

Division of Workers' Compensation
Desk Aid #11 – Impairment Rating Tips: *Updated July 2016*

Please review the following recommendations when assigning impairment ratings:

General Principles

1. **Impairment Ratings Based on Objective Pathology:** Impairment ratings should only be given when a specific diagnosis and objective pathology can be identified. (*Reference: C.R.S. §8-42-107(8)(c)*) In cases with multiple symptoms, the clinician must determine whether separate diagnoses can be established which warrant an impairment rating *OR* the impairment rating provided for a specific diagnosis incorporates the accompanying symptoms of the patient.

For example, in **shoulder cases with accompanying neck pain**, the clinician must determine whether an additional objective work-related Table 53 cervical pathology qualifies for a rating *OR* the symptoms the patient has are those expected from the shoulder pathology and do not qualify for an additional rating.

2. **Impairment Rating for Workers Who Have Undergone an Invasive Treatment Procedure:** The rating physician should keep in mind the *AMA Guides, 3rd Edition (rev.)* definition for impairment: “The loss of, loss of use of, or derangement of any body part, system, or function.” Given this definition, one may assume any patient who has also undergone an invasive procedure which has permanently changed any body part has suffered a derangement under the definition of impairment according to the *AMA Guides, 3rd Edition (rev.)* Therefore, that patient should be evaluated for an impairment by a Level II Accredited Physician. However, not all persons with invasive procedures necessarily qualify for a numerical impairment rating. They may have a zero percent rating. In surgical cases, the rating physician *should* perform the necessary testing as outlined in the *AMA Guides, 3rd Edition (rev.)* for the condition which was *treated* by the invasive procedure.

If the rating physician provides a zero percent rating, this must be justified using the appropriate portions of the *AMA Guides, 3rd Edition (rev.)*. Examples in which the rating procedure is necessary include arthroscopic debridement of the shoulder, anterior cruciate ligament surgery of the knee, facet rhizotomy procedures, and surgery to repair carpal bone instability. (*Also see section on spine procedures below.*)

3. **Range of Motion Measurements:** Only *active* range of motion measurements should be used to determine impairment. The examiner should not assist the patient when obtaining spinal or extremity range of motion. For extremities, passive range of motion may be measured to assess the *validity* of active range of motion measurements. See the Spinal and Extremity Rating section for a more detailed discussion.



4. Impairment Rating “Rounding”: Although the AMA Guides allows rounding of an impairment rating to the nearest whole number ending in 0 or 5, the Division recommends rounding up or down to the nearest whole number when presenting the *final rating*. A number ending in .50 or above should be rounded up. Fractional ratings are not acceptable.

5. Worksheets: Make sure to attach all applicable worksheets to the narrative report and include this information to all legally concerned parties. The Lower Extremity and Mental Impairment forms created by the Division and the spinal and upper extremity forms found in the AMA Guides are required. If a spinal impairment rating is provided, both Figure 84 and the appropriate spinal range of motion worksheet are required. If you need to send an addendum or a response to an incomplete notice, make sure you copy all parties. *Note that you do not have to provide worksheets if you are not giving a rating for the injury(s) in question.*

6. “Grover Meds” and Impairment: If continuing treatment or medications are ordered in a case post MMI (“Grover Meds”), and that treatment was not being given prior to the onset of the work-related injury or condition, there may be a reasonable assumption that there has been a permanent change in a body part under the definition of impairment in the *AMA Guides, 3rd Edition (rev.)*. Therefore, it is incumbent on the physician to perform a full assessment for impairment at the time MMI is determined. This should not be interpreted to say that all persons receiving Grover Meds necessarily qualify for an impairment rating. *If the rating physician provides an assessment of zero or no impairment, yet orders post-MMI treatment, this should be reconciled and justified in the physician’s closing report.*

