

2016

**Garth Gines Appellant/Plaintiff, v. Sean Edwards, Appellee/
Defendant.**

Utah Court of Appeals

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IN THE UTAH COURT OF APPEALS

GARTH GINES,

Appellant/Plaintiff,

v.

SEAN EDWARDS,

Appellee/Defendant.

BRIEF OF APPELLANT

Case No.: 20150259- CA

Civil No. 120400620

**ORAL ARGUMENT
REQUESTED**

APPEAL FROM THE FOURTH JUDICIAL DISTRICT COURT FOR PROVO,
STATE OF UTAH
HONORABLE DEREK PULLAN

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STATEMENT OF JURISDICTION

This court has jurisdiction pursuant to Utah Code Ann. §78A-4-102(3)(j) and the Order of the Utah Supreme Court, R. 241-243, transferring this case to the Utah Court of Appeals under Utah Rule of Appellate Procedure 42(a).

STATEMENT OF ISSUES PRESENTED

1. The first issue presented is whether the trial court abused its discretion when it allowed Alan Goldman, M.D. to testify at trial when the defendant had failed to provide Dr. Goldman's Rule 35 report during fact or expert discovery.

a. Standard of Review: Abuse of Discretion *Coroles v. State* 2015 UT 48, ¶12., to the extent judicial discretion is permitted *Langeland v. Monarch Motors, Inc.* 952 P.2d 1058, 1060 (Utah 1998).

b. Preservation: Plaintiff's First Motion in Limine, order dated September 5, 2014. (R.632)

2. The second issue presented is whether the trial court abused its discretion when it allowed Alan Goldman, M.D. to testify at trial regarding apportionment, when no such opinion was contained in his expert report produced several months after the close of expert

discovery.

a. Standard of Review: Abuse of Discretion *Coroles v. State* 2015 UT 48, ¶12, to the extent judicial discretion is permitted *Langeland v. Monarch Motors, Inc.* 952 P.2d 1058, 1060 (Utah 1998).

b. Preservation: Plaintiff's Motion for Partial Summary Judgment order entered October 15, 2014.(R.1483) , Oral Motion prior to Dr. Goldman taking the stand (R. 1693 at 390:17-22)

3. The third issue presented is whether the Court erred when it instructed the jury on apportionment, when Dr. Goldman admitted outside the presence of the jury that, "he just pulls numbers out of the air" when he apportions between pre-accident and post-accident pathologies .

a. Standard of Review: Correctness *Harris v. Shopko* 2011 UT App 329, ¶13.

b. Preservation: Oral Motion to Limit Dr. Goldman's testimony prior to taking the stand. (1693 at 414:1-416:13) Oral Motion for Directed Verdict at close of Defendant's Case (1693 at 507:1-20). Post-trial Motion for Directed Verdict Post-Trial Motion (R. 1580-1578).

4. The fourth issue presented for appeal is whether the trial court erred

when it denied appellant's motion for a directed verdict on the issue of medical special damages because the defendant failed to provide the jury with a non-arbitrary basis for apportioning damages.

a. Standard of Review: Correctness *Orvis v. Johnson* 2008 UT 2, ¶6

b. Preservation: Oral Motion for Directed Verdict at close of Defendant's Case (1693 at 507:1-20). Post-Trial Motion (R. 1580-1578).

STATEMENT OF THE NATURE OF THE CASE

This personal injury action arises from injuries sustained by the plaintiff when he was rear-ended by the defendant. Prior to trial, the plaintiff moved the court, among other things, for partial summary judgment on issues of liability, causation and his medical economic damages. The Court concluded there were no issues of material fact on liability, and causation but denied the motion as to his medical economic damages.

The case was tried to a jury over a period of five days. The jury was instructed that the defendant was at fault. The jury was instructed that the defendant's negligence was the cause of the plaintiff's injury and that the plaintiff suffered injury in the accident. The issues before the jury were the amount of past and future medical economic damages

and the amount of non-economic damages. At the close of the defendant's case, the plaintiff moved for judgment as a matter of law on the issue of the plaintiff's medical economic damages, relying upon *Harris v. Shopko*. 2013 UT 34 The Court denied that motion. The jury returned a verdict of \$10,000 in medical economic damages and \$7,500 in non-economic damages. The plaintiff then moved the court for judgment as a matter of law after the verdict, which the Court also denied. The appellant now directly appeals those rulings.

The plaintiff seeks judgment as a matter of law for \$61,296.60 in past medical expenses, applicable pre-judgment interest and a new trial limited to the issue of non-economic damages.

STATEMENT OF FACTS

Garth Gines was injured in a rear-end car accident on December 2, 2009 on westbound University Parkway in Orem, Utah. Mr. Gines was the front seat passenger in a vehicle driven by his sister, Christine Fountaine. It is undisputed that Mr. Gines suffered a neck injury in this accident. (R.1483)

Unfortunately for Mr. Gines, this was not his first neck injury. Prior to this accident Mr. Gines had single-level cervical fusion at C3-

C4 in May of 2005. (R.251). In April of 2007 a non-union at that level was discovered and revised, which successfully resulted in fusion. (R.251) Garth Gines had no desire to ever have neck surgery again.

Garth Gines had an immediate onset of aggravated symptoms after the car accident. After the accident it was discovered that Mr. Gines had two disc herniations at C4-C5 and C5-C6. (R.1691 at 171:12-14. Reluctantly, Mr. Gines underwent a surgical procedure in June of 2011 that included a discectomy, decompression of the spinal cord and nerve roots, and a double level fusion at C4-C5 and C5-C6. (R.1691 at 164:4-16). See also (1691 at 166:9-170:15)

Mr. Gines treating physician, Howard Reichman, M.D., opined at trial that the surgery was necessitated by the December 2009 car accident. (R.1691 at 192:2-3)

In connection with the June 2011 surgery, Mr. Gines had screws placed in the C4-C6 vertebrae. One of those screws backed out and catches on his esophagus causing him considerable discomfort and pain. (R. 1692 at 285:6-20).

In connection with the defense of this action, the defendant retained Alan Goldman, M.D. to perform a medical examination of Mr.

Gines pursuant to Rule 35 of the Utah Rules of Civil Procedure. The Rule 35 exam was conducted on December 21, 2012.

Dr. Goldman and John Droge, Ph.D. were designated by the defendant as retained experts pursuant to Rule 26(a)(4) of the Utah Rules of Civil Procedure. The plaintiff elected a report from Dr. Goldman and a deposition from Dr. Droge. The parties disposed Dr. Droge. After the deposition, the plaintiff moved the court to exclude both defense experts pursuant to Rule 26(d) of the Utah Rules of Civil Procedure. Dr. Goldman's Rule 35 report was not disclosed to the Plaintiff until March 18, 2014 after the motion to exclude Dr. Goldman was already pending.

The trial court excluded Dr. Droge on the grounds that his failure to produce all data upon which he relied prior to his deposition was not harmless, but found that the defendant's failure to produce Dr. Goldman's expert report after more than a year and after expert discovery had closed was harmless. (R. 632).

After Dr. Goldman's report was finally disclosed to the plaintiff, the plaintiff thereafter moved for partial summary judgment, alleging that the report did not create material issues of fact with regard to

causation of injury nor the amount of plaintiff's claimed medical expenses. (R.390) The factual basis for the plaintiff's motion was the opinions contained in Dr. Goldman's report.

On that motion, the trial court granted the plaintiff judgment as a matter of law on the issues of liability and fixed the amount of Mr. Gines' claimed past medical bills at \$61,296.60. (R.632). The trial court also ruled on the issue of causation, "The Court concludes that it is undisputed that Mr. Gines suffered at least a musculoskeletal injury to the cervical spine, of the sprain/strain variety with a temporary aggravation and superimposition upon a previously injured and alter symptomatic cervical spine anatomy." (R.632) The trial court also recognized that the reasonableness and necessity of the medical expenses incurred by Garth Gines was undisputed. (R.632). The trial court denied the plaintiff's motion for partial summary judgment as it found disputed issues of material fact regarding the amount of medical bills related to the accident and the need for future medical care. (R.632).

At trial, the Court heard testimony from Dr. Goldman outside the presence of the jury. On direct examination Dr. Goldman offered an

opinions not contained in his report. When asked about what charges would have been appropriately incurred in connection with the injuries he sustained in the accident. Dr. Goldman opined, "I would say that 8 to \$10,000 would probably take care of it." (R.1693 at 403:5-12).

On cross Dr. Goldman admitted his report said, "As Mr. Gines' cervical spine was markedly anatomically altered by his prior surgical procedures and with what appear to be a progressive symptomology prior the December 2nd, '09 MVA it is difficult to define what actual treatments would have been of assistance in light of what appear to be his already ongoing progressive cervical addition function." (R.1693 at 405:2-11). Dr. Goldman admitted he did not opine in his report when Mr. Gines' "temporary" aggravation ended. (R.1693 at 407:9-11). In his report, Dr. Goldman did not allocate specifically as to which bills he actually incurred were related to the accident and which ones were not. (R. 1693 at 407:13-15).

Dr. Goldman testified he was hired to render an opinion apportioning between Mr. Gines' pre-accident pathology and his post-accident pathology. When asked about the methodology employed when doing an apportionment, "it's just kind of picking numbers out of the

air." Dr. Goldman also admitted, "So, there's no specific, you know, recipe, if you will."

After hearing live testimony, the trial court ruled as follows,

I agree with defense counsel that apportionment is not an issue. It is the defendant's position that no part of Mr. Gines' condition today is attributable to the accident. That, at best, Mr. Gines suffered a temporary or at worst, he suffered a temporary aggravation of a preexisting condition. Dr. Goldman does state in his report that if that aggravation were permanent, he would apportion 20 percent to the motor vehicle accident. Ultimately, that apportionment is based on the American Medical Association Guidelines which provide a range of percentages from which practitioners must choose. That discretionary decision is informed by the practitioner's examination, training and experience. And while I agree that that's not a precise science, this is the system relied upon in tort litigation, and by government to do this work. It's the best system that we have to assess these determinations. And for that reason, I conclude that adequate foundation has been laid for Dr. Goldman to testify about apportionment." (R.1693 at 414:13-415:6).

The trial court also ruled in relevant part,

Dr. Goldman will be permitted to testify that a healthy person who suffered a temporary sprain/strain of the cervical spine would incur diagnostic costs and receive treatment consisting of the physical therapy, medication and home exercises that he's described on the stand. That is fairly disclosed in his report.

Dr. Goldman will not be permitted to testify as to what treatment would have been reasonable and necessary for a person with Mr. Gines' altered anatomy. As to that issue, Dr. Goldman in his report states only that it would have been difficult to define what treatments would have been of assistance. And so, I am not

going to get into, well, what treatments would have been provided to Mr. Gines in his condition to treat this temporary sprain/strain. There is just nothing in the report that goes to that issue.” (R.1693 at 415:9-23).

The trial court concluded that the testimony outside the report was harmless, including the \$8,000 to \$10,000 amount of claimed by Dr. Goldman to be attributable to the accident because, “Counsel are experienced attorneys who litigate tort cases and this is generally known to them.” (R. 1693 at 416:1-2).

DR. GOLDMAN’S TRIAL TESTIMONY

The jury returned and Dr. Goldman was permitted to testify outside the opinions expressed in his report. The court allowed Dr. Goldman to stray on three particular topics—Medical Expenses, Impairment Rating and Medical Treatment. The clearest way to demonstrate the differences is by direct comparison.

MEDICAL TREATMENT

Dr. Goldman’s expected testimony at trial was contained in his report,

“As Mr. Gines’ cervical spine was markedly anatomically altered by his prior surgical procedures and with what appeared to be progressive symptomology prior the 12-02-09 MVA, it is difficult to define what actual treatments would have been of assistance in the light of what appeared to be his already ongoing cervical

dysfunction.” (R.233).

At trial, Dr. Goldman testified,

Q: Okay. Doctor, what is the usual normal treatment for somebody who has the diagnosis that you have just described?

A: “Well, for strain/strain injuries, we usually do physical therapy, often chiropractic therapy will be done, in which you try to do stretching, flexion, extension, graduated strengthening exercises. You take the patient through these exercises and teach the patient to do a home exercise. You would put them on some possible muscle relaxants, anti-inflammatory pain medications, not particularly narcotic pain medications. Nowadays, there are also some non-narcotic, non-addicting medications that can stabilize nerve cell membranes and reduce the transmission of a pain impulse. So, they are frequently used for the complaints of pain. And in therapies often there will be massage or hot packs, ice packs, electrical Tens Stimulation Units. So, those therapies are usually done over an approximate four to six week window of time, two to three times a week. Patients seems – if they do well, you taper it down to another two or four weeks in which you’ll do one to two times a week, and then teach the folks how to do a continual home exercise program after that.” (R.1693 at 430:16-431:13).

MEDICAL EXPENSES

Outside the presence of the jury, Dr. Goldman admitted,

Q: Okay. And, also, in your report you did not allocate or tell us specifically which medical bills are related to the accident and which one are not?

A: That’s correct. (R.1693 at 407:12-15).

Q: You recently gave us a figure a moment ago regarding the cost of physical therapy. Is that contained in your report?

A: No (R. 1693 at 410:7-10).

At trial in front of the jury, Dr. Goldman testified:

Q. Okay. Doctor, how much does that typical treatment cost for a person that, typically, an ordinary person that has that kind of presentation? What does that run? And if you could break it out for us specifically, that would be helpful?

A. Well, most folks in accidents go to an emergency room. So, there is an emergency room fee, can be three, four \$500. Then usually x-rays. An MRI can cost anywhere from 500 to 2500 bucks. Usually, they run around a thousand bucks or so. The therapy, my experience has been that the physical therapy session are usually about \$125. Somewhere between 100 and \$150 a session. And using the formula that I talked about, the four to six weeks and one to two week, two to three times, basically, that comes out to 26 therapeutic sessions. So, you multiply that by 125 or 150, and you are up to whatever that is, 3,000 or so dollars. Add a couple thousand more for the images and medications and ER. I think you are talking, as I said previously, somewhere around 7, 8,000, \$10,000 something like that." (R.1693 at 431:14-432:1-7).

IMPAIRMENT RATING

Dr. Goldman's report states in relevant part,

"Does the claimant have or do you anticipate the claimant having a permanent impairment [disability] as a result of this injury? Please provide a permanency rating.

Response: As I have commented in several of my above answer, it is extremely difficult to definitively state that the MVA of 12-02-09 is the cause of Mr. Gines' current complaints as he had a progressive spine dysfunction prior to that date. In my answer to question #6a, I stated I would apportion 80% of Mr. Gines' current symptomology to his underling pre-existing medical conditions

and only 20% to the MVA of 12-02-09. In referencing the *AMA Guides to the Evaluation of Permanent Impairment [Fifth Edition]*, Chapter 15, Section 50.6 Table 15-5 Category III, Page 392, I would award Mr. Gines an 18% Whole Person Impairment, as I did not see any images specifically measuring a possible alteration of spinal motion segment integrity. As I have commented upon an appointment of 20% to the MVA of 12-02-09, mathematically, I would award, I would award Mr. Gines a 3.6% Whole Person Impairment as a result of the 12-02-09 MVA, although I reserve the right to re-address this possible Whole Person Impairment award after a review of his images, as has been requested above. In referencing Chapter 18 of the AMA Guides, Figure 18-1 Algorithm Box 3, Page 574, I would also award Mr. Gines a 1% Whole Person Impairment for his overall sense of headache and neck pains, which would raise his final Whole Person Impairment for those anatomic conditions to 19% which thus, mathematically, then gives Mr. Gines a final Whole Person Impairment of 3.8% as a result of the 12-02-09, allowing for the disclaimer about the images to remain in place as I have written above.” (R.230)

Dr. Goldman testified at trial:

Q: Do you believe that the injury that Mr. Gines suffered was temporary or permanent?

A: I thought it was a temporary exacerbation of his preexisting already injured anatomy. And the record, Dr. Stacy talk about how he was getting worse before the accident, a lot of problems. So I think the just another insult to that. But from a musculoskeletal standpoint , they usually do get better.” (1693 at 433:5-12).

DR. GOLDMAN'S APPORTIONMENT

Dr. Goldman also testified at trial with regard to apportionment.

“Q: Let me ask you a question about your percentages of people

like Garth. You said that 85 to 90 percent get back to normal.

A: Eighty-five to 90 percent of musculoskeletal injuries get back to normal, that is correct.

Q: Okay. And you decided that Garth was in that 85 to 90 percent?

A: For a musculoskeletal dysfunction, yes.

Q: Now, was that arbitrary or was that to a reasonable degree of medical probability?

A: From a reasonable degree of medical probability, 80, 85, 90 of musculoskeletal injuries get better.

Q: So, from a reasonable degree of medical probability, did Garth fit into that?

A: He has an altered anatomy. I don't know if he would fit into that exact thing.

Q: You don't know? So, he might, he might not?

A. No, that is correct

MR. MCGEE: Your Honor, can we approach?

MR MCGEE: This is completely arbitrary. He 85 to 90 percent he might, he might not. I don't know.

THE COURT: Make your arguments in closing. I think you have done very well." (R. 1693 at 449:6-450:5).

Dr. Goldman also testified at trial regarding Mr. Gines "temporary" aggravation.

"Q: Dr. Goldman, with regard to the temporary aggravation, it began at the accident?

A: Yes.

Q: And it ended?

A: You are going to fall. Oh. I can't tell you when it ended. I can just tell you that most musculoligamentous injuries within a three to six month maximum time do resolve and come back to their baseline. That would be the guideline I would use.

Q: With 85 to 90 percent of the people?

A: Yes.

Q: And we don't know if Garth falls into that 85 to 90 percent of people?

A: I do not know that." (R. 1693 at 461:24-462:12)

During closing argument, the defendant argued as follows:

"And counsel has argued that you should award the entire \$61,000 because we can't make an apportionment. Well, see that's not accurate. There is no apportionment to make because the injury's not permanent. Because the injury is of a temporary nature, whatever Mr. Gines is experiencing right now is entirely 100 percent due to his previous injuries, his ongoing degenerative condition. And it's also not accurate when counsel says that he just if you would a number out of a hat. Yes, it's true there is some arbitrariness. It's not – medicine's not a precise and exact science." (R.1693 at 548:4-15).

Before closing arguments and jury instructions, the plaintiff moved for a directed verdict on the issue of apportionment, arguing that Dr. Goldman admitted that his methods in arriving at his apportionment were arbitrary. (1693 at 507:1-20). The plaintiff specifically requested that the court not instruct the jury on

apportionment. The plaintiff requested that the jury be charged that they must assume that all the medical bills submitted by Mr. Gines are related to the accident and that they must attribute all of Mr. Gines' current complaints to the accident.(1693 at 507:1-20).

The jury deliberated for several hours and returned a verdict of \$10,000 for past medical expenses. \$0 for future medical expenses and \$7,500 in non-economic damages. (R.1693 at 573:20-22.).

Within ten days of the trial, the plaintiff renewed his motion for a directed verdict and a new trial, which was summarily denied by the court without a hearing. (R. 1580-1578).

In that post-trial motion, the plaintiff pointed out that not only was Dr. Goldman's method arbitrary and that was directly reflected in the verdict. (R.1598-1582)

SUMMARY OF THE ARGUMENT

Garth Gines should be awarded the full amount of his claimed medical expenses and given a new trial on non-economic damages. The plaintiff's case was harmed when Dr. Goldman's report was not disclosed during discovery. Dr. Goldman should have been excluded on that basis. That error was compounded when Dr. Goldman was allowed

to testify outside the scope of the report about medical expenses,

When Dr. Goldman's opinions were finally fully disclosed during the trial, the court committed further error when denied the plaintiff's motion for a directed verdict and submitted the issue of Mr. Gines medical expenses to the jury with an apportionment instruction, after Dr. Goldman admitted that "he pulls numbers out of the air."

STANDARD OF REVIEW

Courts generally have discretion to manage discovery and if appropriate, sanction parties for failure to fulfill discovery obligations. However this discretion is not unlimited, and is "permitted only after certain conditions have been met." *Langeland v. Monarch Motors, Inc.* 952 P.2d 1058, 1060 (Utah 1998).

With regard to the trial court's failure to grant the plaintiff's multiple motions for summary judgment and a direct verdict the standard is correctness. *Orvis v. Johnson* 2008 UT 2, ¶6. The defendant carried the burden of proof with regard to apportionment and as such the plaintiff's motions for judgment as a matter of law, should be treated as pure questions of law.

ARGUMENT

I. THE TRIAL COURT ABUSED ITS DISCRETION WHEN IT FOUND THE NON-DISCLOSURE OF DR. GOLDMAN'S REPORT TO BE HARMLESS.

Rule 35 of the Utah Rules of Civil Procedure requires unconditional disclosure of, “a detailed written report of the examiner, setting out the examiner’s findings, including results of all tests made, diagnoses and conclusions.” Utah R. Civ. P. 35. The penalty for not complying with Rule 35 is contained in Rule 26(d)(4), “If a party fails to disclose or to supplement timely a disclosure or response to discovery, that party may not use the undisclosed witness, document or material at trial at any hearing or trial unless the failure is harmless and the party shows good cause for the failure. Utah R. Civ. P. 26(d)(4). “In other words, rule 37(h) shifts the burden to the non-disclosing party to show why the undisclosed evidence should not be excluded.” *Coroles v. State* 2015 UT 48, ¶22.

Rule 26 of the Utah Rules of Civil Procedure requires disclosure prior to the expert election of, among other things, “all data and other information that will be relied upon by the witness in forming those opinions.” After the election of a report, the offering party must disclose

the expert report. Utah R. Civ. P. 26(a)(4)(B). The report must be signed and contain, “a complete statement of all opinions the expert will offer at trial and the basis and reasons for them. Such an expert may not testify in a party’s case-in-chief concerning any matter not fairly disclosed in the report.” *Id.*

It is factually undisputed that Dr. Goldman’s Rule 35 report was not disclosed during fact discovery. It is undisputed that Dr. Goldman’s expert report was not disclosed during expert discovery. Dr. Goldman’s report was only disclosed after expert discovery had ended and Dr. Goldman’s exclusion, sought by the plaintiff. The trial court refused to exclude Dr. Goldman as the court found the non-disclosure of his report until March 18, 2014 to be harmless.

Such a finding of harmlessness is without reasonable basis. The plaintiff did not know the several material opinions Dr. Goldman was going to offer at trial. Plaintiffs are tasked with the burden of proof, as such the plaintiffs are entitled to the last word. By delaying disclosure of Dr. Goldman’s report, Dr. Goldman and the defendant obtained the advantage of having the most recent opinion at trial, in essence the last word.

The full harm of Dr. Goldman's non-disclosure did not become apparent until during the trial, when the plaintiff solicited testimony from Dr. Howard Reichman to rebut Dr. Goldman's opinions. (R. 1691 at 187:14-19) The Defendant objected on the grounds that Dr. Reichman was not disclosed as a rebuttal expert. (R.1691 at 187:20-23). The trial court sustained the objection. (R.1691 at 189:1). This ruling placed the plaintiff in an impossible scenario, the need to designate a rebuttal expert during expert discovery, without knowing the substance of the opinion to be rebutted, during expert discovery. This result left Dr. Goldman with the last word on the plaintiff's medical condition, while the plaintiff carried the ultimate burden of proof.

During the pendency of this appeal, the Utah Supreme Court has held that, "Where the exclusion of an expert is tantamount to the dismissal of the lawsuit," "the district court should exercise restraint in choosing this grave step rather than a lesser sanction." *Coroles v. State* 2015 UT 48, ¶29. Excluding Dr. Goldman, would not have resulted in a dismissal of the lawsuit.

The Court analysis in *Coroles*, distinguished between situations where discovery was provided late, and situations where discovery was

not provided at all. *Id* at ¶23. In this case, the defendant had an affirmative duty to disclose absent a request under Rule 35 of the Utah Rules of Civil Procedure, and did not do so at any time during discovery.

II. THE TRIAL COURT ABUSED ITS DISCRETION WHEN IT PERMITTED DR. GOLDMAN TO TESTIFY OUTSIDE THE CONTENTS OF HIS REPORT.

In 2011, amendments to Rule 26 of the Utah Rules of Civil Procedure drastically altered civil discovery practice in Utah. The most significant changes deal with expert discovery. The official commentary states,

“If a party elects a written report, the expert must provide a signed report containing a complete statement of all opinions the expert will express and the basis and reasons for them. The intent is not to require a verbatim transcript of exactly what the expert will say at trial; instead the expert must fairly disclose the substance of and basis for each opinion the expert will offer. The expert may not testify in a party’s case in chief concerning any matter that is not fairly disclosed in the report. To achieve the goal of making reports a reliable substitute for depositions, courts are expected to enforce this requirement.” Comment to Utah R. Civ. P. 26.

When Dr. Goldman’s report was finally disclosed less than 6 months before trial, the plaintiff discovered it did not disclose key opinions necessary to support the defendant’s affirmative defenses. The trial court abused its discretion when it allowed Dr. Goldman to testify

outside his report in three material ways

The court permitted Dr. Goldman to tell the jury that Mr. Gines suffered a mere temporary sprain/strain injury. The court permitted Dr. Goldman to tell the jury what reasonable and necessary treatment would be for a person without altered cervical anatomy. The court did not allow Dr. Goldman to testify as to what treatment would have been necessary for a person with Mr. Gines altered anatomy.

At trial, Dr. Goldman testified that reasonable and necessary medical treatment for a normal person would amount to approximately \$10,000. (R.1693 at 431:14-432:1-7).

This number was not contained in his report. It was a complete and total surprise. It is absolutely certain this testimony hurt the plaintiff's ability to rebut Dr. Goldman's opinions and is directly reflected in the jury's award of \$10,000 for medical economic damages.

III. THE TRIAL COURT ERRED WHEN IT DENIED PLAINTIFF'S MULTIPLE MOTIONS FOR JUDGMENT AS A MATTER OF LAW ON APPORTIONMENT AND MEDICAL ECONOMIC DAMAGES

The trial court started down the wrong path when it concluded that there was nothing to apportion in this case. Mr. Gines clearly had a prior neck condition. Mr. Gines clearly had a current neck condition,

including a surgical screw visibly impinging his esophagus. That screw was not a pre-existing condition. It is undisputed that Mr. Gines further injured his neck due to the defendant's negligence. The central issue of this case was to determine what was caused by the accident and what was not caused by the accident.

In order to apportion the defendant carries the burden of proof. *Harris v. Shopko* 2013 UT 34, ¶28. When allocating causation between preexisting pathologies and a subsequent accident, medical expert testimony is required. *Id* at ¶35.

The required defense medical expert must provide a "non-arbitrary evidentiary basis for the jury to apportion damages." *Id* at ¶32. Apportionment may not be based on "pure speculation." *Id*. Thus, "the determinative question is whether the expert testimony has supplied the jury with a non-arbitrary basis for apportioning damages. *Id* at ¶38.

Dr. Goldman's opinions offered at trial in this matter were arbitrary. He admitted as much. (R.1693 at 433:15-17) Multiple times. (R.1693 at 446:9-19). When ruling on whether Dr. Goldman's apportionment opinion was not arbitrary, the court relied upon the

American Medical Association Guidelines. In doing so, the Court completely missed the boat by confusing the whole person impairment rating with the apportionment between a prior impairment rating and present impairment rating. To highlight this point Dr. Goldman rated Mr. Gines as having a post-accident Whole Person Impairment of 18%.¹ That is not an arbitrary number as it is derived from established standards and ranges set forth in the AMA Guidelines.

The arbitrary part is when Dr. Goldman arbitrarily decided to apportion 20%² of that impairment rating to the subject accident without rating the prior impairment. In determining the apportionment number, Dr. Goldman testified,

“Well it’s a common sense thing. I mean, if you’ve got someone that’s had a pre-existing condition, you have to figure in how that could affect his current status. And sometimes it’s just kind of picking numbers out of the air.” He further testified, “So, there’s no specific, you know, recipe, if you will.”

It is difficult to imagine a scenario that could be any more arbitrary than “Picking numbers out of the air.” There is simply nothing scientific about that.

¹ Dr. Goldman did not disclose what Mr. Gines’ pre-accident whole person impairment was.

² Dr. Goldman recanted at trial and stated 0% of Mr. Gines current condition was attributable to the accident

The Court's decision to deny the Plaintiff's motion for a direct verdict is even more puzzling in light of the court's limitation on Dr. Goldman's testimony to what treatment an average healthy person would need with a neck sprain/strain. The Court correctly recognized, "And so, I am not going to get into, well, what treatments would have been provided to Mr. Gines in his condition to treat this temporary sprain/strain. There is just nothing in the report that goes to that issue." (R.1693 at 415:9-23).

What treatments would have been actually provided to this particular plaintiff to treat the injuries he sustained in the car accident is precisely the question the defendant needed to answer to avoid a directed verdict. Evidence as to what treatment an average person would need, is completely irrelevant. "One who injures another takes him as his is." *Brunson v. Strong* 412 P.2d 451 (Utah 1966). There was no evidence that was fairly disclosed by the defendant in advance of trial that indicated what treatment Mr. Gines actually received was related to this accident. It is undisputed that Mr. Gines sustained some injury due to Sean Edwards negligence. As such, there is something to apportion between Mr. Gines prior injury and the injuries sustained in

the subject accident. As evidenced by the defendant's argument, Dr. Goldman not only did not provide a non-arbitrary basis for apportionment, but absolutely confused the jury regarding what their collective job was.

It is not the jury's role to determine in hindsight which doctors Mr. Gines should have seen or what medical treatment Mr. Gines should have received. Prior to trial, this court ruled that Mr. Gines had received reasonable and necessary medical treatment in the amount of \$61,296.60. Thus, what reasonable treatment looks like and what necessary treatment looks like are completely irrelevant topics for the jury to consider.

The sole issue before the jury was which of those bills actually incurred by Mr. Gines were related to the negligence of Sean Edwards. As argued previously, \$10,000 is a complete nonsense answer to that question, in light of the evidence. It could be higher, or it could be lower, but there is no way to contort Mr. Gine's actual bills to add up to \$10,000 in any rational fashion from the testimony elicited at trial from any of the witnesses.

Dr. Goldman testified at trial that reasonable care for a person

without Mr. Gine's altered anatomy would be "physical therapy or chiropractic treatment for 4-6 weeks at 2-3 times a week tapering off to 1-2 visits for another 2-4 weeks would be appropriate " There was no evidence presented by the defendant regarding what proper treatment would be for a person with Mr. Gine's altered anatomy would be. Dr. Goldman's report was silent on the subject. The answer Dr. Goldman provided at trial, did surprise the plaintiffs and their counsel despite their level of sophistication in personal injury law.

The defendant asserts that no apportionment is necessary because Mr. Gines only sustained a temporary aggravation. At trial Dr. Goldman testified that aggravation clearly began with the accident. He did not testify when Mr. Gine's temporary aggravation ended or whether after several years Mr. Gine's temporary aggravation has ended at all. This uncertainty, as a matter of law, must be construed against the defendant. *See Harris v. Shopko* 2013 UT 34 ¶28.

Dr. Goldman did not inform the jury what the proper course of treatment would be with someone with two cervical procedures and altered anatomy. As Dr. Goldman's ultimate opinion did not encompass the realities of the plaintiff's actual pre-accident physical condition, the

jury was left to speculate regarding what proper care under the circumstances would be. This principle also demonstrates the defendant's failure to provide the jury with a non-arbitrary basis to apportion.

Mr. Gines (or any plaintiff for that matter) is not the average person. It is not the jury's job to determine what an average person would have suffered, or what treatment an average person would have received. *See* CV2018 MUJI 2d. Those are forbidden topics. The question is "what is the extent of Mr. Gines injury?" and "Out of the reasonable and necessary treatment Mr. Gines did receive, what portion was related to the accident?" Dr. Goldman simply could not tell the jury when Mr. Gine's injury ended. Dr. Goldman did not testify whether Mr. Gines fell within the realm of "average." As a result the jury was left to speculate, which speculation was reflected in the jury award. This error obviously affected the jury, as they awarded the precise amount in past medical expenses recommended by Dr. Goldman. The jury's decision is against the weight of the evidence, as there is no combination of Mr. Gine's claimed medical expenses that would add up to exactly \$10,000.

Mr. Gine's medical expenses the day before his surgery only totaled \$6,021.90. Immediately after the surgery, his medical bills totaled \$56,730.04. There was no evidence presented aside from Dr. Goldman's new opinion disclosed for the first time on the witness stand, (and arbitrarily formed) that supports this \$10,000 award. There was no evidence presented at trial that identified the precise metaphysical instant where Mr. Gine's medical bills reached the \$10,000 threshold. Mr. Gines reached the \$10,000 threshold in medical bills while on Dr. Reichmann's operating table. The implication from the award is that beginning the surgery was related to the accident, but finishing the surgery was not. It is hardly shocking to achieve such an arbitrary result, when it is based on an arbitrary opinion. Such cannot be the case. Either Dr. Reichman's services were precipitated by the accident or they weren't. If they were, the jury's \$10,000 figure is not supported by the evidence. If they were not, likewise, the jury's \$10,000 figure is also not supported by the evidence.

Giving the appropriate deference to the jury's \$10,000 award, the rational conclusion is that at least part of the surgical expenses was awarded. There is no rational non-arbitrary justification to award part

of a surgery and not the remainder.

Furthermore, if the need for Dr. Reichman's services was precipitated by the accident, the screw protruding from the plaintiff's C6 vertebrae is likewise related to the accident. The jury awarded Mr. Gines \$0 for future medical expenses, despite the fact, Dr. Reichman indicated that the screw would need to come out if it continued to cause problems, including but not limited to weight loss. Mr. Gines testified that it causes him great discomfort and also testified he had lost weight as a result of the screw affecting his eating habits.

