2015 Non-Musculoskeletal Conditions MMI/IR

Non-Musculoskeletal Conditions MMI/IR

- Historically non-musculoskeletal conditions represent less than 10% of DD exams

- Important points from AMA *Guides* 4th Chapters:
  - 4 Nervous
  - 5 Respiratory
  - 8 Visual
  - 9 ENT
  - 10 Digestive
  - 11 Urinary and Reproductive
  - 13 Skin
  - 14 Mental and Behav

Impairment Rating Concepts

Impairment Rating Considerations

- Assignment of an impairment rating for the current compensable injury shall be based on the injured employee's condition on the MMI date considering the medical record and the certifying examination.
- Assign one whole body impairment rating for the current compensable injury.
- Explain in your report what you believe the compensable injury to be and the basis for this from the medical records and your exam.

How to Determine Impairment Rating

- Review the medical records prior to your exam
- Perform a thorough, relevant physical examination of all compensable body areas/systems.
- Correlate with findings in prior medical records.
- Make referrals, if necessary, to answer question.
- Use the rating criteria contained in the appropriate edition of the AMA *Guides to the Evaluation of Permanent Impairment*, 4th Edition.

How to Determine Impairment Rating

- Use the rating criteria contained in the appropriate edition of the AMA *Guides to the Evaluation of Permanent Impairment*.
- **Show your work!** so that "… any knowledgeable person can compare the clinical findings with the guides criteria and determine whether or not the impairment estimates reflect those criteria." AMA *Guides,* page 8
- Document the findings and explain the impairment rating in your narrative report, plus relevant worksheets.
- Complete and sign the DWC Form-069.

Non-Musculoskeletal Conditions MMI/IR

- Many of these conditions are have ranges for rating
- Consider effects on ADL
- Explain in your report your rationale for selecting the appropriate Class in a Table and the IR percentage within a Class

Non-Musculoskeletal Conditions MMI/IR

Designated Doctor Physical Examination

- Based on the medical records and your physical examination of the injured employee, determine what the compensable injury for certifying MMI and IR is.

Impairment Rating

Question for designated doctor:

**On the certified MMI date,
what is the impairment rating?**

- **Show your work!**

ADL Information

- Table on page 317 and related text
- Other ADL questionnaires/tools
- Confirmed by history

Activities of Daily Living, p. 317

Table. Activities of Daily Living, with Examples.

Activity	Example
Self-care, personal hygiene	Bathing, grooming, dressing, eating, eliminating
Communication	Hearing, speaking, reading, writing, using keyboard
Physical activity	*Intrinsic:* Standing, sitting, reclining, walking, stooping, squatting, kneeling, reaching, bending, twisting, leaning
	Functional: Carrying, lifting, pushing, pulling, climbing, exercising
Sensory function	Hearing, seeing, tactile feeling, tasting, smelling
Hand functions	Grasping, holding, pinching, percussive movements, sensory discrimination
Travel	Riding, driving, traveling by airplane, train, or car
Sexual function	Participating in desired sexual activity
Sleep	Having a restful sleep pattern
Social and recreational activities	Participating in individual or group activities, sports, hobbies

Additional Testing and Referrals

REFER FOR SPECIALTY EVALUATION IF NEEDED!
28 TAC § 127.10 (c)

The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability…

Best Practice
Testing and Referrals

1. Provide injured employee (IE) with information about the referral.
   - Tell injured employee why and to whom they are being referred.
   - If possible, provide IE with written scheduling instructions, before they leave the DD exam.

Best Practice
Testing and Referrals

2. Send written instructions to consulting/testing facility.
   - Provide instructions to the consultant or facility that state ***what*** you need and ***when*** you need the information.
   - Considering providing information about 28 TAC §127.10(c) regarding the lack of need for preauthorization and the prohibition against retrospective review.

Best Practice
Testing and Referrals

3. Send a copy of all pertinent medical records and a copy of the DWC Form-032 to the consultant/testing facility.

Best Practice
Testing and Referrals

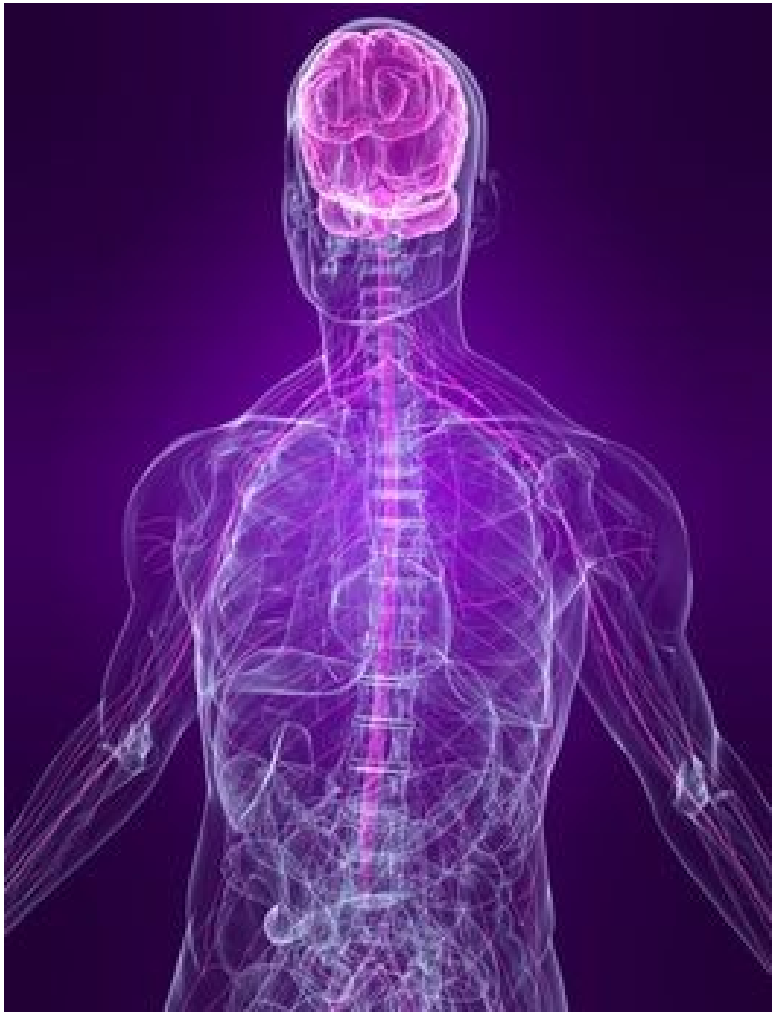
4. If necessary, request an extension of the report due date ***before*** the DD report is due.