7. Facial Disfigurement vs. Scars:

- Facial disfigurement should be rated using the *AMA Guides 3rd Edition (rev.)* Section 9.2 (p. 179).
- Scars should be rated using the *AMA Guides 3rd Edition (rev.)* 13.6 (p.225) (*Reference: Level II Accreditation Curriculum, Dermatology section*) if the physician deems appropriate, or have the claimant go to the ALJ to request an award.
- Note: Providers should be aware that not all scars qualify for an impairment rating and the claimant may request an award for scars from an ALJ. *Colorado Revised Statutes (C.R.S. §8-42-108)*

8. Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy (CRPS/RSD): The Division recommends using the spinal cord table (*Table 1, pg. 109, AMA Guides*) for determining impairment, however the peripheral nerve tables may be used if the evaluator deems them more appropriate (*Table 14, pg. 46; Table 51, pg. 77, Table 10 pg. 42, AMA Guides*). In unusual cases where severe vascular symptoms cause additional impairment of ADL’s the physician may choose to combine additional impairment for the vascular tables with the neurological impairment. (*Table 52, (p.79) and Table 16, (p. 47), AMA Guides*). Range of motion should not be used, as this would be accounted for in the neurologic portion of the rating.



9. **Tinnitus:** The *AMA Guides, 3rd Edition (rev.)* (p.110) suggests that 3-5% impairment may be added to the hearing impairment for tinnitus. Tinnitus impairment can only be provided when a hearing impairment is documented. The hearing impairment need not be from the current injury. Later editions of the *AMA Guides* have clarified that impairment for tinnitus is added to the total binaural hearing impairment rating before it is converted to whole person. If adding impairment for tinnitus to monaural hearing impairment, the 3-5% would be added to the monaural hearing impairment percentage. You always eventually convert to whole person.

10. **Headaches:** Headaches which qualify for a separate work-related impairment rating should be rated using the Episodic Neurological Disorders section in Table 1 (Chapter 4, p. 109). It is important to remember that if the individual has a closed head injury the highest applicable rating from this table is the only rating used. If the headache rating is to be combined with another body part, the rater must be very careful not to rate the activities of daily living deficits in both impairment areas.

11. **Rating Abdominal Hernias:** There are three classes of hernia impairment (*AMA Guides, 3rd Edition (rev.)*, p. 196). Remember that to qualify for a rating in any class at the time of MMI there must, at minimum, be a “palpable defect in the supporting structures of the abdominal wall.”

Apportionment

1. **Apportionment of Prior Conditions:** Asymptomatic conditions cannot be evaluated for prior impairment. Only previously symptomatic conditions should be considered for apportionment. (Reference: *Askew v. Industrial Claim Appeals Office*, 927 P.2d 1333 (Colo. 1996); Rule 12).

- To apportion you must create a rating of the workers’ impairment *immediately prior to* the current injury or disease using the *AMA Guides, 3rd Edition (rev.)*. Subtract this rating from the current total rating at the appropriate levels.
- **For Workers’ Compensation injuries occurring on or after July 1, 2008:**
 - For prior **non-work related** injuries: To apportion prior injuries that are non-work related, they must have been *identified, treated, and independently disabling* at the time of the current work related injury. If the prior non-work related injury was not independently disabling at the time of the current injury, you may not apportion.
 - For prior **work-related** injuries: The Physician may provide an opinion on apportionment for any pre-existing work related permanent impairment to the same body part using the *AMA Guides, 3rd Edition, (rev.)*, where *medical records or other objective evidence substantiate a pre-existing impairment*. Any such apportionment shall be made by subtracting the pre-existing impairment as it existed at the time of the subsequent injury or occupational disease from the injured worker’s total impairment as calculated according to the *AMA Guides, 3rd Edition (rev.)*. The subtraction is best accomplished by deducting at the specific appropriate levels before combining all portions of the rating. The Physician shall explain in their written report the basis of any apportionment. (Rule 12-3) It is critical that complete information is provided, particularly the current total impairment—both apportioned and unapportioned.



- The ‘current total rating’ should represent the person’s current and past impairment rating.
- You may **not** apportion by estimating the percentage attributable to the prior injury or disease; (i.e.: “50% of this impairment was pre-existing.”)
- You *must have medical documentation* for the information that substantiates the previous work related rating.
- Utilize the “Worksheet for Range of Motion Spinal Apportionment” (*Reference: Level II Curriculum, Apportionment section*) to calculate the *past* injury’s range of motion if a prior apportionable spinal condition exists and no range of motion values are given.