That isn't to say that the standard announced by the Utah Supreme Court in 2013 in *Harris v. Shopko* is a medically impossible standard for defendants to meet. There is a very clear way to do it. One example is the guidelines provided by the Utah Labor Commission.

"When a permanent impairment results from the addition or combination of a prior impairment with the existing impairment from the industrial accident, then the permanent impairment is apportioned (or distributed) between the current injury and the prior impairment conditions(s). Physician/raters must understand that apportionment generally applies only to permanent impairments. Apportionment of the final rating is necessary if there is objective medical documentation that a prior ratable impairment existed before the industrial event for the same anatomical area, structure or condition. In order to apportion any condition as a prior impairment, the condition would need to have been ratable by either the AMA Guides or Utah's Impairment

Guides because the industrial event and must be based on reasonable medical probability (i.e. greater than 50%). The total impairment is calculated and then the prior impairment is calculated and deducted. The remaining amount would then be due to the industrial accident. *Utah Labor Commission's 2006 Supplemental Impairment Rating Guides 5/12/2006. §2.2a pg 20*

The Utah Guide goes on to state, "Not all cases can be apportioned. If the physician cannot, with a reasonable degree of medical probability, estimate the level of impairment that would have existed, absent the injury, then the physician cannot apportion the final impairment." *Utah Labor Commission's 2006 Supplemental Impairment Rating Guides 5/12/2006. §2.2a pg 20*

In this case, there was something to apportion. Dr. Goldman failed to provide the jury with a non-arbitrary basis for apportionment. As a result of that failure, the trial court should have awarded the plaintiff his claimed medical expenses as a matter of law.

CONCLUSION

Based on the forgoing, the only appropriate result is to enter a directed verdict in the amount of Mr. Gines' stipulated medical expenses of \$61,296.60, plus pre-judgment interest and hold a new trial on general damages and future medical expenses, without any sort of apportionment instruction. Utah law as outlined by the Utah Supreme Court in 2013 demands this result and only this result, based upon the

defendant's failure to provide the jury with a non-arbitrary basis for apportionment of Mr. Gines' pre- and post-accident pathologies, his post- accident medical expenses and his whole person impairment rating.

DATED this 5th day of October, 2015

Respectfully submitted,



Peter R. Mafflin

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Counsel for Plaintiff and Appellant Garth Gines

CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Utah R. App. P. 24(g)(5)(B) because it contains 3,160 words, excluding the parts of the brief exempted by Utah R. App. P. 24(f)(1)(B).
2. This brief complies with the typeface requirements of Utah R. App. P. 27(b) because it has been prepared in a proportionally spaced typeface using Microsoft Office Word 2010 in 14- point Century Schoolbook.

Dated: October 5, 2015

Respectfully submitted



Peter R. Mifflin

CERTIFICATE OF SERVICE

I hereby certify that on this 5th day of October , 2015, two copies of the Brief for Appellant Garth Gines were served by overnight and email on each of the following:

Karra Porter

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ADDENDUM TABLE OF CONTENTS

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The Order of Court is stated below:

Dated: September 05, 2014
09:17:54 AM

/s/ DEREK P. PULLAN
District Court Judge



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Attorneys for Plaintiff

IN THE FOURTH JUDICIAL DISTRICT COURT
IN AND FOR UTAH COUNTY, STATE OF UTAH

GARTH GINES; and CHRISTINE
FOUNTAINÉ,

Plaintiffs,

v.

SEAN EDWARDS,

Defendants.

ORDER

Civil No. 120400620

Judge Derek P. Pullan

The above matter came before the Court on April 29, 2014 at 2:00 PM for argument on plaintiffs' motion to exclude testimony of defendant's designated experts Dr. John Droge and Dr. Alan Goldman and to exclude photographs taken by Brian Ritucci. Plaintiff was represented by Peter R. Mifflin and Leonard E. McGee. Defendant was represented by Warren Wadsworth.

Having considered plaintiffs' motion, the memoranda and exhibits filed by the parties and the argument of counsel and being fully advised, the Court herewith enters the following Ruling and Order.

The basis for the Court's ruling is set out in greater detail in the record of the hearing of April 28, 2014.

The court finds the following:

1. Dr. John Droge was designated by the defendant to give expert testimony in this case.
2. The Defendant failed to provide Dr. John Droge's case and all of the data upon which his opinion was based.
3. The failure to provide the foundational data for Dr. Droge's opinions was not harmless.
4. Dr. Alan Goldman was also designated by the defendant to give expert testimony in this case.
5. Defendant failed to provide Dr. Alan Goldman's report.
6. The failure to provide Dr. Alan Goldman's report was harmless.
7. Brian Ritucci was not properly disclosed as a fact witness.
8. The defendant did not provide photographs taken by Mr. Ritucci in fact discovery.
9. The failure to provide the photographs was harmless.

For the reasons set forth in the record of the April 28, 2014 hearing,

IT IS HEREBY ORDERED ADJUDGED AND DECREED AS FOLLOWS:

1. Dr. John Droge is hereby excluded and therefore will not be allowed to give testimony at trial in the above matter.
2. Defendant's failure to timely provide Dr. Alan Goldman's reports was harmless and as such will not be excluded from providing testimony at trial in the above matter.

3. Brian Ritucci was not properly disclosed as a witness of fact and as such may not provide testimony at trial in the above matter; however the photos he took are not excluded.

Approved as to form:

/s/Peter R. Mifflin
Attorney for the Plaintiffs

/s/ Warren Wadsworth
Attorney for the Defendant

END OF ORDER

Executed and entered by the Court as indicated by the date and seal at the top of page

The Order of Court is stated below:

Dated: October 15, 2014
01:22:12 PM

/s/ DEREK P. PULLAN
District Court Judge



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IN THE FOURTH JUDICIAL DISTRICT COURT
IN AND FOR UTAH COUNTY, STATE OF UTAH

GARTH GINES; and CHRISTINE
FOUNTAINÉ,

Plaintiffs,

v.

SEAN EDWARDS,

Defendants.

**RULING AND ORDER ON
PLAINTIFFS' MOTION FOR PARTIAL
SUMMARY JUDGMENT**

Civil No. 120400620

Judge Derek P. Pullan

The above matter came before the Court on September 17, 2014 at 1:00 PM for argument on plaintiffs' motion for partial summary judgment on the following issues:

1. The negligence of Sean Edwards.
2. Sean Edward's negligence as the cause in fact and proximate cause of the injuries suffered by Garth Gines.
3. Sean Edward's negligence as the cause in fact and proximate cause of the injuries suffered by Christine Fountaine.

4. The reasonableness and necessity of the medical expenses incurred by Garth Gines.
5. The reasonableness and necessity of the medical expenses incurred by Christine Fountaine.
6. The amount of Garth Gine's past medical bills.
7. The amount of Christine Fountaine's past medical bills.
8. Establishing Garth Gine's need for future treatment.

Plaintiff was represented by Peter R. Mifflin and Leonard E. McGee. Defendant was represented by Warren Wadsworth.

Having considered plaintiffs' motion, the memoranda and exhibits filed by the parties and the argument of counsel and being fully advised, the Court herewith enters the following Ruling and Order.

IT IS HEREBY ORDERED ADJUDGED AND DECREED AS FOLLOWS:

1. On the issue of the negligence of Sean Edwards, the Court concludes there is no dispute of material fact and the Plaintiffs are entitled to judgment in their favor as a matter of law.
2. On the issue of Sean Edward's negligence as the cause in fact and proximate cause of the injuries suffered by Christine Fountaine, the Court concludes there is no dispute of material fact and Christine Fountaine is entitled to judgment in her favor as a matter of law.

3. On the issue of reasonableness and necessity of the medical expenses incurred by Christine Fontaine, the Court concludes there is no dispute of material fact and Christine Fontaine is entitled to judgment in her favor as a matter of law.
4. With regard to the amount of Garth Gine's past medical bills, the Court concludes there is no dispute of material fact and fixes the amount of Mr. Gine's past medical bills at \$61,296.60.
5. With regard to the amount of Christine Fontaine's past medical bills, the Court concludes there is no dispute of material fact and fixes the amount of Ms. Fontaine's past medical bills at \$42,668.80. The Court awards Ms. Fontaine the full amount of her past medical bills as a matter of law. The Court reserves the question of future medical expenses for trial by jury.
6. On the issue Sean Edward's negligence as the cause in fact and proximate cause of the injuries suffered by Garth Gines, the Court concludes that there exists a dispute of material fact and therefore the Plaintiff is not entitled to judgment as a matter of law. The Court concludes that it is undisputed that Mr. Gines suffered at least a musculoskeletal injury to the cervical spine, of the sprain/strain variety with a temporary aggravation and superimposition upon a previously injured and altered symptomatic cervical spine anatomy. Whether Mr. Gines suffered more serious injury as a result of this accident, is factually disputed.

7. On the issue of the reasonableness and necessity of the medical expenses incurred by Garth Gines, the Court concludes that there exists a dispute of material fact and therefore the Plaintiff is not entitled to judgment as a matter of law.
8. On the issue of Mr. Gines need for future medical care, the Court concludes that there exists a dispute of material fact and therefore the Plaintiff is not entitled to judgment as a matter of law.

Approved as to form:

/s/ Peter R. Mifflin
Attorney for the Plaintiffs

/s/ Warren F. Wadsworth
Attorney for the Defendant

END OF ORDER

Executed and entered by the Court as indicated by the date and seal at the top of page

RULE 7(f)(2) NOTICE

You may file your specific objections setting forth any alleged inaccuracies contained in this proposed Ruling and Order. As per Rule 7(f)(2) of the Utah Rules of Civil Procedure you have seven (7) days from the date of service of this proposed order upon you in which to file your objections, if any, with the above entitled court and a copy to the undersigned counsel. Otherwise, the proposed order will be deemed accurate and will be submitted to the Court for signature and entry.

DATED this 30th day of September, 2014.

ROBERT J. DEBRY & ASSOCIATES

/s/Peter R. Mifflin

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December 21, 2012

Ms. Taylor Sokol
c/o IME Services
Corvel Corporation
9815 South Monroe Street, Ste. 302
Sandy, Utah 84070

Re: Garth Gines
Claim No.: ENZ4048806.1 NP
DOI: 12-02-09
Date of evaluation: 12-21-12

Dear Ms. Sokol:

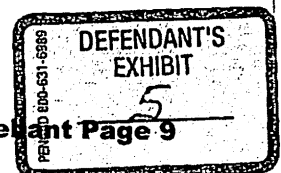
I examined Mr. Garth Gines on December 21, 2012 for a Rule 35 Neurological Evaluation. Prior to today's examination, I reviewed Mr. Gines' voluminous Medical File which I have categorized in the appropriate subsection below. Upon meeting Mr. Gines, I advised him that I would not be serving as a treating physician, that the purpose of today's contact was evaluative in nature only, and that I would be sending my report directly to your office. In addition, I told Mr. Gines that if, during the time of my physical examination, I requested that he perform various activities or assume certain postures which he thought might be painful or injurious to his status, such need not be undertaken.

It was my opinion that Mr. Gines completely understood the parameters of today's Rule 35 Evaluation.

It is my further understanding that you have raised several questions concerning Mr. Gines' medical status following a motor vehicle accident on 12-02-09. To those concerns, I will address the 9 questions that were raised in your cover letter of 12-05-12 at the end of this evaluative report.

Mr. Gines is currently 48 years of age and right-handed.

The following are my findings and conclusions.



Re: Garth Gines
December 21, 2012
Page Two

REVIEW OF MEDICAL RECORDS

12-02-09 – Accident Form, City of Orem. Office Johnson, Badge #345. Both vehicles were traveling westbound on University Parkway attempting to make a right hand turn onto State Street. Vehicle #2 [driven by Christine Fountaine] stopped for traffic and was hit by vehicle #1 [Shawn Edwards], minor damage. Vehicle #2 was a 1998 Ford Explorer. Vehicle #1 was a 2001 Chevrolet Prius.

09-04-12 – Deposition of Garth Gines. Mr. Gines is 46 years of age. He was not working at the time of the accident and had not been working for approximately one year. There was no lost wage claim. In the month prior to the MVA of 12-02-09, an MRI had been obtained showing 0.9 mm bulges at the C4-5 and C5-6 levels. There was also some spinal cord impingement. Surgery was recommended at that time. Mr. Gines indicated that he was planning on doing pain management. He does not recall that surgery had been recommended in the months prior to the car accident. There was no written estimate for damages to the vehicle, although Mr. Wadsworth thought that he had information indicating that there was an \$800.00 estimate. He was a passenger in the vehicle. He was riding in the 1998 Ford Expedition. His sister was driving. He does not think that his sister had had any prior accidents with the Expedition. For five years prior to the MVA of concern, Mr. Gines had had treatment by six different healthcare providers. He has had two prior cervical surgeries. He had also had a heart stent put in. He was seen at the Teton Valley Hospital and at the East Idaho Regional Medical Center. Following the stent placement, he had had a follow-up angiogram but is uncertain if he had another stent put in. He was also seen at the Idaho Heart Institute. Mr. Gines' primary healthcare provider was at the Driggs Health Clinic. He was also in the past seen at the Zoe Interventional Pain Management Center for neck pain. His current healthcare provider is Dr. Darrell Stacey who is in Orem, Utah. He is being treated for headaches, neck pain, and his heart. She was also seen by Mary Naylor, an Orthopedic Surgeon in Jackson Hole, Wyoming. The last date that Mr. Gines had worked was 12-31-08, approximately a year before the accident. He was the Managing Director at a Burger King. Sometimes he would work 7 days a week, 10-12-14 hour days. He was working at that job following his very first surgery. At that surgery, for some reason, "the bones didn't knit together". He was in pain that whole time. In the past, he had also done concrete work and surveying.

Mr. Gines was the front seat passenger in his sister's car coming home from Burger King to home. Their vehicle was stopped. His sister, the driver complained of pain in her lower back following the accident. There was no warning. He was seat-belted. Airbags did not deploy. The vehicle was pushed forward. There was no loss of consciousness. He was able to get out of the car unaided. He had no conversation with the driver of the other car. He believes his sister did. We pulled into the mall and waited for the police officer to come. Mr. Gines then waited in the truck. There was no visible damage to the other vehicle, but Mr. Gines admitted that he really did

Re: Garth Gines
December 21, 2012
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accident has affected him emotionally. He had thought that he could go back to work after everything with his heart had settled down. He would have gotten another job without as much stress. He believes that he could have been doing something. He could sell his jewelry. Because he cannot work, he does feel worthless which he attributes to the MVA.

Copies of a photographs of a Ford Explorer, Utah license plate Z23 0EF were included in the package. A ball trailer hitch ["Reese"] is attached below the license plate. There appear to be no damages to the rear end of the vehicle with the exception of some possible scrapes on the paint of the back bumper. There is also a posterior and inferior displacement of the right bumper. Measurement from the pavement is undertaken with the hitch and lower end of the bumper being approximately 14 ½ inches off of the ground. The hitch extends approximately 10 ½ inches off the ground. The left back bumper also appears to be somewhat posteriorly and possibly inferiorly displaced but this may also be the actual positioning of the rear bumper. The scrapes on the bumper are bilateral on both sides. There also appears to be some damage to part of the bumper as it approaches the license plating. On side view of the bumper it does not appear significantly, if at all, displaced posteriorly or inferiorly. The front part of the vehicle appears quite normal with no damage. There is no damage on the right or left sides of the vehicle. What appear to be copies of pictures of underneath the vehicle were also included as were measurements, apparently from the midline of the bilateral bumpers.

09-24-12 – Brian Mritucci. Indicating that Mr. Gines was riding in a passenger in a Ford Expedition SUV when it struck from behind by another vehicle. He is claiming injuries resulting from the accident. Discussion as to the above photographs was undertaken with Mr. Gines's sister, Christine Fontaine. Ms. Fontaine said that there was no damage to the rear of the vehicle from the subject accident and there had been no repair work done to the backend of the Ford Expedition. The trailer hitch and ball were the same ones that were on the vehicle at the time of the subject accident.

06-25-12 – Leonard McGee, Plaintiff Attorney. Initial Disclosures. A list of medical providers is noted inclusive of spinal interventions, UVRMC, Utah Neurological Clinic, IHC Health Centers, Mountainwest Anesthesia, and Utah Valley Radiology. Prior to the MVA of concern, the patient had been seen by James Tran, Teton Valley Hospital and Surgical Centers, Idaho Heart Institute, Foothill Family Clinic, South, Foothill Family Clinic, North, Eastern Idaho Regional Medical Center. Listing and dating of healthcare providers along with charges are listed with a total medical expenditure of \$61,296.60.

10-29-09 – Darrell Stacey, MD. Department of Workforce Services, Physical Impairment/Disability Report. The patient has neck aches, headaches, numbness, pain intermittently. Pain in the upper extremities intermittently. He cannot stand or walk long, lift greater than 20 pounds, do repetitive lifting or bending. Neck pain started about 10 years ago.

Re: Garth Gines
December 21, 2012
Page Five

Discrete nerve pathology led to surgery in 2005. He had improvement for one year. The second surgery to replace hardware and restore graft in 2006. Improved for six months but symptoms returned, now for the last five years. He also had coronary artery disease and a stent was placed in 2007. Currently has chronic narcotics daily, Phenergan frequently with occasional muscle relaxers, Ambien, Aspirin, multiple cervical injections at pain clinic but ceased due to lack of efficacy. He has full ROM but pain at 30 degrees rotation and beyond. Arm/hand range of motion is full but paresthesias in arms if overhead. Intermittent numbness in both upper extremities, left greater than the right and has weakness in the left arm. He has sensory loss, mild decreased muscle size in the upper extremities and muscle weakness. Fine motor skills are limited when sensation symptoms are present. Neck pain is more hurting if lifting. Gait is not affected. There are no seizures or loss of special senses. He developed angina in 2007. He had a stent placed in July 2007 and repeated in six months. He has Nitro for occasional chest pains. Some rest but also triggered by high exertion level. Chest pain radiates to the left shoulder and arm, dull not sure as it might be from the neck. BP: 112/80; pulse: 82 per minute. There is no congestive heart failure nor dyspnea. He has good pulse and capillary refill. No edema nor skin changes. Occasional mild dyspnea, mainly with weather changes. Chest is clear. There is no clubbing. History of diverticulitis. Colonoscopy was okay. There are no genitourinary, hematologic, lymphatic or endocrine dysfunctions. There are no cancers or immune system disorder. There is no mental dysfunction. Memory for short/long term is intact. Calculations are intact. Judgment is normal. No standardized tests were given. He has neck pain and headaches daily, worse with exertion. Use of neck, back or arms. He feels tired and fatigue, especially related to sleep. He does better if one gets greater than four hours of sleep. This is not the major issue. Diagnosis: Multi-level cervical disc pathology; headaches secondary to that cervical dysfunction; radiculitis related to cervical dysfunction; stenosis of central canal and foramen; coronary artery disease. His condition is not static. It is expected that it will get worse. Surgery may help cervical symptoms but is unpredictable. Limitations of all above as described previously. Limitations vary day to day depending on severity of symptoms. Any treatment will include avoiding, exacerbation. This patient is truly disabled from any regular work. He has failed all conservative measures and surgery twice. I still think surgery is best chance of improvement at this time. All other current treatments are related to symptom control.

The records from the Utah Valley Regional Medical Center are reviewed as follows:

05-06-10 – Elmo Gruwell, MD. ER Report. Acute cephalgia secondary to tension, mass effect in the brain or sinusitis. Demerol and Phenergan were prescribed. CT of head showed no evidence of subarachnoid hemorrhage, mass effect, stroke, or tumor. Diagnosis: Acute cephalgia.

Further contacts with the ER are reviewed for 07-31-02 [the patient had a prior fall with upper thoracic and cervical fracture. Impression: Groin pain. Celebrex is prescribed], 10-03-02 [headaches such as he has had many times in the past. Mostly right-sided behind the right eye

Re: Garth Gines
December 21, 2012
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associated with nausea and vomiting. Very typical symptoms with his history of migraine. Toradol and Phenergan are given], 09-14-03 [laceration in the right hand/right index finger], 09-03-10 [admission to hospital for acute pancreatitis and chronic neck pain].

09-08-10 – Nathan Nelson, MD. Discharged summary for pancreatitis and chronic neck pain. Past history of surgery C2-C6 cervical fusion. He will be discharged on Lortab, Aspirin, and Phenergan. The patient's hospital records inclusive of progress notes, graphic charting, physician's order, nursing notes, the initial history and physical [coronary artery disease, hyperlipidemia, aortic stenosis, GERD, chronic pain syndrome, arthritis, cervical disc herniations, cervical spinal stenosis, headaches, and tobacco use were described. Pharmacy notes were also included in the package.

Further contact with UVRMC were reviewed for 11-11-10 [hospital admission for abdominal pain, thought to be acute pancreatitis of unknown etiology. Physician's orders, graphic charting by the nurses, physician progress notes, and pharmacy notes were also included in the protocol. The patient's discharged diagnosis [11-16-10] was of pancreatitis and chronic neck pain. The etiology of the pancreatitis is said to be "unclear"], 02-21-11 [recurrent admission for pancreatitis of unclear etiology. Physician's orders, physician notes, case management summary notes, and nursing progress notes were again included in the package].

02-24-11 – Jared John Pickus, MD. Discharged Summary. Pancreatitis, chronic neck and back pains, tobacco use, GERD.

02-22-11 – Consultation gastroenterologically by Dr. Daniel Ibarra-Taylor for recurrent pancreatitis is noted. Laparoscopic cholecystectomy is discussed.

02-21-11 – Samuel Inouye, MD. Admission History and Physical in reference to the above stated pancreatitis. The patient has had two stents at separate times, two neck surgeries, and tonsillectomy. History of hypertension, hyperlipidemia, and chronic neck pain is noted. There is no specific comment of the 12-02-09 MVA.

02-27-12 – Stephen Nelson, MD. Evaluation for "flare-up of his chronic neck pain". The patient has had multiple surgeries on his neck. He has been taking Lortab for six years. He had a flare-up two weeks ago. He has a hard time getting on top of his pain. No numbness or tingling in the extremities. No history of recent injury or trauma. Symptoms just started. He gets 180 Lortab 10 mg every month. He is about one early. He has been out of his medications for approximately four days. He has had three cervical surgeries. He smokes a pack of cigarettes a day. Examination is undertaken. Neck is supple without nodes. Scars visual from the previous surgeries. Tenderness to palpation bilaterally at C3-4. The patient states that "is the exact pain that he had had over the years but a little more intense than normal". Neurological examination is

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normal. CT of the C-spine showed no evidence of acute injury. Hardware is visible from previous fusions but unchanged from previous images. Impression: Chronic neck pain. A small amount of Percocet was given. He will contact his PCP.

04-07-12 – Admitting diagnosis is pancreatitis. Discharged summary was 04-10-12 with discharged diagnosis of pancreatitis, hypertension, hyperlipidemia, coronary artery disease, and opioid dependence. Physician's orders, graphic charting, nurse's notes, and grafts were included with this package. In the admission history by Dr. Elsworth, there again is no comment of the 12/09 MVA. An EKG is said to be normal. Mediation listing is included in the protocol.

04-15-12 – Richard Herlevi, MD. Emergency Room Evaluation. The patient is complaining of some pain and redness streaking up his right arm. He was recently discharged from the hospital. No other complaints. He had streaking up his arm from a rabbit scratch several days' prior admission. He had a dose of Rocephin and then developed pancreatitis. History of chronic pancreatitis. Impression: Superficial phlebitis. Ultrasound was normal. No sign of DVT. [No comment of the 12-02-09 MVA is noted].

06-28-12 – CT scan showed small bony growth near the right ear canal. ENT should be evaluated.

07-08-12 – Michael Gemmett, MD. The patient is evaluated because of recurrent pancreatitis. He does smoke heavily. He has a leukocytosis [20,700 cell with increased neutrophil count to 87%] of unclear etiology.

Laboratory studies are included in this package as is an EKG. Physician orders, nurse's chartings, and graphics along with progress notes are reviewed.

07-13-12 – Scott Black, MD. Discharged summary for the above hospitalization. Diagnosis: Acute pancreatitis. CT scan of the abdomen and pelvis showed uncomplicated acute pancreatitis as well as mild diffuse hepatic steatosis. Non-objective bowel gas pattern and bi-basilar lung opacities are also noted. The patient will continue his Lortab and Phenergan.

The records from the Central Orem Family Practice Center were reviewed as follows:

12-03-04 – Darrel Stacey, MD. The patient has neck pain and upset stomach pain. Examination reveals tenderness to the cervical spine at C3-4, tenderness to the trapezius, crepitus, and pain with movement, especially with rotation but also with flexion and extension. Musculoskeletal and neurological diseases are normal. Problem list: Tobacco use, GERD, hyperlipidemia, cervical disc herniations and spinal stenosis, headaches, aortic stenosis, and arthritis.

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Further contact with Dr. Stacey are reviewed for 12-23-04 [GERD, hyperlipidemia, and arthritis], 03-03-05 [headache for two weeks. He has seen a neurosurgeon. He had recent neck surgery. Referred to the headache clinic], 04-12-05 [surgery tomorrow by Dr Gardner for disc disease of the cervical spine. Unable to work as of 04-04-05], 02-07-06 [sleeping problems, headaches, surgery on his neck to help improve his headaches. He has insomnia], 11-17-08 [fairly low energy. He sees a pain clinic. He is getting nerve blocks and trigger point injections. He is not sleeping well], 01-06-09, 03-12-09 [Ambien, Lortab, and Phenergan are being used], 05-05-09 [no change in neck aches. Radiation to the head. Worse when storms come through. Maxalt helps with the headaches. He is taking about 2-3 times a week. No numbness or weakness in the hands], 06-04-09 [headache and stomach pains], 07-21-09 [headaches have been getting a little worse. He has been under increased stress. He also has chest pain. He is a little depressed and sleeping poorly], 08-28-09, 09-02-09 [pain getting worse in the right posterior neck. Some tingling in the left hand and fingers for the last couple of months. Worse when up and about. He has avoided lifting], 09-16-09 [neck pain bad for the past two years, worse in the recent months. MRI last week. He has spasms and locking with his neck with rotation to the right or left. MRI showed surgical changes since the previous scan of 2005. Worse disc bulging and spinal stenosis since last, some foraminal stenosis on the right. At C6-7, new disc herniation since previous. Spinal stenosis and bilateral foraminal stenosis. He has DDD, cervical spinal stenosis, and foraminal stenosis], 09-23-09 [neck pain and headaches are bad. They are not being controlled. Percocet and Voltaren. Follow-up with rehab], 10-20-09 [abdominal pain].

12-04-09 - * The patient was in a motor vehicle accident, rear-ended, two days ago. He has new pain, left of mid-occipital region. Usual occipital pain is on the right. New pain radiating to the left posterior neck, shoulder, and upper back. Worsening of his more usual pains in the neck. Radiation to right shoulder and upper arm. No new numbness or weakness. Neck is tender throughout. Tender paraspinal muscles, similar to in the past. Tender on the left and down into the upper left back and adjacent to the scapula which is new. Full ROM in the upper extremities. Pain with neck flexion, extension, and rotation in both directions. Mildly tender mid-low back and paralumbar muscles, not severe. Impression: Neck and upper back pains, some acute and some chronic. Re-enforced neck and back issues. Continue medication. Consider P.T. if not improving. The patient is on Ambien, Midrin, Septa, Augmentin, Flexeril, Percocet, Lortab, Phenergan, Flagyl, Cipro, and Lortab.

Further contact with Dr. Stacey are reviewed for 12-15-09 [pain in the neck has continued to worsen since accident. He has awakened twice in the past five days with numbness in the left side of the head and scalp to jaw and face which has never happened before. New sensation of pressure in the mid and upper back on the right but is worsened with any movement of the neck. Some knot in the area on the right below the occiput that is new and very tender. Pain in the left neck and upper back is improving. Symptoms are worsening. Repeat MRI scan], 04-28-10 [neck pain has been getting worse causing headaches, usually on the right around the eye and temporal

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and parietal. Sharp pain between the shoulder blades. Neck and head worse when storms come through. He is getting more numbness and pain in the hands, mainly the right. He will drop tools more frequently. Resistant to going back to neurosurgeon as long as he is able to function but states that he has worsened to the point that he is ready to return. Headaches have resolved for a few months after surgery in the past. He is taking more Lortab. On exam, restricted neck ROM with pain. Tenderness to the spine and paraspinal muscles. He has cervical pain related to the disc disease, DJD, and cervical stenosis. Headaches are related to neck pathology, all worsening. He will try Cymbalta], 05-05-10 [headaches are a little better. More tired on new medication. Appointment with neurosurgeon. Stabbing pain between the shoulder blades. Neck is much less tender than before. He appears to have a little better use and movement], 08-03-10 [blurred vision the last 4-5 days. Some spinning and vertigo. Impression: Probable BPV/labrynthitis. Meclizine is prescribed], 11-29-10 [pancreatitis, slow improvement], 03-03-11 [recently in hospital for pancreatitis], 04-11-11.

Records from the Utah Neurological Clinic [Paul Gardner, MD.] were reviewed as follows:

02-17-05 [neck pain and headaches. He has had headaches for the past 20 years. Over the last year-and-a-half these have progressed. He has had all of his teeth pulled which may have helped for two years but now the headaches are back. Hands are numb and legs are numb on occasion. He has neck pain and numbness and pain in the occipital region. He states that this is much more than a normal ear ache. Pain in the ears, base of the neck radiating forward bilaterally, retro-orbitally. He has nausea/vomiting, and photophobia. He is dropping objects on occasion. He feels dizzy on occasion. No B/B dysfunction, incontinence, or retention but blood pressure is said to be okay. He is on Flexeril, Lortab, and Midrin. He has GERD, irritable bowel syndrome, dental and TMJ disease, marked cardiac infarction 10 years ago with mitral valve dysfunction, osteoarthritis, headaches and spine injury. Examination reveals normal movement of the head and neck with negative Spurling's. No spinous process deformity. External and internal rotation of the glenohumeral joints are negative. Strength is normal. No atrophy, fasciculations or wasting. Symmetric reflexes of the upper extremities. MRI of the C-spine shows C3-4 central disc herniation with protrusion. Bilateral C5-6 disc protrusions and slight neural foraminal encroachment is also noted. The brain is normal. Follow-up MRI will be obtained].

Further follow-ups with Dr Gardner are reviewed for 02-22-05 [new MRI appears unchanged. He has failed conservative therapies. The C3-4 disc herniation may be placing pressure on a pain sensitive area. He is not ready for surgical intervention], 04-12-05 [consideration of surgery is noted because of an intensification of his discomfort and failure of cervical management], 04-12-05 [herniation at C3-4 is central putting pressure on the cord which oft time can cause headaches].

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04-14-05 – Paul Gardner, MD. Discharged diagnosis: C3-4 HNP with thecal sac effacement; headache, neck pain, tobacco abuse. The patient has had headaches for many years, unrelenting, progressive. MRI scan shows fairly impressive central C3-4 HNP with thecal sac effacement and cord impingement. The patient was operated upon and did well. He does not have the same headache that he had pre-operatively. He will be discharged home and not lift anything heavier than a gallon of milk. He will not ride or drive a car in the next three weeks. He will wear his soft cervical collar for 10 days and progressively ambulate. Discharged on Valium, Percocet, and Phenergan.

04-13-05 – Paul Gardner, MD. Operative Report: C3-4 anterior cervical discectomy with a Robinson/Smith fusion. Post-op diagnosis: C3-4 HNP. In the surgical report, an HNP at C3-4 was extracted and there was "indentation to the thecal sac noted. Foraminotomies were performed bilaterally."

The hospitalization notes with physician's orders, nursing notes and graphic charting, and anesthetic notes were all included in the package and reviewed.

Post-op reports by Dr. Gardner are reviewed for 05-11-05 [doing well. Headaches have decreased dramatically. He is still getting sporadic headaches. Some muscle spasms in the back. Voice is good. He does have a hard time swallowing, sometimes larger pills. X-rays will be obtained. He will stay off of work until the middle of June].

05-25-10 [the patient was last seen in 2005. Approximately five years ago he went to Driggs, Idaho for work. Unfortunately, he had a myocardial infarction requiring cardiac stents. He started to have more pain in his neck and was seen by Dr. Mary Naylor in Jackson Hole, Wyoming. He had surgery at his C3-4 level again in Wyoming in 2007. The bone had reabsorbed and surgery re-did was at C3-4 level with instrumented fusion again. After six months he felt better in his arms. He currently had neck pain and increasing migraine headache. On 12-31-08, he was told by a physician in Idaho that he should retire and not work any further as he felt that he was disabled. He moved to Utah and has been seen by Dr. Stacey who also suggested that he not return to work. In December, 2009 he was the passenger, restrained in a car that his sister was driving and they were rear-ended. He had progressive pain in his neck. He now notices that he has numbness in his hands as well as weakness in his legs. Paresthesias in his feet, right neck pain fairly constant and constant migraine headache. All of these symptoms have been progressive over the last five years. Balance is probably okay. There is no B/B dysfunction. Valsalva maneuvering does reproduce his neck pain. He had pain management in Idaho for six months with selective nerve root blocks, occipital blocks, and myelograms. For six months he did not see any appreciable relief. MRI scan in September was undertaken following his accident. Examination is undertaken with 4/5 strength in the deltoid, biceps, triceps, brachioradialis, wrist extension, flexion, and intrinsics to the hands, iliopsoas, hamstrings,

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quadriceps, obturators, anterior tibialis, extensor hallucis longus, and gastrocnemius. There is pain with rotation to the head. Probable popping and cracking with facet joint arthropathy. Pain with extension to the neck as well. Image from 12-09-09 shows a lot of magnetic artifact from the prior surgery and metallic plate, C5-6 left herniated HNP and ligament hypertrophy creating some stenosis focal at C5-6. Symptoms are clearly worse now than they were in December. He wants to re-entertain thoughts of surgery. He is on Neurontin. We will repeat his MRI scan].

