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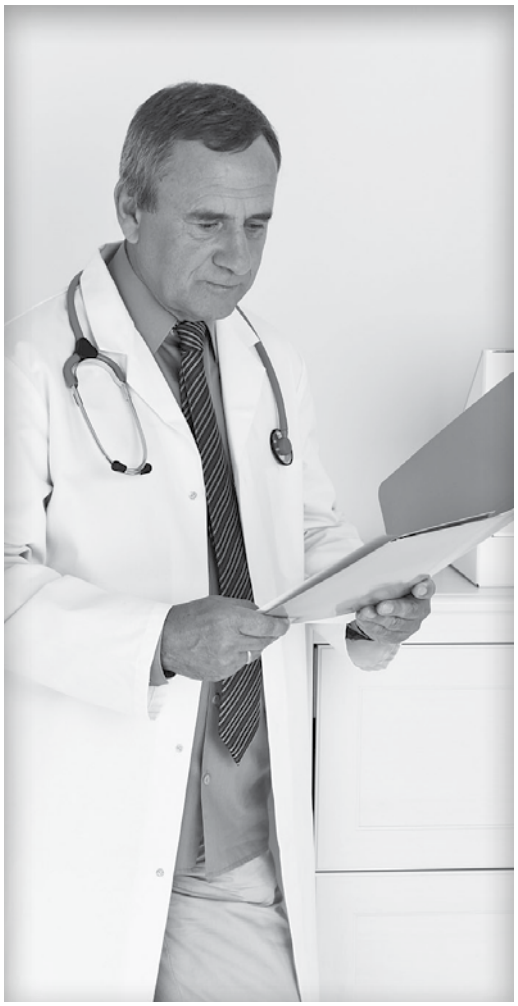
Medical Examiners' Handbook

Impairment Ratings and Independent Medical Examinations in Washington State Workers' Compensation

For IME Examiners, Attending Doctors and Consultants



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This publication contains guidelines, sample reports, and billing procedures for preparing and conducting impairment ratings and independent medical exams (IME) in Washington's Workers' Compensation system. The activity was planned and produced in accordance with the WSMA Essential Elements, Criteria, and Standards of Accreditation of Continuing Medical Education.

Disclosure: None of the faculty involved with developing this handbook or self assessment test online has any financial relationship to disclose nor do they financially benefit from this product.

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The July 2014 updated edition of the Medical Examiners' Handbook contains selected updates to the July 2013 edition. New or updated information is listed in the table below.

Updates and Additions to the *Medical Examiners' Handbook*, July 2014

Chapter	Page	Title	Comments
Cover		Handbook Cover Page	Updated with current date
3	16	Interpreter Services	Added Helpful Information
3	18	Discussing Results	Clarified language
3	20	Releasing Information to other Parties	Clarified language
4	26	Medical Treatment Guidelines	Updated
6	35	Criteria for Allowance of Occupational Disease	Clarified Proximate Cause definition
7	38	Psych Report Elements	Updated to DMS 5 – removed 5 axes reference
8	42	Vocational Issues	Entire chapter updated, including new weights and measures examples and New JA Summary sheet
8	46-47	Common Household/Work Items	Added pictures of common items and other weights
8	48-49	Job Analysis Summary	Added new Department form and sample
12	79	Dorsal Spine Case Example	Corrected error in case example
12	123-129	Vision – Rating Impairment	Entire section updated for clarity
Append A	150-151	Amputations of the Fingers Worksheet	Added worksheet and sample
Append D	194	Useful Resources	Added information for Interpreter Services
Index	1-5	Index	Updated

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Preface

Dear Provider,

The Department of Labor and Industries (L&I) would like to thank you for providing independent medical examinations (IMEs) and impairment ratings for our workers. You play a crucial role in the Washington State workers' compensation system for both State Fund and self-insured employers. Knowing you use the best available medical information, we rely on your unbiased, objective examinations and ratings to help us administer claims effectively and fairly. We work together to serve all workers with dignity and respect.

The Revised Code of Washington (RCW) states that L&I must develop appropriate standards. We want to offer you clear, understandable information and answer your questions about these medical standards. We hope you will find this new edition of the Medical Examiner's Handbook (MEH) useful and helpful.

The MEH test is available online at www.imes.Lni.wa.gov . You will receive category 1 Continuing Medical Education (CME) credit for passing the test. The test is designed to help IME examiners and consultants fulfill the WAC regulations of becoming familiar with the handbook, and the requirement to pass the MEH test when applying for or renewing your IME provider number.

We hope the new format helps you find the information you need quickly. Use the index in the back freely. If you have suggestions for ways to make this book even more usable, please let us know. We will consider them for the next edition. Please send your comments to Hal Stockbridge, MD, MPH, Office of the Medical Director, Department of Labor and Industries, PO Box 44321, Olympia, WA 98504-4321.

Throughout this book we refer to other L&I publications, such as the Attending Doctor's Handbook (Form #F-252-004-000). You may review and/or print publications online at http://www.lni.wa.gov/FormPub/

For more information about L&I, the Office of the Medical Director and Health Services Analysis, visit L&I's Internet: www.LNI.wa.gov.

Thank you for your services and interest.

Sincerely,

Gary M. Franklin

Gary Franklin, MD, MPH, Medical Director

Hal Stockbridge

Hal Stockbridge, MD, MPH, Associate Medical Director

CHAPTER 1

Workers' Compensation in Washington State

Background

Washington's Department of Labor & Industries is one of the largest and oldest providers of workers' compensation in the United States. Industrial insurance laws were enacted in 1911 as a measure to protect both workers and employers by creating a "no-fault" insurance program. The law states employers cannot be sued as the result of an injury or incident. At the same time, workers are guaranteed medical benefits and compensation to offset lost wages during recovery.

Over 180,000 claims are filed with the department each year. Approximately 70% of the claims accepted are administered through the State Fund Program. Both workers and employers pay into the medical aid fund established to pay for medical benefits and time loss.

Thirty percent (30%) of the claims accepted are administered through a unique Self-Insured Program in which certain employers meeting department standards are certified to manage claims and distribute benefits to the worker. A small number of self-insured employers administer their own claims, however, the majority of self-insured employers contract with a third party administrator (TPA) to administer claims for them. Self-insured employers fund the payment of benefits. Workers do not pay into the employer's account.

Oversight of self-insured employers and/ or their TPA decisions and actions is provided by the department's Self-Insurance Program. The same laws, rules, and fee schedules apply to both the State Fund and self-insured employers unless self-insured employers are specifically exempt. Self-insured employers follow the same coverage decisions and Office of the Medical Director Guidelines. However, there may be differences in claim management procedures and the scheduling process of independent medical examinations (IME) between the two programs.

You may hear about a third program administered by the department that schedules IMEs. The Crime Victims Compensation Program (CVCP) was created by the legislature in 1974 to manage claims for victims of violent crime. In 2007, approximately 7500 claims were received by CVCP. CVCP has different laws, rules, and fees than Industrial Insurance. CVCP is funded by the federal government and the budget is supplemented by the state legislature.

Legislative Intent & Department Role

The IME program was created by the legislature. It was the intent of the 1988 legislature that medical examinations for determining permanent disabilities be conducted fairly and objectively by qualified examiners and with respect for the dignity of the injured worker. The legislature charged the department with:

- Developing standards for conducting special medical examinations (IME and rating exams);
- Determining the qualifications of the persons conducting the examinations;
- Establishing a standard for the content of reports;
- Monitoring the quality and objectivity of examinations and reports.

The definition of an IME is a medical examination requested by the department or self-insured employer to answer medical and legal questions about the claim.

Performing independent medical examinations (IME) or ratings requires considerable judgment and understanding of specialized terms and a mastery of skills that may not be part of your original training. Washington Administrative Code (WAC) states that you must be familiar with the contents of this handbook. (WAC 296-23-347) This handbook was developed as a source of information to help you to become an examiner who not only treats the worker respectfully but writes reports that are fair, unbiased, objective, and stands up to scrutiny. Also, you can earn 3 Continuing Medical Education category 1 credits by completing the assessment test online. (see IME websites on page 182)

It is the department's expectation that IMEs and rating examinations be conducted using an open, transparent process. All IME and addendum requests should be in writing to avoid accusations of an influenced medical opinion. All reports received by the department or self-insurer are considered final reports. To correct errors it is best to submit an addendum citing the reason for the change, the date of the change, and who made the change, rather than send a corrected report where the reader must identify the difference between the documents.

Keep in mind other systems (personal injury, private, federal, and other state agencies) may use different definitions and rules for determining impairment and disability. Learning the standards for Washington will establish the foundation you need to conduct high quality IMEs. The questions you answer about the injured worker's medical status make it possible for Claim Managers to adjudicate claims fairly and effectively. A high quality IME report or rating saves time and money for all parties because fewer addendums or letters of clarification are needed.

Reasons Why IMEs are Requested

Over 38,000 pieces of mail are imaged daily by the State Fund program. It is impossible to guess how many documents are received by self-insured employers and TPAs since those documents are not received by the department. Claim Managers in both programs are encouraged to regularly review their assigned claims to ensure the worker receives medically appropriate care and appropriate adjudicative decisions are administered. Claim Managers are encouraged to request information when it is needed to adjudicate the claim, if it has not been received.

Note: Self-insured employers and TPAs retain the original files on claims they administer. The department only receives copies of information in the claim file when it is required to address an issue with the claim or if a department order is required to close the claim.

Since some treating providers are unwilling or not qualified to answer some medical questions or to rate a disability, the Claim Manager is encouraged to request a referral with a consultant for these services. When all attempts fail an IME is requested.

The key reasons for an IME are:

- **Establish a diagnosis**. Prior diagnoses may be controversial or ill-defined;
- **Case Progress**. Outline a treatment program when treatment or progress is controversial or when treatment occurs over an extended period of time with no change in objective findings; Determine whether an injured worker meets OMD surgical guidelines; Establish when the injury or disease/illness has reached maximum medical improvement; Determine the

worker's ability to return to work; Review job analyses in light of the medical condition;

- **Causation**. Evaluate what conditions are related to the injury or disease/illness; Determine whether an industrial injury or occupational disease/illness has worsened a preexisting condition and the extent of that worsening;
- **Rate permanent impairment**. Determine the extent of total body impairment (category rating) or loss of bodily function when maximum medical improvement has been reached; and
- **Reopening**. Evaluate whether the injury or disease/illness has worsened and whether the worker would benefit from additional treatment.

Additional Types of Examinations

Agreed examination: An agreed exam is an IME in which involved parties draft questions, select the examiner, and agree to abide by the findings, conclusions, and recommendations of the examiner. Agreed exams, however, are not always binding. According to state law a worker cannot agree to relinquish any rights (RCW 51.04.060). In addition, the department is not bound by any agreement when L&I has not been a party to the agreement.

Claim Managers in State Fund do not use agreed exams. Claim Consultants and Pension Adjudicators in both the State Fund and Self-Insurance Programs may use an agreed exam to settle a dispute about the claim. Self-insured employers and TPAs may find an agreed exam helpful in resolving treatment issues.

Forensic examinations or record reviews: Forensic examinations are requested when the worker is not available for the physical examination portion of an IME.

CR 35 examination: Infrequently, the Board of Industrial Insurance Appeals orders a CR (Court Rule) 35 examination. This legal examination is requested by the claimant or department to answer legal questions about the claim. If the Board finds there is good cause, the Board will order the exam. The time, place, manner, conditions, scope of the examination and the name of person conducting the examination are part of the order.

Worker requested examination: A worker's representative will sometimes request an approved examiner conduct an IME or rating. The worker's representative drafts the questions and pays for the service. The department or self-insured employer is not bound by the findings of a worker requested examination or rating. It is a common practice for the worker's attorney to request a draft report.

Confidential Information

Medical Records: Workers sign a medical release when submitting a claim with the department or self-insurer. The statement authorizes any physician, hospital, agency, or organization to release any medical records or other information regarding any treatment to the department, employer, or employer's representative.

When an IME is ordered, relevant claim medical information received by the department or self-insurer is provided so the examiner may conduct a thorough review, conduct a physical examination, and write a report. Records provided for an IME must be stored in a secure area and not be released to other parties. Once the IME report is completed an IME firm or examiner may destroy those copies of the records.

HIPAA: The complexity of the Health Insurance Portability and Accountability Act (HIPAA) makes examiners uncertain about their responsibilities to the workers they examine. **All workers' compensation programs are exempt from HIPAA Privacy Rule regulations**. You may disclose personal health information identified during an IME to the department or self-insurer without an additional signed authorization from the worker.

The department has voluntarily elected to participate in the HIPPA Privacy Rule sections about Electronic Protected Health Information, Security Rule, and Unique Identifier Rule (National Provider Identifier) to the extent possible. The State Fund billing system is compliant with HIPPA so you may bill State Fund electronically. More information about HIPAA and workers' compensation is located on the website at http://www.lni.wa.gov/ClaimsIns/Providers/Claims/HIPAA/default.asp.

Prudent privacy practices: In addition to the above, the department has adopted prudent privacy practices. The department requests you do not send claim numbers and worker names over the Internet. Recent changes to our Claims and Account Center (CAC) make it possible for secure messaging communication for State Fund claims. If you are granted access to the claim file through CAC, you may send messages including worker names and claim numbers over this system.

Information faxed to designated department or self-insured employer/TPA numbers can include names and claim numbers. Statute RCW 51.04.050 allows you to waive the patient-physician privilege in industrial insurance cases.

Sensitive medical information: The department has strict confidential safeguards for the release of sensitive medical information such as Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Virus (AIDS), sexually transmitted diseases (STD) and behavioral/mental health status. When an IME report contains sensitive information the report may not be released to the worker's attorney, ancillary health care providers, or employer/employer's staff not involved in handling the claim or determining bill payment. For that reason, follow the guidelines listed below:

- Information about a worker's drug use history and behavioral/mental health status that is relevant to the claim should be included.
- Do not include worker disclosed preexisting physical or mental health conditions not related to the claim.
- Do not include sensitive medical information in the report if the claim is not related to a possible work exposure to those diseases.

If in your professional opinion, the information disclosed during the IME is critical to support your conclusions, contact the Claim Manager and explain the situation. The Claim Manager may request the information in an addendum rather than in the main IME report. You should label each page of the addendum "**CONFIDENTIAL**" in an obvious spot on the page. The top right corner is recommended.

The Claim Manager will take steps to ensure the addendum is not accidentally disclosed to unauthorized parties. In compliance with Washington State Law, a general authorization to release claim information may not be adequate for the release of the medically sensitive information. A specific medical release from the worker may be required. If you have questions about the confidentiality of any information, contact the Claim Manager for guidance.

Claim Manager Role

The Claim Manager in all department programs is responsible for determining when an IME or rating exam is requested. Sometimes the attending provider requests an IME or rating exam but more frequently the Claim Manager identifies one of the reasons listed, earlier in this chapter. The Claim Manager:

- Determines the purpose of the examination.
- Selects the specialty or specialties required.
- Decides whether a single examiner or multiple examiners is required. Most IMEs only require a single examiner.
- Provides a brief summary of the claim.
- Identifies the issues and questions that need to be answered by the examiner.
- Provides either access to the imaged claim file, CD, or hard copies of relevant records.
- Determines whether the worker requires special accommodations to attend the IME.
- Conducts a timely review of the report.

Scheduling IMEs

State Fund Claims

Requests: Examination requests are made by the worker's Claim Manager and sent electronically to the Central Scheduling Unit (CSU). The CSU schedules the examination, notifies the worker of the appointment, makes travel and transportation arrangements, and facilitates access to the claim medical information (CAC). All cancellations and rescheduling requests should be directed to the CSU. Interpreters are scheduled by the IME firm or the examiner's office staff.

Questions: Direct any clarifying questions to the Claim Manager whose name appears on the examination assignment letter.

Reports and bills: Fax the report to fax # 360-902-4567 and send bills to the fax number/ address provided on the examination assignment letter. Do not attach or staple your report to the bill if you need to mail it.

Self-Insured Claims

Self-insured claim numbers are preceded by one of the following letters: S, T, or W. Newer claims are assigned double letters: SA, SB, etc.

On occasion the self-insured employer or TPA will give you a company assigned number for billing or other internal company purposes. WAC 296-20-010 (10) states that all communications with the department or self-insurer must show the worker's full name and claim number. Be sure to record the S, T, or W number on the report.

Requests: Examination requests are scheduled directly by the self-insured employer, the contracted third party administrator (TPA) or the Self-Insurance Program (SI) on default claims. The actual person requesting the IME may be a Claim Manager, a Nurse Case Manager, or a self-insured employer's legal representative. Some employers elect to designate attorney oversight of complex claims. If an IME is requested by any employer's representative, it is an IME and subject to the rules and fee schedule. Examiners must be approved by the department. See the Find a Medical Examiner online list.

Copies of relevant medical records are provided by the requester. The department does not manage the claim so any information imaged on the department's Claim and Account Center is incomplete. The only exception occurs when a self-insured employer defaults. Default claims are managed by the Self-Insurance Program. IMEs requested by the SI program will be scheduled by the CSU and follow the same process as State Fund claims.

Interpreters are scheduled by the requester on self-insured claims. Interpreters are scheduled by the IME firm or examiner on default claims.

Questions: Contact the requester if records are not received 10 days prior to the examination or if there is a need to clarify the IME purpose, accepted conditions, or IME questions. Examiners are not expected to conduct examinations when records or questions have not been received.

Reports and bills: Mail reports and bills directly to the requester or as instructed in the referral letter or cover letter.

Crime Victims Compensation Program Claims

Crime Victims Compensation claim numbers begin with a V.

The CVCP uses a wide range of specialists to provide IMEs. These evaluations assist the Claim Manager in managing controversial or complex issues. The program prefers specialists, especially those providing psychiatric or psychological opinions, who have training and clinical experience in treating crime-related trauma victims. Because the needs of the victim may be greater than the average worker, special consideration and sensitivity is required. The exam may take longer to complete. The report may require more detail than a standard IME format. Forensic examinations or record reviews may be requested to avoid the psychological stress created by an independent medical examination. A large number of the claimants are victims of assault and sexual assault.

Requests: Examination requests are made by the Claim Manager and sent to the Central Scheduling Unit (CSU). The CSU schedules the examination, notifies the claimant of the appointment, coordinates interpreter needs with the IME firm or examiner, and makes travel and transportation arrangements. The CSU mails a CD containing the medical records to the IME firm or examiner. All cancellations and rescheduling requests should be directed to the CSU.

Questions: Contact the requester if records are not received 10 days prior to the examination or if there is a need to clarify the purpose, conditions, or questions.

Reports and bills: Mail reports and bills to the address listed on the examination referral letter.

CHAPTER 2

The Independent Medical Examination Provider

Types of Examiners

Only doctors who have been approved by the department and have active IME provider numbers can perform IMEs for Self-Insurance, the State Fund, or Crime Victims Compensation Program. An IME provider number is NOT the same as a provider number that allows the provider to treat injured workers.

To ensure that independent medical examinations are of the highest quality and propriety, examiners and firms (partnerships, corporations, or other legal entities) that derive income from independent medical exams must apply and meet certain requirements for department approval.

Only providers in the following specialties will be considered:

Doctor is licensed to practice:	Medicine & Surgery	Osteopathic Medicine & Surgery	Podiatric Medicine & Surgery	Chiropractic	Dentistry
In Washington	Yes	Yes	Yes	Yes	Yes
Not in Washington	Yes	Yes	Yes	No	Yes

Limited license providers (for example, dentists, podiatrists, and chiropractors) may only provide ratings for body regions (areas) or conditions within their scopes of practice.

IMEs and impairment ratings are not the same. See Chapters 11 and 12 for information on rating impairment.

The department or self-insurer may order an examination by a single approved IME chiropractor under the following circumstances:

- A chiropractor has exclusively provided treatment for the care of an injured worker.
- The current attending doctor is a chiropractor, and the care has been only for spinal soft tissue injury (no fracture, spinal cord injury, etc.).
- No surgery has been performed even though medical care was provided prior to chiropractic care.
- A claim reopening is requested, clinical findings for reopening need clarification, and no preexisting, non-spinal or temporary conditions are in evidence. In these circumstances it is expected that only standard or limited levels of examination would be requested.

Application Process

The Washington State Department of Labor & Industries (L&I) is responsible for assuring that only qualified and approved examiners conduct examinations for the State Fund, Self-Insured and Crime Victims' programs. Only doctors who are licensed in medicine and surgery, osteopathic medicine and surgery, chiropractic, podiatric medicine and surgery, and dentistry are eligible to apply to become approved examiners.

To apply for approval as an independent medical examiner, you need to complete and sign the IME Provider Account Application and Agreement. The information on the application also allows schedulers to match the specialist's expertise with the worker's injury.

See the web site for the application and additional instructions: www.imes.Lni.wa.gov

Examiner Credentialing Requirements

To ensure that independent medical examinations are of the highest quality and propriety, examiners and firms (partnerships, corporations, or other legal entities) that derive income from independent medical exams must apply and meet the following requirements for department approval. WAC 296-23-317

Examiners must:

- Submit an accurate and complete IME provider application, including any required supporting documentation and sign without modification, an IME provider agreement with the department.
- Be currently licensed, certified, accredited or registered according to Washington state laws and rules or in any other jurisdiction where the applicant would conduct an examination. The license, registration or certification must be free of any restrictions, limitations, or conditions relating to the provider's acts, omissions, or conduct.
- The applicant must not have surrendered, voluntarily or involuntarily his or her professional state license or Drug Enforcement Administration (DEA) registration in any state while under investigation or due to findings resulting from the provider's acts, omissions, or conduct.
- The applicant must not have had clinical admitting and management privileges denied, limited, or terminated for quality of care issues.
- Have no final action by the department to suspend or revoke a previously assigned provider number as a treating provider or independent medical examiner.
- Have no pending civil or administrative action in any jurisdiction that affects the ability or fitness to practice medicine. The department will not process the application until the matter has been resolved.
- Have not been excluded, expelled, terminated, or suspended from any federally or state funded health care programs including, but not limited to, medicare or medicaid programs based on cause or quality of care issues.
- Have no significant malpractice claims or professional liability claims (based on severity, recency, frequency, or repetition)

- Have not been denied approval, or removed, from the provider network as defined in WAC 296-20-01010.
- Attest that all information submitted on the application or credentialing materials is true and accurate and must sign under penalty of perjury.
- Comply with all federal, state, and local laws, regulations, and other requirements with regard to business operations, including specific requirements for the provision of medical services.
- Adhere to the independent medical exam standards of conduct, and all other laws, rules, and policies. These include but are not limited to the following:
    - Provider application agreement;
    - Medical Aid Rules and Fee Schedules (MARFS);
    - Payment policies;
    - Medical Examiners' Handbook.
- Review and sign the IME report and attest to its accuracy.
- Agree to conduct exams in a facility primarily designated as a professional office for medical, dental, podiatric, chiropractic or psychiatric exams where the primary use of the facility is for medical services.
- Have telephone answering capabilities during regular business hours.
- Agree that either they or the department may inactivate their IME provider number(s).
- Agree to keep the department informed and updated with any new information regarding changes or actions that may affect their status as an IME examiner.
- Reapply every three years or when requirements change.
- Achieve a passing score on the *Medical Examiners' Handbook* test prior to initial application and when renewing.

In addition all examiners must meet one of the following two criteria:

- Document a minimum of 768 hours of patient related services (excluding independent medical examinations) per calendar year; or
- Submit documentation showing fulfillment of continuing medical education (CME) hours as required for their respective state licensure. This training must focus on improving the provider's skills in completing IMEs or staying current in their specialty.

Additional Requirements for Specific Examiner Specialties:

Medicine and Surgery (MD), Osteopathic Medicine and Surgery (DO), Podiatric Medicine and Surgery (DPM)

- Applicants must hold a current board certification in their specialty; or have completed a residency and become board certified within five years of completing the residency.
- Residency must be in a program approved by:
    - American College of Graduate Medical Education (ACGME) or;
    - American Osteopathic Association (AOA) or;
    - American Podiatric Medical Association (APMA)

Chiropractic (DC)

- Be an approved chiropractic consultant for L&I for at least two years; and
- Attend the department's chiropractic IME seminar during the 24 months prior to initial application.

In order to become a chiropractic consultant for L&I, you must have a current practice in Washington. Contact the Provider Credentialing and Compliance Unit, PO Box 44322, Olympia, WA 98504-4322 or call (360) 902-6817 for application information. Minimum requirements for becoming a chiropractic consultant include the following:

- Maintain a current license to practice chiropractic in the State of Washington.
- Have an active provider number with L&I.
- Provide proof of completing not fewer than 180 hours of post-graduate continuing education prior to application.
- Maintain an active clinical practice for a minimum of five years with at least two years in Washington. At least 50% of the practice in Washington must be devoted to patient management (direct patient care), including treatment of workers.
- Demonstrate a pattern of practice within the department's utilization standards and Medical Aid Rules and Fee Schedules.
- Attend the department's chiropractic consultant and basic workers' compensation seminars.

After completing two years as a chiropractic consultant, you may apply to become an independent medical examiner.

Dentistry (DDS/DMD)

- Applicants must have a minimum of two years of clinical experience after licensure; **and**
- Hold a current certification in their specialty; **or**
- Have one year of post-doctoral training in a program approved by the American Dental Association Commission on Dental Accreditation (CODA); **or**
- Be a general dentist.

The department accepts certifications from boards recognized by the following as meeting the board certification requirements in WAC 296-23-317:

- American Board of Medical Specialties;
- American Osteopathic Association (AOA)Bureau of Osteopathic Specialties;
- American Podiatric Medical Association; or
- American Dental Association.

Examiner Training Requirements and Opportunities

Attending seminars and courses given by the department is important. You must stay current with the new regulations and policies of the department in order to remain a department-approved IME provider. Failure to stay current in your specialized area and in the areas of impairment rating, performance of IMEs, industrial injury and occupational disease/illness, industrial insurance statutes, regulations and policies can mean possible suspension or termination of your IME provider number. WAC 296-23-337 (3)(d)

Training provided by L&I: L&I offers a number of training opportunities, some of which are classroom-style, some available online and some as videos available on-demand (24 hour/day). For example, watch for videos on how to rate spinal impairment (which may be valuable for both experienced providers and those who are new to rating). For a listing of upcoming trainings, go to: www.Lni.wa.gov and search for "Courses and Seminars" under "Workshops and Training".

Training courses are available from other sources. The department does not endorse any specific training course. Training on the use of the American Medical Association *Guides to the Evaluation of Permanent Impairment* (AMA *Guides*) is available through several sources (including, but not limited to):

- The American College of Occupational and Environmental Medicine (ACOEM), 25 Northwest Point Blvd. Ste 700, Elk Grove Village, Illinois 60007-1030; 847-818-1800
- The American Academy of Disability Evaluating Physicians (AADEP), 223 W. Jackson Blvd. Ste 1104, Chicago, Illinois 60606 1-800-456-6095
- SEAK, Inc., PO Box 729, Falmouth, MA 02541; 508-457-1111

These courses do not include information about the Category Rating System.

L&I offers courses, which cover both the AMA *Guides* and the Category Rating System. For information on these courses, see L&I's web site at:
http://www.lni.wa.gov/ClaimsIns/Providers/WorkshopTrain/default.asp .

Site Standards and Business Requirements

You must provide your medical examinations only in a professional office suitable for medical, podiatric, chiropractic or psychiatric exams where the primary use of the exam space/room is for medical services—not for residential, recreational, commercial, educational or retail purposes.

Make sure that the site either in your office or at the IME firm contains adequate:

- Access,
- Climate control,
- Light,
- Space,
- Equipment for comfort and safety of the worker,
- Privacy for discussion of medical needs,
- Private disrobing area,
- Provision of examination gowns,
- Telephone answering capability during regular business hours (and on Saturday, if open), and
- Compliance with all federal, state and local laws, and regulations, with regard to business operations. WAC 296-23-317 (1) and (4)

Independent Medical Examination Firms

Examiners may choose to conduct IMEs individually or through firm affiliations. Those examiners choosing to arrange, conduct and bill for IMEs themselves work directly with the schedulers or Claim Managers. Those examiners affiliated with (a) firm(s) are scheduled through their designated firm(s) and

often conduct the exam at a site provided by the firm(s). The firm also facilitates many other facets of the exam, such as billing and report preparation.

IME firms or medical groups (panels) are organizations that have scheduling and billing relationships with multiple providers who provide examinations. Department policy, however, states that **you must have an individual provider number for each firm you work for.** If you work for a firm, it is your responsibility to submit your application containing accurate information, including the firm's information.

Firms must also apply for approval to provide IMEs.
To receive approval, the IME firm, partnership, or corporation must have a medical director. The director must be a licensed provider and approved examiner who provides oversight on the quality of IMEs, impairment ratings and reports. WAC 296-23-317 (4)(a)

Requirements for IME Firm Providers

IME firms (panels) are organizations that provide examinations by one or more examiners. To ensure that independent medical exams are of the highest quality and propriety, examiners and firms (partnerships, corporations or other legal entities) that derive income from independent medical exams must apply and meet the following requirements for department approval. Information on starting an IME firm is available from L&I's Provider Credentialing and Compliance Unit, PO Box 44322, Olympia, WA 98504-4322.

The department must have approved and issued a unique provider number to an IME firm so that it can bill for IME services. WAC 296-23-312

IME firms (partnerships, corporations or other legal entities) that derive income from independent medical examinations must:

- Have a medical director. The medical director must be a licensed medical physician and surgeon (MD) or osteopathic physician and surgeon (DO), be responsible to provide oversight on the quality of independent medical examinations, impairment ratings and reports, and be available to resolve any issue that department staff may bring to the medical director's attention. The medical director must have a Washington state medical license and be a department approved independent medical examiner.
- Have no previous business or audit action by the department to suspend or revoke an assigned provider number.
- Have no previous action taken by any federal or state agency for any business previously owned or operated.
- Facilitate scheduling of providers for both the exam and for any required follow up, including amendments to the report, subsequent reports, or for any testimony required.
- Attest that all information on the application is true and accurate and must sign under penalty of perjury.
- Comply with all federal, state, and local laws, regulations, and other requirements with regard to business operations including specific requirements for any business operations for the provision of medical services.

- Adhere to independent medical examination standards of conduct, and all other laws, rules, and policies. These include, but are not limited to, the following:
    - IME provider application agreement;
    - Medical Aid Rules and Fee Schedules (MARFS);
    - Payment policies;
    - *Medical Examiners' Handbook*.
- Ensure that examinations are conducted in a facility primarily designated as a professional office suitable for medical, dental, podiatric, chiropractic or psychiatric exams where the primary use of the facility is for medical services. The facility must not be residential, commercial, educational, or retail in nature. The facility must be clean, sanitary and provide adequate access, climate control, light, space, and equipment. The facility must provide for the comfort and safety of the worker and for the privacy necessary to conduct exams and discuss medical issues. Providers must have a private disrobing area and adequate provision of examination gowns if disrobing is required.
- Have telephone answering capability during regular business hours, including Saturday if the exam site is open on Saturday.
- Agree that either the firm or the department may inactivate their IME provider number or numbers.
- Agree to keep the department informed and updated with any new information such as exam site or administrative office locations, phone numbers or contact information.
- Reapply every three years in order to maintain an active IME provider number.
- Have their medical director and a representative from their quality assurance (QA) staff achieve a passing score on the *Medical Examiners' Handbook* test prior to initial application and when renewal is due or required. WAC 296-23-317 (4)

IME firms may send copies of professional licenses and signed IME Provider Account Applications for the doctors who work for them to the Provider Credentialing and Compliance Unit.

IME firms must maintain billing records and reports with supporting documentation for a minimum of five years for audit purposes. WAC 296-20-02005

Review of Applications

If the department approves your application, we will enter the information you supply into the approved examiner database (IMETS). This database, "Find a medical examiner" can be found at: www.imes.Lni.wa.gov .

If we need more information, we may return your application with a letter, describing the areas that you need to complete. If we approve or deny your application, the Provider Credentialing and Compliance Unit will notify you.

The department's Medical Director or designee considers many factors in disapproving an application. In addition to the requirements above, the department may consider:

- Any action against provider's license;
- Complaints about the provider;

- Quality of reports;
- Late reports;
- Lost or modified privileges;
- Charges regarding any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court or board; and/or
- Convictions of any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court or board.

If you have questions about the Approved Examiner Application, contact the Provider Credentialing and Compliance Unit at 360-902-6815.

Reporting Changes to L&I

Immediately notify L&I in writing of any change in your status that might affect your qualifications to hold an IME provider number. If applicable, providers must include a copy of any charges or final orders. Changes in status may include any of the following:

- Changes in amount of time spent in direct patient care, excluding IMEs;
- Loss or restriction of hospital admitting or practice privileges;
- Changes affecting business requirements;
- Loss of board certification;
- Charges regarding any criminal actions;
- Convictions of any criminal actions; or
- Temporary or permanent probation, suspension, revocation, or limitation on license to practice or Drug Enforcement Administration (DEA) registration in any state or foreign land.

Important to Know

The department does not guarantee referrals to any specific IME approved providers and providers are not obligated to accept any IME assignments.

All IME providers must notify L&I's Provider Credentialing and Compliance Unit of any changes in their qualifications or other information, such as address, exam sites, etc.

To make sure our information is current, you can query and view your information on the department's IME approved examiner database at this website: www.imes.LNI.wa.gov. Click on "Find a Medical Examiner."

If your information has changed or is not correct, please contact:

Department of Labor & Industries
Provider Credentialing and Compliance Unit
PO Box 44322
Olympia, WA 98504-4322

CHAPTER 3

The Independent Medical Exam

Preparing for the Examination

The claim manager will send you an assignment letter or request for an IME. The assignment states the purpose of the IME, information about the condition to be addressed, and questions for you to answer. If you receive questions or correspondence from other parties, such as attorneys or vocational counselors, you should forward them to the claim manager.

- Contact the worker prior to the exam to confirm appointment date, time and location. (The IME firm/panel may perform this service if you work for a firm.)
- Review the purpose of the exam and the questions you will answer in the exam report.
- Provide sufficient time to evaluate fully the provided records.
- Be aware of the contents in the State Fund brochure entitled Your IME Exam that the worker receives in the mail before the visit so that you may answer questions, if necessary. You may find this brochure at this web site address: www.imes.Lni.wa.gov (follow the forms and publications link).

It is the department's expectation that IMEs be conducted by the most appropriately qualified examiner. Occasionally, an IME is scheduled with an examiner of the wrong specialty or field of practice. Check with the requester if you think the exam was scheduled inappropriately. The IME may need to be rescheduled. At other times the correct examiner is selected but is asked to comment on medical issues that are outside their area of expertise. In this case, simply record in the report it is outside your area of expertise and decline to comment.

Missing Documents or Records

You must review and be familiar with all claim documents provided to you. If some **materials are missing or seem incomplete**, contact your referral source before the IME. The referral source will try to obtain them for you before the appointment with the worker.

Interpreter Services

Workers may not bring their own interpreters to the exam. If the worker needs an interpreter to communicate because of limited English-speaking ability or sensory impairment, the department, Crime Victims Compensation Program, or the self-insurer will provide one. For State Fund exams, the examiner or IME firm will arrange for a department approved interpreter and the interpreter will bill the department. For self-insured or crime victims exams, the referral source will arrange for and pay the interpreter. Family members or friends of the worker **may not** act as interpreters. WAC 296-23-362

For detailed information on interpreter services available, see L&I's IME webpage at www.imes.Lni.wa.gov and click on the link for interpreter services. For tips and FAQs for using interpreters, check out www.ctslanguagelink.com and select 'resources'. CTS language Line: 877-626-0678 Pacific Interpreters: 877-810-4721

Who is Allowed to Attend an IME ?

The worker can bring an adult friend or family member to the IME to provide comfort and reassurance. However, no one except an interpreter if needed, may accompany the worker in a psychiatric exam.

The purpose of an IME is to gather information, not to conduct an adversarial proceeding. Therefore, the friend or family member, must quietly observe the exam, cooperate with the examiner and not interfere.

The following WACs apply to examinations requested by L&I, CVCP, and self-insured employers.

WAC 296-23-362

May a worker bring someone with them to an independent medical examination (IME)?

- Workers can bring an adult friend or family member to the IME to provide comfort and reassurance. That accompanying person may attend the physical examination but may not attend a psychiatric examination.
- The accompanying person cannot be compensated for attending the examination by anyone in any manner.
- The worker may not bring an interpreter to the examination. If interpretive services are needed, the department or self-insurer will provide an interpreter.
- The purpose of the IME is to provide information to assist in the determination of the level of any permanent impairment not to conduct an adversarial procedure. Therefore, the accompanying person cannot be:
    - The worker's attorney, paralegal, any other legal representative, or any other personnel employed by the worker's attorney or legal representative; or
    - The worker's attending doctor, any other provider involved in the worker's care, or any other personnel employed by the attending doctor or other provider involved in the worker's care.

The department may designate other conditions under which the accompanying person is allowed to be present during the IME.

May the Worker Record the IME?

No. WAC 296-23-367 does not allow the worker or an accompanying person to record the IME electronically (audio or video).

Examiner Responsibilities

Beginning the examination

- Conduct the exam with dignity and respect for the worker.
- Provide a setting for an IME in a professional setting (office) suitable for medical, podiatric, chiropractic or psychiatric exams. (See Chapter 2 for more details on "Site Standards.")
- Introduce yourself to the worker. A name tag may be helpful, especially if there is a language problem. The worker has a right to know your name and specialty.
- Verify the identity of the worker by asking for a name and/or identifying picture.

- Tell the worker that you have received and reviewed the claims documents from L&I or the self-insurer.
- Explain the examination process, purpose of the exam and how an IME and personal doctor's visit differ.
- If the worker has brought x-rays or MRIs to the exam, acknowledge receipt of them in your report.
- Explain the examination procedure.
- Answer the worker's questions about the examination process. (Refer the worker to the claim manager for questions about the claim and to the attending doctor for medical advice outside the scope of your examination.)
- Advise the worker that he/she should not perform any activities beyond the worker's physical capabilities. Ask the worker to inform you should pain occur.
- The worker must be fully dressed while you take the history.
- Allow an adult friend or adult family member to attend non-psychiatric portions of the examination. (See "Who is allowed to attend an IME?" earlier in this chapter.)

During the examination

- Provide adequate draping and privacy if the worker needs to remove clothing for the examination.
- Refrain from comments about the care the worker has received. While we may ask for your opinions later, please don't express opinions during the exam process.
- Refrain from expressing personal opinions about the worker, the employer, the attending doctor or L&I.
- Conduct an exam that is unbiased, appropriate to the condition being evaluated, and sufficient to answer the Claim Manager's questions.
- Respond to questions asked by the worker about the exam process in an objective and professional manner.

Closing the examination

- Close the exam by telling the worker that the exam is over and ask the worker if they have any questions about the exam.
- Inform the worker that you will send the report directly to the Claim Manager.
- If needed, explain that you feel the necessity of ordering further diagnostic tests for the worker.
- Tell the worker to contact the Claim Manager for questions about their claim or if they would like a copy of the exam report. (1-800-LISTENS). WAC 296-23-347

Discussing the Examination Results with the Worker

You may briefly discuss the results of the exam with the worker if you choose. Record in your report that you have provided some summary comments to the worker's concerns. Remember that an attending doctor may discuss with the worker the IME report and any appropriate treatment, if needed.

Do not advise the worker on benefits (such as time-loss compensation or vocational services). Refer the worker to the Claim Manager. (See Chapter 4 "What to Avoid in the Exam and Report" for examples.)

May I Offer to Provide Ongoing Treatment?

No. The rules state that you should not offer to provide ongoing treatment. However, if a worker voluntarily approaches an IME provider who has previously examined the worker and asks to be treated by that provider, the provider can treat the worker. The provider must document that the worker was aware of other treatment options.

L&I or the self-insured employer must approve any transfer of care. With only a few exceptions, the patient has free choice of a treating doctor. WAC 296-20-065 (Beginning in 2013, workers must see a provider in the Provider Network.)

Ordering Diagnostic Tests

All tests must be proper, medically necessary and related to the industrial injury. Follow the instructions in the assignment letter or referral letter regarding diagnostic testing. In many cases the letter will give you authorization to ask for certain tests. You should simply **arrange for the needed routine test(s) (laboratory or x-rays)** and complete and submit the IME report after you receive the test results **(within l4 calendar days)**. See chapter 4 for information about deadlines. MRIs do not require authorization.

Send **requests for invasive testing** to the Claim Manager, by fax (e.g., myelogram, biopsies, studies with contrast, etc.). Include your recommendation for additional testing in the exam report. An addendum report may be requested after the results are received.

Unable to Complete Examination

If you were unable to complete an examination due to the worker's condition or behavior, contact the Claim Manager immediately, and then write a report to the Claim Manager who requested the examination.

Additional Examiner Needed

If you need an additional specialist to complete the exam, include your reasons why in your report. The Claim Manager will decide whether another specialist is needed after reviewing your report and recommendation.

No Show or Late Cancel

If the worker calls to cancel an appointment or fails to show, you should contact the person who scheduled the exam. The scheduler's contact number will be on the examination assignment letter. It may be possible to reschedule the missed exam. Retain the worker's file and examination assignment (or IME referral letter) until this matter has been resolved.

In some circumstances a cancellation or no-show fee is appropriate. See the Medical Aid Rules and Fee Schedules, published on CD and Internet:
http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2014/MARFS/Chapter13/default.asp

Releasing Information to Other Parties

Before your exam and before you have completed your report:

If you receive correspondence or phone calls from parties other than the claims staff or the attending doctor before the examination and completion of the exam report, direct these communications to the worker's Claim Manager.

Questions from other parties about your report:

If you are contacted by attorneys or any other parties with questions or comments about your report, refer them to the Claim Manager.

Sending reports to other parties:

After you complete the examination, submit the report to the party that requested the exam. On occasion, the exam assignment request will ask you to forward the report to parties involved in the claim (i.e., the attending doctor or the vocational counselor). In such cases you must send a copy of the exam report as directed. Keep one copy of this report for your records.

When other parties express interest in obtaining a copy of the exam report, unless you are directed otherwise, advise them to contact the department or self-insured employer to obtain a copy. It is standard procedure for the department to send this report to the attending doctor and the worker's legal representative, once it is received in the department. In addition, these reports are available to the employer assigned to the claim. If the department has the appropriate medical release, we will send this report to additional interested parties on request. The worker also may request a copy. There is no charge to receive one copy of the exam report from the department or self-insurer.

Even if you have a signed release from the worker, it is generally best if you direct the worker to the Claim Manager or to the attending doctor for a copy of the report. Once you have submitted the exam report to the department, if you are comfortable with the request for a copy of the exam report and you have the appropriate release form from the worker, you may release this report to any other parties. You may charge a copying fee to parties other than the insurer's staff and the attending doctor.

If you are unsure about the validity of a request, it is always appropriate to check with the worker's Claim Manager. For State Fund claims you may call the Provider Hotline at 1-800-848-0811. (The number to call from outside Washington is 1-800-547-8367.) Be sure to reference the claim number and the worker's name to receive claim status information. For self-insured and crime victims claims call the referral source.

Medical Records - Maintenance and Disposal

For audit purposes you must maintain all medical records that show the extent of services you provided the worker. Document the level and type of service for which you seek payment. **You must maintain these documents for a minimum of five years.** [WAC 296-20-02005]

Then discard the worker files in the manner you dispose of other medical records that you have in your office.

Remember to return x-rays and other imaging studies to the worker, hospital or the office that provided them, unless they have directed you not to return them.

Worker's Questions about their Claims

Refer the worker to their Claim Manager if they have questions about the claim or workers' compensation benefits. The L&I toll-free number for workers is 1-800-547-8367 (1-800-LISTENS) or 1-800-831-5227.

CHAPTER 4

The IME Report

Unbiased, Accurate IME Reports Contribute to Equitable Treatment of Workers

Your IME reports will make a difference—a significant difference—for the workers, the employers, the Claim Managers, the attorneys, the vocational counselors and others. Your report will help to determine whether the workers will receive the correct, lawful benefits due to them when Claim Managers make decisions or when someone disputes a decision. Your report must contain unbiased, accurate, sound, and comprehensive information, obtained through a high-quality examination that respects the dignity of the worker.

Due Date for IME Reports

The IME report must be sent within 14 calendar days of the exam or within 14 days of receiving any test results. Failure to provide reports within this period may result in adjustment of payment amount or other penalties. **Do not submit the bill before you submit the report.**

Late Reports

Special circumstances may exist when the Claim Manager must have the report in order to meet statutory deadlines. The exam assignment letter will indicate the date you must submit the exam report. If you are unable to meet this deadline, notify the Claim Manager immediately.

What to Include in an IME Report

WAC 296-23-382

The rules state that an IME report must:

- Contain objective, sound and sufficient medical information;
- Document the review of the claim documents provided by the department or the self-insurer;
- Document the worker's history and the clinical findings;
- Answer all the written questions posed by the department or self-insurer or include a description of what would be needed to address the questions;
- Include objective conclusions and recommendations supported by underlying rationale that links the medical history and clinical findings;
- Be in compliance with current department reporting policies; and
- Be signed by the IME provider performing the examination.

Failure to provide reports with these contents may result in non-payment, recoupment (holding monies from future payments) or other penalties.
IMPORTANT NOTE: In your report, do not express opinions on causation or work-relatedness for any injury or occupational disease unless specifically requested by the Claim Manager. In many cases, once a condition is accepted, the Claim Manager no longer needs an opinion on causation, and receiving such opinions may create unnecessary confusion. If a diagnosis has been accepted on a claim and your opinion

is that the condition is not work-related, you may state in your report that the diagnosis was "administratively accepted."

Appendix A includes sample reports to illustrate content expectations of an IME report.

We do not require that you use the format and template shown in Sample Report # 1, but we strongly recommend it. **We require that IME reports contain all the report elements except those marked by an asterisk (*).** You should only include those marked by an asterisk if the Claim Manager has specifically requested you to do so. Review your report to see that it is complete. The department will look for these elements when reviewing the quality of your documents.

Please make **each examination report unique** to reflect your individual consideration.

Details to Include in the Report

Other health care professionals often scrutinize your IMEs. Remember that your duty is to reduce conflict by being objective and including data that will allow reviewers to understand your conclusions. Areas of the history and physical exam in which detail is often lacking, include portions that deal with pain, swelling, range of motion and skin eruptions. When one or more of these are part of the history or physical exam, you should discuss the following points:

- **Pain**: nature and quality; radiation; severity (including scale); ameliorating/exacerbating factors; effect on activities etc.;
- **Swelling**: location; shape; dimensions; color etc.;
- **Range of motion**: joint (right or left); measurement, for example, with a goniometer (not required, but helpful);
- **Rash**: location/distribution; character (e.g., macular, papular, urticarial), etc.

Why are fair, unbiased reports so important?
Employers, the labor community, the legislature, L&I—all want IME examiners to make a special effort to provide fair, unbiased reports. Reports should neither overstate nor understate a worker's medical condition or impairment.

Biased reports may create significant problems for all parties involved. For example, biased reports may affect the health of the worker and the operation of the employer's business, not to mention that they may lead to litigation, resulting in costly delays and high legal expenses.

When to Sign the IME Report

Sign the IME report after you have reviewed the report to be submitted. Your signature on the report indicates that you have reviewed and approved the content of the report. You will be held accountable for the content of your report.