Note: See pages 15 & 16 of Supplemental Information Section of Training Book for
suggested language for request for extension.

Best Practice
Testing and Referrals

5. Even if negative, incorporate the findings from the consultant/testing facility into the DD report with an explanation of how the information is used in determining MMI/IR, RTW, Extent of Injury, etc.
6. Attach the specialist's report to your narrative report.

Nervous System Chapter 4



Nervous System Impairment Categories

- 4.1 Central Nervous System
  - Cerebrum or Forebrain (p. 140)
- 4.2 Brain Stem (p. 145)
- 4.3 Spinal Cord (p. 147)
- 4.4 Muscular and Peripheral Nervous System (p. 149)
- 4.5 Pain (p. 152)

Overview

- Nervous system impairment criteria are defined by ADL restrictions.
- Neurologic impairment are intimately related to mental/behavioral disorders.
- If the patient has impairments of several parts of the nervous system (i.e. brain, spinal cord and PNS), evaluate each and then combine WP values

Overview

- “In general, only the medical condition causing the greatest impairment should be evaluated.” p. 140.

- Refer to the appropriate specialist if needed (i.e. neuropsychologist/psychologist, ophthalmologist, etc.).

Assessing Impairment in 4.1a – 4.1c

- Goal is to objectively assess change in/loss of functioning due to brain injury or 'concussion' in order to have an accurate rating
- Chapter 4 references Chapter 14 regarding use of standardized psychological testing to provide the data to aid in such assessments
- Chapter 14 notes, "neuropsychological assessment . . . may be useful in determining deficiencies in brain functioning, particularly in individuals with subtle signs such as those that may be seen in traumatic brain injuries."

Assessing Impairment in 4.1a – 4.1c

PSYCHOLOGICAL VS. NEUROPSYCHOLOGICAL TESTING

General Psychological Testing:

- Personality testing – assess mood, emotions, coping, somatization, behavioral and interpersonal functioning, substance abuse, exaggeration/ minimization, malingering (MMPI-2 or MMPI-2-RF, PAI)
- Specific cognitive functions – concentration, memory, attention, effort ("concentration, persistence and pace" in Chp. 14)
- This is type of testing for Chp. 14, Mental Disorders
- Consider referring when appropriate

Assessing Impairment in 4.1a – 4.1c

PSYCHOLOGICAL VS. NEUROPSYCHOLOGICAL TESTING

NEUROPSYCHOLOGICAL ASSESSMENT

- Assesses the effects of known or suspected brain injury through comprehensive, systematic testing of a wide spectrum of cognitive functions:
  - General Intellectual Level
  - Attention And Information Processing
  - Learning And Memory
  - Reasoning, Analysis, Organization, Planning, Self-Correction ("Executive Functions")
  - Visual-Spatial Abilities
  - Language Functioning
  - Sensory-Motor Functioning (Effects Of Brain Injury, Not Physical Injury)
  - Behavioral Functioning (Inhibition, Awareness, Self-Regulation)

Assessing Impairment in 4.1a – 4.1c

For Chapter 4, consider whether neuropsychological assessment would be appropriate.

4.1 Central Nervous System Cerebrum or Forebrain (p.140)

- Pick the ***most severe of the first five categories***
  1. ***Disturbances of consciousness and awareness***
  2. ***Aphasia or communication disturbances***
  3. ***Mental status and integrative functioning abnormalities***
  4. ***Emotional/behavioral disturbances***
  5. ***Special types of preoccupation or obsession***

4.1 Central Nervous System Cerebrum or Forebrain (p.140)

- ***Combine the most severe of the first five categories with any of the last four categories***
  6. ***Major motor or sensory abnormalities***
  7. ***Movement disorders***
  8. ***Episodic neurologic disorders***
  9. ***Sleep and arousal disorders***

4.1 Central Nervous System Cerebrum or Forebrain (p.140)

- Tables with wide ranges within each class.
- Sufficiently explain how you determined the rating within a reasonable degree of medical probability.

- **“Show your work**

4.1d Disturbances of Consciousness and Awareness (p. 142)

Table 4. Impairment of Consciousness and Awareness.

Impairment description	% Impairment of the whole person
Brief repetitive or persisting alteration of state of consciousness, limiting ability to perform usual activities	0 - 14
Prolonged alteration of state of consciousness diminishing capabilities in personal care and other activities of daily living	15 - 29
State of semicoma with complete dependency and subsistence by artificial medical means	30 - 49
Persistent vegetative state, or irreversible coma requiring total medical support	50 - 90

4.1a Aphasia or Communication Disturbances (p. 141)

Table 1. Impairments Related to Aphasia or Dysphasia.