2. **Age:** Because age is considered in the calculation of benefits which the injured worker will receive, there is no additional apportionment for age when awarding impairment ratings (Reference: C.R.S. §8-42-107)

Spinal Rating

1. **Table 53 and Application of Spinal Range of Motion:** In order to be assigned a spinal rating, the patient must have objective pathology and impairment that qualifies for a numerical impairment rating of greater than zero under Table 53. Spinal range of motion impairment must be completed and applied to the impairment rating only when a corresponding Table 53 diagnosis has been established.

(References: Spine section of the *AMA Guides, 3rd Edition (rev.)*; Level II Accreditation Curriculum, Spinal Impairment).

- In unusual cases with established severe shoulder pathology accompanied by treatment of the cervical musculature, an isolated cervical range of motion impairment may be allowed if well-justified by the clinician. Otherwise there are no exceptions to the requirement for a corresponding Table 53 rating.

2. **Impairment Ratings for Invasive Spinal Procedures:** The following procedures are considered surgical and should be rated under Table 53 using II (D) or II (E):

- a. IDEA (intradiscal electrothermal annuloplasty)
- b. Coblation of the nucleus pulposus
- c. Microdiscectomy
- d. Permanent spinal stimulator placement requiring laminotomy
- e. Vertebroplasty or kyphoplasty
- f. Artificial disk placement
- g. Removal of Spinal Hardware: Procedures for removal of spinal hardware are rated under Table 53 II (G) 1, or Table 53 II (G) 2 for subsequent surgical procedures.

3. **Not Rated as Surgical Spinal Procedures:** The following are *not* rated as surgical procedures using Table 53:

- a. Diagnostic or therapeutic spinal injections
- b. Intrathecal drug pumps
- c. Removal of spinal stimulator not requiring laminectomy

4. Rhizotomy: Rhizotomy is also currently known as a Radiofrequency Medial Branch Neurotomy or RF Neurotomy. It is not considered a surgical procedure under Table 53. Rhizotomies should be rated using II(C). A rhizotomy causes only minimal anatomic disruption and may not be permanent. In order to perform a rhizotomy the condition must meet the diagnostic criteria required in the Low Back Pain

Medical Treatment Guideline (see section D). The degree of pathology required to perform a rhizotomy is deemed equivalent to moderate to severe degenerative changes at the facet joint. Most commonly two or more spinal levels are performed with rhizotomy procedures to assure coverage of the appropriate nerves.

To rate rhizotomies the total number of levels at which a rhizotomy is performed should be divided by 2. A two-level bilateral or unilateral rhizotomy receives a rating of II(C) because II(C) accounts for the initial two levels. Three or four-level rhizotomies receive a II(C) plus II F 1% -- for the additional levels. Five or six-level rhizotomies receive II(C) plus II (F) 2% -- for the additional levels.

For example, the Table 53 rating for rhizotomies at 4 lumbar levels would be 8% (II-C of 7% for the first two levels plus II-F of 1% for the additional two levels). Similarly, the Table 53 rating for 6 cervical levels would be 8% (II-C of 6% for the first two levels plus II-F of 2% for the additional four levels). Bilateral rhizotomies at the same spinal level do not receive any additional rating.

5. Rating for SI Joint Dysfunction: Patients who continue to have SI joint symptoms, and thus qualify under the “six months of medically documented pain and rigidity with or without muscle spasm,” Table 53 terminology should be rated as Table 53 II (B) in most circumstances. The appropriate spinal range of motion impairment must be combined with this.

6. Vertebral Fractures: An operatively treated vertebral fracture should be rated under Table 53 section IV (A) or (B). When more than one level has been fused, additional levels are added at 1% each using IV(C). If there are additional vertebral fractures which are not operatively treated, these should be rated under section I and the ratings from I and IV should be combined for a total Table 53 rating. (If multiple non operative fractures are present and rated under section I, these are combined as directed on Table 53.)