Further contacts with Dr. Gardner were reviewed for 06-08-10 [the patient had anterior cervical discectomy and fusion at C3-4 and a re-operation in 2007. He was in an MVA 12/09. MRI showed a herniated disc. He feels significantly worse with the increasing pain in his neck and arm. "We are afraid that the C5-6 disc has actually gotten quite a bit worse in the past seven months. Repeat MRI will be obtained. He has weakness in his deltoid and triceps. He takes pain medication every four to six hours].

07-09-10 – Howard Reichman, MD. The patient's x-rays from prior two surgical procedures showed the fusion to be pretty solid. He had an MVA on 12-04-09 with a significant increase in his neck pain and right-sided radiating pain. He is on Lortab, Gabapentin, and Phenergan and still has a bit of trouble. MRI was compared with the prior image obtained after the 12/09 MVA. It looks like he has progressively had trouble with particularly C5-6 but C4-5 has actually gotten worse since the December scan as well. We are considering taking out the plate at C3-4 and fusing C4-5 and C5-6. He will lose three segments in his neck out of eight and have some stiffness. He is also concerned because his swallowing is an issue. Gastro graph and swallow will be obtained. On exam, significant reduction in the ROM of the neck associated with pain, particularly in extension. The scan looks like those discs were hurt in the accident of December, 2009 and have gotten worse over the last six months. If his esophagus looks tethered we will be able to see it with a vertical incision. We will take the plate out at C3-4, and fuse C4-5 and C5-6, using a polyethylene cage.

Further follow-ups with Dr. Reichman are reviewed for dates 09-21-10 [the patient was seen a long time ago. He had a prior fusion at C3-4 which did not take. We had to redo the C3-4 fusion in April, 2005. At that time he had known degenerative disc disease at other levels but then was in a motor vehicle accident with pain increased considerably. After the accident, the C4-5 level had gotten a lot worse and the C5-6 level was still bad. He is also having a lot of trouble swallowing. He has neck pain turning into bad migraines which are quite disabling. He also has pancreatic dysfunction and was hospitalized about a week ago. He is not able to work currently and I doubt with all of these medical problems, he will be able to find a job or will be employable because he is in chronic pain secondary to his pancreatitis. He has a worn out spine and disabling headaches. At some point he may need to have C4-5 and C5-6 fused which will leave him with a really rigid neck which would be another problem getting a job. He is quite deconditioned. He has lost a lot of muscle mass. He has limited ROM of his neck and radiating

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pain with neck movements in his arms. His balance is off a little bit, probably not myelopathic], 10-26-10 [pain radiates down the right side. He even gets symptoms in his legs but his shoulder blade and his neck which causes bad headache, his right arm, and laterally into his fingers. 90% right-sided and a little bit on the left side. Impression: History of cervical fusion, with redo in 2005; C4-5 and C5-6 discs; right greater than left cervical radiculopathy. Risks of surgery were discussed], 03-03-11 [the patient is going to have surgery but he just got over possible pancreatitis. He uses Lortab every four to six hours], 05-10-11 [significant neck pain and radiating pain into the right arm. The patient had some persistent neck pain requiring a low dose of narcotics, after the accident of 2009, he had to take five or six a day. He has a broad-based bulge with some stenosis at C4-5 and C5-6 with significant far right lateral extension of the disc. It is not as prominent on the left. He will undergo a C4-5 and C5-6 discectomy and fusion, using a PEEK cage. On examination there is some C6 distribution tingling in his hands and some weakness in the right arm, mostly wrist extensor with movements of the neck. His gait is abnormal which I think is more osteoarthritic. He does not have a myelopathy].

06-06-11 – Utah Valley Regional Medical Center. Howard Reichman, MD. Admission History. Diagnosis: Cervical spondylosis with stenosis at C5-6, S/P C3-4 fusion and C4-5 degenerative disease.

06-06-11 – Howard Reichman, MD. Re-exploration of the cervical spine with removal of the old plate at C3-4. C4-5 discectomy with decompression of the spinal cord and nerve roots; C4-5 interbody fusion using the patient's bone and an 8 mm PEEK cage; C5-6 discectomy with decompression of spinal cord and nerve root; C5-6 interbody fusion using the patient's bone and a 7 mm PEEK cage augmented with Nex graft and STDA plate fixation. Pre-operative diagnosis: C4-5 and C5-6 stenosis causing a cervical radiculopathy.

The medical file from the hospital in reference to the above surgery inclusive of physician order, graphic charting, pharmacology charting, and nurse's notes were also reviewed.

Post-operative contacts with Dr. Reichman are reviewed for 07-07-11 [the patient continues to have headaches, right side of the neck, tingling in his right leg and right hand and some difficulty swallowing with medications. Impression: Cervical fusion at C4-5 and C5-6; history of cervical fusion in 2000; degenerative discs at C4-5 and C5-6; right greater than left cervical radiculopathy. Norco and Flexeril will be prescribed as is a soft collar. He will be cautious with activities. No lifting greater than 10 pounds, no jarring activities. He does have a bone stimulator], 09-06-11 [the patient still has some swallowing difficulty but that has been going on for many years. It has not worsened since the last surgery. His pain is intense. He is not able to sleep. He is very tired, depressed, and upset. Bone stimulator makes him nauseous and vomiting. He was unable to use that. He requires more pain medication. The x-ray showed no acute fracture, remote spinous fracture at C2, multi-level cervical fusion and backing out of the screw

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at C6. It is not mentioned on the report but it is there. The patient has right greater than left cervical radiculopathy. He does not want to go to a pain clinic. He takes Lortab every four to six hours], 10-04-11 [still has cervical pain. Difficult time swallowing. Esophageal swallow was undertaken and all that was noted was that a C6 screw was partially disengaged but not causing any obstruction, just a mild impression of the posterior esophagus, mild weakness of swallow. Otherwise normal. Esophageal spasm was noted. He had a difficult time drinking the contrast. Right leg went numb on Friday. His toes are still numb as is the top of his foot. Pins and needles from the knee down to the top of the right foot. Knee has been going out on the right as well. He has numbness in the hands, bilaterally. His thumbs are numb, bilaterally. We will try to get an MRI of his C-spine. He has new occurrence of LBP with a right radiculopathy and a lumbar MRI will also be obtained as will an Electrodiagnostic study], 11-10-11 [continued spine pain. Residual difficulty with swallowing. On the swallowing evaluation there was nothing significantly problematic. The patient has significant right leg numbness going on since the first part of October and a pins and needles sensation from the knee down to the top of his foot. NCV/EMG of the upper and lower extremities was normal; MRI of the lumbar spine showed broad-based possible compression of the left L3 nerve; C-spine shows no stenosis or narrowing. Stable hardware and fusion at C4-5 and C5-6. The patient is working with Dr. Fabere at pain management. He is on Suboxone and Clonidine. We will try to get him off Lortab. Nerve blocks and possible radio frequency will be undertaken in reference to his cervical and lumbar pains. We will also review the C6 disengaged screw].

The following records were obtained prior to the 12-02-09 MVA.

05-13-06 – Robert Wolfe, MD. Teton Valley Hospital and Surgery Center, Driggs, Idaho. The patient noted some vague chest “pressure” one week ago, mostly in the left lateral chest. In the last day or so it has migrated to involve his shoulder blade. He has also had difficulty taking a cleaning breath. He denies chest wall trauma or symptoms with exertion. He feels like he is under a lot of stress. He has chronic issues with headaches and has been taking Valium and Lortab with variable results. Headache has been unchanged in character for several years and is described as diffuse occipital discomfort which seems to involve sensitivity to light and nausea after several hours of gradual build up. The patient has chronic neck discomfort relating to a discectomy a couple of years ago. There are no other associated symptoms. Examination is undertaken. Neck is supple and tender. EKG shows leftward axis with a generous QRS complex and non-specific ST segment changes in V1. No evidence of acute coronary syndrome. Chest x-ray is normal. The patient was given an injection of Phenergan as well as Ketorlac for his headache. Impression: Atypical chest pain. He does not have any evidence for an acute coronary syndrome or underlying pathology in his chest. He should stop smoking and will follow-up with his primary healthcare provider.

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07-07-06 – Larry Curtis, MD. Assessment: Migraine headache, cervical radiculopathy. Valium and Aleve are used.

Further contact with Dr. Curtis at the Driggs Health Clinic were reviewed for 07-10-06 [exertional chest pain. EKG shows ST elevation anterior].

07-13-06 – Chad Horrocks, MD. Teton Valley Hospital and Surgery Center. Discharged
Diagnosis: Unstable angina, tobacco use, positive non-evasive exercise stress test. Lipitor, Toprol, Ancteric coated Aspirin and sublingual nitroglycerin are prescribed at discharge. The EKG was compatible with myocardial ischemia. Chest x-ray was unremarkable.

Further contact with Dr. Curtis are reviewed for 07-20-06 [the patient has had a coronary artery bypass graft of one vessel and is still a little short of breath], 07-27-07 [cannot get breath at times. Arteriosclerotic cardiovascular disease is improved, coronary artery bypass graft, exertional chest pain. The patient is on Aspirin, Lopressor, Lisinopril, Zocar, Plavix, and Tylenol], 08-01-06 [tiredness. Vitamin B12 was given], 08-14-06 [left shoulder pain; tiredness is improved], 10-18-06 [migraine cephalgia], 10-23-06 [migraine cephalgia. Ultram is prescribed as is Chantix for smoking cessation], 10-25-06 [left shoulder pain/chest pain], 11-29-06 [cervical radiculopathy], 01-02-07 [migraine cephalgia. Lortab, Phenergan, and Indural LA is prescribed], 02-06-06 [cervical radiculopathy, worsened. ASCVD].

03-02-07 – Chad Horrocks, MD. The patient has history of arteriosclerotic coronary artery disease with stenting in 2006 along with chronic neck pain. He was recently placed on a Medrol dose pack six days ago and began developing chest pain. He does, however, point to his epigastric region. It is said to be burning in nature. Impression: Gastritis secondary to steroids.

04-13-07 – Don Lassetter, MD. Left heart catheterization with select coronary angiography and left ventricular angiography. Impression: Normal left ventricular systolic function; stent in the left anterior descending coronary artery; mild non-objective coronary disease of the two remaining arteries. The patient will continue medical therapy. No interventions or surgery is necessary at this time.

Further contact with the Driggs Health Clinic [Elizabeth Louise Gammel, PA-C]. The patient has depression since his cardiac catheterization. He has been very fatigued. He became depressed after the stent placement last year but was able to pull himself out of it. He is also complaining of migraines. Scheduled for an MRI of the neck. He believes headaches are related to weather. Medrol dose pack was of some assistance but then the pain started up again. He cannot take ibuprofen because of Plavix. Anti-depressants when he was younger. He takes vitamin B12 shots every two weeks. Examination is unremarkable. His mood and affect show no depression, anxiety, or agitation. Judgment is intact. Impression: Depression, hydrocodone,

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Aspirin, Plavix, Tylenol, Cyanocobalamin, nitroglycerin complete his medication profile], 05-10-07 [cervical fusion has not taken and foraminal stenosis [?]. Surgery has been considered. Epidural blocks have been recommended], 05-29-07 [the patient had cervical vertebral fusion two years ago. He has had progressively worsening symptoms and persistent headache for about a year. He is questioning changes to his Plavix medication since his stent as well as to discuss neck surgery], 07-17-07 [after neck surgery pain is better. Moderate GI upset. Impression: Cervical radiculopathy; cervical C2-3 fusion and C6], 10-12-07 [doing okay. Some left anterior shoulder pain this last week, worse with the storm. Slight stress at work], 10-19-07 [headache for one week similar to prior. It was to the right and now to the left. Norco is being used], 01-21-08 [currently on Promethazine and Amitriptyline. He has headache and neck pain. He feels depressed, anxious, snippy and agitated. He feels depression and change of attitude is related to increased pain. Lortab takes the edge off of his pain], 01-25-08 [tries to go to work. Persistent pain in the last month but not constant. Disability examination will be undertaken], 03-05-08 [headaches have returned at the base of the neck. He had received treatment for prolonged period of time and was referred to pain management but did not keep that appointment due to work constraints. He needs refill on Norco and Amitriptyline. He is taking four tablets a day instead of three].

07-13-06 – Eastern Idaho Regional Medical Center. Douglas Blank, MD. A 42-year-old gentleman with no significant history of heart disease. He presented to the hospital yesterday with chest pain and abnormal stress test today. He has shortness of breath, nausea, and diaphoresis over the last several days. Symptoms get worse with exertion. Not completely relieved with rest. Exercise stress test showed ST segment depression with reproducible chest discomfort. Cardiac enzymes were normal. IV nitroglycerin dropped his blood pressure to under 90 mmHg. He was transferred to ER RMC for further evaluation. The patient has a remote history of mitral valve abnormality 15 years ago which resolved. Examination is undertaken. Impression: Chest pain with positive stress test. The patient does have risk factors for heart disease; tobacco abuse; history of migraine cephalgia. The patient will be monitored overnight. Beta blocker and ACE inhibitor will be initiated.

07-13-06 – Douglas Blank, MD. A left heart catheterization with coronary angiography, left ventriculography and percutaneous intervention to the mid portion of the left anterior descending coronary artery. The patient also had closure of the femoral arterial site. Final impression: Initially significant single vessel coronary artery disease with 95% mid LAD stenosis; normal left ventricular systolic function. Ejection fraction 68%. Anti-thrombin therapy with Lovenox. Percutaneous intervention to the left anterior descending coronary artery with placement of a Johnson and Johnson Drug Eluting Stent. Plavix. Preclosure of the femoral artery site.

07-14-06 – Douglas Blank, MD. Discharged summary for the above hospitalization. Discharged diagnosis: Coronary artery disease, dyslipidemia, migraine headache, tobacco abuse.

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04-13-07 – John Lassiter, MD. Left heart catheterization selective coronary angiography and left ventricular angiography. Impression: Normal left ventricular systolic function; patent stent in the left anterior descending coronary artery; mild non-objective coronary disease in the two remaining arteries.

08-16-06 – Douglas Blank, MD. Exercise thallium stress test: Good exercise tolerance; good BP and HR response to exercise. No inducible ischemia. The patient did have chest pain but did not increase during the test. Normal gated wall motion and normal LV chamber size. Hint of LVH. Reversible ischemia in the anterior wall which is where his stent is placed. There was a hint of it in the distal end of the inferior wall. This is a low risk cardiac stress result. In comparing this test to the catheterization one month ago, there is no progression of his LAD disease.

04-05-07 – Mary Neal, MD. Orthopedic Surgeon. The patient has neck pain, peri-auricular pain, intrascapular pain, daily headaches and pain in the left lateral arm with numbness and tingling in the ulnar three digits, bilaterally. He has done rodeo for 20+ years. He had an anterior cervical discectomy and fusion in 2004 after which he was pain-free for almost one year. Symptoms have returned. There is no point tenderness. Good range of motion without reproduction of pain in the cervical examination. Intact sensation examination, motor exam, and symmetric reflexes. C-spine x-ray in the office shows anterior plate with non-union at C3-4. Impression: C3-4 symptomatic non-union. Cervical spine and myelogram with post-myelogram CT will be obtained. He probably needs a revision.

Further contact with Dr. Neal for 04-26-07 [electrodiagnostic evaluation of the LUE shows ulnar nerve changes. Post-myelogram CT shows non-union at C3-4 and mild facet arthropathy at C5-6. MRI of the C-spine shows signal changes consistent with non-union at C3-4 and DDD with mild central and mild to moderate bilateral neural foraminal narrowing at C5-6. Naprosyn and Prilosec are recommended. Diagnostic left C6 nerve root block will be undertaken.

04-26-07 – Electrodiagnostic testing showing decrease ulnar motor amplitude. Computer generated analysis should be reviewed by the treating physician. Left ulnar motor amplitude is abnormal. Isolated upper extremity motor finding is of unclear significance.

Further contact with Dr. Neal are reviewed for 06-12-07 [cervical intervention is appropriate. Risks are described. A nerve block will be undertaken prior to a final decision with regards to surgery].

06-20-07 – Phillip Blum, MD. Teton Outpatient Services, Pain Consultation. The patient has severe neck, shoulder, upper extremity pain, and associated headaches. Problems have been going on for about 15 years. He had an anterior cervical fusion several years ago which provided him with modest improvement. Pain is intensified over the last month. He is worse with physical

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activity and can be improved with proper movement and pressure. There is numbness in the LUE. Pain has been essentially unresponsive to previous P.T. and chiropractic manipulation. The consideration of a selective nerve root injection at C6 is undertaken. The patient's examination showed some weakness in the C6 or C7 distribution of the left arm. Marked trapezius muscle tightness as well as posterior cervicalgia, muscle tightness with no easily identified trigger points. Impression; Cervicalgia and cervical radiculopathy probably secondary to a non-union from his previous cervical fusion. A C5-6 injection was undertaken of Depo-Medrol.

06-23-07 – Mary Neal, MD. Operative Report: C3-4 anterior cervical hardware removal, exploration of huge mass, partial vertebrectomy of C3 and C4, C3-4 interbody arthrodesis, stabilization and harvesting of the left anterior iliac crest bone graft. Post-op diagnosis: C3-4 non-union with retained hardware.

Post-operative contacts with Dr. Neal are reviewed for 07-03-07 [the patient feels better after surgical procedure. Doing well], 08-07-07 [pre-op upper extremity paresthesias have resolved. Some of his headaches are starting to return. Lortab and Phenergan are used], 09-11-07 [he is improving. Swallowing is better. Pain is less. X-rays show good positioning of the hardware without evidence of failure. Fusion mass is visible], 04-01-08 [still having trouble with headaches. Neurological examination is intact. Cervical spine CT scan will be obtained. If solid, we will obtain a cervical MRI].

03-26-08 – Holly Zoe, Zoe Interventional Pain Management Center. The patient is being evaluated for headache and stiff neck. He has right-sided headaches radiating to the right ear behind the right eye for many years. It is rated between 5-10/10. Headaches have been worse over the last six months. He has numbness in the right arm at the second, third, and fourth fingers. There is no weakness. He has had many injections to the head and neck before but nothing has been of assistance. He had neck surgery twice with an anterior fusion. Examination is undertaken. The neck is stiff with decreased ROM of forward flexion, side flexion to the left, and right. There are trigger points, bilaterally at the left lower facet line, worse than on the right and the right upper facet line. Neurological examination is normal. Impression: C3-4 discotomy and fusion with revision, 06/07, for non-union. The patient has cervicalgia and post-laminectomy syndrome in the cervical region. Hydrocodone/Tylenol is prescribed.

Further contact with the pain management center are reviewed for 06-06-08 [post-laminectomy syndrome of the cervical region; migraine headache without aura; transient insomnia. Median branch blocks on the right at C4, C5, and C6 are scheduled], 06-06-08 [right occipital neuralgia; neck muscle spasm; post-laminectomy syndrome of the cervical region; cervicalgia. An injection in the greater occipital nerve will be undertaken], 07-13-08 [median branch block at the right, C2, C3, C4, C5, and C6 will be scheduled], 08-01-08 [C-spine x-ray will be obtained. ESI is being canceled at the moment], 08-29-08 [left ESI will be undertaken. Trigger point injections

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will also be done on follow-up visit], 10-06-08 [diagnosis: Cervical spinal stenosis with spondylolysis, C2 on C3, post-laminectomy syndrome, migraine headaches without aura, neck pain].

11-11-11 – Katherine Black, APRN, NP. Spinal Intervention. The patient has pain. Pictogram shows the neck and the hemi-cranium, right greater than left along with bilateral feet and knees. Examination is normal with the exception of a slight tongue tremor. C-spine exam shows acutely diminished ROM in all directions with pain. No tenderness over the facets but tenderness to palpation in the midline at C3-4 and the occiput. ROM of the lumbar exam with pain and palpable tenderness over the facets at L5-S1 and the midline. Impression: Cervical radiculopathy, degenerative intervertebral disc disease, cervical disc displacement with myelopathy of the cervical spine, and lumbar radiculopathy. The patient has upper and lower extremity electrodiagnostic testing. His cervical radiculopathy extends over the anterior and posterior shoulders and down the medial arms through the hands and fingers. Lateral arm pain and numbness radiate to just below the elbow. Lumbar radiculopathy extends from the arch of both feet out the toes. He is hyperalgesic on Lortab. We will change to Suboxone.

The following image reports were reviewed:

08-26-04 – Kimball Taylor, MD. MRI C-spine: Central disc herniations, small at C2-3 and C4-5 and moderate at C3-4. There is some deformity of the cord at C3-4 and narrowing of the spinal canal to approximately 8 mm in the AP plane.

02-18-05 – Wendell Gibby, MD. MRI C-spine: Continued central C3-4 disc herniation causing mild ventral cord compression. Shallow central disc protrusion at C4-5. Diffuse bulging of the C5-6 disc extending into the foramen, bilaterally, right greater than left, with potential right C6 nerve root impingement. "This seems to be the most significant of the levels imaged".

05-13-05 – John Collins, MD. C-spine x-ray: Anterior screw and plate at C3-4. Adequate position and alignment. Old fracture of the spinous process at C2. This was also seen on the prior film of 04-13-05.

08-04-05 – Rodney Petersen, MD. Two view C-spine film: Stable with effusion at C3-4.

04-16-07 – Richard Ofstein, MD. MRI C-spine: C3-4 fusion, either old non-united C2 spinous process fracture of incomplete fusion of the ossification center. Bilateral foraminal narrowing at C5-6, right greater than left. Slight anterior subluxation of C2 to C3 with bilateral facet hypertrophy, left greater than right.

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09-11-09 – John Collins, MD. Degenerative changes and post-surgical changes, most significantly affected level are C4-5 and C5-6. The extension of the disc at C4-5 goes to the spinal cord measuring 9 mm. Some extension into the far lateral right neural foramen. At C5-6 the canal measurement is 9 mm. Narrowing of the bilateral neural foramen may impinge the bilateral exiting C6 nerve roots.

12-19-09 – Carl Black, MD. MRI C-spine: Slight interval progression of central canal narrowing at C5-6. Mild osteophytic sludge disc complex in addition to ligament flavum laxity. No cord deformity. Possible mild narrowing of the neural foramen without definite intra-foraminal root impingement.

07-08-10 – Danielle Corey, MD. MRI C-spine: Multi-level DDD with facet arthropathy, most prominent at C5-6 with unchanged moderate to severe bilateral neural foraminal narrowing. Prior discectomy at C3-4. Mild retrolisthesis at C5-6.

06-01-11 – Daniel Rasband, MD. C-spine x-ray: C4-5 fusion without evidence of complication. Mild spondylolisthesis with flexion and extension.

09-05-11 – Carl Black, MD. C-spine x-ray: No acute fracture of subluxation. Remote spinous process fracture at C2. Multi-level cervical fusion. [C3-C6].

09-08-11 – Roy Hammon, MD. Esophagus x-ray: The patient could only tolerate a few swallows. Impression: Cervical plate from C4-C6. A screw at the C6 level is partially disengaged from the vertebral body projecting out of the plate and causes a mild impression on the posterior esophagus but no obstruction. Mild weakness of the swallow. Esophageal spasm and small hiatal hernia. Limited study due to the patient's inability to swallow more contrast.

10-21-11 – Kimball Taylor, MD. MRI of the C-spine: Post-operative changes, C3-6. Mild residual spinal canal narrowing at C5-6 due to mild residual posterior hypertrophic changes. Mild bilateral neural foraminal narrowing at C5-6.

10-21-11 – Kimball Taylor, MD. MRI LS spine: Six non-bearing lumbar bodies. Left lateral and intraforaminal disc protrusions at L4-5 with neural foraminal narrowing.

02-27-12 – Matthew McNairy, MD. CT cervical spine: C3-6 cervical fusion. Left C6 screw protrudes anterior from the plate. Unchanged from the prior image. No acute injury.

06-28-11 – Curtis Kendall, MD. CT of the orbits: Intra auditory canals are normal. In extra auditory canal there is bony prominence from the anterior wall of the right external auditory canal extending into the canal. There may be some localized thickening of the posterior wall of

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the external auditory canal adjacent to the bony prominence. The prominence is non-specific and appears benign. This could be exostosis which could be developmental or reactive. Osteochondroma is also a consideration.

A number of chest x-rays and abdominal images were obtained in association with Mr. Gines' history of pancreatitis.

A number of pharmacy entries for various medications and laboratory studies were included in the protocol and reviewed. A number of ledgers and billings for some of the above stated healthcare providers were also reviewed.

HISTORY OF PRESENT ILLNESS

Pre-Injury Employment: Mr. Gines was not employed at the time of the 12-02-09 MVA.

Pre-Injury Status: Prior to the MVA of 12-02-09, Mr. Gines had had two cervical surgical procedures at his C3-4 intervertebral disc space level for an initial disc herniation [04-13-05] and a "re-do of the initial fusion due to non-union with hardware implantation" [06-23-07]. Mr. Gines' Medical File also outlined his pre-12-02-09 continued cervical discomforts, headaches, and treatments consisting of narcotic medications and injections. An MRI of his cervical spine was obtained on 09-11-09, approximately three months prior to the 12-02-09 MVA of concern, which showed degenerative and post-surgical changes, most significantly affecting the C4-5 and C5-6 intervertebral disc space levels, with spinal canal narrowings to 9 mm and with the radiologist, Dr. John Collins, reporting that there was also "narrowing of the bilateral neural foramina which may impinge the bilateral exiting C6 nerve roots".

In addition, Mr. Gines has had several other underlying medical diseases which will be outlined in the appropriate subsection below.

Description of Injury: Garth Gines was the seat-belted, front seat passenger in a vehicle driven by his sister that was stopped at a red light on 12-02-09. Without warning, the vehicle in which Mr. Gines was traveling was rear-ended by another vehicle and was pushed forward by the force of the impact. Mr. Gines is uncertain as to if he struck any objects inside of his vehicle. He had immediate pain in his neck, shoulders, head, and eyes. There was no loss of consciousness. There was no blood on his body. Mr. Gines' vehicle's airbags did not deploy.

Post-Injury Treatment: Two days post accident, Mr. Gines was seen by Dr. Darrell Stacey at the Central Orem Family Practice Center who reported that "he [Garth Gines] has new pain in the

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left of the mid-occipital region radiating to the left posterior neck, shoulder, and upper back... worsening of his more usual pains in the neck..." Although Dr. Stacey reported "tender paraspinal muscles", he also noted that they were "similar to in the past". Dr. Stacey diagnosed Mr. Gines as having "neck and upper back pains, some acute and some chronic... re-enforced neck and back issues".

Over the next several months, Mr. Gines continued to be monitored by Dr. Stacey. Another MRI of the cervical spine was obtained [12-19-09] which showed a slight progression of the central canal narrowing at the C5-6 levels.

With a continuation of head and neck pains along with numbness radiating into both upper extremities, right greater than left, a neurosurgical evaluation with Dr. Paul Gardner was obtained [05-25-10]. After re-iterating Mr. Gines' prior status, inclusive of his two surgeries, Dr. Gardner noted that Mr. Gines' numbness in his hands, weakness in his legs, paresthesias in his feet, right neck pain, and constant migraine headaches "have been progressive over the last five years". Mr. Gines' neurological examination revealed weakness in the extremities with Dr. Gardner opining that Mr. Gines' symptoms "are clearly worse now than they were in December [2012]." A second neurosurgical opinion was obtained with Dr. Howard Reichman [07-09-10] who also compared Mr. Gines' various images and noted degenerative progression at the C4-5 and C5-6 levels. On 09-21-10, Dr. Reichman opined that Mr. Gines "has a worn out spine and disabling headaches". On 06-06-11, Dr. Reichman, thus, performed a re-exploration and removal of the old cervical plates at C3-4, discectomies with decompressions of the spinal cord and nerve roots at the C4-5 and C5-6 levels, and an interbody fusion with hardware implantation at these last two levels.

Mr. Gines continued, unfortunately, to have pain following his last surgical procedure and difficulty swallowing, however, Dr. Reichman noted [09-06-11] that his swallowing difficulties "has been going on for many years". An esophageal motility x-ray on 09-08-11 showed the cervical fusion and a screw at the C6 level being partially disengaged from the vertebral body and projecting out of the plate and causing a mild impression on the posterior esophagus, but with no obstruction. During that study, a mild weakness of the swallow was reported by the radiologist, Dr. Roy Hammon, along with esophageal spasm and a small hiatal hernia.

A post-operative MRI of the cervical spine [10-21-11] showed no significant impositions across the spinal cord and only mild spinal canal and neural foraminal narrowing at the C5-6 level.

Mr. Gines also entered a pain management program and was placed on further medications with discussion, thereafter, being undertaken for possible radio frequency ablation procedures.

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Electrodiagnostic testing was said to have shown radiculopathies through the hands and fingers and a lumbar radiculopathy extending from the arch of both feet out to the toes [Katherine Black, APRN, NP, Spinal Intervention Center; 11-11-11].

On 02-27-12, Mr. Gines had a CT scan of his cervical spine. That study was said to be "unchanged" from the prior image and showed no acute injury. The C3-6 cervical fusions were demonstrated as was the left C6 screw protruding anteriorly from the fusion plate.

Current Status: Garth Gines claims every day, all day neck pain "as bad or even worse than before my surgery". Mr. Gines has weakness in his right arm in a diffuse manner and difficulty swallowing. He also claims that he has pain in-between his shoulder blades, "like a knife". On a scale of zero to ten with ten being the worse pain that he has ever had, Mr. Gines indicated that, prior to the MVA of 12-02-09, his neck pain was rated as between a 3 and a 4 whereas now, his ongoing neck pain is rated as an 8.

Mr. Gines also notes a tingling/numb sensation in the third, fourth, and fifth fingers of his right hand and a sense of numbness in his right big toe and the adjacent second and third toes.

Mr. Gines also has headaches, two to three times weekly. These headaches, which he refers to as "migraines", are located behind his right eye and deep into his right ear with radiation to the suboccipital/occipital regions of his scalp and upper thoracic spine. The more severe headaches can last for days and are accompanied with nausea and vomiting. Mr. Gines claims that he has lost a significant amount of weight, which has also been noticed in the medical file.

When specifically asked as to which of his pains are the worse, Mr. Gines replied, "it depends on the day".

At the time of today's evaluation, Mr. Gines remains on narcotic medications. He is in no conservative supervised physical therapy. He has never received chiropractic care. He continues to be followed by Dr. Stacey. There have been some discussions/considerations of further possible surgical procedures.

PAST MEDICAL/SURGICAL AND PSYCHIATRIC HISTORY

Medical Illnesses:

Aside from the above stated complaints, Mr. Gines has a history of cardiac disease necessitating two cardiac stents, hypercholesterolemia, multiple episodes of pancreatitis [both before and after the

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MVA of 12-02-09], diverticulitis, and hypertension. Reports in the Medical File of migraines in calendar year 2002 and angina pectoralis are also noted.

Previous Surgery:

The three cervical procedures have been referenced above. Mr. Gines has also had a tonsillectomy and the above stated cardiac stenting.

Non-Industrial Injuries/Accidents:

None of significance described.

Work-Related Injuries/Accidents:

None of significance described.

Previous Psychiatric Contact:

None described.

Review of Systems:

Mr. Gines has endorsed weight loss, appetite change, loss of balance, unexplained night fevers, night sweats, difficulty sleeping, pain, stiffness, and swelling in his joints, recurring belly pain, diarrhea, difficulty swallowing, recurring cough, and shortness of breath with normal activities.

Family History:

Mr. Gines' father had Alzheimer's disease and a stroke.

Current Prescription Medications:

Lortab 5/10 mg, six times daily; Phenergan, as necessary; Nitroglycerin, as necessary.

Drug Allergies:

Morphine, Percocet, Novocain, and Gabapentin.

SOCIAL HISTORY

Mr. Gines does not drink alcohol. He does smoke. He has completed an 11th grade education. He is divorced. He has two children.

OCCUPATIONAL HISTORY

Mr. Gines last worked on 12-31-08 as the Managing Director of a Burger King restaurant.

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EXAMINATION

General Medical Examination

General: Garth Gines is a well-developed, well-nourished male, with a thin but normal body build. He appeared to be in no distress. The anterior cervical scar from the prior surgeries was noted. There were no other scars, birth marks, birth defects, or tattoos noted on the exposed skin.

Vital Signs:

Blood Pressure	118/84 mmHg (Rt. Arm Sitting)
Pulse	86 beats per minute
Respiration	14 per minute

Musculoskeletal Examination

Cervical Spine: There was no cervical paraspinal muscle spasming nor pain to palpation over the cervical paraspinal region.

Anterior Flexion	17°	Pain
Extension	27°	Pain
Right Lateral Bend	24°	Pain
Left Lateral Bend	14°	Pain

Neurologic Examination

Mental Status: Normal cognition to bedside conversation. There was no aphasia nor dysarthria.

Sensation: Vibration was diminished in the right ankle. Pin prick was diminished in the right upper and both lower extremities in a diffuse manner. Light touch with the examining hand was normal throughout. All sensory modalities were normal on the face.

Motor Exam: Normal bulk, tone and strength in the left upper and both lower extremities. There was a slight weakness [5-/5] in a diffuse manner throughout the right upper extremity.