Description	% Impairment of the whole person
Minimal disturbance in comprehension and production of language symbols of daily living	0 - 9
Moderate impairment in comprehension and production of language symbols of daily living	10 - 24
Inability to comprehend language symbols; production of unintelligible or inappropriate language for daily activities	25 - 39
Complete inability to communicate or comprehend language symbols	40 - 60

4.1b Mental Status and Integrative Functioning (p. 142)

Table 2. Mental Status Impairments.

Impairment description	% Impairment of the whole person
Impairment exists, but ability remains to perform satisfactorily most activities of daily living	1 - 14
Impairment requires direction and supervision of daily living activities	15 - 29
Impairment requires directed care under continued supervision and confinement in home or other facility	30 - 49
Individual is unable without supervision to care for self and be safe in any situation	50 - 70

4.1c Emotional or Behavioral Disturbances (p. 142)

Table 3. Emotional or Behavioral Impairments.

Impairment description	% Impairment of the whole person
Mild limitation of daily social and interpersonal functioning	0 - 14
Moderate limitation of *some* but not all social and interpersonal daily living functions	15 - 29
Severe limitation impeding useful action in *almost all* social and interpersonal daily functions	30 - 49
Severe limitation of all daily functions requiring total dependence on another person	50 - 70

- Also used with Chapter 14 for mental/behavioral conditions.
- Used for "other kinds of CNS responses" such as "5. Special types of preoccupation or obsession".

The Last Four Categories

- ***Combine the most severe of the first five categories with any of the last four categories.***
- May use as a single method for an appropriate condition.

4.1e Episodic Neurologic Disorders

Table 5. Impairments Related to Epilepsy, Seizures, and Convulsive Disorders.

Impairment description	% Impairment of the whole person
Paroxysmal disorder with predictable characteristics and unpredictable occurrence that does not limit usual activities but is a *risk* to the patient or limits performance of daily activities	0 - 14
Paroxysmal disorder that interferes with *some* activities of daily living	15 - 29
Severe paroxysmal disorder of such frequency that it limits activities to those that are supervised, protected, or restricted	30 - 49
Uncontrolled paroxysmal disorder of such severity and constancy that it *totally limits* the individual's daily activities	50 - 70

- Syncope/loss of awareness.
- Convulsive disorders.
- Sleep and arousal disorders (Table 6).
- Document onset, frequency, duration and effect on ADLs and attempts to control.

4.1e Episodic Neurologic Disorders - Sleep and Arousal Disorders

Table 6. Impairment Criteria for Sleep and Arousal Disorders.

Description	% Impairment of the whole person
Reduced daytime alertness with sleep pattern such that patient can carry out most daily activities	1 - 9
Reduced daytime altertness requiring some supervision in carrying out daytime activities	10 - 19
Reduced daytime alertness that significantly limits daily activities and requires supervision by caretakers	20 - 39
Severe reduction of daytime alertness that causes the patient to be unable to care for self in any situation or manner	40 - 60

4.1f The Cranial Nerves

- CN I (Olfactory)
  - Anosmia (only if interferes with ADLs) = 5% WP
- CN II, III, IV, VI
  (Optic, Oculomotor, Trochlear, Abducens)
  - Refer to Visual System (Chapter 8)
- CN VIII (Auditory)
  - Refer to ENT Chapter
  - Significant equilibrium/balance ADL limitations due to CN VIII may be rated with Table

4.2b The Pons-Cerebellum Segment

Table 9. Cranial Nerve V (Trigeminal) Impairment Criteria.

Impairment description	% Impairment of the whole person
Mild impairment due to uncontrolled facial neuralgic pain	0 - 14
Moderately severe, uncontrolled, facial neuralgic pain	15 - 24
Severe, uncontrolled, neuralgic pain, unilateral or bilateral	25 - 35

4.2b The Pons-Cerebellum Segment

Table 10. Impairment Criteria for Cranial Nerve VII (Facial) and Adjoining Region.

Impairment description	% Impairment of the whole person
Complete loss of taste of anterior tongue	1 - 4
Mild unilateral facial weakness	1 - 4
Mild bilateral facial weakness	5 - 19
Severe *unilateral* facial paralysis with 75% or greater facial involvement	5 - 19
Severe *bilateral* facial paralysis with 75% or greater facial involvement	20 - 45

4.2b The Pons-Cerebellum Segment

Table 11. Impairment Criteria for Cranial Nerve VIII (Auditory Nerve).

Impairment description	% Impairment of the whole person
Minimal impairment of equilibrium exists, with limitation required only of activities in hazardous surroundings	1 - 9
Minimal impairment of equilibrium exists, with limitation required of all daily activities except simple ones for self-care	10 - 29
Moderate impairment of equilibrium exists, with limitation required of all daily activities including those for self-care	30 - 49
Severe impairment of equilibrium exists, with such limitation of daily activities that assistance is required for self-care and ambulation, and confinement may be needed	50 - 70

4.2c The Medulla or Posterior Hindbrain

Table 12. Impairment Criteria for Cranial Nerves IX and XII.

Impairment description	% Impairment of the whole person
Mild dysarthria, dystonia, or dysphagia with choking on liquids or semisolid food; or uncontrolled spasmodic torticollis	1 - 14
Moderately severe dysarthria or dysphagia with hoarseness, nasal regurgitation, and aspiration of liquids or semisolid foods	15 - 39
Severe inability to swallow or handle oral secretions without choking, with need for assistance and suctioning	40 - 60

4.3 The Spinal Cord

- 4.3a Station and Gait
- 4.3b Use of Upper Extremities
- 4.3c Respiration
- 4.3d Urinary Bladder Dysfunction
- 4.3e Anorectal Dysfunction
- 4.3f Sexual Function
- May combine multiple impairments

4.3a Station and Gait

Table 13. Station and Gait Impairment Criteria.