7. Using Table 53 to differentiate between II (B), (C) and (F) regarding x-ray findings: Physicians should be aware that in the asymptomatic population, disk bulges, annular tears or high intensity zone areas, and disk height loss are commonly reported in the lumbar spine from 40 – 60% of the time depending on the condition and study. (*Reference: Medical Treatment Guidelines, Low Back Pain, E.I.*) In the cervical spine the prevalence of disc degeneration or loss of signal intensity on MRI is greater than 50% in the 50 years and older asymptomatic population. Cervical disc bulging and posterior disc protrusion, while not rare, are more commonly symptomatic than in the lumbar spine due to the smaller cervical spinal canal. Mild reduction in the cross-sectional spinal cord may be seen without myelopathy in patients older than 40. (*Reference: Medical Treatment Guidelines, Cervical Spine Injury, E.I.*) Therefore, the existence of these anatomic findings cannot be considered pathological unless there are clear physiologic ties and correlation with clinical findings in an individual patient. The mere presence of these changes is not a sufficient justification to attribute correlation to a non-specific spinal complaint. The physician should not rate findings by diagnostic imaging *if they have not been clearly*

defined as contributing significantly to the patient's condition. This applies to the use of II(C) as well as the use of II (F).

Asymptomatic moderate to severe lumbar facet degeneration has also been reported in 30% or more of the population 55 or older but is uncommon in the younger population. Clear disk extrusion and nerve impingement are much less frequent in asymptomatic individuals. Symptomatic disk extrusion/herniation is rated under II(C). Due to these discrepancies between x-ray findings and pathological conditions, it is incumbent on physicians to carefully examine and apply other diagnostic tests as appropriate to identify the true pain generators in a patient and plan their treatment and impairment rating accordingly.

8. Table 54: Although Tables 53 and 54 are mutually exclusive and cannot be used in the same rating (*Reference: Level II Accreditation Curriculum, Spine/Lower Extremity, Diagnosis-Related Factors and pg. 81 AMA Guides*), remember that in some cases with ankylosis as a pre-existing condition Table 54 can be used for apportionment. In such cases, Table 53 can be used for the current rating and Table 54 can be used for the previous rating.

9. Straight-Leg Raise Check (SLR) for Invalidation of Lumbar Flexion: The SLR check applies to lumbar flexion only. Of the SLR measurements for each leg, the evaluator records the MAXIMUM SLR for each leg. Then the 'tightest' or the 'lowest' of these two maximum measurements for the right and left leg is used to compare to the sum of sacral flexion and extension (*Reference: Level II Accreditation Curriculum, Range of Motion Testing for the Spine*). If the SLR check is invalid, the claimant must be given another visit to repeat the range of motion (see below, #10. Invalidation of Spinal Range of Motion.)

10. Invalidation of Spinal Range of Motion (cervical, thoracic, lumbar): To invalidate spinal range of motion impairment, claimants must have two visits. Two sets of three measurements must be taken on each visit (12 measurements total). When a physician performing a Division IME finds range of motion measurements invalid (due to SLR check or for physiologic reasons) such physician may fulfill this requirement by accepting invalidated measurements from other reports in lieu of bringing the claimant back for a second set of measurements. The physician must, however, report his/her own initial sets of measurements. (*Reference: Level II Accreditation Curriculum, Range of Motion Testing for the Spine*).

11. Lumbar Flexion Impairment: When using Table 60, you must first reference the sacral flexion angle (1st column), then the true lumbar flexion angle to calculate the impairment percentage for true lumbar flexion. (Reference: Table 60, pg. 98, *AMA Guides, 3rd Edition (rev.)*).

12. Angle of Minimum Kyphosis, Thoracic Flexion Worksheet: Angle of minimum kyphosis must be recorded in addition to the other measurements. This is because it is the GREATER of the two impairments (between thoracic flexion and angle of minimum kyphosis) which is used in the rating (*Reference: Section 3.3d, pg. 91, AMA Guides, 3rd Edition (rev.)*).