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Jamar Dynamometer Strength Testing
(3 Successive Attempts in Pounds)

Right - (Dominant)	119/99/85
Left	121/101/107

Reflexes: Mr. Gines is areflexic in his upper extremities. There were bilaterally symmetric 1+ patella and Achilles reflexes in the lower extremities. Plantar stimulations were flexor. There were no pathological reflexes.

Cranial Nerves: I: Not tested; II-XII: Normal. There was no increase in intracranial pressure on fundoscopic examination. There were no asymmetries or dysfunctions of any of the cranial nerves.

Coordination: There were no tremors at rest or unusual movements. Gait was cautious but with no apraxia nor ataxia. Romberg examination and tandem walk were normal. Upper extremity dexterity was normal.

REVIEW OF IMAGES

None submitted.

DIAGNOSES

1. Status post motor vehicle accident [12-02-09] with probable musculoskeletal injury to the cervical spine, of the sprain/strain variety, with aggravation and superimposition upon a previously injured and altered symptomatic cervical spine anatomy.
2. Status post two surgical decompressive cervical procedures prior to 12-02-09 and a third procedure [06-06-11] consisting of a take-down of the prior C3-4 level fusion, discectomies and foraminotomies at C4-5 and C5-6, and hardware implantation fusions.
3. Headaches, probably tension type and vascular/migrainous in nature in association with prior cervical injuries and surgeries.
4. Multiple episodes of pancreatitis with other underlying medical dysfunctions inclusive of hypertension, arteriosclerotic vascular disease, and diverticulitis, deferred to the primary treating physician or designated specialists.

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5. Status post tonsillectomy and placement of two cardiac stents [resolved, stable].
6. MRI evidence of disc protrusions in the lumbar spine with neural foraminal narrowing but with no neuronal displacements.

DISCUSSION

I will now address the nine questions that were raised in your cover letter of 12-05-12.

1. Please take a detailed medical history from the claimant on details of the accident, prior subsequent injuries, conditions or events, and inquire from the claimant as to whether a treatment plan has been discussed with the treating provider. Does it appear that objectives have been defined? Your current diagnosis is also required.

Response: Please see my diagnostic and other listings of your various above concerns in this question in the body of the report above.

- 1a. Comment in detail on the records you reviewed noting any pre-existing medical records reviewed, significant gaps in treatment between the date of the accident and the onset of treatment, and whether the complaints/symptoms shown on the Application of Benefits or initial care records match those complaints/symptoms for which the claimant is currently seeking treatment.

Response: Please see my listing of the records reviewed in the body of the report above.

There were no gaps of treatment between the date of the injury and the onset of treatment. There was no Application of Benefits. As noted several times in the body of my report above, Mr. Gines has had significant cervical dysfunctions/impairments and headaches along with other medical problems pre-existent to the 12-02-09 motor vehicle accident of concern. It is quite significant to note that, within the five months prior to the MVA of concern, Mr. Gines' headaches were reported to be getting worse [07-21-09] and that, just three months prior to the MVA of concern, Dr. Stacey reported "some tingling in the left hand and fingers for the last couple of months... pain is getting worse in the right posterior neck... he has avoided lifting" [09-02-09], and that "neck pain is bad for the last two years, worse in recent months... has spasms and locking with his neck with rotation to the right or left... MRI of last week shows worse disc bulging and spinal stenosis since last study, some foraminal stenosis on the right... at C6-7, a new

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disc herniation since previous study... spinal stenosis and bilateral foraminal stenosis..." [09-16-09]. One week later [09-23-09], Dr. Stacey reported that Mr. Gines' "neck pain and headaches are bad. They are not being controlled. Percocet and Voltaren are prescribed..."

Although Mr. Gines indicated that his neck and headache symptoms intensified after the 12-02-09 MVA, it is obvious that he had significant, ongoing, and progressive problems prior to that date including the usage of pain management, injections, a discussion of possible median bundle branch blocks, and narcotic medications.

Following Dr. Howard Reichman's 06-06-11 cervical surgical procedure, Mr. Gines continued to have headaches, neck pain, extremity paresthesias and further pain management contacts.

Although I have not reviewed many of Mr. Gines' images, it is difficult to discern from the reports as to if his continued degenerative findings are simply as a result of the progression of his underlying known degenerative disc disease or possibly associated with the 12-02-09 MVA. Obvious progression before that date, however, were reported.

- 1b. Please inquire about any other activities and/or physical work or hobbies that may be causing the current condition?

Response: This does not appear to be an issue.

- 1c. If minimal damage [impact] to the vehicle was involved, comment on the typical physical effects that would cause, based on your experience.

Response: It has been my experience that the amount of physical damage to a vehicle may not directly correlate with the injuries sustained by its inhabitants. Unfortunately, Mr. Gines had a compromised cervical anatomy at the time of the 12-02-09 MVA and what appears to have been significant and progressive symptoms in his cervical spine along with headaches and extremity paresthesias. He was actively being evaluated and treated by his healthcare providers. It is thus my opinion that Mr. Gines' injuries on 12-02-09 constituted a probable *aggravation* to his already injured cervical spine anatomy.

2. Based on the records provided, what is the typical, necessary treatment, frequency, and duration of care for an injury of this type?

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Response: Absent Mr. Gines' prior two cervical procedures and altered anatomy, musculoligamentous injuries of the spine axis are usually treated by a physical therapist or chiropractor for approximately 4-6 weeks, 2-3 times weekly, with a protocol of flexion, stretching, extension, and graduated strengthening exercises. Thereafter, and depending upon the response of the patient to these initial therapies, a tapering of such therapies is undertaken over the next 2-4 weeks to a 1-2 times weekly regimen. A home exercise protocol is, thereafter, recommended, if necessary. In addition, the use of anti-inflammatory/pain medications and possible muscle relaxants are used as deemed appropriate. Modalities such as massage, hot/cold packs, and TENS units can also often supplement the above stated exercise protocols. Within a matter of 3-6 months, most individuals with musculoskeletal spine axis dysfunctions significantly reduce, if not resolve, their symptoms and return to their normal baselines although, from-time-to-time and depending upon their possible positionings, activities, or weather changes, they can have a transient "remembrance" of that injury.

As Mr. Gines' cervical spine was markedly anatomically altered by his prior surgical procedures and with what appeared to be progressive symptomology prior to the 12-02-09 MVA, it is difficult to define what actual treatments would have been of assistance in the light of what appeared to be his already ongoing progressive cervical dysfunction.

- 2a. Regarding treatment related to the accident in question, do you feel that the treatment to date and/or the diagnostic studies have been reasonable and necessary?

Response: Yes.

- 2b. Regarding the diagnostic studies, were they reasonable and necessary?

Response: Given Mr. Gines' prior altered anatomy and what appears to have been continuing progression of symptoms prior to and after the 12-02-09 event, the follow-up diagnostic studies also seemed to be reasonable and necessary.

3. Are subjective complaints supported by objective findings based on your examination?

Response: Mr. Gines had a decrease of some sensory appreciations in his right upper and lower extremities along with a subtle weakness in force-against-force activity and grip strength in his right upper extremity. In addition, there was said to be a decrease in the ranges of motion of his head and neck with some pain at the end point positioning, which

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would be expected given his three-level fusion and prior surgical procedures/injuries. I was, in fact, quite pleased that Mr. Gines did not have more abnormal physical findings. It appears that his greatest complaint, at this time, is subjective in nature [pain], which cannot be easily objectively measured.

4. Does the claimant currently require further medical and/or chiropractic treatment or diagnostic studies for the condition resulting from the accident? If so, please specify type, frequency, and duration.

Response: Mr. Gines, as noted in my answer to question #3, continues to have what he described as significant subjective complaints of pain in his neck and headaches. I noted in Dr. Walter Reichman's 11-10-11 follow-up report that an electrodiagnostic evaluation of the bilateral upper and lower extremities was said to be normal. I have also noted that Mr. Gines' last reported image of his cervical spine was on 02-27-12. In that study, the left C6 screw was said to be protruding anterior from the plate but "unchanged from the prior image... no acute injury". The consideration of further cervical spine x-rays and CT scanings in reference to the positioning of that screw may be necessary as Mr. Gines continues to complain of neck pain and swallowing difficulties, although such swallowing difficulties were also said to be present prior to the MVA of 12-02-09.

The consideration of pain management with products to stabilize nerve cell membranes such as Topamax or Lyrica may be of assistance in reference to a diminution of Mr. Gines' overall sense of headaches and neck pains. I am hesitant to endorse cervical epidural steroids or median bundle branch blocks or ablations due to his altered cervical anatomy from his three surgical procedures. I feel, in short, that Mr. Gines should be followed by his primary treating physician in reference to his medication management with an attempt to reduce his possible dependence on narcotics and use other medications that would not interfere with his underlying medical conditions as a means of stabilization of his discomfort. In addition, I would suggest a single educational session with an experienced physical therapist to teach him a home protocol of stretching, flexion, extension, and graduated strengthening exercises to his cervical spine. The possibility of a prophylactic medication for his migraine headaches could also be considered. The use of the above stated medications to block the transmission of pain impulses may also afford him significant relief from his migraine headaches.

5. If films are available for the exams, please describe the radiographic findings.

Response: As previously noted, no films were available. I would very much like to review all of Mr. Gines' cervical spine images and, if requested, by supplemental report discuss any possible progressions that those images may be showing.

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6. Does the medical documentation support a causal relationship between the accident in question and the injuries sustained?

Response: Partially. As I have commented, several times, Mr. Gines has had excellent documentation of headaches and cervical dysfunctions *with progression* prior to the 12-02-09 MVA. I cannot tell from the image reports if there had been any *acute* changes or progressions following the MVA of concern or if this was, as are most musculoskeletal dysfunctions, only a *temporary* aggravation to his previous progressive underlying and altered anatomy/cervical spine disease which has continued to progress, and probably would have even absent the 12-02-09 event. It is for this reason that I am hopeful that a more in-depth review of his images can be undertaken.

- 6a. If the accident in question is only partially contributing to the current condition, please indicate and apportion the current condition between this accident and other condition or events.

Response: As noted in my answers to several of your above questions, it is extremely difficult to discern as to what actual effect the probable musculoligamentous injury to the cervical spine following the 12-02-09 MVA may be having now, three years and a major cervical surgery later. Overall, if I was to assume that the 12-02-09 MVA may have caused a *permanent* aggravation to Mr. Gines' pre-existent head and neck problems, in light of his prior documented abnormalities with progression, I would apportion 80% of his current symptomology to his pre-existing cervical spine and headaches status and 20% to the MVA of 12-02-09. A final answer to this question may have to wait for a closer review of Mr. Gines' images.

7. Is the claimant capable of working? Please indicate what, if any, work restrictions the claimant has as a result of the accident, and if temporary, give anticipated duration.

Response: Mr. Gines has several significant underlying medical conditions inclusive of recurrent bouts of pancreatitis and arteriosclerotic vascular disease necessitating two cardiac stents. In addition, prior to the MVA of 12-02-09, apparently several of his healthcare providers recommended that he retire and seek disability. I believe, at this point, that Mr. Gines is not capable of entering the workforce for a structured, salaried position on the basis of his underlying medical conditions and his pre-existent and progressive cervical spine and secondary headache conditions. Dependent, however, upon his possible response to further medical and/or rehabilitative therapies to his cervical spine, it is conceivable that he may be able to return to a *Sedentary* work position sometime in the future.

Re: Garth Gines
December 21, 2012
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8. Does the claimant have or do you anticipate the claimant of having a permanent impairment [disability] as a result of this injury? Please provide a permanency rating.

Response: As I have commented in several of my above answers, it is extremely difficult to definitively state that the MVA of 12-02-09 is the cause of Mr. Gines' current complaints as he had a progressive cervical spine dysfunction prior to that date. In my answer to question #6a, I stated that I would apportion 80% of Mr. Gines' current symptomology to his underlying pre-existing medical conditions and only 20% to the MVA of 12-02-09. In referencing the *AMA Guides to the Evaluation of Permanent Impairment [Fifth Edition], Chapter 15, Section 50.6, Table 15-5, Category III, Page 392*, I would award Mr. Gines an 18% Whole Person Impairment, as I did not see any images specifically measuring a possible alteration of spinal motion segment integrity. As I have commented upon an apportionment of 20% to the MVA of 12-02-09, mathematically, I would award Mr. Gines a 3.6% Whole Person Impairment as a result of the 12-02-09 MVA, although I reserve the right to re-address this possible Whole Person Impairment award after a review of his images, as has been requested above.

In referencing Chapter 18 of the *AMA Guides, Figure 18-1, Algorithm Box 3, Page 574*, I would also award Mr. Gines a 1% Whole Person Impairment for his overall sense of headache and neck pains, which would raise his final Whole Person Impairment for those anatomic conditions to 19% which thus, mathematically, then gives Mr. Gines a final Whole Person Impairment of 3.8% as a result of the 12-02-09, allowing for the disclaimer about the images to remain in place as I have written above.

I will defer all possible Whole Person Impairments in reference to Mr. Gines' cardiac and gastrointestinal conditions to the expertise of specialists within those fields.

9. Please review the deposition transcript of Mr. Gines.

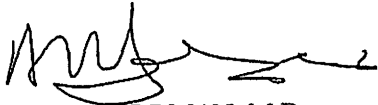
Response: Such has been undertaken in the Medical File Review.

I thank you for allowing me to have evaluated Garth Gines. Please be advised that the entire history, physical examination, review of the outside medical records, the dictation, and the editing of this report was done solely by me. Finally, please also be advised that I have never attempted to achieve a doctor/patient relationship with Mr. Gines.

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December 21, 2012
Page Thirty-two

If I can be of any further assistance, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Alan J. Goldman', with a stylized flourish at the end.

ALAN J. GOLDMAN, M.D.
Diplomate, American Board of Neurology & Psychiatry

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January 25, 2013

Ms. Taylor Sokol
c/o IME Services
Corvel Corporation
9815 South Monroe Street, Ste. 302
Sandy, Utah 84070

Re: Garth Gines
Claim No.: ENZ4048806.1 NP
DOI: 12-02-09
Date of report: 01-25-13

Dear Ms. Sokol:

As you are aware, I performed a Rule 35 Neurological Evaluation on Mr. Garth Gines on December 21, 2012. At that time, I opined that Mr. Gines had sustained a motor vehicle accident [12-02-09] with a probable musculoskeletal injury to his cervical spine, of the sprain/strain variety, with aggravation and super-imposition upon a previously injured and altered symptomatic cervical spine anatomy. Mr. Gines had had two cervical surgical decompressive procedures prior to that 12-02-09 MVA and a third procedure on 06-06-11, consisting of a take-down of the prior C3-4 level fusion, discectomies and foraminotomies at the C4-5 and C5-6 levels, and hardware implantation fusions. Mr. Gines was also thought to have headaches which were probably tension type and vascular/migrainous in nature in association with his prior cervical injuries and surgeries. In addition, and unassociated with the above stated motor vehicle accidents, Mr. Gines has had a number of underlying medical illnesses inclusive of multiple episodes of pancreatitis, hypertension, arteriosclerotic vascular disease, and diverticulitis. All of these medical concerns were deferred to his primary treating physician or his designated specialists.

On pages 26-31 of my report, I addressed a number of questions concerning Mr. Gines' medical status and re-iterated Mr. Gines' "significant cervical dysfunction/impairments and headaches along with other medical problems pre-existent to the 12-02-09 motor vehicle accident of concern". I further commented upon reports in Mr. Gines' medical file of his headaches getting

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worse prior to the 12-02-09 MVA and that, just three months before the MVA of concern, Dr. Stacey reported "some tingling in the left hand and fingers for the last couple of months... pain is getting worse in the right posterior neck... he has avoided lifting". In addition, Dr. Stacey reported further changes in Mr. Gines' cervical spine images and that Mr. Gines' neck pains and headaches "are not being controlled..." I also noted that, following Dr. Howard Reichman's 06-06-11 cervical surgical procedure, "Mr. Gines continues to have headaches, neck pain, extremity paresthesias, and further pain management contacts".

I requested a review of Mr. Gines' cervical spine images in an attempt to discern if there had been progression of his pre 12-02-09 degenerative disease and also to gauge possible effects of that accident of concern on any possible MRI changes. In addition, Mr. Gines' last reported image of his cervical spine [02-27-12], showed the left C6 screw to be protruding anterior to its plate and I had hoped to review the positioning of that screw as a possible cause of Mr. Gines' continued neck pain and swallowing difficulties.

Please be advised that I have now reviewed Mr. Gines' following images.

REVIEW OF RECENTLY SUBMITTED IMAGES

06-01-11 – An intra-operative x-ray of the cervical spine in a somewhat extended position is obtained with an endotracheal tube in place. The C3-4 fusion and intervertebral spacer is easily identified. There appears to be a subtle increase in degenerative scalloping of the other cervical vertebrae.

06-06-11 – A second lateral intraoperative x-ray view again shows the endotracheal tube in place and the C4-5, C5-6, and C6-7 plate and screw fusions with intervertebral disc spacers at the C4-5 and C5-6 levels. The C3-4 fusion and the intervertebral disc spacer is also seen.

06-01-11 – A single lateral C-spine x-ray in slight extension again shows the C3-4 fusion and spacer, as noted above. A decrease of the C5-6 intervertebral disc space is noted as is a minimum [grade I] retrolisthesis of the C3-4 fusion behind the C5 vertebra.

10-21-11 – MRI of the cervical spine. This study is of fair quality due to the artifactual metallic emission interference from the above stated C3-4, C4-5, C5-6, and C6-7 fusion plate and screws. There appears to be a posterior disc bulge at the C5-6 level but with no imposition across the spinal cord. The spinal cord itself appears normal. These films are difficult to interpret due to the artifactual presence. On the axial views, there appears to be a slight rightward disc and osteophytic protrusion with narrowing of the central vertebral canal in the lower-most levels but with no displacements of the spinal cord or neuronal elements.

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10-21-11 – MRI of the lumbosacral spine. Mild degenerative changes are noted with a slight decrease in the intervertebral disc height space at the L5-S1 level. There were no significant posterior disc protrusions on the lateral views although a far left lateral intra-foraminal mild disc protrusion was noted at the L4-5 level.

07-08-10 – MRI of the cervical spine. This study is of good quality. The C3-4 fusion with metallic emission artifact is again noted. There appears to be a disc protrusion at the C4-5 intervertebral disc space and a slight narrowing at the C7-T1 intervertebral disc space. On the T2 weighted emission sagittal sections, a disc protrusion and osteophytic complex at the C5-6 level is noted which is larger than the above stated C4-5 posterior protrusion. On the axial cuts, bilateral neural foraminal narrowing/stenosis is noted at the C5-6 level. There is no impingement across the spinal cord.

12-19-09 – MRI of the cervical spine. The C3-4 fusion with metallic artifactual emissions is again noted as are the posterior protrusions at the C4-5 and C5-6 levels. There is a somewhat "hourglass" constriction of the vertebral canal at the C5-6 level with osteophytic protrusions, anterior and posterior to the spinal cord and loss of the spinal fluid emissions at that level. There are no abnormal emissions from within the spinal cord itself. On the T2 weighted axial images, significant left neural foraminal stenosis is noted as is bilateral extension of the disc at the C4-5 level. Compression of the central vertebral canal is noted at the C5-6 level in accompaniment to the bilateral neural foraminal stenosis.

05-13-05 – Cervical spine x-ray. The C3-4 fusion and the intervertebral disc spacer is noted. The fusion, at this level, consists of a plate and screws.

A CT scan of the brain [05-06-02], an ultrasound of the abdomen [09-03-10], a portable chest x-ray [09-03-10], and an ultrasound of the abdomen [09-03-10] were also included on this disc. The brain scan was normal. All other images were outside my field of Neurology and were not reviewed.

02-27-12 – CT scan of the cervical spine. The accompanying AP and lateral C-spine x-rays show the three level fusions at C4-5, C5-6, and C6-7 and the intervertebral disc spacer at the C3-4 fusion. The left lower most screw [C6 level] is protruding quite measurably anteriorly from the fusion plate.

09-05-11 – An anterior C-spine x-ray shows the three-level fusions with the plate and screw device in place. The extension of the lower-most left-sided C6 screw is easily demonstrated. Flexion and extension views show no discernible movement of the vertebral bodies.

Re: Garth Gines
January 25, 2013
Page Four

Other images on this disc included a single view portable chest x-ray [02-20-11], a CT scan of the abdomen [09-08-10], a lateral x-ray of an esophageal swallow with what appeared to be the above protruding C6 screw impinging on the posterior aspect of the esophagus [09-08-11] and a CT scan of the abdomen and pelvis [07-09-12]. Aside from the esophageal swallowing image, the other images were not thoroughly reviewed as they are outside my field of Neurology.

06-28-12 – CT scan of the orbits, sella tursica, and lateral internal auditory canal. This study is of good quality. There were no skull fractures. The internal auditory canal appeared normal. A question of a bony prominence from the anterior wall of the right external auditory canal was noted with some localized thickening of the posterior wall of the external auditory canal. No other findings were obvious.

This disc also contained CT scans of the pelvis and abdomen [11-12-10; 09-04-10], which were not reviewed as that anatomy is outside my Specialty of Neurology.

06-28-12 – CT of the orbit and right internal auditory canal/ear. This study appears normal in reference to the bony architecture.

This disc also contained a CT scan of the abdomen [09-08-10] which was not viewed due to that anatomy being outside my Specialty of Neurology.

08-04-05 – Utah Valley Regional Medical Center. Two views of the cervical spine. There is a plate and screw fusion at the C3-C4 levels with an intervertebral disc spacer. There are no fractures, dislocations, or subluxations. The intervertebral disc height spaces appeared normal at all of the other levels. There are, at worse, minimal other degenerative changes. The AP view shows no other pathological findings.

This disc also contained images of Mr. Gines' abdomen [07-10-12; 08-04-05], a venous duplex ultrasound of his right upper extremity [04-15-12], a CT scan of the abdomen and pelvis [04-07-12], two chest x-rays [06-06-11; 04-13-05], and a CT scan of the abdomen and pelvis [07-09-12]. As these images are outside the concern of my Specialty of Neurology, they were not reviewed.

DISCUSSION

I thank you for allowing me the opportunity to have reviewed these images. It is my overall impression, as noted in my 12-21-12 evaluation, that Mr. Gines has had a continued mild progression of his underlying degenerative and surgically altered anatomy disc disease. Most

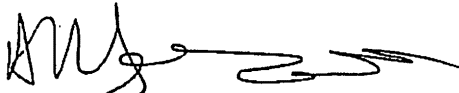
Re: Garth Gines
January 25, 2013
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clinically concerning to me is the extension of his left lower C6 fusion screw into the posterior aspect of his esophagus which may be the cause for some of his continuing neck discomfort and mild weakness of his swallowing, as was reported by the reviewing radiologist, Dr. Roy Hammon.

After carefully reviewing all of the answers in my 12-21-12 report, I do not have a need to change any of those responses as a result of this image review. As noted in my answer to question #6 [page 30], I did not note any *acute* changes or significant progressions on the images following the 12-02-09 MVA and, therefore, continue to feel that that event was a *temporary* aggravation to his previous underlying progressive degenerative cervical spine disease and altered cervical anatomy from his prior surgical procedures.

Please be advised that the entire review of these images and my prior evaluation report, the dictation, and the editing of this report was done solely by me. If I can be of any further assistance, please do not hesitate to contact me.

Sincerely,



ALAN J. GOLDMAN, M.D.
Diplomate, American Board of Neurology & Psychiatry

AJG/dh

**Utah Labor Commission's Supplemental 2006
Impairment Rating Guides®**
Effective July 11, 2006

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This guide is to be used for all impairment ratings done in Utah and is a supplement to the American Medical Association's Guides to the Evaluation of Permanent Impairment 5th Edition, (hereafter referred to as the *AMA Guides*) for workers' compensation purposes. It is to clarify the definitions and practices contained in the *AMA Guides* from a unique workers' compensation context. The purpose of this work is to add more refinement and uniformity to the impairment process. It is produced by medical providers skilled in occupational medicine and impairment rating for workers' compensation, with input from regulators and benefit administrators. To provide rating methodology that facilitates consistency throughout the Guides, the Utah impairment committee reviewed, simplified and updated these guides within the Functional, Anatomic, and Diagnostic model as listed in the spine, upper and lower extremity chapter.

Acknowledgments

The report is the result of many dedicated people who want to improve the functioning of the workers' compensation system. In particular, the contributors share a passion for delivering fair compensation to injured workers in Utah. Fairness has many dimensions, but this committee has a particular interest in, and competency on, the reliable and valid measurement of bodily impairments due to work injury.

This handbook is produced by the Utah Labor Commission's Impairment Rating Committee. Since its creation in 1993, this committee has been led by Alan L. Colledge, MD, Medical Director of the Labor Commission. Special thanks are extended to the following individuals who played a particularly important role in the drafting and publishing these Utah 2006 Impairment Guides:

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Chapter One: Introduction

1.0 Introduction

The concept of compensating people for injuries received "on-the-job" has been present for many years. Even pirates who roamed and plundered in the 7th Century had their own elaborate code of "compensation."¹ It wasn't until the early 20th century that "workers' compensation" became a legislated right in the United States. Each jurisdiction has been designed to ensure the worker prompt, but limited benefits and to assign to the employer sure and predictable compulsory liability insurance with established parameters. The principal components that have received legislative expression in all systems include: (1) A statutory program. (2) Expeditionous resolution of disputed issues. (3) Limited liability without fault: (Since workers' compensation is a no-fault insurance program, determining negligence or blame is often irrelevant). (4) Automatic benefits which include: (a) Medical treatment coverage including: medical care, services and supplies as necessary to cure or relieve the effects of an on the job injury. This means that the employee does not incur any deductible or out-of-pocket expense for the medical treatment of a work-related injury or illness. (b) Indemnity payments replacing wages while the injured employee recovers from an industrial injury and/or reaches medical stability. All states have varying formulas for the calculation of these indemnity payments, which are often tax-free. (c) Death benefits, providing weekly payments to the surviving spouse and dependent children of a worker whose work-related injury result in death. Burial and funeral expenses are also paid. (d) An impairment settlement giving compensation to an injured worker for permanent physical loss from a work-related injury (i.e., scars, disfigurement, amputation, etc.), according to a defined compensation schedule. The most severely injured workers are those who are left with some permanent loss, qualifying for an impairment rating.

In some countries, government insurance programs cover occupational and non-occupational disability with the same administrative and benefit laws. However, in other countries, particularly Australia, Canada, and the United States, workers' compensation uses its own distinct approach to the compensation of occupational disability. By 1949, all 50 states had adopted some form of workers' compensation legislation.² The scope and amount of payments for these agreed upon services are determined by the individual state and in some cases by federal law. In these places where separate workers' compensation laws exist, there is commonly a legal process for qualifying and quantifying certain injuries for a class of benefits for "permanent disability." This process is distinct from other social insurance programs covering disability, private disability insurance, or damage measurements made in connection with civil legal proceedings. Thus, the measurement of total disability for US Social Security disability qualification has no relation whatsoever to a permanent total disability rating in workers' compensation. Private disability insurance claims adjusters, while they may ask about permanent physical loss, are mainly concerned with vocational and job performance issues.

Workers' compensation is a system based on a heterogeneous collection of national and sub-national (individual state and provincial) laws. There are no binding national or international standards for how workers' compensation impairment ratings are to be done. A few programs are listed to illustrate the wide range of government insurance systems in the United States alone that have their own rating systems for occupational disability:

- Black Lung Benefits
- Longshoreman and Harbor Workers Program
- Railroad Workers Program
- Veterans Benefits
- Federal Employees Compensation Act (civilian)

Knowing that it has its own distinct system, with enforced rules of adjudicating claims, may prevent the physician/rater from consciously or unconsciously misapplying techniques or methods used for evaluating other kinds of permanent injury or disability. This guide focuses on issues specific, or particularly common, to an occupational injury.

Physicians who make impairment ratings should understand the basic and universal principles of workers' compensation law to respond to the clinical and procedural demands of rating the permanent residual consequences of work-related injury or disease. This introduction covers this essential background. In addition, it explains the purposes and use of this supplemental guide.

Studies have shown that those who incur impairments have a significant impact on their future wage income.^{3 4 5} As with the other benefits, there are significant differences between the states on the value of settlement amounts and the *methodology utilized* to calculate total disability benefits.^{6 7 8}

The inconsistencies inherent with current rating systems used to calculate injured worker's residual loss or impairment can be frustrating for patients, physicians, risk managers, state administrators and payors.⁹ One of the major problems with impairment ratings is the lack of consistency between physician raters of impairments.^{10 11 12} Unfortunately, this variability becomes a source of dispute, which is both costly to the employer, insurer, and state regulator and stressful to the employee.

Reducing variability in calculating impairment ratings has significant benefits to the workers' compensation system including:

- Greater equity across injured workers, regardless of who rated their impairment.
- Speedier payments to workers because of fewer questions and challenges by claims adjusters.
- Resolution of injured workers frustrations, which facilitates the moving forward with their lives.
- Fewer disputes and litigation because the rules for calculating an impairment rating are clear and consistently applied.
- Lower administrative costs.
- Comparable statistics permitting jurisdiction comparisons, tracking, and research.
- Evolution of an international standard for jurisdictions to consider.

The *AMA Guides*, for reasons explained below, fall short of a guide for workers' compensation. Indeed, there is much diversity among the states in the fundamentals of how and when benefits should be paid. This is especially true concerning approaches to measuring and compensating the injured worker for the lasting, or permanent consequences of an industrial injury.

1.0a. Utah's Guides

The Utah Guide and the *AMA Guides* are tools that can be used to convert medical information about permanent losses into numerical values i.e., impairments. These impairment values are to be used for permanent rating purposes only and are not to be used for causation determinations. As the long list of critical papers in the literature will attest, the calculation of impairment is not an objective science and is based largely on consensus rather than scientific evidence (Holmes, 2002; Gloss & Wardle, 1982; Disler, Battrass & Nischke, 1999; Clark et. al, 1988). Many US states, including Utah, do not recognize the complete *AMA Guides* for rating impairment, and have instead developed their own internal standards or guides for raters.

Below is a brief introduction to the *AMA Guides*, followed by a statement of how this supplement interacts with impairment rating guides published by the AMA. In 1993, the Labor Commission's Workers' Compensation Advisory Council commissioned the Impairment Rating Committee to address the needs of workers' compensation claims payers and system administrators in rating permanent impairment. It was believed that by improving the rating criteria physicians were required to utilize would reduce variability for the impairment ratings. It was also noted that experience and a certain skill level was necessary to accurately and consistently calculate impairment ratings. The Committee's mission was to evolve toward the best practices in rating methodology. It was not the committee's purpose to be unduly critical of the existing impairment systems, as all attempts to classify and communicate about this rather complicated problem, are fraught with difficulty. However, the inherent weaknesses necessitated the development of

a system, which represented current medical science and was as objective as possible, given current technological limitations. In 1994, after reviewing different rating systems, utilizing examples and different unique models, the committee developed and the state of Utah adopted the American Medical Association's 4th Edition of the Guides, with a completely new Utah impairment rating system to be used in place of the AMA Guides. These guides were updated in 1997 and again in 2001 clarify ratings for spinal conditions, upper-extremity peripheral neuropathies, temporomandibular joint dysfunction, dental loss and painful upper and lower extremity conditions.¹³ Since adopting these Utah impairment guides, it is estimated that litigation over impairment ratings has reduced to less than 1%.¹⁴ This reduction of litigation has assisted in making Utah the least costly state in the nation for a manufacturer to obtain workers' compensation insurance,¹⁵ while maintaining the medical fee schedule above the national average.¹⁶ Additional supplemental bulletins or guides were expected to be periodically issued as medical science and the AMA Guides evolve.

1.0b. American Medical Association Impairment Guides

Originally published as a series of articles in the *Journal of the American Medical Association*, the AMA Guides have been revised periodically, and are now in the 5th Edition. As shown in Appendix A, 35 US states reference some version of the AMA Guides in their workers' compensation law (Brigham, 2002). Other sources site a slightly different usage (AMA, 2000; Bavon, 1993).

Most jurisdictions that utilize some edition of the AMA Guides for injured workers' impairment ratings note unnecessary physician/rater reporting variability in the impairment rating for what appears to be the same physical loss. This variability creates unnecessary patient anger, suspicion, hostility, litigation, and costs.

Regarding impairment ratings, this variability is attributed to several non-medical factors. These factors include the individual examining physician's lack of knowledge or skills, difficulties in differentiating subjective complaints from objective findings, confusion between the concepts of impairment and disability, bias, poor quality medical reports, difficult causation analysis questions, and the apportionment processes. Members of the Utah Occupational Impairment Rating Guide Committee believe that by improving the rating criteria requirements, physicians/raters can improve fairness and resolution for injured workers, reduce variability and thus reduce unnecessary overall expense to the regulators, payors and the patient for the impairment ratings.

1.1 Legal and Historical Background

Providing claims information can be extremely frustrating and time consuming for physicians/raters and their support staff. This section reviews legal and administrative issues to equip physicians and their staffs to better respond to the demands made on their time and medical expertise by disability and workers' compensation claims processors. It explains benefit types and nomenclature.

1.1a. Overview of Occupational Benefits

The categories listed below describe the four broad divisions of claims and their common abbreviations for benefits payable under Utah workers' compensation.

- Medical-only
- Temporary disability, for wage loss indemnity (TTD)
- Permanent disability, divided into Permanent Total (PT) and Permanent Partial Impairment (PPI)
- Death (including burial)

Most workers' compensation injuries require only medical attention and do not involve lengthy time away from work, nor do they leave residual effects on the worker. In the United States, "medical-only claims" are about 72 percent of all compensable injuries (Telles, 2001). These are claims that do not involve compensation for lost work time, only medical expenses related to an injury. The percentage of medical-only claims is a function of the quality and speed of medical care, the length of lost time required before

an injury qualifies for indemnity benefits, and how scrupulously employers report claims as workers' compensation.