Impairment description	% Impairment of the whole person
Patient can rise to a standing position and can walk but has difficulty with elevations, grades, stairs, deep chairs, and walking long distances	1 - 9
Patient can rise to a standing position and can walk some distance with difficulty and without assistance but is limited to level surfaces	10 - 19
Patient can rise to a standing position and can maintain it with difficulty but cannot walk without assistance	20 - 39
Patient cannot stand without help of others, mechanical support, and a prosthesis	40 - 60

4.3b Use of Upper Extremities

Table 14. Criteria for One Impaired Upper Extremity.

Impairment description	% Impairment of the whole person	
	Preferred extremity	Nonpreferred extremity
Patient can use the involved extremity for self-care, daily activities, and holding, but has difficulty with digital dexterity	1 - 9	1 - 4
Patient can use the involved extremity for self-care, can grasp and hold objects with difficulty, but has *no* digital dexterity	10 - 24	5 - 14
Patient can use the involved extremity but has difficulty with self-care activities	25 - 39	15 - 29
Patient cannot use the involved extremity for self-care and daily activities	40 - 60	30 - 45

Table 15. Criteria for Two Impaired Upper Extremities.

Impairment description	% Impairment of the whole person
Patient can use both upper extremities for self-care, grasping, and holding, but has difficulty with digital dexterity	1 - 19
Patient can use both upper extremities for self-care, can grasp and hold objects with difficulty, but has *no* digital dexterity	20 - 39
Patient can use both upper extremities but has difficulty with self-care activities	40 - 79
Patient cannot use upper extremities	80+

4.3c Respiration

Table 16. Neurologic Impairment of Respiration.

Impairment description	% Impairment of the whole person
Patient can breathe spontaneously but has difficulty in activities of daily living that require exertion	5 - 19
Patient is capable of spontaneous respiration but is restricted to sitting, standing, or limited ambulation	20 - 49
Patient is capable of spontaneous respiration but to such a limited degree that he or she is confined to bed	50 - 89
Patient has no capacity for spontaneous respiration	90+

- Only for respiratory deficit due to neurologic condition.
- See Respiratory Chapter.

4.3d Urinary Bladder

Table 17. Criteria for Neurologic Impairment of Bladder.

Impairment description	% Impairment of the whole person
Patient has some degree of voluntary control but is impaired by urgency or intermittent incontinence	1 - 9
Patient has good bladder reflex activity, limited capacity, and intermittent emptying without voluntary control	10 - 24
Patient has poor bladder reflex activity, intermittent dribbling, and no voluntary control	25 - 39
Patient has no reflex or voluntary control of bladder	40 - 60

- Bladder function due to spinal cord/CNS deficit.
- Cystometric or other objective testing may be needed.
- See Urinary and Reproductive Chapter.

4.3e Anorectal Section

Table 18. Criteria for Neurologic Anorectal Impairment.

Impairment description	% Impairment of the whole person
Anorectum has reflex regulation but only limited voluntary control	1 - 19
Anorectum has reflex regulation but no voluntary control	20 - 39
Anorectum has *no* reflex regulation or voluntary control	40 - 50

- Due to spinal cord or other neurologic deficit.

4.3f Sexual Functioning

Table 19. Sexual Impairment Criteria.

Impairment description	% Impairment of the whole person
Sexual functioning is possible but with difficulty of erection or ejaculation in men or lack of awareness, excitement, or lubrication in either sex	1 - 9
Reflex sexual functioning is possible but there is no awareness	10 - 19
No sexual functioning or awareness is present	20

- Due to spinal cord or other neurologic deficit.

4.4 Muscular and Peripheral Nervous System

- Largely repeats methodology in Chapter 3.

- LE – adds instructions on partial peripheral nerve loss (p. 150-151) with Tables 20 and 21 for rating severity of loss (same as Tables 11 and 12 in Chapter 3).

4.4d Autonomic Nervous System

Table 22. Impairments Related to Syncope or Transient Loss of Awareness.*

Level	Description	% Impairment of the whole person
1	*Mild* loss of awareness with drop in blood pressure of 15 mm Hg/10 mm Hg without compensatory increase in pulse rate, lasting more than 2 minutes after precipitating event	1 - 9
2	*Moderate* loss of blood pressure of 25 mm Hg/15 mm Hg, with loss of awareness or consciousness lasting 1-2 minutes	10 - 29
3	Levels 1 and 2 are present with *repeated severe* losses of blood pressure of 30 mm Hg/20 mm Hg, and additional neurologic symptoms or signs of focal or generalized nature also are present	30 - 49
4	Level 3 is present with *uncontrolled loss of consciousness* and muscle control without recognized cause and with risk of body injury	50 - 70

*This table is applicable to patients receiving treatment.

- Secondary to neurologic conditions i.e. polyneuropathy, Guillain-Barre, spinal cord and brain tumors, etc.

4.4e Nerves of the Head and Neck, Trunk and Inguinal Region

- Tables 23 and 24 list maximum values.
- Maximum motor or sensory value for a thoracic nerve is 2% WP.
- Evaluate sensory and motor function, using severity ranges from Tables 20 and 21, p. 151.
- Combine sensory and motor.