13. Only Unassisted, Active Range of Motion Measurements Can Be Used in Impairment Rating:

*The AMA Guides to the Evaluation of Permanent Impairment, 3rd edition (rev.), uses only active, patient-initiated range of motion to determine spinal impairment. (AMA Guides 3rd edition (rev.) (p.18, 55, 81)). Any form of “assisted range of motion” is not part of the impairment rating process. If there is a significant, non-physiologic difference between the active and passive ranges of motion, physicians should have the patient stretch and repeat the measurements. When the physician believes the active range of motion obtained is non-physiologic, the physician is encouraged to inform the patient of their impression and the fact that it may affect the patient’s rating, before obtaining another trial of measurements. *If repeat measurements continue to appear significantly non-physiologic, the physician may use measurements obtained by other providers when there is reason to believe the measurements were performed according to the AMA Guides standards.**

Extremity Ratings

1. Rating of Extremities Using Contralateral Joint/ “Normalization”: In some cases, the contralateral joint is a better representation of the patient’s pre-injury state than the *AMA Guides* population norms. The 3rd Revised Edition has little commentary on this procedure, however the 5th Edition and the Division consider it reasonable to compare both extremities when there are specific conditions which would make the opposite, non-injured extremity serve as a better individual baseline. (This procedure is ***not an apportionment procedure*** as it does not reflect a prior pathologic condition with impairment; therefore, avoid using the term “apportionment” when referring to this process. This process can be termed “normalization.”) Therefore, when deemed appropriate, the physician may subtract the contralateral joint ROM impairment from the injured joint’s ROM impairment. (An example would be a patient with limited knee flexion due to obesity.) However, this subtraction should not be done if the contralateral joint has a known previous injury because that joint may not reflect the ‘normal’ ROM for that individual. Make sure that you explain your methodology and your rationale in your report.

2. Shoulder Surgery:

- Resection arthroplasty referred to in the *AMA Guides 3rd Edition (rev.)* is to be used only for partial resection of the humeral head, a procedure rarely performed currently.
- Neither resection nor implant arthroplasty values should be used for a distal clavicular resection. If providing a rating for a distal clavicular resection, the upper extremity value is 10%.
- The *AMA Guides 4th and 5th Editions* continue to suggest that subacromial arthroplasty should be rated using ROM, and when appropriate, ‘joint crepitation with motion’ from the “Other Disorders” section. In general, when any additional rating for subacromial arthroplasty is deemed appropriate in a case with or without crepitus because “...other factors have not adequately rated the extent of the impairment,” it should not exceed 10%. (*AMA Guides 3rd Edition (rev.)* p. 52).

3. Partial Shoulder Joint Replacement:

- Total implant arthroplasty of the shoulder is a 30% rating per *The AMA Guides 3rd Edition (rev.)* Total arthroplasty is defined as an implant arthroplasty of the humeral head accompanied by resurfacing of the glenoid with any substance including metal, polyethylene or soft tissue graft.



- If a hemi-arthroplasty is done, the rating will generally be 20%. Hemi-arthroplasty includes resurfacing of the humeral head via a resurfacing cap or stemmed humeral replacement. The 20% rating should be combined with range of motion impairment and any peripheral nerve impairment ratings. Crepitus and synovial changes should not be rated as their ratings would be duplicative and the surgical procedure has presumably eliminated those anatomic derangements.

4. Partial Knee Joint Replacements: The *AMA Guides 3rd Edition (rev.)* allows a 20% rating for an optimally placed full knee arthroplasty. If a partial knee joint replacement is performed, the rating will generally be for a hemiarthroplasty or 10% for the knee replacement. The physician should take into account any additional pathology present in that knee ratable under Table 40 and combine it with the 10%. Degenerative changes for which the arthroplasty was performed should not be rated since the surgical procedure has presumably eliminated those anatomic derangements. Range of motion is always recorded and combined with Table 40 ratings.