Where to Send the IME Report

If you fax your report for State Fund, the report will go directly into the worker's claim file. The Fax number for State Fund IME reports is 360-902-4567.

If you mail your report, you must use different addresses for State Fund, Self-Insurance, and Crime Victims' Compensation Program reports.

For State Fund: Do not attach or staple your bills to your reports. Send bills and reports to different addresses. If you send medical reports to the billing address, the report may not reach the Claim Manager. A post office box number makes a big difference in our mail delivery.

When Examiners Disagree on IME Conclusions

Multiple-examiner IMEs should be conducted at the same site on the same day as much as possible. This helps avoid disagreements on the conclusions in the report.

Claim Managers rely on the examiners' reports to help make their decisions. If IME reports contain widely divergent opinions, the Claim Managers have trouble making decisions about cases. All examiners, therefore, must consult and discuss their findings with all other examiners while preparing the IME report. If differences of opinions exist among examiners, the IME report must discuss the reason for the differences of opinion and provide options, if appropriate. Remember all examiners must sign the report after it is completed, certifying that the report accurately represents their findings and opinions.

Addendum Report

L&I or the self-insurer may ask you to complete an addendum report after receiving your IME report. If the request asks you to respond to a question that you overlooked in the examination assignment or request letter, we expect you to send the addendum report promptly (within 14 calendar days of receipt of the request) for no additional payment.

If we ask you to answer new questions, then you may bill for the report and receive payment. **Return the addendum report within 14 calendar days of receipt of the request**. If you cannot address the new questions based on your record of examination, contact the Claim Manager to discuss the kind of information needed or identify the additional expertise needed.

What is Meant by 'more-probable-than-not' in an IME?

We may ask you to determine whether the worker's condition is caused by an industrial injury or exposure on a more probable than not basis. Under Washington law, a causal relationship exists if you find that a **greater than 50% chance** exists that the condition resulted from the industrial accident or

exposure. Multiple causes may exist in a condition, and the industrial injury or exposure does not need to be the sole cause.

Maximum Medical Improvement (MMI)

L&I considers the terms “MMI” and “fixed and stable” to be synonymous. (“Fixed and stable” is the legal term.)

An accepted condition has reached maximum medical improvement (that is, fixed and stable) when it is reasonably certain that further medical treatment will not improve the illness or medical condition.

“Fixed” does not necessarily mean “healed” or “static.” Rather, it means the worker has reached a stable plateau from which further recovery is not expected, although the passage of time may produce some benefit.

Be sure to specify the condition for which you are determining MMI, and whether it is an accepted condition on the claim. For example: “With respect to the accepted condition, lumbar strain, Mr. Y has reached MMI. With respect to his left knee complaint, which is not an accepted condition on this claim, Mr. Y has not reached MMI, and he may need to follow up with his attending physician.”

A worker may be at MMI and still require ongoing treatment. Asthma is one example. A worker may have work-related asthma that has reached a plateau from which further recovery is not expected - and at the same time may require ongoing treatment with medications.

Treatment Recommendations

Do not provide treatment recommendations unless the Claim Manager specifically asked you to do so in the IME assignment letter. If the Claim Manager asked you to provide treatment recommendations, please indicate which recommendations are for accepted conditions and which are for preexisting or unrelated conditions. The Claim Manager may also ask you to provide treatment recommendations for conditions that are retarding recovery (WAC 296-20-055). The department can only consider treatment of conditions that are retarding recovery if the accepted conditions are not at maximum medical improvement (MMI).

For example: “With respect to Mr. Y’s accepted condition of lumbar strain, the worker is not at MMI, and may benefit from physical therapy. With respect to Mr. Y’s left knee complaint, it is not an accepted condition, but it may retard recovery. Mr. Y would likely also benefit from limited physical therapy for the left knee.”

Guidelines, Coverage Decisions, and Policies on Specific Medical Conditions and Treatment Recommendations

IME providers must be familiar with the diagnostic and treatment guidelines, policies, and coverage decisions established by the department. Your opinions should, as much as possible, be consistent with these guidelines, policies, and coverage decisions. In general, IME providers should not recommend treatments that L&I does not cover. It creates problems for the worker and their providers when IME providers recommend treatments that L&I does not pay for.

You may access the Medical Treatment Guidelines online about these topics at http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/TreatGuide/ :

- Acute Cauda Equina Syndrome
- Ankle/foot surgery
- Antiepileptic drugs guideline for chronic pain
- Carpal Tunnel Syndrome
- Cervical Nerve Root, Single
- Complex Regional Pain Syndrome (CRPS)
- Facet Neurotomy
- Knee surgery
- Low Back Pain, Guideline for Hospitalization
- Lumbar Fusion, Guidelines for (Arthrodesis
- Lumbar Nerve Root, Single (Lumbar Laminectomy)
- Prescribing Opioids to Treat Pain in Injured Workers **(effective July 1, 2013)**
- Proximal Median Nerve Entrapment (PMNE)
- Psychiatric Conditions
- Radial Nerve Entrapment Diagnosis and Treatment
- Shoulder Conditions Diagnosis and Treatment Guideline - **NEW**
- Thoracic Outlet Syndrome – Neurogenic
- Thoracic Outlet Syndrome – Vascular
- Ulnar Neuropathy at the Elbow (UNE) Diagnosis and Treatment

L&I issued Provider Bulletins (PB) are temporary communications to announce changes to rules, law, policies and coverage decisions.

Coverage Decisions: In addition to the guidelines discussed above, IME providers must be familiar with the "coverage decisions" which L&I has issued on a number of topics. More information about coverage may be found in the Condition and Treatment Index at: http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/default.asp. Some conditions NOT covered include autologous blood injections, fibromyalgia, kyphoplasty, sacroplasty, and vertibroplasty, percutaneous discectomy for disc herniation, electrodiagnostic sensory nerve conduction threshold, extracorporeal shockwave therapy, percutaneous discetomy for disc herniation, percutaneous neuromodulation therapy (PNT), spinal cord stimulation, thermal shrinkage for instability.

Opioids, Pain Management and Controlled Substances

IME providers may be asked to address questions about treatment of chronic pain, including prescribing practices for narcotics and other medications. An important guideline to be familiar with is the Agency Medical Directors' Group (AMDG) "Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain." Also, IME providers should be aware of regulations on pain management enacted by the Department of Health (DOH), the Medical Quality Assurance Commission (MQAC), and other professional commissions in 2011.

FREE Category 1 CME is available to learn about the AMDG Guideline and the DOH rules.

A free online calculator is available to help providers assess compliance with the AMDG Guideline and the DOH Rules. The calculator converts doses of one (or multiple) opioids to daily morphine equivalent dose (MED). The calculator is available at: www.agencymeddirectors.wa.gov .

For State Fund exams drug summaries are available upon request to IME providers who would find it helpful to see a list of all medications prescribed for injured workers. For Self-Insured exams a drug summary may not be available so document drug, dose and frequency taken.

What to Avoid in the Examination or Report

Your IME report should not include the following types of items:

- **Statements about the claim status**: Please don't state things like "Keep the claim open. . . …or deny reopening." L&I is responsible for these administrative decisions, and we will use your findings to make them.
- **Speculation about services**: Avoid such statements as, "This worker needs vocational retraining," or "The insurer should pay for this worker to get a high school diploma." Don't comment on vocational issues unless the Claim Manager specifically asks you to address the worker's ability to work or to perform a specific job.

If you are asked to discuss the worker's ability or inability to work in a specific job, focus on the worker's physical abilities and provide complete information regarding any restrictions, including the basis for the restrictions.

- **Inconsistencies**: Make sure no inconsistencies exist in your report, for example, saying the worker has reached MMI but requires six more weeks of physical therapy.
- **Discussion of fault**: Since Washington is a "no-fault" state, avoid discussing fault (anyone's) with the worker. Coverage exists regardless of fault. Your examination report should not determine fault.
- **Discussion of finances**: Do not discuss financial need or assets.

If the Injured Worker needs Treatment from a different provider

Under Washington law, workers may choose their attending doctors who may hold licenses in many different areas. Workers may sometimes choose doctors who are not qualified to provide the care that the worker needs. So, in your report recommend the specific treatment and the type of specialist needed. The attending doctor is the one to make the referral.

If you expect that further treatment, such as the type the worker has been receiving, will not be curative, then say this in the report. Avoid statements about the attending doctor that are based on your objection to general principles of a profession or area of specialty.

Reopening a Closed Claim (worsening, objective findings)

If the accepted condition of a worker objectively worsens, a closed industrial insurance claim may be reopened. We may ask you, as an examiner, to perform reopening exams to answer specific questions. An administrative decision about claim status will be made based on your report. Do not tell the worker their claim will or will not be reopened.

L&I or the self-insurer may arrange for a reopening exam in order to do the following:

- Determine whether the accepted condition has worsened;
- Assess whether further treatment is needed;
- Document objective signs or findings and rate the increased permanent impairment, if appropriate;
- Determine whether the current condition is causally related to the injury or exposure covered under the claim.

Important things for you to do at the reopening exam:

- Document the findings substantiating any worsening of the worker's condition and the reason for the worsening.
- Describe the activity, if any, that caused the change in objective findings. Examples: Did symptoms start after loading firewood? After bending over to tie a shoe? Where did the activity occur?
- Be sure to review the worker's medical records at the time of last claim closure or last denial of reopening. It is not necessary to review records before that time.

New injury versus worsening of previous injury:

- If you are unsure whether a condition is a new injury or worsening of a previous injury, please check with the Claim Manager.

When worsening (aggravation) has occurred, an injured worker may be entitled to further treatment or additional compensation, if:

The causal relationship between the injury and the worker's impairment is established by medical evidence on a "more-probable-than-not" basis; and

- The medical evidence, backed in part by objective findings, shows that the worker's condition worsened; and
- The medical evidence, backed in part by objective findings, shows that the worker's condition worsened since the last closing order. (Check with the Claim Manager if you are unsure of the closing date.)

Note: A condition need not worsen enough to increase the impairment rating. Reopening depends on evidence of worsening, regardless of whether or not the impairment rating has increased.

See Chapter 5 for further discussion on aggravation of preexisting conditions.

Definition of worsening (aggravation): In workers' compensation, these terms refer to a worsening of the industrial injury or occupational disease that results in the need for further treatment or a temporary or permanent increase in impairment. Industrial insurance cannot cover conditions when other factors cause the worsening, such as an intervening injury, natural progression of a preexisting condition, etc. The opinion that the condition has worsened must be based at least in part on **objective evidence** (Wilber v. Department of Labor and Industries, 1963).

CHAPTER 5

Preexisting Conditions, Lighting Up, and Segregation

Industrial insurance law recognizes that not all workers are in perfect physical condition before their injury or exposure. Sometimes an industrial injury or occupational exposure can exacerbate a preexisting medical problem. Sometimes a preexisting condition can change independently of an industrial injury or occupational exposure.

IMPORTANT NOTE: When L&I has accepted the full effects of a preexisting condition, the doctor should NOT make any determination regarding segregation of preexisting impairment when completing a rating examination. Similarly, unless explicitly requested by the Claim Manager, the doctor should NOT express any opinion on causation or work-relatedness for any conditions diagnosed by the IME examiner.

Aggravation (also referred to as "worsening" or "exacerbation"—the three terms are used synonymously in Washington workers' compensation) of a preexisting condition occurs when an injured worker has a preexisting condition, symptomatic or asymptomatic, which is made worse by the industrial incident or exposure.

Your role, as an examiner, is to provide documentation of clinical observations and conclusions, so that the law can be applied correctly. Here are four examples of situations you might face:

- A worker may have had a condition that was asymptomatic and non-disabling, and then the injury or occupational disease caused the condition to become a problem for the worker.
- A worker may have an injury or contract an occupational disease that accelerates a preexisting symptomatic or disabling condition, or causes it to become worse.
- A worker may have an underlying condition that was temporarily affected by an injury or occupational disease, and now has returned to pre-injury status.
- A worker may have a preexisting condition which is not affected by an injury or occupational disease.

The department and self-insured employers apply two legal concepts in cases of preexisting conditions: **lighting up and segregation**. When these legal concepts are applied, we know if we are to accept full responsibility for a preexisting condition, partial or limited responsibility for the preexisting condition, or to deny responsibility for the preexisting condition. Whether a condition has been "lighted up" or needs to be "segregated" is a legal determination made by the department. In order to make this determination, we need your best medical judgment of the worker's condition before and after the industrial injury, and whether the industrial injury "lighted up," aggravated (permanently or temporarily) the condition, or whether the condition is totally unrelated to the industrial injury.

When does L&I accept full responsibility for a preexisting condition? "Lighting Up"

If an injury activates a previously asymptomatic AND non-disabling condition, the entire resulting impairment is attributed to the injury rather than to the preexisting condition. The law allows compensation for preexisting asymptomatic conditions that became symptomatic and disabling, or "lit up," as a proximate result of the industrial injury. "Lighting up" occurs if 1) a preexisting condition was not symptomatic and did not result in any limitations on the worker's ability to function prior to the industrial injury, 2) the preexisting condition is now symptomatic and it imposes some functional limitations on the worker, and 3) the industrial injury proximately caused the preexisting condition to become symptomatic and a source of functional limitations. The "lighting up" principle was established by the legal case of *Miller v. the Department (1939).* When the department or self-insured employer has accepted the full effects of a preexisting condition, the doctor should NOT make any determination regarding segregation of preexisting impairment when completing a rating examination. (See Sample Report #4 in Appendix A.)

When does L&I accept limited responsibility for a preexisting condition? "Segregation"

When medical evidence discloses that a preexisting condition was disabling and symptomatic prior to the injury, our responsibility is limited to the increase in impairment due to the industrial injury. We must segregate (subtract) the prior impairment from the overall impairment. In these cases, the doctor needs to advise us both of the impairment due to the industrial injury and of the preexisting impairment. There are no hard and fast rules about how to determine prior impairment. In many cases the apportionment must rely on the doctor's best medical opinion, (for example, in cases where no x-rays were obtained prior to the injury.) In some cases, the doctor may have a long-standing relationship with the patient and may have detailed medical records which allow a fairly accurate estimate of prior impairment (see Sample Report #5, Appendix A). In some cases, the Claim Manager may be able to provide records to which the attending doctor does not have easy access. In any case, the expectation of the examining doctor is simply to make the best determination possible, and to provide a brief explanation of the basis for that determination.

Temporary treatment of an unrelated condition may be allowed, upon prior approval by the department or self-insurer, provided these conditions directly retard recovery of the accepted condition. The department or self-insurer will not approve or pay for treatment for a known preexisting unrelated condition for which the claimant was receiving treatment prior to his industrial injury or occupational disease, which is not retarding recovery of his industrial condition.

When does L&I deny responsibility for a preexisting condition?

When a condition is totally unrelated to the industrial injury or occupational exposure, or if the worker has a preexisting condition and medical evidence does not establish that the condition was aggravated by the industrial injury or exposure, L&I may deny responsibility for the preexisting condition. In addition, we are not responsible for the natural progression of the preexisting condition or for changes due to the natural aging process.

What should I do to address preexisting conditions?

To summarize, when L&I has accepted the full effects of a preexisting condition, the doctor should NOT make any determination regarding segregation of preexisting impairment when completing a rating examination. If asked by the Claim Manager, and if you find that the preexisting condition was symptomatic AND disabling prior to the worker's injury, you should:

1) Rate the impairment that existed prior to the worker's injury; and

2) Document the basis for your opinion. At a minimum this should include the following:

- A discussion concerning how often the condition was symptomatic prior to the injury;
- The last time the condition was symptomatic prior to the injury;
- Any treatment the worker received for the condition prior to the injury (including the use of over-the-counter medications);
- A synopsis of prior medical records and diagnostic studies;
- The effect, if any, of the preexisting condition on the worker's daily activities/lifestyle prior to the injury (for example, did the worker miss time from work, require bed rest, need to refrain from performing certain household activities, etc.); and
- Any prior impairment award which the worker received for the condition.

CHAPTER 6

Occupational Diseases

Occupational diseases are different from occupational injuries. Carpal tunnel syndrome, noise-induced hearing loss, dermatitis, and asthma, when work-related, are examples of conditions which L&I considers occupational diseases. The Revised Code of Washington (RCW) defines an occupational disease as an infection or disease that "arises naturally and proximately" out of employment (RCW 51.08.140).

Unlike other questions in medicine where 90% or 95% certainty may be preferred for clinical decisions, in the workers' compensation system a degree of certainty greater than 50% is what is required for you to conclude that a condition is work-related on a more-probable-than-not basis.

Claims based on mental conditions caused by stress are excluded by law from this definition (RCW 51.08.142).

Why do claim managers need so much information about occupational disease claims?
Various laws and court decisions have created a legal standard different for occupational disease claims than that which pertains to industrial injuries. These legal aspects make it necessary for claim managers to gather detailed information from approved examiners on occupational disease claims to guide their legal decisions. This additional information is especially vital where several jobs with different employers may have contributed to the diagnosed condition. **In the legal process we may have to apportion or pro-rate the cost of benefits among the multiple employers whose employment contributed to the condition.**

An example of a court decision is *Dennis v. Department of Labor and Industries* (1987). For more detailed information on the criteria for allowance for occupational disease claims, see the box titled "Criteria for Allowance of an Occupational Disease." Since the legal standard is different in occupational diseases, we need additional information from you for occupational claims.

The Occupational Disease Report

IME examiners should ONLY provide this report if specifically requested by the claim manager.

Required content: This extra report MUST include all the content illustrated in Sample Report #6 in Appendix A. To complete this extra report you should review information provided by the worker on the work history form (sample in Appendix A.)

IMPORTANT NOTE: By following the specific format in Sample Report #6 and answering Questions 1 through 6 in that format, you will provide all the information needed by the Claim Manager. Even if you find that none of the jobs contributed to the contended occupational disease, completing this report will provide the necessary rationale to support your opinion. As you answer these 6 questions, you may find the definitions below helpful.

Special billing codes may be used to compensate IME examiners, attending doctors and consultants for the work required to file the extra report called the Doctor's Assessment of Work-Relatedness for Occupational Diseases. Depending on the diagnosis, it may or may not be necessary or appropriate to file this report. Refer to the Medical Aid Rules and Fee Schedules for billing codes.

Criteria for allowance of an occupational disease

"Occupational disease" is a disease or infection that arises naturally* and proximately** out of employment. Criteria used by Claim Managers for allowance of an occupational disease, based on law and regulation, include the following:

a) A physician must present an opinion that work conditions, on a more-probable-than-not basis (a greater than 50% chance), are the cause of the illness or have aggravated a preexisting condition; AND

b) Objective medical findings support the diagnosis; AND

c) The disease must arise "naturally and proximately" out of employment [RCW51.08.140].

*"Naturally": To meet the definition of arising "naturally" out of employment [*Dennis v. Department of L&I (1987)*], a disease must be regarded as a natural consequence of distinctive conditions of the work process, including any of the following:

- The disease is unique to the employment. The disease or disease-based disability does not arise naturally out of employment if it is caused by conditions of everyday life or all employments in general." OR
- The worker's occupation exposed the worker to the likelihood of contracting the disease or the disease-based disability. OR
- The disease is caused by continuous and specific activity required to perform the job.

**"Proximately": To meet the definition of arising "proximately" out of employment, "the cause must be proximate in the sense that there existed no intervening independent and sufficient cause for the disease, so that the disease would not have been contracted but for the [distinctive] condition existing in the …employment." [*Simpson Timber Company v. Department of L&I* (1949)] It is not required that the industrial injury or exposure be the only proximate cause of the condition [*Hurwitz v. the Department of L&I* (1951)]. For example, asbestos exposure can be a proximate cause of lung cancer, even though the worker is also a smoker. If the work exposure is one of the causes of the condition (a proximate cause, not necessarily the only proximate cause), the examiner should conclude that the condition is work-related. In the occupational disease setting, providers should document their opinion that, on a more-probable-than-not basis, the work exposure was (or was not) a cause of the condition for which the claimant is seeking benefits.

CHAPTER 7

Psychiatric IME reports

The department expects you to conduct a full psychiatric evaluation that should generally include the required report elements below. The format follows a general psychiatric interview, with additional features unique to workers' compensation.

Neuropsychologists: Neuropsychologists may be asked to provide testing for the IME examiner, especially for claims involving cognitive issues. They are not approved to perform IMEs. They should not answer any IME assignment questions from Claim Managers, including those regarding job analyses, etc. Those questions should be answered by the IME examiner.

If your examination includes an impairment rating, follow the instructions in the Mental Health Section of the Impairment Rating (chapter 12).

In your discussion with the worker, it is important to note the following guidelines:

- The evaluation report is **not confidential**.
- No one is permitted to accompany the worker to a psychiatric interview.
- The purpose of the evaluation is to provide information regarding the worker's medical/mental condition.
- You will **not** provide medical treatment or advice to the worker.

REQUIRED REPORT ELEMENTS	
1. Identifying Information	■ Name and address ■ Date of injury ■ Claim number ■ Date of birth ■ Employer at time of injury ■ Date of examination ■ Location of examination ■ Examiner face-to-face time spent with the worker
2. Introduction, Purpose of this Examination and Statement of Non-Confidentiality	■ Explanations you give the worker about the purpose and procedures of the exam; ■ Statement about who accompanied the worker to the site (including name of interpreter, if any) ■ Other pertinent data

REQUIRED REPORT ELEMENTS	
3. Record Review (This is a review separate from the worker history.)	Psychiatric and medical records: ■ Accident report (ROA) (Immediate clinical findings at time of injury). Helpful information includes: description of injury; area of body injured; length of employment; and length of time between the injury and filing of the claim. Review physician and employer portions of ROA. ■ Timing of psychiatric complaints. Include length of time between the injury and mental health complaints. (The presence of psychiatric findings immediately following the injury may suggest a preexisting condition.) ■ Past medical and mental health history (including mental health history before the date of injury – it may be necessary to request additional records from the Claim Manager. ■ If asked about vocational and physical therapy records, focus on attendance and compliance.
4. History from the Worker	a) History of the present injury (how did the injury occur, etc.) b) Psychiatric complaint(s) as related to injury in the worker's own words, including chronic pain o Current symptoms with specific examples and how examples affect functioning o Have symptoms changed over time? Describe. o Current and history of treatment and response c) Pre-injury functioning (life and "pattern of adjustment" before and at time of injury – self-care, social interaction, work, etc.) d) Post-injury functioning (impact of injury) including life "pattern of adjustment" changes e) Other stressors including medical conditions, psychosocial (relationships, financial, etc.) f) Worker's Compensation/work history o Brief history of employment o Worker's relationship with the employer since the injury o Plans for return to work o Prior vocational attempts o History of other claims g) Past psychiatric history h) Family psychiatric history i) Drug and alcohol history j) Legal history k) Trauma history (physical and/or sexual abuse; life-changing events; etc.) l) Medical history (concurrent; past; relevant childhood history)

REQUIRED REPORT ELEMENTS	
	m) Social history o Childhood (including physical and/or sexual abuse) o Education o Relationships, marital status (including abuse) o Impact of the injury on daily activities, finances, etc. o Has another family member had to assume additional responsibility? o Occupation o Military experience o Current living situation
5. Psychiatric Examination and Testing	Mental Status Exam: General appearance; Demeanor; Eye contact; Psychomotor behavior; Gait; Speech; Mood; Affect; Thought Process; Thought Content; Cognition Testing: Discuss results of any testing you have performed and provide copies of raw data. Perform psychological testing, as indicated: Tests may include the Minnesota Multiphasic Personality Inventory (MMPI). NOTE: Neuropsychological testing may be requested. Neuropsychological testing is not a standard part of a psychiatric IME. If you determine that a neuropsychological battery of tests is needed, contact the Claim Manager.
6. Diagnosis(es) and Findings	This report must contain data that support your diagnoses and conclusions. Use the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. Include detailed information about symptoms pertinent to the diagnostic criteria for your diagnoses. Also if you have ruled out other doctors' diagnoses, then include the detailed information as to why your opinion differs. Follow the format of the current *Diagnostic and Statistical Manual of Mental Disorders (DSM)* to report your diagnosis. The diagnosis needs to meet DSM criteria for the specific disorder. Discuss your diagnoses for this case, including those findings that support your diagnoses. In a multi-examiner examination, review your diagnoses and recommendations with other examiners. a) Accepted conditions (as stated on the assignment letter from the Claim Manager); b) Current diagnoses c) Basis or rationale for above DSM diagnoses d) Pre-existing conditions (based on history and medical record review

REQUIRED REPORT ELEMENTS	
7. Discussion, Including Assessment of Work-Relatedness and Pre-Existing Conditions	■ Is the condition diagnosed related to the injury? ■ Are there preexisting conditions? ■ Were the pre-existing conditions aggravated on a temporary basis? ■ Were the pre-existing conditions aggravated on a permanent basis? ■ See #7 to address treatment of a pre-existing condition as an aid to recovery. As you answer these questions, be sure to apply the criteria that apply to all occupational diseases, as described earlier in Chapter 6.

Stress-related conditions are not allowed as an occupational disease under the Washington Industrial Insurance Act. See RCW and WAC below.

RCW 51.08.142 "Occupational disease" — Exclusion of mental conditions caused by stress.
The department shall adopt a rule pursuant to chapter 34.05 RCW that claims based on mental conditions or mental disabilities caused by stress do not fall within the definition of occupational disease in RCW 51.08.140.

WAC 296-14-300 Mental condition/mental disabilities.
(1) Claims based on mental conditions or mental disabilities caused by stress do not fall within the definition of an occupational disease in RCW 51.08.140.
Examples of mental conditions or mental disabilities caused by stress that do not fall within occupational disease shall include, but are not limited to, those conditions and disabilities resulting from:

a) Change of employment duties;
b) Conflicts with a supervisor;
c) Actual or perceived threat of loss of a job, demotion, or disciplinary action;
d) Relationships with supervisors, coworkers, or the public;
e) Specific or general job dissatisfaction;
f) Work load pressures;
g) Subjective perceptions of employment conditions or environment;
h) Loss of job or demotion for whatever reason;
i) Fear of exposure to chemicals, radiation biohazards, or other perceived hazards;
j) Objective or subjective stresses of employment;
k) Personnel decisions;
l) Actual, perceived, or anticipated financial reversals or difficulties occurring to the businesses of self-employed individuals or corporate officers.

(2) Stress resulting from exposure to a single traumatic event will be adjudicated with reference to RCW 51.08.100.

RCW 51.08.100 "Injury" means a sudden and tangible happening, of a traumatic nature, producing an immediate or prompt result, and occurring from without, and such physical conditions as result therefrom.

REQUIRED REPORT ELEMENTS	
8. MMI or Treatment Recommendations	Be complete. If the injured worker has or has not received psychiatric treatment or if you recommend treatment or additional treatment, explain the following: ■ Why is treatment needed? If you recommend psychiatric treatment, is it on a temporary basis as an aid to recovery from the physical injuries that have been accepted on the claim? ■ How long will the psychiatric treatment take? ■ Do you recommend medication or other treatment? ■ Is time needed to taper off treatment or medication for the worker? ■ Is time needed to determine whether a new medication will be of benefit to the worker? ■ What is the prognosis of this treatment? ■ What is the prognosis for return to work? ■ What barriers exist to prevent or delay successful treatment?
9. Impairment Rating	If asked to provide an impairment rating, first determine if the worker is at MMI with respect to the mental health condition which has been accepted on this claim. If the worker is not at MMI for the accepted mental health condition, do not provide an impairment rating (unless otherwise instructed by the Claim Manager). If the worker is at MMI, provide the 5 essential elements of all rating reports. 1) MMI 2) Examination findings (describe your own observations of behavior and function, as well as symptoms reported by the worker – note discrepancies) 3) Diagnostic studies (such as MMPI, etc.) 4) Rating 5) Rationale

REQUIRED REPORT ELEMENTS	
	Preexisting mental health conditions Answer the following 5 questions (WAC 296-20-330). Are the differences in adjustment patterns before and after the industrial condition (on a more-probable-than-not basis): 1) The result of the industrial condition and its sequelae, in the sense they would not have occurred had there not been the industrial condition? 2) Permanent? 3) More than the normal, self-correcting and expectable response to the stress of the industrial condition? 4) An impairment psychosocially or physiologically? 5) Susceptible to treatment?
10. Answers to Specific Questions from the Claim Manager	If the Claim Manager asks about any specific issues, please be sure to answer them in your report. In particular, if asked, address the issues below: a) Ability to work: Are there any restrictions relating to the accepted mental health condition that prevent this worker from returning to work? If so, what are they? In addition, include your assessment of whether the worker can: 1) Maintain focus on work? 2) Understand and follow work rules and instructions? 3) Be aware of and follow safety precautions? 4) Work with or near other workers? 5) Keep emotions under control? 6) Interact with public and customers? b) Job analyses: You may be asked to approve one or more job analyses and/or suggest modifications. Your recommendation on the job analysis should be limited to the mental health conditions accepted on the claim.

CHAPTER 8

Vocational Issues

Only address physical restrictions, job analyses (JA), and other vocational issues, if specifically requested by the claim manager in the IME assignment letter.

Clear information about the worker's physical or mental capacities is vital to include in your IME report. We need this information in order to decide the vocational issues of a claim. All providers participating on a panel examination must review or comment on JAs.

For administrative and legal reasons, we request that you not give opinions regarding transferable skills, education, or labor market, etc. A vocational professional does this assessment. We also request that you not make a direct statement that a person is totally and permanently disabled. Please objectively describe those limitations that may be barriers to returning to work.

Avoid using the word "retraining" in your recommendation. The term "retraining" has a specific legal and administrative meaning that limits which workers are eligible for these services. You and the claim manager may not be using the same definition. A worker who hears your recommendation for "retraining" may become frustrated or angry if the claim manager cannot meet the worker's expectations. **If you have questions about job requirements (e.g., workplace modification or job analyses), contact the claim manager.**

Job Analyses and/or Job Descriptions

Job analyses or job descriptions (JD) should be included with the IME assignment letter. If not, the JA or JD should be provided at least five working days before the examination. Claim managers may fax JAs or JDs to the panels. You will not be required to review documents received after five days. If the CM needs your comments after the examination, an addendum request will be made.

The JA or JD should provide detailed information regarding specific physical demands and environmental conditions required for a job.

Job Analysis

A registered vocational rehabilitation counselor specifically develops a job analysis. These job analyses appear similar to job descriptions and may be presented in a variety of formats. It is a detailed evaluation of a specific job or type of job per WAC 296-19A-170.

You will be asked to review a maximum of four job analyses, although more may be sent in complex cases if authorized by the claim manager. If you feel that you are being asked to review unnecessary job analyses, discuss your concerns with the claim manager who requested the IME.

Definition of allowed number of JAs and reimbursement to providers for review may be found in Chapter 27 Reports and Forms of the Medical Aid Rules and Fee Schedules .

Job Description

A job description is a written description of a job by the employer that is available to the worker.

- Employers use no standard format.
- Is typically for the worker's job of injury or an alternative job available to the worker
- May identify potential modifications to the job of injury
- Should include a summary of job duties/tasks, equipment and tools used, and a description of specific physical demands
- May be part of a Job Offer Letter

See the Attending Doctors' Return to Work Desk Reference for further information and differentiation between job description and job analysis.

Reviewing a Job Analysis or Job Description

Review and report on job analysis (JA) and job descriptions in the same way.

In 2014, a Job Analysis Summary was developed by the department. (see pages 48,49) VRCs are asked to include this form as a cover sheet to JAs provided for IMEs. This form should reduce medical provider's time and duplication in reviewing physical capacities. It is similar to the Activity Prescription Form (APF) and specifies the physical requirements of the job described in the job analysis. If a JA summary sheet is provided please only sign this form.

During the review, please focus your attention only on the physical and/or mental demands of the job. Considering your specialty please answer the following question in your JA response: "Can the patient physically and/or mentally perform the tasks as described?" If not, state the objective evidence to support your conclusion.

Do not consider wages, personal issues, or employability.

When you approve the JA or job description, you are approving the maximum physical requirements of the job—not the minimum.

Your conclusions about the worker's ability to perform physical demands must be consistent with the JAs or job description, Doctor's Estimate of Physical Capacity form (PCE), and any physical restrictions contained in your IME report.

The job analysis(es) or JA summary sent with the IME assignment letter must be completed and submitted with the IME report.

Addressing Physical Capacities

In assessing physical restrictions, consider the effects of the injury and any restrictions due to preexisting conditions as those restrictions existed at the time of injury. You must clearly state in your report if the worker has:

- Unique limitations from the injury,
- A preexisting unrelated condition that has progressed since the date of injury,
- Restrictions due to post injury progression of a pre-existing condition.

For example, a worker may be able to perform work at the medium level, considering an accepted knee injury, but the worker's preexisting unrelated cervical degenerative disc disease has progressed post-injury and cervical spinal stenosis is now limiting the worker to sedentary work.

State what conditions cause the restrictions. These conditions can include the following:

- Accepted conditions,
- Preexisting conditions and/or
- Conditions that occurred after the industrial injury (post-injury).

For example, if a worker has an accepted back injury, he or she may be able to work at light work. The worker's cardiac condition, however, may prevent his or her return to work.

Both temporary and permanent restrictions should:

- Have a reasonable medical basis with objective findings to support the restrictions
- Be based on diagnoses given in your report

Differentiating between "permanent" and "temporary": If physical restrictions are temporary or time limited, label clearly. Also give an estimate of how long the temporary restrictions will last. For example, you might state: "Avoid heavy lifting for three months"; or "Increase activity level over the next six weeks." Keep permanent restrictions consistent with your medical examination.

Sometimes you may not be able to address the work restrictions completely. If you can't, simply explain why or advise what information you need to help you address the restrictions, i.e. requesting a Performance Based Physical Capacities Evaluation (PBPCE) Here are some examples:

- You may not be able to predict the course of illness or recovery adequately.
- You may be evaluating the worker because of your special expertise in a particular body system. For example, an IME dentist may not have the expertise needed to give an opinion about ability to work.

Completing your report

The IME report content described in Sample Report # 1 in Appendix A, includes one element called "Physical Restrictions" which relates to vocational issues.

Physical capacities can be addressed by:

- Review and comment of job analysis or job description, only complete the JA summary sheet if provided
- Review and comment on a Performance-Based Physical Capacities Evaluation (PB-PCE), or
- Completion of the form "IME Doctor's Estimate of Physical Capacities (PCE) form. This form may be photocopied.

You should specify restrictions in your IME report, see sample report #1 in Appendix A. Also, see Appendix A for a description of physical demands and environmental conditions.

Common Household/Work Items

2 lbs – Hammer

3 lbs - Quart of Paint

4 lbs - Traffic Cone

4.5 lbs - 2 Qts Juice

5 lbs - Pop

5 lbs – Drill

5 lbs - Ream of Paper

7 lbs – Trimmer

8 lbs - Pop 12 can Fridge Pack

9 lbs - Gal Milk

9 lbs-2x4 Stud (8')

10 lbs - Metal Folding Chair

10 lbs - Blower (gas)

12 lbs - Gallon of Paint

Produced by WA Labor and Industries 04/16/2007 with thanks to Home Depot and Fred Meyer

16 lbs - 5 Gal Shrub (dry)

17 lbs - Infant 4 mos

20 lbs - Beer 30 cans

25 lbs - Aluminum Ladder

25 lbs - Fertilizer

26-28 lbs - Toddler 2 yrs

30 lbs - Kitty Litter

30 lbs - Metal Hand Truck

36 lbs - Child 4 yrs

47 lbs - Water

50 lbs - Dog Food

65 lbs - 5 gal Paint

Produced by WA Labor and Industries 04/16/2007 with thanks to Home Depot and Fred Meyer

Department of Labor and Industries
Physician Billing Codes
Summary included in JA review
1038M – Limit one per day
1028M – Additional review: up to 5 per day per worker

Job Analysis Summary

Full Job Analysis (JA) Attached for Reference

Vocational Providers:

- This form is the first page of your JA and serves as a summary and healthcare provider signature page.
- Fill out the "APF" grid to reflect the physical demands as documented in the JA.

Name	Date	Claim Number
Accepted Conditions		
Job Title		
Brief Job Description/Duties		
☐ Full time ☐ Part time	☐ Light Duty ☐ Job of Injury ☐ Transferable Skills Job ☐ Potential Retraining Goal	

Worker will:				**Never**	**Seldom 1-10% 0-1 hour**	**Occasional 11-33% 1-3 hours**	**Frequent 34-66% 3-6 hours**	**Constant 67-100% Not restricted**
Sit								
Stand / Walk								
Climb (ladder / stairs)								
Twist								
Bend / Stoop								
Squat / Kneel								
Crawl								
Reach **L**eft, **R**ight, **B**oth	**L**	**R**	**B**					
Work above shoulders	**L**	**R**	**B**					
Keyboard	**L**	**R**	**B**					
Wrist (flexion/extension)	**L**	**R**	**B**					
Grasp (forceful)	**L**	**R**	**B**					
Fine manipulation	**L**	**R**	**B**					
Operate foot controls	**L**	**R**	**B**					
Vibratory tasks; high impact	**L**	**R**	**B**					
Vibratory tasks; low impact	**L**	**R**	**B**					
Lifting / Pushing	**L**	**R**	**B**	**Never**	**Seldom**	**Occasional**	**Frequent**	**Constant**
Lift	**L**	**R**	**B**	lbs	lbs	lbs	lbs	lbs
Carry	**L**	**R**	**B**	lbs	lbs	lbs	lbs	lbs
Push / Pull	**L**	**R**	**B**	lbs	lbs	lbs	lbs	lbs

Approve ☐ Yes ☐ Yes, with the following modifications		
Disapprove ☐ If temporarily disapproved, for how long?		
Healthcare Provider's Printed Name	**Healthcare Provider's Signature**	Date

Optional Comments

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Job Analysis Summary Sample

Department of Labor and Industries
Physician Billing Codes
Summary included in JA review
1038M – Limit one per day
1028M – Additional review: up to 5 per day per worker

Job Analysis Summary

Full Job Analysis (JA) Attached for Reference

Vocational Providers:

- This form is the first page of your JA and serves as a summary and healthcare provider signature page.
- Fill out the "APF" grid to reflect the physical demands as documented in the JA.

Name John Smith	Date 7/1/2014	Claim Number N100000
Accepted Conditions sprain and strain of sacroiliac and lumbar		
Job Title Social Services Aide		
Brief Job Description/Duties Assists professional staff of public social service agency, performing any combination of following tasks: Interviews individuals and family members to compile information on social, educational, ciminal, institutional, or drug history. Visits individuals in homes or attends group meetings to provide information on agency services, requirements, and procedures. Provides rudimentary counseling to agency clients. Oversees day-to-day group activities of residents in institution. Meets with youth groups to acquaint them with consequences of delinqent acts. Refers individuals to various public or private agencies for assistance. May care for children in client's home during client's appointments. May accompany handicapped individuals to appointments.		
☐ Full time ☒ Part time	☐ Light Duty ☐ Job of Injury ☐ Transferable Skills Job ☐ Potential Retraining Goal	

Worker will:				**Never**	**Seldom 1-10% 0-1 hour**	**Occasional 11-33% 1-3 hours**	**Frequent 34-66% 3-6 hours**	**Constant 67-100% Not restricted**
Sit							X	
Stand / Walk							X	
Climb (ladder / stairs)					X			
Twist					X			
Bend / Stoop					X			
Squat / Kneel					X			
Crawl				X				
Reach **L**eft, **R**ight, **B**oth	**L**	**R**	**XB**		X			
Work above shoulders	**L**	**R**	**XB**		X			
Keyboard	**L**	**R**	**XB**			X		
Wrist (flexion/extension)	**L**	**R**	**XB**			X		
Grasp (forceful)	**L**	**R**	**XB**				X	
Fine manipulation	**L**	**R**	**XB**			X		
Operate foot controls	**L**	**R**	**XB**		X			
Vibratory tasks; high impact	**L**	**R**	**B**	X				
Vibratory tasks; low impact	**L**	**R**	**B**	X				
Lifting / Pushing	**L**	**R**	**XB**	**Never**	**Seldom**	**Occasional**	**Frequent**	**Constant**
Lift	**L**	**R**	**XB**	lbs	lbs	10 lbs	lbs	lbs
Carry	**L**	**R**	**XB**	lbs	lbs	10 lbs	lbs	lbs
Push / Pull	**XL**	**XR**	**B**	lbs	lbs	10 lbs	lbs	lbs

Approve ☐ Yes ☐ Yes, with the following modifications		
Disapprove ☐ If temporarily disapproved, for how long?		
Healthcare Provider's Printed Name	**Healthcare Provider's Signature**	Date

Optional Comments

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CHAPTER 9

Providing Testimony

Providing testimony is an important part of the IME process. While you may not be asked to testify on each medical exam you perform, when you are asked to testify your testimony can be critical to the protest or appeal under consideration.

Examiner Responsibility

When you sign the application to become an IME provider, you agree to perform the exams as well as be reasonably available to testify if needed. Your payment for an IME compensates you for the detailed nature of your examination and report, the complexity of the questions you must address, and your willingness to testify at some time in the future.

When performing the IME, you are determining clinical observations and conclusions in the claim at a point in time. All parties can then use this information. You may, therefore, be called as a witness for the worker, the employer, the State Fund, the Self-Insured Employer or their representative, or by any combination of these.

The Washington Administrative Code (WAC) for IME testimony was changed and became effective on March 1, 2010. It states:

WAC 296-23-387 What are the responsibilities of an independent medical examination (IME) provider regarding testimony? IME providers must make themselves reasonably available to testify at the board of industrial insurance appeals (board) or by deposition. **Reasonably available** to all parties means cooperating in the timely scheduling of the pretestimony conference and testimony and being available to testify during business hours (7:00 a.m. to 6:00 p.m.) as ordered by the judge and within the dates ordered by the board to complete testimony, unless a different time is needed and agreed upon by all parties. In signing the application to be an independent medical examination provider, the provider agrees to perform examinations and be available to testify and to answer questions about the medical facts of the case at rates established under the authority of Washington industrial insurance law. The department may fine the firm and/or examiner up to five hundred dollars per violation for failure to comply with these requirements, whether the failure was intentional or not.

In addition, failure to comply with these requirements may result in suspension or termination of the IME provider number.

If you are unwilling to testify or make yourself reasonably available, you must decline to perform examinations. Realize that only a small portion of claims involving IMEs go before the Board of Industrial Insurance Appeals. Appearances before the Board are an important part of the services you provide to workers, employers and L&I.

Deposition or Live Testimony

The Board prefers all witnesses, including doctors, to appear at hearings in person. The Board holds hearings throughout the state in the region where the exam was conducted. Attorneys must meet timelines set by the Board but will attempt to accommodate your schedule when arranging for your testimony when possible. The Board has subpoena power to require your attendance if scheduling of testimony becomes too difficult.

Most attorneys are willing to accommodate the medical examiner by taking the testimony by deposition. If you prefer this option, notify the requester promptly. Depositions are allowed in every instance unless expressly precluded by the Board. It is often more persuasive for an Industrial Insurance Appeals Judge to hear testimony "live," as opposed to reading the transcript of a deposition.

To prepare for a deposition or testimony you should obtain a copy of your IME report and review it prior to the appointment. If you need additional information or need more time to complete your review, contact the party who requested your service.

Fee Schedule for Testimony

If you are needed to testify, you will be paid separately for those services. You will need to discuss fees and billing requirements with the party requesting your testimony. Be aware that requests for a non-refundable amount will be denied and state agencies are prohibited from prepaying for any service. Any exceptions to the fee schedule will be considered on a case by case basis. The payment policy and fee schedule for providing testimony is contained in Chapter 15, Medical Testimony in the Medical Aid Rules and Fee Schedule. Please see the current fee schedule for any revisions or updates.

Appeal Process

The table below presents an overview of the appeal process, from the Board of Industrial Insurance Appeals to the Washington State Supreme Court. The information is provided to help you understand the complexity of the legal processes affecting your work in the industrial insurance system. Your involvement is most likely to be at the Board of Industrial Insurance Appeals (BIIA) level.

For more information about the BIIA call 360-753-6823 or visit their website at www.biia.wa.gov.

L&I APPEAL PROCESS OVERVIEW

Level of Appeal	What Can be Appealed to this Tribunal?	What types of Information Are Considered on this Appeal?	What Are the Possible Outcomes?
Board of Industrial Insurance Appeals	All department decisions, awards, and orders issued by the department can be appealed to the Board.	Both parties introduce evidence relevant to the appeal. This includes depositions or in-person testimony of medical and lay witnesses. The Board does not receive the Department claim file, but parties may introduce information from the file as evidence.	The Board will issue an order accepting or denying the appeal. The appealing party may voluntarily dismiss the appeal, or the parties may settle the case. If the case proceeds to hearing, the Industrial Appeals Judge will issue a proposed order either affirming, reversing or modifying the Department order. This order will become a final order if not appealed. Either party may appeal the proposed order. In that case, the Board will review it, and issue a final order.
Superior Court	Employer and worker may appeal any Board order to the Superior Court. The Department may only appeal Board orders with disputed issues of law.	The record created at the Board, including transcripts of testimony, will be read to the court. No new testimony or exhibits are permitted.	The Superior Court will affirm or reverse the Board order.

Level of Appeal	What Can be Appealed to this Tribunal?	What types of Information Are Considered on this Appeal?	What Are the Possible Outcomes?
Court of Appeals	Only questions of law may be taken to the Court of Appeals.	The Court of Appeals considers the same evidence as the Supreme Court.	The Court of Appeals may affirm, reverse, or modify the Superior Court order. A published decision (that is not appealed to the Supreme Court) creates case law that must be followed by Washington Superior Courts and administrative tribunals.
Supreme Court	The Supreme Court will consider appeals, generally from the Court of Appeals, and determine whether to review them.	The Supreme Court considers the same evidence as the Court of Appeals.	The Supreme Court may affirm, reverse or modify the Court of Appeals decision. Supreme Court decisions create case law that must be followed by all Washington courts and administrative tribunals.

CHAPTER 10

Complaints about the Independent Medical Exam

Complaints or Comments about an IME

Complaints about IMEs are received from different sources, such as the injured worker, their attorney, internal staff, and providers. Regardless of who sends the complaint or whether the complaint was about a state fund or self-insured IME, each complaint is reviewed and appropriate action is taken as necessary. Provider Credentialing and Compliance Unit (PCC) may track complaints from workers covered under self-insurance, but the self-insurance program will follow up as necessary on individual complaints. The number and type of complaints are tracked and monitored by PCC.

Types of Complaints

Worker complaints:
Worker complaints about a doctor's conduct during an IME may be sent to the doctor for review and response. Based on the nature of the complaint, we may refer a complaint to the Department of Health. (WAC 296-23-372) Complaints alleging physician malpractice, substance abuse, or sexually inappropriate conduct are forwarded to the appropriate section of the Department of Health.

Worker complaints about the IME report or impairment rating are not sent to the doctor for response. Complaints of this nature are claim management issues. The claim manager may contact you for clarification or additional information.

Claim staff complaints:
If we receive complaints about poor report quality or late reports, the Department may review your reports and contact you for remedial action. The department bases its review on the quality of the examination and report, not on whether your recommendations are perceived as favorable or unfavorable to the parties involved.

Other types of complaints:
Other types of complaints are reviewed and evaluated based on their merit and whether appropriate action should be taken. This action could range from no action to suspension or termination of the IME provider number.