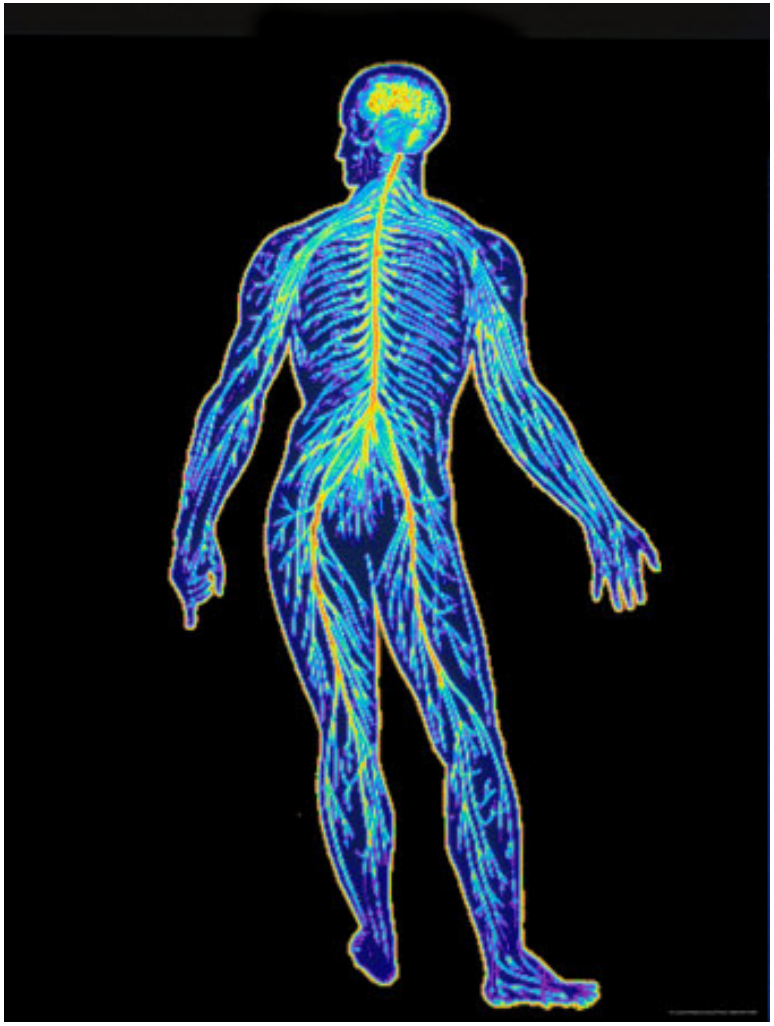
Table 23. Impairments of Spinal Nerves in the Head and Neck Region.

Nerve	% Impairment of the whole person	
	Due to sensory deficit, pain, or discomfort	Due to loss of strength
Greater occipital	5	0
Lesser occipital	3	0
Great auricular	3	0

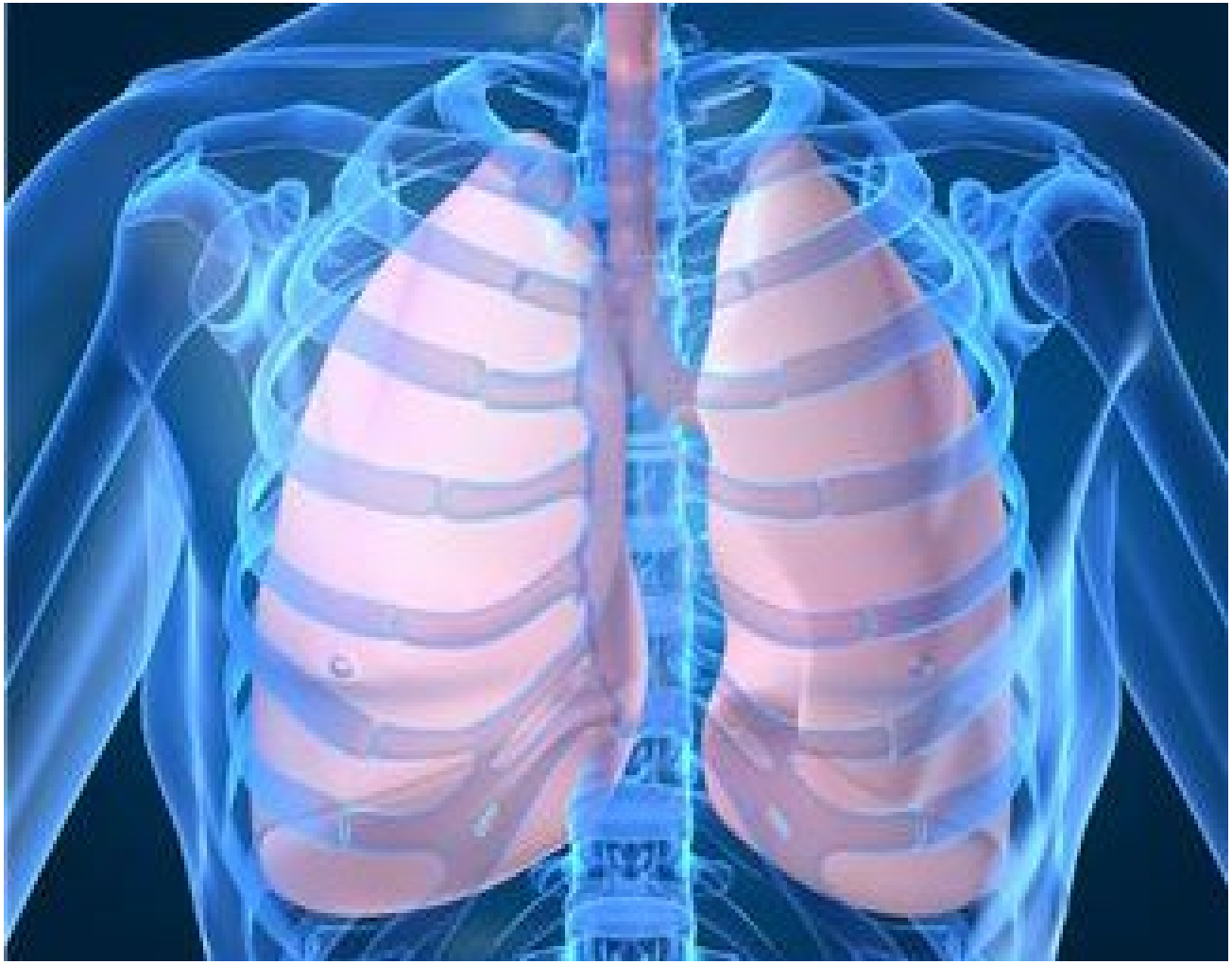
Table 24. Impairments of Spinal Nerves Affecting the Inguinal and Perineal Regions.