Under Utah's workers' compensation law, when the injured worker has missed 3 days of time from work, he/she is eligible for wage indemnification, with the amount determined a set state formula. Wage loss benefits continue until the disabling condition either permits a return to work, or reaches a plateau where healing ends and no significant improvement is likely. When this occurs, the injured worker may be entitled to another class of benefits to compensate for any permanent residual loss, i.e., PPI.

The cost for providing the monetary loss for residual impairments is substantial. As Table 1 below shows, about a quarter of claims in the United States involve permanent injury benefits, yet they produce about two thirds of the cash benefits paid. Of the \$25.3 billion in cash benefit payments going directly to injured workers in 1999; nearly \$19 billion were for compensation of permanent injury.

Schedule 1
Workers' Compensation Cases in the United States, 2000

Type of Workers' Compensation Claim	Percentage of Cases	Percentage of Cash Benefits
Temporary	72%	25%
Permanent Partial	27	62
Permanent Total	1	13

Source: National Academy of Social Insurance,
Workers' Compensation: Benefits, Coverage, and Costs, May 2001

In summary, several different classes of benefits are paid under workers' compensation. *Permanent injury claims account for a very large share of benefits paid.* These benefits are largely controlled by medical judgments made by physicians and communicated in reports to claims adjusters and workers' compensation administrators. Physician-raters must be cognizant that Utah statutes administrative rules, and case law are Utah specific and at times may seem impractical as one reviews the relative severity of injury for purposes of quantifying benefits to be awarded for permanent injury.

1.1b. Measuring Permanent Loss from Injury

The impairment rating process for workers' compensation is part of a larger process of claim adjudication. Medical issues and reports drive the settlement of most claims. The medical issues can be divided into three phases:

1. Verifying that a specific injury or disease has occurred.
2. Providing information to help establish the causation of the injury.
3. Measuring the permanent residual losses secondary to the injury.
4. Establishing the worker's capability.

Number 3 is technically referred to as "impairment rating" and number 4 latter as "disability rating." Confusion between the two concepts is rampant.

Some of the varying definitions of "impairment" found in the literature:

- Alteration of an individual's health status that is assessed by medical means (J.B. Moore, Disability Systems).
- A medical assessment of a patient's physical or anatomical deficit or loss use of function, represented by a percentage value for each deficit or functional loss, expressed in terms of the whole person (Gerald Lipinsky, "Spinal Impairment and Disability").
- Alteration of an individual's health status; a deviation from normal in a body part or organ system and its functioning (AMA Guides, 5th Edition).

- Any loss or abnormality of psychological, physiological or anatomical structure or function. (World Health Organization).
- An impairment that results from anatomical, physiological, or psychological abnormalities, which can be shown by medically acceptable clinical and laboratory diagnostic techniques (US Social Security Administration).

Disability rating, on the other hand, measures a patient's inability to perform specific and important activity of daily living or work. In some contexts this might be ordinary household tasks, in others, schoolwork. For occupational disability the focus is on:

1. The tasks that the patient was previously able to do in their job or profession, and, if pre-injury work is impossible,
2. The alternative tasks that a person might perform.

Disability and Impairment seldom match closely. Classic examples of the lack of correspondence of physical and economic/job limits are:

- A piano player losing a little finger would be rated at 5% percent whole person impairment. He/she may also be rated as 100% disabled for the preinjury occupation, and 50% disabled from a loss of earning capacity (because there are other related careers). A physician could lose the same finger, be rated at 5% whole person impairment, and yet have little or no impact on his/her earning capacity.
- An attorney could lose his or her eyesight and receive a total impairment rating in a given system. Yet, with proper accommodation, he/she might not lose his/her preinjury job, or suffer any loss of income.

A given physical loss would have dramatically different effects on a worker depending on:

- Occupation
- Education
- Age
- Language skills
- Geographical opportunities
- Employer's flexibility to modify job duties

One of the ongoing challenges in workers' compensation is to define how permanent physical loss is calculated in a defensible and consistent way. The *AMA Guides* is the most common methodology utilized to calculate impairment.¹ The *AMA Guides* adopt the widely accepted view that impairment is a deviation in a body part or organ system and its functioning. ***Impairment is not equivalent to disability.***

The consequences of any given limitation are difficult to generalize to the whole working population. Moreover, these consequences may differ dramatically from what the injured worker was able to do before the injury. Similarly, how these consequences relate to other jobs, other activities of daily life, or personal happiness varies considerably.

1.1b.i. Impairment / Disability Relationship in Workers' Compensation

An impairment rating is the threshold determinate for certain benefits needed to calculate the financial compensation for the residual deficits from the injury or event, after an injured worker reaches medical stability.

¹ Some jurisdictions have separate processes for: (1) making a finding of impairment, and (2) calculating the impairment rating. Findings of impairment are done by physicians/raters. Insurers then rate the impairment by applying state adopted rating standards to the findings. Thus, the technical aspects of coming up with an impairment "score" for benefit calculation is an administrative function.

An injured worker must receive an impairment rating within six years of an injury or file an application for a hearing to hold a claim open for 12 years from the date of injury (see Glossary).

1.1b.ii. Medical Care Responsibility

Medical care for a workplace injury continues for the life of the claimant so long as the claimant sees a physician who bills the carrier/employer at least once every 3 years.

1.1b.iii. Medical Evidence Needed in the Calculation of Impairment Ratings

The goal of the 2006 *Utah Guides* is to improve the uniformity and accuracy of impairment ratings. The standard impairment schedule considers percentage of loss on an arbitrary continuum, with 0% reflecting no residual or loss and 100% whole person impairment equaling a state approaching death. As an example, a complete amputation of the ring or little finger equals 5% whole person impairment. For the complete loss of an eye, one is awarded 24%, and for the complete loss of a leg at the hip, 40% is awarded.

As stated in Utah Code 34A-2-102(8), "impairment" is a purely medical condition reflecting any anatomical or functional abnormality or loss. Impairment may be temporary or permanent, industrial or non-industrial. Utah Administrative Rule R612-7-3 sets forth the method for rating.

For rating all impairments, which are not expressly listed in Section 34A-2-412, the Commission adopts Utah's 2006 Impairment Guides as published by the Commission for all ratings of impairments on or after July 11, 2006. For those conditions or exclusions not found in Utah's 2006 Impairment Guides, the AMA Guides are to be used.

R612-7-3 incorporates by reference the "Utah 2006 Impairment Guides" and the *AMA Guides*. The Labor Commission issues clarification and of these guides from time to time. Substantive changes to the guides are only made after public notice is given and hearings held pursuant to the provisions of the State's Administrative Procedures Act (Title 63-46a, Utah Code Annotated).

According to Utah Code 34A-2-412 (C), in rating extremities, "permanent and complete loss of use shall be deemed equivalent to loss of the member."

Utah has a permanent statutory benefit found in 34A-2-412 for permanent partial disability. These benefits have been used as a template for the Utah Guides. Most of these statutory conditions are for stand alone impairments such as amputation and vision loss. These are listed as "weeks" with 312 being the maximum or 100% impaired.

- (A) Arm and shoulder (forequarter amputation) 218
- (B) Arm at shoulder joint, or above deltoid insertion 187
- (C) Arm between deltoid insertion and elbow joint, at elbow joint, or below elbow joint proximal to insertion of biceps tendon 178
- (D) Forearm below elbow joint distal to insertion of biceps tendon 168
- (ii) Hand
 - (A) At wrist or midcarpal or mid metacarpal amputation 168
 - (B) All fingers except thumb at metacarpophalangeal joints 101
- (iii) Thumb
 - (A) At metacarpophalangeal joint or with resection of carpometacarpal bone 67
 - (B) At interphalangeal joint 50
- (iv) Index finger
 - (A) At metacarpophalangeal joint or with resection of metacarpal bone 42
 - (B) At proximal interphalangeal joint 34
 - (C) At distal interphalangeal joint 18
- (v) Middle finger
 - (A) At metacarpophalangeal joint or with resection of metacarpal bone 34
 - (B) At proximal interphalangeal joint 27
 - (C) At distal interphalangeal joint 15

- (vi) Ring finger
 - (A) At metacarpophalangeal joint or with resection of metacarpal bone 17
 - (B) At proximal interphalangeal joint 13
 - (C) At distal interphalangeal joint 8
- (vii) Little finger
 - (A) At metacarpophalangeal joint or with resection of metacarpal bone 8
 - (B) At proximal interphalangeal joint 6
 - (C) At distal interphalangeal joint 4
- (b) Lower extremity
 - (i) Leg
 - (A) Hemipelvectomy (leg, hip and pelvis) 156
 - (B) Leg at hip joint or three inches or less below tuberosity of ischium 125
 - (C) Leg above knee with functional stump, at knee joint or Gritti-Stokes amputation or below knee with short stump (three inches or less below intercondylar notch) 112
 - (D) Leg below knee with functional stump 88
 - (ii) Foot
 - (A) Foot at ankle 88
 - (B) Foot partial amputation (Chopart's) 66
 - (C) Foot mid metatarsal amputation 44
 - (iii) Toes
 - (A) Great toe
 - (I) With resection of metatarsal bone 26
 - (II) At metatarsophalangeal joint 16
 - (III) At interphalangeal joint 12
 - (B) Lesser toe (2nd -- 5th)
 - (I) With resection of metatarsal bone 4
 - (II) At metatarsophalangeal joint 3
 - (III) At proximal interphalangeal joint 2
 - (IV) At distal interphalangeal joint 1
 - (C) All toes at metatarsophalangeal joints 26
 - (iv) Miscellaneous
 - (A) One eye by enucleation 120
 - (B) Total blindness of one eye 100
 - (C) Total loss of binaural hearing 109

Physicians should express a rating as a Whole Person impairment, stating the specific derivations used in calculating the rating, i.e., % hand to % of upper extremity to % Whole Person. Physicians must report the impairment to the nearest whole number, rounding up or down, i.e., 12.3% = 12%; 12.5% = 13%.

To provide consistency, the physician/rater should understand that the Labor Commission is generally first looking for physicians to provide objective and consistent information about the physical limitations, losses, or abnormalities of the body and its function, of impairment. Utah cases generally do not require an assessment of employability, and thus is outside of the medical expertise.

As a general rule, not all harm, damage to, or suffering of the injured worker from a covered injury is compensated under the law. This is different from civil law, or tort, where these issues are a major part of lawsuits. Workers' compensation is a system of laws that departs from the principles of tort law. In exchange for prompt and predictable payments for covered injuries, it limits or excludes subjective or difficult-to-quantify harm to the worker. Once understood, this tradeoff between speed and predictability for compensation can help to make the benefit limits of workers' compensation seem more reasonable and fair.

In Utah, the use of the impairment rating provided by the medical practitioner is converted by law into "weeks of disability payments."

Physician/raters must remember that the range of benefit outcomes is beyond the role of medical practice, and impairment ratings should not be manipulated by the physicians/raters to adjust for perceived low or high benefit payments. Physicians/raters are only expected to calculate the physical loss or impairment rating based on their clinical observations and the impairment guides that are mandated.

The physician/rater should understand that establishing fair compensation for lasting or serious harm to a worker is a mix of medical and legal issues. This report does not attempt to judge the rationale or adequacy of benefits and how Utah administers them. The remaining components of this document outline the general principles for the physician/rater to perform an impairment rating and report.

1.1b.iv. Problems with Impairment Ratings

There are two standards by which rating systems, including instructions and guides to raters, should be evaluated. The first is consistency of ratings across injuries and raters. The second is the validity of the ratings. A departure from either of these weakens the workers' compensation system.

Consistency is essential, without it impairment ratings become a source of dispute. Claimants can often get upset when they learn what they are going to receive in compensation for the ongoing residual symptoms workers' compensation benefits are seldom generous and are often arbitrary in the level of compensation for different injuries. When workers discover that peers with similar injuries in different administrative systems, (FELA-Personal Injury) received significantly more money than they were offered under worker's compensation, they become even angrier. Their confusion and anger often motivates them to seek legal counsel, to formally complain to the regulatory agency, to complain to their elected representatives, and to launch a legal action. All of these reactions impose unnecessary financial costs and administrative burdens on the WC administrative system, delay the worker from receiving their often much needed benefits and impede the worker in adapting to the loss and moving on with life. Formal legal disputes within a workers' compensation system are a sign of breakdown of the unique WC exclusive remedy.

Perfect reliability is unachievable. Even the same physician/rater may produce a slightly different rating on the same fact situation from time to time. Cross-rater variation is unavoidable given different backgrounds, training and clinical practices. However, as a practical goal for workers' compensation, the same diagnosis and same patient characteristics should produce ratings that are consistent within a tolerable range.

Validity is the second test of a good impairment system. This means that the rating assigned to a given bodily loss should measure what it intends to measure. If the goal is to quantify loss of use and function due to the injury, then the rating should have a logical and factual basis. A second goal might be that the ratings for different injuries bear a logical and defensible ordinal or cardinal ranking. The most common scale is the percentage of loss to the body as a whole. Using this, the relationship between individual body part losses should receive reasonably related percentages for whole body loss. Thus, the loss of a single phalanx of a finger should be less than the loss of the whole finger, which in turn is less than the loss of a hand, and the loss of a hand is less than the loss of the arm.

The reliability and validity of impairment ratings can be improved by clear guidance to physician/raters in three areas:

1. The scale or measures of impairment to a given body part.
2. How to perform or record measurements that support the scale given in (1) above.
3. How to convert loss to a specific body part to loss to the body as a whole.

In the remainder of this chapter guidance is provided in each of these areas based on the consensus of practitioners with considerable experience in occupational medicine and the administration of impairment ratings.

1.2 General Guidance for Physician/Raters

Workers' compensation law places great deference on medical evidence and judgment in administering permanent disability benefits. Except in some isolated cases, the qualification of an individual for a permanent injury benefit must be triggered by a doctor's written opinion as to a qualifying event, condition, or rating. Rating applies to those cases where the physician/rater must quantify the degree or extent of some injury or impairment that triggers a benefit. This quantification process is often complex, requiring careful measurement and thorough evaluation. The process is not simply empirical. Expert judgment is often called for.

The following principles apply to all impairment ratings. Specific injuries, to the upper or lower extremity and to the spine, will be treated in later chapters.

1.2a. Duties of Rating Physician/Rater

The impairment rating should be based on the objective condition of the patient along with the credible subjective findings. The credibility of patient representations should be interpreted in light of their consistency across time and accordance with objective findings. Also, subjective findings should be considered reasonable in those workers who have residual loss resulting from an occupational injury.

In making these interpretations and judgments, the physician/rater has duties and obligations that are distinct from the duty of care as a treating physician. The impairment rating is not considered a portion of any medical service previously rendered and is not included in routine post-operative care. Unless treating physicians are uncomfortable with this process, they are encouraged to declare the patient stable, and, if applicable and if they are qualified, to calculate an impairment rating. The skills involved in assessing impairment are two-fold: clinical assessment and criteria application. An experienced attending clinician may be unfamiliar with the correct process of rating impairment.

The patient's history should be based primarily on the individual's own statements rather than secondhand information. The physician/rater should consider information from sources, including medical records. However, caution should be used in the interpretation of subjective information, particularly in the context of litigation and the potential for secondary gain. If information from the individual is inconsistent with what is known about the medical condition, circumstances, or written reports, the physician/rater should comment on the inconsistencies and base ratings on consistent historical reports and findings (Ibid, p. 374 & p. 524).

1.2b. What Metric to Use?

Numbers help third parties, such as attorneys, administrative law judges, and claims adjusters understand the extent of a patient's residual limitations from injuries. A numerical rating is a bridge between medical issues and legal determinations of fault, compensability, or benefit entitlements. For example, a claims adjuster may not understand the clinical significance of a medical report citing "L4/L5 disc herniation with L5 radiculopathy," but with a percentage rating in hand he/she can determine statutory benefits as they are converted to weeks. In Utah this is a rule that converts impairment percentage into weeks of indemnity compensation.

One of the sources of error and frustration in impairment rating is the measurement system to be used. Percentages of loss make intuitive sense. However, there is sometimes doubt about whether the percentage applies to a limb, organ, or the whole body.

- The 100 percentage-point scale that is used by the *AMA Guides* illustrates this challenge. It is difficult to form a consensus on how badly impaired an organ or body system must be to merit a 100% impairment rating.
- The *AMA Guides* speak of "a state that is approaching death" as the standard for 95-100% Whole Person Impairment.

1.2c. Medical Report at Stability

The medical report at "stability" is a comprehensive report prepared after the injured worker is medically stable, sometimes referred to as Maximal Medical Improvement (MMI), medical stability, permanent and stationary or fixed state of recovery. For those involved in therapy, the RSA Form 221 is objective evidence of when functional stability has been reached. It is important to note that medical stability may not be used to terminate necessary medical care. The date of medical stability and the date when the worker qualifies for an impairment rating can be two separate dates. Impairment rating is not to be calculated before it is legally appropriate.

1.2d. Reporting of Impairment Ratings

The impairment rating should be based solely on the objective maximum condition achieved by the patient. The calculation of an impairment rating is considered reasonable and necessary for those workers who have residual loss secondary to an industrial event. The impairment rating is not considered a portion of any medical service previously rendered and is not included in the routine post-operative care. There are special code numbers for payment for this service. Unless treating physicians are uncomfortable with this process, they are encouraged to complete the case, declare the patient stable and if appropriately trained calculate an impairment rating. The attending physician is the person most knowledgeable regarding the condition, progress and final status of the injured employee. Therefore the treating physician is encouraged to render the final impairment rating.¹⁷

If, for any reason, the attending physician prefers not to make this evaluation, they should notify the insurance carrier. The treating physician may then refer the patient to a physician/rater, or request that the carrier refer the patient to a physician that has training and expertise with the patient's condition and Utah's impairment rating methodology. The physician needs to ensure that the examinee understands that the evaluation's purpose is medical assessment, not medical treatment. However, if new diagnoses are discovered, the physician has a medical obligation to inform the requesting party and individual about the condition and recommend further medical assessment.¹⁸

When the physician/rater is uncertain about which method to use in the calculation of an impairment rating, or if more than one method can be used, the physician should calculate the impairment rating using different alternatives and choose the method or combination of methods that gives the most clinically accurate and highest impairment rating.¹⁹

The history should be based primarily on the individual's own statements rather than secondhand information. The physician/rater should consider information from sources, including medical records; however, caution should be used in the interpretation of subjective information. It is not appropriate to question the individual's integrity. If information from the individual is inconsistent with what is known about the medical condition, circumstances, or written reports, the physician should simply comment on the inconsistencies.²⁰

Because it serves administrative and legal purposes, the final report of the physician/rater should include the following information:

1.2d.i. Diagnosis. The physician/rater needs to clearly state the diagnosis as substantiated from the medical record and clinical assessment. The physician/rater should also define, as clearly as possible, the relationship of the diagnosis to the industrial event (causation). It is recognized that in many cases, specific pathologic diagnoses are not clearly evident. The physician/rater has the responsibility to provide a diagnostic impression that is as closely correlated to the clinical findings as possible.

1.2d.ii. Stability. Maximal Medical Improvement (MMI), medical stability, permanent and stationary or fixed state of recovery" refers to a date when the period of healing has ended and the condition of the

worker is not expected to materially improve or deteriorate by more than 3% Whole Person in the ensuing year.^{21 22 23 24 25} It is important to note that medical stability may not be used to terminate necessary medical care. The date of medical stability and the date when the worker qualifies for an impairment rating can be two separate dates. Impairment rating is not to be calculated before it is legally appropriate.

This situation can be best understood with the example of low back pain treated non-surgically. If after 8 weeks of treatment, the patient's condition has reached a plateau, and it is determined that what can be done to improve his/her condition has been done, he/she would be at MMI and if the patient has not already returned to work, temporary disability benefits (TTD) cease. However, it is obviously too early to determine that this individual has a permanent lifetime loss. It would be appropriate to have the patient wait at least six months to determine the issues of permanency.

1.2d.iii. Calculation of Impairment. Using these *Utah Guides* (or the *AMA Guides* for those conditions not found in the *Utah Guides*), the examiner should calculate the residual impairment, based on clinical findings established during the medical examination and information found in the medical records.

1.2div. Apportionment. Impairment ratings must be apportioned between the current injury and prior impairment conditions as outlined in the Apportionment section of this guide.

1.2e. Time Periods for Certain Conditions to Reach Medical Stability

Those who perform impairment ratings must be aware that for some conditions there is a certain time period that must pass before a condition is considered to be at MMI. Suggested guidelines are listed below:

- **Soft Tissue Spinal Complaints.** The majority of patients with soft tissue spinal complaints recover without any permanent residual loss, or "impairment."^{26 27} Therefore, before considering any patient with residual soft tissue, developmental and degenerative spine complaints for an impairment rating, the patient's symptoms must have been present for a minimum of six consecutive months.
- **Range of Motion.** Often, maximum range of motion is not obtained until one year from the time of the accident or surgery. Loss of motion is not to be considered permanent until it is demonstrated that the patient is at least six months (or applicable statutory limits) from accident or surgery, and has reached a plateau in his/her progress.
- **Upper and Lower Extremity Painful Organic Syndromes.** These schedules are for musculoskeletal condition characterized by pain (and weakness) with use of the affected member, attributed to a lesion in the soft tissue (capsule, ligament, tendon, fascia, muscle) and documented by clinical findings that have been present for longer than six months.

1.2f. Capabilities Assessment

When requested, the physician/rater should discuss any restriction of work activities, and give clear examples. For example, if after knee surgery, an examinee has no restriction other than downhill skiing, that restriction should be clearly stated. The impairment rating report should reflect how the actual impairment impacts daily living. The physician/rater should make a statement as to the current functional capacity of the patient as it relates to the impairment's impact on their activities of daily living, ADLs. It is the physician/rater's responsibility to determine if the impairment results in functional limitations and to inform the employee and the employer about an individual's abilities and limitations. The physician/rater should state whether or not there are work restrictions or work limitations. Work limitations are based on limited capacity. Work restrictions are based on risk of harm. Deciding to work or not to work based on subjective patient tolerance for the activity in question is best left as a patient's decision, and is not a basis for physician/rater imposed work restrictions or comments about work limitations. It is the employer's responsibility to identify and determine if reasonable accommodations are possible to enable

the individual's performance of the essential job functions. Physician/raters may be asked to suggest possible reasonable work accommodations. If so, physicians should identify physical abilities considering all body systems available. This information facilitates the patient/employer relationship for return to work. *The Workplace Functional Ability Medical Guidelines*,² published by the Utah Medical Association and currently utilized by the Utah Health Department provides an excellent, comprehensive system review and report form. Functional capability evaluations (FCE) should be only performed when requested and must be pre-authorized. Currently, the validity of FCEs has not been established.^{28 29 30}

1.2g. Future Medical Treatment

Depending on the individual case, the physician/rater may be required to state a prognosis and the need for any possible required medical treatment in the future as a direct result of the industrial accident. This information is critical in those cases that may require lifetime medical benefits for the establishment of financial reserves. For this reason, the physician should be as specific as possible. This would also certainly be the case if a lump sum settlement of the claim was being negotiated by the claimant and payer.

1.2h. Impairment Ratings for Conditions not found in the Utah 2006 Edition or the AMA 5th Edition

As always, the physician/rater should use the appropriate parts of the guides to evaluate impairment. If information in the guides is lacking, the physician/rater may derive an impairment percent based on the severity of the effect and describe in detail their methodology for calculating an impairment rating. In certain instances, the treatment of an illness may result in apparently total remission of the person's signs and symptoms, yet it is debatable whether the worker has actually regained the previous status of normal good health. Such examples would be individuals with deep vein thrombosis requiring chronic anti-coagulants for more than a year, or organ transplant recipients who were treated with immunity suppressing pharmaceuticals. In these cases the physician may increase the impairment estimate by three percent.³¹

1.2i. Impairment Rating for those Patients who Decline Surgical, Pharmacological, or Therapeutic Treatment

If the patient declines recommended treatment for an injury or illness, that decision neither decreases nor increases the estimated percentage of the individual's impairment. However, the physician/rater is to make a written comment in the medical evaluation report about the suitability of the therapeutic approach, and to describe the basis of the individual's refusal. The physician will need to address whether the patient is medically stable without treatment and estimate the permanent impairment that would be expected to remain after the recommended correction.

1.3 Administrative Issues

While not directly related to a medically correct impairment rating, certain administrative issues need to be understood by the physician/rater to insure prompt handling of benefits to the patient and payment to the provider. Even a highly professional impairment rating founded on excellent medical reasoning may encounter administrative problems if the above procedures are not followed closely. This results in delay of payment to the worker and to the medical provider and additional calls and administrative work between the agency and provider's office. Utah has its own idiosyncratic forms and completion rules. The following are some principles that apply to rating permanent impairment In Utah.

² An electronic copy of this publication maybe obtained from the Labor Commission, 801-530-7611

1.3a. Who is to Perform Impairment Ratings

Because the impairment rating process includes the medical issues of diagnosis, determining permanency, and determining the need for ongoing or future medical care, only licensed physicians should perform impairment ratings. The raters should be trained in the rating process by attending training courses taught by the Utah Labor Commission.

When the treating physician is unable to, or is uncomfortable in, performing the impairment rating, it is recommended that one who has training and expertise with the patient's condition and the Utah impairment rating methodology should perform the rating. Because Utah has its own comprehensive rating guidelines, training and certification courses will be offered for those physicians doing ratings for injured workers. Being "Board Certified" to do impairment ratings has no credence within the Utah Workers' Compensation System.

1.3b. Forms

Utah does have specific forms for reporting various impairment ratings. These include Spine, Upper and Lower Extremities and are found within these guidelines. These forms facilitate and standardize how impairment ratings are to be done and reported. The physician/rater is also encouraged to use the hand and upper extremity charts from the AMA 5th Edition when calculating impairment ratings from this section.

1.3c. Billing for Impairment Ratings

The physician/rater is not entitled to reimbursement under the codes listed in the following section if his/her report does not conform to the established criteria as outlined in these guides. It is required that the physician/rater doing the rating list their licensure after signature, so that payer is fully aware of the credentials of the individual who has performed the rating.

1.3d. Billing for Impairment Ratings Done by the Treating Physician

The current AMA Current Procedural Terminology, CPT, book lists specific codes for impairment ratings. When submitting impairment ratings to the insurance carrier and/or employer for billing purposes this is the book to use. An Impairment rating is considered an extension or continuation of the treatment process, which includes the usual evaluation and management of the office visit, a review of the medical records, diagnostic studies, and current physical findings on which the rating is based, and generation of a written report.

The Utah fee schedule requires these codes be utilized dependent on the complexity of the case, the time required in the evaluation and report writing, and the examiner's time. Because the current Resource Based Relative Value Scale (RBRVS) system does not apply a unit value to Impairment codes, Utah has adopted the following unit values.

Schedule 2

Code	Procedure	RVU
99455	Work related or medical disability examination by the treating physician that includes: completion of a medical history commensurate with the patient's condition — performance of an examination commensurate with the patient's condition — formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment — development of future medical treatment plan — and completion of necessary documentation/certificates and report. To be used for each 30 minutes increment.	2.0

Schedule 3
Billing for Impairment Ratings Done by Someone Other than the Treating Physician
(i.e., Rating Physician or Other Rater)

Code	Procedure	RVU
99456	Work related or medical disability examination by other than the treating physician that includes: completion of a medical history commensurate with the patient's condition — performance of an examination commensurate with the patient's condition — formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment — development of future medical treatment plan — and completion of necessary documentation/certificates and report. To be used for each 30 minutes increment.	2.65

1.3e. General Rules for Calculating Impairment Ratings

The following rules are provided in order for the evaluator to properly execute an impairment rating. These rules can be applied to all systems of the body.

1. The final impairment value, whether the result of a single or combined impairment, shall be rounded off to the nearest whole number percentile.
2. There is no difference between dominant or preferred side and the non-dominant extremity.

1.3f. Rules for When to Combine and When to Add Impairment Values

Always combine all of the ratings of a region—digit, hand and upper extremity— prior to converting to the next higher level, the hand-upper extremity-Whole Person. The same process is used in the lower extremity.

In other words, when there is more than one impairment of a member, such as abnormal motion, neurological loss and amputation, the impairments must be combined at the lowest level before conversion to the next larger unit.

The impairment of an upper extremity is never to exceed the amputation value, which is 60% whole person. Nor is the impairment of the lower extremity to exceed the amputation value, which is 60% whole person. All impairments for the body cannot exceed 100% whole person.

Range of motion loss in the same joint is added.

Range of motion loss in multiple joints is combined.

Exception: Carpal Meta Carpal (CMC), Metacarpal Phalangeal (MP) and Interphalangeal (IP) are added in the thumb because they are each a portion of a complex motion

Ankle and subtalar are also added for the same reason.

Impairment percentages for the thumb, index, middle, ring and the little fingers are added, not combined.

Ankylosis: If multiple ankyloses are present in the same joint or area, use the largest figure for the rating.

Spinal impairments for multiple regions are combined.

Everything else is combined.

1.4 Summary

Consistent and prompt payment of benefits to injured workers is a universal goal of all workers' compensation systems. Workers due permanent partial disability benefits suffer the most from delayed and inconsistent benefit evaluations. Problematic impairment ratings breed disputes over the benefits payable. Delayed payments unnecessarily stress injured workers' lives, increase administrative costs, and generally cause stake holders to have less confidence in the system.

Measuring the degree of functional loss to an organ or body system can be a very complex and challenging task. But these inherent problems are aggravated by physicians/raters evaluating permanent impairments who do not understand and use practical standards with which to measure and report on the degree of physical impairment. As the *AMA Guides 5th Edition* evolved they have provided direction and a foundation of consistency and fairness to the process of rating impairments. The five editions of the *AMA Guides* demonstrate that reforming the process of rating is ongoing. However, on some important definitional and conceptual issues, there continues to be significant evidence demonstrating that the *AMA Guides* have been unable to meet Utah needs for workers' compensation.

This guide is a supplement to the *AMA Guides 5th Edition* to be used for Utah's workers' compensation purposes to clarify the definitions and practices contained in the *AMA Guides* from Utah's workers' compensation context. It is produced by medical providers skilled in occupational medicine and impairment rating for workers' compensation, with input from regulators and benefit administrators. Our goal is to add more refinement and uniformity to the process, so as to provide a more consistent, universal, and fair process.

This chapter of the *Utah Guides* lays out basic principles for impairment evaluations. These principles are carried forward in other parts of the *Utah Guides* dealing with specific body parts or systems.

Chapter Two: Pain, CRP Syndromes and Apportionment

2.0 Pain

Putting a dollar value on pain is a highly contentious issue. First, pain is inherently subjective with objective pathology often only showing a modest correlation. An examiner must rely on communications from a patient rather than on laboratory or imaging studies in order to assess pain. Because of the subjective nature of pain, awards under tort law can vary enormously depending on the nature of the case involved and the judge or jury. The early framers of workers' compensation law wanted to avoid these disputes and highly variable outcomes. Even today, most systems avoid explicit compensation for pain from a workplace injury.

Clearly, work injuries can produce excruciating pain. Moreover, pain can manifest itself in predictable physical outcomes, some of which can be measured with a reasonable degree of precision. If not measurable, some symptoms of pain are classic and experienced similarly in occupational and non-occupational contexts, e.g., phantom pain after an amputation.

Pain is subjective and has been shown to be influenced by depression, anxiety, beliefs, expectations, rewards, attention and training. These markers reflect social and environmental factors as much as they reflect pain.³² Prospective studies consistently show that the onset of disabling pain is highly associated with issues such as job dissatisfaction, lack of support at work, stress, perceived inadequacy of income, family support, and anxiety about family and/or job. Once initiated, the progression of pain to chronicity is contingent upon similar factors. Financial compensation, receipt of work-related sickness payments and compensation related litigation are also associated with chronicity, as are social and economic factors as poor education, language problems and low income. Chronicity is also favored by individual tendencies to be preoccupied with one's body and symptoms (AMA 5th Edition, p. 581). Even those individuals with clear-cut radicular pain from disk herniation, application for retirement at six months was best predicted by depression and daily hassles at work. In the case of injured workers, performance on functional capacity evaluation is reduced if the worker is informed that the test results will be used to determine work classification. Industrial injuries and compensation situations appear to provide a disproportionate number of individuals with such issues.³³

2.0a. Pain Rating Guidelines

Unique to the AMA Guides 5th Edition, is a chapter on rating pain, which allows additional ratings for subjective pain. This new methodology provides the rating physician leeway to add up to an additional 3% Whole Person impairment if the rater believes the individual to have a pain-related impairment that has "increased the burden of his or her condition slightly" or significantly.³⁴

The basic challenge for such a system of rating pain related impairments is to incorporate the subjectivity associated with pain into an impairment rating system, whose fundamental premise is that impairment assessment should be based on objective findings. The inherent subjectivity of pain is incongruent with the *Guides'* attempts to assess impairment on the basis of objective measures of organ dysfunction, as it requires that determinations of pain intensity and the restrictions imposed by it must be largely based on subjective patient's reports.³⁵

After reviewing the various philosophies, chapters and charts on pain, the Utah Impairment Rating committee expressed considerable concern that this new subjective methodology for awarding percentages of impairment for pain related behaviors has not been used and tested on a widespread basis, as have other impairment ratings systems.³⁶ The committee felt that adopting this subjective methodology would increase interrater variability, secondary litigation, and cost. With time, this concern appears to be justified.

