicator gets his/her turn.

What do you believe is/are the cause(s) of the patients current complaints and limitations. Explain yourself.

REMEMBER

Experienced lawyers and all worker's compensation judges have seen reports on these conditions many, many times. They are quite familiar with the medical issues at hand and know what are and are not mainstream opinions about them. They will not accept your opinion simply because you are a doctor. You need explain your reasoning to justify WHY you think what you do.

Criteria for Industrial Causation

- Any – and I mean ANY – industrial contribution to causation triggers acceptance as an industrial claim.

Even the "1% rule" (1% industrial causation triggers an industrial claim) isn't enough.
ANY, ANY, ANY industrial contribution counts!

Substantial Evidence

- The opinion must be based on medical facts or other evidence and those facts must be applied to support the opinion or conclusion.
- In order for a medical opinion to constitute substantial evidence, it must be predicated on reasonable medical probability. It must also set forth the the reasoning behind the physician's opinion.
- A medical report is not substantial medical evidence if it is based on facts no longer germaine, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture or guess.

Phrases

- Good: “Reasonable medical probability”

Bad: “Presumably”

Display your thought process on paper.

Aggravation vs. Exacerbation

- Aggravation: The industrial event has caused a PERMANENT increase in the severity of a pre-existing condition, giving rise to permanent disability based on the industrial event (apportionment applies)

- Exacerbation: The industrial event created a TEMPORARY increase in symptoms which then, after treatment, return to baseline.

Compensable Consequence Injury

- The industrial injury causes a direct injury to an alternate part of the body or a medical condition requiring treatment and/or resulting in disability.

- Alternatively, treatment, or a non-industrial event related to the injury, causes further injury.

Patient is entitled to treatment and, if permanent, a permanent disability award.

Examples: Knee injury causes an altered gait that creates a back injury.

Car accident on the way to physical therapy causes back injury.

Patient develops CRPS after carpal tunnel surgery.

Compensable Consequence of Injury

- Patient has a pre-existing, non-industrial condition that requires treatment in order for the patient to benefit from treatment of the industrial injury. Treatment of the non-industrial condition is "reasonable and necessary to cure or relieve" the effects of an industrial condition.

Patient is entitled to treatment, but NOT to a permanent disability award.

Example: Patient needs to have diabetes and hypertension stabilized before being cleared for surgery.

Temporary Disability

A lawyer's letter may well ask you if periods of temporary disability were appropriate. Very rarely will you have reason to take issue with whatever a treating physician has said. If the patient was off work without explicit designation from the treating physician, then you need to make some retroactive judgement about the medical appropriateness of that time off. Saying that information is inadequate to offer an opinion, is perfectly fine. Just say you can't tell.

Permanent and Stationary (P&S)

Permanent and stationary does NOT mean “all better.” It means you do not anticipate substantial change within the next year. If you are looking at a case that has aged (NOT like fine wine). You can consider the patient permanent and stationary at some point in the past when he/she stopped changing.

If the patient is NOT permanent and stationary, then try to offer treatment and a time frame when you anticipate they will BECOME permanent and stationary.

Necessary Medical Care and Estimated Time to Maximum Medical Improvement (MMI)

MMI = P&S

Remember that the defense (insurance company) will want to treat your plan leading to MMI as gospel. If there are uncertainties make sure you say so. Patient needs ___, ___, ___. Presuming that he/she responds to treatment, I anticipate MMI in [time frame].

Impairment Rating

1. ***AMA Guides*** ratings: "strict ratings"

2. Chapter 1 (page 11)

"Given the range, evolution, and discovery of new medical conditions, the Guides cannot provide an impairment rating for all impairments. Also, since some medical syndromes are poorly understood and are manifested only by subjective symptoms, impairment ratings are not provided for those conditions. The Guides nonetheless provides a framework for evaluating new or complex conditions. Most adult conditions with measurable impairments can be evaluated under the Guides. In situations where impairment ratings are not provided, the Guides suggests that physicians use clinical judgment, comparing measurable impairment resulting from the unlisted condition to measurable impairment resulting from similar conditions with similar impairment of function in performing activities of daily living."

Almaraz-Guzman

- A statute providing that a fact or group of facts is prima facie evidence of another fact establishes a rebuttable presumption.

Translation: The whole person impairment ratings provided in the ***AMA Guides*** can be disputed.

HOWEVER

The physician's opinion must constitute "substantial evidence."

Almaraz-Guzman (cont.)

SHOW YOUR WORK:

1. Start with a standard rating.
2. Explain why the standard rating is not “accurate.” Focus on function: limitations of activities of daily living or losses not considered by the standard rating. Do not include work activity.
3. Look anywhere within the “4 corners” of the ***Guides*** for a better rating. Stay within the same ***Guides*** chapter if you can. Analogize to that rating.
4. Explain why your analogy is more accurate than the standard rating.