Nerve	% Impairment of the whole person	
	Due to sensory deficit, pain, or discomfort	Due to loss of strength
Iliohypogastric	3	0
Ilioinguinal	5	0
Coccygeal	5	0

Questions?



Respiratory System Chapter 5



How to Determine Respiratory Impairment

- Perform focused history
  - Dyspnea (Table 1, p 154)
  - Cough, Sputum, Hemoptysis
  - Wheezing
  - Tobacco Use
  - Occupational History

How to Determine Respiratory Impairment

- Perform Physical Examination
  - Vitals
  - Accessory muscle use, breath pattern
  - Cyanosis, digital clubbing
  - Thoracic cage/spine deformity
  - Chest percussion
  - Auscultation
- Chest X-ray

How to Determine Respiratory Impairment

Spirometry

- Use Crapo and Morris normative values.
- At least 3 repetitions, use the best 2 repetitions that are with 5% of each other.
- FEV_1, FVC and FEV_1/FVC ratio.
- Use the highest FVC and the highest FEV_1 to calculate the FEV_1/FVC ratio.
- Best effort with or without bronchodilator.
- Black men and women – 88% of predicted values for FEV_1 and FVC.

How to Determine Respiratory Impairment

- DCO
  - Measures gas transfer.
  - Single breath.
  - No smoking for at least 8 hours prior.
- Pulmonary Exercise Testing (VO2 or MET)
  - Adjunctive test; expensive; used very selectively
  - Not used in normal or severe impairment cases or with cardiorespiratory contraindications
- Arterial Oxygenation
  - Invasive; rarely used

How to Determine Respiratory Impairment

- Consult Tables 2-7 for predicted values for gender, height (cm), age and race.
- Determine class of respiratory impairment from Table 8, page 162.
  - 4 classes
  - No rating from 1-9%
  - Wide ranges for classes 2-4
  - Provide rationale/explanation of value selected within the range in your

How to Determine Respiratory Impairment

- Consult Tables 2-7 for predicted values for gender, height (cm), age and race
- Determine class of respiratory impairment from Table 8, page 162
  - 4 classes
  - No rating from 1-9%
  - Wide ranges for classes 2-4
  - Provide rationale/explanation of value selected within the range in your narrative

Visual System
Chapter 8

Visual System Impairment

- Visual acuity
  - Rate corrected near and far visual acuity (p. 209).
- Visual field
- Ocular motility with diplopia
  - Rate without correction with colored lenses or prisms (p. 217).
- Additional impairments
  - Cosmetic defects of the orbit (0%-10%, p. 222).
  - Occular or adnexal deformities which impair visual function but do not affect 3 primary functions (5%-10%, p. 209).

Visual System Impairment

- Necessary Equipment
  - Visual acuity charts (near and far)
  - Visual field testing
  - Refraction equipment
- Refer to Ophthalmologist/ Optometrist if needed

Central Acuity of One Eye

- Measure near and far vision both corrected and uncorrected.
- Rate corrected vision.
- May use contacts or glasses.
- Snellen notation for distance; Snellen, Revised Jaeger, or American Point system for near.
- Determine status of lens.
  - Monocular aphakia and pseudoaphakia = 50% loss of central vision.
- Consult Table 3 p. 212 for single eye impairment %.

Example p. 211

- Distance = 20/30
- Near = 14/24
- Native lens intact
- Single eye impairment=9%
- If aphakia or pseuodoaphakia = 54

Visual Field Testing

- Binocular field testing
  - No diplopia present
  - Good alignment of both eyes (no strabismus, etc.)
  - Proper equipment needed
- Monocular field testing
  - 8 principal meridians
  - Determine the degree of visual field retained
  - **Add** the degrees of field (Table 4, p. 212); normal total = 500
  - Calculate % loss from Table 5, p. 214
  - **Add** 5% -10% for scotoma, hemianopia to % loss (p. 213)

Ocular Motility and Binocular Diplopia

- Unless diplopia is with looking downward or within 30^{o} of center of fixation, it rarely causes significant visual impairment.
- Measure 8 principal meridians, without colored light or correcting prisms (p. 217).
- Calculate % loss – Figure 3, p. 217.
- **Add** 2 or more meridians.
- **Combine** with other visual impairments.
- Diplopia within central 20^{o} = total loss of vision in one eye = 25% visual impairment = 24% WPI.

Calculating Visual Impairment

- Combine % loss for central near and far vision with % loss for visual field in each eye.
- Combine the larger of the two above with % loss for ocular motility in that eye.
- Ignore the ocular motility loss for the better eye.
- Use Table 7, pp. 219-221 to determine visual system impairment.
- Combine % loss for the worst eye with the % loss for better eye.
- Use Table 6, p. 218 to convert visual system impairment to WPI.

Questions?

Ear, Nose, Throat and Related Structures, Chapter 9

- Ear
  - Hearing
  - Equilibrium
- Face
  - Structural Integrity
  - Facial Disfigurement

Ear, Nose, Throat and Related Structures, Chapter 9

- Nose, Throat and Related Structures
  - Respiration
  - Mastication and Deglutition (teeth, TMJ, etc.)
  - Olfaction and Taste
  - Speech

Hearing

- Test ***without*** prosthetic devices (hearing aids) – p. 224.
- Test each ear separately with pure tone audiometer and record levels at 500, 1000, 2000 and 3000 Hz.
- 100 dB in the maximum; 0 dB in the minimum.