Possible Department Actions

The department could suspend or terminate your IME provider number if a consistent pattern of complaints develops, as illustrated in the following examples:

- Substantiated worker complaints or patterns of complaints, such as rudeness, lack of respect, unprofessional behavior;
- Poor examination and substandard report quality;
- Untimely reports;

- Action taken by the Department of Health against your license to practice; or
- Unavailability or unwillingness to testify or inability to support your opinions in any legal proceeding as evidenced by board decisions finding the testimony less credible.

You can find a complete list of reasons for suspension or termination in WAC 296-23-337. The above list contains only a few of the reasons for termination as an approved IME examiner.

If the department suspends or terminates your IME provider number, you will receive no further IME referrals until you are returned to active status.

CHAPTER 11

Impairment Rating- General Information

The Difference between "impairment" and "disability," and why it is important

"Impairment" is the loss of function of an organ or part of the body. See WAC 296-20-200 (4) for a further detailed description. "Disability" means the inability to perform a specific task or job.

For example, if a classical pianist and a truck driver both lose the same finger, both have the same impairment and receive the same award amount. However, their disabilities may be different: the truck driver may be able to continue performing the job, while the pianist may not.

This distinction is important because state law requires that awards be based on impairment, not on disability.

Is an IME the Same as an Impairment Rating Examination?

No. IMEs and impairment rating exams are not synonymous. A rating exam may be part of an IME or a consultation. It may also be part of an office visit to the attending doctor. The department or self-insurer may request an IME for various reasons. Most IMEs do contain impairment ratings.

IMEs establish medical facts about an injured worker's physical and/or mental condition so that the department or self-insurer can give appropriate assistance to the worker and can make fair administrative decisions about the claim.

Who May Rate Impairment?

IME examiners: Any doctor who is an L&I-approved IME examiner may do rating exams as part of an IME if requested by the Claim Manager. Ratings by IME examiners must be accompanied by an IME report described in **Appendix A, Sample Report 1**. If you are asked to perform a "rating only IME," use **Sample Report 2**.

Attending doctors: Attending doctors may be asked by the Claim Manager to rate impairment for their own patients. Rating reports (see Appendix A, Sample Report 3) are shorter than IME reports, since ratings are just one of many elements in an IME.

Doctors licensed in medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, and dentistry may conduct these exams on their own patients. Chiropractors who are approved IME examiners may also conduct these exams on their own patients if requested by a Claim Manager (WAC 296-20-0210).

If the attending doctor does not wish to rate his/her own patient, the department encourages him/her to ask a consultant to perform the rating exam. (See "Consultants" below.) In the terminology of the department, consultations are different from IMEs. One difference is that the examiner in an IME is generally chosen by the department or self-insured employer, while a consultant is generally chosen by the attending doctor.

If you need assistance in selecting a consulting doctor, names of approved IME examiners may be found on the web at https://fortress.wa.gov/lni/imets/ . If more than one specialty is needed to evaluate the impairment, notify the Claim Manager so the option of an IME can be considered.

Consultants for rating impairment: Consultants must be familiar with the *Medical Examiners' Handbook* and follow its standards and guidelines and provide an impairment rating report as described in **Appendix A, Sample Report 2**. Doctors performing consultations involving a rating of permanent impairment may use the billing codes for consultant ratings. If you are a consultant and become an approved IME examiner, you do NOT need to be affiliated with an IME panel, and you are NOT obligated to accept referrals for IMEs.

Limited license providers: Limited license providers (for example, dentists, podiatrists, and chiropractors) may only provide ratings for regions or conditions within their scope of practice. Chiropractors must be approved IME examiners.

When to Rate Impairment

When the worker's industrial injury or disease has reached maximum medical improvement (fixed and stable), the Claim Manager may ask you to rate the accepted condition. If the worker's condition is not at MMI, the worker's impairment should not be rated unless you have special instructions from the Claim Manager. Please see Chapter 4 for the definition of MMI.

The Five Required Components of ALL Impairment Reports

Depending on the circumstances, an impairment rating may be performed by an attending doctor, an IME examiner or a consultant. In the context of an IME, the rating is often just one of many elements of a full IME report. When performed by an attending doctor, the rating report may be a stand-alone report or may be part of a chart note, a closing report or other types of reports.

Regardless of who performs it, reports on impairment rating MUST contain ALL of the following five sections:

1) **MMI**: A statement that the patient has reached maximum medical improvement (MMI) and that no further curative treatment is recommended for the accepted condition.
2) **Examination**: Pertinent details of the physical or psychiatric examination performed (both positive and negative findings)
3) **Diagnostic tests**: Pertinent results of any diagnostic tests performed (both positive and negative). Include copies of pertinent tests ordered as part of the exam.
4) **Rating**: An impairment rating consistent with the findings and a statement of the system on which the rating was based (Washington State Category Rating System, the AMA *Guides*, etc.)
5) **Rationale**: The rationale for the rating system is one of the most important parts of the rating report. The rationale must be supported by specific references to the clinical findings, especially objective findings and supporting documentation, including the specific rating system, tables, figures and page numbers on which the rating was based. The rationale must restate all objective findings. (WAC 296-20-2010 & WAC 296-23-377)

IMPORTANT NOTE: Be sure to attach worksheets used to formulate the rating so readers easily understand your methods. For example, the upper extremity worksheet on pages 436-437 of the AMA *Guides*, Fifth Edition is especially important.

IMPORTANT NOTE: Even if you conclude that there is no impairment, it is still required that you document your rationale for arriving at that conclusion, including all 5 elements above. This is critical because Claim Managers need this information well-documented in the event workers request to re-open a closed claim.

Medical Judgment in the Rating Process

Most of the information in this handbook constitutes guidelines on how to rate impairment. Guidelines are NOT hard and fast rules. Sound medical judgment plays an important part in the process of rating impairment. Both the Category Rating System and the American Medical Association *Guides to the Evaluation of Permanent Impairment* (the two rating systems most commonly used in Washington state workers' compensation) emphasize the importance of medical judgment in this area.

At the same time, you should base your conclusions on objective findings, and you should state your rationale clearly.

For example, if your impairment rating is more or less than the rating specified in the AMA *Guides*, it is extremely important to explain in detail your rationale and methods for reaching your conclusion.

Objective Findings in the Rating Process for Physical and Psychiatric Impairment

An impairment rating must be supported at least in part by objective findings (*Cooper v. Department, 1944*). Objective findings are those findings on examination that are "independent of voluntary action and can be seen, felt, or consistently measured by examiners" (WAC 296-20-220[i]).

Psychiatric impairments do not require the same extent of objective findings as do physical injuries (*Price v. Department, 1984*) You must document objective observations and other findings. See Chapter 7 for details on a psychiatric IME report.

What Rating Systems Should I Use?

Four rating systems are generally used to rate impairment in Washington State Workers' Compensation. The use of these four systems is restricted to certain conditions by law, as described below and summarized in Table 2 based on WAC 296-20-2015.

Injuries before 1974 and conditions not otherwise addressed are dealt with differently. You should also be aware of special considerations regarding impairment due to pain. (These topics are discussed further later in the chapter.)

Table 2: Overview of Systems for Rating Impairment

Rating System	Used for these Conditions	Form of the Rating
1. Category Rating System (Washington State)	Spine, neurologic system, mental health, respiratory, taste & smell, speech, skin, and disorders affecting other internal organs	Select the category that most accurately indicates overall impairment
2. AMA *Guides*	Loss of function of extremities, partial loss of vision and hearing	Determine the percentage of loss of function, as compared to amputation value listed in RCW 51.32.080
3. RCW 51.32.080 (see next section)	Specified disabilities: loss by amputation, total loss of vision and hearing	Supply the level of amputation or total loss
4. Total Bodily Impairment (TBI)	Impairments not addressed by any of the rating systems above	Supply the percentage of TBI. (Note: This is an unusual situation.)

1. Washington State Category Rating System.

To rate impairment resulting from back disorders, psychiatric disorders, neurologic disorders, respiratory disorders and other disorders affecting the internal organs, you **must use** the Washington State Category Rating System. The intent of the Category Rating System is to reduce litigation and to establish more uniformity in the rating of unspecified permanent partial impairment. The category rules do not allow you to express a rating as a percentage.

Chapter 12 presents details about the Category Rating System for the spine, respiratory system, and all other systems included. For most body systems, the Category Rating System is expected to be self-explanatory. Since the creation of the Category Rating System in 1974, doctors have been expected to read the statutes and regulations (RCWs and WACs) and figure out the rating on their own. Here are a few points that may help to understand how to use this system:

Flexibility of the Category Rating System: In many cases, there are bound to be reasonable differences in how clinicians interpret findings. Sound medical judgment will play an important role. Doctors should understand that there is considerable flexibility in the Category Rating System. It is not necessary for doctors to be unduly rigid in interpreting the regulations (WACs) or the guidelines presented in this guide.

If the worker seems to fit more than one category: The department recognizes there are situations where a patient's findings may be found in more than one category. Except for pelvis, taste and smell, the doctor should select the ONE category which most closely describes the patient's condition. The doctor

SHOULD NOT "split" categories. For example, the doctor should NOT give a rating of Category 2.5 if the patient seems to be between a Category 2 and a Category 3. Medical judgment should be used to select the best category, as described above. For rating cervico-dorsal, dorso-lumbar and lumbo-sacral impairment, you may find it helpful to use the worksheets provided in chapter 12.

RCWs and WACs: Doctors who are interested in having a detailed understanding of the Category Rating System may wish to read the full text of the statutes and regulations pertaining to this topic (Appendix C).

2. American Medical Association *Guides to the Evaluation of Permanent Impairment* (AMA *Guides*).
If the injury or occupational disease is not included in the Category Rating System and is not an amputation or total loss of vision or hearing (as described in #3, "RCW 51.32.080" below), then you rate the impairment as a percentage, using the edition of the American Medical Association *Guides to the Evaluation of Permanent Impairment* designated by the department. (Currently the department has designated the Fifth Edition)

Washington State has specific rules for Washington state workers' compensation regarding the use of AMA *Guides*. For example, you should be familiar with the WACs that deal with the question "To what extent is pain considered in an award for permanent partial disability?" This issue is addressed in WAC 296-20-19030. Similarly, you must be familiar with proper use of the AMA *Guides* for rating extremities, vision and hearing, and all parts of this handbook pertaining to impairment rating, including but not limited to chapter 12.

The AMA *Guides* is available from the Order Department, American Medical Association, PO Box 109050, Chicago, Illinois 60610-9050; 1-800-621-8335 or 312-464-5651.

3. RCW 51.32.080.
This system is used for disabilities specified in RCW 51.32.080, namely: loss by amputation; loss of one eye by enucleation; loss of central visual acuity in one eye; complete loss of hearing in both ears; complete loss of hearing in one ear. For these impairments, rate by indicating the disability specified in RCW 51.32.080 it most closely resembles or approximates in degree of disability. The term "specified disabilities" refers to disabilities that are listed in that RCW.

4. Rating other impairments.
There are unusual circumstances in which the rating may need to be stated as a percentage of total bodily impairment. The AMA's *Guides* may be a helpful reference in making this determination.

Table 3: WHICH RATING SYSTEM TO USE

(for claims date of injury after October 1, 1974)

ORGAN SYSTEM, BODY PART OR TYPE OF INJURY	RATING SYSTEM	SEE PAGE IN THIS BOOK:
Amputation	Specified in RCW	97-100
Back (Cervical, Thoracic, Lumbo-Sacral)	Category Rating System	65-91
Cardiac	Category Rating System	93
Cognitive Impairment	AMA *Guides*	105
Convulsive Neurologic Disorders (Seizures, Epilepsy)	Category Rating System	93-94
Dental, tooth loss	Contact Claim Manager	94
Digestive Tract	Category Rating System	95-97
Extremities (upper and lower)	AMA *Guides*	97-100
Hearing * Total loss * Partial loss	Specified in RCW AMA *Guides*	100-104
Hernia, (Inguinal, Umbilical etc.)	AMA *Guides*	105
Mental Health	Category Rating System	105-110
Pelvis	Category Rating System	92
Respiratory * Air Passages ** Chronic Sinusitis	Category Rating System *Category Rating System **AMA *Guides*	110-117
Skin	Category Rating System	117-118
Speech	Category Rating System	119

ORGAN SYSTEM, BODY PART OR TYPE OF INJURY	RATING SYSTEM	SEE PAGE IN THIS BOOK:
Taste and Smell	Category Rating System	120
Urologic	Category Rating System	120-122
Vascular	AMA *Guides*	123
Visual System * Enucleation ** Total loss *** Partial loss	*Specified in RCW **Specified in RCW ***AMA *Guides*	123-129
Others not listed above	Total bodily impairment	59-60

How are Injuries Prior to October 1974 Handled?

Injuries between 1971 and 1974: Injuries or exposure occurring on or after July 1, 1971, but before October 1, 1974, are rated as a percentage of total bodily impairment, but do not use the Category Rating System. The examination request letter will ask you to "express your rating as a percentage of total bodily impairment."

The percentage rating that you provide should reflect how the impairment affects the function of the person, as a whole, in the ordinary pursuits of life. This is described as a percentage of total bodily impairment. The edition of the AMA *Guides* designated by the department may be helpful in making this determination. (Currently the department has designated the Fifth Edition)

Injuries prior to 1971: For an injury or exposure that occurred prior to July 1, 1971, you should rate impairments to extremities, hearing loss and vision impairment in terms of percentage of loss of function of that area of the body. Use the edition of the AMA *Guides* designated by the department to rate theses impairments. (Currently the department has designated the Fifth Edition)

For all other impairments, rate by indicating the specified disability it most closely resembles or approximates in degree of disability. The term "specified disabilities" refers to disabilities that are listed in RCW 51.32.080. The Category Rating System should not be used, as it applies only to Washington claims on or after October 1, 1974. Again, please use the edition of the AMA *Guides* designated by the department to rate these impairments.

How is Pain Considered in an Impairment Rating?

WAC 296-20-19030

To what extent is pain considered in an award for permanent partial disability?
The categories used to rate unspecified disabilities incorporate the worker's subjective complaints. Similarly, the organ and body system ratings in the AMA *Guides to the Evaluation of Permanent Impairment* incorporate the worker's subjective complaints. A worker's subjective complaints or symptoms, such as a report of pain, cannot be objectively validated or measured. There is no valid, reliable or consistent means to segregate the worker's subjective complaints of pain from the pain already rated and compensated for in the conventional rating methods. When rating a worker's permanent partial disability, reliance is primarily placed on objective physical or clinical findings that are independent of voluntary action by the worker and can be seen, felt or consistently measured by examiners. No additional permanent partial disability award will be made beyond what is already allowed in the categories and in the organ and body system ratings in the AMA *guides*.

For example:

Chapter 18 of the 5th Edition of the AMA *Guides to the Evaluation of Permanent Impairment* attempts to rate impairment caused by a patient's pain complaints. The impairment caused by the worker's pain complaints is already taken into consideration in the categories and in the organ and body system ratings in the AMA *guides*. There is no reliable means to segregate the pain already rated and compensated from the pain impairment that Chapter 18 purports to rate. Chapter 18 of the 5th Edition of the *Guides to the Evaluation of Permanent Impairment* cannot be used to calculate awards for permanent partial disability under Washington's Industrial Insurance Act.

Does the Rating Process Include Consideration of the Worker's Financial Need?

Industrial insurance law determines disability payments to the worker on the basis of the amount of impairment. You are not asked to consider the worker's financial situation. For example, a worker with a knee injury who owns two homes and a boat will receive the same award as a worker with a similar knee injury who is in financial need. For conditions not accepted as work-related, Social Security Disability, a federal program, may be available to disabled workers who have contributed to the Social Security trust fund. The worker can be referred to the Social Security Administration at 1-800-772-1213.

CHAPTER 12

Impairment Rating - Detailed Instructions

Video Training and other Assistance

If you have questions about which rating system to use or have other technical rating questions, contact IME Quality Assurance. (see Appendix D)

Also, the L&I website has a library of brief videos which you may watch on demand (mostly 5 to 15 minutes long). Go to www.Lni.wa.gov and search on "Courses and Seminars" – look under the tab "Online Videos and Tools."

Detailed Instructions for Rating Various Body Systems

This chapter should be used in conjunction with Chapter 11, which gives general instructions on how to rate impairment. Also, please refer to Table 3 in Chapter 11, which summarizes where to look for the appropriate rating system for a given condition or diagnosis. Please note: The regulations (WACs) cited here are specific to the body systems. You can find other WACs relating to IMEs and rating impairment in Appendix C.

Body Systems

Back Impairment	Page 65
A. Cervical and Cervico-Dorsal Spine	Page 67-77
B. Dorsal Spine	Page 78-79
C. Dorso-Lumbar and Lumbo-Sacral Spine	Page 79-91
D. Pelvis	Page 92
Cardiac	Page 93
Convulsive Neurologic Disorders (Seizure Disorders, Epilepsy)	Page 93-94
Dental, tooth loss	Page 94
Digestive Tract	Page 95-97
Extremities (Upper and Lower, including amputations)	Page 97-100
Hearing Loss	Page 100-104
Hernia (Inguinal,Umbilical, etc.)	Page 105
Mental Health and cognitive impairment	Page 105-110
Respiratory and Air Passages (including sinusitis)	Page 110-117
Skin	Page 117-118
Speech	Page 119
Taste and Smell	Page 120
Urologic	Page 120-122
Vascular	Page 123
Visual System	Page 123-129

AMA *Guides* - General Instructions

In general, the American Medical Association *Guides to the Evaluation of Permanent Impairment* (the AMA *Guides*) is used for conditions not covered by the Washington State Category Rating System or RCW 51.32.080 (see Chapter 11). **Use the edition of the AMA *Guides* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition. Currently the department has designated the Fifth Edition.)**

For conditions covered by the Washington State Category Rating System or RCW 51.32.080, do NOT use the AMA *Guides*.

When using the AMA *Guides*, you should follow these general principles:

- **IMPORTANT NOTE: You must give an exact percentage, NOT a range of percentages**. Several sections of the AMA *Guides* instruct the rating examiner to choose among several "Classes", each with a range of percentages. After you decide the appropriate Class, you must give your best estimate of a specific percentage (not a range). Without your estimate of the exact percentage the Claim Manager will not be able to calculate the impairment award.

  Examples include chapters in the AMA *Guides* dealing with conditions involving cognition, hernias, vascular disease, vision and others.

- **WHOLE PERSON VERSUS EXTREMITY (or some other level):** Be sure to explicitly state whether the percentage from the AMA *Guides* is intended to be a percent of whole person or some other body part. For example, some tables in the *Guides* provide percentages of the upper or lower extremity; others are percentages of part of an extremity; others are for whole person. **In some situations, such as extremity ratings, you should NEVER state the rating as a percent of whole person. Follow instructions in the sections below**. If you do not clearly explain this, and be consistent with the tables in the *Guides*, the Claim Manager will not be able to calculate the impairment award.

Back Impairment

Cervical and Lumbo-Sacral Worksheets, Guidelines, Case Examples, Sample Reports

For most organ systems, the Category Rating System is expected to be self-explanatory. Since the creation of the Category Rating System in 1974, doctors have been expected to read the statutes and regulations and figure out the rating on their own.

The department has developed tools to improve the consistency, fairness, and "user-friendliness" of the Category Rating System. As you see in the table below, these tools include two worksheets.

IMPORTANT NOTE FOR ALL RATINGS OF THE SPINE: Make reference to the worksheet in the body of your report, and return the completed worksheet as an attachment to your report. Sending the worksheet will help Claim Managers and others clearly understand your rating and allow them to adjudicate the claim correctly.

These tools are:	Found on:
The “Doctor’s Worksheet for Rating Cervical and Cervico-Dorsal Impairment”	Page 70 - 71
The “Doctor’s Worksheet for Rating Dorso-Lumbar and Lumbo-Sacral Impairment”	Page 84 - 86
The “Guidelines for Interpretation of the Category Rating System for Cervical and Cervico-Dorsal Impairment”	Page 72 - 73
The “Guidelines for Interpretation of the Category Rating System for Dorso-Lumbar and Lumbo-Sacral Impairment”	Page 81 - 83
Case examples of cervico-dorsal impairment	Page 74 - 77
Case examples of lumbo-sacral impairment	Page 87 - 91

Cervical and Cervico-Dorsal Spine

General Principles

Several general principles should be followed when rating cervical and cervico-dorsal impairment. These include the following:

- **Worksheet**: Use the worksheet, guidelines and case examples in this chapter. IMPORTANT NOTE FOR ALL RATINGS OF THE SPINE: Make reference to the worksheet in the body of your report, and return the completed worksheet as an attachment to your report. Sending the worksheet will help Claim Managers and others clearly understand your rating and allow them to adjudicate the claim correctly. In cases of severe impairment see page 65.
- **Bladder and/or bowel sphincter impairments**: Objectively demonstrated bladder and/or bowel sphincter impairments must be evaluated separately, using the Washington State Category Rating System. See "Urologic" and "Digestive Tract" sections.
- **Paraplegia and quadriplegia**: You may be asked to perform an examination on a worker with a severe spinal cord injury. The worker may be a complete or incomplete paraplegic or quadriplegic. After receipt of the examination request and before the examination takes place, please contact the assigned Pension Adjudicator. The Pension Adjudicator will provide guidance and answer any questions you may have regarding the evaluation. To contact a State Fund Pension Adjudicator, call 360-902-5119. To contact a Self-Insurance Pension Adjudicator, call 360-902-6911 or 360-902-6937.

IMPORTANT NOTE: Discectomy, and fusion: An individual who has undergone a discectomy and/or a fusion is NOT an automatic Category 2. There are no automatic ratings. Your rating should be based on the clinical outcome and objective findings.

- For example, a discectomy patient with:
  - an average outcome may be a Category 2
  - an excellent outcome may also be a Category 2
  - a poor outcome may be a Category 3 or above
- Case Example: An injured worker has had a discectomy with a poor outcome. Would he automatically be a Category 2 cervical impairment?
- Answer: No, it would not be automatic. Your rating should be based on the clinical outcome and objective findings.

Rules (WAC 296-20-230)

1) Rules for evaluation of cervical and cervico-dorsal impairments are as follows:

a) Muscle spasm or involuntary guarding, bony or fibrous fusion, any arthritic condition, internal fixation devices or other physical finding shall be considered in selecting the appropriate category, only insofar as productive of cervical or cervico-dorsal impairment.
b) Gradations of clinical findings of cervico-dorsal impairments in terms of “mild”, “moderate” or “marked” shall be based on objective medical tests.
c) Categories 2, 3, 4 and 5 include the presence of complaints of whatever degree in the neck or extremities.
d) Bladder and/or bowel sphincter impairments deriving from cervical and cervico-dorsal impairment shall be evaluated separately.
e) Neck as used in these rules and categories shall include the cervical and adjacent areas.

Categories (WAC 296-20-240)

Choose the category below which best describes the patient’s impairment:

Category 1. No objective clinical findings are present. Subjective complaints may be present or absent.

Category 2. Mild cervico-dorsal impairment, with objective clinical findings of such impairment with neck rigidity substantiated by x-ray findings of loss of anterior curve, without significant objective neurological findings.

- This and subsequent categories include the presence or absence of pain locally and/or radiating into an extremity or extremities.
- This and subsequent categories also include the presence or absence of reflex and/or sensory losses.
- This and subsequent categories also include objectively demonstrable herniation of a cervical intervertebral disc with or without discectomy and/or fusion, if present.

Category 3. Mild cervico-dorsal impairment, with objective clinical findings of such impairment, with neck rigidity substantiated by x-ray findings of loss of anterior curve, narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins, with significant objective findings of mild nerve root involvement.

- These and subsequent categories include the presence or absence of any other neurological deficits not otherwise specified in these categories with the exception of bladder and/or bowel sphincter impairments.

Category 4. Moderate cervico-dorsal impairment, with objective clinical findings of such impairment, with neck rigidity substantiated by x-ray findings of loss of anterior curve, narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins, with objective findings of moderate nerve root involvement with weakness and numbness in one or both upper extremities.

Category 5. Marked cervico-dorsal impairment, with marked objective clinical findings of such impairment, with neck rigidity substantiated by x-ray findings of loss of anterior curve, narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins,

with objective findings of marked nerve root involvement with weakness and numbness in one or both upper extremities.

Doctor's Worksheet for Rating Cervical and Cervico-Dorsal Impairment

Instructions:
To improve consistency, fairness and "user-friendliness," a worksheet has been developed through a cooperative effort with input from representatives of the medical, osteopathic, and chiropractic communities, along with input from representatives of business, labor, and the legal community.

- The worksheet serves as the rating report (when it is filled out completely, signed and dated by the doctor).

Attending Doctors: This worksheet is all you need to send to the claim manager if you are the attending doctor (assuming that you have provided all the required documentation - chart notes, history and physical, etc.). Please attach a separate note to provide additional detail when appropriate. For example, it can be important to the claimant if there is a worsening of the condition and a re-opening application is filed. In such cases, details about the findings at the time of the impairment rating will generally be needed to compare with the findings at the time of application to re-open the claim.

IME examiners and consultants: You must attach the worksheet to the full IME report as described in Chapter 11. Include additional detail in your full IME report if more space is required.

- Caution regarding SEVERE impairment: This worksheet is NOT designed for the rare patient with severe impairment such as patient's long tract signs. For a patient such as this, you should refer to the WACs in Appendix C, along with general information on impairment rating in other sections of this handbook.
- Paraplegia and quadriplegia: You may be asked to perform an examination on a worker with a severe spinal cord injury. The worker may be a complete or incomplete paraplegic or quadriplegic. After receipt of the examination request and before the examination takes place, please contact the assigned Pension Adjudicator. The Pension Adjudicator will provide guidance and answer any questions you may have regarding the evaluation. To contact a State Fund Pension Adjudicator, call 360-902-5119. To contact a Self-Insurance Pension Adjudicator, call 360-902-6911 or 360-902-6937.
- Caution regarding Preexisting conditions: As with any impairment rating, examiners should be familiar with procedures when a worker has preexisting conditions. Please refer to Chapter 5 of this handbook for details.
- Bladder and/or bowel sphincter impairment: Objectively demonstrated bladder and/or bowel sphincter impairments must be evaluated separately. See "Digestive Tract" and "Urologic" sections. This impairment should be reported by attaching a separate page to the worksheet. (Be sure to put the worker's name and claim number on every page of all attachments in case they become separated from the worksheet.)
- The worksheet should be used in conjunction with the WACs. You should read and be familiar with the WACs. You may also find it helpful to use the guidelines and the case examples in this chapter.

Why was the worksheet designed this way? You may wonder why the Worksheet and Guidelines were designed the way they were. Part of the explanation is that both tools must, of necessity, be consistent with the Category Rating System. They do not, and cannot, replace the Category Rating System. The Category Rating System is established in the Washington Administrative Code (WAC).

The worksheet, along with a SAMPLE worksheet filled out for a case example, are included on the following pages. Please feel free to photocopy the worksheet.

Example

Mr. Y, a 45 year old male, has a six-month history of neck pain with parathesias globally from the elbow distally in the left upper extremity. Treatment included physical therapy and epidural steroid injections. Reflex, sensation and motor exams were within normal limits. Foramina compression test was positive on the left. Cervical range-of-motion was within normal limits. MRI showed mild circumferential disc bulges at C 5-6 and C 6-7. X-rays showed reversal of the cervical lordotic curve.

A	B	C
Nerve Root Involvement *(See Notes below.)*	**Neck Rigidity Substantiated by Imaging** *(Only include findings which are consistent with the clinical picture. Age related changes may not be significant in some cases --- see Notes.)*	**Range-of-Motion, Spasm, and Other Findings** *(Describe briefly in space below-- see Notes.)*
Circle one	**Circle one**	**Circle one**
none **(1)**	none **(1)**	none **(1)**
Decrease in reflexes; mild sensory loss; and/or root tension and compression signs (e.g., foramina compression test, etc.) (2)	Loss of anterior curve; and/or herniation at one level (2)	Mild (2)
		Moderate (3)
Mild weakness and sensory loss in one or both extremeties (3)	Mildly narrowed disc spaces; mild osteoarthritic lipping of vertebral margins; herniation at more than one level; and/or findings from discectomy or fusion (one level) indicative of siginficant neck rigidity. (3)	Marked (4)
		Describe ROM, spasm, etc. here: **Normal ROM**
Moderate distal weakness and sensory loss in one or both upper extremities. (4)	Moderately narrowed disc spaces; moderate lipping of vertebral margins; and/or findings from discectomy or fusion (more than one level) indicative of significant neck rigidity. (4)	
Marked distal weakness; moderate or marked proximal weakness; and marked sensory loss in one or both extremities (5)	Markedly narrowed disc spaces and/or osteoarthritic lipping (5)	

Step 4: Calculate Rating *(If you want L&I to do the calculation, copy the numbers into the 1st 3 boxes and go to Step 5.)*

Box number circled in Column A:	2
Box number circled in Column B:	1
Box number circled in Column C:	1
Total	4
Average (total divided by 3)	1 1/3
Enter the average rounded to nearest whole number (1.1=1, 1.5=2, etc.) This is the rating:	1

NOTES:

Column A: **Mild Weakness** = 4/5 (Complete motion against gravity and less than full resistance);
Moderate = 3/5 (Barely complete motion against gravity);
Marked = 2/5 - 0/5 (Complete motion with gravity eliminated to no evidence of contractility).
If lower extremities are involved (e.g., paraparesis), consult the *Medical Examiners' Handbook.*

Column C: Only include findings which are consistent with the clinical picture. NOT TO BE CONSIDERED: OSWESTRY OR OTHER PAIN SCALES. Pain is considered in the rating, but must be reflected in findings described on this worksheet (for example, decreased range of mothon). Bladder and bowel sphincter impairment should be rated separately.

Step 5: Certification	**I certify that I have examined the patient within the last 8 weeks and that the above report truly and correctly sets forth my findings and opinion.**		
	Doctor's address ZIP+4: 123 Maple Dr. Seattle, WA 98xxx-xxxx		Provider No.: 12345
	Print Dr's name: John Smith M.D.	Today's date: 3/1/05	Doctor's signature: John Smith M.D.

The Physician should photocopy this worksheet for their medical records. Doctors should refer to the Medical Examiner's Handbook for instructions on the use of this worksheet.

F252-056-000 worksheet/cervical & cervico-dorsal 5-05

Doctor's Worksheet for Rating Cervical and Cervico-Dorsal Impairment

Claimant's name	Claim #

Step 1: (a) Has the worker's condition reached maximum medical improvement? ☐ Yes ☐ No If no, do not rate. Please provide treatment recommendations.
(b) If there is a pre-existing condition, was it permanently aggravated by the industrial injury? ☐ Yes ☐ No If yes, attach explanation.

Step 2: Is there any permanent impairment? ☐ Yes ☐ No

Step 3: Circle one box in each column A through C below. Give brief explanation below (REQUIRED). Your entries should reflect the patient's current condition, as is including findings which may pre-date the injury. (See examples on page 2 of this worksheet)

A	B	C
Nerve Root Involvement *(See Notes below.)*	**Neck Rigidity Substantiated by Imaging** *(Only include findings which are consistent with the clinical picture. Age related changes may not be significant in some cases --- see Notes.)*	**Range-of-Motion, Spasm, and Other Findings** *(Describe briefly in space below-- see Notes.)*
Circle one	**Circle one**	**Circle one**
none **(1)**	none **(1)**	none **(1)**
Decrease in reflexes; mild sensory loss; and/or root tension and compression signs (e.g., foramina compression test, etc.) (2)	Loss of anterior curve; and/or herniation at one level (2)	Mild (2)
		Moderate (3)
Mild weakness and sensory loss in one or both extremeties (3)	Mildly narrowed disc spaces; mild osteoarthritic lipping of vertebral margins; herniation at more than one level; and/or findings from discectomy or fusion (one level) indicative of siginficant neck rigidity. (3)	Marked (4)
		Describe ROM, spasm, etc. here:
Moderate distal weakness and sensory loss in one or both upper extremities. (4)	Moderately narrowed disc spaces; moderate lipping of vertebral margins; and/or findings from discectomy or fusion (more than one level) indicative of significant neck rigidity. (4)	
Marked distal weakness; moderate or marked proximal weakness; and marked sensory loss in one or both extremities (5)	Markedly narrowed disc spaces and/or osteoarthritic lipping (5)	

Step 4: Calculate Rating *(If you want L&I to do the calculation, copy the numbers into the 1st 3 boxes and go to Step 5.)*

Box number circled in Column A:	
Box number circled in Column B:	
Box number circled in Column C:	
Total	
Average (total divided by 3)	
Enter the average rounded to nearest whole number (1.1=1, 1.5=2, etc.) This is the rating:	

NOTES:

Column A: **Mild Weakness** = 4/5 (Complete motion against gravity and less than full resistance);
Moderate = 3/5 (Barely complete motion against gravity);
Marked = 2/5 - 0/5 (Complete motion with gravity eliminated to no evidence of contractility).
If lower extremities are involved (e.g., paraparesis), consult the *Medical Examiners' Handbook.*

Column C: Only include findings which are consistent with the clinical picture. NOT TO BE CONSIDERED: OSWESTRY OR OTHER PAIN SCALES. Pain is considered in the rating, but must be reflected in findings described on this worksheet (for example, decreased range of mothon). Bladder and bowel sphincter impairment should be rated separately.

Step 5: Certification	**I certify that I have examined the patient within the last 8 weeks and that the above report truly and correctly sets forth my findings and opinion.**		
	Doctor's address	ZIP+4	Provider No.
	Print Dr's name	Today's date	Doctor's signature

The Physician should photocopy this worksheet for their medical records. Doctors should refer to the Medical Examiner's Handbook for instructions on the use of this worksheet.

F252-056-000 worksheet/cervical & cervico-dorsal 5-05

Guidelines For Cervical and Cervico-Dorsal Impairment (Category Rating System)

Use of these guidelines is NOT required. You are encouraged to use them as you deem appropriate. These tools are NOT hard and fast rules. They are intended to offer guidance. As always, sound medical judgment should be used in application of these materials. If you prefer to refer directly to the WACs, see Appendix C.

This guideline attempts to give better definition and clarity to terms used in the Category Rating System, such as "mild but significant," "moderate," and "marked." As such, the "Doctor's Worksheet" and this guideline are companion documents, to be used together to avoid problems that might be encountered in the WAC.

These guidelines should not be construed as rigid rules, but rather basic guidelines intended to offer general guidance to clinicians in the use and interpretation of the Washington State Category System as it relates to cervical and cervico-dorsal impairment.

In all sections of these guidelines, examiners should only consider findings which are consistent with the clinical picture.

1) **Atrophy**

   For the arm or forearm, a difference in circumference of:

   - 1-1.9 cm. = mild
   - 2-2.9 cm = moderate
   - 3+ cm = marked

   Atrophy should not be considered in the rating if it can be explained by non-spine-related problems (for example, wrist fracture) or contralateral hypertrophy, as might occur with a dominant limb or greatly increased use of a limb.

2) **EMG Abnormalities**

   EMG abnormalities are considered significant if unequivocal electrodiagnostic evidence exists of acute nerve root compromise, such as multiple positive sharp waves or fibrillation potentials; or H-wave absence or delay greater than 3 mm/sec; or chronic changes such as polyphasic waves in peripheral muscles.

3) **Muscle Weakness**

   - Mild = 4/5 (Complete motion against gravity and less than full resistance);
   - Moderate = 3/5 (Barely complete motion against gravity);
   - Marked = 2/5 - 0/5 (Complete motion with gravity eliminated, to no evidence of contractility)

4) **Reflex Loss**

   In general, only asymmetric reflex losses should be considered significant for the purposes of impairment rating.

5) **X-ray or Imaging Findings**

The categorization given below is NOT intended to be a comprehensive list of findings which may be described as mild, moderate or marked. Also, be sure to only include findings which are consistent with the clinical picture.

Mild	Moderate	Marked
Any of the following without hypermobility or radiculopathy: ■ spondylolysis ■ spondylolisthesis ■ vertebral body fracture with less than 25% compression of one vertebral body ■ post-surgical state	■ hypermobility or translation >3.5 mm at a single level ■ vertebral body fracture with 25-50% compression of one vertebral body	■ hypermobility or translation > 3.5 mm at multiple levels ■ vertebral body fracture with > 50% compression of one vertebral body
Other findings: ■ Disc bulge or degenerative changes in the absence of concurrent clinical presentation should be considered insignificant. ■ Disc narrowing, spurring, and arthrosis are part of the aging process and may be considered insignificant, depending on the circumstances of the individual patient. However, principles pertaining to preexisting conditions must be considered. For example, an industrial injury can light up degenerative changes in a 55-year-old worker which may result in the payment of an award for impairment. See Preexisting Conditions and Segregation in Chapter 5.		

6) **Miscellaneous Findings**

The chart below is NOT intended to be a comprehensive list of findings which may be considered for the purposes of impairment ratings. *Also, be sure to only include findings which are consistent with the clinical picture.*

These should not be considered in impairment rating:	These may be considered in an impairment rating:
■ Pain scales (for example, the Oswestry pain scale)	■ Dermatomal sensory loss ■ Muscle guarding ■ Asymmetric loss of active range-of-motion ■ Foraminal compression test, i.e., upper extremity symptoms in a radicular pattern (Spurling's maneuver)

Case Examples of Cervical Back Impairment

As you rate the examples of cervical impairment below, consider how the objective findings fit into Columns A-C of the Doctor's Worksheet. Column A=nerve root involvement; Column B=neck rigidity substantiated by imaging; Column C=range-of-motion, spasm, and other findings. Averages should be rounded to the nearest whole number (1.1=1, 1.5=2, etc.).
Also, keep in mind that there is no single "correct" rating for these 7 case examples. See Chapter 11 for further discussion of this point.

Use of these case examples for guidance is NOT required. You are encouraged to use them as you deem appropriate. These tools are NOT hard and fast rules. They are intended to offer guidance. As always, sound medical judgment should be used in application of these materials. If you prefer to refer directly to the WACs, see Appendix C.

Case Examples

1. A 45-year-old insurance salesman has a 6 month history of neck pain, bilateral arm pain, and numbness of the thumb and index finger on the right. There is no weakness of specific muscle groups. Reflexes are 1+ and symmetrical in the upper extremities. The foramina compression test is positive for neck pain, but there is no radicular pain on either side. Cervical range of motion was 30 degrees on right rotation (80 degrees on the left), and 10 degrees on right lateral flexion (30 degrees on the left). There was decreased sensation to pinprick in the C6 dermatome. Moderate palpable and visible cervical spasms were observed. Cervical spine films revealed a loss of cervical lordosis but disc heights were normal and there was no significant spurring or osteophyte formation.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	= TOTAL	AVERAGE (Total / 3 rounded to the nearest whole number)
2	+ 2	+ 3	= 7	CATEGORY 2

2. A 35-year-old man has neck pain radiating into the upper thoracic area bilaterally. He has give-way weakness in the upper extremities and all major muscle groups tested. There is no muscle atrophy and his EMG within the past four months was negative. Reflexes were 2+ and symmetrical in the upper extremities. Foramina compression testing was positive for neck pain, but no radicular pain. There was no significant muscle spasm and neck range of motion was essentially within normal limits. The cervical spine films were normal, with no loss of cervical lordosis.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	= TOTAL	AVERAGE (Total / 3 rounded to the nearest whole number)
	+	+	=	CATEGORY

Case Examples

3. A 55-year-old woman has chronic neck pain with radiation to the right arm associated with weakness (3/5) of her biceps and deltoid on the right. She has a 2.2 cm muscle atrophy in the right upper arm and a decreased right biceps reflex. The foramina compression test was positive on the right with radicular pain. Active neck extension and flexion were markedly restricted. Moderate palpable and visible cervical spasm were observed. Cervical spine films revealed a 50% loss of disc height at C4-C5 and C5-C6 with hypermobility of 3.5 mm at C4-C5 on flexion and extension. She has had no cervical surgery. Her EMG several months previously had revealed evidence of a chronic, right-sided C-5 radiculopathy.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	= TOTAL	AVERAGE (Total / 3 rounded to the nearest whole number)
	+	+	=	CATEGORY

4. A 28-year-old logger fell from a 15-foot height and developed bilateral arm weakness and numbness. He underwent emergency myelogram which revealed the presence of a very large central herniated disc at C4-5 pressing on the spinal cord and producing bilateral foramina stenosis. He underwent emergency surgery, but continued to have residual bilateral arm pain and loss of the biceps reflex on the left. He had residual weakness of the biceps on the left as well (3/5) with a 2.0 cm reduction in the left upper arm compared to the right. Active neck extension and flexion were moderately restricted. Moderate palpable and visible cervical spasm were observed.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	= TOTAL	AVERAGE (Total / 3 rounded to the nearest whole number)
	+	+	=	CATEGORY

5. A 35-year-old man had undergone two cervical anterior interbody fusions, initially at C6-C7 and then later at C5-C6. He suffered from chronic neck pain and headaches. On examination he had 3 cm of atrophy of the right upper arm and a diminished triceps reflex on the right. He had sensory loss in the right middle finger. His bowel and bladder functions were intact. Foramina compression test was positive on the right for neck pain with radiation to the right arm. Triceps strength was 2/5 on the right. Active neck extension and flexion were moderately restricted. No spasm was observed.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	= TOTAL	AVERAGE (Total / 3 rounded to the nearest whole number)
	+	+	=	CATEGORY

Case Examples

6. A 45-year-old landscaper has a past history of multiple previous injuries resulting in a previous cervical-dorsal rating of Category II. He experienced a new injury in January of 1995 and at the time of the IME, treatment had plateaued. His subjective complaints consisted of ongoing neck and right arm pain and he was requesting vocational assistance. On exam the foramina compression test was positive on the right for radicular pain. His right biceps reflex was diminished compared to the left. There was no muscle atrophy or weakness. Hypesthesia was present in the C6 distribution. Active neck flexion was limited to 30 degrees. Mild to moderate palpable and visible cervical spasm were observed. X-rays demonstrated a 25% loss of disc height at C5-C6 with some mild anterior spurring at multiple levels in the cervical spine.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	= TOTAL	AVERAGE (Total / 3 rounded to the nearest whole number)
	+	+	=	CATEGORY

7. A 51-year-old shuttle driver injured his neck when rear-ended at the airport. He reported left hand tingling, numbness and weakness. Exam revealed cervical rigidity and spasm and left C5 sensory/motor changes. MRI revealed disc protrusion at C4-5 with left C5 nerve root impingement. Treatment was discectomy/fusion at C4-5 followed by extensive physical therapy for 6 months. Exam revealed cervical range of motion slightly limited, no spasm and normal neurological exam. EMG revealed a persistent C5 radiculopathy.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	= TOTAL	AVERAGE (Total / 3 rounded to the nearest whole number)
	+	+	=	CATEGORY

Suggested Ratings for Seven Case Examples of Cervical Impairment

There is no single correct rating for any of these 7 case examples. This is partly because there are bound to be reasonable differences in how clinicians interpret the facts presented in these vignettes. In real-life cases, sound medical judgment will play an important role, and you might elicit additional information that would lead to a different rating. Doctors should understand that there is considerable flexibility in the Category Rating System. It is not necessary to be unduly rigid in interpreting the regulations or the guidelines presented in this Handbook.

That said, here are reasonable ratings for these vignettes. The numbers in parentheses refer to the numbers which would be circled in Columns A-C, in that order, of the "Doctor's Worksheet" (see earlier in Chapter 12). Column A=nerve root involvement; Column B=neck rigidity substantiated by imaging; Column C=range-of-motion, spasm, and other findings. The numbers are added and averaged as on the worksheet, rounding to the nearest whole number (1.3=1, 1.6=2, etc.).

CASE # 1:	Category 2	(2+2+3 = 7; 7 ÷ 3 = 2.3, rounds to Category 2)
CASE # 2:	Category 1	(1+1+1 = 3; 3÷3 = 1 , Category 1)
CASE # 3:	Category 4	(5+4+3 = 12; 12 ÷ 3 = 4, Category 4)
	Or Category 4	(5+4+4 = 13; 13 ÷ 3 = 4.3, rounds to Category 4)
CASE # 4:	Category 4	(5+3+3 = 11; 11 ÷ 3 = 3.6, rounds to Category 4)
CASE # 5:	Category 4	(5+4+3 = 12; 12 ÷ 3 = 4 , Category 4)
CASE # 6:	Category 2	(2+3+2 = 7; 7 ÷ 3 = 2.3, rounds to Category 2)
	Or Category 3	(2+3+3 = 8; 8÷3 = 2.6, rounds to Category 3)
CASE # 7:	Category 2	(2+3+1 = 6; 6 ÷ 3 = 2 , Category 2)
	Or Category 2	(2+3+2 = 7; 7 ÷ 3 = 2.3, rounds to Category 2)

Dorsal Spine

General Principles

Several general principles should be followed when rating impairment due to conditions involving ONLY the dorsal (thoracic) spine. These include the following:

- **Dorsal/cervical and dorsal/lumbar combinations**: For patients who have spinal pathology that involves the dorsal and lumbar regions (for example, involvement of T11-L2; or to give a second example, T5-T6 and L4-L5), impairment must be rated using ONLY the dorsolumbar and lumbosacral categories described in WAC 296-20-280 (NOT the categories for the dorsal spine). The same principle applies to pathology involving the cervical and dorsal regions.
- **Bladder and/or bowel sphincter impairments**: Objectively demonstrated bladder and/or bowel sphincter impairments must be evaluated separately, using the Washington State Category Rating System. See "Digestive Tract" and "Urologic" sections.

Rules (WAC 296-20-250)

1. Rules for evaluation of permanent dorsal area impairments are as follows:

   (a) Muscle spasm or involuntary guarding, bony or fibrous fusion, any arthritic condition, internal fixation devices or other physical finding shall be considered, in selection of the appropriate category, only insofar as productive of dorsal area impairment.

   (b) Gradations of clinical findings of dorsal impairments in terms of "mild", "moderate" or "marked" shall be based on objective medical tests.

   (c) Categories 2 and 3 include the presence of complaints of whatever degree.

   (d) Bladder and/or bowel sphincter impairments deriving from impairments of the dorsal area shall be evaluated separately.

   (e) Impairments which also involve the cervical or lumbar areas shall be evaluated only under the cervical and cervico-dorsal or dorsolumbar and lumbosacral categories.

Categories (WAC 296-20-260)

Choose the category below which best describes the patient's impairment:

Category 1. No objective clinical findings are present. Subjective complaints may be present or absent.

Category 2. Mild or moderate dorsal impairment, with objective clinical findings of such impairment, without significant objective neurological findings, with or without x-ray changes of narrowed intervertebral disc spaces and/or osteoarthritic lipping of intervertebral margins. Includes the presence or absence of reflex and/or sensory losses.

- This and the subsequent category include the presence or absence of pain, locally or radiating from the dorsal area.

Category 3. Marked dorsal impairment, with marked objective clinical findings, with marked x-ray findings of narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins, with significant objective neurological deficits, complaints and/or findings, deriving from dorsal impairment.