It is the committee's belief that the statement as found in the 3rd, 4th and 5th Editions of the AMA Guides "The impairment ratings in the body organ system chapters make allowances for any accompanied pain" ³⁷ adequately considers pain. Therefore the committee recommended that until advances in diagnostic technology and clinical experience make pain related impairment ratings feasible for individuals with pain syndromes except for severe persistent *extraordinary* painful conditions as listed below, no additional award will be calculated for pain under Chapters 13, 15, 16, 17 and 18 of the AMA 5th Edition of the Guides, or for conditions rated by these UTAH Guidelines.

Impairment for pain can be considered for only those with severe persistent *extraordinary* painful conditions that are listed in this section and that are typical of a medical disorder that is well recognized, relatively uncommon, and that has persisted for a minimum of 6 months. These conditions are limited to and include 1) amputations with phantom pain, 2) headaches secondary to severe head trauma or skull fractures, and 3) post paraplegic pain.

For these conditions, the committee recommended adding an additional 5% whole person impairment to be combined with the final calculated impairment.

2.0a.i. Post Traumatic Head Syndrome. In order to qualify for severe post traumatic headaches, the head trauma would have to result in a sub or epidural hematoma, brain contusion seen on MRI, or a score of ≤ 10 on the Glasgow Coma Scale upon arrival in the emergency room shortly after injury. Because residual headaches are often associated with neck pain, the 5% whole person for post traumatic head syndrome encompasses any award from the Utah non surgical spinal section, schedule 1-b or 1-c or chapter 13 of the AMA 5th Edition (See example 6 in spine section).

2.0a.ii. Glasgow Coma Scale. ³⁸ The Glasgow Coma Scale is the most widely used scoring system used in quantifying level of consciousness following traumatic brain injury. It is used primarily because it is simple, has a relatively high degree of interobserver reliability, and because it correlates well with outcome following brain injury. ^{39 40}

A Coma Score of 15-13 indicates a mild brain injury, 12-9 a moderate injury, and 8 -3 a severe brain injury.

Glasgow Comma Scale

Chose one response in each category	Score
Eye Opening Response	
· Spontaneous	4
· To Speech	3
· To Pain	2
· None	1
Best Motor Response	
· Obeys Command	6
· Localizes Pain	5
· Flexor Withdrawal to Pain	4
· Abnormal Spastic Stereotypes Flexion Posture	3
· Extensor Response at Elbow	2
· No Movement	1
Verbal Response	
· Oriented Conversation	5
· Confused Conversation	4
· Inappropriate Words	3
· Incomprehensible Sounds	2
· No Vocalization	1
Total Score Possible	3 to 15

2.0a.iii. Examples of extraordinary pain syndromes.

Example 1: Twelve months ago, a 25 year-old male public transit worker fell under a moving rail car at work and incurred a complete below-the-knee amputation. His post-operative and rehabilitate course was unremarkable. He has been declared medically stable and is left with severe phantom leg pain (not just the common phantom leg sensations). His impairment is 80% lower extremity or 32% whole person for the amputation and 5% whole person for the accompanying extraordinary chronic pain. His total impairment is 35% whole person (32% combined with 5 %).

Example 2: 14 months ago a 34 year old male roofer fell 14 feet onto concrete, striking his head. He was found to be unconscious and taken to the emergency room, where his Glasgow Coma Scale was charted at 10 in the ER. He regained consciousness after 5 minutes in the ER and a MRI scan was found to be within normal limits. He was not admitted to the hospital. Over time he was plagued with persistent headaches that are significantly bothersome. He requires daily prophylactic medications and occasional abortive medications. He complains of neck pain, and with a MRI showing mild chronic spondylosis. He is seen for an impairment rating. He meets no other objective criteria for impairment. He would qualify for 5% whole person for his continual extraordinary painful condition of post traumatic headaches. The examiner would need to describe the frequency with which and the degree to which his ADLs are impacted by his headaches. There is no additional impairment for his neck pain under Schedule 1-b and 1-c.

2.0a.iv. Functional somatic syndromes that are not characteristic of any well-recognized medical disorder. Chronic Fatigue Syndrome: Myofascial Pain Syndrome, Fibromyalgia, Sick Building Syndrome, Multiple Chemical Sensitivity (Idiopathic Environmental Intolerance), Neurogenic Thoracic Outlet Syndrome, Spinal Subluxations not visible on MRI or CT scan, "Myositis" and "Fascitis" without objective findings, and other functional somatic syndromes are based on an individual's report of widespread subjective discomfort and reports of tenderness during physical examination. Despite extensive research, no specific underlying biological abnormality has been discovered to explain the reports of these people. In that the medical community has not achieved consensus on how to construe such conditions, these conditions are not to be rated.⁴¹

2.1 Utah's Chronic Regional Pain Syndromes (CRPS) Type 1 or 2

As discussed extensively by Barth and Bohr,⁴² CRPS-1-2 is a diagnosis that is plagued by problems with reliability and validity.^{43 44 45}

Recent research by Butler demonstrated that many of the clinical signs of CRPS can be produced in healthy volunteers with simply casting a limb for one month.⁴⁶

Unfortunately there is a significant lack of inter-physician reliability for these "signs" in CRPS, as well as for the diagnosis.^{47 48 49}

The treating physicians and those doing the impairment rating must be cognizant of the overlap of the diagnosis of CRPS and Pain Disorders as listed under the somatoform disorders, as in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR.⁵⁰

2.1a. Calculation of Impairment Rating in Utah

The Committee recommends that for the diagnosis of CRPS to be given, it must first meet the criteria as described in the AMA Guides 5th Edition 16.5e, p 495 for injured workers in Utah. Because of the poor inter-rater reliability, and because some signs/symptoms can be reproduced by cast immobilization, ratings specifically for CRPS are to be awarded only rarely, when there is a preponderance of findings to justify that level of impairment. Thus, only when at least 8 of the criteria listed in Table 16-16 (5th Edition, pg 496 Ibid) are met, can a rating be awarded. When applicable, the severity is first calculated as

described on pg 496 and 497, and using Table 16-10 (5th Edition pg 482 Ibid). Rather than using this value as the upper (or lower) limb impairment, that severity should be multiplied, by the amputation value for the area involved (Table 16-4, pg 440 for the upper limb and Table 17-32, pg 545 Ibid for the lower limb). The result is to be combined with any applicable rating for Range of Motion (ROM) loss. In cases where there are signs or symptoms of CRPS, but <8 criteria are met, other methods for rating should be applied, or Schedule IX, which is a stand alone rating, may be utilized.

Example 1:

A 33 year old female was involved in a MVA where the car she was driving was hit broadside on the left by a 1 ton delivery truck. Although she had no fractures, she had significant soft tissue trauma to her left wrist area. Over the course of 1 year, her hand and wrist continued to bother her with hyperalgesia from the wrist distally. In addition to marked loss of motion, she had signs of a much cooler, swollen and mottled hand, nail changes, and thin, hairless, non-elastic skin. Her radiographs were consistent with disuse osteoporosis. She was declared medically stable with a diagnosis of CRPS Type 1. She is seen for an impairment rating.

On physical examination, it is apparent she has significant objective pathology, consistent with CRPS Type 1 that historically is contiguous with her physical injury. She really does not meet the criteria for a somatoform or malingering disorder. Using Table 16-4 (amputation table) her Maximum impairment rating would be 92% upper extremity. This is multiplied by 40% from Utah's Schedules for Calculating Neurological Loss, Spine Section.

3	Diminished light touch with some abnormal sensations or pain, interfering with activity	40
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92% x 40 is 36% upper extremity. This value is combined with 18% for her loss of motion to her hand and wrist, equaling 48% upper extremity or 29% whole person.

Also see example 4 in the Lower Extremity Chapter.

2.2. Apportionment

It is important for physician/raters doing impairment ratings to be aware of some of the Utah laws to which they are reporting.

To facilitate this discussion and understanding, the standard terminology "prior impairment" will be used and replaces various other descriptors, such as: preexisting conditions, preexisting symptomatic conditions, previously existing conditions, and previously existing symptomatic conditions.

The allocation of damage among possible contributing causes is naturally imprecise. The chief problem is the lack of reliable measurement on body functions involved before and after each injury or point of damage. Measuring deterioration or limitation from non-occupational disease or from the aging process is also difficult.

Various assumptions are made and included based on reasonable medical probability, which in Utah generally means greater than 50% chance.

To arrive at the most reliable and valid conclusion, the rater needs information. Measurements on current physical condition can be ordered. Comparing these with previous measurements and history may be difficult. The physician may be constrained in what is available or what he or she can request. Unfortunately, data on prior injuries is often not available.

It should also be born-in-mind that prior permanent impairment requires the same standards as rating present permanent impairment. If because of lack of evidence a physician cannot reliably rate preexisting limits or reduced functions, the greater share of the compensation burden will fall on the current employer.

2.2a. When and How Impairment Benefits are Apportioned:

When a permanent impairment results from the addition or combination of a prior impairment with the existing impairment from the industrial accident, then the permanent impairment is apportioned (or distributed) between the current injury and the prior impairment condition(s). Physician/raters must understand that apportionment generally applies only to permanent impairments. Apportionment of the final rating is necessary if there is objective medical documentation that a prior ratable impairment existed before the industrial event for the same anatomical area, structure or condition. In order to apportion any condition as a prior impairment, the condition would need to have been ratable by either the AMA Guides or Utah's Impairment Guides before the industrial event and must be based on reasonable medical probability (i.e., greater than 50%). The total impairment is calculated and then the prior impairment is calculated and deducted. The remaining amount would then be due to the industrial accident.

Not all cases can be apportioned. If the physician cannot, with a reasonable degree of medical probability, estimate the level of impairment that would have existed, absent the injury, then the physician cannot apportion the final impairment.

Apportionment cannot be based solely on the existence of a disease, abnormality, or disorder. If a person has an occult disorder (spondylolysis, spondylolisthesis or significant degenerative changes, etc.) that would not have qualified for a rating before an event, then the final rating is not subject to apportionment. (Such a condition, while not clearly increasing the incidence of injury, does increase the morbidity, lessen the degree of recovery and increases the likelihood of surgery. Those issues that cannot be measured in any reasonable, objective way cannot qualify for an apportionment.)

2.2b. The Schedule to Use When Apportioning Preexisting Conditions

If an individual has received a prior rating from Utah's 1994, 1997, 2002, or Utah's 2006 Guides, the 4th or 5th Edition of the AMA Guides involving the same anatomical area as the industrial accident, then this prior rating would be subtracted from the new rating. If the person has received a prior rating for conditions from any other schedule than those listed above, the physician/rater is to subtract the prior rating from the new rating, up to the amount he/she *would have received for the same condition under this schedule*. If the person has a preexisting condition that is listed in these guidelines and has not been rated for this problem, the physician should use these guidelines to document, as best they can, a rating for the preexisting conditions, which is then subtracted from the current rating. (See Spine Example 24)

If the person has preexisting conditions that are not found in these guidelines and has not been rated for these problems, the physician should use the Fifth Edition of the AMA Guidelines with these 2006 Utah Supplemental Guides to document, as best they can, a rating for the pre-existing conditions, which is then subtracted from the current rating.

Schedule 4 What Schedule to Use When Apportioning Prior Ratable Conditions	
Patient has a prior ratable condition for the same body area being rated	What schedule to apply
For all conditions other than spine, if the prior impairment was calculated from the AMA's 4th or the 5th Edition Impairment Guides, or The 1994, 1997, 2002, or the 2006 Utah Guides	Subtract prior impairment directly for the new calculated impairment.
For spine ratings from the AMA's 4th or the 5th Edition Impairment Guides	Establish what the rating would have been under these "Utah's 2006 Guides." Subtract this % impairment from the total impairment %.
Prior impairment was calculated from any schedule other than the above:	Establish what the rating would have been under the schedule, "Utah's 2006 Guides." If the condition to be rated is not included there, use the AMA's Guides 5 th Edition. Subtract this % impairment from the total impairment %.
A prior condition existed that was never rated, but contributes to the final rating.	Establish what the rating would have been under this schedule, "Utah's 2006 Guides." If the condition to be rated is not included here, use the 5 th Edition. Subtract this % impairment from the total impairment %. If the condition is a non operative spine injury and it does not directly fit into schedule I (history of injury type, imaging findings and written information indicating that the prior injury would have resulted in functional work restrictions lasting >6 months), the physician rater is to use Schedule V to establish the rating, beginning at 5% for soft tissue injury, 7% for a spondylolisthesis, or 10% for a radiculopathy. After applying schedule 5 to the above condition, Subtract this % impairment from the total impairment %. (See examples 5, 14, 15, 19 and 24 in spine section.)

Chapter Three: Spinal Injuries and Conditions

3.0 Introduction

This is Chapter Three of a series of the Utah Labor Commission's Supplemental Guides and resources that have been developed by the Utah Labor Commission to assist workers' compensation authorities and physicians in the process of rating permanent impairments. Please see Chapter One for a general introduction and for principles of rating.

This part of the supplement deals with spinal injuries and conditions. The user should be aware that the use of Chapter Three may depend on, or amplify principles introduced in, Chapters One and Two. This is especially true of issues regarding the rating of pain.

The impairment methodology found within the current AMA Guides 5th Edition recommends two separate ways to calculate one rating. How one selects which method to use for rating remains subjective and unnecessarily complicated.ⁱ A number of studies have demonstrated that the spinal range of motion methodology lacks validity and reliability.^{iii iiiii iv ivi} Further studies have shown that spinal range of motion is non-reliable and dependent on the age and sex of the patient,^{lvii lviii} osteoarthritis,^{lix} the time of the day the measurements were taken,^{lx} and have no relationship to disability.^{lxi}

The implication is that impairments calculated using the current AMA Guides 5th Edition methodology is inaccurate and costly to employees, employers, and insurers who rely on the *AMA Guides'* system of assessment for legal and administrative determinations. With increased costs and emphasis on measurable outcomes, it is vital that unreliable methods not be accepted as "good enough" or "near enough."

With consideration of the medical literature and measurable outcomes, the Utah Impairment Rating Committee has further clarified the spinal DRE and ROM models found within the current AMA Guides 5th Edition, developed the methodology listed below. This methodology is based on Functional-Anatomic and Diagnosis Based (FAD) information and has been found to provide thousands of consistent and reliable spinal ratings for the past 6 years in the State of Utah.^{lxd}

3.1 Spine and Pelvis Conditions

Physicians are to use the following sections to rate patients with residual spinal problems from an industrial accident. With these *Utah Spinal Impairment Guides*, the patient is placed in the category that best describes his/her condition. The physician should not combine two impairments for the same spinal areas, except for completely different problems, which situation would be unusual. For example, if one has an L1 compression fracture and a herniated disc at L4, these would be regarded separately and combined. There will be unusual cases that do not fit these categories and they should be rated in relationship to and the utilization of these categories.

Before an impairment rating is considered, the patient must be medically stable. Medical stability, permanent and stationary, maximum medical improvement, (MMI), or fixed state of recovery,^{lxdii} refers to a date in which the period of healing has ended and the condition of the worker is not expected to materially improve or deteriorate by more than 3% Whole Person in the ensuing year.^{lxdv lxdv lxdvi lxdvii lxdviii} It is important to note that medical stability may not be used to terminate necessary medical care. The date of medical stability and the date when the worker qualifies for an impairment rating can be two separate dates.

The majority of patients with soft tissue spinal complaints resolve without any permanent residual injury. Regardless of the cause of back pain, approximately 70% of affected people recover in 2 to 3 weeks and 90% in 6 weeks (Andersson, Svensson, & Oden, 1983; Nachemson, 1982). This "recovery curve" plateaus at 6 months, and therefore it is the consensus of the impairment committee that before

considering any patient with residual soft tissue, developmental and degenerative spine complaints at MMI for impairment, their **symptoms must have been present for a minimum of six consecutive months.**

3.1a. Apportionment of Soft Tissue Impairment

We recognize that most impairment ratings are estimates. Apportionment in soft tissue spine impairments is particularly variable and unreliable. Schedule V, The Severity Indexing Schedule for Apportionment, in this guide is to be used with those with a prior history of non surgical back pain that does not meet the criteria for direct apportionment of Schedule I. Although Schedule V may have shortcomings, many variables have been considered by the Committee. Schedule V appears to be a reasonable and logical approach to improve uniformity and reliability.

Each spinal area involved, the cervical, thoracic, and lumbar is considered a one-organ system. All numbers *within* Schedules I or II are to be added. When ratings involve two or more spinal areas from Schedule I (Cervical-Thoracic and Thoraco Lumbar) or Schedule II (Cervical Thoracic and/or Lumbar) they are *combined*. When other organ systems are involved, such as neurological loss, their values are also combined with the spine.

3.1b. Spine Impairment Concepts

Following are some general definitions of key concepts used in this chapter.

- If a person has a clinically significant disc protrusion or extrusion excision, followed by a quiescent stabilized period and then, later, incurs a recurrent disc *at the same level*, this new protruded disc would be rated and the impairment rating for the initial disc injury/surgery would be apportioned from the current total impairment. This is true even though the circumstances that precipitated a recurrence may be minimal. There is no additional impairment for a recurrent disc treated conservatively, unless there is evidence of additional residual radiculopathy. [See Example 15]
- If a person has a disc herniation or excision followed by a stabilization period and later, incurs a herniation of a disc at a different level, the additional rating for the second herniation would be according to schedule I or II. The prior event should be included in the rating and apportioned off so the net result would be the same. [See Examples 15, 16, 24, 25]
- Add-ons for additional levels II-B, II-D and II-F can be applied only one time for the same level.
- Repeat explorations at the same level, or repeat fusions at the same level, only increase the impairment rating by 2% per surgery. [See II-C]
- If a person had only prior degenerative changes (no ratable conditions on Schedule V) and later he/she sustains a specific pathological condition, such as a herniated disc, no apportionment to the degeneration is made, as the previous condition was asymptomatic and not ratable.
- Two completely different spinal areas involved should be calculated separately and combined.

3.2 Spinal Translocation or Isolated Spinal Segmental Instability (ISSI)

Determining and awarding for ISSI has become a controversial issue that originated in the 3rd, 4th, and now the 5th Edition of the AMA Guides 5th Edition. The methodology currently utilized in the AMA Guides 5th Edition has a high rate of false-positive and false-negative tests.⁶⁹

Currently there is no universally accepted criterion for evaluating ISSI, with the medical literature reporting a large range of "normal" motion values and a significant overlap of symptomatic and asymptomatic motion patterns.^{70 71 72 73} ISSI is an *extremely rare condition* and is only seen with a significant history of severe trauma or severe preexisting degenerative disc disease (not with minor low speed motor vehicle accidents) the committee recommends that until a more practical, consistent and universally accepted methodology evolves for assessing ISSI, ratings for this condition are only to be given utilizing the other methods described in Schedule 1 of this spine section.

3.3 Schedules I – VI

This section contains a series of schedules that will assist in quantifying rating values for various spinal conditions

3.3a.SCHEDULE I-- SOFT TISSUE-NON SURGICALLY TREATED CONDITIONS BASED ON FUNCTIONAL-ANATOMIC and DIAGNOSTIC BASED CRITERIA (FAD) (Whole Person Impairment)		
Schedule I requires a minimum duration of six months of symptoms from the time of the injury to the impairment rating and no surgical intervention. The rater is to use only one condition from category 1A through IE, one time.		
Placement of a patient within one of these categories is dependent primarily on the history and physical findings. The examiner should also consider any "pain behaviors" that may be present. (See 5 TH Edition of the AMA Guides)	CERVICAL-THORACIC	THORACIC-LUMBAR
I-A. Medically documented injury event with subjective symptoms and clinical findings that are consistent with spinal pathology. No evidence of acute changes on imaging and no activity modifications required.	0%	
I-B. Medically documented minor injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology. May have evidence of none to minimal changes on imaging and may have permanent activity restrictions.	3%	
I-C. Medically documented moderate injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology. May have imaging evidence of moderate to severe changes. Likely to have permanent activity restrictions.	5%	
I-D. Medically documented moderate-severe injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology including imaging evidence of disc herniation(s) that displaced nervous tissue or spondylolysis with or without spondylolisthesis (Grade I or II). Should have permanent activity restrictions.	7%	
I-E. Medically documented moderate-severe injury event with subjective symptoms persisting for a minimum of six months with a spondylolisthesis, Grade III or IV.	8%	
ADD-ONS for above conditions in Schedule I. (Whole Person)		
I-F. Medically documented injury, subjective symptoms persisting for a minimum of six months, and clinical findings which are consistent with continued pain, decreased motion and Imaging evidence of a 2 nd disc herniation that displaces nervous tissue that has occurred from a 2 nd injury at another level than the first prior disc herniation, and neither disc herniation was treated surgically.	3% per level	
I-G. Neurological: Persisting Radicular Neurologic Deficit. If the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 15-15 and 15-16, modified from the AMA Guides 5 th Edition, and combine the new radiculopathy rating, in place of the 3% listed here. [See Radiculopathy Schedule]	3% for each involved nerve root (Combined)	

Notes:

*This schedule should only be used if no surgery has been performed.

** Injury events should be classified based on the following categories: Minor/Mild, Moderate, Severe/Significant

Minor: Sedentary to light work activity*, similar to common activities of daily personal living, e.g., picking up and handling light objects (less than 20 lbs), climbing stairs, using a computer for e-mail, or raking a lawn.

Moderate: Medium work activity that would be uncommon for normal personal activities, e.g., lifting 20 to 50 lbs, highly repetitive motions (hammering, cutting), sharp motions and twisting, falling or jumping 1 or 2 meters, or maintaining unusual or stressful positions (stooped posture) for longer than an hour.

Severe: Heavy to Very Heavy taxing work activity even for persons in the patient's occupation, e.g., lifting heavy weights (>50 to >100 lbs), being struck, uncontrolled falling over 3 meters, or repeated motions under very heavy loads.

3.3b. SCHEDULE II. SURGICALLY TREATED SPINE CONDITIONS BASED ON FUNCTIONAL-ANATOMIC and DIAGNOSTIC BASED CRITERIA (FAD) (Whole Person Permanent Impairment)	
For conditions found in Schedules II and IV, no amount of time is required from the injury to the calculation of impairment. Apportionment for conditions listed below is direct and Table V's methodology does not apply. (See Examples at the end of Chapter 2)	
Placement of a patient within one of these categories is dependent primarily on the history and physical findings. The examiner should also consider any "pain behaviors" that may be present as defined in the AMA Guides, 5 th Edition.	CERVICAL - THORACIC- LUMBAR
II-A. First minimally invasive spinal surgery such as a percutaneous or and endoscopic procedure done as an attempt to decompress a herniated disc, performed at one level in a given spinal region, for a significant disc abnormality, (Assigned one time per patient)	5% (one time per patient)
II-B. Minimally invasive spinal surgery, performed at another level than the first in a given spinal region, for significant disc abnormality,	2% (one time per disc)
II-C. First spinal surgery at one level in a given spinal region, including significant disc abnormality, posttraumatic changes, spondylolisthesis, instability, and spinal stenosis (includes foraminal stenosis). (Assigned one time per patient)	10% (one time per patient)
ADD-ONS for Schedule II-A. (Whole Person)	
II-D. Medically documented injury with continued pain, decreased motion, and imaging evidence of a 2 nd disc herniation that displaces nervous tissue and has occurred from the same or subsequent injury at a different level than the first disc herniation and this 2 nd disc space was treated either conservatively or surgically. This would also include surgery for posttraumatic changes, spondylolisthesis, segmental instability, and spinal stenosis. (This is applied only one time per level per patient and is not to be applied to levels explored, but not found to require partial discectomy or foraminotomy.)	Add 3% (one time per disc)
II-E. Second or subsequent spinal operation (not to include minimal invasive surgical procedures) in a given spinal region, including herniated discs, spondylolisthesis, segmental instability, and spinal stenosis.	Add 2% per operation
II-F. Spinal Fusions or placement of a single "artificial disc" (for the first level fusion that spans 2 vertebra).	Add 3% for first level (use one time only)
II-G. Fusions or placement with an "artificial disc," additional level(s) (i.e., a fusion that spans 3 or more vertebra). This is to be used only one time per level.	Add 2% for each additional level. This is to be used only one time per level
II-H. Neurological: Persisting Radicular Neurologic Deficit * (If, after 6 months, the neurological deficits exceed 3% WP, then calculate the deficits as described using tables 15-15 and 15-16 modified from the AMA Guides 5th Edition, and combine the new radiculopathy rating, in place of the 3% listed here.	Combine 3% for each involved nerve root
II-I. Minor procedures or operations, such as removal of internal fixation devices.	0%

* Dictionary of Occupational Titles, US Department of Labor Rev 4th Edition 1991

3.3c.SCHEDULE III. RADICULOPATHY BASED ON FUNCTIONAL-ANATOMIC and DIAGNOSTIC BASED CRITERIA (FAD)

Residual radicular pain >6months after surgery is usually investigated with post operative imaging. It is not the intent of this table to award 2 points for pre-operative imaging changes when the surgery has resulted in major improvement in the size of the herniation and the radicular pain.
(Must have a score greater than or equal to 3 to qualify)

Objective Testing	Documented Objective Findings at the Time of Rating	Score
Imaging	Significant disc protrusions that displace nerve tissue (which correlates with clinical picture) and/or bony/mechanical nerve root encroachment on the imaging	2
Muscle Involvement	Objective muscle weakness and/or thigh atrophy >2cm compared to uninvolved limb, or leg, arm, or forearm atrophy >1 cm	2
EMG Changes	Findings of fibrillation potentials and or high amplitude polyphasic potentials and decreased recruitment seen in at least 2 muscles in the distribution of a nerve root	2
Sensory Involvement	Reproducible alteration of sensation (sharp/dull, hot /cold, light touch,) consistent with specific dermatomal distribution	1
Reflex Changes	Loss of/or diminished deep tendon reflexes, (biceps-triceps-brachioradialis-patellar-or ankle jerk) as compared to non-affected side.	1
Tension –Compression Signs	Spurling's Sign ³ Straight Leg Raise ⁴ Femoral Stretch ⁵	1

³ Spurling's Sign is defined as pain in the distribution of a cervical nerve root that is produced by simultaneous neck extension, ipsilateral rotation, and axial compression.

⁴ Straight Leg Raise is defined as pain in the distribution of the L5 or S1 lumbar nerve root that is produced when the ipsilateral hip is flexed from 10 degrees to 70 degrees, while the knee remains in full extension.

⁵ Femoral Stretch is defined as a pain in the distribution of the L2-L3-L4 nerve root that is produced when the patient is prone, the involved knee is flexed and the hip extended.

3.3d. SCHEDULE IV. VERTEBRAL FRACTURES BASED ON FUNCTIONAL, ANATOMIC, and DIAGNOSTIC BASED CRITERIA (FAD)**(Whole Person Permanent Impairment)**

The impairments listed below are the same with or without surgery. The rater is to use only the highest ratings from either sections IV-A or IV-B or IV-C. Non-adjacent fractures at distinctly different areas may be rated separately and combined. Accompanying impairments to other organ systems are calculated separately and combined with the fracture impairment.

Schedules for fractures, spinal soft tissue and surgical procedures are mutually exclusive for a given spinal region.

COMPRESSION FRACTURE THAT REMAINS AT MEDICAL STABILITY

The impairments listed below are the same with or without surgery.

If surgery, fusion, vertebroplasty, or kyphoplasty is performed, the pre-operative compression percentage amount is used for the rating. Pre-existing compression fractures should be rated only when there has been aggravation by a new injury, shown by objective radiological findings of worsening of the pre-existing fracture. These values should be addressed as a pre-existing factor.

IV-A: % VERTEBRAL COMPRESSION FRACTURE	<i>VERTEBRA</i>		
	CERVICAL	THORACIC	LUMBAR
IV-A-1: 10% or less	3%	2%	3%
IV-A-2: 11% to 25%	6%	4%	4%
IV-A-3: 26% to 50%	14%	6%	10%
IV-A-4: Greater than 50% (Burst Fracture)	19%	9%	(Include T12 with Lumbar) 15%
IV-A-5: Fusion- If it is required to extend the fusion over more than two vertebra add			5% one time
IV-A-6: For multiple fractures listed in IV-A, with more than one level involved			Add 2% for each additional fracture
IV-A-7: Radiculopathy * (If, after 6 months, the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 15-15 and 15-16 modified from the AMA Guides 5 th Edition, and combine the new radiculopathy rating, in place of the 3% listed here.			Combine 3% one time

IV-B: X-RAY EVIDENCE OF VERTEBRAL BODY FRACTURE WITH ASSOCIATED FRACTURES/DISLOCATIONS INVOLVING POSTERIOR ELEMENTS (REGARDLESS OF DEGREE OF VERTEBRAL COMPRESSION)

Including Those Fractures Which Involve the Pedicle, Lamina, Articular Process, Transverse or Spinous Process.

IV-B-1 No Surgery is performed and reduction is to normal or "anatomic" position	6%
IV-B-2: Surgery performed and reduction is to normal or "anatomic" position (Includes fusion)	14%
IV-B-3: No surgery performed and reduction is not to normal or "anatomic" position	17%
IV-B-4: Surgery performed with significant persisting bony deformity (includes fusion)	20%
IV-B-5: Fusion- If it is required to extend the fusion more than three vertebra add	5% one time
IV-B-6: For multiple fractures listed in IV-B, with more than two vertebrae involved	Add 3% one time
IV-B-7: Persisting Neurologic Deficit * (If, after 6 months, the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 15-15 and 15-16 modified from the AMA Guides 5 th Edition, and combine the new radiculopathy rating, in place of the prior 3%	Combine 3% one time

*See Radiculopathy Schedule page 42

3.3d.SCHEDULE IV. VERTEBRAL FRACTURES (Whole Person Permanent Impairment)

The impairments listed below are the same with or without surgery. If a fracture(s) is healed without any symptoms and without any functional limitations, without functional impairment there is no rating given. If there are no symptoms, no limitations with either a fracture or soft tissue injury, then an impairment award is not justified. Rater is to use only the highest ratings from either sections IV-A or IV-B or IV-C. Non-adjacent fractures at distinctly different areas may be rated separately and combined. Accompanying impairments to other organ systems are calculated separately and combined with the fracture impairment.

IV-C: OTHER FRACTURES NOT LISTED ABOVE: Fractures of Posterior Elements only, without vertebral body involvement

The below listed impairments are the same with or without surgery.

IV-C-1. Fracture of one or more transverse processes or spinous processes healed without significant displacement or symptoms.	0%
IV-C- 2. Fracture of one or more transverse processes or spinous processes fractures with or without displacement BUT WITH persistent symptoms remaining>6 months.	5%
IV-C-3. Fracture of posterior elements, healed without displacement or symptoms.	0%
IV-C-4. Fracture of Posterior element, healed with or without displacement, but requiring spinal surgical intervention.	10%
IV-C-5. Fracture of posterior elements healed with or without displacement requiring surgical fusion.	Add 3%
IV-C-6. Fusions over more than two vertebra add: (This is not to be used in conjunction with IV-A-5.)	5% one time
IV-C-7. Persisting Neurologic Deficit * (If, after 6 months, the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 15-15 and 15-16. (Modified from the AMA Guides 5 th Edition and combine the new radiculopathy rating, in place of the 3% listed here.)	Combine 3% one time

*See Radiculopathy Schedule

3.3e. Severity Indexing for Spine Injuries Schedule 1, Apportionment

It is recognized that impairment ratings involve best estimates. Arriving at apportionment for spine impairments in the past has been extremely variable and unreliable. While Schedule V (Severity Indexing for apportionment of Schedule I) may have some shortcomings, many variables have been considered and it appears to be a reasonable and logical approach to improve uniformity and reliability.

3.3f. Process to Apportion from Schedule I

Schedule V only applies to non operative spine conditions. If the prior condition is not ratable in these impairment guides (does not have a documented history of the type of injury, imaging findings and written information indicating that the prior injury would have resulted in functional work restrictions lasting >6 months), the physician rater is to use Schedule V. The rater is to calculate the rating, beginning at 5% for all soft tissue spinal injuries, 7% for a spondylolisthesis, or 10% for a documented radiculopathy. After applying Schedule V, the rater is to subtract this prior impairment from the new calculated total impairment. (See examples 5, 14, 15, 19 and 24 in spine section.)

SCHEDULE V. SEVERITY INDEXING FOR APPORTIONMENT OF SCHEDULE I BASED ON FUNCTIONAL, ANATOMIC, and DIAGNOSTIC BASED CRITERIA (FAD) (This applies only to the Impairment Process/Disability Process.) Schedule I requires a minimum of six months duration of symptoms, from the time of the injury and the impairment rating.			
	0	1pt.	2pts.
V-A. Time lost from work in the last 12 months because of symptoms in the same spinal region	0	1-3 days	>3 days
V-B. Number of prior episodes in the same spinal region	0	1-3	>3
V-C. Time elapsed since last episode/injury	>3 years	1-3 Years	<1year
V-D. Prior permanent work restrictions because of problems in the same spinal region	None	Temporary	Permanent
V-E. Prior objective testing to the same spinal region: EMG-NCV, X-ray, MRI-CT, Bone Scan	0	If any performed prior to 2 years	If any performed within the last 2 years
V-F. Prior to latest claim, what ongoing medical, chiropractic visits, physical therapy visits were received for an injury to the same spinal region	0 -2 times in last 3 yrs	3-6 times in last 3 yrs	>6 in last 3 yrs
V-G. Spondylolysis with Spondylolisthesis		<25% slip	>25% Slip
V-H. Radiculopathy at same level (as objectified by Radiculopathy Schedule)	No History		Prior History

Formula for apportionment using points generated in Schedule V:

1-2 pts. = no apportionment

3pts. = 10% may be apportioned off as a prior ratable condition

4pts. = 20% may be apportioned off as a prior ratable condition

5pts. = 30% may be apportioned off as a prior ratable condition

6pts. = 40% may be apportioned off as a prior ratable condition

7pts. = 50% may be apportioned off as a prior ratable condition

8pts. = 70% may be apportioned off as a prior ratable condition

9pts. = 90% may be apportioned off as a prior ratable condition

≥10 pts. = 100% may be apportioned off as a prior ratable condition

Summary of Basic Principles of Apportionment

- Apportionment applies only to permanent impairment
- *Impairment that directly results from the current injury being evaluated is not apportioned*
- Ratable impairment that existed prior to the injury is subject to apportionment
- In all cases, the criteria for apportionment may not be speculative

Actual factors of prior impairments are to be discussed with sufficient reason in support of the apportionment.