5. Peripheral Nerve Injuries Resulting from Cumulative Trauma: All peripheral nerve injuries should be rated under the peripheral nerve tables in the *AMA Guides 3rd Edition (rev.)*: for upper extremity – Table 14 (p. 46), and for lower extremity – Table 51 (p. 77). The peripheral nerve values are then multiplied by percentages in Table 10 (grading scheme sensory function-p. 42), or Table 11 (grading scheme for motor function-p. 42). For further information, you may also consult ‘Helpful Hints for Grading Neurological Deficits’ (*Level II Accreditation Curriculum*). Range of motion or the CTD rating system should only be used if there is a separate and distinct non neurologic cumulative trauma diagnosis (such as DeQuervain’s).

6. Musculoskeletal Cumulative Trauma Disorders:

Cumulative trauma staging is used to rate permanent impairment of specific disorders when no other rating is available in the *American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, 3rd Edition (rev.)*. Specific diagnoses must be provided prior to the assignment of an impairment rating. Remember that the terms ‘cumulative trauma disorder,’ repetitive motion syndrome,’ ‘repetitive strain injury,’ and other similar nomenclatures are umbrella terms that are not acceptable diagnoses. CTCs can be staged only after taking a thorough history and performing an appropriate physical examination (see History and Physical Examination). The factors included in the CTC Staging Matrix are:

- A = History and Physical Examination.
- B = Response to Modification of Specific Aggravating Factors.
- C = Activities of Daily Living.

It is expected that objective signs on physical examination will correlate with subjective symptoms. The signs and symptoms are staged in the Cumulative Trauma Staging Matrix as:

- Stage 1 = Minimal.
- Stage 2 = Mild.
- Stage 3 = Moderate.
- Stage 4 = Severe.

Stages 3 and 4 frequently may be associated with other secondary symptoms of chronic pain such as sleep alteration or depression.

When using the Staging Matrix for impairment rating at maximum medical improvement (MMI), assignment of the patient to a stage should be based primarily on limitations in ADLs and history and physical examination findings. The response to modification of specific aggravating activities may be used to aid the rater in choosing a number within the available rating range.

The staging number chosen from the “Impairment Grades at MMI” row is to be used as a multiplier in conjunction with the *AMA Guides to the Evaluation of Permanent Impairment, 3rd Edition (rev.)*, Chapter 3, and Table 17, to determine the impairment rating for each specific diagnosis. The primary presenting joint that corresponds to each specific established diagnosis should be rated. Descriptions of painful conditions without clear physiologic findings may not be rated using this chart. Examples include pain in the elbow or other upper extremity joint and myofascial pain disorder.

The staging matrix is only used to rate a CTC diagnosis when there is no impairment rating under range of motion and/or the specific diagnosis in the *AMA Guides 3rd Edition (rev.)*. All impairment ratings from this table are provided in upper extremity terms, and then converted to whole person. The table is not intended to distinguish between permanent partial disability as paid under 8-42-107 (2) and 8-42-107 (8).

Cumulative Trauma Staging Matrix

	Stage 1 (Minimal)	Stage 2 (Mild)	Stage 3 (Moderate)	Stage 4 (Severe)
History and Physical Examination	1 to 2 symptoms with signs identified on history and supported by physical examination with consistency of subjective and objective findings	2 or more symptoms with signs identified and supported by physical examination with consistency of subjective and objective findings	3 or more symptoms with signs identified and supported by the physical examination with consistency of subjective and objective findings	3 or more symptoms with signs identified and supported by physical examination with consistency of subjective and objective findings
	AND	AND	AND	AND
Response to Modification of Specific Aggravating Factors	Symptoms and/or signs improve or resolve with modification of specific aggravating activity	Symptoms and/or signs may improve but will not resolve completely with modification of specific aggravating activity	Symptoms and/or signs do not improve with modification of the specific aggravating activity, but may improve with elimination of the specific aggravating activity	Symptoms and/or signs do not improve with modification or elimination of the specific aggravating activity
	OR	OR	OR	OR
Activities of Daily Living (ADLs)	Minimal problems with ADLs	Noticeable aggravation by more difficult ADLs	Significant interference with most ADLs	Severe limitations of ADLs
Impairment Grades at MMI (See Note below to obtain Multiplier)	0-10%	11-20%	21-30%	31-40%

