Essential Components of the Impairment Evaluation

Examination for determining musculoskeletal system impairments is based on traditional approaches for recording the medical history, performing the physical examination and documenting objective clinical findings. The impairment examination and report should not be separated from the generally accepted principals of medical practice or the consensus of medical knowledge and experience.

Chapter 2, Page 17 of the Guides state *" Two physicians, following the methods of the Guides to evaluate the same patient, should report similar results and reach similar conclusions. Moreover, if the clinical findings are fully described, any knowledgeable observer may check the findings with the Guides criteria."*

Simply quoting subjective complaints and Tables in the Guides is not sufficient enough to warrant an impairment rating. The Guides state in Chapter 2, Page 21, that a *"clear accurate and complete report is essential to support a rating of permanent impairment".*

Section 2.6a states that the evaluator must, *"Assess **current clinical status**, including current symptoms, review of symptoms, physical examination".*

The elements of the narrative report include; a medical history, a work history, current symptoms, physical examination and discussion of diagnosis and basis for MMI and impairment rating. A comprehensive physical examination should include, but is not limited to, pertinent ranges of motion, palpation, sensory and motor evaluation and current diagnostic studies.

Chapter 2, Section 2.6b states that when calculating the impairment rating the evaluator must *"Compare the medical findings with the impairment criteria listed within the Guides and calculate the appropriate impairment rating".* The evaluator must also, *"Discuss how specific findings relate to and compare with the criteria described in the applicable Guides chapter".*

Chapter 2, Section 2.6c states that the evaluator must, *"Include an explanation of each impairment value with reference to the applicable criteria of the Guides".*

Physician has provided no clear explanation as to how he arrived at this impairment rating. He has also failed to provided reference to the criteria used or reference to the applicable sections of the Guides.

A mere conclusion that the Claimant has sensory and/or motor deficits in the upper extremity, absent any discussion as to the rational for the doctor's opinion that is based on current electrodiagnostic studies is speculative and should not be considered substantial evidence; therefore the rating physician does not meet his burden of proof.

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Medical opinion is not substantial evidence if it is based on inadequate medical histories, examinations, speculation, conjecture, or guess.

Chapter 15, Section 15.1a provides instructions pertaining to the examination of the spine. The Guides state, *"Guided by the history, the physician should focus on spine-related physical findings such as range of motion, reflexes, muscle strength, atrophy, sensory deficits, root tension signs, gait and the need for assistive devices".*

Section 15.3, Page 383 of the Guides states; "*Since an individual is evaluated after having reached MMI, a previous history of objective findings may not define the current, ratable condition but, is important in determining the course and whether MMI has been Reached. The impairment rating is based on the condition once MMI is reached, not on prior symptoms or signs"*

The Guides provide specific instructions pertaining to the examination of the upper extremity. Chapter 16, Section 16.1b states *"The medical evaluation is the basis for determination of permanent anatomic impairment of the upper extremity….It must be accurate, objective, and well documented. It must be through and should include several elements: status of activities of daily living, careful observations; both local and general physical examinations; appropriate imaging evaluation; laboratory tests; and preferably, a photographic record….An impairment evaluation is based on the examiners actual findings…….A complete and detailed examination of the upper extremity is necessary for accurate impairment evaluation".*

Chapter 16, Section 16.1b states; *"the medical evaluation is the basis for determination of permanent impairment of the upper extremity.* ***It must be accurate, objective and well documented",*** furthermore, *"an impairment evaluation is* ***based on the examiner's actual findings****".*

Chapter 17, Section 17.1, Page 524 states, *"The evaluation should include a comprehensive, accurate medical history; a review of all pertinent records; a comprehensive description of the individual's symptoms and their relationship to daily activities; a careful and thorough physical examination"……Guided by the history and physical examination, the physician records lower extremity related physical findings such as range of motion, limb length discrepancy, deformity, reflexes, motor and sensory deficits, and specific diagnoses such as fractures and bursitis".*

Chapter 17, Section 17-1, Page 524 states, *"It is essential that the rater include in the report a description of how the impairment rating was calculated. Because many ratings are reviewed by other physicians and third party administrators, the explanation of the calculation will lead to a better understanding of the method used and the report will be considered more valid".*