3.3g. SCHEDULE VI. THE PELVIS (Whole Person Permanent Impairment)	
Healed fracture without displacement or residual symptoms ...0%	Healed fracture(s) with or without displacement, deformity, and residuals symptoms(s) involving:
Healed fracture with displacement and without residual symptoms(s) involving:	a. Single ramus.....2%
a. Single ramus.....0%	b. Rami, bilateral and /or superior and inferior.....5%
b. Rami, bilateral.....0%	c. Ilium2%
c. Ilium.....0%	d. Ischium, displaced 1 inch or more10%
d. Ischium.....0%	e. Symphysis pubis, displaced or separated15%
e. Symphysis pubis, without separation.....0%	Sacrum.....5%
f. Sacrum.....0%	f. Sacrum, into sacroiliac joint or sacroiliac joint dislocation with anatomic reduction.....10%
g. Coccyx.....0%	g. Sacroiliac joint dislocation with NON-anatomic reduction15%
	h. Coccyx, non-union or excision..... 5%
	i. Coccyx, displacement.....3%*
	j. Fracture into acetabulum.....Evaluate according to hip

3.3h. Schedules for Calculating Neurological Loss

The methodology and schedules to be used in the calculation of neurological loss is contained in the Spine section of the 5th Edition of the AMA Guides 5th Edition, page 424 with the following simplification of tables.

SENSORY DEFICITS CLASSIFICATION FOR DETERMINING IMPAIRMENT DUE TO NERVE ROOT DISORDERS (Severity Multiplier)		
Class	Description of sensory loss or pain	% Sensory
5	No loss of sensibility, abnormal sensation, or pain	0
4	Diminished light touch with or without minimal abnormal sensations or pain, forgotten during activity	20
3	Diminished light touch with some abnormal sensations or pain, interfering with activity	40

SENSORY DEFICITS CLASSIFICATION FOR DETERMINING IMPAIRMENT DUE TO NERVE ROOT DISORDERS (Severity Multiplier)		
2	Decreased protective sensation (sharp dull discrimination) with abnormal sensations or moderate pain that may prevent some activity	60
1	Deep pain present, but no protective sensation (no sharp dull discrimination), severe pain or that prevents most activity	80
0	Absent sensibility, abnormal sensations or severe pain that prevents all activity	100

* Adapted and modified from the AMA Guides 5th Edition, Table 15-15, page 424

Schedule MOTOR DEFICITS CLASSIFICATION FOR DETERMINING IMPAIRMENT DUE TO LOSS OF FUNCTION RESULTING FROM NERVE DISORDERS (Upper or Lower Extremity Value)		
Class	Description of Muscle Function	% Motor Deficit
5	Active movement against gravity with full resistance	0
4	Active movement against gravity with some resistance	20
3	Active movement against gravity only without resistance	40
2	Active movement with gravity eliminated	60
1	Slight contraction and no movement	80
0	No contractions	100

* Adapted and modified from the AMA Guides 5th Edition, Table 15-16, page 424

3.3i. Spine with Associated Severe Neurological Injuries

For consistency in evaluating spinal impairments with associated severe neurological involvement, the following should be used whenever possible, eliminating the need for multiple system evaluations. (These are best applied in more isolated circumstances or for other conditions.) They are included by identification or implications in the categories as listed below. For spinal conditions with related impairments that clearly fall within the following classifications, use the AMA Guides 5th Edition, "Rating Corticospinal Tract Damage" (page 395) and the related text in these Guides.

3.4 Schedule Forms

The following schedule forms may be of assistance to the rating physician. It is recommended that the following applicable forms, along with supporting documentation, be submitted for spine impairments ratings:

- Schedule I Form for Computing Spinal Impairments
- Schedule II Form for Computing Surgical Spinal Impairments

**3.4a. FORM FOR COMPUTING SPINAL IMPAIRMENTS – SCHEDULE I
BASED ON FUNCTIONAL, ANATOMIC, and DIAGNOSTIC BASED CRITERIA (FAD)**
Use this schedule if no surgery has been performed.

Patient's Name:		Date:	
Placement of a patient within one of these categories is dependent primarily on the history and physical findings. The examiner should also consider any "pain behaviors" that may be present.		CERVICAL- THORACIC	THORACIC- LUMBAR
I-A. Medically documented minor/mild injury and subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology. No evidence of acute changes on imaging and none to minimal activity modifications required.	0%		
I-B. Medically documented minor injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology. May have evidence of none to minimal changes on imaging and may have permanent activity restrictions.	3%		
I-C. Medically documented moderate injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology. May have imaging evidence of moderate to severe changes. Likely to have permanent activity restrictions.	5%		
I-D. Medically documented moderate-severe injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology including imaging evidence of disc herniation(s) that displaced nervous tissue or spondylolysis with or without spondylolisthesis (Grade I or II). Should have permanent activity restrictions.	7%		
I-E. Medically documented moderate-severe injury event with subjective symptoms persisting for a minimum of six months with a spondylolisthesis, Grade III or IV.	8%		

ADD-ONS for conditions in Schedule I-D. or 1-E. (Whole Person)			
I-F. Medically documented injury, subjective symptoms persisting for a minimum of six months, and clinical findings which are consistent with continued pain, decreased motion and Imaging evidence of a 2 nd disc herniation that displaces nervous tissue that has occurred from a 2 nd injury at another level than the first prior disc herniation, and neither disc herniation was treated surgically.	3%		
Add Impairment (Total Amount for Spine):			
I-G. Persisting Radicular Neurologic Deficit * If, the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 15-15 and 15-16 modified from the AMA Guides 5 th Edition, and combine the new radiculopathy rating, in place of the 3% listed here.	3% Com bined		
Total Impairment Value Without Apportionment:			
Apportionment:			
Final Impairment Related to the Last Event:			
Signature and Title of Physician doing Rating:			

* See Radiculopathy Schedule

3.4b. FORM FOR COMPUTING SURGICAL SPINAL IMPAIRMENTS – SCHEDULE II BASED ON FUNCTIONAL, ANATOMIC, and DIAGNOSTIC BASED CRITERIA (FAD) Use for surgically treated spine conditions.				
Patient's Name:		Date:		
Injury Events		Initial Event	Second Event	Third Event
II-A. First minimally invasive spinal surgery such as a percutaneous or and endoscopic procedure done as an attempt to decompress a herniated disc, performed at one level in a given spinal region, for a significant disc abnormality. (Assigned one time per patient)	5%			
II-B. Minimally invasive spinal surgery, performed at another level than the first in a given spinal region, for significant disc abnormality (one time per disc).	2%			
II-C. First spinal surgery at one level in a given spinal region, including significant disc abnormality, posttraumatic changes, spondylolisthesis, instability, and spinal stenosis (includes foraminal stenosis). (Assigned one time per patient)	10% (one time per patient)			
ADD-ONS for Schedule II-A. (Whole Person)				
II-D. Medically documented injury with continued pain, decreased motion, and imaging evidence of a 2 nd disc herniation that displaces nervous tissue and has occurred from the same or subsequent injury at a different level than the 1st disc herniation and this 2 nd disc space was treated either conservatively or surgically. This would also include surgery for posttraumatic changes, spondylolisthesis, segmental instability, and spinal stenosis. (This is applied only one time per level per patient and is not to be applied to levels explored, but not found to require partial discectomy or foraminotomy.)	Add 3% (one time per level per patient)			
II-E. Second or subsequent spinal operation (not to include minimal invasive surgical procedures) in a given spinal region, including herniated discs, spondylolisthesis, segmental instability, and spinal stenosis.	Add 2% per operation			
II-F. Spinal Fusions or placement of a single "artificial disc" (for the first level fused that spans 2 vertebra).	Add 3%			
II-G. Fusions or placement with an "artificial disc," additional level(s) (i.e., a fusion that spans 3 or more vertebra). This is to be used only one time per level.	Add 2%			
II-I. Minor procedures or operations, such as uncomplicated removal of internal fixation devices.	0%			
Add Impairment (Total Amount for Spine):				
II-H. Neurological: Persisting Radicular Neurologic Deficit (If, after 6 months, the neurological deficits exceed 3% WP, then calculate the deficits as described using tables 15-15 and 15-16 modified from the AMA Guides 5 th Edition, and combine the new radiculopathy rating, in place of the 3% listed here. [See Radiculopathy Schedule])	3% Combined			
Total Impairment Value Without Apportionment:				
Apportionment:				
Final Impairment Related to the Last Event:				
Signature and Title of Physician doing Rating:				

3.5 Examples of Spine Impairments

Experiences of the authors have shown that a series of examples (clinical scenarios) can greatly assist the practitioner in the calculation of impairment ratings. Included are 28 specific examples of spine injuries and rating methods.

Example 1: Mechanical Back Pain

A 34 year-old construction worker sustained a relatively minor low back event/injury six months ago after he lifted a 10-foot 2 x 4 off the ground. He had a course of physical therapy, medications, and chiropractic physician visits. Although he continued to work, he had subjective complaints of intermittent low back pain and over-the-counter medications are occasionally used. He was declared medically stable and released to full duty. X-rays were normal.

EXAMPLE 1	
SCHEDULE I FORM FOR COMPUTING SPINAL IMPAIRMENTS (Whole Person)	THORACIC-LUMBAR
I-A. Medically documented minor/mild injury and subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology. No evidence of acute changes on imaging and none to minimal activity modifications required.	0%
Final Impairment Related to the Last Event:	0%

Example 2: Mechanical Back Pain

A 23 year-old construction worker had a low-back injury claim six months ago following a slip on the ice wherein he landed on his buttocks. He had no known medical history of prior back pain. His x-rays were read as normal and he has undergone a course of physical therapy and medications. Although he has continued to work, he still complains of intermittent low-back pain with referred pain into the back of the legs that does not go into his feet. These symptoms remained consistent without any pain behaviors noted. He uses primarily over-the-counter medications, but occasionally requires a prescription anti-inflammatory. Occasionally he uses an L.S. brace to work. He was declared medically stable and released to full duty.

EXAMPLE 2	
SCHEDULE I FORM FOR COMPUTING SPINAL IMPAIRMENTS	THORACIC-LUMBAR
I-B. Medically documented minor injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology. May have evidence of none to minimal changes on imaging and may have permanent activity restrictions.	3%
Add Impairments:	3%
Apportionment (The amount apportioned from Schedule I must agree with Schedules I & V):	
Impairment Related to the Last Event:	3%

Example 3: Mechanical Back Pain

A 44 year-old female has a history of a low-back injury claim incurring six months ago, when a 3 foot bar stool collapsed under her at work and she landed on her buttocks. She had no known history of prior back trouble. She had a course of physical therapy and medications. She continued to complain of intermittent low back pain with referred pain into the back of the legs that does not go into her feet. She missed some time at work and now mostly uses a prescription anti-inflammatory and occasionally an L.S. brace to work. Her physical examination did not demonstrate any neurological deficit. She was declared medically stable and with a permanent 30-lb occasional lifting weight-restriction based on pain tolerance. X-rays show moderate to severe disc space narrowing.

EXAMPLE 3 SCHEDULE I FORM FOR COMPUTING SPINAL IMPAIRMENTS		THORACIC- LUMBAR
I-C. Medically documented moderate injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology. May have imaging evidence of moderate to severe changes. Likely to have permanent activity restrictions.		5%
Add Impairments:		5%
Apportionment (The amount apportioned from Schedule I must agree with Schedules I & V):		
Impairment Related to the Last Event:		5%

Example 4: Mechanical Back Pain with Referred Pain

Six months ago, a 48 year-old male had a low-back injury claim after he lifted an 80-lb concrete panel. He had a course of physical therapy, medications, and chiropractic physician's care. He continued to work, still complaining of intermittent low back pain with referred pain into the back of the legs, which radiated into the lateral aspect of his right leg. He did not have reflex changes, weakness, or dermatomal sensory changes. He occasionally missed some time from work and mostly uses a prescription anti-inflammatory and an L.S. brace at work. He was declared medically stable with a permanent 50-lb occasional weight restriction, based on pain tolerance. X-rays showed early degenerative disc disease, with a MRI scan showing a disc bulge at L4-L5 touching, but not displacing the nerve roots. He had no prior significant history of prior back injury and exhibited no pain behaviors.

EXAMPLE 4 SCHEDULE I FORM FOR COMPUTING SPINAL IMPAIRMENTS (Whole Person Permanent Impairment)		THORACIC LUMBAR
I-C. Medically documented moderate injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology. May have imaging evidence of moderate to severe changes. Likely to have permanent activity restrictions.		5%
Add Impairments:		5%
Apportionment (The amount apportioned from Schedule I must agree with Schedules I & V):		
Impairment Related to the Last Event:		5%

Discussion: Although this patient has subjective referred pain into the lateral aspect of his right leg, this alone does not qualify as a radiculopathy.

Example 5: Mechanical Back Pain with Referred Pain and with Prior History

A 48 year-old male injured his back six months ago lifting an 80-lb concrete panel. He had a course of physical therapy, medications, and chiropractic physician's care. Although he continued to work, he still complains of intermittent low-back pain with referred pain into the back of the legs, which does go into the lateral aspect of his right foot. He did not have reflex changes, weakness, dermatomal sensory changes, or signs of pain behavior. He occasionally missed work. He has been declared medically stable with a permanent 50-lb occasional weight restriction, based on pain tolerance. X-rays showed early degenerative disc disease, with a MRI scan showing a disc bulge at L4-L5 touching, but not displacing the nerve roots. He had two prior episodes of back pain, one 4 years ago in which he had no lost time and a second episode 1 year ago, with lost time of three days. He had ten chiropractic physician visits for the episode 1 year ago, with a CT scan completed then. Prior to his latest injury, he had formally been given no permanent work restrictions.

Because he had no prior history of ongoing functional limitations >6 months, Schedule V would apply, beginning at 5% whole person.

SCHEDULE V. SEVERITY INDEXING FOR APPORTIONMENT OF SCHEDULE I (This applies only to the Impairment Process.)			
If the history was significant enough to automatically qualify for a rating in these <i>UTAH Guides</i> , apportion directly. See Chapter 1 of this guide for methodological notes on apportionment.			
Score	0	1pt.	2pts.
V-A. Time Lost from Work in the Last 12 Months Because of Symptoms in the Same Spinal Region	0	1-3 days	>3 days
V- B. Number of Prior Episodes in the Same Spinal Region	0	<u>1-3</u>	>3
V-C. Time since Last Episode/Injury	0	<u>1-3 Years</u>	<1year
V- D. Prior Permanent Work Restrictions Because of Problems in the Same Spinal Region	<u>None</u>	Temporary	Permanent
V-E. Prior Objective Testing to the Same Spinal Region: EMG-NCV, X-ray, MRI-CT, Bone Scan	0	If ever taken	<u>If taken within the last 2 years</u>
V-F. Prior to latest claim, what ongoing Medical, Chiropractic Visits, Physical Therapy Visits were received for an injury to the Same Spinal Region	0 -2 times in last 3 yrs	3-6 times in last 3 yrs	<u>>6 in last 3 yrs</u>
V-G. Spondylolysis with Spondylolisthesis		<25% slip	>25% Slip
V-H. Radiculopathy (As objectified by Radiculopathy Schedule)			Prior History

1-2 pts. = no apportionment

3pts. = 10% may be apportioned off as a prior ratable condition

4pts. = 20% may be apportioned off as a prior ratable condition

5pts. = 30% may be apportioned off as a prior ratable condition

6pts. = 40% may be apportioned off as a prior ratable condition

7pts. = 50% may be apportioned off as a prior ratable condition

8pts. = 70% may be apportioned off as a prior ratable condition

9pts. = 90% may be apportioned off as a prior ratable condition

≥10 pts. = 100% may be apportioned off as a prior ratable condition

EXAMPLE 5 SCHEDULE I FORM FOR COMPUTING SPINAL IMPAIRMENTS (Whole Person Permanent Impairment)		THORACIC- LUMBAR
I-C. Medically documented moderate injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology. May have imaging evidence of moderate to severe changes. Likely to have permanent activity restrictions.		5%
Add Impairments:		5%
Less Apportionment= 6 pts from table V = 40%, 40% of 5% (I-C.) = 2% WP		- 2%
Impairment Related to the Last Event:		3%

Example 6: Cervical-Thoracic Pain without Radiculopathy

Six months ago while at work, a 28 year-old male was sitting in the driver's seat of the vehicle he was driving, waiting at a red light, when he was struck from behind by a pickup truck traveling approximately 50 miles per hour. His diagnostic workup included plain x-rays and a MRI, which demonstrated moderate degenerative disc disease with desiccation and moderate bulges. He was treated with chiropractic manipulation, physical therapy, anti-inflammatories, and muscle relaxers. Although these treatments helped, he continued to complain of neck pain and mid-scapular pain, with associated headaches. He continued with occasional medication and he had to permanently modify his occupation to avoid extensive overhead work. His physical examinations did not disclose any overt pain behaviors and he had no prior history of cervical or thoracic injuries.

EXAMPLE 6 SCHEDULE I FORM FOR COMPUTING SPINAL IMPAIRMENTS (Whole Person Permanent Impairment)		CERVICAL- THORACIC
I-C. Medically documented moderate injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology. May have imaging evidence of moderate to severe changes. Likely to have permanent activity restrictions.		5%
Add Impairments:		5%
Apportionment (The amount apportioned from Schedule I must agree with Schedules I & V):		
Impairment Related to the Last Event:		5%

Discussion: Although he continues to have pain in both the cervical and thoracic area, these are both considered under I-C and awarded 5% Whole Person (WP). Any additional impairment for headaches would not be awarded.

Example 7: Cervical-Thoracic Pain without Radiculopathy and With Clinical Manifestations of Overt Pain Behaviors

Six months ago while at work, a 32 year-old female was sitting in the driver's seat, waiting at a red light, when she was struck from behind by a pickup truck traveling approximately 5 miles per hour, incurring no damage to either vehicle. She continued to complain of neck and thoracic pain. Her diagnostic workup included plain x-rays and a MRI, which were found to be within normal limits. She was treated with chiropractic manipulation, physical therapy, anti-inflammatories, and muscle relaxers. Although these treatments helped, she continued to complain of neck and mid-scapular pain, with associated headaches. She required occasional medication and was given permanent activity restrictions to avoid extensive overhead work, based on pain tolerance. Her physical examinations demonstrated pain behavior with

both verbal and non-verbal communication of distress and suffering, including embellishing her medical history, exaggerated pain drawings, and providing responses on the physical examination inconsistent with known physiology. She denies any prior trauma or symptoms to this area.

EXAMPLE 7 SCHEDULE I FORM FOR COMPUTING SPINAL IMPAIRMENTS		CERVICAL-THORACIC
I-B. Medically documented minor injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology. May have evidence of none to minimal changes on imaging and may have permanent activity restrictions.	3%	
Add Impairments:	3%	
Apportionment (The amount apportioned from Schedule I must agree with Schedules I & V):		
Impairment Related to the Last Event:	3%	

Discussion: Residual symptoms in both the cervical and thoracic areas are both considered under I-B and awarded 3% WP. For ratings that fall between categories, pain behaviors may be considered for placement in a lesser impairment percentage category.

Example 8: Low-Back Pain with Radiculopathy (No Surgery)

A 53 year-old female dockworker injured her lower back while lifting an 80-lb box eight months ago. She initially had pain into her right leg down to the ball of her foot, with associated numbness, tingling, and weakness. She underwent a MRI, which demonstrated a L5-S1 HNP with right S1 nerve root displacement. Treatment has included an epidural steroid injection, physical therapy, medications, and bracing. She now has been declared medically stable with persisting back pain and occasional radiation pain symptoms down to the ball of her foot. She was released for work with permanent restrictions of occasional lifts of 40 lbs. Her physical exam continued to show an absent right ankle jerk, straight leg lift at 40 degrees, and leg atrophy of 2 cm comparing right to left. She has no significant history of back problems.

EXAMPLE 8 SCHEDULE I FORM FOR COMPUTING SPINAL IMPAIRMENTS		THORACIC-LUMBAR
I-D. Medically documented moderate-severe injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology including imaging evidence of disc herniation(s) that displaced nervous tissue or spondylolysis with or without spondylolisthesis (Grade I or II). Should have permanent activity restrictions.	7%	7%
Add Impairment: (Total Amount for Spine)		7%
I-G. Neurological: Persisting Radicular Neurologic Deficit. If the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 15-15 and 15-16 modified from the AMA Guides 5 th Edition, and combine the new radiculopathy rating, in place of the 3% listed here.	3% Combined	3%
Total Impairment Value Without Apportionment:		10%
Apportionment (The amount apportioned from Schedule I must agree with Schedules I & V):		
Final Impairment Related to the Last Event:		10%

This patient should be followed up at one year to assess for any additional radiculopathy that may be present.

*See Radiculopathy Schedule.

Example 9: Low-Back Pain (Post-Surgery)

A 48 year-old female dockworker injured her low back while lifting an 80-lb box nine months ago. She initially had pain into her right leg down to the ball of her foot, with associated numbness, tingling, and weakness. She underwent a MRI, which demonstrated a L5-S1 HNP with a right S1 nerve root displacement. Treatment included an epidural, physical therapy, medications, bracing, and eventually an L5-S1 discectomy four months ago. She has been declared medically stable and released for work with restrictions as tolerated. Her physical exam has essentially returned to normal except for her Achilles reflex, with complaints of occasional back and leg pain, stopping at the knee. She had no significant history of prior back pain.

EXAMPLE 9 SCHEDULE II. USE FOR SURGICALLY TREATED SPINE CONDITIONS		Initial Event
II-C. First spinal surgery at one level in a given spinal region, including significant disc abnormality, posttraumatic changes, spondylolisthesis, instability, and spinal stenosis (includes foraminal stenosis). (Assigned one time per patient.)	10% one time per patient	10%
Add Impairments:		10%
Apportionment:		
Final Impairment Related to the Last Event:		10%

Example 10: Low-Back Pain with Radiculopathy (Post-Surgery)

A 35 year-old female warehouse worker injured her low back while lifting a 50-lb box eight months ago. She initially had pain into her right leg down to the ball of her foot, with associated numbness, tingling, and weakness. She underwent a MRI, which demonstrated a L5-S1 HNP with a right S1 nerve root displacement. Treatment included an epidural steroid injection, physical therapy, medications, bracing, and surgical discectomy at L5-S1. She now has been declared medically stable and released for work with permanent restrictions permitting occasional lifts of 40 lbs. Her physical exam continues to show an absent right ankle jerk. Straight leg lift at 30 degrees produces radicular leg pain in a S1 pattern. She has leg atrophy of 2 cm comparing right to left. She has had no significant history of prior back pain.

EXAMPLE 10 SCHEDULE II. USE FOR SURGICALLY TREATED SPINE CONDITIONS		Initial Event
II-C. First spinal surgery at one level in a given spinal region, including significant disc abnormality, posttraumatic changes, spondylolisthesis, instability, and spinal stenosis (includes foraminal stenosis). (Assigned one time per patient.)	10% one time per patient	10%
Add Impairment (Total Amount for Spine):		10%
II-H. Neurological: Persisting Radicular Neurologic Deficit * (If, after 6 months, the neurological deficits exceed 3% WP, then calculate the deficits as described using tables 15-15 and 15-16 modified from the AMA Guides 5 th Edition, and combine the new radiculopathy rating, in place of the 3% listed here. [See Next Schedule]*)	3% Combined	3%
Add Impairments:		13%
Apportionment:		0
Final Impairment Related to the Last Event:		13%

This patient should be followed up at one year to assess for any additional radiculopathy that may be present.

*See Radiculopathy Schedule.

Example 11: Low Back Pain with Foot Drop (Post-Surgery with persistent radicular findings that exceed 3% whole person.

A 35 year-old female warehouse worker injured her low back while lifting a 50-lb box. She initially had pain into her right leg down to the lateral aspect of her leg, with associated numbness, tingling, and the inability to dorsiflex her foot against gravity. She had a MRI, which demonstrated a L4-L5 HNP with right L5 nerve root displacement. Treatment included an epidural steroid injection, physical therapy, medications, bracing, and surgical discectomy at L4-L5. She was declared medically stable and released for work with permanent restrictions permitting occasional lifts of 20 lbs. Her physical exam demonstrated the inability to dorsiflex her right foot through a full range of motion against gravity. She was required to wear a dorsiflexion assist brace. She has leg atrophy of 2 cm comparing right to left. Her pain was minimal, but she did have decreased light touch perception and decreased sharp-dull recognition in the L5 distribution. She had no significant history of prior back pain and is now one year post-surgery.

SENSORY DEFICITS* CLASSIFICATION FOR DETERMINING IMPAIRMENT DUE TO NERVE ROOT DISORDERS (Severity Multiplier)		
Class	Description of sensory loss or pain	% Sensory
5	No loss of sensibility, abnormal sensation, or pain	0
4	Diminished light touch with or without minimal abnormal sensations or pain, forgotten during activity	20
3	Diminished light touch with some abnormal sensations or pain, interfering with activity	40
2	Decreased protective sensation (sharp dull discrimination) with abnormal sensations or moderate pain that may prevent some activity	60
1	Deep pain present, but no protective sensation (no sharp dull discrimination), severe pain or that prevents most activity	80
0	Absent sensibility, abnormal sensations or severe pain that prevents all activity	100

* Adapted and Modified from the AMA Guides 5th Edition, Table 15-15, page 424

Sensory component, = 60% of nerve multiplied by the L5 Sensory Nerve Root value, 5%, (see page 424, Table 15-15) = 3% Lower Extremity

MOTOR DEFICITS CLASSIFICATION FOR DETERMINING IMPAIRMENT DUE TO LOSS OF FUNCTION RESULTING FROM NERVE DISORDERS (Upper or Lower Extremity Value)		
Class	Description of Muscle Function	% Motor Deficit
5	Active movement against gravity with full resistance	0
4	Active movement against gravity with some resistance	20
3	Active movement against gravity only without resistance	40
2	Active movement with gravity eliminated	<u>60</u>
1	Slight contraction and no movement	80
0	No contractions	100

* Adapted and Modified from the AMA Guides 5th Edition, Table 15-16, page 424

Motor Deficit, = 60% of nerve value multiplied by the L5 (see page 424, Table 15-16) Motor nerve value 37%, =22%
 Lower Extremity 22% for the motor value combined with 3% for the sensory value = 24% Lower Extremity
 24% Lower Extremity = 10% WP (100% Lower Extremity = 40% WP)

EXAMPLE 11 SCHEDULE II. USE FOR SURGICALLY TREATED SPINE CONDITIONS		Initial Event
II-C. First spinal surgery at one level in a given spinal region, including significant disc abnormality, post traumatic changes, spondylolisthesis, instability, and spinal stenosis (includes foraminal stenosis). (Assigned one time per patient.)	10% one time per patient	10%
Add Impairment (Total Amount for Spine):		10%
II-H. Neurological: Persisting Radicular Neurologic Deficit * (If, after 6 months, the neurological deficits exceed 3% WP, then calculate the deficits as described using tables 15-15 and 15-16 modified from the AMA Guides 5 th Edition, and combine the new radiculopathy rating, in place of the 3% listed here.		10%
Final Impairment Related to the Last Event:		19%

* See Radiculopathy Schedule

Example 12: Spondylolisthesis without History

A 45 year-old male slipped and fell four feet, landing flat on his back six months ago. An x-ray demonstrated an L5 spondylolysis with a grade one spondylolisthesis. He was treated with a course of physical therapy and medication, and used a brace occasionally. He continued to have back pain and occasional leg pain to the back of his legs, but no reflex changes, atrophy, or dermatomal changes. He was released to work with permanent restrictions not to lift over 40 lbs, based on pain tolerance. He had no significant history of back pain.

EXAMPLE 12 SCHEDULE I FORM FOR COMPUTING SPINAL IMPAIRMENTS		THORACIC-LUMBAR
I-D. Medically documented moderate-severe injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology including imaging evidence of disc herniation(s) that displaced nervous tissue or spondylolysis with or without spondylolisthesis (Grade I or II). Should have permanent activity restrictions.	7%	7%
Add Impairments:		7%
Apportionment:		0%
Impairment Related to the Last Event:		7%

No apportionment is calculated. Prior to his fall he would not have qualified for an impairment rating.

Example 13: Spondylolisthesis with Radiculopathy and Without Prior History

A 45 year-old male slipped and fell four feet, landing flat on his back seven months ago. An x-ray demonstrated a L5 spondylolysis with a grade one spondylolisthesis and L5 bilateral foraminal narrowing. He was treated with a course of physical therapy and medication, and uses a brace occasionally. He continues to have back pain and moderate right leg pain to the outside of his foot. His physical exam demonstrates that a straight leg raise at 30 degrees causes dermatomal leg pain. There is sensory loss

in the L5 distribution. An EMG demonstrated fibrillations, consistent with a right L5 radiculopathy. A CAT scan demonstrated bilateral pars defects at L5, old in nature with severe foraminal stenosis. He has declined surgery and has been released to work with a permanent restriction not to lift over 30 lbs. He uses occasional medications and bracing. Prior to his industrial accident, he had no history of back pain or leg pain.

EXAMPLE 13 SCHEDULE I FORM FOR COMPUTING SPINAL IMPAIRMENTS		THORACIC- LUMBAR
I-D. Medically documented moderate-severe injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology including imaging evidence of disc herniation(s) that displaced nervous tissue or spondylolysis with or without spondylolisthesis (Grade I or II). Should have permanent activity restrictions.	7%	7%
Add Impairment (Total Amount for Spine):		7%
I-G. Neurological: Persisting Radicular Neurologic Deficit. If the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 15-15 and 15-16 modified from the AMA Guides 5 th Edition, and combine the new radiculopathy rating, in place of the 3% listed here. [See Radiculopathy Schedule]*	3% Combined	3%
Total Impairment Value Without Apportionment:		10%

No apportionment is calculated. Prior to his fall he would not have qualified for an impairment rating.

Example 14: Spondylolisthesis with Radiculopathy and With Prior History

A 45 year-old male slipped and fell four feet, landing flat on his back seven months ago. An X-ray demonstrated an L5 spondylolysis with a grade one spondylolisthesis and L5 bilateral foraminal narrowing. He was treated with a course of physical therapy and medication, and used a brace occasionally. He continued to have back pain and moderate right leg pain radiating to the outside of his leg and to the top of his foot. His physical exam demonstrates that straight leg raise at 30 degrees on the right causes right leg dermatomal pain. He did have sensory loss in the L5 distribution. An EMG demonstrated fibrillations, consistent with a right L5 radiculopathy. A CAT scan demonstrated a bilateral pars defect at right L5, old in nature. He was released to work with permanent restrictions not to lift over 50 lbs, based on pain tolerance. He uses occasional medications and bracing. He had a prior history of back pain from when he hurt himself taking out very heavy garbage 11 months ago. With that episode he had x-rays taken, missed three days of work and saw his personal physician two times. During these visits, the physician noted he had radiculopathy with a positive straight leg raise, and sensation loss at the L5 distribution. Between his first and second episode, he continued to use a brace and NSAIDs intermittently.

Because he had no prior written information that would have resulted in functional work restrictions lasting >6 months, Schedule V would apply, beginning at 10% whole person because of his preexisting spondylolisthesis and radiculopathy.

SCHEDULE V. SEVERITY INDEXING FOR APPORTIONMENT OF SCHEDULE I (This applies only to the Impairment Process/Disability Process)			
If the history was significant enough to automatically qualify for a rating in these <i>UTAH Guides</i> , apportion directly.			
Score	0	1pt.	2pts.
V-A. Time lost from work in the last 12 months because of symptoms in the same spinal region	0	<u>1-3 days</u>	>3 days
V-B. Number of prior episodes in the same spinal region	0	<u>1-3</u>	>3
V-C. Time elapsed since last episode/injury	0	1-3 Years	<u><1year</u>
V-D. Prior permanent work restrictions because of problems in the same spinal region	<u>None</u>	Temporary	Permanent
V-E. Prior objective testing to the same spinal region: EMG-NCV, X-ray, MRI-CT, Bone Scan	0	If ever taken	<u>If taken within the last 2 years</u>
V-F. Prior to latest claim, what ongoing medical, chiropractic visits, physical therapy visits were received for an injury to the same spinal region	<u>0-2 times in last 3 yrs</u>	3-6 times in last 3 yrs	>6 in last 3 yrs
V-G. Spondylolysis with Spondylolisthesis		<u><25% slip</u>	>25% Slip
V-H. Radiculopathy (As objectified by Radiculopathy Schedule)			<u>Prior History*</u>

9pts. = 90% may be apportioned off as a prior ratable condition

EXAMPLE 14 SCHEDULE I FORM FOR COMPUTING SPINAL IMPAIRMENTS		THORACIC-LUMBAR
I-D. Medically documented moderate-severe injury event, subjective symptoms persisting for a minimum of six months, and clinical findings that are consistent with spinal pathology including imaging evidence of disc herniation(s) that displaced nervous tissue or spondylolysis with or without spondylolisthesis (Grade I or II). Should have permanent activity restrictions.	7%	7%
Add Impairment (Total Amount for Spine):		7%
I-G. Neurological: Persisting Radicular Neurologic Deficit. If the neurological deficits exceed 3% WP, then calculate the deficits as described from tables 15-15 and 15-16 modified from the AMA Guides 5 th Edition, and combine the new radiculopathy rating, in place of the 3% listed here. [See Radiculopathy Schedule]*	3% Combined	3%
Total Impairment Value Without Apportionment:		10%
Apportionment (Amount apportioned from Schedule I must agree with Schedules I & V):		-9%
Final Impairment Related to the Last Event:		1%

If there was no radiculopathy before his industrial lifting episode, the radiculopathy (3%) could not be apportioned. This radiculopathy would be subject to apportionment because it existed prior to his industrial lifting event.