CASE EXAMPLE:
A 48 year old glazer fell 16' landing on his back approximately nine months ago. He sustained a 60% anterior compression fracture at T8. Since the injury he has had ongoing mid-back pain. His condition is aggravated by prolonged standing, bending and lifting. He has had conservative care and is now at maximum medical improvement. He had not been able to return to his job of injury and is on permanent light duty. He had no prior history of thoracic complaints. Objectively there is moderate to marked muscle guarding in the mid-thoracic area. There is increased tenderness to percussion of the T8 spinous process. Visually there is a hyperkyphosis with the apex at T8. X-rays show marked degenerative disc disease with anterior and lateral spurring from T4 to T10 with an anterior compression fracture at T8. The most appropriate rating in this case is Category 2. Rationale: There are no neurological deficits.

PLEASE NOTE: If both dorsal and lumbar (or dorsal and cervical) are accepted conditions on this case, you should NOT use WAC 296-20-260, but rather use the WACs for lumbo-sacral and/or cervical impairment.

Dorso-Lumbar and Lumbo-Sacral Spine

General Principles for Low Back Impairment
Several general principles should be followed when rating low back impairment. These include the following:

- **Worksheet**: Use the worksheet, guidelines and case examples in this chapter. **IMPORTANT NOTE FOR ALL RATINGS OF THE SPINE**: Make reference to the worksheet in the body of your report, and return the completed worksheet as an attachment to your report. Sending the worksheet will help Claim Managers and others clearly understand your rating and allow them to adjudicate the claim correctly. In cases of severe impairment see page 80.
- **Bladder and/or bowel sphincter impairments**: Objectively demonstrated bladder and/or bowel sphincter impairments must be evaluated separately, using the Washington State Category Rating System. See "Digestive Tract" and "Urologic" sections.
- **Paraplegia and quadriplegia**: You may be asked to perform an examination on a worker with a severe spinal cord injury. The worker may be a complete or incomplete paraplegic or quadriplegic. After receipt of the examination request and before the examination takes place, please contact the assigned Pension Adjudicator. The Pension Adjudicator will provide guidance and answer any questions you may have regarding the evaluation. To contact a State Fund Pension Adjudicator, call 360-902-5119. To contact a Self-Insurance Pension Adjudicator, call 360-902-6901.

IMPORTANT NOTE: Laminectomy, discectomy, and fusion: An individual who has undergone a laminectomy or discectomy is NOT an automatic Category 3. An individual who has undergone a fusion is NOT an automatic Category 4. There are no automatic ratings. Your rating should be based on the clinical outcome and objective findings.

- **For example**, a laminectomy patient with:
  - an average outcome may be a Category 3
  - an excellent outcome may be a Category 2
  - a poor outcome may be a Category 4 or above

- **Case example**: An injured worker has had a laminectomy with a very good outcome, would they automatically be a Category 3 lumbar impairment?

- **Answer**: No, it would not be automatic. Your rating should be based on the clinical outcome and objective findings.

Rules (WAC 296-20-270)

1. Rules for evaluation of permanent dorso-lumbar and lumbo-sacral impairments are as follows:

   (a) Muscle spasm or involuntary guarding, bony or fibrous fusion, any arthritic condition, internal fixation devices or other physical finding shall be considered, in selecting the appropriate category, only insofar as productive of low back impairment.

   (b) Gradations of clinical findings of low back impairments in terms of “mild”, “moderate” or “marked” shall be based on objective medical tests.

   (c) All of the low back categories include the presence of complaints of whatever degree.

   (d) Any and all neurological deficits, complaints, and/or findings in other bodily areas or systems which are the result of dorso-lumbar and lumbo-sacral impairments, except for objectively demonstrated bladder and/or bowel sphincter impairments, shall be evaluated by the descriptions contained in the categories of dorso-lumbar and lumbo-sacral impairments.

   (e) Bladder and/or bowel sphincter impairments deriving from dorso-lumbar and lumbo-sacral impairments shall be evaluated separately.

   (f) Low back as used in these rules and categories includes the lumbar and adjacent areas.

Categories (WAC 296-20-280)

Choose the category below which best describes the patient’s impairment:

Category 1. No objective clinical findings. Subjective complaints and/or sensory losses may be present or absent.

Category 2. Mild low back impairment, with mild intermittent objective clinical findings of such impairment but no significant x-ray findings and no significant objective motor loss. Subjective complaints and/or sensory losses may be present.

Category 3. Mild low back impairment, with mild continuous or moderate intermittent objective clinical findings of such impairment but without significant x-ray findings or significant objective motor loss. This and subsequent categories include:

*the presence or absence of reflex and/or sensory losses;

*the presence or absence of pain locally and/or radiating into an extremity or extremities;

*the presence or absence of a laminectomy or discectomy with normally expected residuals.

Category 4. Mild low back impairment, with mild continuous or moderate intermittent objective clinical findings of such impairment, with mild but significant x-ray findings and with mild but significant motor loss objectively demonstrated by atrophy and weakness of a specific muscle or muscle group. This and subsequent categories include the presence or absence of a surgical fusion with normally expected residuals.

Category 5. Moderate low back impairment, with moderate continuous or marked intermittent objective clinical findings of such impairment, with moderate x-ray findings and with mild but significant motor loss objectively demonstrated by atrophy and weakness of a specific muscle or muscle group.

Category 6. Marked low back impairment, with marked intermittent objective clinical findings of such impairment, with moderate or marked x-ray findings and with moderate motor loss objectively demonstrated by atrophy and weakness of a specific muscle or muscle group.

Category 7. Marked low back impairment, with marked continuous objective clinical findings of such impairment, with marked x-ray findings and with marked motor loss objectively demonstrated by marked atrophy and weakness of a specific muscle or muscle group.

Category 8. Essentially total loss of low back functions, with marked x-ray findings and with marked motor loss.

Guidelines For Dorso-Lumbar and Lumbo-Sacral Impairment (Category Rating System)

Use of these guidelines is NOT required. You are encouraged to use them as you deem appropriate. These tools are NOT hard and fast rules. They are intended to offer guidance. As always, sound medical judgment should be used in application of these materials. If you prefer to refer directly to the WACs, see Appendix C.

This two-page guideline attempts to give better definition and clarity to terms used in the Category Rating System, such as “mild but significant,” “moderate,” and “marked.” As such, the “Doctor’s Worksheet” and this guideline are companion documents, to be used together to avoid problems that might be encountered in the WAC.

These guidelines should not be construed as rigid rules, but rather basic guidelines intended to offer general guidance to clinicians in the use and interpretation of the Washington State Category System as it relates to dorso-lumbar and lumbo-sacral impairment.

In all sections of these guidelines, examiners should only consider findings which are consistent with the clinical picture.

1) Atrophy

For the calf or thigh, a difference in circumference of:

- 1-1.9 cm. = mild
- 2-2.9 cm = moderate
- 3+ cm = marked.

Atrophy should not be considered in the rating if it can be explained by non-spine-related problems (for example, ankle fracture) or contralateral hypertrophy, as might occur with a dominant limb or greatly increased use of a limb.

2) EMG Abnormalities

EMG abnormalities are considered significant if unequivocal electrodiagnostic evidence exists of acute nerve root compromise, such as multiple positive sharp waves or fibrillation potentials; or H-wave absence or delay greater than 3 mm/sec; or chronic changes such as polyphasic waves in peripheral muscles.

3) Muscle Weakness

- Mild = 4/5 (Complete motion against gravity and less than full resistance);
- Moderate = 3/5 (Barely complete motion against gravity);
- Marked = 2/5 - 0/5 (Complete motion with gravity eliminated, to no evidence of contractility)

4) Reflex Loss

In general, only asymmetric reflex losses should be considered significant for the purposes of impairment rating.

5) X-ray or Imaging Findings

The categorization given below is NOT intended to be a comprehensive list of findings which may be described as mild, moderate or marked. Also, be sure to only include findings which are consistent with the clinical picture.

Mild	Moderate	Marked
Any of the following without hypermobility or radiculopathy: ■ spondylolysis ■ spondylolisthesis ■ vertebral body fracture with less than 25% compression of one vertebral body ■ post-surgical state	■ hypermobility or translation >4.5 mm at a single level ■ vertebral body fracture with 25-50% compression of one vertebral body	■ hypermobility or translation > 4.5 mm at multiple levels ■ vertebral body fracture with > 50% compression of one vertebral body
Other findings: ■ Disc bulge or degenerative changes in the absence of concurrent clinical presentation should be considered insignificant. ■ Disc narrowing, spurring, and arthrosis are part of the aging process and may be considered insignificant, depending on the circumstances of the individual patient. However, principles pertaining to preexisting conditions must be considered. For example, an industrial injury can light up degenerative changes in a 55-year-old worker which may result in the payment of an award for impairment. See Preexisting Conditions and Segregation.		

6) Miscellaneous Findings

The chart below is NOT intended to be a comprehensive list of findings which may be considered for the purposes of impairment ratings. *Also, be sure to only include findings which are consistent with the clinical picture.*

These should not be considered in impairment rating:	These may be considered in an impairment rating:
■ Pain scales (for example, the Oswestry pain scale)	■ Dermatomal sensory loss ■ Positive straight-leg-raising with a radicular pattern ■ Muscle guarding ■ Asymmetric loss of active range-of-motion ■ Femoral nerve stretch ■ Foraminal compression test, i.e., lower extremity symptoms in a radicular pattern (Kemps sign) ■ Waddell's signs*
* *Waddell's signs are non-organic physical signs in low back pain (such as axial loading and cogwheel "give-way" weakness). They are distinguishable from the standard clinical signs of physical pathology and correlate with other psychological data. For more information, see Waddell, G., et al.: Non-organic physical signs in low back pain, Spine 5:117, 1980.*	

Doctor's Worksheet for Rating Dorso-Lumbar & Lumbo-Sacral Impairment

Instructions:

To improve consistency, fairness and "user friendliness," a worksheet has been developed through a cooperative effort with representatives of the medical, osteopathic, and chiropractic communities, along with input from representatives of business, labor, and the legal community.

- The worksheet is only one page. The worksheet, itself, serves as the rating report (when it is filled out completely, signed and dated by the doctor).

Attending Doctors: This worksheet is all you need to send to the claim manager if you are the attending doctor (assuming that you have provided all the required documentation - chart notes, history and physical, etc.). Please attach a separate note to provide additional detail when appropriate. For example, it can be important to the claimant if there is a worsening of the condition and a re-opening application is filed. In such cases, details about the findings at the time of the impairment rating will generally be needed to compare with the findings at the time of application to reopen the claim. (See sample rating report #3 in Appendix A)

IME examiners and consultants: You must attach the worksheet to the full IME report as described in chapter 11. Include additional detail in your full IME report if more space is required.

- Caution regarding SEVERE impairment: This worksheet is NOT designed for the rare patient with severe impairment such as patients with long tract signs. For a patient such as this, you should refer to the WACs in Appendix C along with general information on impairment rating in other sections of this handbook.

- Paraplegia and quadriplegia: You may be asked to perform an examination on a worker with a severe spinal cord injury. The worker may be a complete or incomplete paraplegic or quadriplegic. After receipt of the examination request and before the examination takes place, please contact the assigned Pension Adjudicator. The Pension Adjudicator will provide guidance and answer any questions you may have regarding the evaluation. To contact a State Fund Pension Adjudicator, call 360-902-5119. To contact a Self-Insurance Pension Adjudicator, call 360-902-6911 or 360-902-6937.

- Caution regarding preexisting conditions: As with any impairment rating, examiners should be familiar with procedures when a claimant has preexisting conditions. Please refer to Chapter 5 of this handbook for details.

- Bladder and/or bowel sphincter impairment: Objectively demonstrated bladder and/or bowel sphincter impairments must be evaluated separately. See "Digestive Tract" and "Urologic" sections. This impairment should be reported by attaching a separate page to the worksheet. (Be sure to put the patient's name and claim number on every page of all attachments in case they become separated from the worksheet.)

- The worksheet should be used in conjunction with the WACs. You should read and be familiar with the WACs. You may also find it helpful to use the guidelines and the case examples in this chapter.

Why was the worksheet designed this way? You may wonder why the Worksheet and Guidelines were designed the way they were. Part of the explanation is that both tools must, of necessity, be consistent with the Category Rating System. They do not, and cannot, replace the Category Rating System. The Category Rating System is established in the Washington Administrative Code (WAC). As such, it can only be changed through a formal process involving public hearings and broad stakeholdering, including stakeholdering with the Business and Labor communities.

The worksheet, along with a SAMPLE worksheet filled out for a case example, are included on the following pages. Please feel free to photocopy the worksheet.

Example

Mr. X, a 28 year old male, was injured when lifting a 50 pound container out of a van. He developed sharp back pain, radiating down the left leg into the left foot. The patient received non-operative treatment, including physical therapy and non-steroidal medications. At the time of the impairment rating examination Mr. X reported moderate intermittent pain. Physical examination was unremarkable except for diminished ankle jerk on the left and tenderness at L4-L5 and L5-S1 with deep pressure. MRI showed central disc herniation at L5-S1 slightly eccentric to the left not impinging on a nerve root. The worksheet for Mr. X would look like the Sample Worksheet below.

A	B	C		D	
Muscle Weakness ***AND:*** **EITHER Atrophy or EMG abnormalities** (See "notes" below.)	**Reflex loss** *(In general only Asymmetric losses are significant.)*	**Imaging and X-ray findings** **EXAMPLES:** Degenerative disk disease, fracture disrupting the spinal canal, bulging disc ***(Only include findings which are consistent with clinical picture.)***		**Other Findings** **EXAMPLES:** Dermatomal sensory loss, decreased range-of-motion, muscle guarding, +SLR ***(Only include findings which are consistent with the clinical picture.)*** NOT TO BE CONSIDERED: OSWESTRY OR OTHER PAIN SCALES	
Circle one	**Circle one**	**Circle one**	**Explain:**	**Circle one**	**Explain:**
none **(1)**	none **(1)**	none **(1)**	**MRI shows central disc herniation at L5-S1 not impinging on nerve root.**	none **(1)**	
				mild intermittent **(2)**	
	knee ☐ yes ankle ☐ yes **(3)**			mild continuous or moderate intermittent **(3)**	
mild but significant **(4)**		mild but significant **(4)**			
		moderate **(5)**		moderate continuous or marked intermittent **(5)**	
moderate **(6)**		marked **(6)**			
marked **(7)**				marked continuous **(7)**	
Give muscle group and specific abnormalities:				essentially total loss of low back functions **(8)**	

Step 4: Calculate Rating *(If you want L&I to do the calculation, copy the numbers into the 1st 4 boxes and go to Step 5.)*

Box number circled in Column A:	1
Box number circled in Column B:	3
Box number circled in Column C:	4
Box number circled in Column D:	1
Total	9
Average (total divided by 4)	2.25
Enter the average rounded to nearest whole number (1.1=1, 1.5=2, etc.) This is the rating:	2

Notes:
- Column A: **Mild Weakness** = 4/5 (Complete motion against gravity and less than full resistance); **Moderate** = 3/5 (Barely complete motion against gravity); **Marked** = 2/5 - 0/5 (Complete motion with gravity eliminated to no evidence of contractility).
- Pain is considered in the rating, but must be reflected in findings described on this worksheet (for example, decreased range-of-motion).

Step 5: Certification

I certify that I have examined the patient within the last 8 weeks and that the above report truly and correctly sets forth my findings and opinion.

Doctor's address	ZIP+4	Provider No.
123 Maple Dr. Seattle, WA 98xxx-xxxx		12345

Print Dr's name	Today's date	Doctor's signature
John Smith M.D.	1/1/05	*John Smith M.D.*

Developed jointly by representatives of the medical, osteopathic and chiropractic communities with input from Labor and Business; based on WAC 296-20-280

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Doctor's Worksheet for Rating Dorso-Lumbar & Lumbo-Sacral Impairment

Claimant's name | Claim #

Step 1. (a) Has the worker's condition reached maximum medical improvement? ☐ Yes ☐ No If "No," do not rate. Please provide treatment recommendations.
(b) If there is a pre-existing condition, was it permanently aggravated by the industrial injury? ☐ Yes ☐ No ☐ N/A If "Yes," attach explanation.
Step 2. Is there any permanent impairment? ☐ Yes ☐ No
Step 3. Circle one box in each column A through D below. Give brief explanation below (REQUIRED). *Your entries should reflect the patient's current*

Tear on perforated line

A	B	C		D	
Muscle Weakness ***AND:*** **EITHER Atrophy or EMG abnormalities** (See "notes" below.)	**Reflex loss** *(In general only Asymmetric losses are significant.)*	**Imaging and X-ray findings** **EXAMPLES:** Degenerative disk disease, fracture disrupting the spinal canal, bulging disc ***(Only include findings which are consistent with clinical picture.)***		**Other Findings** **EXAMPLES:** Dermatomal sensory loss, decreased range-of-motion, muscle guarding, +SLR ***(Only include findings which are consistent with the clinical picture.)*** NOT TO BE CONSIDERED: OSWESTRY OR OTHER PAIN SCALES	
Circle one	**Circle one**	**Circle one**	**Explain:**	**Circle one**	**Explain:**
none **(1)**	none **(1)**	none **(1)**		none **(1)**	
				mild intermittent **(2)**	
	knee ☐ yes ankle ☐ yes **(3)**			mild continuous or moderate intermittent **(3)**	
mild but significant **(4)**		mild but significant **(4)**			
		moderate **(5)**		moderate continuous or marked intermittent **(5)**	
moderate **(6)**		marked **(6)**			
marked **(7)**				marked continuous **(7)**	
Give muscle group and specific abnormalities:				essentially total loss of low back functions **(8)**	

Step 4: Calculate Rating *(If you want L&I to do the calculation, copy the numbers into the 1st 4 boxes and go to Step 5.)*

Box number circled in Column A:	
Box number circled in Column B:	
Box number circled in Column C:	
Box number circled in Column D:	
Total	
Average (total divided by 4)	
Enter the average rounded to nearest whole number (1.1=1, 1.5=2, etc.) This is the rating:	

Notes:
- Column A: **Mild Weakness** = 4/5 (Complete motion against gravity and less than full resistance); **Moderate** = 3/5 (Barely complete motion against gravity); **Marked** = 2/5 - 0/5 (Complete motion with gravity eliminated to no evidence of contractility).
- Pain is considered in the rating, but must be reflected in findings described on this worksheet (for example, decreased range-of-motion).

Step 5: Certification

I certify that I have examined the patient within the last 8 weeks and that the above report truly and correctly sets forth my findings and opinion.

Doctor's address		ZIP+4	Provider No.
Print Dr's name	Today's date	Doctor's signature	

The Physician should photocopy this worksheet for their medical records. Doctors should refer to the Medical Examiner's Handbook *for instructions on the use of this worksheet.*

Developed jointly by representatives of the medical, osteopathic and chiropractic communities with input from Labor and Business; based on WAC 296-20-280

F252-006-000 worksheet/dorso-lumbar & lumbo sacral 9-00

Case Examples of Low Back Impairment

As you rate the examples of low back impairment below, consider how the objective findings fit into Columns A-D of the Doctor's Worksheet. Column A=muscle weakness, atrophy, EMG; Column B=reflex loss; Column C=imaging and x-ray findings; Column D=other findings. Averages should be rounded to the nearest whole number (1.1=1, 1.5=2, etc.).

Also, keep in mind that there is no single "correct" rating for these 11 case examples. See page V 24 for further discussion of this point.

Use of these case examples is NOT required. You are encouraged to use them as you deem appropriate. These tools are NOT hard and fast rules. They are intended to offer guidance. As always, sound medical judgment should be used in application of these materials. If you prefer to refer directly to the WACs, see Appendix C.

Case Examples

1. A 45-year-old man has a six month history of mild low back pain, bilateral sciatica, and subjective numbness of the right fifth toe. There is no weakness of specific muscle groups. Reflexes are 1+ and symmetrical at the knee and ankle. Straight leg produces low back pain at 80 degrees of hip flexion bilaterally. Sensory exam is within normal limits. Lumbar spine films show mild spurring at L4-5. MRI reveals loss of disc height and desiccation at L4-5 and L5-S1. There is a moderate sized central lumbar disc protrusion at L1-2 without impingement on the thecal sac.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	+ D	= TOTAL	AVERAGE (Total / 4 rounded to the nearest whole number)
1	+ 1	+ 4	+ 1	= 7	CATEGORY 2

2. A 22-year-old grocery clerk has low back pain, radiating to the buttocks bilaterally, no neurological deficit. Give-way weakness in the lower extremities and all major muscle groups tested. No muscle atrophy. Reflexes two plus and symmetrical at patellar and Achilles tendons. Supine SLR negative (producing only low back pain at 30 degrees bilaterally). Sitting SLR negative to 90 degrees. Axial loading and en bloc rotation of the torso produce low back pain. Lumbar spine films normal. CT scan reveals loss of disc height at L5-S1 but is otherwise within normal limits.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	+ D	= TOTAL	AVERAGE (Total / 4 rounded to the nearest whole number)
	+	+	+	=	CATEGORY

Case Examples

3. A 36-year-old meat wrapper had low back pain and left lower extremity (thigh and leg) pain with weakness of hamstrings and EHL on the left. MRI revealed a herniated disc at L4-5 on the left. Laminotomy and discectomy were performed at L4-5 on the left, with relief of lower limb (but not back) pain. On examination, he has residual sensory radiculopathy in the left L5 distribution. There is no weakness in specific muscle groups. Patellar and Achilles tendon reflexes were symmetrical. SLR was positive on the left for radicular pain. No follow-up diagnostic studies had been obtained.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	+ D	= TOTAL	AVERAGE (Total / 4 rounded to the nearest whole number)
	+	+	+	=	CATEGORY

4. A 28-year-old logger fell from a 15 foot height and developed bilateral lower extremity weakness and numbness plus loss of bowel and bladder control. Emergency myelogram revealed a large central herniated disc at L1-2 pressing on the conus medullaris and a left posterolateral disc herniation at L5-S1. Following emergency discectomy, he regained bowel and bladder control but has residual bilateral sciatica, loss of Achilles tendon reflex on the left, and residual 2/5 weakness on ankle plantar flexion. Left leg circumference was 3.0 cm smaller due to calf muscle atrophy. There was loss of sensation in the S1 nerve root distribution; guarding at the L5-S1 level; SLR positive for radicular pain. Repeated office visits have revealed a consistent pattern of asymmetric range-of-motion limitation, including decreased extension and left lateral flexion.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	+ D	= TOTAL	AVERAGE (Total / 4 rounded to the nearest whole number)
	+	+	+	=	CATEGORY

5. A 35-year-old male had chronic low back pain. X-ray revealed grade two spondylolisthesis. At nine months of low back pain, he underwent lumbar fusion. Currently, x-rays reveal the presence of one-level lumbar fusion at L5-S1. Examination is entirely within normal limits. There are no neurological symptoms or signs.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	+ D	= TOTAL	AVERAGE (Total / 4 rounded to the nearest whole number)
	+	+	+	=	CATEGORY

Case Examples

6. A 54-year-old woman has chronic low back pain and lateral right thigh pain, numbness of the right anterolateral leg, and grade 3/5 weakness of the EHL and hamstrings on the right. Right leg circumference is 2.5 cm smaller due to muscle atrophy. Reflexes are intact. Positive SLR on right at 45 degrees with radicular pain and increased pain on dorsiflexion of the right ankle. Lumbar spine films reveal 50% loss of disc height at L4-5 and L5-S1 and hypermobility of 6mm at L4-L5 and at L5-S1 on flexion and extension. EMG reveals evidence of chronic right L5 radiculopathy.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	+ D	= TOTAL	AVERAGE (Total / 4 rounded to the nearest whole number)
	+	+	+	=	CATEGORY

7. A 35-year-old chronic pain patient has undergone five lumbar surgeries, including laminotomy and discectomy at L4-5 and L5-S1, followed by repeat laminotomy-discectomy procedures times two at L4-5, and eventually L4-S1 fusion. Diagnostic studies reveal pseudoarthrosis of the lumbar fusion with 30% loss of disc height at L4-5 and L5-S1. On examination he has 1.5 cm of leg atrophy and diminished Achilles tendon reflex on the right. There is no sensory loss. Bowel and bladder function are intact. SLR is positive at 60 degrees on the right for low back pain and sciatica. There is grade 4/5 weakness on toe walking.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	+ D	= TOTAL	AVERAGE (Total / 4 rounded to the nearest whole number)
	+	+	+	=	CATEGORY

8. A 42-year-old mechanic has low back pain radiating to the left leg and subjective hypesthesia in the calf and lateral left foot. There is no weakness or atrophy, and knee and ankle reflexes are normal. Sensation to pinprick over the left calf and lateral left foot is diminished. SLR was positive at 60 degrees on the left with increased radicular pain on ankle dorsiflexion. Kemps signs is positive for left radicular pain. X-rays show 25% loss of disc height of L5-S1.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	+ D	= TOTAL	AVERAGE (Total / 4 rounded to the nearest whole number)
	+	+	+	=	CATEGORY

Case Examples

9. A 35-year-old insurance salesman has low back pain without radiation. Spasms are present at L4-L5 and L5-S1 bilaterally. Flexion is limited at 45 degrees with spasms visualized, no reversal of lumbar lordosis, and two phase recovery. SLR is negative (no radiating pain) but produces some low back discomfort. Neither weakness nor atrophy are present. X-rays show mild degenerative joint disease of L4-5 and L5-S1 facet joints bilaterally.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	+ D	= TOTAL	AVERAGE (Total / 4 rounded to the nearest whole number)
	+	+	+	=	CATEGORY

10. A fifty-six-year-old overweight truck driver has chronic non-radiating low back pain. He has full thoracolumbar motions in all directions with pain at end-range. Soto Hall, Nachlas, Elys, and Hibbs all cause low back pain. No spasm is present. X-rays show mild degenerative disc disease throughout the lumbar spine.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	+ D	= TOTAL	AVERAGE (Total / 4 rounded to the nearest whole number)
	+	+	+	=	CATEGORY

11. A 45-year-old female with a history of multiple previous injuries and lumbosacral Category 2 impairment rating was doing well before an industrial injury on January 12 1995. Her condition has now plateaued. Current complaints consist of ongoing low back pain and right leg pain. SLR is positive on the right at 50 degrees with radicular pain on ankle dorsiflexion. Right Achilles reflex is diminished. No atrophy or weakness is evident, but there is hypesthesia in the S1 distribution. X-rays show 25% loss of disc height at L5-S1.

OBJECTIVE FINDINGS TO SUPPORT RATING:

Column A	+ B	+ C	+ D	= TOTAL	AVERAGE (Total / 4 rounded to the nearest whole number)
	+	+	+	=	CATEGORY

Suggested Ratings for Eleven Case Examples of Lumbo-Sacral Impairment

There is no single correct rating for these 11 case examples. This is partly because there are bound to be reasonable differences in how clinicians interpret the facts presented in these vignettes. In real-life cases, sound medical judgment will play an important role, and you might elicit additional information that would lead to a different rating. Doctors should understand that there is considerable flexibility in the Category Rating System. It is not necessary to be unduly rigid in interpreting the regulations or the guidelines presented in this Supplement.

That said, here are reasonable ratings for these vignettes. The numbers in parentheses refer to the numbers which would be circled in Columns A-D, in that order, of the ìDoctor's Worksheetî (see previous section). Column A=muscle weakness, atrophy, EMG; Column B=reflex loss; Column C=imaging and x-ray findings; Column D=other findings. The numbers are added and averaged as on the worksheet, rounding to the nearest whole number (1.1=1, 1.5=2, etc.).

CASE # 1:	Category 1	(1+1+1+1 = 4; 4/4 = 1, Category 1)
	Or Category 2	(1+1+4+1 = 7; 7/4 = 1.75, rounds to Category 2)
CASE # 2:	Category 1	(1+1+1+1 = 4; 4/4 = 1, Category 1)
	Note: positive Waddell's Signs	
CASE # 3:	Category 3	(1+1+4+5 = 11; 11/4 = 2.75, rounds to Category 3)
CASE # 4:	Category 5	(7+3+5+3 = 18; 18/4 = 4.5, rounds to Category 5)
	Or Category 6	(7+3+5+7 = 22; 22/4 = 5.5, rounds to Category 6)
CASE # 5:	Category 2	(1+1+4+1 = 7; 7/4 = 1.75, rounds to Category 2)
	Or	(1+1+6+1 = 9; 9/4 = 2.25, rounds to Category 2)
CASE # 6:	Category 4	(6+1+5+3 = 15; 15/4 = 3.75, rounds to Category 4)
	Or Category 5	(7+1+6+5 = 19; 19/4 = 4 .75, rounds to Category 5)
CASE # 7:	Category 4	(4+3+6+3 = 16; 16/4 = 4, Category 4)
	Or Category 5	(4+3+6+5 = 18; 18/4 = 4.5, rounds to Category 5)
CASE # 8:	Category 2	(1+1+4+3 = 9; 9/4 = 2.25, rounds to Category 2)
	Or Category 3	(1+1+4+5 = 11; 11/4 = 2.75, rounds to Category 3)
CASE # 9:	Category 2	(1+1+4+2 = 8; 8/4 = 2, Category 2)
	Or Category 3	(1+1+4+5 = 11; 11/4 = 2.75, rounds to Category 3)
CASE #10:	Category 2	(1+1+4+1 = 7; 7/4 = 1.75, rounds to Category 2)
CASE #11:	Category 3	(1+3+4+3 = 11; 11/4 = 2.75, rounds to Category 3)
	Or	(1+3+4+5 = 13; 13/4 = 3.25, rounds to Category 3)

Use of these case examples for guidance is NOT required. You are encouraged to use them as you deem appropriate. These tools are NOT hard and fast rules. They are intended to offer guidance. As always, sound medical judgment should be used in application of these materials. If you prefer to refer directly to the WACs, see Appendix C.

Pelvis

Rules (WAC 296-20-290)

1. Rules for impairment of the pelvis:

   (a) All of these categories include the presence of complaints of whatever degree.

   (b) Categories 2, 5, 6 and 7 describe separate entities and more than one may be selected when appropriate. Category 9 includes the findings described in Category 3, and Category 8 includes the findings described in Category 4.

Categories (WAC 296-20-300)

Choose the category(ies) below which best describes the patient's impairment (more than one category may be chosen):

Category 1. Healed pelvic fractures without displacement, without residuals; healed fractures with displacement without residuals, of: Single ramus, bilateral rami, ilium, innominate or coccyx; or healed fracture of single rami with displacement with deformity and residuals.

Category 2. Healed fractures with displacement with deformity and residuals of ilium.

Category 3. Healed fractures of symphysis pubis, without separation with displacement without residuals.

Category 4. Healed fractures of sacrum with displacement without residuals.

Category 5. Healed fracture of bilateral rami with displacement with deformity and residuals.

Category 6. Excision or nonunion of fractures of coccyx.

Category 7. Healed fractures of innominate, displaced one inch or more, with deformity and residuals.

Category 8. Healed fractures of sacrum extending into sacroiliac joint with deformity and residuals.

Category 9. Healed fractures of symphysis, displaced or separated, with deformity and residuals.

IMPORTANT NOTE: More than one category may be selected in your impairment rating.

Case Example: A 39 year old worker received a crush injury to the pelvis when a 10 ton steel roller machine, used to roll out ribbons of steel, broke loose from its mounting and pinned him against a concrete wall. He sustained a fracture to the sacrum that extended into the right sacroiliac joint with widening of the joint. There was a small avulsion fracture in the posterior aspect of the right sacroiliac joint. He had a 3 cm. separation of the symphysis pubis. He had surgery where a plate with multiple screws and a large lag bolt was used to repair the right sacroiliac joint. He had a metal prosthesis installed to join the symphysis. He is now at MMI. He has no ongoing pain in the pelvic area. His physical examination is negative. Imaging shows a healed fracture at the sacrum and good alignment of the symphysis both with internal fixation remaining in place.

What is his rating? The correct rating would be a category 8 impairment and a category 9 impairment. Category 8 would address the healed fracture of the sacrum extending into the sacroiliac joint and category 9 would address the fracture with separation of the symphysis. If you said a category 3, this is included in the category 9 rating and if you said a category 4, this is included in the category 8 rating.

Cardiac

Rules (WAC 296-20-350)

1. Rule for evaluation of permanent cardiac impairments:

   (a) Classification of impairment using the following categories shall be based upon a carefully obtained history, thorough physical examination and the use of appropriate laboratory aids.

Categories (WAC 296-20-360)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings are present. Subjective complaints may be present or absent.

Category 2. Objective findings of mild organic heart disease but no signs of congestive heart failure. No medically appropriate symptoms produced by prolonged exertion or intensive effort or marked emotional stress.

Category 3. Objective findings of mild organic heart disease but no signs of congestive heart failure. Medically appropriate symptoms produced by prolonged exertion or intensive effort, or marked emotional stress but not by usual daily activities.

Category 4. Objective findings of moderate organic heart disease but no signs of congestive heart failure. Medically appropriate symptoms produced by prolonged exertion or intensive effort or marked emotional stress but not by usual daily activities.

Category 5. Objective findings of marked organic heart disease with minimal signs of congestive heart failure with therapy. Medically appropriate symptoms produced by usual daily activities.

Category 6. Objective findings of marked organic heart disease with mild to moderate signs of congestive heart failure despite therapy. Medically appropriate symptoms produced by usual daily activities.

Convulsive Neurologic Disorders (Seizure Disorders, Epilepsy)

Rules (WAC 296-20-310)

1. Rules for evaluation of convulsive neurological impairments:

   (a) The description of categories 2, 3 and 4 include the presence of complaints of whatever degree.

Categories (WAC 296-20-320)
Choose the category below which best describes the patient's impairment:

Category 1. No electroencephalogram findings of convulsive neurological disorder. Subjective complaints may be present or absent.

Category 2. Electroencephalogram findings of convulsive neurological disorder, but on appropriate medication there are no seizures.

Category 3. Electroencephalogram findings of convulsive neurological disorder, and on appropriate medication there are each year either one through four major seizures or one through twelve minor seizures.

Category 4. Electroencephalogram findings of convulsive neurological disorder, and on appropriate medication there are each year more than four major seizures or more than twelve minor seizures.

Dental, Tooth Loss

To rate impairment due to tooth loss, you will not need to use any rating system, but rather simply answer the following three questions in your impairment rating report:

1) Were any complete original teeth lost? If so, which ones? Identify each tooth by tooth number.
2) Were parts of teeth lost? Is so, which ones?
3) For each lost tooth, please state whether the tooth loss was caused by the industrial injury, on a more probable than not basis.

IMPORTANT NOTE: The department pays an impairment award only for complete loss of original teeth, whether or not the tooth is replaced by a bridge, denture or implant. The department does not pay impairment awards for loss of part of a tooth.

Other related impairments: To rate impairment due to temporomandibular joint (TMJ) injury, dislocated jaw, and other similar conditions, use the Ear, Nose and Throat chapter of the AMA *Guides*. For example, if mastication or deglutition is impaired, use the AMA *Guides*. Use the edition of the AMA *Guides* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition. Currently the department has designated the Fifth Edition.) If speech, taste or smell is impaired, you must use the Washington State Category Rating System, as presented elsewhere in this handbook.

Digestive Tract

Upper Digestive Tract

Rules (WAC 296-20-490)

1. Rule for evaluation of permanent impairments of the upper digestive tract, stomach, esophagus or pancreas.

   (a) Categories 2, 3, 4 and 5 include complaints of whatever degree.

Categories (WAC 296-20-500)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings are present. Subjective complaints may be present or absent.

Category 2. There are objective findings of digestive tract impairment but no anatomic loss or alteration, continuous treatment is not required and weight can be maintained at the medically appropriate level.

Category 3. There are objective findings of digestive tract impairment, or there is anatomic loss or alteration. Dietary restrictions and drugs control symptoms, signs and/or nutritional state, and weight can be maintained at least 90 percent of medically appropriate level.

Category 4. There are objective findings of digestive tract impairment, or there is anatomic loss or alteration. Dietary restrictions and drugs do not completely control symptoms, signs and/or nutritional state. Weight can be maintained at 80-90 percent of medically appropriate level.

Category 5. There are objective findings of digestive tract impairment, or there is anatomic loss or alteration. Dietary restrictions and drugs do not control symptoms, signs and/or nutritional state. Weight cannot be maintained as high at 80 percent of medically appropriate level.

Lower Digestive Tract

Rules (WAC 296-20-510)

1. Rule for evaluation of permanent lower digestive tract impairments.

   (a) Categories 2, 3 and 4 include the presence of complaints of whatever degree.

Categories (WAC 296-20-520)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings of impairment of lower digestive tract. Subjective complaints may be present or absent.

Category 2. The objective findings of lower digestive tract impairment are infrequent and of brief duration, and there is limitation of activities, but special diet or medication is not required, and there are neither systemic manifestations nor impairment of nutrition.

Category 3. There are objective findings of lower digestive tract impairment or anatomic loss or alteration and mild gastrointestinal symptoms with occasional disturbance of bowel function, accompanied by moderate pain and minimal restriction of diet; mild symptomatic therapy may be necessary; no impairment of nutrition.

Category 4. There are moderate to marked intermittent bowel disturbances with continual or periodic pain; there is restriction of activities and diet during exacerbations, there are constitutional manifestations such as fever, anemia or weight loss. Includes but is not limited to any permanent ileostomy or colostomy.

Anal Function

Rules (WAC 296-20-530)

1. Rule for evaluation of permanent impairment of anal function.

   (a) Categories 2, 3 and 4 include the presence of complaints of whatever degree.

Categories (WAC 296-20-540)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings of impairment of anal function. Subjective complaints may be present or absent.

Category 2. There are objective findings of mild organic disease, anatomic loss or alteration with loss of anal function and mild incontinence involving gas and/or liquid stool.

Category 3. There are objective findings of moderate anal disease, anatomic loss or alteration with loss of anal function and moderate incontinence requiring continual care.

Category 4. There are objective findings of marked anal disease, anatomic loss, alteration and/or complete fecal incontinence.

Liver and Biliary Tract

Rules (WAC 296-20-550)

1. Rule for evaluation of permanent liver and biliary tract impairments.

   (a) Categories 2, 3, 4 and 5 include complaints of whatever degree.

Categories (WAC 296-20-560)

Choose the category below which best describes the patient's impairment:

Category 1. There are no objective findings of impair-ment of the liver or biliary tract. Subjective complaints may be present or absent.

Category 2. There are objective findings on biochemical studies of minimal impairment of liver function with or without symptoms, or there are occasional episodes of loss of function of the biliary tract, but nutrition and strength are good.

Category 3. There are objective findings on biochemical studies of mild impairment of liver function without symptoms, or there is recurrent biliary tract impairment, but no ascites, jaundice or bleeding esophageal varices and nutrition and strength are good.

Category 4. There are objective findings on biochemical studies of moderate impairment of the liver function with jaundice, ascites, bleeding esophageal varices or gastric and nutrition and strength may be affected; or there is irreparable obstruction of the common bile duct with recurrent cholangitis.

Category 5. There are objective findings on biochemical studies of marked impairment of liver function and nutritional state is poor; or persistent jaundice, bleeding esophageal or gastric varices.

Extremity Ratings (Upper and Lower)

IMPORTANT NOTE FOR ALL UPPER EXTREMITY RATINGS (INCLUDING ALL AMPUTATIONS): You must complete the rating worksheet on pages 436-437 of the AMA *Guides*, Fifth Edition (Figure 16-1). You must make reference to the worksheet in the body of your report, and return the completed worksheet as an attachment to your report.

AMA *Guides* and RCW

Except for straight amputations (for which RCW is used--see Appendix C), impairment of the upper or lower extremities is generally rated using the edition of the American Medical Association *Guides* to the Evaluation of Permanent Impairment designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition.)

IMPORTANT NOTE: Be sure to attach worksheets used to formulate the rating so readers easily understand your methods. For example, the upper extremity worksheet on pages 436-437 of the AMA *Guides*, Fifth Edition is especially important.

IMPORTANT NOTE: Extremity ratings should NEVER be expressed as a percentage of whole person impairment (WPI, also known as Total Bodily Impairment or TBI).

- If the AMA *Guides* provides a whole person rating, you must convert it to the level of the whole extremity using a table such as Table 16-3 on page 439 or Table 17-3 on page 527 of the AMA *Guides*, Fifth Edition.
- If both right and left extremities are involved, you must present separate ratings for each extremity – do NOT combine to whole person.

Example: A worker had a left foot calcaneal fracture and an accepted diagnosis of Complex Regional Pain Syndrome (CRPS) of the left lower extremity. The combined impairment rating was 10% whole

person (WPI). Using Table 17-3 on page 527 of the AMA *Guides*, Fifth Edition, the final impairment rating is 26% impairment of the left lower extremity.

Rating Extremities Other Than Amputations

Extremities must be evaluated by a percentage rating system. To rate impairment of the upper and lower extremities, use the edition of the American Medical Association *Guides to the Evaluation of Permanent Impairment* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition.)

In rating extremities, please note the following important points:

- **IMPORTANT NOTE:** Be sure to attach worksheets used to formulate the rating so readers easily understand your methods. For example, the upper extremity worksheet on pages 436-437 of the AMA *Guides*, Fifth Edition is especially important.
- **Total joint replacement**: Impairment due to total joint replacement must be done using the AMA *Guides*. Use the edition of the AMA *Guides* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition. Currently the department has designated the Fifth Edition.)
- **Grip strength, pinch strength and manual muscle testing**: In accordance with the AMA *Guides*, Fifth Edition, strength measurements does not play a large role in rating impairment, partly because it is subject to the individual's conscious or unconscious control. (This is covered in Section 16.8 on pages 507 through 511, for example.) Therefore you must follow the AMA *Guides* and choose a method other than strength measurements. **In a rare case, if you feel strength measurement is appropriate, you must clearly and in detail explain the basis for your decision**. If your rationale does not clearly explain your reasoning, then it may be difficult for the Claim Manager to use your rating.
- **"Amputation Value":** You may be asked to express the rating as a percent of the "amputation value" of an extremity (or part of an extremity) in circumstances where the worker has not suffered an actual amputation. In this case, what the Claim Manager is asking for is a rating expressed as a percent of the entire extremity (or part of the extremity), which is provided in the AMA *Guides*.

Case example: A worker has undergone a right partial medial meniscectomy. The Claim Manager asks you for the amputation value of the worker's impairment. Use Table 17-33 on page 546 of the AMA *Guides*, Fifth Edition. That table gives you the rating of 2% of the lower extremity. In the "Rationale" portion of your report, simply explain how you concluded that the rating is 2% of the lower extremity, and be sure to state that your rating of 2% applies to the amputation value of the entire lower extremity (rather than the amputation value at the knee or at any other point). The Claim Manager will then clearly understand how to use this information to convert your impairment rating into the monetary PPD award (using the appropriate amputation values established by the legislature in statute).

Amputations

By law, your patient's monetary award for impairment from amputations is made according to the level of the amputation. Therefore, the AMA *Guides to the Evaluation of Permanent Impairment* should NOT be used for actual amputations.

The doctor should choose the level in Table 4 (from RCW 51.32.080) which best describes the patient's amputation. Your description of the impairment should correspond to one of the descriptions listed in the law. A case example for a simple amputation is presented on the next page.

CASE EXAMPLE

Amputation
Mr. F. sustained an amputation of his right dominant thumb. Attempted replantation failed, and he underwent revision of the amputation to the level of the metacarpal head.

Rating: As listed in RCW 51.32.080, this amputation corresponds most closely to "amputation of thumb at metacarpophalangeal joint."

Table 4: AMPUTATION LEVELS ACCORDING TO RCW 51.32.080
Select the level which best describes the patient's amputation.
See Appendix C for details.

Leg ■ Of leg above the knee joint with short thigh stump (3" or less below the tuberosity of ischium) ■ Of leg at or above knee joint with functional stump ■ Of leg below knee joint ■ Of leg at ankle (Syme) ■ Of foot at mid-metatarsals ■ Of great toe with resection of metatarsal bone	■ Of great toe at metatarsophalangeal joint ■ Of great toe at interphalangeal joint ■ Of lesser toes (2nd to 5th) with resection of metatarsal bone ■ Of lesser toe at metatarsophalangeal joint ■ Of lesser toe at proximal interphalangeal joint ■ Of lesser toe at distal interphalangeal joint

Table 4: AMPUTATION LEVELS ACCORDING TO RCW 51.32.080 Select the level which best describes the patient's amputation. See Appendix C for details.	
Arm ■ Of arm at or above the deltoid insertion or by disarticulation at the shoulder ■ Of arm at any point from below the deltoid insertion to below the elbow joint at the insertion of the biceps tendon ■ Of arm at any point from below the elbow joint distal to the insertion of the biceps tendon to and including mid-metacarpal amputation of the hand with resection of carpometacarpal bone ■ Of thumb at interphalangeal joint ■ Of all fingers except the thumb at metacarpophalangeal joints ■ Of thumb at metacarpophalangeal joint or with resection of metacarpal bone ■ Of index finger at metacarpophalangeal joint or with resection of metacarpal bone ■ Of index finger at proximal interphalangeal joint	■ Of index finger at distal interphalangeal joint ■ Of middle finger at metacarpophalangeal joint or with resection of metacarpal bone ■ Of middle finger at proximal interphalangeal joint ■ Of middle finger at distal interphalangeal joint ■ Of ring finger at metacarpophalangeal joint or with resection of metacarpal bone ■ Of ring finger at proximal interphalangeal joint ■ Of ring finger at distal interphalangeal joint ■ Of little finger at metacarpophalangeal joint or with resection of metacarpal bone ■ Of little finger at proximal interphalangeal joint ■ Of little finger at distal interphalangeal joint

Amputation AND Additional Loss of Function: If a patient has BOTH amputation AND additional loss of function to an extremity, two determinations need to be made:

1) Report the actual amputation, and
2) Using guidelines for rating extremities, rate the loss of function at the highest involved joint without taking into consideration the impairment caused by the actual amputation. For example, if a worker has loss of one finger and limitation of wrist motion, you would describe the amputation of the finger and then describe the impairment at the wrist.

Hearing Loss

AMA *Guides* and Worksheet

In the Washington State workers' compensation system, partial impairment of hearing is rated using the edition of the American Medical Association *Guides to the Evaluation of Permanent Impairment* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition.) To assist doctors in using the *Guides*, a two-page "Hearing Impairment

Calculation Worksheet" is included later in this chapter. Doctors are encouraged to photocopy this worksheet and include the completed worksheet with the written report.

IMPORTANT NOTE: Per the worksheet, if there is hearing loss in only one ear, you should not use the "combined hearing loss formula" in the box at the bottom of the worksheet.

In addition to the worksheet, please provide the audiogram with your report. Also, indicate if you recommend a hearing aid or other intervention.

If hearing loss is complete, report it as: (1) Complete loss of hearing in both ears, or (2) Complete loss of hearing in one ear. See RCW 51.32.080, Permanent partial disability, miscellaneous, Appendix C.

Audiometric Testing

Audiometric testing should be performed at least 14 hours after the last exposure to noise. Prosthetic devices (e.g., hearing aids) must not be used during the evaluation of hearing sensitivity.