Hearing

- Add the 4 db levels for each ear (Decibel Sum Hearing Threshold or DSHL).
- Use Table 1, p. 225 to determine monaural hearing loss % for each ear.
- Use Table 2, pp. 226-227 to determine binaural hearing loss %.
- Use Table 3, p. 228 to convert binaural hearing loss % to WPI.
- 100% binaural hearing loss = 35% whole person (Table 3, p. 228).

Tinnitus

- Not measurable, usually not ratable.
- In the presence of unilateral or bilateral hearing loss may impair speech discrimination - may add up
to 5% for the hearing.

Equilibrium

- Rating based on objective findings and ADL assessment.
- Classes 1-5 – pp. 228-229.

Face

- 2 different methods for assigning impairment.
  - Structural Integrity.
    - 1-4 classification system p.229.
  - Facial Disfigurement.
    - Table 4, p. 230.

Nose, Throat and Related Structures

- Respiration (air passage defects).
  - 1-5 classification system.
  - Table 5, p 231.

Nose, Throat and Related Structures

- Mastication and Deglutition (teeth, TMJ, etc.).
  - Rated by dietary restrictions.
  - Table 6, p. 231.
- Nose, Throat and Related Structures
  - Olfaction and Taste
    - Only complete loss is rated; rare
    - Complete loss of smell = 3%
    - Any smell or taste sense = 0%

Nose, Throat and Related Structures

- Speech
  - Based on ability to effectively communicate.
  - Evaluated for audibility, intelligibility, functional efficiency.
  - Examiner must have normal hearing.
  - IE reads “The Smith House” Table 8, p. 233; 8 feet away with back to examiner.
  - 1-5 scale classification system Table 7, p.233.
  - Select the class that represents the greatest impairment.
  - Speech impairment % converts to WPI Table 9, p. 234.

Digestive System Chapter 10

Impairment based on:

- Signs and symptoms.
- Objective findings/tests.
- ADL impact.
- Need for treatment.
- Desirable weight (Table 1, p. 237).

Impairment of the Upper Digestive Tract

- Table 2, p. 239.
- 1-4 scale classification system.

Classes of Colonic and Rectal Impairment

- Table 3, p. 241.
- 1-4 scale classification system.

Classes of Anal Impairment

- Table 4, p. 243.
- 1-3 scale classification system.

Impairments from Surgically Created Stomas

- Table 5, p. 243.
- Combine with % impairment

  for related

Classes of Liver and Biliary Tract Impairment

- Table 6, p. 245.
- 1-4 scale classification system.

Classes of Hernia Related Impairments

- Sections 10.9 “Hernias of the Abdominal Wall”.
- Most common digestive disorder impairment .
- Table 7, p. 247.
- 1-3 scale classification system.
- Must have palpable defect present at MMI.
- Single whole person IR for the abdominal wall for multiple hernia – see Class 3 example on pp. 247-248.

Urinary and Reproductive Systems
Chapter 11

Upper Urinary Tract Impairments

- Table 1, p.251.
- 1-4 scale classification system.
- Loss of one kidney = 10% impairment (p. 250).
- Dialysis – Class 4 impairment (65%-90%, p. 250).
- Renal transplant – Class 2 impairment, with possible +5% if continuous observation and medication required (p. 250).

Other Conditions

- Impairments from Urinary Diversion.
  - Table 2, p. 253.
- Bladder Impairment.
  - 1-4 scale classification system – pp. 254-255.
  - Combined with values for upper urinary tract, if appropriate.
- Urethra.
  - 1-2 scale classification system – pp. 254-255.

Other Conditions

- Penis
  - 1-3 scale classification system – pp. 256 – 257.
  - Age modifiers (p. 256):
    - % in text are for men aged 40-65 y.o.
    - <40 y.o. - increase % by 50%.
    - >65 y.o. – decrease by 50%.
- Scrotum
  - 1-3 scale classification system – p. 257.
- Testes, Epididymides and Spermatic Cord.

Skin - Chapter 13

- Table 2, p.280.
- Based on the effect on ADL.
- Most surgical scars are not rated separately.
- If burn scar or graft results in limited ROM, that impairment should be rated according to Chapter 3.
- IR accrues from both the burn scar and the limited ROM; combine the whole person impairments.

Questions?

Mental and Behavioral Disorders
Chapter 14

Mental and Behavioral Impairment

- Mental disorders are considered a separate "body system".
- Use **Chapter 14** for rating mental and behavioral disorders.
- Use **Chapter 4 (CNS)** for rating effects of **brain injury.**
- May use both depending on diagnoses and cause of behavioral disorder (brain injury vs. purely mental).

Mental and Behavioral Impairment

Conceptual approach identical to other systems:

- Must have a mental disorder diagnosis.
- Opportunity for adequate treatment.
- Condition is at maximum medical improvement.
- Diagnosis or its severity is not necessarily indicative of impairment.

Mental and Behavioral Impairment

Based on loss of functioning in four areas:

- Activities of Daily Living.
- Social Functioning.
- Concentration, Persistence, and Pace.
- Deterioration or Decompensation in Work or Work-Like Settings.

Activities of Daily Living

- Self-care, hygiene, communication, postures, travel, sexual function, sleep, social and recreational activities.
- Judged based on independence, appropriateness, and effectiveness;
  overall degree of restriction.
- Based on **mental disorder only**
  (not physical limitations).

Social Functioning

- Capacity to interact appropriately and communicate effectively.
- Includes family, friends, neighbors, supervisors, coworkers, clerks, etc.
- Look for history of altercations, evictions, firing, fear of people, avoidance, withdrawal.
- Judge on overall degree of interference.