Almaraz-Guzman Rating

Almaraz-Guzman Considerations: I am charged with finding the "most accurate" description of the patient's functional impairment anywhere within the "four corners" of the ***AMA Guides***.

Additional Award for Pain

“Physicians recognize the local and distant pain that commonly accompanies many disorders. Impairment ratings in the Guides already have accounted for pain. For example, when a cervical spine disorder produces radiating pain down the arm, the arm pain, which is commonly seen, has been accounted for in the cervical spine impairment rating” (p. 10). Thus, if an examining physician determines that an individual has pain-related impairment, he or she will have the additional task of deciding whether or not that impairment has already been adequately incorporated into the rating the person has received on the basis of other chapters of the Guides.” (pg. 570)

Rating Pain

"Because percentages for pain-related impairment have not been used and tested on a widespread basis, as have other impairment ratings used in the Guides, it was decided that impairment ratings for pain disorders would not be expressed as percentages of whole person impairment. Future scientific evidence may emerge that will enable a more quantifiable approach to be adopted." (Pg. 570)

Rating Pain (cont.)

“If the individual appears to have pain-related impairment that has increased the burden of his or her condition slightly, the examiner may increase the percentage found in A by up to 3%.” (pg. 573)

“The examiner should perform a formal pain related impairment assessment if any of the following conditions are met: …. If the examiner performs a formal pain-related impairment rating, he or she may increase the percentage found in step A by up to 3% …” (pg. 573)

Combining Impairments

The Combined Values Chart (pg. 604)**:** Prevents total rating > 100% and acknowledges that different impairments may create overlapping disabilities.

HOWEVER

"A combination of some impairments could decrease overall functioning more than suggested by just adding the impairment ratings for the separate impairments (eg, blindness and inability to use both hands). When other multiple impairments are combined, a less than additive approach may be more appropriate." (pg. 10)

Kite

Adding Impairments: Allows impairments to be added PROVIDED the doctor describes

synergy: i.e., the combination of impairments INCREASES overall level of impairment beyond that provided by the combined values chart (e.g. bilateral impairments that remove the possibility of compensation by the contralateral limb).

accuracy: impairments that are entirely unrelated, so there is no overlap in the disabilities created

Apportionment

Apportionment is an artificial concept, with no science or mathematical formulas to objectively verify accuracy. In most cases, apportionment is based on philosophy and the ability of the physician to explain his or her rationale.

All medical reports MUST include a opinion regarding apportionment.

Apportionment (cont.)

1. Apportionment applies to disability ONLY and is determined when the patient becomes permanent and stationary. Risk factors are related to the cause of injury, NOT cause of disability.

2. Causation of injury is NOT the same thing as causation of disability.

Hikida: Patient with carpal tunnel syndrome, 90% industrial, 10% non-industrial. After carpal tunnel surgery, she developed CRPS causing 100% permanent and total disability. The cause of disability was CRPS (due to surgery) and therefore, apportionment of carpal tunnel was irrelevant. Causation of DISABILITY was carpal tunnel surgery and therefore disability was apportioned 100% industrial.

Determining Apportionment

Elements of legally valid apportionment (Escobedo):

1. Based on “reasonable medical probability.”
2. Based on “substantial evidence.”
3. The physician must explain the “HOW AND WHY” of the apportionment determination.

Escobedo

May apportion to:

underlying pathology

asymptomatic prior conditions

retroactive prophylactic conditions

Benson

If there are successive injuries to the same body part, then permanent disability needs to be assigned separately to each injury.

HOWEVER

In some situations it is not possible to determine apportionment separately. In those situations, the evaluator MUST explain why it is not possible to assign permanent disability separately.

Benson Example

Patient has had two injuries to the low back:

1. Total permanent disability: 70%, award = $134,176.98 plus lifetime pension of $77.31/week

2. Apportionment of 80% to first injury and 20% to the second: $80,487.39 and $10,637.50 for total $91,124.89 and no lifetime pension.

Difference: $43,052.09 and no lifetime award

WORK/ACTIVITY RESTRICTIONS:

This section determines whether YOU BELIEVE the patient can return to his/her previous occupation.

With accommodations

Without accommocations

BE SPECIFIC AND BE REAL

WORK/ACTIVITY RESTRICTIONS:

If the patient cannot return to full duty (or the employer cannot accommodate restrictions) then the patient is entitled to a vocational retraining voucher.

A retraining voucher can be converted to cash money in the settlement. Even if the patient plans to retire, they still want you to make the eligible for a voucher.

CURRENT/FUTURE MEDICAL CARE:

Future medical benefits can be converted into cash money. Be specific as best you can.

“Ongoing management as per a treating physician” translates into almost no money.

“Provision for total knee replacement surgery and postoperative physical therapy” translates into big bucks.

“The Red Queen shook her head. "You may call it 'nonsense' if you like," she said, "but I've heard nonsense, compared with which that would be as sensible as a dictionary!”

— **Lewis Carroll, Through the Looking-Glass and What Alice Found There**