There are no laws or regulations under the industrial insurance statutes pertaining to standards for audiometric testing. However, there are several laws, regulations, and policies which may be pertinent in certain cases:

- Hearing aid establishments need to be licensed and need to employ at least one licensed fitter-dispenser at all times, and must annually submit proof that all audiometric equipment at that establishment has been properly calibrated (RCW 18.35.030). This statute is administered by the Washington State Department of Health.
- Employers must establish and maintain a mandatory audiometric testing program for all employees whose exposures equal or exceed an 8-hour time-weighted average of 85 dBA, as provided in Part K of the General Occupational Health Standards (WAC 296-62-09027). Audiometric tests must be performed by a licensed or certified audiologist, otolaryngologist, or other qualified physician, or by a technician who is certified by the Council of Accreditation in Occupational Hearing Conservation. A technician who performs audiometric tests must be responsible to an audiologist, otolaryngologist, or other qualified physician. Mandatory appendices in the standard cover the audiometric testing requirements (for example, booth requirements, audiometer calibration, etc.). This regulation (WAC 296-62-090, Part K, Hearing Conservation Standard) is administered by the Department of Labor and Industries, Section of Compliance and Consultation.
- The American Medical Association *Guides to the Evaluation of Permanent Impairment*, Fifth Edition, instructs doctors to use an audiometer that is calibrated according to American National Standards Institute (ANSI) audiometer specifications S3.6-1996 (or more recent ANSI specifications). The date of the most recent audiometer calibration should be specified in each audiometry report. Also, the same regulations that apply for mandatory audiometric testing programs apply to audiometric testing to determine impairment for hearing loss claims.

Presbycusis

In the Washington state workers' compensation system, partial impairment of hearing is rated using the edition of the American Medical Association *Guides to the Evaluation of Permanent Impairment* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition.) Rating of work-related hearing impairment due to noise exposure is not apportioned between age-related hearing impairment and work-related hearing impairment.

Because the effect of noise on hearing does not progress after the cessation of exposure, it is important to base impairment ratings on valid audiometric testing performed as close as possible to the last work-related exposure (whenever such tests are readily available). In some cases, a claim is filed and the sole valid audiogram was performed years after the claimant has ceased working with injurious noise.

Regardless of when the audiogram is performed, the award will be based on the schedule of benefits in effect at the time hearing loss became manifest, which is the earlier of when hearing loss required medical treatment or became disabling. "Disabling" could be demonstrated by a valid audiogram.

By way of example: An 85-year-old files a claim in 1996 for occupational hearing loss. Although his last exposure to injurious workplace noise was in 1976, the first valid audiogram was performed in 1996. The 1996 audiogram shows 10% bilateral hearing loss. Rather than pay the award according to the 1996 schedule of benefits, the department would look to the schedule in effect no later than the date of the last exposure in 1976. The department would not use a schedule of benefits later than the last date of injurious exposure. In this example, if that 85-year-old had a valid audiogram or received hearing aids in 1971 (and a hearing loss claim had not previously been filed), the department would look to the schedule in effect in 1971, as the audiogram/hearing aid would be documentation of the manifestation of the hearing loss condition.

As always, please refer to department publications and/or information on the web for the most current information on this topic.

Tinnitus

A physician may choose to rate (or not rate) tinnitus, according to his/her medical judgment and the specifics of each individual patient. When a physician chooses to rate tinnitus, he or she must use the edition of the American Medical Association *Guides to the Evaluation of Permanent Impairment* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition.) The physician may add up to 5% (depending on severity). (See the "Hearing Impairment Calculation Worksheet" later in this chapter to understand how the amount added to each ear is translated into a binaural value.) To assess severity, the physician may wish to consider such factors as: whether the tinnitus is constant or intermittent; the perceived loudness of the tinnitus; and whether the tinnitus interferes with the patient's ability to detect noises and/or interferes with perception or comprehension of speech.

According to department policy, physicians may rate tinnitus only in the presence of an otherwise compensable unilateral or bilateral hearing loss. If there is no otherwise compensable hearing loss, there is no award for tinnitus.

Tinnitus awards cannot exceed 5% during a worker's lifetime.

Department of Labor & Industries
Office of The Medical Director
PO Box 44321
Olympia WA 98504-4321

HEARING IMPAIRMENT CALCULATION WORKSHEET

Date	Date of audiogram	Claim number
10/1/05	7/5/05	A111111
Name: Joe Worker		Hours since last exposure to noise (must be more than 14): 48

Monaural Hearing Loss Formula: A.N.S.I. 1969

([([500 Hz + 1000 Hz + 2000 Hz + 3000 Hz] ÷ 4) - 25] x 1.5) = % of loss

LEFT EAR (X)

Hz	dB level
500	35
1000	25
2000	20
3000	35
Total	115

STOP here if total is 100 or less

Avg threshold for 4 frequencies	÷ 4 =	28.75
Less threshold fence of 25 dB	- 25 =	3.75
Multiplied by 1.5 equals the % of monaural loss	x 1.5 =	5.63
Add rating for tinnitus of 0 through 5%		2.0
Total percent monaural hearing loss		7.63

RIGHT EAR (0)

Hz	dB level
500	35
1000	25
2000	20
3000	25
	105

STOP here if total is 100 or less

Avg threshold for 4 frequencies	÷ 4 =	26.25
Less threshold fence of 25 dB	- 25 =	1.27
Multiplied by 1.5 equals the % of monaural loss	x 1.5 =	1.88
Add rating for tinnitus of 0 through 5%		2.0
Total percent monaural hearing loss		3.88

STOP HERE IF EITHER OF THE MONAURAL HEARING LOSS %'s ARE ZERO!!!

****

Combined Hearing Loss Formula:

([% better ear x 5] + [% worse ear]) ÷ 6 = % of loss

% better ear 3.88	x 5 =	19.4
Plus % worse ear	+	7.63
	Sub-Total	27.03
Sub-Total divided by 6	÷ 6 =	4.51 % Binaural Hearing Loss

F252-007-000 hearing impairment calculation worksheet 9-00

Department of Labor & Industries
Office of The Medical Director
PO Box 44321
Olympia WA 98504-4321

HEARING IMPAIRMENT CALCULATION WORKSHEET

Date	Date of audiogram	Claim number
Name		Hours since last exposure to noise (must be more than 14)

Monaural Hearing Loss Formula: A.N.S.I. 1969

([([500 Hz + 1000 Hz + 2000 Hz + 3000 Hz] ÷ 4) - 25] x 1.5) = % of loss

LEFT EAR (X)

Hz	dB level
500	
1000	
2000	
3000	
Total	

STOP here if total is 100 or less

Avg threshold for 4 frequencies	÷ 4 =
Less threshold fence of 25 dB	- 25 =
Multiplied by 1.5 equals the % of monaural loss	x 1.5 =
Add rating for tinnitus of 0 through 5%	
Total percent monaural hearing loss	

RIGHT EAR (0)

Hz	dB level
500	
1000	
2000	
3000	

STOP here if total is 100 or less

Avg threshold for 4 frequencies	÷ 4 =
Less threshold fence of 25 dB	- 25 =
Multiplied by 1.5 equals the % of monaural loss	x 1.5 =
Add rating for tinnitus of 0 through 5%	
Total percent monaural hearing loss	

STOP HERE IF EITHER OF THE MONAURAL HEARING LOSS %'s ARE ZERO!!!

****

Combined Hearing Loss Formula:

([% better ear x 5] + [% worse ear]) ÷ 6 = % of loss

% better ear	x 5 =	
Plus % worse ear	+	
	Sub-Total	
Sub-Total divided by 6	÷ 6 =	% Binaural Hearing Loss

F252-007-000 hearing impairment calculation worksheet 9-00

Hernia (Inguinal, Umbilical, etc.)

Impairment due to hernias (inguinal, umbilical, etc.) should be rated using the AMA *Guides*. **PLEASE NOTE: You must give an exact percentage, NOT a range of percentages.** This section of the AMA *Guides*, like several others, instructs the rating examiner to choose Class 1, 2 or 3, each with a range of percentages. After you decide the appropriate Class, you must give your best estimate of a specific percentage (not a range), based on your best clinical judgment. Without your estimate of the exact percentage the Claim Manager will not be able to calculate the impairment award. Per the AMA *Guides*, your percentage will be a percent of whole person impairment (WPI, or total bodily impairment, TBI). Whole person impairments are not appropriate for the vast majority of impairment ratings, but for hernias, you should state clearly in your report that your rating is a percent of whole person impairment.

Mental Health

The section below focuses on rating impairment from mental health conditions. Refer to Chapter 7, "Psychiatric IME Reports" for general information about mental health IME reports, including assessment of work-relatedness.

Use objective observations and/or findings to support your conclusions. For example, document observed behaviors, etc. – not only what the worker reports. Document discrepancies between your objective observations and what the worker reports.

Cognitive Impairment vs. Psychiatric Impairment

If an injury or illness results in impairment which is primarily psychiatric in nature, the Category Rating System must be used (described below). If the impairment is primarily cognitive in nature or involves some other dysfunction of the central nervous system, use the AMA *Guides*. Use the edition of the AMA *Guides* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition. Currently the department has designated the Fifth Edition.)

If there are both significant cognitive impairment and mental health impairment, then they should be rated separately using both the Category Rating System and the AMA *Guides*.

Stress Not Covered

Stress-related conditions (such as, stress from financial difficulties, employment, claim management) are not compensable as an occupational disease under the Washington Industrial Insurance Act. See the RCW and WAC in Chapter 7, "Psychiatric IME Reports."

General Requirements for Rating Mental Health Impairment

IMPORTANT NOTES

- **Only rate impairment that is due to the accepted industrial injury or occupational disease. WAC 296-20-330 1(b).**
- **Do not rate impairment when the quality of daily life does not differ substantially from the pre-injury pattern. WAC 296-20-330 1(f).**

The five following components are required of all rating reports:	
1) MMI	**Do not rate impairment unless it is medically probable that the emotional reactions are permanent.** WAC 296-20-330 1(g). If the worker is at maximum medical improvement (MMI), include a statement that the patient has reached MMI and that no further curative treatment is recommended.
2) Examination	Details of the physical or psychiatric examination performed (both positive and negative findings). Your report must include your assessment of pre-injury (baseline) and post- injury pattern of "adjustment to life" and the impact of the accepted mental condition on "ordinary living." Include assessment of: a. Activities of daily living b. Social functioning c. Thinking, concentration and judgment d. Adaptation to work and non-work obligations. State whether the differences in "adjustment patterns" after the industrial condition are more than the "normal, self-correcting and expectable response to the stress of the industrial condition." WAC 296-20-330 1(d).
3) Diagnostic tests	Results of any diagnostic tests performed (both positive and negative). Include copies of pertinent tests ordered as part of the exam.
4) Rating	An impairment rating consistent with the findings and a statement of the system on which the rating was based (e.g., Washington State Category Rating System, or the AMA *Guides* for cognitive or other dysfunction of the central nervous system). **Only rate impairment due to the accepted industrial injury or occupational disease.** WAC 296-20-330 1(b).
5) Rationale	Rationale for the rating in your report is one of the most important elements. Your rationale must restate objective observations and findings and give your supporting documentation. WAC 296-20-2010 & WAC 296-23-377 **Do not rate impairment when the quality of daily life does not differ substantially from the pre-injury pattern.** WAC 296-20-330 1(f). If your rationale does not clearly explain whether and how the worker's quality of daily life differs from the pre-injury pattern, then it may be difficult for the Claim Manager to use your rating.

Rules (WAC 296-20-330)

1. Rules for evaluation of permanent impairment of mental health:

   (a) Mental illness means malfunction of the psychic apparatus that significantly interferes with ordinary living.

   (b) Each person has a pattern of adjustment to life. The pattern of adjustment before the industrial injury or occupational disease serves as a base line for all assessments of whether there has been a permanent impairment due to the industrial injury or occupational disease.

   (c) To determine the preinjury pattern of adjustment, all evaluations of mental health shall contain a complete preinjury history including, but not necessarily limited to: Family background and the relationships with parents or other nurturing figures; extent of education and reaction to it; military experience, if any; problems with civil authorities; any history of prolonged illness, and difficulty with recovery; any history of drug abuse or alcoholism; employment history, the extent of and reaction to responsibility, and relationships with others at work; capacity to make and retain friends; relationships with spouses and children; nature of daily activities, including recreation and hobbies; and lastly, some summary statement about the sources of the patient's self-esteem and sense of identity. Both strengths and vulnerabilities of the person shall be included.

   (d) Differences in adjustment patterns before and after the industrial injury or occupational disease shall be described, and the report shall contain the examining physician's opinion as to whether any differences:

      (1) Are the result of the industrial injury or occupational disease and its sequelae, in the sense they would not have occurred had there not been the industrial injury or occupational disease;
      (2) are permanent or temporary;
      (3) are more than the normal, self-correcting and expectable response to the stress of the industrial injury or occupational disease;
      (4) constitute an impairment psychosocially or physiologically; and
      (5) are susceptible to treatment, and, if so, what kind. The presence of any unrelated or coincidental mental impairment shall always be mentioned.

   (e) All reports of mental health evaluations shall use the diagnostic terminology listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

   (f) No classification of impairment shall be made for complaints where the quality of daily life does not differ substantially from the preinjury pattern. A patient not currently employed may not engage in the same activities as when working, but the level and variety of his activities and zest for them shall distinguish the purely situational difference from cases of regression and withdrawal. In cases where some loss of use of body member is claimed, no category or impairment shall be assigned unless there are objective findings of physiologic regression or consistent evidence of altered adaptability.

(g) The physician shall identify the schizoid, antisocial, inadequate, sociopathic, passive, hysterical, paranoid, or dependent personality types. Patients with these longstanding character disorders may show problem behavior that seems more related to current stress than it is, sometimes unconsciously insinuating themselves into difficult situations of which they then complain. Emotional reactions to an injury and subsequent events must be carefully evaluated in these patients. It must be medically probable that such reactions are permanent before a category of impairment can be attributed to the injury; temporary reactions or preexisting psychopathology must be differentiated.

Categories (WAC 296-20-340)

Choose the category below which best describes the patient's impairment:

Category 1 Nervousness, irritability, worry or lack of motivation following an injury and commensurate with it and/or other situational responses to injury that do not alter significantly the life adjustment of the patient may be present.

Category 2

- Any and all permanent worsening of preexisting personality traits or character disorders where aggravation of preexisting personality trait or character disorder is the major diagnosis;
- mild loss of insight, mildly deficient judgment, or rare difficulty in controlling behavior;
- anxiety with feelings of tension that occasionally limit activity;
- lack of energy or mild apathy with malaise;
- brief phobic reactions under usually avoidable conditions;
- mildly unusual and overly rigid responses that cause mild disturbance in personal or social adjustment;
- rare and usually self-limiting psycho-physiological reactions;
- episodic hysterical or conversion reactions with occasional self limiting losses of physical functions;
- a history of misinterpreted conversations or events, which is not a preoccupation;
- is aware of being absentminded, forgetful, thinking slowly occasionally or recognizes some unusual thoughts;
- mild behavior deviations not particularly disturbing to other;
- shows mild over-activity or depression;
- personal appearance is mildly unkempt.

Despite such features, productive activity is possible most of the time. If organicity is present, some difficulty may exist with orientation; language skills, comprehension, memory; judgment; capacity to make decisions; insight; or unusual social behavior; but the patient is able to carry out usual work day activities unassisted.

Category 3

- Episodic loss of self-control with risk of causing damage to the community or self;
- moments of morbid apprehension;
- periodic depression that disturbs sleep and eating habits or causes loss of interest in usual daily activities but self-care is not a problem;
- fear motivated behavior causing mild interference with daily life;
- frequent emotogenic organ dysfunctions requiring treatment;
- obsessive-compulsive reactions which limit usual activity;
- periodic losses of physical function from hysterical or conversion reactions;
- disturbed perception in that patient does not always distinguish daydreams from reality;
- recognizes his/her fantasies about power and money are unusual and tends to keep them secret;
- thought disturbances cause patient to fear the presence of serious mental trouble;
- deviant social behavior can be controlled on request;
- exhibits periodic lack of appropriate emotional control;
- mild disturbance from organic brain disease such that a few work day activities require supervision.

Category 4

- Very poor judgment, marked apprehension with startle reactions, foreboding leading to indecision, fear of being alone and/or insomnia;
- some psychomotor retardation or suicidal preoccupation;
- fear-motivated behavior causing moderate interference with daily life;
- frequently recurrent and disruptive organ dysfunction with pathology of organ or tissues;
- obsessive-compulsive reactions causing inability to work with others or adapt;
- episodic losses of physical function from hysterical or conversion reactions lasting longer than several weeks;
- misperceptions including sense of persecution or grandiosity which may cause domineering, irritable or suspicious behavior;
- thought disturbance causing memory loss that interferes with work or recreation;
- periods of confusion or vivid daydreams that cause withdrawal or reverie;
- deviations in social behavior which cause concern to others;
- lack of emotional control that is a nuisance to family and associates;
- moderate disturbance from organic brain disease such as to require a moderate amount of supervision and direction of work day activities.

Category 5

- Marked apprehension so as to interfere with memory and concentration and/or to disturb markedly personal relationships;
- depression causing marked loss of interest in daily activities, loss of weight, unkempt appearance, marked psychomotor retardation, suicidal preoccupation or disruptive

behavior;

- psychophysiological reactions resulting in lasting organ or tissue damage;
- obsessive-compulsive reactions that preclude patient's usual activity;
- frequent or persistent loss of function from conversion or hysterical reactions with regressive tissue or organ change;
- defects in perception including frank illusions or hallucinations occupying much of the patient's time;
- behavior deviations so marked as to interfere seriously with the physical or mental well-being or activities of others;
- lack of emotional control including marked irritability or over activity.

Respiratory and Air Passages

Respiratory

Rules–For claims with a date of injury before March 1, 1994 (WAC 296-20-370)

1. Rules for evaluation of permanent respiratory impairments:

   (a) All reports of physical examination of persons for respiratory impairment shall include: Date of examination, name, sex, address, birth date, marital status, and occupation of the person being examined; height, weight, temperature, pulse rate, blood pressure and respiratory rate and physical findings on inspection, palpation, percussion, and auscultation, vital capacity tests including one-second forced expiratory volume, forced vital capacity and maximum voluntary ventilation; all symptoms such as wheeze, cough, orthopnea, chest pain, paroxysmal nocturnal dyspnea, expectoration, hemoptysis, as to date of onset, course with descriptions, variation, whether influenced by bodily activity, emotional stress, posture, allergens, immediate environmental factors, medications, frequency and duration, and how they are affected by respiratory infections; the history of the particular exposure, a history of any previous chest x-rays, any allergies, cardiac symptoms or diagnosis, chest surgery or deformities, trauma, or other conditions such as pneumothorax, pulmonary infarct or chemical bronchitis; all pertinent personal history of habits such as smoking, weight gain or loss, fatigability, appetite; use of medications such as steroids, digitalis, antibiotics, bronchodilators, expectorants, etc., and occupational history.

   (b) Categories 2 through 6 in WAC 296-20-380 include the presence of complaints of whatever degree.

   (c) Dyspnea is the major complaint of respiratory impairment, and can usually be explained by the presence of abnormal lung ventilation, perfusion, or diffusion, measured either at rest or exercise. Since mechanisms of respiratory tract damage may differ widely, individual lung functions tests may not wholly correspond to the following categories of impairment, but the examining physician should be able to categorize the vast majority of persons, using a "best fit" method for the following respiratory impairment Categories I through VI.

(d) Persisting variable respiratory impairment due to allergic or irritative disorders or the respiratory tract, such as bronchial asthma or reactive airway disease, caused or substantially aggravated by factors in the work place, shall be evaluated by detailed narrative report, including rationale for the work relationship, relative importance of nonwork-related co-factors, such as preexisting asthma, tobacco usage, or other personal habits, the need for regular medication to substantially improve or control the respiratory condition, and the prognosis. If tests of ventilatory function, done when the person is in clinical remission, are nearly normal (1) second forced expiratory volume 80 percent or greater of predicted, (2) an appropriate provocative bronchial challenge test should be done to demonstrate the presence of unusual respiratory sensitivity. When the respiratory condition (asthma or reactive airway disease) is thought to be permanent, but the degree of respiratory impairment varies, then the examining physician shall give an estimate of percentage of total bodily impairment, as per Rule 15 or WAC 296-20-220.

Rules—For claims with a date of injury on or after March 1, 1994 (WAC 296-20-370)

1. Rules for evaluation of permanent respiratory impairments:

(a) Definitions.

i. "FEV1" means the forced expiratory volume in 1 second as measured by a spirometric test performed as described in the most current *American Thoracic Society Statement on Standardization of Spirometry*, and using equipment, methods of calibration, and techniques that meet American Thoracic Society (ATS) criteria including reproducibility. The measurement used must be taken from a spirogram which is technically acceptable and represents the patient's best effort. The measurement is to be expressed as both an absolute value and as a percentage of the predicted value. The predicted values are those listed in the most current edition of the *American Medical Association (AMA) Guidelines* for rating permanent respiratory impairment.

ii. "FVC" means the forced vital capacity as measured by a spirometric test in accordance with criteria described in (a)(i) of this subsection.

iii. "FEV1/FVC" is a ratio calculated based on the ATS Guides criteria as described in the most current American Thoracic Society Statement on Standardization of Spirometry.

iv. "Significant improvement" means a fifteen percent or greater improvement in FEV1 (volume) after a post-bronchodilator pulmonary function test.

v. "DLCO" means the diffusion capacity of carbon monoxide as measured by a test based on predicted values demonstrated to be appropriate to the techniques and equipment of the laboratory performing the test according to current ATS standards. DLCO may be considered for impairment rating only if accompanied by evidence of impaired gas exchange based on exercise testing.

vi. "VO2 Max" means the directly measured oxygen consumption at maximum exercise capacity of an individual as measured by exercise testing and oxygen consumption expressed in ml/kilo/min corrected for lean body-weight. Estimated values from treadmill or other exercise tests without direct measurement are not acceptable. The factor limiting the exercise must be identified.

vii. "Preexisting impairment" shall be reported as described in WAC 296-20-220 (l)(h).
viii. "Coexisting" is a disease or injury not due to or causally related to the work-related condition that impacts the overall respiratory disability.
ix. "Apportionment" is an estimate of the degree of impairment due to the occupational injury/exposure when preexisting or coexisting conditions are present.
x. "Dyspnea" is the subjective complaint of shortness of breath. Dyspnea alone must not be used to determine the level of respiratory impairment. Dyspnea unexplained by objective signs of impairment of spirometry requires more extensive testing (i.e., VO2 Max).
xi. Copies of the *American Thoracic Society Statement on Standardization of Spirometry* and ATS standards for measuring DLCO can be obtained by ordering *Pulmonary Function Testing* from The American Thoracic Society, 17640 Broadway, New York, NY 10019-4374, Attn: ATS Statements. Copies of this document are available for review in the section of the Office of the Medical Director, Department of Labor & Industries, Tumwater building.

These standards are also available through the following references: "American Thoracic Society of Committee on Proficiency Standards for Pulmonary Function Laboratories: Standardization of Spirometry-1987 update." *Am Rev Respir Dis* 1987; 136:1285-1298. "American Thoracic Society DLCO Standardization Conference: Single breath carbon monoxide diffusing capacity (transfer factor): Recommendations for a standard technique." *Am Rev Respir Dis* 1987; 136:1299-13707.

(b) Evaluation procedures. Each report of examination must include the following, at a minimum:

i. Identification data: Worker's name, claim number, gender, age, and race.
ii. Detailed occupational history: Job titles of all jobs held since employment began. A detailed description of typical job duties, protective equipment worn, engineering controls present (e.g., ventilation) as well as the specific exposures and intensity (frequency and duration) of exposures. More detail is required for jobs involving potential exposure to known respiratory hazards.
iii. History of the present illness: Chief complaint and description of all respiratory symptoms present (e.g., wheezing, cough, phlegm, chest pain, paroxysmal nocturnal dyspnea, dyspnea at rest and on exertion) as well as the approximate date of onset, and duration of each symptom, and aggravating and relieving factors.
iv. Past medical history: Past history of childhood or adult respiratory illness, hay fever, asthma, bronchitis, chest injury, chest surgery, respiratory infections, cardiac problems, hospitalizations for chest or breathing problems and current medications.
v. Lifestyle and environmental exposures: Descriptive history of exposures clinically related to respiratory disease including, but not limited to, tobacco use with type and years smoked. Use of wood as a primary heat source at home or hobbies that involve potential exposure to known respiratory tract hazards, and other environmental exposures.
vi. Family history: Family history of respiratory or cardiac disease.

vii. Physical examination findings: Vital signs including a measured height without shoes, weight, and blood pressure. Chest exam shall include a description of the shape, breathing, breath sounds, cardiac exam, and condition of extremities (e.g., cyanosis, clubbing, or edema).

viii. Diagnostic tests: A chest x-ray shall be obtained in all cases. When available, the x-ray should be obtained using International Labor Organization (ILO) standard techniques and interpreted using the ILO classification system. The presence or absence of pleural thickening or interstitial abnormalities shall be noted. Also include pulmonary function reports including a description of equipment used, method of calibration, and the predicted values used. A hard copy of all pulmonary functions tracings must be available for review. The report must contain a minimum FEV1 and FVC and a narrative summary of an interpretation of the test results and their validity.

ix. The rating of respiratory impairment. The rating of respiratory impairment shall be based on the pulmonary function test most appropriate to the respiratory condition. A prebronchodilator and postbronchodilator test must be performed on and results reported for all patients with demonstrated airway obstruction. The largest FEV1 of FVC, on either the prebronchodilator or postbronchodilator trial must be used for the rating impairment. If the FEV1 and FEV1/FVC result in different categories of impairment, the value resulting in a higher category on impairment will be used.

x. The rating of persisting variable respiratory impairment with abnormal baseline function. If resting FEV1 is “abnormal” (below eighty percent predicted) and shows significant bronchodilator improvement (a greater than or equal to fifteen percent improvement in FEV1) one category of impairment must be added to the given category rating, but only when the work-related disease being rated is obstructive in nature. If there is substantial variability from test to test (and good effort) the severity of impairment may be rated, using the best fit into the category system, as described in WAC 296-20-380.

xi. The rating of persisting variable respiratory impairment with normal baseline spirometry. Variable respiratory impairment due to allergic or irritative disorder of the respiratory tract, such as bronchial asthma or reactive airway disease, caused or permanently aggravated by factors in the work place, shall be evaluated by detailed narrative report, including the causal relationship to work factors, a discussion of the relative importance of nonwork related cofactors, such as preexisting asthma, tobacco usage, or other personal habits, the need for regular medication to substantially improve or control the respiratory condition, and the prognosis. When tests of ventilatory function, done when the patient is in a clinical steady state, are normal (one second forced expiratory volume eighty percent or greater if predicted), an appropriate provocative bronchial challenge test (i.e., methacholine or histamine) shall be done to demonstrate the presence of unusual respiratory sensitivity.

xii. At the time of the rating, the patient shall be off theophylline for at least twenty-four hours, beta agonists for at least twelve hours, and oral and/or inhaled steroids or cromolyn for at least two weeks, in order to determine severity of air-flow obstruction, unattenuated by therapy. If withdrawal of medication would produce a

hazardous or life threatening condition, then the impairment cannot be rated at this time, and the physician must provide a statement describing the patient's condition and the effect of medication withdrawal.

xiii. The method for standardizing provocative bronchial challenge testing, using either histamine or methacholine, shall be used. The test drug may be given either by continuous tidal volume inhalation of known concentrations, using an updraft nebulizer, for two minutes, or by the technique of intermittent deep breaths of increasing test drug strengths either via a Rosenthal dosimeter or updraft nebulizer, and the results shall be expressed either as the mg/ml concentration of test drug, or the cumulative breath units (1 breath of a 1 mg/ml solution equals one breath unit) which result in a prompt and sustained (at least three minute) fall in the FEV1, greater than twenty percent below baseline FEV1. Medications that can blunt the effect of bronchoprovocation testing shall be withheld prior to testing. Once testing is complete, the results shall be expressed in terms of normal, mild, moderate, or marked bronchial reactivity, as described in WAC 296-20-385.

If multiple bronchoprocative inhalation challenge tests have been done, the examining physician shall select the one category (normal, mild, moderate, or marked) which most accurately indicates the overall degree of permanent impairment at the time of rating.

If the results of serial pulmonary function testing are extremely variable and the clinical course and use of medication also indicate major impairment, then the physician must make a statement in the formulation and medical evaluation containing, at a minimum: Diagnosis and whether work-related or nonwork-related; nature and frequency of treatment; stability of condition and work limitations; impairment.

xiv. Further treatment needs. In all cases, the examining physician shall indicate whether further treatment is indicated and the nature, type, frequency, and duration of treatment recommended.

Categories of permanent respiratory impairments – For Claims with a date of injury before March 1, 1994 (WAC 296-20-380)

Category 1. Tests of ventilatory functions are not less than 85 percent of predicted normal for the person's age, sex and height. Arterial oxygen saturation at rest and after exercise is 93 percent or greater. Subjective complaints may be present or absent.

Category 2. Tests of ventilatory function range from 70 to 85 percent of predicted normal for the person's age, sex and height. Arterial oxygen saturation at rest and after exercise is 93 percent or greater. Dyspnea consistent with ventilatory function and arterial oxygen saturation.

Category 3. Tests of ventilatory function range from 60 to 70 percent of predicted normal for the person's age, sex and height and/or arterial oxygen saturation at rest is normal but after exercise is 88 to 93 percent. Dyspnea consistent with ventilatory function and arterial oxygen saturation.

Category 4. Tests of ventilatory function range from 50 to 60 percent of predicted normal for the person's age, sex and height. Arterial oxygen saturation at rest and after exercise is 88 to

93 percent. The single breath diffusing capacity (if performed) is greater than 50 percent predicted. Dyspnea consistent with ventilatory function and arterial oxygen saturation.

Category 5. Tests of ventilatory function range from 40 to 50 percent of predicted normal for the person's age, sex and height. Arterial oxygen saturation at rest and after exercise is less than 88 percent. The single breath diffusing capacity is greater than 40 percent predicted. Dyspnea consistent with ventilatory function and arterial oxygen saturation.

Category 6. Tests of ventilatory function are below 40 percent of predicted normal for the person's age, sex and height. Arterial oxygen saturation at either rest or exercise is less 83 percent or less. The single breath diffusing capacity is 40 percent or less of predicted. Grade III or IV dyspnea is present, measured on a scale of 0 to 4.

Categories of permanent respiratory impairments – For claims with a date of injury on or after March 1, 1994 (WAC 296-20-380)

Choose the category below which best describes the patient's impairment:

Category 1. The FVC and FEV1 are greater than or equal to eighty percent of predicted normal for the person's age, sex and height. The FEV1/FVC ratio is greater than or equal to .70. Subjective complaints may be present or absent. If exercise testing is done, the maximum oxygen consumption is greater than 25cc/kilo/min.

Category 2. The FVC or FEV1 is from seventy to seventy-nine percent of predicted, and if obstruction is present, the FEV1/FVC ratio is .60-.69. If exercise testing is done, the maximum oxygen consumption is 22.5-25cc/kilo/min.

Category 3. The FVC or FEV1 is from sixty to sixty-nine percent of predicted, and if obstruction is present, the FEV1/FVC ratio is .60-.69. If exercise testing is done, the maximum oxygen consumption is 20-22.4cc/kilo/min.

Category 4. The FVC or FEV1 is from fifty-one to fifty-nine percent of predicted. The FEV1/FVC ratio is .51-.59. If exercise testing is done, the maximum oxygen consumption is 17.5-19.9cc/kilo/min.

Category 5. FVC from fifty-one to fifty-nine percent of predicted, or the FEV1 from forty-one to fifty percent of predicted, and if obstruction is present, the FEV1/FVC ratio is .41-.50. If exercise testing is done, the maximum oxygen consumption is 15-17.4cc/kilo/min.

Category 6. The FVC is equal to or less than fifty percent of predicted or the FEV1 is equal to or less than forty percent of predicted. The FEV1/FVC ratio is equal to or less than .40. If exercise testing is done, the maximum oxygen consumption is less than 15cc/kilo/min.

Categories of persisting variable respiratory impairment with normal baseline spirometry–for claims with a date of injury on or after March 1, 1994 (WAC 296-20-385)

Choose the category below which best describes the patient's impairment:

Category 1. "Normal" bronchial reactivity is demonstrated by an insignificant (less than twenty percent) fall from baseline FEV1 at test doses of histamine or methacholine, up to 16mg/ml (continuous inhalation method) or up to 160 breath units (cumulative, repeated deep breath technique).

Category 2. "Mild" bronchial hyperactivity (BHR) is a significant (equal to or greater than twenty percent) fall in the FEV1 at test doses of 2.1-16-mg/ml, or 21-160 breath units.

Category 3. "Moderate" BHR is a significant (equal to or greater than twenty percent) fall in the FEV1 at test doses of 0.26-2-mg/ml, or 2.6-20 breath units.

Category 4. "Marked" BHR is a significant (equal to or greater than twenty percent) fall in FEV1 at test doses equal to or less than .25 mg/ml, or 2.5 breath units.

Air Passages

Rules (WAC 296-20-390)

1. Rule for evaluation of permanent air passage impairments:

   (a) Categories 2, 3, 4 and 5 include the presence of complaints of whatever degree.

Categories (WAC 296-20-400)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings are present. Subjective complaints may be present or absent.

Category 2. Objective findings of one or more of the following air passage defects: partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, complete obstruction of nasopharynx or of nasal passages bilaterally. No dyspnea caused by the air passage defect even on activity requiring prolonged exertion or intensive effort.

Category 3. Objective findings of one or more of the following air passage defects: partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, complete obstruction of nasopharynx or of nasal passages bilaterally, dyspnea caused by the air passage defect produced only by prolonged exertion or intensive effort.

Category 4. Objective findings of one or more of the following air passage defects: partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, complete obstruction of nasopharynx or of nasal passages bilaterally, with permanent tracheostomy or stoma, dyspnea caused by the air passage defect produced only by prolonged exertion or intensive effort.

Category 5. Objective findings of one or more of the following air passage defects: partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, with or without permanent tracheostomy or stoma if dyspnea is produced by moderate exertion.

Category 6. Objective findings of one or more of the following air passage defects: partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, with or without permanent tracheostomy or stoma if dyspnea is produced by mild exertion.

Nasal Septum Perforations

Rules (WAC 296-20-410)

1. Rules for evaluation of permanent air passage impairments due to nasal septum perforation.

(a) These categories, if appropriate, are to be used in addition to the Categories of Permanent Air Passage Impairment.

(b) Categories 1 and 2 include complaints of whatever degree.

Categories (WAC 296-20-420)
Choose the category below which best describes the patient's impairment:

Category 1. Perforation or perforations posterior to the cartilaginous septum.

Category2. Perforation or perforations through or anterior to the cartilaginous septum.

Chronic Sinusitis

The AMA *Guides* should be used for rating of impairment from chronic sinusitis.

Skin

Rules (WAC 296-20-470)
1. Rules for evaluation of permanent skin impairments.

(a) Evaluation of permanent impairment of the skin shall be based upon actual loss of function and cosmetic factors shall not be considered.

(b) Categories 2, 3, 4, 5 and 6 include the presence of complaints of whatever degree.

Categories (WAC 296-20-480)
Choose the category below which best describes the patient's impairment:

Category 1. Objective findings of skin disorder may be present or absent but there is no, or minimal limitation in daily activities. Subjective complaints may be present or absent.

Category 2. Objective findings of skin disorder are present and there is discomfort and minimal limitation in the performance of daily activities.

Category 3. Objective findings of skin disorder are present and there is limitation in some daily activities, including avoidance of and protective measures against certain chemical or physical agents. Intermittent symptomatic treatment is required.

Category 4. Objective findings of skin disorders are present and there is limitation in many daily activities, including avoidance of and protective measures against certain chemical or physical agents. Continuous symptomatic treatment is required.

Category 5. Objective findings of skin disorder are present and there is limitation in most daily activities, including avoidance of and protective measures against certain chemical or physical agents. Continuous symptomatic treatment is required.

Category 6. Objective findings of skin disorder are present and there is limitation in all daily activities, including avoidance of and protective measures against certain chemical or physical agents. Continuous symptomatic treatment is required.

IMPORTANT NOTE: "Skin" is viewed as an organ system under the WAC rules. In using these WACs on skin impairment, be aware of the following points:

1) If a body part has been amputated and significant skin grafting is required (for example, after a de-gloving accident), it may be appropriate to rate skin impairment in addition to the impairment from the amputation itself. Also, it may be appropriate to rate impairment from the donor site for the skin grafts. In all cases, the impairment must be based on the factors included in WAC 296-20-470 and 296-20-480. For example, the impairment must be based in part on the effects on daily activities, and those effects must be clearly documented and included in the rationale section of your impairment rating report.

2) If more than one part of the body is affected by skin conditions (for example, burns of the right arm, left leg and neck; or skin allergies affecting more than one part of the body; or skin grafts from multiple sites), you must provide a single skin impairment rating that reflects the effects on all involved parts of the skin. If some parts of the skin are affected more than others, you must choose the category that best describes the "totality" of the effect, with special attention to the overall impact on daily activities. Under no circumstance should you give more than a single skin impairment rating. (For example, consider a situation where one arm is severely burned, and one leg is only slightly burned, and a skin graft from another part of the body results in moderate effects. In this example, you must rate the impairment from all the skin conditions taken together, giving a single category rating that considers the factors in WAC 296-20-470 and WAC 296-20-480, including impact on daily activities. If there are other diagnoses, such as bone fracture, etc., it may be appropriate to rate impairment from these conditions separately, using the appropriate rating system. You should not "combine" or "add" ratings for other diagnoses to your rating for the skin condition - simply state them separately.)

3) For chronic osteomyelitis with active drainage involving the lower extremity, do NOT use these categories. Instead, use the AMA *Guides*. Use the edition of the American Medical Association *Guides to the Evaluation of Permanent Impairment* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition. Currently the department has designated the Fifth Edition.) For example, on page 550 of the Fifth Edition, Table 17-36 provides a method for rating such conditions.

Speech

Rules (WAC 296-20-450)

1. Rules for evaluation of permanent speech impairments.

   (a) The physician making an examination for evaluation of permanent speech impairment should have normal hearing and the examination should be conducted in a reasonably quiet office which approximates the noise level conditions of everyday living.

   (b) Selection of the appropriate category of permanent speech impairment shall be based on direct observation of the speech of the person being examined, including, but not limited to: response to interview, oral reading, and counting aloud. The observation shall be made with the physician about eight feet from the person being examined both when he faces the physician and with his back to the physician.

Categories (WAC 296-20-460)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings of significant speech impairments are present. Subjective complaints may be present or absent.

Category 2. Can produce speech of sufficient audibility, intelligibility and functional efficiency for most everyday needs, although this may require effort and occasionally exceed capacity; listeners may occasionally ask for repetition and it may be difficult to produce some elements of speech, and there may be slow speaking and hesitation.

Category 3. Can produce speech of sufficient audibility, intelligibility and functional efficiency for many everyday needs, is usually heard under average conditions but may have difficulty in automobiles, busses, trains, or enclosed areas; can give name, address, and be understood by a stranger, but may have numerous inaccuracies and have difficulty articulating; speech may be interrupted, hesitant or slow.

Category 4. Can produce speech of sufficient audibility, intelligibility and functional efficiency for some everyday needs such as close conversation, conversation with family and friends, but has considerable difficulty in noisy places; voice tires rapidly and tends to become inaudible in a few seconds, strangers may find patient difficult to understand; patient may be asked to repeat often, and often can only sustain consecutive speech for brief periods.

Category 5. Can produce speech of sufficient audibility, intelligibility and functional efficiency for few everyday needs; can barely be heard by a close listener or over the telephone; may be able to whisper audibly but has no voice; can produce some speech elements; may have approximation of a few words such as names of family members which are, however, unintelligible out of context; cannot maintain uninterrupted speech flow, speech is labored, and its rate is impractically slow.

Category 6. Is unable to produce speech of sufficient audibility, intelligibility and functional efficiency for any everyday needs.

Taste and Smell

Rules (WAC 296-20-430)

1. Rule for evaluation of permanent loss of taste and smell.

   (a) If the person being examined can detect any odor or taste, even though it cannot be named, no category shall be assigned.

Categories (WAC 296-20-440)

Choose the category below which best describes the patient's impairment:

Category 1. Loss of sense of taste.

Category 2. Loss of sense of smell.

IMPORTANT NOTE: If the worker has both loss of sense of taste AND loss of sense of smell, provide an impairment rating using both Category I and Category II.

Urologic

Spleen, Loss of One Kidney and Surgical Removal of Bladder with Urinary Diversion

Rules (WAC 296-20-570)

1. Rule for evaluation of permanent impairments of the spleen, loss of one kidney, and surgical of bladder with urinary diversion.

   (a) Categories 1, 2 and 3 include complaints of whatever degree.

Categories (WAC 296-20-580)

Choose the category below which best describes the patient's impairment (more than one category may be chosen):

Category 1. Loss of spleen by splenectomy after age eight.

Category 2. Loss of one kidney by surgery or complete loss of function of one kidney.

Category 3. Surgical removal of bladder with urinary diversion.

IMPORTANT NOTE: More than one category may be selected in your impairment rating.

Upper Urinary Tract

Rules (WAC 296-20-590)

1. Rule for evaluation of permanent impairment of upper urinary tract.

   (a) Categories 2, 3, 4 and 5 include the presence of complaints of whatever nature.

Categories (WAC 296-20-600)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings of impairment of the upper urinary tract. Subjective complaints may be present or absent.

Category 2. Loss of upper urinary function as evidenced by creatinine clearance of 75 to 90 liters/24 hr (52 to 62.5 ml/min) and PSP excretion of 15 percent to 20 percent in 15 minutes; or if there are intermittent objective findings of upper urinary tract disease or dysfunction not requiring continuous treatment or surveillance.

Category 3. Loss of upper urinary tract function as evidenced by creatinine clearance of 60 to 75 liters/24 hr (42 to 52 ml/min) and PSP excretion of 10 percent to 15 percent in 15 minutes; or although function is greater than test levels, there are objective findings of upper urinary tract disease or dysfunction requiring continuous surveillance and frequent symptomatic treatment.

Category 4. Loss of upper urinary tract function as evidenced by creatinine clearance of 40 to 60 liters/24 hr (28 to 42 ml/min) and PSP excretion of 5 percent to 10 percent in 15 minutes; or although function is greater than these levels, there are objective findings of mild or moderate upper urinary tract disease or dysfunction which can be only partially controlled.

Category 5. Loss of upper urinary tract function as evidenced by creatinine clearance below 40 liters/24 hr (28 ml/min) and PSP excretion below 5 percent in 15 minutes; or although function is greater than these levels there are objective findings of severe upper urinary tract disease or dysfunction which persists despite continuous treatment.

Upper Urinary Tract (due to surgical diversion)

Rules (WAC 296-20-610)

1. Rule for evaluation of additional permanent impairments of upper urinary tract due to surgical diversion.

   (a) These categories include the presence of complaints of whatever degree.

Categories (WAC 296-20-620)

Choose the category below which best describes the patient's impairment:

Category 1. Uretero-intestinal diversion of cutaneous ureterostomy without intubation.

Category 2. Nephrostomy or intubated ureterostomy.

Bladder

Rules (WAC 296-20-630)

1. Rules for evaluation of permanent impairment of bladder function.

   (a) In making examinations for evaluation of impairments of bladder function, physicians shall use objective techniques including, but not limited to, cystoscopy, cystography, voiding cystourethrography, cystometry, uroflometry, urinalysis and urine culture.

   (b) Categories 2, 3, 4 and 5 include the presence of complaints of whatever degree.

Categories (WAC 296-20-640)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings are present. Subjective complaints may be present or absent.

Category 2. Objective findings of bladder dysfunction, intermittent treatment required, but there is no dysfunction between such intermittent attacks.

Category 3. Objective findings of bladder dysfunction, continuous treatment required or there is good bladder reflex activity but no voluntary control.

Category 4. Objective findings of bladder dysfunction, there is poor reflex activity with intermittent dribbling and no voluntary control.

Category 5. Objective findings of bladder dysfunction, there is no reflex or voluntary control and there is continuous dribbling.

Testicular

Rules (296-20-650)

1. Rule for evaluation of permanent anatomical or functional loss of testes.

   (a) Categories 2, 3, 4 and 5 include the presence of whatever complaints.

Categories (WAC 296-20-660)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings. Subjective complaints may be present or absent.

Category 2. Anatomical or functional loss of one testicle.

Category 3. Anatomical or functional loss of both testes after the age of 65.

Category 4. Anatomical or functional loss of both testes between the ages of 40 and 65.

Category 5. Anatomical or functional loss of both testes before the age of 40.

Vascular Conditions

Impairment due to vascular conditions should be rated using the AMA *Guides*. Use the edition of the American Medical Association *Guides to the Evaluation of Permanent Impairment* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition. Currently the department has designated the Fifth Edition.)

IMPORTANT NOTE: You must give an exact percentage, NOT a range of percentages. This section of the AMA *Guides*, like several others, instructs the rating examiner to choose Class 1, 2, 3, etc., each with a range of percentages. After you decide the appropriate Class, you must give your best estimate of a specific percentage (not a range). Without your estimate of the exact percentage the Claim Manager will not be able to calculate the impairment award.

Vision

A. How Rating Impairment of the Visual System for L&I Differs from Rating with the AMA *Guides*

There are several key reasons why you must not simply rate using the AMA *Guides*. Instead, you must rate as described in this section, taking into account unique aspects under Washington statute. Briefly, these include:

- **Complete loss of vision:** Loss of central visual acuity of 20/200 or greater by Snellen notation (without correction) is considered to be equal to 100% loss of central visual acuity - sometimes called "industrial blindness". (See details below.)
- **Uncorrected versus corrected vision:** The law requires doctors to base impairment ratings on uncorrected vision. (See details below.)
- **Monocular versus binocular**: In general, when the only abnormality is loss of visual acuity and only one eye is affected, DO NOT rate impairment of the visual system as a whole. (See details below.)
- **Pre-injury status:** To help you assess pre-injury acuity, etc., the Claim Manager will often but not always obtain pre-injury records. When records are not available, you will need to use your best medical judgment to estimate pre-injury status. See Sample Reports #1 and #2.

The table below summarizes how to rate various conditions using parts of this section:

Worker's condition	Rate using	Brief Notes (see details on following pages):
Complete loss of vision (in one or both eyes)	Part B	Includes loss of central visual acuity of 20/200 or greater (without correction)
Partial loss of visual acuity (in one or both eyes)	Part C	Use AMA *Guides*. Base rating on uncorrected acuity. Rate each eye individually (not binocular).
Loss of visual fields in one or both eyes, without loss of visual acuity	Part D	Use AMA *Guides*. Calculate FFS and give a specific percent - see Part D for details.
Loss of visual fields and/or diplopia, with loss of visual acuity	Part E	Use AMA *Guides*. Calculate VSI – see Part E for details.

B. Complete Loss of Vision

To rate complete loss of vision in an eye, do NOT use the AMA *Guides*. Instead, as illustrated in Sample Rating Report #1 below, cite RCW 51.32.080 and simply report the impairment as either one of the following: (1) Loss of one eye by enucleation, or (2) Loss of central visual acuity in one eye, per the following statute:

RCW 51.32.080 Permanent partial disability— Injury after permanent partial disability.