Concentration, Persistence, and Pace

- Ability to sustain focused attention sufficient to permit timely completion of daily household and work tasks.
- Assess through direct observation, ***formal psychometric testing***, work samples.
- Judge based on errors, time for completion, degree of assistance required.

Deterioration or Decompensation in Work or Work-like Settings

Repeated failure to adapt to stressful circumstance causing person to withdraw or experience exacerbation of symptoms of the mental disorder.

Difficulty with: attendance, decision-making, task completion, interpersonal interaction.

Assessment

- Review of records
- Psychodiagnostic interview
- Collateral information
- Observations

Assessment

- Psychological/cognitive testing - adds objectivity, controls for exaggeration or malingering.
- Requires psychiatrist or psychologist with training and experience assessing disability applicants - forensic, health/rehab, or neuro-psychologist.

Assessment

REFER FOR SPECIALTY EVALUATION IF NEEDED!

28 TAC § 127.10 (c)

The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability…

Psychological Testing

- Validity scales to assess exaggeration or under reporting.
- If valid allows comparison of self-reports to test data and reference samples.
- Severity of patterns reflected in test data should be consistent with other reports. If not, needs to be accounted for, and may affect weight given to self-reports and thus modify impairment rating.

Psychological Testing

- Personality testing (MMPI-2/MMPI-2RF) to assess exaggeration, symptom patterns, overall level of pathology/impairment.
- Cognitive testing to assess concentration, attention, memory, and effort on those tests.
- Full neuropsychological assessment for brain injury under Chapter 4.

IR: Special Categories

- Effects of Structured Settings (chronic mental disorders, unlikely in WC).
- Substance Abuse (unlikely permanent).
- Personality Disorders (not injury produced).
- Mental Retardation/Developmental Disorders (not injury produced).

IR: Special Categories

- **Effects of medication** – rate any residual impairment and **side effects** if they cause impairment.
- **Malingering** – may modify or exclude any rating.
- **Lack of motivation** - due to mental disorder, character, 1^{o} or 2^{o} gain?

IR: Special Categories

PAIN

- Only rate in Chap. 14 if pain is due to a mental disorder **only** (would not be compensable).
- Ratings in other body systems include allowances for pain.

How to Determine Mental and Behavioral Impairment

Apply Findings to Four Areas of Functioning:

- Activities of Daily Living.
- Social Functioning.
- Concentration/Persistence/Pace.
- Deterioration or Decompensation in Work or Work-like Settings.

How to Determine Mental and Behavioral Impairment

- May assign rating globally, **or** assign to each area of functioning and **average** (10+10+40+20=80/4=20%).
  - **"Show your work!"**
- Determine appropriate class from "the Table" Chapter 14, p. 301.
- Consult Chapter 4, Table 3, p. 142.
- Determine appropriate % impairment value from Chapter 4, Table 3, p. 142.
- Combine with other body systems using the Combined Values Chart, pp. 322-324.

"The Table" p. 301
Classification of Impairments due to Mental and Behavioral Disorders

Table. Classification of Impairments Due to Mental and Behavioral Disorders.

Area or aspect of functioning	**Class 1:** **No impairment**	**Class 2:** **Mild impairment**	**Class 3:** **Moderate impairment**	**Class 4:** **Marked impairment**	**Class 5:** **Extreme impairment**
Activities of daily living Social functioning Concentration Adaptation	*No* impairment is noted	Impairment levels are compatible with *most* useful functioning	Impairment levels are compatible with *some*, but not all, useful functioning	Impairment levels *significantly impede* useful functioning	*Impairment levels preclude* useful functioning

"The Table" p. 301

Classification of Impairments due to Mental and Behavioral Disorders

Area of Function	CLASS 1 No Impairment	CLASS 2 Mild	CLASS 3 Moderate	CLASS 4 Marked	CLASS 5 Extreme
ADL					
Social	No impairment	Most useful function	Some, but not all useful function	Significant loss of useful function	Precludes useful function
Concentration, Pace					
Adaptation					

Chapter 4, Table 3, p. 142

Table 3. Emotional or Behavioral Impairments.

Impairment description	% Impairment of the whole person
Mild limitation of daily social and interpersonal functioning	0 - 14
Moderate limitation of *some* but not all social and interpersonal daily living functions	15 - 29
Severe limitation impeding useful action in *almost all* social and interpersonal daily functions	30 - 49
Severe limitation of all daily functions requiring total dependence on another person	50 - 70

Chapter 14 Table 1, p. 301	Chapter 4 Table 3, p. 142
Class 1: None	None
Class 2: Mild – Most useful function	Mild: 0 – 14%
Class 3: Moderate – Some but not all useful function	Moderate: 15 – 29%
Class 4: Marked – Significantly impedes useful function	Severe: 30 – 49% Impedes almost all daily function
Class 5: Extreme – Precludes useful function	Severe: 50 – 70% Total dependence

How to Determine Mental and Behavioral Impairment

- May assign rating globally, **or** assign to each area of functioning and **average** (10+10+40+20=80/4=20%).
  - "Show your work!"
- Determine appropriate class from "the Table" Chapter 14, p. 301.

How to Determine Mental and Behavioral Impairment

- Consult Chapter 4, Table 3, p. 142.
- Determine appropriate % impairment value from Chapter 4, Table 3, p. 142.
- Combine with other body systems using the Combined Values Chart pp. 322-324.

How to Determine Mental and Behavioral Impairment

- Even if negative, incorporate the findings from the consultant/testing facility into the DD report with an explanation of how the information
  is used in determining MMI/IR, RTW, Extent of Injury, etc.
- Attach the specialist's report to your narrative report.

Questions?