DIME Panel Physician Notes

- 1. DIME Application:** When completing the narrative and worksheets for the DIME, make sure you address all of the issues and/or all of the body parts listed on the DIME application. You are not required to provide a rating for every condition listed on the DIME application. For example, if you do not believe the condition is work related, or has resulted in physiologic impairment, a rating may not be necessary. You should, however, acknowledge all conditions in some fashion and explain your reasoning. *Remember that you do not have to provide worksheets if you are not giving a rating for the injury(s) in question.*
- 2. DIME Physicians Must Perform Complete Assessments and Exams, including All Applicable Measurements:** As a Division Independent Medical Examiner you are required to perform your own examination of the claimant and ensure that all required measurements are performed and documented on the appropriate worksheets. If you utilize another medical professional (such as a physical therapist) to perform range of motion measurements or other specialized tests and assessments (such as an audiogram), you are responsible for ensuring that the medical professional performs the assessments in accordance with the AMA Guides and other professional standards. After completing the evaluation, in rare instances you may decide that another physician's impairment rating better reflects the condition being evaluated. Examples include instances where you find another physician's range of motion more physiologically credible than the measurements you have obtained or when another physician has more training in a particular area than you do, such as a psychiatrist. *If you then decide to adopt another physician's rating, you should discuss in your report your own findings and clearly justify the reasons for using another physician's rating.* If you do not provide such a discussion your report will be returned as incomplete.
- 3. MMI Status:** Be specific about MMI status and date of MMI. If you agree with an authorized treating physician regarding MMI status and date, state the name of that doctor as well as the MMI date. If you decide to provide a different date of MMI, please provide a discussion of your reasoning. If you find the case is not work related and therefore is not awarded an impairment rating, it is still useful to provide information as to whether future care may be necessary for that condition.
- 4. Impairment when "Not at MMI":** Remember that a DIME is a legal/medical proceeding and you are being asked to provide specific information. *If the party requesting the DIME has asked that impairment be addressed, and if you find the patient not at MMI for that work-related injury, you should nevertheless provide a rating for that injury.* This information can be used by the parties for negotiations, settlement, or to help assess further treatment needs.
- 5. Recommendations for Additional Treatment:** Division Independent Medical Examiners frequently recommend further treatment. Remember that the statute defines MMI as: "A point in time when any medically determinable physical or mental impairment...has become stable and when no further treatment is reasonably expected to improve the condition. The *requirement for future medical maintenance* which will not significantly improve the condition or the possibility of improvement or deterioration resulting from the passage of time shall not affect a finding of [MMI]."

To avoid ambiguity and controversy, we recommend that independent medical examiners consider the following legal opinion issued by the Industrial Claim Appeals Office, *Gebert v. Nordstrom, Inc.*, W.C. No. 4-428-645 (ICAO, June 20, 2003), “A recommendation for therapies which present a reasonable prospect for improving physical function may be viewed as evidence that the claimant’s condition is not stable, and the resulting impairment is not measurable. Therefore, such treatment recommendations are inconsistent with MMI...”

- Treatment which is provided merely to *maintain* the claimant’s condition by preventing deterioration, or to relieve continuing symptoms, is not inconsistent with MMI and may be awarded as maintenance care.”
- The DIME physician must clearly indicate whether the treatment recommendations in the DIME report are intended as maintenance treatment or if the treatment could affect the MMI date given.
- If the examiner indicates that the treatment recommended would affect the MMI date, the examiner should also indicate whether the patient would be at maximum medical improvement as of a specific date in the event the patient refused to undertake the treatment suggested by the examiner. That “specific date” may or may not be the date of your exam.

6. Diagnostic Tests and MMI: There are times when a patient is placed at MMI but the examiner will nevertheless order a diagnostic test. If there is a reasonable possibility that the results of a diagnostic test (such as an MRI or EMG) will change the patient’s MMI status, then in most instances the patient will not be at MMI. If the diagnostic test is necessary only to provide impairment rating information, this would not affect the MMI date.