- Loss of one eye by enucleation
- Loss of central visual acuity in one eye

IMPORTANT NOTE: The Department has a longstanding policy that any industrially caused loss of central visual acuity of 20/200 or greater by Snellen notation is considered to be industrial blindness and entitles the claimant to receive the full statutory amount allowed for loss of central visual acuity in the affected eye. In this situation, in your report, simply give the Snellen notation for each eye separately. Do not use the AMA *Guides* to rate loss of acuity in this case.

- **Monocular versus binocular:** In general, when the only abnormality is loss of visual acuity and only one eye is affected, DO NOT rate impairment of the visual system as a whole. (See details below.) The reason for this is that the PPD calculation by the Claim Manager is based on the statutory loss of vision in each eye.

SAMPLE RATING REPORT #1 – COMPLETE LOSS OF CENTRAL VISUAL ACUITY (excerpt: the 4th and 5th of the five essential elements of all rating reports):

4. IMPAIRMENT RATING: Mr. Jones' impairment resulting from the accepted condition is 100% of the value of complete loss of central visual acuity in the right eye, as provided in RCW 51.32.080.

5. RATIONALE: Mr. Jones' injury has resulted in loss of visual acuity in his right eye.

Current condition: The visual acuity in his right eye and left eye (respectively) without correction, are currently 20/300 and 20/20 by Snellen notation. His binocular visual acuity without correction is currently 20/20 by Snellen notation.

Pre-injury condition: No records have been provided documenting pre-injury acuities. Based on my history from the worker, my examination of the worker, and my best medical judgment, it is my opinion on a more-probable-than-not basis that Mr. Jones' pre-injury right, left, and binocular acuities were all 20/20 by Snellen notation.

Rating: According to the Medical Examiners' Handbook, by department policy 20/300 is considered to be industrial blindness. Therefore, under RCW 51.32.080, there is impairment of 100% of the value of complete loss of central visual acuity in the right eye.

C. Partial Loss of Visual Acuity (without visual field loss or other abnormalities)

Partial loss of visual acuity is rated as a percentage of complete loss of central visual acuity in each eye. When evaluating vision, provide central visual acuity data in your report.

1) **20/200 – defined as blindness:** The Department has a longstanding policy that <u>any industrially caused loss of central visual acuity</u> of 20/200 or greater by Snellen notation is considered to be industrial blindness and entitles the claimant to receive the full statutory amount allowed for loss of central visual acuity in the affected eye. In this situation, in your report, simply give the Snellen notation for each eye separately. Do not use the AMA *Guides* to rate loss of acuity in this case. (See Part B above, "Complete Loss of Vision.")

2) **Use uncorrected vision:** To rate loss of uncorrected visual acuity, use the edition of the AMA *Guides* designated by the department (currently the Fifth Edition). Describe the worker's condition without correction, without the aid of glasses. (Disregard AMA *Guides* instructions to use best-corrected visual acuity as described on page 282, Section 12.2b.3.)
PLEASE NOTE: Although the AMA *Guides* has instructed examiners to use corrected visual acuities for the rating, RCW 51.36.020 requires that the rating of visual impairment be based on the loss of sight <u>before correction</u>. Therefore, examiners should use uncorrected visual acuities for the rating.

RCW 51.36.020 (2) indicates:
"Every worker whose injury results in the loss of one or more limbs or eyes shall be provided with proper artificial substitutes and every worker, who suffers an injury to an eye producing an error of refraction, shall be once provided proper and properly equipped lenses to correct such error or refraction **and his or her disability rating shall be based upon the loss of sight before correction."**

3) **IMPORTANT NOTE - Rate each eye separately.**
In general, when the only abnormality is loss of visual acuity:

- DO NOT rate impairment of the visual system as a whole.
- DO NOT STATE THE RATING AS AN IMPAIRMENT OF THE WHOLE PERSON. Instead, give the impairment as a percent of "the value of complete loss of central visual acuity in the right or left eye, as provided in RCW 51.32.080." (See "Complete loss of vision" above)

4) **Use Snellen notation and Table 12-2:** Provide uncorrected monocular measurements for both eyes (even if only one eye has been injured). Use Table 12-2 on page 284 of the AMA *Guides*, Fifth Edition to calculate the Visual Acuity Impairment % based on Snellen notation for each eye. For example, Table 12-2 shows that a visual acuity of 20/80 corresponds to a Visual Acuity Impairment Rating of 30%. (No need to use Table 12-3, etc. to evaluate the visual system as a whole.) Your rating report simply states "x% impairment of the eye" using language demonstrated in Sample Report #2.

5) **Pre-injury status:** If the Claim Manager requests that you compare post-injury and pre-injury vision, provide this data in your report. The Claim Manager may pay the difference between the two ratings, depending on the circumstances. You should not calculate the difference - simply state the pre- and post-injury acuity impairment percentages. If pre-injury data are not available, notify the Claim Manager to see if the data can be obtained. If the data cannot be obtained, use your best medical judgment to estimate pre-injury, uncorrected visual acuity. If the worker had a symptomatic pre-existing condition, the department is only responsible for the increase in impairment. See Chapter 5 for more information on pre-existing conditions.

6) **Rationale:** In your report, cite all the page numbers and table numbers you use (along with the complete title of the AMA *Guides*, including the edition of the AMA *Guides* designated by the department (currently the Fifth Edition). Make it easy for readers to understand how you reached your conclusions.

7) **Treatment recommendations:** Give treatment recommendations, if requested by the Claim Manager.

SAMPLE RATING REPORT #2 – PARTIAL LOSS OF VISUAL ACUITY (excerpt: the 4th and 5th of the five essential elements of all rating reports):

4. IMPAIRMENT RATING: Mr. Jones' impairment resulting from the accepted condition is 35% of the value of complete loss of central visual acuity in the right eye, as provided in RCW 51.32.080.

5. RATIONALE: Mr. Jones' injury has resulted in loss of visual acuity in his right eye.

Current condition: The visual acuities without correction are currently 20/100 in the right eye and 20/20 in the left eye by Snellen notation. His binocular visual acuity without correction is currently 20/20 by Snellen notation.

Pre-injury condition: Records have been provided documenting pre-injury acuities. A medical record dated May 17, 2014 – 3 months prior to the date of injury on this claim - gives measurements of uncorrected vision of 20/40 in the right eye and 20/20 in the left eye. Based on my history from the worker, my examination of the worker, and my best medical judgment, it my opinion on a more-probable-than-not basis that Mr. Jones' pre-injury right and left acuities were 20/40 and 20/20, respectively, by Snellen notation.

Rating: According to Table 12-2 on page 284 of the AMA Guides, Fifth Edition, his Visual Acuity Impairment Rating in the right eye is 35% of the value of complete loss of central visual acuity in the right eye, as provided in RCW 51.32.080. [If the Claim Manager asks about pre-existing acuities, you may add: "Prior to the industrial injury, his acuity of 20/40 without correction equates to 15% loss of central visual acuity in the right eye."]

D. Loss of Visual Fields in One or Both Eyes, without Loss of Visual Acuity

When there is visual field loss in one or both eyes, follow the AMA instructions carefully. Begin on page 298, Table 12-10 and refer to the part of the table titled "Both eyes have normal visual acuity and…" Decide whether the patient best fits under "visual fields better than 50 degrees," "visual fields better than 30 degrees" etc. To make this determination, use the AMA *Guides* Fifth Edition, Section 12.3b, pages 288 to 295. In your report, state the Class that corresponds. **Then select the exact percent of Whole Person impairment within that class, based on your best medical judgment.**

- **IMPORTANT NOTE: You must give an exact percentage, NOT a range of percentages.** Several sections of the AMA *Guides* instruct the rating examiner to choose among several "Classes", each with a range of percentages. After you decide the appropriate Class, you must give your best estimate of a specific percentage (not a range). Without your estimate of the exact percentage the Claim Manager will not be able to calculate the impairment award.

  Example: In the context of visual field loss, Table 12-10 on page 298 gives 6 Classes of impairment. If the worker fits best under "visual fields better than 30 degrees", that places the worker in Class 2, which has a range of 10% to 29% impairment of the visual field. **For your impairment rating, you will need to choose a specific percent from within that range (for example 20%), based on your professional judgment, and state it clearly in your report.**

- **Rationale:** Cite the pages and tables you use. Make it easy for readers to understand how you reached your conclusions. For example, be sure to state which method you have used to measure visual fields, as described on page 287. Be specific. For example, when Goldmann visual field equipment is used, the III4e isopter should be plotted.
- **Medical judgment:** Some visual fields, by position of the loss or the binocularity of the loss, create greater impairment than is reflected in the AMA *Guides*. For example, temporal loss in one eye is a greater impairment than nasal loss in one eye, even though by the *Guides* they would come out as the same impairment. In such circumstances, you may use your best judgment to estimate an additional percent impairment (generally not to exceed an additional 10%). **It is imperative that your report describe your rationale for making this adjustment.**

Need help? For assistance with ratings involving loss of visual fields, feel free to contact a rating specialist at L&I. You may contact the Claim Manager and they will put you in touch with the appropriate individual.

E. Diplopia and Loss of Visual Fields, with Loss of Visual Acuity

The following method to rate impairment should be used in the two circumstances below.

1) Any condition affecting both eyes (including, for example, diplopia), except when the only abnormality is loss of visual acuity (see Part C);

2) Any condition affecting one or both eyes with changes in BOTH visual acuity and visual fields

Step 1: Calculate Visual System Impairment (VSI):

Use the AMA *Guides* Fifth Edition, pages 296-300 to calculate the "Visual System Impairment Rating," or VSI, for the whole visual system (in other words, for binocular vision, assessing function of both eyes). (Assess the worker's condition without correction, without the aid of glasses – see above.) The VSI is described on page 296 and 298 and is equal to 100 minus the FVS (Functional Vision Score). As required by RCW, the rating must be for uncorrected vision.

Diplopia, etc.: Please note that Section 14.b "Individual Adjustments" on page 297 for diplopia, glare sensitivity, etc. allows for a limited increase in the impairment rating of the visual system by, at most, 15 points.

- If the worker has diplopia which can be minimized and/or eliminated by prisms in glasses, provide data on the diplopia both with and without prism correction. You must base your impairment rating on the extent of diplopia without prism correction.
- Pre-existing diplopia: When requested by the Claim Manager, give your assessment of the worker's diplopia prior to the injury. See Part C above.

Step 2: Calculate Whole Person Impairment (WPI):

As described in the footnote in Table 12-10 on page 298, WPI is calculated as follows:

- If VSI is less than or equal to 50%, WPI=VSI.
- If VSI is greater than 50%, WPI = 50 + 0.7 x (VSI-50).

SAMPLE RATING REPORT #3 for visual field loss with loss of visual acuity – VSI less than or equal to 50%:
In your report, state something like the following:

> "Per my findings above and using the AMA Guides, Fifth Edition, pages 296 to 300, the Visual System Impairment Rating (VSI) for Mr. Jones' visual field loss and loss of visual acuity is 40%. Per Table 12-10 on page 298, this VSI corresponds to a Whole Person Impairment (WPI) of 40%. "

SAMPLE RATING REPORT #4 for visual field loss with loss of visual acuity – VSI greater than 50%:
In your report, state something like the following:

> "Per my findings above and using the AMA Guides, Fifth Edition, pages 296 to 300, the Visual System Impairment Rating (VSI) for Mr. Jones' visual field loss and loss of visual acuity is 60%. Per Table 12-10 on page 298, this VSI corresponds to a Whole Person Impairment (WPI) of 57%. "

Need help? For assistance with ratings involving loss of visual fields, feel free to contact a rating specialist at L&I. You may contact the Claim Manager and they will put you in touch with the appropriate individual.

CHAPTER 13

Billing Information

Department rules, coverage decisions, treatment guidelines and payment policies apply to all claims administered by State Fund and Self-Insured Employers unless otherwise noted.

All providers must follow:

- Department laws and administrative rules.
- Department condition and treatment index. Conditions we cover or do not cover can be found at: http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/default.asp.
- Payment policies are contained in the Medical Aid Rules and Fee Schedules (MARFS) http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/.
- Other related information such as treatment guidelines and utilization review, can be found at http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/TreatGuide/.

The Crime Victims Compensation Program follows the Medicaid fee schedules for most services rather than MARFS. The fee schedule for IMEs, lab or other tests for the Crime Victims Compensation Program can vary significantly from the fees listed in the MARFS. To determine the appropriate reimbursement rate for the Crime Victims Compensation Program, go to http://www.lni.wa.gov/ClaimsIns/CrimeVictims/MentalHealthFees/Default.asp.

Department rules and policies take precedence (WAC 296-20-010) if there are any services, procedures or text contained in the Physicians‘ Current Procedural Terminology (CPT®) and federal Healthcare Common Procedure Coding System (HCPCS) coding books that are in conflict with MARFS.

MARFS is published in July of each calendar year. To obtain the latest updates, visit L&I’s Fee Schedules page at: www.FeeSchedules.Lni.wa.gov . Questions concerning coverage and reimbursement may be directed to:

- State Fund the Provider Hotline at 1-800-848-0811
- Crime Victims Compensation Program at 1-800-762-3716
- Self-insured employer or their third party administrator. For contact information see the list of self-insured employers at http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/.

Medical Aid Rules and Fee Schedules (MARFS)

The payment for services by medical providers, including IME medical examiners, is clearly referenced in the RCWs and WACs. **These payments apply equally whether the provider is being paid from the State Fund or by a self-insured employer.**

RCW 51.04.030(2) directs the establishment of a fee schedule by the director for the maximum charges to be paid to any medical provider. It states that "no service covered under this title, including services provided to injured workers, […], shall be charged or paid at a rate or rates exceeding those specified in such fee schedule, and no contract providing for greater fees shall be valid as to the excess."

WAC 296-20-020 identifies who is governed by the department's fee schedule. This WAC states "the filing of an accident report or the rendering of treatment to a worker who comes under the department's or self-insurer's jurisdiction, as the case may be, constitutes acceptance of the department's medical aid rules and compliance with its rules and fees."

WAC 296-20-125 explains the department's billing procedures. It states that "all services rendered must be in accordance with the medical aid rules, fee schedules, and department policy. The department or self-insurer may reject bills for services rendered in violation of these rules. Workers may not be billed for services rendered in violation of these rules."

It is appropriate for the provider to bill their usual and customary fee for the service(s) provided. However, if the usual and customary fee is greater than the department's fee schedule, the payment will be adjusted to the amount shown in the fee schedule. If the usual and customary fee for service(s) is less than the department's fee schedule, then the usual and customary fee is paid. This applies to IMEs performed for state fund or self-insured claims.

Billing for an IME

You must bill using the IME billing codes found in the Medical Aid Rules and Fee Schedules (MARFS), Billing & Payment Policies, when billing for any IME services to any insurer. Here is the link to Chapter 13: Independent Medical Exams (IME) in MARFS.

http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2014/MARFS/Chapter13/default.asp

Billing for an Impairment Rating – For Non-IME Providers

Codes used to bill rating examinations by the attending doctors and consultants are found in Chapter 12: Impairment Rating Services of MARFS, Billing & Payment Policies:

http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2014/MARFS/Chapter12/default.asp

Doctors who may rate impairment must be currently licensed in medicine and surgery (including osteopathic and podiatric) or dentistry, and department approved chiropractors (WAC 296-20-2010).

APPENDIX A

Sample Reports and Forms

This appendix presents templates of reports you should follow to make sure your report includes all required information.

Please be sure to refer to other portions of this handbook for more information. In particular, please note that Chapter 12, includes worksheets for cervical and cervico-dorsal, lumbar and lumbo-sacral, and hearing loss impairment rating.

Sample Report	Use this format if you are:	Page
#1: Required Content of IME report	Approved IME examiners, when requested by Claim Manager	133 - 137
#2:"Impairment rating only"	Consultants* and approved IME examiners	138 - 139
#3: Attending Doctor impairment rating	Attending Doctors authorized to rate impairment and requested by Claim Manager	140
#4: Impairment rating, example of "lighting up" in previously asymptomatic worker	All - attending doctors, IME examiners, consultants*	140 - 141
#5: Impairment rating, example of "lighting up" in previously symptomatic worker	All - attending doctors, IME examiners, consultants*	141 - 142
#6: Doctor's Assessment of Work-Relatedness for Occupational Diseases	All - attending doctors, IME examiners, consultants*	142 - 146
Occupational Disease Work History Form	Worker fills out this form. Examining doctor reviews it with worker to complete Doctor's Assessment of Work-Relatedness for Occupational Diseases	147 - 148
IME Doctor's Estimate of Physical Capacities Form	IME examiners, if requested	149
L&I Amputation of the Fingers, Wrist, Hand Worksheet	All - attending doctors, IME examiners, consultants*	150 - 151

** Note regarding consultants: The referral source is the attending doctor who has been asked by the Claim Manager to perform an impairment rating. Attending doctors may not wish to perform the rating, but prefer to select a consultant.*

Sample Report #1: Required Content of IME Reports in Washington State Workers' Compensation

All elements are required in all IME reports except those marked by an asterisk. ✱ Elements marked by an asterisk should be included ONLY if specifically requested by the claim manager.

Please use this Sample Report as a "template" when you dictate your reports so you remember to include all the information required. Your transcriptionist may download the template from the L&I web page . See L&I websites on Page 183.

A. INTRODUCTION
The introduction should include explanations given to the worker about the purpose and procedures of the exam, a statement about who accompanied the claimant, and other general information about the exam.

B. HISTORY OF PRESENT INJURY
A history from the worker describing both the course of injury or treatment and his or her present status (to be reported separately and distinctly from the record review). The report should distinguish when events described are based on the worker's history alone.

C. CURRENT SYMPTOMS
When the worker describes pain, swelling or rash, be sure to elicit and report details such as location, distribution, effect on activities, etc. See Chapter 4.

IDENTIFYING INFORMATION

Name:	John Smith	**Claim #:**	N100000
Address:	2424 Poplar Drive	**Date of injury:**	July 7, 2003
	Seattle, WA 98100	**Date of birth:**	June 2, 1948

Employer at time of injury: ABC Lumber, Inc.
Date of examination: March 2, 2005
Location of examination: Seattle Clinic
Examiners: Tim Jones, M.D., Hand Surgeon (dictating)
Susan Barnes, M.D., Neurologist

INTRODUCTION

The opinions expressed in this report are those of the physicians and reflect agreement by both examining physicians on all conclusions, except where otherwise specified. The opinions do not reflect the opinions of XYZ Panel, Inc. Mr. Smith was informed that this examination was at the request of the Washington State Department of Labor and Industries (L&I). He was also informed that a written report would be sent to L&I and to his attending doctor, Dr. X, as requested in the assignment letter from the claim manager. Mr. Smith was also informed that the examination was for evaluative purposes only, intended to address specific injuries or conditions as outlined by L&I, and was not intended as a general medical examination.

Mr. Smith was asked at the time of the examination not to engage in any physical maneuvers beyond what he could tolerate, or which he felt were beyond his limits, or which could cause harm or injury.

Mr. Smith was an excellent historian. The historical portion of this report is being dictated in the presence of the claimant so that additions or corrections can be made if necessary.

Mr. Smith was accompanied by his friend, Sally Rogers, during the entire examination.

HISTORY FROM THE WORKER

Chief complaints:

1) Decreased strength in the dominant right hand
2) Tingling and numbness in the both hands.

History of present injury:

Mr. Smith is a 56-year-old greenchain puller at ABC Lumber. He has held this job for 20 years. He...

Current symptoms

At the time of today's exam, Mr. Smith reports moderate tingling and numbness in both hands, right greater than left. The distribution of the tingling is …. In the last few days the sensation has been getting worse, which he associates with …. He also reports decreased strength in his right hand. He denies pain in any part of either upper extremity ….

Sample Report #1: Required Content of IME Reports in Washington State Workers' Compensation

D. OCCUPATIONAL HISTORY

See "Occupational Diseases," Chapter 6 for the additional information required for occupational carpal tunnel syndrome, occupational hearing loss, and other work-related diseases. For occupational injuries, a brief occupational history will suffice.

E. CURRENT WORK STATUS

This is a statement from the worker about whether he or she is employed at the time of the examination, and if unemployed, why.

F. PAST MEDICAL HISTORY

This should include a medication history that documents a worker's current medications, past and present illicit drug use, if any, and pattern of alcohol and tobacco intake. A negative or positive history must be recorded. Confounding conditions (diabetes, etc.) should be addressed.

G. SOCIOECONOMIC HISTORY

This should include education, marital status and military experience.

H. REVIEW OF SYSTEMS

A review of systems is needed to determine if other illnesses or conditions are present.

I. RECORD REVIEW

The record review must provide a detailed chronology of the injury or condition including:

- Mechanism of injury or exposure.
- Diagnostic studies or results.
- Treatments and outcomes, including names of all practitioners involved in treatment.

As always, put the claim number in the top right corner of every page.

March 2, 2005
John Smith, Claim # N100000
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Occupational history:
Since the diagnoses include an occupational disease (carpal tunnel syndrome), and because we have been requested by the claim manager to provide the Doctor's Assessment of Work-Relatedness for Occupational Diseases, we are attaching the requested report as an addendum.

Current work status:
Mr. Smith states he is not working at present because....

Past medical history:
Injuries: Lumbar strain, 1985
Illnesses: Pneumonia, 1982
Operations: Hernia repair, 1990
Hospitalizations: None
Allergies: No known allergies
Medications: None
Substance use:
- **Tobacco:** One pack per day for the last 20 years
- **Alcohol:** One beer per week; no history of DWIs or black-outs
- **Illicit drugs:** History of marijuana use over 25 years ago

Family history: Father with diabetes….

Socioeconomic history:
Marital status and dependents: Single; no dependents
Education: Finished 10th grade; GED.
Military: Served 4 years in the army 1966-70, honorable discharge with no service-connected disability.
Non-work activities, hobbies:

Review of systems:
Non-contributory except mild depression for the last two months, without suicidal ideation, weight loss, insomnia or other....

RECORD REVIEW

The chart has been reviewed in detail. Records reviewed and pertinent data from those records include the following:

- Chart notes of Brian Johnson, M.D., Family Practice, from 7/28/02 through 3/3/04.
  7/28/02: Dr. Johnson saw Mr. Smith for the first time. Chief complaint at that visit was low back pain. Examination revealed normal neurologic exam, ...Lumbo-sacral spine x-rays revealed....

  8/7/02: Mr. Smith reported substantial improvement in his symptoms with conservative care.....
- Chart notes of Mary Miller, D.O., Neurologist, from 9/5/00 through 11/4/01.
  9/5/00: Dr. Miller saw Mr. Smith for the first time. She reported a normal neurologic exam....
- Electrodiagnostic report of William Jones, M.D., Neurologist, performed on 1/3/05.
  EMG revealed.....

Significant missing records included those of the most recent clinical visits and an electrodiagnostic report referenced in the chart notes of Dr. Johnson on 11/3/03.

Sample Report #1: Required Content of IME Reports in Washington State Workers' Compensation

J. PHYSICAL EXAMINATION

Please give sufficient detail of both positive and negative findings to support examination conclusions. This will establish a record that you may be asked to discuss in the future. Non-organic signs (such as Waddell's signs) should be reported when appropriate. When swelling, rash, or abnormal range of motion are observed, be sure to report details such as location, distribution, character, etc. Goniometric measurement of ROM is not required but may be helpful.

See the IME Report in Chapter 4 for more information.

K. MULTIPLE EXAMINATIONS

For IMEs with multiple examiners, each specialty should report physical exam findings separately (orthopedic exam, neurologic exam, etc.).

L. DIAGNOSTIC STUDIES

If diagnostic testing is needed to complete the examination, please arrange for the needed test, then complete the report. Invasive testing (myelogram, biopsies, etc.) should be referred back to the attending doctor. Opinions on testing should, as much as possible, be consistent with guidelines established by the department.

See the IME Report in Chapter 4 for more information.

March 2, 2005
John Smith, Claim # N100000
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PHYSICAL EXAMINATION

Vital signs: Height: 6' 1". Weight: 240 pounds. Blood pressure: 130/76. Pulse: 88 and regular. Temperature: 98.6. Dominant hand: right.

ORTHOPEDIC EXAM:

Mr. Smith is a well-developed, well-nourished male who appears his stated age. He is alert, oriented, and cooperative. He is appropriately attired.....Range of motion of the wrist reveals dorsiflexion to .....Non-organic signs are not present.....

NEUROLOGIC EXAM:

Neurologic exam shows strength to be 5/5 in all the major muscle groups. Reflexes are +2 and equal bilaterally. Sensation is ....

[*Complete orthopedic, neurologic, psychiatric exams are expected when the IME is performed by specialists in these fields.*]

DIAGNOSTIC STUDIES

Studies performed prior to this IME are summarized in Record Review above. No new studies are indicated for the purpose of this IME....

PAIN STATUS INVENTORIES

Please see the attached pain diagram.... We interpret the pain diagram to indicate....

CONCLUSIONS

Accepted conditions (as stated on the assignment letter from the claims manager):

#1: Right carpal tunnel syndrome

Diagnoses and assessment of work-relatedness:

Diagnoses:
#1: Right carpal tunnel syndrome
#2: Epicondylitis, right upper extremity, resolved

Pre-existing conditions:
None.

M. PAIN STATUS INVENTORIES

Optional: Include pain status inventories if you deem them appropriate for the worker's condition.

N. ACCEPTED CONDITIONS

You should simply repeat exactly the accepted conditions in the assignment letter. This is for administrative purposes, since the accepted conditions may differ from your diagnoses.

O. DIAGNOSES AND WORK-RELATEDNESS

Specific diagnoses must be presented in the way listed below.

Diagnoses. Give a brief, one-line statement of each diagnosis.

Pre-existing conditions. State whether they are worsening on their own or as a result of the accepted condition.

(See Pre-existing Conditions, and Lighting Up, Chapter 5.)

Sample Report #1: Required Content of IME Reports in Washington State Workers' Compensation

O. DIAGNOSES AND WORK-RELATEDNESS (continued)

Conditions acquired after the industrial injury or exposure. The worker might mention new conditions or injuries. When this occurs, document the following facts for the medical record:

- Diagnosis or description of the new condition.
- Date the new condition occurred or became manifest.
- Mechanism of injury, if applicable.
- Effects of the new condition on the accepted condition.
- Conclusions about whether the accepted condition caused the new condition in whole or in part Support your conclusion with medical facts.
- Statements about how these conditions interact.

P. DISCUSSION AND ASSESSMENT OF WORK-RELATEDNESS *

The claim manager may prefer that you NOT express an opinion about work-relatedness. Only address work relatedness if you are specifically asked to do so in the assignment letter. This could be, for example, because a condition has already been accepted and, for administrative reasons, a statement of your opinion may create difficulties.

If the claim manager does ask you to express an opinion on work-relatedness for one or more diagnoses, be sure to include the phrase "on a more probable than not basis," since this is the standard established by law. "On a more probable than not basis" does not imply a high degree of medical probability; rather it means greater than 50% certainty. See Occupational Diseases in Chapter 6 and preexisting conditions in Chapter 5.

OCCUPATIONAL DISEASES: *

If one or more of the diagnoses is an occupational disease, the claim manager will need additional information.

March 2, 2005
John Smith, Claim # N100000
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Conditions acquired after the industrial injury or exposure:
Mild reactive depression.

Discussion and assessment of work-relatedness:

#1: Carpal tunnel syndrome, right upper extremity. Objective findings (positive and negative) supporting this diagnosis include positive NCVs on 1/3/05 and .....

As requested by the claims manager, we have attached the report called Doctor's Assessment of Work-Relatedness for Occupational Diseases. Please see this report for more detail on our assessment of work-relatedness.

#2: Epicondylitis, right upper extremity, resolved. Objective findings (positive and negative) supporting this diagnosis include:.....

Prognosis: Not requested in the claims manager's assignment letter.

Q. PROGNOSIS

If applicable or if requested.

Physical Restrictions

Mr. Smith should not engage in repetitive forceful use of the hands as described on the Doctor's Estimate of Physical Capacities (see attachment). The basis for this restriction is his carpal tunnel syndrome…. This is a permanent restriction….

R. PHYSICAL RESTRICTIONS *

See Chapter 8 and Appendix B 17. **Be sure to state the basis for the restrictions and whether permanent or temporary.** Attach the completed "Doctor's Estimate of Physical Capacities" as appropriate.

Review of Job Analyses

Job analysis #1 — Security Guard:

It is our opinion that Mr. Smith can perform the physical demands....except tasks which involve.... Job modifications should be considered to address ....

Job analysis #2 — Cashier:

It is our opinion that Mr. Smith is physically unable to perform the tasks as described because.....

S. REVIEW OF JOB ANALYSES *

See Chapter 8.

* **Elements marked by an asterisk should be included ONLY if specifically requested by the claim manager.**

Sample Report #1: Required Content of IME Reports in Washington State Workers' Compensation

T. RECOMMENDATIONS *

Your recommendations may address both conditions related to the injury, as well as conditions unrelated but hindering recovery.

TREATMENT *

- Clearly state the goal of further treatment. Is it curative or palliative in nature?
- Clearly indicate if treatment is likely to restore function and/or reduce impairment. If the treatment might make a permanent improvement, even if the impairment rating remains the same, the injury is not yet stable and rating is premature.
- How long should it continue and what is the result expected?
- Guidelines. Opinions should, as much as possible, be consistent with department guidelines.

See Pages 25-26.

U. REFERRAL FOR FINDINGS UNRELATED TO THE ACCEPTED CONDITION

Findings not related to the industrial injury may come to light during the examination. For example, you may note an elevated blood pressure while examining an injured ankle. Write a paragraph separate from your findings about the industrial injury. State that a finding, unrelated to the injury, was made and requires follow-up by the attending doctor. Comments on these conditions should be directed to the attending doctor. In some instances, it may be a good idea to phone the attending doctor to communicate your concerns directly.

V. IMPAIRMENT RATINGS *

The rating content described in Chapter 11 is REQUIRED for all IMEs (and for ratings by attending doctors and consultants). Do NOT rate impairment if the worker is not at maximum medical improvement or if further treatment is likely to restore function. See Sample Reports #4 and #5 for rating with Pre-existing Conditions and Lighting Up.

March 2, 2005
John Smith, Claim # N100000
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Recommendations:

Diagnostic: No further testing is indicated.

Therapeutic: Mr. Smith may benefit from.... Such treatment would be palliative.... This treatment is not likely to restore function, but it could achieve.... A 3-month period of treatment would probably be sufficient to ....

Follow-up care: The treatment described above could probably be provided by Mr. Smith's current attending doctor, Dr. X. If Dr. X prefers not to provide this treatment, it may be appropriate to refer Mr. Smith to a neurologist or a specialist in ....

Findings unrelated to the accepted condition: Our exam revealed a skin condition over the posterolateral portion of the .... It appears to be .... We recommend that Mr. Smith follow-up with his attending doctor, Dr. X, as soon as possible....

Impairment Rating Report

MMI: Mr. Smith has (or has not) reached maximum medical improvement....

Physical exam: Examination reveals....

Diagnostic tests: Electrodiagnostic studies show....

Rating: According to the *AMA Guides to the Evaluation of Permanent Impairment*, 5th edition,...

Rationale: The rationale for this rating is that, according to Table....

ANSWERS TO SPECIFIC QUESTIONS FROM THE CLAIM MANAGER

The information under "Conclusions" above gives complete answers to questions #1, 2, 3, 5, 6, 7 and 8 in the referral letter from L&I. Answers to remaining questions are given below:

Question #4: How does your physical assessment differ or concur with prior medical information regarding the patient's physical limitations? Please explain.

Answer: The physical assessment appears to concur with prior medical information.

Signed: _____ _____

Tim Jones, MD
Hand Surgery
Today's date: _____

Susan Barnes, MD
Neurology
Today's date: _____

W. ANSWERS TO CLAIM MANAGER'S QUESTIONS

If you cannot answer a question, please explain requirements for addressing it.

X. ISSUES NOT TO ADDRESS

In your recommendations and throughout your report avoid statements about the claim status such as, "The worker's claim should remain open," or "The worker's claim should be closed." Also avoid speculation about services that may be covered by industrial insurance, like, "The employer should retrain this worker." For more about this, see Chapter 4.

* **Elements marked by an asterisk should be included ONLY if specifically requested by the claim manager.**

Sample Report #2: Impairment Rating Only for Consultants and IME Examiners

(For brevity, the sample report below presents only key elements, omitting many details that would be expected in an actual report. Please see WAC 296-23-377 and Chapter 11 of this handbook for report requirements.)

Impairment Rating Report

Identifying Information

Name:	John Smith	Claim #:	Y100000
Address:	2424 Poplar Drive	Date of injury:	July 7, 2002
	Seattle, WA 98100	Date of birth:	June 2, 1953

Employer at time of injury:	ABC Lumber, Inc.
Date of examination:	March 2, 2003
Location of examination:	Seattle Clinic
Examiners:	Tim Jones, MD, Orthopedic Surgery, Hand Surgery

Introduction

The opinions expressed in this report are those of the examiner. Mr. Smith was informed that this examination was at the request of the Washington State Department of Labor and Industries (L&I) and a written report would be sent to L&I and to his attending doctor, Dr. X. Mr. Smith was also informed that the examination was for evaluative purposes only, intended to address specific injuries or conditions as outlined by L&I, rather than to constitute a general medical examination.

Mr. Smith was asked at the time of the examination not to engage in any physical maneuvers beyond what he could tolerate, or which he felt were beyond his limits, or which could cause harm or injury.

The historical portion of this report is being dictated in the presence of the claimant so that additions or corrections can be made if necessary. His friend, Sally Rogers, accompanied Mr. Smith to the exam.

History From the Worker

Chief complaints (current symptoms):

1) Decreased strength in the right hand, dominant extremity
2) Tingling in the right hand and palm with intermittent tingling and numbness in the left hand.

History of present injury:

Mr. Smith is a 49-year-old greenchain puller at ABC Lumber. He has held this job for 13 years. He...

Record Review

The chart has been reviewed in detail. Records reviewed and pertinent data from those records include the following:

- Chart notes of Brian Johnson, M.D., Family Practice, from 3/2/02 through 1/3/03. 7/7/02: Dr. Johnson saw Mr. Smith for complains about his right hand....1/3/03: Mr. Smith reported substantial improvement in his symptoms with conservative care....
- Chart notes of Mary Miller, D.O., Neurologist, from 9/5/02 through 11/4/02. 9/5/02: Dr. Miller saw Mr. Smith for the first time. She reported a normal neurologic exam....
- Electrodiagnostic report of William Jones, M.D., Neurologist, performed on 10/3/02. EMG revealed.....

Physical examination

Neurologic exam shows strength to be 5/5 in all the major muscle groups, except in the hand, as described below. Reflexes are...

[Complete physical examination is expected as appropriate for the issues involved in the case.]

Diagnosis

#1: Carpal tunnel syndrome, right upper extremity

#2: Epicondylitis, right upper extremity, resolved

Impairment Rating

1. **MMI:** I concur with the January 3, 2003 report from Dr. Johnson, the attending physician, that Mr. Smith has reached maximum medical improvement.

2. **Physical exam:** Positive and negative examination finding relevant to the impairment rating include the following: atrophy of the thenar muscles; presence of Phalen's sign; moderate weakness of thumb abduction: ....

3. **Diagnostic tests:** On October 3, 2002 electrodiagnostic studies revealed... No new studies are indicated for the purpose of this IME ...

4. **Rating:** According to the American Medical Association *Guides to the Evaluation of Permanent Impairment*, 5th Edition, it is my opinion that the findings correspond most closely to a rating of ...

5. **Rationale:** The rationale for this rating is that, using Section 16.5d on pages 491 through 495 of the 5th edition of the AMA *Guides to the Evaluation of Permanent Impairment* ...

Signed: _____

Tim Jones, MD
Orthopedic Surgery, Hand Surgery

Sample Rating Report #3: Required Content of an Attending Doctor Rating Report

This sample report illustrates the five required components of an Attending Doctor rating report.

For a patient with this clinical data ... :

Mr. A., a 28-year-old male, was injured lifting a 50-pound container out of a van. He developed sharp low back pain radiating down the left lower extremity into the foot. The patient received non-operative treatment, including physical therapy and non-steroidal medications. At the time of the impairment rating examination, Mr. A. reported moderate intermittent pain. Physical examination was remarkable for decreased sensation to pinprick over the lateral left leg and foot; positive SLR on the left at 30 degrees with increased radicular pain on ankle dorsiflexion; and tenderness at L5-S1 with deep pressure. X-rays showed 25% loss of disc height at L5-S1 disc.

The Rating Report should read as follows:
MMI: Mr. A. has reached maximum medical improvement. No further curative treatment is recommended.

Physical exam: Examination does not reveal any muscle weakness, atrophy, or reflex loss. There is decreased sensation to pinprick over the lateral left leg and foot; positive SLR at 30 degrees with increased radicular pain on ankle dorsiflexion; and tenderness at L5-S1 with deep pressure.

Diagnostic tests: X-rays show 25% loss of disc height at L5-S1 disc.

Rating: According to the Washington State Category Rating System, it is my opinion that these findings correspond most closely to an impairment rating of Category 2.

Rationale: The rationale for this rating is that I consider the 25% loss of disc height at the L5-S1 disc to be "mild but significant." I consider his findings of decreased sensation in a dermatomal distribution and positive SLR to be "moderate intermittent." He has no atrophy, muscle weakness, reflex loss or other significant findings.

Sample Rating Report #4: Previously asymptomatic worker, with preexisting x-ray findings ("Lighting Up" & the Miller decision)

This sample report illustrates the "lighting up" principle described in the Miller decision. (Please see Chapter 5 for details about dealing with preexisting conditions, segregation, and "lighting up.")

As illustrated in this sample rating report, in cases of "lighting up" the doctor should NOT segregate preexisting impairment or express any opinion about the significance of preexisting findings. (Please compare this with sample rating report #5.)

For a patient with this clinical data :

Mr. B. is a 50-year-old truck driver with no history of back symptoms or disabling back condition. He sustains an injury lifting a 50-pound crate. After conservative treatment, he reaches a plateau at which he continues to experience moderate, intermittent radicular pain. Physical examination was remarkable for

decreased sensation to pinprick over the lateral left leg and foot; positive SLR on the left at 30 degrees with increased radicular pain on ankle dorsiflexion; tenderness at L5-S1 with deep pressure. X-rays reveal mild-to-moderate degenerative changes at L5-S1.

The report could read something like this:

MMI: Mr. B. has reached maximum medical improvement. No further curative treatment is recommended.

Physical exam: Examination does not reveal any muscle weakness, atrophy, or reflex loss. Examination was remarkable for decreased sensation to pinprick over the lateral left leg and foot; positive SLR on the left at 30 degrees with increased radicular pain on ankle dorsiflexion; tenderness at L5-S1 with deep pressure.

Diagnostic tests: On x-ray he has degenerative changes at L5-S1.

Rating: According to the Washington State Category Rating System, it is my opinion that these findings indicate an impairment of Category 2.

Rationale: The rationale for this rating is that I consider the degenerative changes at L5-S1 to be "mild but significant," and consistent with the pain Mr. B describes. I consider his findings of decreased sensation in a dermatomal distribution and positive SLR to be "moderate intermittent." He lacks other significant findings.

Sample Rating Report # 5: Patient with symptomatic preexisting condition, whose medical records include data on which to base a rating of preexisting impairment, and the claim manager explicitly asked the examiner to segregate

Patient with symptomatic preexisting condition, whose medical records include data on which to base a rating of preexisting impairment, and the Claim Manager explicitly asked the examiner to segregate

This sample report illustrates a patient with a symptomatic preexisting condition, where the "lighting up" principle described in the Miller decision does NOT apply. (Please see Chapter 5 for details about dealing with preexisting conditions, segregation, and "lighting up.")

As illustrated in this sample rating report, in cases where the "lighting up" principle does not apply, the doctor should rate the impairment that existed prior to the worker's injury, and provide documentation. (Please compare this with sample rating report #4.)

Report:

MMI: Mr. C. has reached maximum medical improvement. No further curative treatment is recommended.

Physical exam: Examination reveals 2 cm. of calf atrophy on the right and diminished Achilles reflex on the right. There is mild muscle weakness and mild decrease in sensation to pinprick over the lateral right leg and foot. There are no other significant findings.

Diagnostic tests: He has x-ray changes from his fusion at L5-S1.

Rating: According to the Washington State Category Rating System, it is my opinion that the most appropriate impairment rating for Mr. C.'s current condition is Category 5.

Rationale: The rationale for this rating is that Mr. E. has pseudoarthrosis of the lumbar fusion with 30% loss of disc height at L5-S1, which I would categorize as marked. He has 2 cm. of calf atrophy on the right and diminished Achilles reflex on the right. There is mild muscle weakness and mild decrease in sensation to pinprick over the lateral right leg and foot. There were no other significant findings.

Preexisting conditions: Mr. C. had a previous non-industrial back injury on July 15, 1988. I have been seeing him periodically for this injury since January, 1991. I examined Mr. C. three months prior to the industrial injury. At that time, examination did not reveal any muscle weakness, atrophy, reflex loss, sensory loss, or other significant findings. He did have a bulging disc at L5-S1, which I considered insignificant. According to the Washington State Category Rating System, it is my opinion that these findings indicate a preexisting impairment rating of Category 1.

Sample Report #6: Required Content of the Doctor's Assessment of Work Relatedness for Occupational Diseases

On the following pages are the Doctor's Assessment of Work Relatedness for Occupational Diseases and a blank copy of the Occupational Disease Work History form. The form is filled out and signed by the worker at the request of the Claim Manager. The information is used to determine which jobs, if any, contributed to the alleged occupational disease.

What do you need to do?

The Occupational Disease Work History form, already completed by the worker, should be provided to you by the Claim Manager prior to the IME with the rest of the medical records.

Review the completed work history form with the worker to gather additional detail about each job's activities. Use the detail to support your conclusions.

Sample Report #6: Required Content of Occupational Disease Reports in Washington State Workers' Compensation

Please use this Sample Report as a "template" when you dictate your reports so you remember to include all the information required.

B. SOURCE OF INFORMATION FOR THIS REPORT

When IME examiners are requested to submit this report, the claim manager should provide you with a copy of the "Occupational Disease Work History Form" already filled out by the worker. Attending doctors and consultants may request it from the claim manager. **The doctor must review the form with the worker to gather information necessary to provide the occupational history described below.**

See i). below

C. ANSWERS TO THE FOUR REQUIRED QUESTIONS ABOUT WORK ACTIVITIES

For legal reasons, you MUST re-state each of the four questions in your report, EXACTLY as written below.

C.1 The answer to this question should almost always be "yes."

C.2 Briefly (in one line or so) state your diagnosis or diagnoses. Number each diagnosis for later reference.

DOCTOR'S ASSESSMENT OF WORK-RELATEDNESS FOR OCCUPATIONAL DISEASES

A. IDENTIFYING INFORMATION

Name:	Mary Johnson	**Claim #:**	P200000
Address:	9898 Tulip Street, Anywhere, WA 98100	**Date of Injury:**	December 1, 1992
		Date of Birth:	April 1, 1958

Employer at Time of the Claim: Chicken Industries, Inc.

Date of Examination: June 12, 2002

Location of Examination: XYZ Clinic, Seattle, WA

Examiners: Joanne Taylor, M.D., Neurology

B. SOURCE OF INFORMATION FOR THIS REPORT

The Occupational Disease Work History Form was provided to us by the claims manager prior to the examination. It had been completed by Ms. Johnson at home. I have discussed the information on the form with Ms. Johnson and gathered additional details, which form the basis for the opinions presented below. In addition, a job analysis for job #1 was provided by the claims manager and is discussed in the next section. Also, an industrial hygiene report was available for job #2 and is described below. No documentation was available for jobs #3 through #10, so opinions are based solely on the patient's history.

For the record, I am attaching a copy of the Occupational Disease Work History Form which Ms. Johnson filled out. I have numbered the jobs for easy reference in this report. Numbers start with #1 (Poultry worker at Chicken Industries, Inc. from 1994-2000) and go in reverse chronological order through #10 (Cashier at ABC Food Stop from 1979-1980).

C. ANSWERS TO THE FOUR REQUIRED QUESTIONS ABOUT WORK ACTIVITIES

Question #1: **Have you discussed with the claimant the work activities of ALL jobs listed in the work history (including discussion of protective equipment and engineering controls)?**

Yes.

Question #2: **What conditions have you diagnosed?**

Diagnosis #1: Carpal tunnel syndrome, right upper extremity

i). If the claim manager has not provided the Occupational Disease and Employment History form to you, you may request it from the Claim Manager, or you may ask the worker to complete the form (or a form of equivalent content). This form may be downloaded at www.Lni.wa.gov/Forms/pdf/F242-071-000.pdf .

As much as possible, the claim manager will provide industrial hygiene reports, Material Safety Data Sheets, job analyses, or any other material that may be helpful to you for your assessment of work-relatedness.

Sample Report #6: Required Content of Occupational Disease Reports in Washington State Workers' Compensation

C.3 Certain jobs are known to create a recognizable risk of contracting work-related conditions relative to everyday life.

See ii). below.

C.4a This information is needed to establish the legal requirement of proximate cause. Please reference industrial hygiene reports, information from the employer and/or coworkers, Material Safety Data Sheets (MSDSs), or any other documentation that supports your opinion that the activity/exposure occurred.

C.4a Personal protective equipment is used or worn by the worker to reduce personal exposures and include such things as ear plugs, gloves, hard hats, safety glasses and respirators. Engineering controls are designed as part of the work process or environment to reduce personal and/or general area exposures, examples of which include ventilation hoods, machine guards or enclosures, mechanical lifts and vibration or sound-absorbing materials and mats.

As always, put the claim number in the top right corner of every page.

June 15, 2002
Mary Johnson, Claim #P200000
Page 2 of 4

Question #3: **For each condition in Question #2 which is considered a disease (rather than an injury), which jobs in the work history created a recognizable risk of contracting (or worsening) this work-related condition *relative to the risks in everyday life*, on a more-probable-than-not basis? Which jobs did NOT create such a risk?**

Diagnosis # 1: Carpal Tunnel Syndrome, Right Upper Extremity

On a more-probable-than-not basis, jobs #1 and #2 created a recognizable risk of contracting this condition, relative to the risks in everyday life.

Jobs #3-10 did not create such a risk, on a more-probable-than-not basis.

Question #4: **For each job that did create a recognizable risk, answer BOTH of the following questions:**

a) Describe the job. Be sure to include the work activities and/or exposures which contributed to (or protected the worker from) the disease (proximate causes). Describe any protective equipment or engineering controls (or lack thereof) that may have affected the exposure.

b) Describe the basis for your opinion that the workplace activities contributed to the disease. Please include:

- **A description of the temporal relationship. In your description of the temporal relationship, be sure to mention, for each job, when the worker began to experience symptoms and how the onset and pattern of symptoms related to work activities.**
- **Any other information you deem relevant (such as supporting references from the medical literature).**

JOB #1

Job title:	Poultry worker
Employer:	Chicken Industries, Inc.
Employer's city and state:	Tacoma, WA
Approximate dates of employment:	September 1994-December 2000

a) Job description: Ms. Johnson reports that her job includes cutting up chicken parts with a hand-held knife to remove bones from the meat. The job involves a significant amount of repetition and force. Ms. Johnson estimates that she spends at least 6.5 hours a day at this task. The work rate is 90 chickens an hour. The claims manager provided a job analysis from the employer which confirms the nature and duration of the task and adds that they are in the process of trying to reduce the "repetitiveness" of the task by incorporating job rotation into their work practices policy.

Be sure to include information requested in part a) of this question (see C.4a above).

ii). Examples include:
- Health care workers and the development of latex sensitivity.
- Meat packers or poultry plant workers and the development of carpal tunnel syndrome.
- Bakers and the development of asthma.

Other jobs may not have such a well-established association, but may nevertheless contribute, on a more-probable-than-not basis. In all cases, your answer to Question #4 should adequately support your answer to Question #3.

Sample Report #6: Required Content of Occupational Disease Reports in Washington State Workers' Compensation

C.4b Describe the basis for your opinion that the workplace activities contributed to the disease. **Be sure to include information requested in part (b) of this question.**

See previous page and See iii). below

June 15, 2002
Mary Johnson, Claim #P200000
Page 3 of 4

b) Basis for my opinions: The repetitive, forceful work of cutting up chicken parts is likely to have contributed to Ms. Johnson's carpal tunnel syndrome. It is well documented in the medical literature that repetitive tasks which require force are associated with the development of carpal tunnel syndrome. This disorder is common among workers from other industries and occupations that are also associated with repetitive, forceful work. Furthermore, there is a clear temporal relationship between the onset and pattern of her symptoms and her work activities. Her symptoms began approximately six months after... In August 1992 Ms. Johnson took a week-long vacation during which her symptoms...

Repeat the steps above for each job that created a recognizable risk.

JOB #2

Job title:	Laborer
Employer:	ABC Wallboard International
Employer's city and state:	Tacoma, WA
Approximate dates of employment:	April 1991-June 1991

a) Job description: This job involved the installation of wallboard in both residential and non-residential buildings. Ms. Johnson described the job to

be very demanding. The tasks associated with installing wallboard include repetitive and forceful motions, specifically with the use of a pneumatic nail gun, which was so heavy it required the use of both arms to operate. The nature of the work often required that the nail gun be used in awkward postures. The employer's description of the job was consistent with that of Ms. Johnson. An industrial hygiene report was also available. It documented....

b) Basis for my opinions: The repetitive, forceful work of installing wallboard is likely to have contributed to Ms. Johnson's carpal tunnel syndrome. I have observed this condition in laborers before. Just as in Job #1, it is well documented in the medical literature that repetitive tasks which require force are associated with the development carpal tunnel syndrome. The types of motions known to be associated with carpal tunnel syndrome were demonstrated by Ms. Johnson in her description of operating the nail gun as well as in other tasks necessary to perform her job such as handling the wallboard. Also, there is a clear temporal relationship between the onset and pattern of her symptoms and her work activities. Although her symptoms in this job were not as severe as in Job #1, ...

iii). In many cases only limited information on the work exposures will be available. The claim manager understands that it may be difficult to assess work-relatedness without complete information. Therefore, the expectation is that you will make as accurate a determination as possible, based on whatever information is available at the time of the examination.

Sample Report #6: Required Content of Occupational Disease Reports in Washington State Workers' Compensation

D. ANSWERS TO THE TWO REQUIRED QUESTIONS ABOUT NON-WORK ACTIVITIES

For legal reasons, you MUST re-state each of the two questions in your report, exactly as written below.

D.5 Does the worker report any non-work activities or exposures that may have an effect on the diagnosed condition? An example is a receptionist who has bilateral carpal tunnel syndrome which may be a result of crocheting projects done on non-work time.

D.6 Give a clear statement of the association (or lack of association) between the exposure and the condition, on a more-probable-than-not basis. Please include, for example, a description of the temporal relationship, supporting references from the medical literature, and any other information you deem relevant.

June 15, 2002
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D. ANSWERS TO THE TWO REQUIRED QUESTIONS ABOUT NON-WORK ACTIVITIES

Question #5: **Describe non-work activities or conditions that may have an effect on the disease.**

Ms. Johnson's hobbies include body work on her car and the cars of friends and relatives. She reports doing body work roughly 2 hours per week over the last two years....

Question #6: **If you believe the disease was caused SOLELY by non-work activities or conditions, describe the basis for your opinion. Please include, for example, a description of the temporal relationship, supporting references from the medical literature, and any other information you deem relevant.**

Not applicable.

D.6 You should not answer this question if you indicated in Question #3 that any of the jobs the worker has performed created a recognizable risk of contracting the condition relative to the risks in everyday life.

Signed: _____

Joanne Taylor, M.D., Attending Doctor
Neurology

Today's Date: _____

Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

OCCUPATIONAL DISEASE & EMPLOYMENT HISTORY

Name	Claim Number

Occupational Disease Information Form

This form must be completed if the claim isn't the result of a specific incident.
An occupational disease is a condition caused by job duties or work conditions over a period of time.

For allowance of an occupational disease claim, there must be:

- Medical evidence supported by objective medical findings that the disease exists.
- Medical opinion that the diagnosis is caused by work activities on a more probable than not basis.
- Documentation that the disease was caused by work rather than conditions in everyday life or all employment in general.

We require completion of this form to decide if the claim is allowable and to determine which job(s) contributed to the diagnosed condition.

Instructions for Worker

- Complete the **Worker Information** and the **Employment History**.
- Include all current and past employer(s).
- Provide as much detail as possible about your employer(s) and your job duties.
- Inaccurate or incomplete information may delay our decision.
- Failure to complete and submit this form may result in claim rejection.

Worker Information

What symptoms are you having? _____

When did you first notice these symptoms? ____/____/____

What were you doing when these symptoms began?

Has there been any recent change in your work duties that have affected your symptoms? ☐ YES ☐ NO

If yes, please describe: _____

Have you ever been seen by a provider for these symptoms in the past?
☐ YES ☐ NO

If yes: Provider's name: _____
Date/Year Seen: _____
Provider's Address/City/State: _____

If yes, complete the attached medical records release form.

Have you previously filed any claims for this condition?
☐ YES ☐ NO If yes, please list the states and claim numbers:

State:	Claim Number:

Other Activities – *Complete the following for activities that you currently do or have done in the past.*

☐ Sports – type _____ hrs per day: ____ days per wk: ____
Performed From: _____/_____/_____ To: _____/_____/_____

☐ Sewing, Knitting, Crocheting, Crafts, etc. hrs per day: ____ days per wk: ____
Performed From: _____/_____/_____ To: _____/_____/_____

☐ Woodworking/Construction/Painting/Gardening hrs per day: ____ days per wk: ____
Performed From: _____/_____/_____ To: _____/_____/_____

☐ Computers, Keyboarding, Gaming, Text Messaging, etc. hrs per day: ____ days per wk: ____
Performed From: _____/_____/_____ To: _____/_____/_____

☐ Musical Instruments – type _____ hrs per day: ____ days per wk: ____
Performed From: _____/_____/_____ To: _____/_____/_____

☐ Auto/Engine Repair, Firearms, Power Tools, etc. hrs per day: ____ days per wk: ____
Performed From: _____/_____/_____ To: _____/_____/_____

☐ Other – describe: _____ hrs per day: ____ days per wk: ____
Performed From: _____/_____/_____ To: _____/_____/_____

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Occupational Disease & Employment History

Name _____ Claim Number _____

Employment History – *Include **all** employers. Copy this page if you need more space.* | **For LNI use**

Current or
Last Employer: _____
Job Title: _____
Dates Employed: From ____/____/____ To ____/____/____
Phone Number: _____
Address: _____
City/State: _____
Was there a gap of more than two months between this job and your prior job? Yes ☐ No ☐ If yes, please briefly explain: _____

Check the specific job condition(s) you believe caused your symptoms:

Job Duties	Hrs per day	Days per week
☐ Pushing/Pulling	_____	_____
☐ Use of Vibratory Tools	_____	_____
☐ Kneeling	_____	_____
☐ Overhead Work	_____	_____
☐ Pinching	_____	_____
☐ Keyboarding	_____	_____
☐ Lifting/Carrying	_____	_____
☐ Other Repetitive Tasks:	_____	_____

Prior Employer: _____
Job Title: _____
Dates Employed: From ____/____/____ To ____/____/____
Phone Number: _____
Address: _____
City/State: _____
Was there a gap of more than two months between this job and your prior job? Yes ☐ No ☐ If yes, please briefly explain: _____

Check the specific job condition(s) you believe caused your symptoms:

Job Duties	Hrs per day	Days per week
☐ Pushing/Pulling	_____	_____
☐ Use of Vibratory Tools	_____	_____
☐ Kneeling	_____	_____
☐ Overhead Work	_____	_____
☐ Pinching	_____	_____
☐ Keyboarding	_____	_____
☐ Lifting/Carrying	_____	_____
☐ Other Repetitive Tasks:	_____	_____

Prior Employer: _____
Job Title: _____
Dates Employed: From ____/____/____ To ____/____/____
Phone Number: _____
Address: _____
City/State: _____
Was there a gap of more than two months between this job and your prior job? Yes ☐ No ☐ If yes, please briefly explain: _____

Check the specific job condition(s) you believe caused your symptoms:

Job Duties	Hrs per day	Days per week
☐ Pushing/Pulling	_____	_____
☐ Use of Vibratory Tools	_____	_____
☐ Kneeling	_____	_____
☐ Overhead Work	_____	_____
☐ Pinching	_____	_____
☐ Keyboarding	_____	_____
☐ Lifting/Carrying	_____	_____
☐ Other Repetitive Tasks:	_____	_____

Prior Employer: _____
Job Title: _____
Dates Employed: From ____/____/____ To ____/____/____
Phone Number: _____
Address: _____
City/State: _____
Was there a gap of more than two months between this job and your prior job? Yes ☐ No ☐ If yes, please briefly explain: _____

Check the specific job condition(s) you believe caused your symptoms:

Job Duties	Hrs per day	Days per week
☐ Pushing/Pulling	_____	_____
☐ Use of Vibratory Tools	_____	_____
☐ Kneeling	_____	_____
☐ Overhead Work	_____	_____
☐ Pinching	_____	_____
☐ Keyboarding	_____	_____
☐ Lifting/Carrying	_____	_____
☐ Other Repetitive Tasks:	_____	_____

Worker Statement: I declare that the information I've provided on this form is true to the best of my knowledge and understanding.

Worker's Signature: _____ Date: _____

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IME Doctor's Estimate of Physical Capacities

Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

IME DOCTOR'S ESTIMATE OF PHYSICAL CAPACITIES

Name of Claimant

Claim Number

Important: Please complete the following items based on your clinical evaluation of the claimant and other testing results. Any item that you do not believe you can answer should be marked N/A. Percentages refer to a workday.

I. In an 8 hour workday, worker can: (Circle full capacity for each activity)

	Total at one time (hours)											Total during entire 8 hour day (hours)										
A)	Sit	0	1/2	1	2	3	4	5	6	7	8	A)	Sit	0	1/2	1	2	3	4	5	6	7	8
B)	Stand	0	1/2	1	2	3	4	5	6	7	8	B)	Stand	0	1/2	1	2	3	4	5	6	7	8
C)	Walk	0	1/2	1	2	3	4	5	6	7	8	C)	Walk	0	1/2	1	2	3	4	5	6	7	8

II. Worker can lift: *(Address any restrictions in lifting from the floor or to overhead in "Remarks" section)*

III. Worker can carry:

	Not at all		Seldom (1 - 10%)		Occasionally (11 - 33%)		Frequently (34 - 66%)		Continuously (67 - 100%)	
	Lift	**Carry**	**Lift**	**Carry**	**Lift**	**Carry**	**Lift**	**Carry**	**Lift**	**Carry**
A) Up to 5 lbs										
B) 6 - 10 lbs										
C) 11 - 20 lbs										
D) 21 - 25 lbs										
E) 26 - 50 lbs										
F) 51 - 100 lbs										

IV. Worker can use hands for repetitive tasks such as:

	Simple grasping		Pushing & pulling		Fine manipulating	
A) Right	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
B) Left	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

V. Worker can use feet for repetitive movements as in operating foot controls:

Right ☐ Yes ☐ No Left ☐ Yes ☐ No

VI. Worker is able to:

	Not at all	Seldom (1-10%)	Occasionally (11 - 33%)	Frequently (34 - 66%)	Continuously (67 - 100%)
A) Bend					
B) Squat					
C) Kneel					
D) Crawl					
E) Climb					
F) Reach above shoulder level					

VII. Restriction on activities involving:

	Yes	No	If "Yes," explain:
A) Unprotected heights			
B) Being around moving machinery			
C) Exposure to marked changes in temp & humidity			
D) Driving automotive equipment			

E) Exposure to dust, fumes and gasses (Restrictions): _____

Remarks (on above, on other functional limitations):

If a performance-based physical capabilities evaluation is requested, may the worker be tested to tolerance? If not, what are the restrictions?

☐ Yes ☐ No

Date Signature of Physician

F242-387-000 IME Dr's est of physical capacities 09-2007

L&I Amputations of the Fingers Worksheet

Use for finger amputations only	Injured Worker's Name	
	Claim Number	Date

Step 1: Your findings:

INSTRUCTIONS: Use if there has been a complete amputation of part or all of the hand. If there are no amputations, do not use this form.

For rating actual amputations, the law RCW 51.32.080 directs the doctor to indicate the level which best describes the worker's amputation.

If a worker has BOTH amputation AND additional loss of function to an extremity, two determinations need to be made:

(1) Report the actual amputation, and
(2) Rate additional impairments, such as loss of sensation or range of motion, using the Fifth Edition of the AMA *Guides to the Evaluation of Permanent Impairment.*

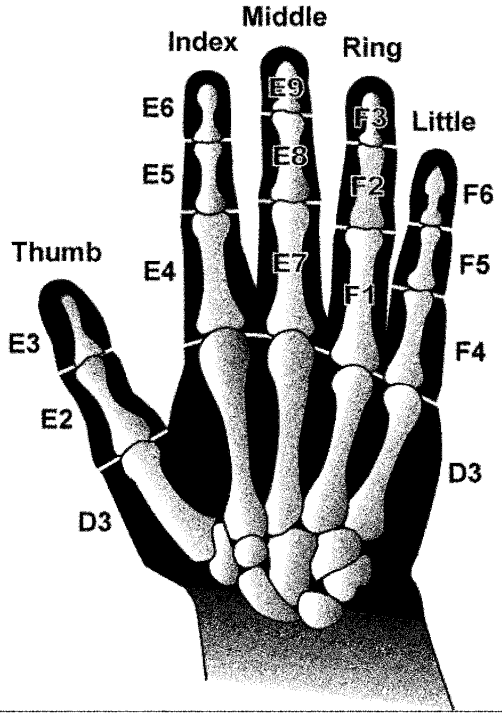
Claim managers make administrative calculations, remaining amputation value, so impairments are not counted twice.

☐ Right ☐ Left

Use a pen to mark with a line precisely where the amputation(s) is/are located…..

If both extremities are affected, you must use a separate worksheet for each extremity.

Doctors may disregard D, E & F Codes. They are for use by claim managers.



Step 2: Additional impairment due to loss of range of motion and/or sensation (you must use the AMA *Guides*, Fifth Edition for this portion of the worksheet):

	Per AMA *Guides*, the percent impairment due to loss of:	range of motion	sensation	Combined *	*For Office Use Only*
You must attach Figure 16-1a on pages 436-437 of the AMA *Guides*, Fifth Edition to present your measurements and calculations.	Thumb	%	%	%	*E2*
	Index	%	%	%	*E4*
	Middle	%	%	%	*E7*
	Ring	%	%	%	*F1*
	Little	%	%	%	*F4*

* Combined: In this column enter total impairment due to loss of range of motion and sensation, calculated for each digit by using the Combined Values Chart on pages 604-606 of the AMA *Guides* Fifth Edition.

Step 3: Other impairment: ☐There is additional impairment not reflected on this worksheet. I am attaching an additional report with my findings and rationale for my impairment rating.

Step 4: Signature: I certify that I have examined the patient, and that the above report truly and correctly sets forth my findings and opinion.

Doctor's address	Today's date
Doctor's Name (print)	Doctor's signature

F252-078-000 L&I Amputations of the Fingers Worksheet 05-2014

Amputations of the Fingers Worksheet Sample

L&I Amputations of the Fingers Worksheet

Use for finger amputations only	Injured Worker's Name John Smith	
	Claim Number ABC12345	**Date** 06/06/2014

Step 1: Your findings:

INSTRUCTIONS: Use if there has been a complete amputation of part or all of the hand. If there are no amputations, do not use this form.

For rating actual amputations, the law RCW 51.32.080 directs the doctor to indicate the level which best describes the worker's amputation.

If a worker has BOTH amputation AND additional loss of function to an extremity, two determinations need to be made:

(1) Report the actual amputation, and
(2) Rate additional impairments, such as loss of sensation or range of motion, using the Fifth Edition of the AMA *Guides to the Evaluation of Permanent Impairment.*

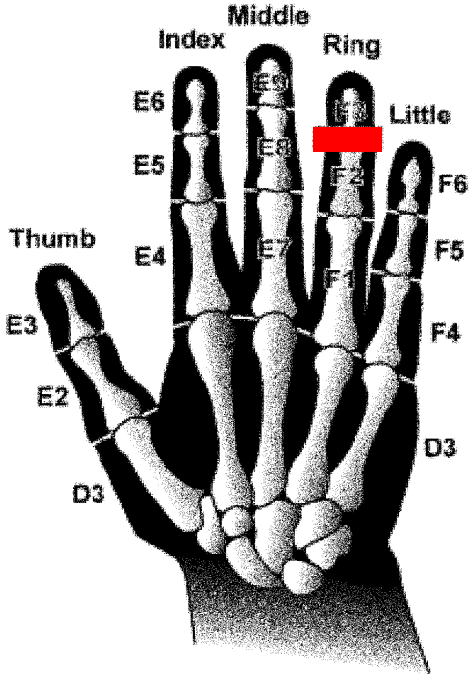
Claim managers make administrative calculations, remaining amputation value, so impairments are not counted twice.

☒ Right ☐ Left

Use a pen to mark with a line precisely where the amputation(s) is/are located…..

If both extremities are affected, you must use a separate worksheet for each extremity.

Doctors may disregard D, E & F Codes. They are for use by claim managers.



Step 2: Additional impairment due to loss of range of motion and/or sensation (you must use the AMA *Guides*, Fifth Edition for this portion of the worksheet):

	Per AMA *Guides*, the percent impairment due to loss of:	range of motion	sensation	Combined *	*For Office Use Only*
You must attach Figure 16-1a on pages 436-437 of the AMA *Guides*, Fifth Edition to present your measurements and calculations.	Thumb	%	%	%	*E2*
	Index	%	%	%	*E4*
	Middle	%	%	%	*E7*
	Ring	5%	3%	8%	*F1*
	Little	%	%	%	*F4*

* Combined: In this column enter total impairment due to loss of range of motion and sensation, calculated for each digit by using the Combined Values Chart on pages 604-606 of the AMA *Guides* Fifth Edition.

Step 3: Other impairment: ☐There is additional impairment not reflected on this worksheet. I am attaching an additional report with my findings and rationale for my impairment rating.

Step 4: Signature: I certify that I have examined the patient, and that the above report truly and correctly sets forth my findings and opinion.

Doctor's address 123 Main Street	Today's date 06/17/2014
Doctor's Name (print) John Doe	Doctor's signature *Dr. John Doe*

F252-078-000 L&I Amputations of the Fingers Worksheet 05-2014

Physical Demand Definitions

U.S. Department of Labor classification of physical demands and environmental conditions

Physical demands analysis is a systematic way of describing the physical activities that a job requires. It is concerned only with the physical demands of the job; it is not concerned with the physical capacity of the worker. Environmental conditions are the surroundings in which a job is performed. To be considered present, an environmental condition must be specific and related to the job.

The above information was taken from *The Revised Handbook for Analyzing Jobs, U.S. Department of Labor, 1991, Pages 12-1 to 12-13*.

Physical Demands

1. Strength

This factor is expressed by one of five terms: sedentary, light, medium, heavy and very heavy. In order to determine the overall rating, an evaluation is made of the worker's involvement in the following activities:

Position

Standing: Remaining on one's feet in an upright position at a workstation without moving about.

Walking: Moving about on foot.

Sitting: Remaining in a seated position.

Weight/Force

Lifting: Raising or lowering an object from one level to another (includes upward pulling).

Carrying: Transporting an object, usually holding it in the hands or arms or on the shoulder.

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 toward the force (includes jerking).

Lifting, pushing and pulling are expressed in terms of both intensity and duration. Judgments regarding intensity involve consideration of the weight handled, position of the worker's body or the part of the worker's body used in handling weights, and the aid given by helpers or by mechanical equipment. Duration is the total time spent by the worker in carrying out these activities. Carrying most often is expressed in terms of duration, weight carried and distance carried.

Controls: Hand-Arm and Foot-Leg Controls entail use of one or both arms or hands (hand-arm) or one or both feet or legs (foot-leg) to move controls on machinery or equipment. Controls include but are not limited to buttons, pedals, levers and cranks.

Sedentary Work

Exerting up to 10 pounds of force occasionally or a negligible amount of force frequently to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work

involves sitting most of the time, but may involve walking or standing brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

Light Work

Exerting up to 20 pounds of force occasionally, or up to 10 pounds of force frequently, or a negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for sedentary work. Even though the weight lifted may be only a negligible amount, a job should be rated light work: (1) when it requires walking and standing to a significant degree; (2) when it requires sitting most of the time but entails pushing and pulling of arm or leg controls; or (3) when the job requires working a production rate pace entailing the constant pushing or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.

Medium Work

Exerting 20 to 50 pounds of force occasionally, or 10 to 25 pounds of force frequently, or greater than negligible up to 10 pounds of force constantly to move objects.

Heavy Work

Exerting 50 to 100 pounds of force occasionally, or 25 to 50 pounds of force frequently, or 10 to 20 pounds of force constantly to move objects.

Very Heavy

Exerting in excess of 100 pounds of force occasionally, or in excess of 50 pounds of force frequently, or in excess of 20 pounds of force constantly to move objects.

2. Climbing: Ascending or descending ladders, stairs, scaffolding, ramps, poles and the like, using feet and legs or hands and arms. Body agility is emphasized.

3. Balancing: Maintaining body equilibrium to prevent falling when walking, standing, crouching, or running on narrow, slippery, or erratically moving surfaces; or maintaining body equilibrium when performing gymnastic feats.

4. Stooping: Bending the body downward and forward by bending the spine at the waist, requiring full use of the lower extremities and back muscles.

5. Kneeling: Bending the legs at the knees at come to rest on the knees or knees.

6. Crouching: Bending the body downward and forward by bending the legs and spine.

7. Crawling: Moving about on the hands and knees or hands and feet.

8. Reaching: Extending, the hand(s) and arm(s) in any direction.

9. Handling: Seizing, holding, grasping, turning or otherwise working with the hand or hands. Fingers are involved only to the extent that they are an extension of the hand, such as to turn a switch or shift automobile gears.

10. Fingering: Picking, pinching or otherwise working primarily with the fingers rather than with the whole hand or arm as in handling.

11. Feeling: Perceiving attributes of objects, such as size, shape, temperature or texture, by touching with skin, particularly that of fingertips.

12. Talking: Expressing or exchanging ideas by means of the spoken word to impart oral information to clients or to the public and to convey detailed spoken instructions to other workers accurately, loudly, or quickly.

13. Hearing: Perceiving nature of sounds by ear.

14. Tasting/Smelling: Distinguishing, with a degree of accuracy, differences or similarities in intensity or quality of flavors or odors, or recognizing particular flavors or odors, using tongue or nose.

15. Near Acuity: Clarity of vision at 20 inches or less.

16. Far Acuity: Clarity of vision at 20 feet or more.

17. Depth Perception: Three-dimensional vision. Ability to judge distances and spatial relationships in order to see objects where and as they actually are.

18. Accommodation: Adjustment of lens of eye to bring an object into sharp focus. This factor is required when doing near point work at varying distance from the eye.

19. Color Vision: Ability to identify and distinguish colors.

20. Field of Vision: Observing an area that can be seen up and down or to right or left while eyes are fixed on a given point.

Environmental Condition Factors

1. Exposure to Weather: Exposure to outside atmospheric conditions.

2. **Extreme Cold**: Exposure to non-weather-related cold temperatures.

3. Extreme Heat: Exposure to non-weather-related hot temperatures.

4. Wet and/or Humid: Contact with water or other liquids or exposure to non-weather-related humid conditions.

5. Noise Intensity Level: The noise intensity level to which the worker is exposed in the job environment. This factor is expressed by one of five levels. Consider all the benchmarks within a level as providing an insight into the nature of the specific level.

6. Vibrations: Exposure to a shaking object or surface.

7. Atmospheric Conditions: Exposure to conditions such as fumes, noxious odors, dusts, mists, gases and poor ventilation, that affect the respiratory system, eyes or skin.

8. Proximity to Moving Mechanical Parts: Exposure to possible bodily injury from moving mechanical parts of equipment, tools or machinery.

9. Exposure to Electrical Shock: Exposure to possible bodily injury from electrical shock.

10. Working in High, Exposed Places: Exposure to bodily injury from falling.

11. Exposure to Radiation: Exposure to possible bodily injury from radiation.

12. Working with Explosives: Exposure to possible injury from explosions.

13. Exposure to Toxic or Caustic Chemicals: Exposure to possible bodily injury from toxic or caustic chemicals.

14. Other Environmental Conditions: Explain other environmental conditions, not defined above, in Environmental Conditions Comments.

APPENDIX B

Safety for Examiners and Staff

Although rare, it is possible you could encounter a hostile or violent injured worker when you are conducting an IME. Awareness and preparation are important keys to remember before the encounter starts. The department values your safety and does not expect you to take unnecessary risks when doing an IME.

Prevention is the key to your safety. If a situation evolves on the day of the examination, follow the procedures established by the office where the exam is being conducted. For emergency assistance on the day of the exam, call 911. Whenever possible review the claim file a few days before the examination. If a potential situation is identified, follow the steps below before the exam date.

Options

- Request approval for an off-duty plain-clothed law enforcement agent to be present in the clinic during the exam.
- For State Fund claims call 1-360-902-6818
- For Self- Insured Employer claims contact the requester of the exam.

Contact the appropriate law enforcement agency for the clinic location and request an off-duty police officer. Each jurisdiction may have different procedures to obtain services.

This process may take several days, so do not wait until the last moment.

Personal Conduct to Minimize Violence

Follow these suggestions in your daily interactions with people to de-escalate potentially violent situations. If at any time a person's behavior starts to escalate beyond your comfort zone, disengage.

Do	Do Not
■ Project calmness, move and speak slowly, quietly and confidently. ■ Be an empathetic listener: Encourage the person to talk and listen patiently. ■ Focus your attention on the other person to let them know you are interested in what they have to say. ■ Maintain a relaxed yet attentive posture and position yourself at a right angle rather than directly in front of the other person. ■ Acknowledge the person's feelings. Indicate that you can see he/she is upset. ■ Ask for small, specific favors such as asking the person to move to a quieter area.	■ Use styles of communication which generate hostility such as apathy, brush off, coldness, condescension, robotism, going strictly by the rules or giving the runaround. ■ Reject all of a client's demands from the start. ■ Pose in challenging stances such as standing directly opposite someone, hands on hips or crossing your arms. Avoid any physical contact, finger pointing or long periods of fixed eye contact. ■ Make sudden movements which can be seen as threatening. Notice the tone, volume and rate of your speech.

Do	Do Not
■ Establish ground rules if unreasonable behavior persists. Calmly describe the consequences of any violent behavior. ■ Use delaying tactics which will give the person time to calm down. For example, offer a drink of water (in a disposable cup). ■ Be reassuring and point out choices. Break big problems into smaller, more manageable problems. ■ Accept criticism in a positive way. When a complaint might be true, use statements like "You are probably right" or "It was my fault." If the criticism seems unwarranted, ask clarifying questions. ■ Ask for his/her recommendations. Repeat back to him/her what you feel he/she is requesting of you. ■ Arrange yourself so that a visitor cannot block your access to an exit.	■ Challenge, threaten, or dare the individual. Never belittle the person or make him/her feel foolish. ■ Criticize or act impatiently toward the agitated individual. ■ Attempt to bargain with a threatening individual. ■ Try to make the situation seem less serious than it is. ■ Make false statements or promises you cannot keep. ■ Try to impart a lot of technical or complicated information when emotions are high. ■ Take sides or agree with distortions. ■ Invade the individual's personal space. Make sure there is a space of three feet to six feet between you and the person.

**From Combating Workplace Violence: Guidelines for Employers and Law Enforcement. International Association of Chiefs of Police. 1996.*

Five Warning Signs of Escalating Behavior

Warning Signs	Possible Responses
Confusion	
Behavior characterized by bewilderment or distraction. Unsure or uncertain of the next course of action.	■ Listen to their concerns. ■ Ask clarifying questions. ■ Give them factual information.
Frustration	
Behavior characterized by reaction or resistance to information. Impatience. Feeling a sense of defeat in the attempt of accomplishment. May try to bait you.	■ See steps above. ■ Relocate to quiet location or setting. ■ Reassure them. ■ Make a sincere attempt to clarify concerns.
Blame	
Placing responsibility for problems on everyone else. Accusing or holding you responsible. Finding fault or error with the action of others. They may place blame directly on you. Crossing over to potentially hazardous behavior.	■ See steps above. ■ Disengage and bring second party into the discussion. ■ Use teamwork approach. ■ Draw client back to facts. ■ Use probing questions. ■ Create “Yes” momentum.
Anger - Judgment call required	
Characterized by a visible change in body posture and disposition. Actions include pounding fists, pointing fingers, shouting or screaming. This signals very risky behavior.	■ Utilize venting techniques. ■ Don’t offer solutions. ■ Don’t argue with comments made. ■ Prepare to evacuate or isolate. ■ Contact supervisor and/or security office.
Hostility - Judgment call required	
Physical actions or threats which appear imminent. Acts of physical harm or property damage. Out-of-control behavior signals they have crossed over the line.	■ Disengage and evacuate. ■ Attempt to isolate person if it can be done safely. ■ Alert supervisor and contact security office immediately.

Helpful Resources

- More detailed information can be found at http://www.lni.wa.gov/IPUB/417-140-000.pdf.
- WAC 296-800-140, Accident Prevention Program http://www.lni.wa.gov/Safety/Basics/Programs/Accident/default.htm , requires employers to conduct a workplace hazard assessment and address all identified hazards in writing. Violence is a recognized hazard in many healthcare workplaces as verified by the statements made by the IM group.
- In addition, any hospital or hospital owned clinic (along with other specific workplaces, e.g. home health) is required to have a workplace violence plan under RCW 49.19 http://apps.leg.wa.gov/rcw/default.aspx?cite=49.19 .

APPENDIX C

Relevant Laws and Regulations

Washington state laws (Revised Code of Washington – RCW) and regulations (Washington Administrative Code – WAC) relevant to independent medical exams are listed in this appendix.

Regulations (WACs) relevant to specific impairment ratings of body systems can be found in chapter 12.

Laws

RCW 51.04.050
Physician or licensed advanced registered nurse practitioner's testimony not privileged

In all hearings, actions or proceedings before the department or the board of industrial insurance appeals, or before any court on appeal from the board, any physician or licensed advanced registered nurse practitioner having theretofore examined or treated the claimant may be required to testify fully regarding such examination or treatment, and shall not be exempt from so testifying by reason of the relation of the physician or licensed advanced registered nurse practitioner to patient.

RCW 51.08.100
Injury

"Injury" means a sudden and tangible happening, of a traumatic nature, producing an immediate or prompt result, and occurring from without, and such physical conditions as result therefrom.

RCW 51.08.140
Occupational disease

"Occupational disease" means such disease or infection as arises naturally and proximately out of employment under the mandatory or elective adoption provisions of this title.

RCW 51.08.142
"Occupational disease"—Exclusion of mental conditions caused by stress

The department shall adopt a rule pursuant to chapter 34.05 RCW that claims based on mental conditions or mental disabilities caused by stress do not fall within the definition of occupational disease in RCW 51.08.140.

RCW 51.32.055 (4)
Determination of permanent disabilities—Closure of claims by self-insurers
The department or, in cases authorized in subsection (9) of this section, the self-insurer, may require that the worker present himself or herself for a special medical examination by a physician or physicians selected by the department, and the department or, in cases authorized in subsection (9) of this section, the self-insurer may require that the worker present himself or herself for a personal interview. The costs of

the examination or interview, including payment of any reasonable travel expenses, shall be paid by the department or self-insurer, as the case may be.

RCW 51.32.080
Permanent partial disability – Specified – Unspecified, rules for classification – Injury after permanent partial disability

1. (a) Until July 1, 1993, for the permanent partial disabilities here specifically described, the injured worker shall receive compensation as follows:

Loss By Amputation

Of leg above the knee joint with short thigh stump (3" or less below the tuberosity of ischium)	$54,000.00
Of leg at or above knee joint with functional stump	48,600.00
Of leg below knee joint	43,200.00
Of leg at ankle (Syme)	37,800.00
Of foot at mid-metatarsals	18,900.00
Of great toe with resection of metatarsal bone	11,340.00
Of great toe at metatarsophalangeal joint	6,804.00
Of great toe at interphalangeal joint	3,600.00
Of lesser toes (2nd to 5th) with resection of metatarsal bone	4,140.00
Of lesser toe at metatarsophalangeal joint	2,016.00
Of lesser toe at proximal interphalangeal joint	1,494.00
Of lesser toe at distal interphalangeal joint	378.00
Of arm at or above the deltoid insertion or by disarticulation at the shoulder	54,000.00
Of arm at any point from below the deltoid insertion to below the elbow joint at the insertion of the	51,300.00
Of arm at any point from below the elbow joint distal to the insertion of the biceps tendon to and	48,600.00
Of all fingers except the thumb at metacarpophalangeal joints	29,160.00
Of thumb at metacarpophalangeal joint or with resection of carpometacarpal bone	19,440.00
Of thumb at interphalangeal joint	9,720.00
Of index finger at metacarpophalangeal joint or with resection of metacarpal bone	12,150.00
Of index finger at proximal interphalangeal joint	9,720.00
Of index finger at distal interphalangeal joint	5,346.00
Of middle finger at metacarpophalangeal joint or with resection of metacarpal bone	9,720.00
Of middle finger at proximal interphalangeal joint	7,776.00
Of middle finger at distal interphalangeal joint	4,374.00
Of ring finger at metacarpophalangeal joint or with resection of metacarpal bone	4,860.00
Of ring finger at proximal interphalangeal joint	3,888.00
Of ring finger at distal interphalangeal joint	2,430.00
Of little finger at metacarpophalangeal joint or with resection of metacarpal bone	2,430.00
Of little finger at proximal interphalangeal joint	1,944.00
Of little finger at distal interphalangeal joint	972.00
Miscellaneous	
Loss of one eye by enucleation	21,600.00
Loss of central visual acuity in one eye	18,000.00
Complete loss of hearing in both ears	43,200.00
Complete loss of hearing in one ear	7,200.00

(b) Beginning on July 1, 1993, compensation under this subsection shall be computed as follows:

i. Beginning on July 1, 1993, the compensation amounts for the specified disabilities listed in (a) of this subsection shall be increased by thirty-two percent; and
ii. Beginning on July 1, 1994, and each July 1 thereafter, the compensation amounts for the specified disabilities listed in (a) of this subsection, as adjusted under (b) (i) of this subsection, shall be readjusted to reflect the percentage change in this consumer price index calculated as follows: The index for the calendar year preceding the year in which the July calculation is made, to be known as "calendar year A," is divided by the index for the calendar year preceding calendar year A, and the resulting ratio is multiplied by the compensation amount in effect on June 30 immediately preceding the July 1st on which the respective calculation is made. For the purposes of this subsection, "index" means the same as the definition in RCW 2.12.037(1).

2. Compensation for amputation of a member or part thereof at a site other than those specified in subsection (1) of this section, and for loss of central visual acuity and loss of hearing other than complete, shall be in proportion to that which such other amputation or partial loss of visual acuity or hearing most closely resembles and approximates. Compensation shall be calculated based on the adjusted schedule of compensation in effect for the respective time period as prescribed in subsection (1) of this section.

3. (a) Compensation for any other permanent partial disability not involving amputation shall be in the proportion which the extent of such other disability, called unspecified disability, shall bear to the disabilities specified in subsection (1) of this section, which most closely resembles and approximates in degree of disability such other disability, and compensation for any other unspecified permanent partial disability shall be in an amount as measured and compared to total bodily impairment. To reduce litigation and establish more certainty and uniformity in the rating of unspecified permanent partial disabilities, the department shall enact rules having the force of law classifying such disabilities in the proportion which the department shall determine such disabilities reasonably bear to total bodily impairment. In enacting such rules, the department shall give consideration to, but need not necessarily adopt, any nationally recognized medical standards or *guides* for determining various bodily impairments.

(b) Until July 1, 1993, for purposes of calculating monetary benefits under (a) of this subsection, the amount payable for total bodily impairment shall be deemed to be ninety thousand dollars. Beginning on July 1, 1993, for the purposes of calculating monetary benefits under (a) of this subsection, the amount payable for total bodily impairment shall be adjusted as follows:

i. Beginning July 1, 1993, the amount payable for total bodily impairment under this section shall be increased to one hundred eighteen thousand eight hundred dollars; and
ii. Beginning July 1, 1994, and each July 1 thereafter, the amount payable for total bodily impairment prescribed in (b) (i) of this subsection shall be adjusted as provided in subsection (1) (b) (ii) of this section.

(c) Until July 1, 1993, the total compensation for all unspecified permanent partial disabilities resulting from the same injury shall not exceed the sum of ninety thousand dollars. Beginning on July

1, 1993, total compensation for all unspecified permanent partial disabilities resulting from the same injury shall not exceed a sum calculated as follows:

i. Beginning on July 1, 1993, the sum shall be increased to one hundred eighteen thousand eight hundred dollars; and
ii. Beginning on July 1, 1994, and each July 1 thereafter, the sum prescribed in (b)(i) of this subsection shall be adjusted as provided in subsection (1)(b)(ii) of this section.

4. If permanent partial disability compensation is followed by permanent total disability compensation, any portion of the permanent partial disability compensation which exceeds the amount that would have been paid the injured worker if permanent total disability compensation had been paid in the first instance, shall be deducted from the pension reserve of such injured worker and his or her monthly compensation payments shall be reduced accordingly.

5. Should a worker receive an injury to a member or part of his or her body already, from whatever cause, permanently partially disabled, resulting in the amputation thereof or in an aggravation or increase in such permanent partial disability but not resulting in the permanent total disability of such worker, his or her compensation for such partial disability shall be adjudged with regard to the previous disability of the injured member or part and the degree or extent of the aggravation or increase of disability thereof.

6. When the compensation provided for in subsections (1) through (3) of this section exceeds three times the average monthly wage in the state as computed under the provisions of RCW 51.08.018, payment shall be made in monthly payments in accordance with the schedule of temporary total disability payments set forth in RCW 51.32.090 until such compensation is paid to the injured worker in full, except that the first monthly payment shall be in an amount equal to three times the average monthly wage in the state as computed under the provisions of RCW 51.08.018, and interest shall be paid at the rate of eight percent on the unpaid balance of such compensation commencing with the second monthly payment. However, upon application of the injured worker or survivor the monthly payment may be converted, in whole or in part, into a lump sum payment, in which event the monthly payment shall cease in whole or in part. Such conversion may be made only upon written application of the injured worker or survivor to the department and shall rest in the discretion of the department depending upon the merits of each individual application. Upon the death of a worker all unpaid installments accrued shall be paid according to the payment schedule established prior to the death of the worker to the widow or widower, or if there is no widow or widower surviving, to the dependent children of such claimant, and if there are no such dependent children, then to such other dependents as defined by this title.

7. Awards payable under this section are governed by the schedule in effect on the date of injury.

RCW 51.32.100

Preexisting disease.

If it is determined that an injured worker had, at the time of his or her injury, a preexisting disease and that such disease delays or prevents complete recovery from such injury, it shall be ascertained, as nearly as possible, the period over which the injury would have caused disability were it not for the diseased

condition and the extent of permanent partial disability which the injury would have caused were it not for the disease, and compensation shall be awarded only therefor.

RCW 51.32.110
Medical examination – Refusal to submit – Traveling expenses – Pay for time lost.

1. Any worker entitled to receive any benefits or claiming such under this title shall, if requested by the department or self-insurer, submit himself or herself for medical examination, at a time and from time to time, at a place reasonably convenient for the worker and as may be provided by the rules of the department. An injured worker, whether an alien or other injured worker, who is not residing in the United States at the time that a medical examination is requested may be required to submit to an examination at any location in the United States determined by the department or self-insurer.

2. If the worker refuses to submit to medical examination, or obstructs the same, or, if any injured worker shall persist in unsanitary or injurious practices which tend to imperil or retard his or her recovery, or shall refuse to submit to such medical or surgical treatment as is reasonably essential to his or her recovery or refuse or obstruct evaluation or examination for the purpose of vocational rehabilitation or does not cooperate in reasonable efforts at such rehabilitation, the department or the self-insurer upon approval by the department, with notice to the worker, may suspend any further action on any claim of such worker so long as such refusal, obstruction, non-cooperation, or practice continues and reduce, suspend, or deny any compensation for such period: PROVIDED That the department or the self-insurer shall not suspend any further action on any claim of a worker or reduce, suspend, or deny any compensation if a worker has good cause for refusing to submit to or to obstruct any examination, evaluation, treatment or practice requested by the department or required under this section.

3. If the worker necessarily incurs traveling expenses in attending the examination pursuant to the request of the department, such traveling expenses shall be repaid to him or her out of the accident fund upon proper voucher and audit or shall be repaid by the self-insurer, as the case may be.

4. (a) If the medical examination required by this section causes the worker to be absent from his or her work without pay: (i) in the case of a worker insured by the department, the worker shall be paid compensation out of the accident fund in an amount equal to his or her usual wages for the time lost from work while attending the medical examination; or (ii) in the case of a worker of a self-insurer, the self-insurer shall pay the worker an amount equal to his or her usual wages for the time lost from work while attending the medical examination.

   (b) This subsection (4) shall apply prospectively to all claims regardless of the date of injury.

RCW 51.32.112
Medical examination – Standards and criteria –Special medical examinations by chiropractors – Compensation guidelines and reporting criteria.

1. The department shall develop standards for the conduct of special medical examinations to determine permanent disabilities, including, but not limited to:

   (a) The qualifications of persons conducting the examinations;

(b) The criteria for conducting the examinations, including guidelines for the appropriate treatment of injured workers during the examination; and

(c) The content of examination reports.

2. Within the appropriate scope of practice, chiropractors licensed under chapter 18.25 RCW may conduct special medical examinations to determine permanent disabilities in consultation with physicians licensed under chapter 18.57 or 18.71 RCW. The department, in its discretion, may request that a special medical examination be conducted by a single chiropractor if the department determines that the sole issues involved in the examination are within the scope of practice under chapter 18.25 RCW. However, nothing in this section authorizes the use as evidence before the board of a chiropractor's determination of the extent of a worker's permanent disability if the determination is not requested by the department.

3. The department shall investigate the amount of examination fees received by persons conducting special medical examinations to determine permanent disabilities, including total compensation received for examinations of department and self-insured claimants, and establish compensation guidelines and compensation reporting criteria.

4. The department shall investigate the level of compliance of self-insurers with the requirement of full reporting of claims information to the department, particularly with respect to medical examinations, and develop effective enforcement procedures or recommendations for legislation if needed.

Intent -- 1988 c 114: "It is the intent of the legislature that medical examinations for determining permanent disabilities be conducted fairly and objectively by qualified examiners and with respect for the dignity of the injured worker."

RCW 51.32.114
Medical examination – Department to monitor quality and objectivity.

The department shall examine the credentials of persons conducting special medical examinations and shall monitor the quality and objectivity of examinations and reports for the department and self-insured claimants. The department shall adopt rules to ensure that examinations are performed only by qualified persons meeting department standards.

RCW 51.36.060
Duties of attending physician or licensed advanced registered nurse practitioner – Medical information.

Physicians or licensed advanced registered nurse practitioners examining or attending injured workers under this title shall comply with rules and regulations adopted by the director, and shall make such reports as may be requested by the department or self-insurer upon the condition or treatment of any such worker, or upon any other matters concerning such workers in their care. Except under RCW 49.17.210 and 49.17.250, all medical information in the possession or control of any person and relevant to the

particular injury in the opinion of the department pertaining to any worker whose injury or occupational disease is the basis of a claim under this title shall be made available at any stage of the proceedings to the employer, the claimant's representative, and the department upon request, and no person shall incur any legal liability by reason of releasing such information.

RCW 51.36.070
Medical examination – Reports – Costs.
Whenever the director or the self-insurer deems it necessary in order to resolve any medical issue, a worker shall submit to examination by a physician or physicians selected by the director, with the rendition of a report to the person ordering the examination. The department or self-insurer shall provide the physician performing an examination with all relevant medical records from the worker's claim file. The director, in his or her discretion, may charge the cost of such examination or examinations to the self-insurer or to the medical aid fund as the case may be. The cost of said examination shall include payment to the worker of reasonable expenses connected therewith.

Regulations (WACs)

In addition to the regulations presented next, refer to WACs 296-20-230 through 296-20-660 (Category Rating System for cervical, cardiac, urologic impairment, etc.) in Section V. These regulations are specific to impairment and, therefore, listed there, not below.

WAC 296-14-300
Mental condition/mental disabilities.

1. Claims based on mental conditions or mental disabilities caused by stress do not fall within the definition of an occupational disease in RCW 51.08.140.

   Examples of mental conditions or mental disabilities caused by stress that do not fall within occupational disease shall include, but are not limited to, those conditions and disabilities resulting from:

   (a) Change of employment duties;

   (b) Conflicts with a supervisor;

   (c) Actual or perceived threat of loss of a job, demotion, or disciplinary action;

   (d) Relationship with supervisors, coworkers, or the public;

   (e) Specific or general job dissatisfaction;

   (f) Work load pressures;

   (g) Subjective perceptions of employment conditions or environment;

   (h) Loss of job or demotion for whatever reason;

   (i) Fear of exposure to chemicals, radiation, biohazards, or other perceived hazards;

(j) Objective or subjective stresses of employment;

(k) Personnel decisions;

(l) Actual, perceived, or anticipated financial reversals or difficulties occurring to the businesses or self-employed individuals or corporate officers.

2. Stress resulting from exposure to a single traumatic event will be adjudicated with reference to RCW 51.08.100.

WAC 296-20-055
Limitation of treatment and temporary treatment of unrelated conditions when retarding recovery. Conditions preexisting the injury or occupational disease are not the responsibility of the department. When an unrelated condition is being treated concurrently with the industrial condition, the attending doctor must notify the department or self-insurer immediately and submit the following:

1. Diagnosis and/or nature of unrelated condition.

2. Treatment being rendered.

3. The effect, if any, on industrial condition.

Temporary treatment of an unrelated condition may be allowed, upon prior approval by the department or self-insurer, provided these conditions directly retard recovery of the accepted condition. The department or self-insurer will not approve or pay for treatment for a known preexisting unrelated condition for which the claimant was receiving treatment prior to his industrial injury or occupational disease, which is not retarding recovery of his industrial condition.

A thorough explanation of how the unrelated condition is affecting the industrial condition must be included with the request for authorization.

The department or self-insurer will not pay for treatment of an unrelated condition when it no longer exerts any influence upon the accepted industrial condition. When treatment of an unrelated condition is being rendered, reports must be submitted monthly outlining the effect of treatment on both the unrelated and the accepted industrial conditions.

The department or self-insurer will not pay for treatment for unrelated conditions unless specifically authorized. This includes prescription of drugs and medicines.

WAC 296-20-19000
What is a permanent partial disability award?
Permanent partial disability is any anatomic or functional abnormality or loss after maximum medical improvement (MMI) has been achieved. At MMI, the worker's condition is determined to be stable or nonprogressive at the time the evaluation is made. A permanent partial disability award is a monetary award designed to compensate the worker for the amputation or loss of function of a body part or organ system. Impairment is evaluated without reference to the nature of the injury or the treatment given. To ensure uniformity, consistency and fairness in rating permanent partial disability, it is essential that injured workers with comparable anatomic abnormalities and functional loss receive comparable

disability awards. As such, the amount of the permanent partial disability award is not dependent upon or influenced by the economic impact of the occupational injury or disease on an individual worker. Rather, Washington's Industrial Insurance Act requires that permanent partial disability be established primarily by objective physical or clinical findings establishing a loss of function. Mental health impairments are evaluated under WAC 296-20-330 and 296-20-340.

WAC 296-20-19010
Are there different types of permanent partial disabilities?
Under Title 51 RCW, there are two types of permanent partial disabilities.

1. Specified disabilities are listed in RCW 51.32.080 (1) (a). They are limited to amputation or loss of function of extremities, loss of hearing or loss of vision.

2. Unspecified disabilities include, but are not limited to, internal injuries, back injuries, mental health conditions, respiratory disorders, and other disorders affecting the internal organs.

WAC 296-20-19020
How is it determined which impairment rating system is to be used to rate specified and unspecified disabilities?
1. Specified disabilities are rated in one of two ways:

   (a) Impairment due to amputation, total loss of hearing, and total loss of vision are rated according to RCW 51.32.080;

   (b) Impairment for the loss of function of extremities, as well as partial loss of hearing or vision, is rated using a nationally recognized impairment rating guide unless otherwise precluded by department rule.

2. Unspecified disabilities are rated in accordance with WAC 296-20-200 through 296-20-660.

WAC 296-20-19030
To what extent is pain considered in an award for permanent partial disability?
The categories used to rate unspecified disabilities incorporate the worker's subjective complaints. Similarly, the organ and body system ratings in the AMA *Guides to the Evaluation of Permanent Impairment* incorporate the worker's subjective complaints. A worker's subjective complaints or symptoms, such as a report of pain, cannot be objectively validated or measured. There is no valid, reliable or consistent means to segregate the worker's subjective complaints of pain from the pain already rated and compensated for in the conventional rating methods. When rating a worker's permanent partial disability, reliance is primarily placed on objective physical or clinical findings that are independent of voluntary action by the worker and can be seen, felt or consistently measured by examiners. No additional permanent partial disability award will be made beyond what is already allowed in the categories and in the organ and body system ratings in the AMA *guides*.

For example:

- Chapter 18 of the 5th Edition of the AMA *Guides to the Evaluation of Permanent Impairment* attempts to rate impairment caused by a patient's pain complaints. The impairment caused by the worker's pain complaints is already taken into consideration in the categories and in the organ and body system ratings in the AMA *guides*. There is no reliable means to segregate the pain already rated and compensated from the pain impairment that Chapter 18 purports to rate. Chapter 18 of the 5th Edition of the *Guides to the Evaluation of Permanent Impairment* cannot be used to calculate awards for permanent partial disability under Washington's Industrial Insurance Act.

WAC 296-20-200
General information for impairment rating examinations by attending doctors, consultants or independent medical examination (IME) providers.

1. The department of labor and industries has promulgated the following rules and categories to provide a comprehensive system of classifying unspecified permanent partial disabilities in the proportion they reasonably bear to total bodily impairment. The department's objectives are to reduce litigation and establish more certainty and uniformity in the rating of unspecified permanent partial disabilities pursuant to RCW 51.32.080(2).

2. The following system of rules and categories directs the provider's attention to the actual conditions found and establishes a uniform system for conducting rating examinations and reporting findings and conclusions in accord with broadly accepted medical principles.

   The evaluation of bodily impairment must be made by experts authorized to perform rating examinations. After conducting the examination, the provider will choose the appropriate category for each bodily area or system involved in the particular claim and include this information in the report. The provider will, therefore, in addition to describing the worker's condition in the report, submit the conclusions as to the relative severity of the impairment by giving it in terms of a defined condition rather than a personal opinion as to a percentage figure. In the final section of this system of categories and rules are some rules for determining disabilities and the classification of disabilities in bodily impairment is listed for each category. These last provisions are for the department's administrative use in acting upon the expert opinions which have been submitted to it.

3. In preparing this system, the department has complied with its duty to enact rules classifying unspecified disabilities in light of statutory references to nationally recognized standards or guides for determining various bodily impairments. Accordingly, the department has obtained and acted upon sound established medical opinion in thus classifying unspecified disabilities in the reasonable proportion they bear to total bodily impairment. In framing descriptive language of the categories and in assigning a percentage of disability, careful consideration has been given to nationally recognized medical standards and guides. Both are matters calling for the use of expert medical knowledge. For this reason, the meaning given the words used in this set of categories and accompanying rules, unless the text or context clearly indicates the contrary, is the meaning attached to the words in normal medical usage.

4. The categories describe levels of physical and mental impairment. Impairment is anatomic or functional abnormality or loss of function after maximum medical improvement has been achieved. This is the meaning of "impairment" as the word is used in the *guides* mentioned above. This standard applies to all persons equally, regardless of factors other than loss of physical or mental function. Impairment is evaluated without reference to the nature of injury or the treatment therefore, but is based on the functional loss due to the injury or occupational disease. The categories have been framed to include conditions in other bodily areas which derive from the primary impairment. The categories also include the presence of pain, tenderness and other complaints. Workers with comparable loss of function thus receive comparable awards.

5. These rules and categories (WAC 296-20-200 through 296-20-690) shall only be applicable to compensable injuries occurring on or after the effective date of these rules and categories.

6. These rules and categories (WAC 296-20-200 through 296-20-690) shall be applicable only to cases of permanent partial disability. They have no applicability to determinations of permanent total disability.

WAC 296-20-2010
General rules for impairment rating examinations by attending doctors and consultants.
These general rules must be followed by doctors who perform examinations or evaluations of permanent bodily impairment.

1. Impairment rating examinations shall be performed only by doctors currently licensed in medicine and surgery (including osteopathic and podiatric) or dentistry, and department-approved chiropractors subject to RCW 51.32.112. The department or self-insurer may request the worker's attending doctor conduct the impairment rating when appropriate. If the attending doctor is unable or unwilling to perform the impairment rating examination, a consultant, at the attending doctor's request, may conduct a consultation examination and provide an impairment rating based on the findings. The department or self-insurer can also request an impairment rating examination from an independent medical examiner (IME) provider. A chiropractic impairment rating examination may be performed only when the worker has been clinically managed by a chiropractor.

2. Whenever an impairment rating examination is made, the attending doctor or consultant must complete a rating report that includes, at the minimum, the following:

   (a) Statement that the patient has reached maximum medical improvement (MMI) and that no further curative treatment is recommended;

   (b) Pertinent details of the physical examination performed (both positive and negative findings);

   (c) Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of any pertinent tests or studies ordered as part of the exam;

   (d) An impairment rating consistent with the findings and a statement of the system on which the rating was based (for example, the AMA *Guides to the Evaluation of Permanent Impairment* and

edition used, or the Washington state category rating system—refer to WAC 296-20-19000 through 296-20-19030 and WAC 296-20-200 through 296-20-690); and

(e) The rationale for the rating, supported by specific references to the clinical findings, especially objective findings and supporting documentation including the specific rating system, tables, figures and page numbers on which the rating was based.

3. It is the responsibility of attending doctors and consultants to be familiar with the contents of the Medical Examiner Handbook section on how to rate impairment.

4. Attending doctors and consultants performing impairment ratings must be available and willing to testify on behalf of the department or self-insurer, worker or employer and accept the department fee schedule for testimony.

5. A complete impairment rating report must be sent to the department or self-insurer within fourteen calendar days of the examination date, or within fourteen calendar days of receipt of the results of any special tests or studies requested as a part of the examination. Job analyses (JAs) sent to the IME provider at the time of the impairment rating exam must be completed and submitted with the impairment rating report.

WAC 296-20-2015
What rating systems are used for determining an impairment rating conducted by the attending doctor or a consultant?
The following table provides guidance regarding the rating system generally used. These rating systems or others adopted through department policies should be used to conduct an impairment rating.

Overview of Systems for Rating Impairment

Rating System	Used for These Conditions	Form of the Rating
RCW 51.32.080	Specified disabilities: Loss by amputation, total loss of vision or hearing	Supply the level of amputation
AMA Guides to the Evaluation of Permanent Impairment	Loss of function of extremities, partial loss of vision or hearing	Determine the percentage of loss of function, as compared to amputation value listed in RCW 51.32.080
Category Rating System	Spine, neurologic system, mental health, respiratory, taste and smell, speech, skin, or disorders affecting other internal organs	Select the category that most accurately indicates overall impairment
Total Bodily Impairment (TBI)	Impairments not addressed by any of the rating systems above, and claims prior to 1971	Supply the percentage of TBI

WAC 296-20-2025

May a worker bring someone with them to an impairment rating examination conducted by the attending doctor or a consultant?

1. Workers can bring an adult friend or a family member to the impairment rating examination to provide comfort and reassurance. The accompanying person may attend the physical examination but may not attend a psychiatric examination.

2. The accompanying person cannot be compensated for attending the examination by anyone in any manner.

3. The worker may not bring an interpreter to the examination. If interpretive services are needed, the department or self-insurer will provide an interpreter.

4. The purpose of the impairment rating examination is to provide information to assist in the determination of the level of any permanent impairment, not to conduct an adversarial procedure. Therefore, the accompanying person cannot be:

   (a) The worker's attorney, paralegal, any other legal representative, or any other personnel employed by the worker's attorney or legal representative; or

   (b) The worker's attending doctor, any other provider involved in the worker's care, or any other personnel employed by the attending doctor or other provider involved in the worker's care.

The department may designate other conditions under which the accompanying person is allowed to be present during the impairment rating examination.

WAC 296-20-2030

May the worker videotape or audiotape the impairment rating examination conducted by the attending doctor or a consultant?

The use of recording equipment of any kind by the worker or accompanying person is not allowed.

WAC 296-20-220

Special rules for evaluation of permanent bodily impairment

1. Evaluations of permanent bodily impairment using categories require uniformity in procedure and terminology. The following rules have been enacted to produce this uniformity and shall apply to all evaluations of permanent impairment of an unspecified nature.

   (a) Gradations of relative severity shall be expressed by the words "minimal," "mild," "moderate" and "marked" in an ascending scale. "Minimal" shall describe deviations from normal responses which are not medically significant. "Mild," "moderate" and "marked" shall describe ranges of medically significant deviations from normal responses. "Mild" shall describe the least severe third. "Moderate" shall describe the middle third. "Marked" shall describe the most severe third.

(b) “Permanent” describes those conditions which are fixed, lasting and stable, and from which within the limits of medical probability, further recovery is not expected.

(c) “Impairment” means a loss of physical or mental function.

(d) “Total bodily impairment,” as used in these rules, is the loss of physical or mental function which is essentially complete short of death.

(e) The examiner shall not assign a percentage for permanent bodily impairment described in the categories established herein.

(f) The method of evaluating impairment levels is by selection of the appropriate level of impairment. These descriptive levels are called “categories.” Assessments of the level of impairment are to be made by comparing the condition of the injured workman with the conditions described in the categories and selecting the most appropriate category.

These rules and categories for various bodily areas and systems provide a comprehensive system for the measurement of disabling conditions which are not already provided for in the list of specified permanent partial disabilities in RCW 51.32.080(1). Disabilities resulting from loss of central visual acuity, loss of an eye by enucleation, loss of hearing, amputation or loss of function of the extremities will continue to be evaluated as elsewhere provided in RCW 51.32.080.

The categories have been classified in percentages in reasonable proportion to total bodily impairment for the purpose of determining the proper award. Provision has been made for correctly weighing the overall impairment due to particular injuries or occupational disease in cases in which there are preexisting impairments.

(g) The categories of the various bodily areas and systems are listed in the order of increasing impairment except as otherwise specified. Where several categories are given for the evaluation of the extent of permanent bodily impairment, the impairments in the higher numbered categories, unless otherwise specified, include the impairments in the lesser numbered categories. No category for a condition due to an injury shall be selected unless that condition is permanent as defined by these rules.

The examiner shall select the one category which most accurately indicates the overall degree of permanent impairment unless otherwise instructed. Where there is language in more than one category which may appear applicable, the category which most accurately reflects the overall impairment shall be selected.

The categories include appropriate subjective complaints in an ascending scale in keeping with the severity of objective findings, thus a higher or lower category is not to be selected purely on the basis of unusually great or minor complaints.

(h) When the examination discloses a preexisting permanent bodily impairment in the area of the injury, the examiner shall report the findings and any category or impairment appropriate to the worker’s condition prior to the industrial injury in addition to the findings and the categories appropriate to the worker’s condition after the injury.

(i) Objective physical or clinical findings are those findings on examination which are independent of voluntary action and can be seen, felt, or consistently measured by examiners.

(j) Subjective complaints or symptoms are those perceived only by the senses and feelings of the person being examined which cannot be independently proved or established.

(k) Muscle spasm as used in these rules is an involuntary contraction of a muscle or group of muscles of a more than momentary nature.

(l) An involuntary action is one performed independently of the will

(m) These special rules for evaluation of permanent bodily impairment shall apply to all examinations for the evaluation of impairment, in accordance with RCW 51.32.080, for the body areas or systems covered by or enumerated in WAC 296-20-230 through 296-20-660.

(n) The rules for evaluation of each body area or system are an integral part of the categories for that body area or system.

(o) In cases of injury or occupational disease of bodily areas and/or systems which are not included in these categories or rules and which do not involve loss of hearing, loss of central visual acuity, loss of an eye by enucleation or loss of the extremities or use thereof, examiners shall determine the impairment of such bodily areas and/or systems in terms of percentage of total bodily impairment.

(p) The words used in the categories of impairments, in the rules for evaluation of specific impairments, the general rules, and the special rules shall be deemed, unless the context indicates the contrary, to have their general and accepted medical meanings.

(q) The rating of impairment due to total joint replacement shall be in accordance with the limitation of motion guidelines as set forth in the *Guides to the Evaluation of Permanent Impairment* of American Medical Association, with department of labor and industries acknowledgement of responsibility for failure of prostheses beyond the seven year limitation.

WAC 296-21-270
Psychiatric Services
The following rules supplement information contained in the fee schedules regarding coverage and reimbursement for psychiatric services.

Treatment of mental conditions to workers is to be goal directed, time limited, intensive, and limited to conditions caused or aggravated by the industrial condition. Psychiatric services to workers are limited to those provided to psychiatrists and licensed psychologists, and according to department policy. For purposes of this rule, the term “psychiatric” refers to treatment by psychologists as well as psychiatrists.

Initial evaluation, and subsequent treatment must be authorized by department staff, as outlined by department policy. The report of initial evaluation, including test results, and treatment plan are to be sent to the worker’s attending provider, as well as the department. A copy of sixty-day narrative reports to the department is also to be sent to the attending provider.

All providers are bound by the medical aid rules in chapter 296-20 WAC. Reporting requirements are defined in chapter 296-20 WAC. In addition, the following are required: Testing results with scores, scales, and profiles; report of raw data sufficient to allow reassessment by a panel or independent medical examiner. Use of the current Diagnostic and Statistical Manual of the American Psychiatric Association axis format in the initial evaluation and sixty-day narrative reports, and explanation of the numerical scales are required.

A report to the department will contain, at least, the following elements:

- Subjective complaints;
- Objective observations;
- Assessment of the worker's condition and goals accomplished; and
- Plan of care.

The codes, reimbursement levels, and other policies for psychiatric services are listed in the fee schedules.

WAC 296-23-302
Definitions.

Approved Independent Medical Examination (IME) provider - A licensed doctor or firm whose credentials are approved to conduct an independent medical examination, rating evaluation, or provide IME associated services including but not limited to file preparation, scheduling of examinations and processing billing. An approved IME provider is assigned a unique provider number.

Department – For the purpose of this rule, department means the Department of Labor and Industries industrial insurance workers' compensation State Fund and self-insured programs.

Direct patient care - For the purpose of meeting the qualifications of an independent medical examination (IME) provider, direct patient care means face-to-face contact with the patient for the purpose of evaluation and management of care that includes, but is not limited to:

- History taking and review of systems;
- Physical examination;
- Medical decision making;
- Coordination of care with other providers and agencies.

This does not include time spent in independent medical examinations.

Impairment rating examination - An examination to determine whether or not the injured/ill worker has any permanent impairment(s) as a result of the industrial injury or illness after the worker has reached maximum medical improvement. An impairment rating may be conducted by the attending provider, a medical consultant, or an approved examiner. An impairment rating may be a component of an IME.

Independent medical examination (IME) - An objective medical-legal examination requested to establish medical findings, opinions, and conclusions about a worker's physical condition. These examinations may only be conducted by department approved examiners.

Independent medical examination (IME) provider - A firm, partnership, corporation, or individual licensed doctor (examiner) who has been approved and given an independent medical examination (IME) provider number by the department to perform IMEs.

Medical director - A licensed doctor and approved IME examiner in the firm, partnership, corporation or other legal entity responsible to provide oversight on quality of independent medical examinations, impairment ratings and reports.

Medical Examiners' Handbook - A handbook developed by the department containing department policy and information to assist providers who perform independent medical examinations and impairment rating examinations.

Patient related services – Patient related services are defined as one or more of the following professional activities:

- Direct Patient Care
- Locum tenens
- Clinical consultations for treating/attending doctors
- Clinical instruction of medical, osteopathic, dental, podiatry, or chiropractic students and/or residents
- On-call emergency services
- Volunteer clinician providing patient care services in his or her specialty

Provider number - A unique number(s) assigned to a provider by the Department of Labor and Industries. The number identifies the provider and is linked to a tax identification number that has been designated by the provider for payment purposes. A provider may have more than one provider number assigned by the department.

Suspension – A department action during which the provider is approved by the department but not available to accept referrals.

Temporarily unavailable – Provider is approved by the department but is temporarily unavailable to accept referrals. Temporarily unavailable applies at the provider's request for personal reasons or by the department as part of an administrative action. Provider remains unavailable until the issue is resolved.

Termination – The permanent removal of a provider from the list of approved IME examiners. All IME provider numbers assigned to the examiner are inactivated.

WAC 296-23-307
Why are independent medical examinations requested?
Independent medical examinations (IMEs) are requested by the department or the self-insurer. Generally, IMEs are ordered for one or more of the following reasons, including, but not limited to:

1. Establish a diagnosis;
2. Outline a program of treatment;
3. Evaluate what, if any, conditions are related to the claimed industrial injury or occupational disease/illness;
4. Determine whether an industrial injury or occupational disease/illness has aggravated a preexisting condition and the extent or duration of that aggravation;

5. Establish when the accepted industrial injury or occupational disease/illness has reached maximum medical improvement;
6. Establish an impairment rating;
7. Evaluate whether the industrial injury or occupational disease/illness has worsened; or
8. Evaluate the worker's mental and/or physical restrictions as well as the worker's ability to work.

WAC 296-23-312
Can a provider conduct independent medical examinations (IMEs) for the department or self-insurer without an active IME provider number from the department?
No. Only doctors who possess an active IME provider number can provide independent medical examinations for the department or self-insurer. Providers must submit an IME provider application and be approved by the department to receive this number.

WAC 296-23-317 - What qualifications must a provider meet to become an approved independent medical examination (IME) provider and be assigned an IME provider number?
To ensure that independent medical examinations are of the highest quality and propriety, examiners and firms (partnerships, corporations, or other legal entities) that derive income from independent medical exams must apply and meet the following requirements for department approval:

1. Examiners must:

   (a) Submit an accurate and complete IME provider application, including any required supporting documentation and sign without modification, an IME provider agreement with the department.

   (b) Be currently licensed, certified, accredited or registered according to Washington state laws and rules or in any other jurisdiction where the applicant would conduct an examination.

      i. The license, registration or certification must be free of any restrictions, limitations, or conditions relating to the provider's acts, omissions, or conduct.
      ii. The applicant must not have surrendered, voluntarily or involuntarily his or her professional state license or Drug Enforcement Administration (DEA) registration in any state while under investigation or due to findings resulting from the provider's acts, omissions, or conduct. The department may grant an exception for any restriction, limitation, or condition deemed by the department to be minor or clerical in nature or for a case where the restriction, limitation, or condition has been removed.
      iii. If any restriction once existed against the applicant's license, registration, or certification, the department must automatically deny the application if the applicant's record has not been clear for at least five years. If after five years the record has been cleared, then the department exclusively reserves the right to grant or deny the application based on the nature of the prior restriction.
      iv. Exception to the five-year limit may be granted for any restriction or offense deemed by the department to be of a minor or clerical nature.

(c) Not have had clinical admitting and management privileges denied, limited, or terminated for quality of care issues.

i. If an applicant has any pending action on their privilege to practice by any court, board, or administrative agency, or by any health care institution such as a hospital in any jurisdiction, the department exclusively reserves the right to grant or deny the application based upon the nature of the action.
ii. If the applicant has any criminal history, history of a violation of statutes or rules by any administrative agency, court or board in any jurisdiction, the department must automatically deny the application if such history exists within five years of the application. If such history exists but is older than five years, then the department exclusively reserves the right to grant or deny the application based upon the nature of the history.
iii. Exception to the five-year limit may be granted for any restriction or offense deemed by the department to be of a minor or clerical nature.

(d) Have no final action by the department to suspend or revoke a previously assigned provider number as a treating provider or independent medical examiner.

(e) Have no pending civil or administrative action in any jurisdiction that affects the ability or fitness to practice medicine. The department will not process the application until the matter has been resolved.

(f) Have not been excluded, expelled, terminated, or suspended from any federally or state funded health care programs including, but not limited to, medicare or medicaid programs based on cause or quality of care issues.

(g) Have no significant malpractice claims or professional liability claims (based on severity, recency, frequency, or repetition).

(h) Have not been denied approval, or removed, from the provider network as defined in WAC 296-20-01010.

(i) Attest that all information submitted on the application or credentialing materials is true and accurate and must sign under penalty of perjury.

(j) Comply with all federal, state, and local laws, regulations, and other requirements with regard to business operations, including specific requirements for the provision of medical services.

(k) Adhere to the independent medical examination standards of conduct, and all other laws, rules, and policies. These include but are not limited to the following:

- IME provider application agreement;
- *Medical Aid Rules and Fee Schedules* (MARFS);
- Payment policies;
- *Medical Examiners' Handbook.*

(l) Review and sign the IME report and attest to its accuracy.

(m) Conduct examinations in a facility primarily designated as a professional office for medical, dental, podiatric, chiropractic or psychiatric examinations where the primary use of the facility is for medical services. The facility must not be residential, commercial, educational or retail in nature. The facility must be clean, sanitary and provide adequate access, climate control, light, space, and equipment. The facility must provide for the comfort and safety of the worker and for the privacy necessary to conduct examinations and discuss medical issues. Providers must have a private disrobing area and adequate provision of examination gowns if disrobing is required.

(n) Have telephone answering capability during regular business hours, Monday through Friday, in order to facilitate scheduling of independent examinations and means for workers to contact the provider regarding their scheduled examination. If the office is open on Saturday, telephone access must be available.

(o) Agree that either they or the department may inactivate their IME provider number or numbers. If an IME provider number has been inactivated and the examiner wishes to resume performing IMEs, they must reapply and meet current requirements.

(p) Agree to keep the department informed and updated with any new information regarding changes or actions that may affect their status as an IME examiner.

(q) Reapply every three years in order to maintain an active IME provider number.

i. In the first year of the new rule, effective March 1, 2013, all current examiners must reapply.
ii. Examiners may have until March 1, 2014, to comply with the new continuing education (CE) documentation requirement.
iii. Examiners will be notified by mail sixty days prior to their renewal application due date.

(r) Achieve a passing score on the Medical Examiners' Handbook test prior to initial application and when renewal is due or required.

2. Requirements for specific examiner specialties:

(a) Medical physician and surgeon (MD) or osteopathic physician and surgeon (DO) applicants must: Hold a current board certification in their specialty; or have completed a residency and become board certified within five years of completing the residency.

i. Residency must be in a program approved by the American College of Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) or equivalent approving body.
ii. Fellowships will not be accepted in lieu of accredited residency training though they may be used to determine examination specialty qualifications.

(b) Podiatric physician (DPM) applicants must: Have a current board certification in their specialty or have completed a residency and become board certified within five years of completing the residency.

i. Complete a residency program approved by the American Podiatric Medical Association (APMA).
ii. Fellowships will not be accepted in lieu of accredited residency training though they may be used to determine examination specialty qualifications.

(c) Chiropractic physician (DC) applicants must be a chiropractic consultant for the department for at least two years and attend the department's chiropractic IME seminar in the twenty-four months before initial application.

(d) Dentist (doctor of dental science/doctor of dental medicine) (DDS/DMD) applicants must have at least two years of clinical experience after licensure, and:

i. Hold current certification in their specialty; or
ii. Have one year of postdoctoral training in a program approved by the American Dental Association Commission on Dental Accreditation (CODA); or
iii. Be a general dentist.

3. All examiners must meet the continuing education (CE) requirement for their respective state licensure. Washington state CE requirements are shown in the table below.

Doctors licensed to practice:

	Medicine & surgery	Osteopathic medicine & surgery	Podiatric medicine & surgery	Chiropractic	Dentistry
Required continuing education hours:	50 hours per year or 200 hours in 4 years	50 hours per year or 150 hours in 3 years	25 hours per year or 50 hours every 2 years	25 hours per year	21 hours per year

Applicants must submit documentation of CE hours with their initial application and when renewal is due or required. This training must focus on subject areas relevant to the provider's specialty or skills required to complete IMEs.

Exception: The requirement to submit CE documentation will be waived for applicants who provide documentation of a minimum of seven hundred sixty-eight hours of patient related services (excluding independent medical examinations) per calendar year.

Only examiners in the following practice specialties who meet all other requirements may perform IMEs:

Doctors licensed to practice:

	Medicine & surgery	Osteopathic medicine & surgery	Podiatric medicine & surgery	Chiropractic	Dentistry
Examiner is: In Washington	Yes	Yes	Yes	Yes	Yes
Outside Washington	Yes	Yes	Yes	No	Yes

4. IME firms (partnerships, corporations or other legal entities) that derive income from independent medical examinations must:

   (a) Have a medical director. The medical director must be a licensed medical physician and surgeon (MD) or osteopathic physician and surgeon (DO), be responsible to provide oversight on the quality of independent medical examinations, impairment ratings and reports, and be available to resolve any issue that department staff may bring to the medical director's attention.

      i. IME firms conducting exams in Washington state must have a medical director who has a Washington state medical license.
      ii. The medical director must be an approved independent medical examiner.

   (b) Have no previous business or audit action by the department to suspend or revoke an assigned provider number.

   (c) Have no previous action taken by any federal or state agency for any business previously owned or operated.

   (d) Facilitate scheduling of providers both for the examination and for any required follow up, including amendments to the report, subsequent reports, or for any testimony required. If the provider fails to participate in scheduling or otherwise causes an undue expense to the department, whether intentionally or not, the department may fine the provider up to five hundred dollars per violation.

   (e) Attest that all information submitted on the application is true and accurate and must sign under penalty of perjury.

(f) Comply with all federal, state, and local laws, regulations, and other requirements with regard to business operations including specific requirements for any business operations for the provision of medical services.

(g) Adhere to the independent medical examination standards of conduct, and all other laws, rules, and policies. These include, but are not limited to, the following:

- IME provider application agreement;
- *Medical Aid Rules and Fee Schedules* (MARFS);
- Payment policies;
- *Medical Examiners' Handbook.*

(h) Ensure that examinations are conducted in a facility primarily designated as a professional office for medical, dental, podiatric, chiropractic or psychiatric examinations where the primary use of the facility is for medical services. The facility must not be residential, commercial, educational or retail in nature. The facility must be clean, sanitary and provide adequate access, climate control, light, space, and equipment. The facility must provide for the comfort and safety of the worker and for the privacy necessary to conduct examinations and discuss medical issues. Providers must have a private disrobing area and adequate provision of examination gowns if disrobing is required.

(i) Have telephone answering capability during regular business hours, Monday through Friday, in order to schedule independent medical examinations and communicate with workers about scheduled examinations. If an exam site is open on Saturday, telephone access must be available.

(j) Agree that either the firm or the department may inactivate their IME provider number or numbers. If an IME provider number has been inactivated and the firm wishes to resume related services, they must reapply and meet current requirements.

(k) Agree to keep the department informed and updated with any new information such as exam site or administrative office locations, phone numbers or contact information.

(l) Reapply every three years in order to maintain an active IME provider number.

    i. In the first year of the new rule, effective March 1, 2013, all IME firms must reapply.
    ii. Firms will be notified by mail sixty days prior to their renewal application due date.

(m) Have their medical director and a representative from their quality assurance (QA) staff achieve a passing score on the *Medical Examiners' Handbook* test prior to initial application and when renewal is due or required.

WAC 296-23-322

What boards are recognized by the department for independent medical examination (IME) provider approval?

The department accepts certifications from boards recognized by the following as meeting the board certification requirements in WAC 296-23-317:

1. American Board of Medical Specialties;
2. American Osteopathic Association (AOA) Bureau of Osteopathic Specialties;
3. American Podiatric Medical Association;
4. American Dental Association.

WAC 296-23-327

What other factors may the department's medical director consider in approving or disapproving an application for an independent medical examination (IME) provider number?

The department's medical director considers other factors in approving or disapproving an IME application, including, but not limited to, the following:

1. Complaints about the provider;
2. Quality of reports;
3. Timeliness of reports;
4. Charges regarding any crime, gross misdemeanor, felony or violation of statutes or rules by any administration agency, court or board;
5. Convictions of any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court or board.

WAC 296-23-332

What are the requirements for notifying the department or self-insurer if an independent medical examination (IME) provider has a change in status?

Providers must immediately notify the department of any change in status that might affect their qualifications for an independent medical examination (IME) provider number. The notification must be in writing. Providers must include a copy of any charges or final orders if applicable. Changes in status include, but are not limited to:

1. Changes in time spent in direct patient care;
2. Loss or restriction of hospital admitting or practice privileges;
3. Changes affecting business requirements (WAC 296-23-317);
4. Loss of board certification;
5. Charges regarding any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court or board;

6. Convictions of any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court or board;
7. Temporary or permanent probation, suspension, revocation, or limitation placed on their license to practice by any court, board, or administrative agency in any state or foreign jurisdiction.

WAC 296-23-337
For what reasons shall the department's medical director or designee suspend or terminate approval of an independent medical examination (IME) examiner or firm?
To ensure high quality independent medical examinations (IMEs), the department's medical director or designee may, in the situations described below, terminate, suspend, or inactivate approval of examiners or firms (partnerships, corporations, or other legal entities) that derive income from IMEs. IME providers must have an active provider account number to perform IMEs or provide IME related services.

FOR EXAMINERS:

1. AUTOMATIC TERMINATION. The department's medical director or designee may terminate approval of examiners in situations including, but not limited to, the following:
   (a) Their license has been revoked in any jurisdiction.
   (b) A final order or stipulation to informal disposition has been issued against the examiner by a state authority in any jurisdiction including, but not limited to, the Washington state department of health, when such charges involve conduct or behavior as defined in chapter 18.130 RCW, Uniform Disciplinary Act. These include, but are not limited to:
      i. Sexually inappropriate conduct, behavior or language.
      ii. Behavior that puts a patient's safety or well-being at risk.
   (c) The examiner has committed perjury or falsified documents provided to the department or insurer.
   (d) The examiner has a criminal felony history in any jurisdiction.
   (e) The examiner has failed to reapply every three years.
2. AUTOMATIC SUSPENSION. The department's medical director or designee may suspend approval of examiners in situations including, but not limited to, the following listed below. The department will initiate a review within ninety days of notification. The results of the review will determine if further action is necessary, which may include termination of approval status.
   (a) The examiner has failed to meet or maintain the requirements for approval as an IME examiner.
   (b) The examiner's license or Drug Enforcement Administration (DEA) registration has been restricted in any jurisdiction. Exceptions may be granted for any restriction or offense deemed by the department to be of a minor or clerical nature.
   (c) The examiner has lost hospital privileges for cause.

(d) A statement of charges has been filed against the examiner by a state authority in any jurisdiction, including, but not limited to the Washington state department of health, when such charges involve conduct or behavior as defined in chapter 18.130 RCW, Uniform Disciplinary Act. These include, but are not limited to:

i. Sexually inappropriate conduct, behavior or language.
ii. Behavior that puts a patient's safety or well-being at risk.

(e) The examiner has any pending or history of criminal charges or violation of statutes or rules by any administrative agency, court or board in any jurisdiction.

3. OTHER EXAMINER ACTIONS. In addition to automatic terminations and suspensions described in subsections (1) and (2) of this section, the department's medical director or designee may consider any of the following factors in determining a change in status for examiners. These status changes include temporarily unavailable, suspension or termination of the approval to conduct IMEs.

These factors include, but are not limited to:

(a) Substandard quality of reports, failure to comply with current department policy on report contents, or inability to effectively convey and substantiate medical findings, opinions, and conclusions, concerning workers.

(b) Unavailable or unwilling to testify on behalf of the department, worker, or employer.

(c) Failure to cooperate with attorneys representing a party in industrial insurance litigation at the board of industrial insurance appeals (board) by not cooperating in a timely manner to schedule preparatory activities and/or testimony during business hours and within the dates and locations ordered by the board to complete testimony.

(d) Failure to stay current in the area of specialty and in the areas of impairment rating, performance of IMEs, industrial injury and occupational disease/illness, industrial insurance statutes, regulations and policies.

(e) Substantiated complaints or pattern of complaints about the provider.

(f) Other disciplinary proceedings or actions not listed in subsections (1) and (2) of this section.

(g) Other proceedings in any court dealing with the provider's professional conduct, quality of care or criminal actions not listed in subsections (1) and (2) of this section.

(h) Untimely reports.

(i) Unavailable or unwilling to communicate with the department in a timely manner.

(j) Misrepresentation of information provided to the department.

(k) Failure to inform the department of changes or actions that may affect the approval status as an IME examiner.

(l) Failure to comply with the department's orders, statutes, rules, or policies.

(m) Failure to accept the department fee schedule rate for independent medical examinations, testimony, or other IME related services.

(n) Any pending action in any jurisdiction.

FOR FIRMS:

4. AUTOMATIC TERMINATION. The department's medical director or designee may terminate approval of firms when they fail to reapply every three years.

5. AUTOMATIC SUSPENSION. The department's medical director or designee may suspend approval of firms in situations including, but not limited to, those listed below. The department will review the matter to determine if further action is necessary, which may include termination of approval status.

   (a) The firm no longer meets requirements for approval as an IME provider.

   (b) The firm's representative has committed perjury or falsified documents provided to the department or insurer.

   (c) A firm representative's behavior has placed a patient's safety or well-being at risk.

6. OTHER FIRM ACTIONS. In addition to automatic terminations and suspensions described in subsections (4) and (5) of this section, the department's medical director or designee may consider any of the following factors in determining a change in status for firms. These status changes include temporarily unavailable, suspension or termination of the approval to provide IME related services.

   These factors include, but are not limited to:

   (a) Substantiated complaints or pattern of complaints about the firm.

   (b) Other disciplinary proceedings or actions not listed in subsections (4) and (5) of this section.

   (c) Other proceedings in any court dealing with the provider's professional conduct, quality of care or criminal actions not listed in subsections (4) and (5) of this section.

   (d) Untimely reports.

   (e) Unavailable or unwilling to communicate with the department in a timely manner.

   (f) Misrepresentation of information provided to the department.

   (g) Failure to inform the department of changes affecting the firm's status as an IME provider.

   (h) Failure to comply with the department's orders, statutes, rules, or policies.

   (i) Failure to accept the department fee schedule rate for independent medical examinations and services.

   (j) Any pending action in any jurisdiction.

WAC 296-23-342

Are providers entitled to referrals from the department or self-insurer?

No. The department or self-insured employer refers industrially injured or ill workers for independent medical examination (IME) services at their sole discretion. No provider is entitled to referrals from the referral source.

WAC 296-23-347

What are the independent medical examination (IME) provider's responsibilities in an examination?

1. The IME provider's responsibilities prior to the examination are to:
   - (a) Be familiar with the contents of the medical examiner's handbook;
   - (b) Review all claim documents provided by the department or self-insured employer;
   - (c) Contact the worker prior to the examination to confirm the appointment date, time and location; and
   - (d) Review the purpose of the examination and the questions to be answered in the examination report.
2. The IME provider's responsibilities during the examination are to:
   - (a) Introduce himself or herself to the worker;
   - (b) Verify the identity of the worker;
   - (c) Let the worker know that the claim documents from the department or self-insurer have been reviewed;
   - (d) Explain the examination process and answer the worker's questions about the examination process;
   - (e) Advise the worker that he/she should not perform any activities beyond their physical capabilities;
   - (f) Allow the worker to remain fully dressed while taking the history;
   - (g) Ensure adequate draping and privacy if the worker needs to remove clothing for the examination;
   - (h) Refrain from expressing personal opinions about the worker, the employer, the attending doctor, or the care the worker has received;
   - (i) Conduct an examination that is unbiased, sound and sufficient to achieve the purpose and reason the examination was requested;
   - (j) Conduct the examination with dignity and respect for the worker;
   - (k) Ask if there is any further information the worker would like to provide; and
   - (l) Close the examination by telling the worker that the examination is over.
3. The IME provider's responsibilities following the examination are to:

(a) Send a complete IME report to the department or self-insurer within fourteen calendar days of the examination date, or within fourteen calendar days of the receipt of the results of any special tests or studies requested as a part of the examination. Reports received after fourteen calendar days may be paid at a lower rate per the fee schedule. The report must meet the requirements of WAC 296-23-382; and

(b) The claim file information received from the department or self-insurer should be disposed of in a manner used for similar health records containing private information after completion of the IME or any follow-up test results are received. IME reports should be retained per WAC 296-20-02005.

WAC 296-23-352

Must the independent medical examination (IME) provider address job analyses (JAs) at the request of the department or self-insurer?

Job analyses (JAs) sent to the IME provider at the time of the IME referral must be completed and submitted with the IME report. JAs submitted within sixty calendar days after the IME must be completed and returned within fourteen days of receipt of the JAs.

WAC 296-23-357

May an independent medical examination (IME) provider offer to provide ongoing treatment to the worker?

No. However, if a worker voluntarily approaches an IME provider who has previously examined the worker and asks to be treated by that provider, the provider can treat the worker. The provider must document that the worker was aware of other treatment options.

WAC 296-23-362

May a worker bring someone with them to an independent medical examination (IME)?

1. Workers can bring an adult friend or family member to the IME to provide comfort and reassurance. That accompanying person may attend the physical examination but may not attend a psychiatric examination.
2. The accompanying person cannot be compensated for attending the examination by anyone in any manner.
3. The worker may not bring an interpreter to the examination. If interpretive services are needed, the department or self-insurer will provide an interpreter.
4. The purpose of the IME is to provide information to assist in the determination of the level of any permanent impairment not to conduct an adversarial procedure. Therefore, the accompanying person cannot be:

   (a) The worker's attorney, paralegal, any other legal representative, or any other personnel employed by the worker's attorney or legal representative; or

(b) The worker's attending doctor, any other provider involved in the worker's care, or any other personnel employed by the attending doctor or other provider involved in the worker's care.

The department may designate other conditions under which the accompanying person is allowed to be present during the IME.

WAC 296-23-367
May the worker videotape or audiotape the independent medical examination?
The use of recording equipment of any kind by the worker or accompanying person is not allowed.

WAC 296-23-372
Can a worker file a complaint about a provider's conduct during an independent medical examination?
Workers can send written complaints about a provider's conduct during an independent medical examination to the self-insurer or department. Based on the nature of the complaint, the department may refer the complaint to the Department of Health.

WAC 296-23-377
If an independent medical examination (IME) provider is asked to do an impairment rating examination only, what information must be included in the report?
When doing an impairment rating examination, the IME provider must first review the determination by the attending doctor that the worker has reached maximum medical improvement (MMI).

1. If, after reviewing the records, taking a history from the worker and performing the examination, the IME provider concurs with the attending doctor's determination of MMI, the impairment rating report must, at a minimum, contain the following:

   (a) A statement of concurrence with the attending doctor's determination of MMI;

   (b) Pertinent details of the physical or psychiatric examination performed (both positive and negative findings);

   (c) Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of pertinent tests with the report;

   (d) An impairment rating consistent with the findings and a statement of the system on which the rating was based (for example, the AMA *Guides to the Evaluation of Permanent Impairment* and edition used, or the Washington state category rating system—refer to WAC 296-20-19000 through 296-20-19030 and WAC 296-20-200 through 296-20-690); and

   (e) The rationale for the rating, supported by specific references to the clinical findings, especially objective findings and supporting documentation including the specific rating system, tables, figures and page numbers on which the rating was based.

2. If, after review of the records, a history from the worker and the examination, the IME provider does not concur with the attending doctor's determination of MMI, an IME report must be completed. (See WAC 296-23-382.)

WAC 296-23-381
What rating systems are used for determining an impairment rating conducted by an independent medical examination (IME) provider?
The following table provides guidance regarding the rating systems generally used. These rating systems or others adopted through department policies should be used to conduct an impairment rating.

Overview of Systems for Rating Impairment

Rating System	Used for These Conditions	Form of the Rating
RCW 51.32.080	Specified disabilities: Loss by amputation, total loss of vision or hearing	Supply the level of amputation
AMA Guides to the Evaluation of Permanent Impairment	Loss of function of extremities, partial loss of vision or hearing	Determine the percentage of loss of function, as compared to amputation value listed in RCW 51.32.080
Category Rating System	Spine, neurologic system, mental health, respiratory, taste and smell, speech, skin, or disorders affecting other internal organs	Select the category that most accurately indicates overall impairment
Total Bodily Impairment (TBI)	Impairments not addressed by any of the rating systems above, and claims prior to 1971	Supply the percentage of TBI

WAC 296-23-382
What information must be included in an independent medical examination (IME) report?
1. It is the department's intention to purchase objective examinations to ensure that sure and certain determinations are made of all benefits to which the worker might be entitled. The independent medical examination report must:

   (a) Contain objective, sound and sufficient medical information;

   (b) Document the review of the claim documents provided by the department or self-insurer;

   (c) Document the worker's history and the clinical findings;

(d) Answer all the written questions posed by the department or self-insurer or include a description of what would be needed to address the questions;

(e) Include objective conclusions and recommendations supported by underlying rationale that links the medical history and clinical findings;

(f) Be in compliance with current department reporting policies; and

(g) Be signed by the IME provider performing the examination.

2. An impairment rating report may be requested as a component of an IME. Impairment rating reports are to be done as specified in WAC 296-20-200 and 296-20-2010 (2) (a) through (e) and 296-23-377.

WAC 296-23-387
What are the responsibilities of an independent medical examination (IME) provider regarding testimony?

IME providers must make themselves reasonably available to testify at the Board of Industrial Insurance Appeals (Board) or by deposition. Reasonably available to all parties means cooperating in the timely scheduling of the pre-testimony conference and testimony and being available to testify during business hours (7am – 6pm) as ordered by the judge and within the dates ordered by the Board to complete testimony.

In signing the application to be an independent medical examination provider, the provider agrees to perform examinations and be available to testify and to answer questions about the medical facts of the case at rates established under the authority of Washington industrial insurance law.

The Department may fine the firm and or examiner up to $500 per violation for failure to comply with these requirements, whether the failure was intentional or not.

In addition, failure to comply with these requirements may result in suspension or termination of the IME provider number.

WAC 296-23-392
Is there a fee schedule for independent medical examinations (IMEs)?

The maximum fee schedule for performing independent medical examinations is published by the department in the Medical Aid Rules and Fee Schedules (MARFS) available from the department.

APPENDIX D

Addresses and Numbers

Useful Resources	
IME reports for State Fund Department of Labor & Industries PO Box 44239 Olympia, WA 98504-4239 fax: 360-902-4567	IME bills for State Fund Department of Labor & Industries PO Box 44269 Olympia, WA 98504-4269
Questions about State Fund billing Provider Toll-Free Line: 1-800-848-0811 Online Claim and Account Center www.ClaimInfo.LNI.wa.gov	IME reports and bills for crime victims Department of Labor & Industries Crime Victims Section PO Box 44520 Olympia, WA 98504-4520
IME reports and bills for self-insurers Use address on IME cover letter	General information about self-insurers Department of Labor & Industries Self-Insurance Section PO Box 44892 Olympia, WA 98504-4892
Application information, updates, IME complaints Department of Labor & Industries Provider Credentialing and Compliance PO Box 44322 Olympia, WA 98504-4322 Phone: 360-902-6822 Web page for Independent Medical Examinations: www.imes.Lni.wa.gov	Seminars and trainings on IMEs, impairment rating and other Department of Labor & Industries Provider Education Manager PO Box 44321 Olympia, WA 98504-4321 phone: 360-902-6817 fax: 360-902-4249 e-mail: mdan235@LNI.wa.gov
L&I Central Scheduling Unit: Main Phone 1 800 468-7870 or fax 206 515-2791	

Useful Resources	
Assistance with IMEs and impairment ratings IME Quality Assurance phone: 360-902-6818 e-mail: brit235@LNI.wa.gov	Order the AMA *Guides to the Evaluation of Permanent Impairment* Order Department American Medical Association PO Box 109050 Chicago, Illinois 60610-9050 Phone: 1-800-621-8335
Order L&I publications (e.g., Attending Doctors Handbook) (*Medical Examiners' Handbook* is available online only) Labor & Industries Warehouse PO Box 44843 Olympia, WA 98504-4843 OR Provider Toll Free Line: 1-800-848-0811	Suggestions to improve this handbook Hal Stockbridge, MD, MPH Department of Labor and Industries PO Box 44321 Olympia, WA 98504-4321 360-902-5022

Useful Resources

L&I web sites:

L&I web site, main page
www.Lni.wa.gov

Web page for Independent Medical Examinations
including report template
www.imes.Lni.wa.gov

Find an Approved Medical Examiner
www.imes.Lni.wa.gov/ and click on "Find a Medical Examiner."
or
https://fortress.wa.gov/lni/imets/

Main web page for providers
www.Lni.wa.gov/ClaimsIns/Providers

Online Claim and Account Center
www.ClaimInfo.Lni.wa.gov

Interpreter Services – Tips & FAQs
www.ctslanguagelink.com
(or)
www.imes.Lni.wa.gov and click on "interpreter services"

Topic page that includes links to Provider Bulletins and
the Medical Treatment Guidelines
www.Lni.wa.gov/Main/ProviderTopics.asp

Direct link to treatment information
http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/

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Other formats for persons with disabilities are available on request.
Call 1-800-547-8367. TDD users, call 360-902-5797.
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