Example 15: Prior History of Disc Problems Requiring Surgery and Now With a Recurrent Disc Herniation, Needing another Surgery

Four months ago, a 30 year-old secretary fell from her roller stool and injured her back. She was found to have a recurrent L4-L5 disc herniation. Two years earlier she had a non-work related L4-L5 disc surgical excision with moderate remaining symptoms but no radiculopathy or activity modification. She has now undergone repeat surgery for the recurrent L4-L5 disc. She has done well, with occasional back and leg pain, but no radicular symptoms.

EXAMPLE 15		Initial Event	Second Event
SCHEDULE II. USE FOR SURGICALLY TREATED SPINE CONDITIONS			
II-C. First spinal surgery at one level in a given spinal region, including significant disc abnormality, posttraumatic changes, spondylolisthesis, instability, and spinal stenosis (includes foraminal stenosis). (Assigned one time per patient.)	10% one time per patient	10%	
II-E. Second or subsequent spinal operation (not to include minimal invasive surgical procedures) in a given spinal region, including herniated discs, spondylolisthesis, segmental instability, and spinal stenosis.	2%		2%
Add Impairments:			12%
Apportionment:		10%	
Final Impairment Related to the Last Event:			2%

There is no rating given for the first disc excision, but she would be entitled to a 2% rating for the second operation because of the recurrent disc excision at the same level. There is no additional impairment for a recurrent disc treated conservatively, unless there is evidence of residual radiculopathy.

Example 16: Second Disc Injury, Treated Non-Operatively

A 40 year-old female slipped and fell at work, which left her with pain into her right quadriceps area, with numbness and weakness on standing. Her healing was protracted and therefore a MRI was obtained, demonstrating a L4-L5 far lateral disc protrusion, displacing the right L4 nerve root. She underwent a conservative program and eventually was declared stable with residual problems and no radiculopathy. Her history was significant with a prior non-industrial problem of a disc herniation at L5-S1, and surgical discectomy five years prior.

EXAMPLE 16 SCHEDULE II FORM FOR COMPUTING SPINAL IMPAIRMENTS		THORACIC- LUMBAR
II-D. Medically documented injury with continued pain, decreased motion, and imaging evidence of a 2 nd disc herniation that displaces nervous tissue and has occurred from the same or subsequent injury at a different level than the first disc herniation and this 2 nd disc space was treated either conservatively or surgically. This would also include surgery for posttraumatic changes, spondylolisthesis, segmental instability, and spinal stenosis. (This is applied only one time per level per patient and is not to be applied to levels explored, but not found to require partial discectomy or foraminotomy.)	Add 3%	3%
Add Impairments:		3%
Apportionment:		
Impairment Related to the Last Event:		3%

This is a different disc and receives the rating for a subsequent disc. The prior surgery is unrelated to the L4-5 level. If one were to include the rating for the prior disc, it would be deducted as preexisting, so the net result is the same. If one is asked to include all of the prior ratable condition impairment rating, then report the 10% and deduct it under apportionment.

Example 17: First Industrial Disc Injury, Second Disc Herniation Requiring a Second Surgery

A 32 year-old secretary fell from her roller stool and injured her back. Two years earlier she had a non-work related L4-L5 disc excision with moderate remaining symptoms and permanent activity modifications. She incurred an occupational low back injury, causing an L5-S1 herniated disc. This eventually required surgery and she was left with no radiculopathy; however, her pain and functional status were not quite as they were before her occupational fall. Her spinal motion was found to be mildly decreased.

EXAMPLE 17 SCHEDULE II. USE FOR SURGICALLY TREATED SPINE CONDITIONS		Second Event
II-E. Second or subsequent spinal operation (not to include minimal invasive surgical procedures) in a given spinal region, including herniated discs, spondylolisthesis, segmental instability, and spinal stenosis.	2%	2%
II-D. Medically documented injury with continued pain, decreased motion, and imaging evidence of a 2 nd disc herniation that displaces nervous tissue and has occurred from the same or subsequent injury at a different level than the 1st disc herniation and this 2 nd disc space was treated either conservatively or surgically. This would also include surgery for posttraumatic changes, spondylolisthesis, segmental instability, and spinal stenosis. (This is applied only one time per level per patient and is not to be applied to levels explored, but not found to require partial discectomy or foraminotomy.)	Add 3%	3%
Add Impairments:		5%
Apportionment:		
Final Impairment Related to the Last Event:		5%

This is a different disc and receives the rating for the second operation and level. No rating is given for the prior surgery. [See explanation above.]

Example 18: Disc Injury, Undergoing Three Surgeries, Including a Fusion

A 40 year-old office worker lifted and twisted with a computer monitor, which caused sudden pain in the back and down the leg. He eventually had a L5-S1 disc excision. He returned to work, only to have recurrent back pain and eventually he had a second surgical procedure with a disc excision at the L4-L5 level. He returned to work. One year later, without an intervening injury, he began to develop progressive worsening back pain with no radiculopathy. He had his third surgical procedure of a L4-L5 and a L5-S1 disc excision and fusion with instrumentation. His fusion was solid at twelve months, with continued leg pain to his foot, 2 cm of leg atrophy and EMG changes consistent with unilateral radiculopathy. He continued to have back pain and so had the instrumentation removed, without an appreciable change in his condition. Prior to lifting the monitor, he had no significant history of back pain.

EXAMPLE 18 SCHEDULE II FORM FOR COMPUTING SPINAL IMPAIRMENTS FOR INDIVIDUAL AREAS				
SCHEDULE II. Use for Surgically Treated Spine Conditions		Initial Event	Second Event	Third Event
II-C. First spinal surgery at one level in a given spinal region, including significant disc abnormality, posttraumatic changes, spondylolisthesis, instability, and spinal stenosis (includes foraminal stenosis). (Assigned one time per patient.)	10% one time per patient	10%		
II-D. Medically documented injury with continued pain, decreased motion, and imaging evidence of a 2 nd disc herniation that displaces nervous tissue and has occurred from the same or subsequent injury at a different level than the first disc herniation and this 2 nd disc space was treated either conservatively or surgically. This would also include surgery for posttraumatic changes, spondylolisthesis, segmental instability, and spinal stenosis. (This is applied only one time per level per patient and is not to be applied to levels explored, but not found to require partial discectomy or foraminotomy.)	Add 3%		3%	
II-E. Second or subsequent spinal operation (not to include minimal invasive surgical procedures) in a given spinal region, including herniated discs, spondylolisthesis, segmental instability, and spinal stenosis.	2%		2%	2%
II-F. Spinal Fusions or placement of a single "artificial disc" (For the first level fused that spans 2 vertebra.)	3%			3%
II-G. Fusions or placement with an "artificial disc," additional level(s) (i.e., a fusion that spans 3 or more vertebra). This is to be used only one time per level.	2%			2%
Add Impairment (Total Amount for Spine):		10%	5%	7%
II-H. Neurological: Persisting Radicular Neurologic Deficit * (If, after 6 months,** the neurological deficits exceed 3% WP, then calculate the deficits as described using tables 15-15 and 15-16 modified from the 5 th Edition of the AMA Guides 5 th Edition, and combine the new radiculopathy rating, in place of the 3% listed here.	3% Combined			3%
Total Impairment Value Without Apportionment:		25%		
Apportionment:				

*See Radiculopathy Schedule

This patient should be followed up at one year to assess for any additional radiculopathy that may be present.

Notes: These impairments are listed separately for clarity though all are due to the same event.

No impairment is given for internal fixation device removal.

Example 19: Degenerative Disc Disease with Two-Level Decompression

Ten years ago a 50 year-old man who does moderately heavy work fell at home. This left him with recurrent LBP with episodes ten years, six years, and two years ago. X-rays taken 6 years ago showed moderate to severe degenerative changes. A chiropractic physician treated him each time with his last visit two months before his industrial claim. For all of his prior episodes, he has missed a total of approximately ten days of work, seven of which have been in the last 12 months with no radiculopathy documented. He has had no prior MRIs or CT scans. Eight months ago, while lifting the tongue of a trailer, he had the onset of severe back pain, with subsequent development of a radiculopathy. After two months of conservative care, he eventually underwent a L4-L5 and a L5-S1 discectomy. He obtained moderately good results, with no residual radiculopathy, but is unable to be as active in his work as he was before lifting the trailer. He has been released with a permanent restriction permitting occasional lifting of 20-30 lbs, due to tolerance and risk.

The reason that 5% apportionment is not direct is because there is no written information that would have resulted in functional work restrictions lasting >6 months. Schedule V would therefore apply, beginning at 5% whole person to apportion off what he would have had before his industrial event.

SCHEDULE V. SEVERITY INDEXING FOR APPORTIONMENT OF SCHEDULE I (This applies only to the Impairment Process/Disability Process)			
Schedule I requires a minimum of six months duration of symptoms, from the time of the injury and the impairment rating.			
Score	0	1pt.	2pts.
V-A. Time lost from work in the last 12 months because of symptoms in the same spinal region	0	1-3 days	<u>>3 days</u>
V-B. Number of prior episodes in the same spinal region	0	<u>1-3</u>	>3
V-C. Time elapsed since last episode/injury	0	1-3 Years	<u><1year</u>
V-D. Prior permanent work restrictions because of problems in the same spinal region	<u>None</u>	Temporary	Permanent
V-E. Prior objective testing to the same spinal region: EMG-NCV, X-ray, MRI-CT, Bone Scan	0	<u>If taken prior to 2 years</u>	If taken within the last 2 years
V-F. Prior to latest claim, what ongoing medical, chiropractic visits, physical therapy visits were received for an injury to the same spinal region	0 -2 times in last 3 yrs	3-6 times in last 3 yrs	<u>>6 in last 3 yrs</u>
V-G. Spondylolysis with Spondylolisthesis		<25% slip	>25% Slip
V-H. Radiculopathy (As objectified by Radiculopathy Schedule.)	<u>None</u>		Prior History

8pts. = 70% of his maximal soft tissue award would be apportioned off as a prior ratable condition

EXAMPLE 19		Initial Event	Second Event
SCHEDULE II. USE FOR SURGICALLY TREATED SPINE CONDITIONS			
II-C. First spinal surgery at one level in a given spinal region, including significant disc abnormality, posttraumatic changes, spondylolisthesis, instability, and spinal stenosis (includes foraminal stenosis). (Assigned one time per patient.)	10% one time per patient		10%
II-D. Medically documented injury with continued pain, decreased motion, and imaging evidence of a 2 nd disc herniation that displaces nervous tissue and has occurred from the same or subsequent injury at a different level than the 1st disc herniation and this 2 nd disc space was treated either conservatively or surgically. This would also include surgery for posttraumatic changes, spondylolisthesis, segmental instability, and spinal stenosis. (This is applied only one time per level per patient and is not to be applied to levels explored, but not found to require partial discectomy or foraminotomy.)	Add 3%		3%
Add Impairments:			13%
Apportionment: = 8 pts. =70% I-C = 5%, 5% X 70% severity index = 4%		-4%	
Final Impairment Related to the Last Event:			9%

He does not have apportionment due to degenerative changes alone, but rather to the symptomatic and prior ratable status of those changes.

Apportionment only applies to the initial 5% preexisting ratable condition.

Example 20: Compression Fractures with Prior History and Rating

Eight months ago a 33 year-old roofer fell 18 feet and landed on his feet. He had immediate back pain and was taken to the hospital where x-rays demonstrated acute compression fractures of T11 (20%), T12 (30%) and L1 (10%). He was treated surgically with a three-level vertebral fusion and has now been declared stable. His complaints continue to be back pain with referral into the back of his legs. He had no objective radicular signs or neurological sequelae. He did have a history of an industrial back claim from a lifting injury three years ago, for which he received a 5% rating and was given permanent lifting restrictions of 30 lbs.

EXAMPLE 20	
SPINE IMPAIRMENT EXAMPLE	
COMPRESSION FRACTURES WITH PRIOR HISTORY	
Pathology	Impairment
IV-A-3: 26% to 50% T12 (30%) Worst	6%
IV-A-6: Multiple fractures: (Second, T11 (20% Compression) and Third, L1 (10% Compression))	2% + 2%
IV-A-5: Fusion – If it is required to extend the fusion over three or more vertebral, add	5% one time
Final Impairment Related to the Last Event (Added):	15%
(Prior rating not related) Apportionment:	0
Impairment Industrial is responsible for:	15%

The 5% prior rating is not considered for apportionment, as it bears no relationship to the current injury or impairment.

Example 21: Burst Fracture Requiring Fusion

Eighteen months ago, a 40 year-old male fell twenty-five feet, incurring a burst fracture at L1 of 60%, with partial neurological loss. He eventually underwent a fusion that extended from T10 to L3. He is now medically stable, and with complete restoration of his neurological deficit. He had no prior spinal pain.

EXAMPLE 21 SPINE IMPAIRMENT EXAMPLE BURST FRACTURES WITH FUSION	
Pathology	Impairment
IV-A-4: Burst Fractures-Compression of 60%	15%
IV-A-6: Fusion- If it is required to extend the fusion over three or more vertebral segments	5%
Impairment (added):	20%
(Prior rating not related) Apportionment:	0
Impairment Industrial is responsible for:	20%

Example 22: Coccygodynia

Twelve months ago, a 33 year-old female slipped and fell on the ice, landing on her buttocks. She had x-rays taken, showing a deviated coccyx. No prior films were available for comparison and she denies having any significant history of problems prior to the fall. She has had conservative treatment and continued to have intermittent pain with trouble sitting. A rectal examination was significant for a palpable step off of the sacral-coccygeal joint and reproduction of her usual and typical pain with provocative motion.

EXAMPLE 22 SPINE IMPAIRMENT COCCYGODYNIA	
Pathology	Impairment
V. H - Healed fracture(s) with displacement, deformity and residuals signs(s) involving: h. Coccyx, displacement	3%
Impairment:	3%
Apportionment:	0%
Impairment Industrial is responsible for:	3%

Example 23: Prior Non-Industrial Injury with Two Industrial Injuries and Ratings

An 18 year-old male injured his L4-L5 disc while playing high school football in 1985. He subsequently re-injured this same area a second time doing summer construction work 10 years later lifting heavy bags of concrete. X-rays were taken, showing degenerative disc disease. He was recommended to find work that would not require him lifting over 40 lbs. His treatment consisted of physical therapy following both incidents. Following this 1st work-related accident, he was rated in accordance with the 3rd Edition

(Revised) of the AMA Guides 5th Edition and was awarded a 10% (WP) impairment with 5% due to the 1985 football injury and 5% due to the 1987 construction industrial accident. 20 years later, while working on an oil rig, he injured his L4-L5 area again, requiring a lumbar discectomy. He has again been declared medically stable.

EXAMPLE 23 SPINE IMPAIRMENT PRIOR NONINDUSTRIAL INJURY WITH TWO INDUSTRIAL INJURIES AND RATINGS		
Date	Pathology	Impairment
3 rd Injury	II-C. First spinal surgery at one level in a given spinal region, including significant disc abnormality, posttraumatic changes, spondylolisthesis, instability, and spinal stenosis (includes foraminal stenosis). (Assigned one time per patient.)	10% one time per patient
Impairment:		10%
1985 & 1987 Injuries Apportionment of his prior rating by current Physical Impairment Guides I-C. Medically documented injury and subjective symptoms persisting for a minimum of six months with a clinical history of a significant injury event. May have imaging evidence of moderate to severe degenerative changes. Should have permanent activity restrictions.		-5%
Additional Impairment Industrial is responsible for: (related to 1996)		5%

Discussion: From his 3rd industrial claim he incurred another separate injury, requiring surgery. Therefore, for the sake of consistency it is recommended that the impairment he would have been awarded for his 1st and 2nd injuries be deducted calculated using these current *Impairment Guides*. In this case he would have directly qualified for 5% WP for his prior injuries, (documentation of severity of injury, imaging findings and recommended work restrictions), which allow direct apportionment off his new total award.

Example 24: Prior Industrial Rating with another System, Now With a New Injury

A 30 year-old male injured his back at work in 1991 after falling 3 feet landing on his back. He was treated and x-rays demonstrated degenerative disc disease. He was diagnosed with mechanical back pain and an impairment of 14% WP was calculated using the 3rd Edition of the *AMA Guides* "Range of Motion Model." He was given permanent restrictions to not lift over 40 lbs, probably based on pain tolerance. Three years later while working for another employer, he re-injured his back, which later required surgery, including a two-level discectomy and fusion with now persistent, worsened pain. He has now returned to work and has been declared medically stable.

EXAMPLE 24 SCHEDULE II. USE FOR SURGICALLY TREATED SPINE CONDITIONS		Initial Event	Second Event
II-C. First spinal surgery at one level in a given spinal region, including significant disc abnormality, posttraumatic changes, spondylolisthesis, instability, and spinal stenosis (includes foraminal stenosis). (Assigned one time per patient.)	10% one time per patient		10%
II-D. Medically documented injury with continued pain, decreased motion, and imaging evidence of a 2 nd disc herniation that displaces nervous tissue and has occurred from the same or subsequent injury at a different level than the first disc herniation and this 2 nd disc space was treated either conservatively or surgically. This would also include surgery for posttraumatic changes, spondylolisthesis, segmental instability, and spinal stenosis. (This is applied only one time per level per patient and is not to be applied to levels explored, but not found to require partial discectomy or foraminotomy.)	Add 3%		3%
II-F. Spinal Fusions or placement of a single "artificial disc" (for the first level fuse that spans 2 vertebra).	3%		3%
II-G. Fusions or placement with an "artificial disc," additional level(s) (i.e., a fusion that spans 3 or more vertebra). This is to be used only one time per level.	2%		2%
Add Impairments:			18%
Apportionment:		5%	
Final Impairment Related to the Last Event:			13%

Discussion: Apportionment is indicated. With his prior significant history he would have qualified for 5% whole person according to these 2006 Utah Guides. This is based on his prior history, mechanism of injury and work restrictions. The 14% awarded prior for soft tissue complaints was inflated. He has incurred another separate injury. For the sake of consistency it is recommended that the maximum impairment he would have been awarded under these current 2006 *UTAH Guides* (5%), rather than the 14% would be used to apportion off his preexisting condition. In this case it is 5% WP, which is apportioned off of his new total award.

Example 25: Prior Industrial Rating with another System, Now With a New Injury

A 40 year-old male incurred an industrial accident in 1985. He underwent a L5-S1 discectomy and was declared medically stable and given a 5% impairment. In 1988, he herniated another disc at L4-L5 and in 1989, underwent an L4-L5 discectomy. He was declared stable and was given another 5% impairment rating. In 2003, while working for another employer, he fell off a ladder, causing pain in his quadriceps area. He was later diagnosed with a L3-L4 disc herniation. He elected to have a third discectomy - this time with a fusion from L3-S1. This was carried out in 2004 and he was declared medically stable. He has continued to have pain in the quadriceps area, with a loss of quadriceps strength, loss of the knee reflex, and a unilaterally positive EMG (with changes in the L4 nerve root distribution). His fusion is solid and he has been declared medically stable.

EXAMPLE 25 SCHEDULE II FORM FOR COMPUTING SPINAL IMPAIRMENTS FOR INDIVIDUAL AREAS				
SCHEDULE II. Use for Surgically Treated Spine Conditions		Initial Event	Second Event	Third Event
II-C. First spinal surgery at one level in a given spinal region, including significant disc abnormality, posttraumatic changes, spondylolisthesis, instability, and spinal stenosis (includes foraminal stenosis). (Assigned one time per patient.)	10% one time per patient	10%		
II-D. Medically documented injury with continued pain, decreased motion, and imaging evidence of a 2 nd disc herniation that displaces nervous tissue and has occurred from the same or subsequent injury at a different level than the 1st disc herniation and this 2 nd disc space was treated either conservatively or surgically. This would also include surgery for posttraumatic changes, spondylolisthesis, segmental instability, and spinal stenosis. (This is applied only one time per level per patient and is not to be applied to levels explored, but not found to require partial discectomy or foraminotomy.)	Add 3%		3%*	3%
II-E. Second or subsequent spinal operation (not to include minimal invasive surgical procedures) in a given spinal region, including herniated discs, spondylolisthesis, segmental instability, and spinal stenosis.	2%		2%*	2%
II-F. Spinal Fusions or placement of a single "artificial disc" (for the first level fuse that spans 2 vertebra).	3%			L3-L4 3%
II-G. Fusions or placement with an "artificial disc," additional level(s) (i.e., a fusion that spans 3 or more vertebra). This is to be used only one time per level.	2%			L5-S1 2%* L4-L5 2%*
Add Impairment (Total Amount for Spine):		10%	5%	12%
II-H. Neurological: Persisting Radicular Neurologic Deficit * (If, after 6 months, the neurological deficits exceed 3% WP, then calculate the deficits as described using tables 15-15 and 15-16 modified from the 5 th Edition of the AMA Guides 5 th Edition, and combine the new radiculopathy rating, in place of the 3% listed here.	3% Combined			3%
Total Impairment Value Without Apportionment:		30%		
Apportionment:		10%	5%	15%

*See Radiculopathy Schedule

Example 26: Impairment Related to One Event and Operation on Two Discs

A 35 year-old male picked up a 100-lb container and fell, hurting his back. He had pain into his right leg and his foot. He had sensory changes, reflex changes, and muscle weakness that were all consistent with a S1 radiculopathy. A MRI demonstrated a L5-S1 HNP, displacing his right S1 nerve root and a broad based L4-L5 central disc bulge, producing moderate spinal stenosis. Conservative treatment of six weeks did not give him acceptable relief; therefore he elected L5-S1 and L4-L5 discectomies. He is now four months post-op and he is left with occasional low back pain, but without radiculopathy. Prior to his industrial event, he had no significant history of back pain.

EXAMPLE 26 <i>SCHEDULE II. USE FOR SURGICALLY TREATED SPINE CONDITIONS</i>		Initial Event
II-C. First spinal surgery at one level in a given spinal region, including significant disc abnormality, posttraumatic changes, spondylolisthesis, instability, and spinal stenosis (includes foraminal stenosis). (Assigned one time per patient.)	10% one time per patient	10%
II-D. Medically documented injury with continued pain, decreased motion, and imaging evidence of a 2 nd disc herniation that displaces nervous tissue and has occurred from the same or subsequent injury at a different level than the 1st disc herniation and this 2 nd disc space was treated either conservatively or surgically. This would also include surgery for posttraumatic changes, spondylolisthesis, segmental instability, and spinal stenosis. (This is applied only one time per level per patient and is not to be applied to levels explored, but not found to require partial discectomy or foraminotomy.)	Add 3%	
Add Impairments:		13%
Apportionment:		
Final Impairment Related to the Last Event:		13%

If instead of a 2-level discectomy during one operation, the second disc was operated on at a later time, there would be another 2%, II-C, added.

Example 27: Impairment Related to Fractured Pelvis

A 40 year-old female was struck by pick up truck, fracturing her sacrum with residual dislocation. After 6 months she was left with chronic sacral iliac pain. Prior to this industrial event, she had no significant history of back pain.

EXAMPLE 27 <i>SCHEDULE VI Fractures of the Pelvis</i>		Initial Event
VI g. Sacral iliac joint dislocation with non anatomical reduction		15%
Apportionment:		0%
Final Impairment Related to the Last Event:		15%

Example 28: Impairment Related To Percutaneous Discectomy At 2 Levels.

A 26 year-old male injured his back lifting a 45 box of automotive supplies. He complained of pain in his back and down to the back of his legs. A MRI was taken showing a concentric disc bulge, grade II at both the L4-L5 and the L5-S1 levels. Over 3 months he failed to make improvement with conservative treatment and was given a "percutaneous discectomy at the L4-5 and L5-S1 levels with minimal improvement. He is now 6 months post procedure with continued low back pain.

EXAMPLE 28 SCHEDULE II. SURGICALLY TREATED SPINE CONDITIONS BASED ON FUNCTIONAL-ANATOMIC and DIAGNOSTIC BASED CRITERIA (FAD) (Whole Person Permanent Impairment)		Initial Event
II-A. First minimally invasive spinal surgery such as a percutaneous or and endoscopic procedure done as an attempt to decompress a herniated disc, performed at one level in a given spinal region, for a significant disc abnormality. (Assigned one time per patient.)		5%
II-B. Minimally invasive spinal surgery performed at another level than the first in a given spinal region, for significant disc abnormality, 2% (one time per disc).		2%
Apportionment:		0%
Final Impairment Related to the Last Event:		7%

Chapter Four: Upper Extremity

To be used to clarify the AMA 5th Edition Chapter 16

4.0 Introduction to Upper Extremity

The 5th Edition of the *American Medical Association Guides to the Evaluation of Permanent Impairment* (AMA Guides) provides a number of methods that can be utilized in the calculation of the impairment rating in the upper extremity. To provide rating methodology that facilitates consistency and objectivity the Utah impairment committee has reviewed, simplified and updated the upper extremity rating process within the Functional, Anatomic and Diagnostic (FAD) model as listed below. As with other sections of the *UTAH Supplemental Guides for Rating Permanent Impairment* (Utah Guides), the rater is reminded that the rating of a part should never be greater than that which is allowed for the whole part. This would mean that the maximum rating a physician could award for the upper extremity would be equal to 100% UE, (amputation of the upper extremity or shoulder disarticulation) which is equal to 60% Whole Person. Impairment ratings for the upper extremity have not been adjusted for hand dominance, therefore hand dominance should not be considered in the determination of disability (AMA 5th Edition, p. 435, 16.1B).

In that there are a number of different ways an extremity can be rated, Utah has adopted the following worksheet based upon the FAD methodology. This worksheet not only facilitates the process for those doing complicated impairment ratings, but greatly helps those reading the rating to better understand the derivation of the final number.

Only the following methods from the 5th Edition of the *AMA Guides* that are listed on this worksheet have been approved for rating impairments of the upper extremity. Physicians and/or raters are reminded that the individual components of this upper extremity chapter are to be combined.

The rater is requested to utilize this upper extremity work sheet along with the worksheets found on page 436-437 of the 5th Edition. The utilization of these worksheets not only facilitates the process for those doing these complicated ratings, but also those reviewing the rating to understand the derivation of the final number.

4.1 2006 Utah's Upper Extremity Rating Guidelines

4.1 2006 UTAH'S UPPER EXTREMITY RATING GUIDELINES WORKSHEET Section/Page numbers correspond to 5 th Edition of the AMA Guides unless stated to correspond to UTAH Guides Total impairment is not to exceed 60% whole person			
Name: _____ Age _____ Sex _____ Date _____			
Side <input type="checkbox"/> R <input type="checkbox"/> L Diagnosis: _____			
Schedules to use for a rating of the Upper Extremity per Utah's Supplemental Impairment Guides		Section # (Page)	% Upper Ext
Functional	Range of Motion including Ankylosis	16-4 (450)	
Anatomic	Finger and Hand Impairment Methodology	16-1a (436)	
	Amputation	16-2 (441)	
	Peripheral Nerve Disorders	16-5 (480-495)	
	Utah's CRPS type 1 or 2 (See page 86)	16-5e (495)	
	Vascular	16-6 (497)	
	Shoulder bursitis/cuff tendinitis	Page 87 Utah's	
	Rotator cuff tear, Partial or full thickness	Page 87 Utah's	
	Acromioclavicular joint resection arthroplasty	Page 87 Utah's	
	Complete acromionectomy	Page 87 Utah's	
Diagnosis Based	Entrapment Neuropathies	Page 87 Utah's	
	Dermatological	18 (173)	
	Impairments Due to Other Disorders (Specify)	16-7a (499)	
	Arthroplasty	16-7b, (505)	
	Musculotendinous Impairment	16-7c (506)	
	Utah's Specific Upper Extremity Neuro-Muscular Impairments	Page 90 Utah's	
Stand Alone: Utah's Specific Upper Extremity Painful Organic Syndromes Not to be Combined with Other Ratings		Page 90 Utah's	
Total Upper Extremity Impairment:			

If more than one method can be used to calculate a rating, the physician should calculate the impairment rating using different alternatives and choose the method or combination of methods that gives the most clinically accurate and highest impairment rating (AMA 5th Edition, p. 526-527).

4.1a. Schedules in AMA 5th Not to be Used for Upper Extremity Ratings in Utah

Carpal Tunnel Syndrome (495) <i>Use Utah's Upper Extremity Entrapment Neuropathies</i>
Strength Testing for Grip and Pinch, (507) except as found under Utah's Upper Extremity Neuro-Muscular Impairments. <small>16-7d 16-7e 16-7f 16-7g 16-7h 16-7i 16-7j 16-7k 16-7l 16-7m 16-7n 16-7o 16-7p 16-7q 16-7r 16-7s 16-7t 16-7u 16-7v 16-7w 16-7x 16-7y 16-7z 16-7aa 16-7ab 16-7ac 16-7ad 16-7ae 16-7af 16-7ag 16-7ah 16-7ai 16-7aj 16-7ak 16-7al 16-7am 16-7an 16-7ao 16-7ap 16-7aq 16-7ar 16-7as 16-7at 16-7au 16-7av 16-7aw 16-7ax 16-7ay 16-7az 16-7ba 16-7bb 16-7bc 16-7bd 16-7be 16-7bf 16-7bg 16-7bh 16-7bi 16-7bj 16-7bk 16-7bl 16-7bm 16-7bn 16-7bo 16-7bp 16-7bq 16-7br 16-7bs 16-7bt 16-7bu 16-7bv 16-7bw 16-7bx 16-7by 16-7bz 16-7ca 16-7cb 16-7cc 16-7cd 16-7ce 16-7cf 16-7cg 16-7ch 16-7ci 16-7cj 16-7ck 16-7cl 16-7cm 16-7cn 16-7co 16-7cp 16-7cq 16-7cr 16-7cs 16-7ct 16-7cu 16-7cv 16-7cw 16-7cx 16-7cy 16-7cz 16-7da 16-7db 16-7dc 16-7dd 16-7de 16-7df 16-7dg 16-7dh 16-7di 16-7dj 16-7dk 16-7dl 16-7dm 16-7dn 16-7do 16-7dp 16-7dq 16-7dr 16-7ds 16-7dt 16-7du 16-7dv 16-7dw 16-7dx 16-7dy 16-7dz 16-7ea 16-7eb 16-7ec 16-7ed 16-7ee 16-7ef 16-7eg 16-7eh 16-7ei 16-7ej 16-7ek 16-7el 16-7em 16-7en 16-7eo 16-7ep 16-7eq 16-7er 16-7es 16-7et 16-7eu 16-7ev 16-7ew 16-7ex 16-7ey 16-7ez 16-7fa 16-7fb 16-7fc 16-7fd 16-7fe 16-7ff 16-7fg 16-7fh 16-7fi 16-7fj 16-7fk 16-7fl 16-7fm 16-7fn 16-7fo 16-7fp 16-7fq 16-7fr 16-7fs 16-7ft 16-7fu 16-7fv 16-7fw 16-7fx 16-7fy 16-7fz 16-7ga 16-7gb 16-7gc 16-7gd 16-7ge 16-7gf 16-7gg 16-7gh 16-7gi 16-7gj 16-7gk 16-7gl 16-7gm 16-7gn 16-7go 16-7gp 16-7gq 16-7gr 16-7gs 16-7gt 16-7gu 16-7gv 16-7gw 16-7gx 16-7gy 16-7gz 16-7ha 16-7hb 16-7hc 16-7hd 16-7he 16-7hf 16-7hg 16-7hi 16-7hj 16-7hk 16-7hl 16-7hm 16-7hn 16-7ho 16-7hp 16-7hq 16-7hr 16-7hs 16-7ht 16-7hu 16-7hv 16-7hw 16-7hx 16-7hy 16-7hz 16-7ia 16-7ib 16-7ic 16-7id 16-7ie 16-7if 16-7ig 16-7ih 16-7ii 16-7ij 16-7ik 16-7il 16-7im 16-7in 16-7io 16-7ip 16-7iq 16-7ir 16-7is 16-7it 16-7iu 16-7iv 16-7iw 16-7ix 16-7iy 16-7iz 16-7ja 16-7jb 16-7jc 16-7jd 16-7je 16-7jf 16-7jg 16-7jh 16-7ji 16-7jj 16-7jk 16-7jl 16-7jm 16-7jn 16-7jo 16-7jp 16-7jq 16-7jr 16-7js 16-7jt 16-7ju 16-7jv 16-7jw 16-7jx 16-7jy 16-7jz 16-7ka 16-7kb 16-7kc 16-7kd 16-7ke 16-7kf 16-7kg 16-7kh 16-7ki 16-7kj 16-7kk 16-7kl 16-7km 16-7kn 16-7ko 16-7kp 16-7kq 16-7kr 16-7ks 16-7kt 16-7ku 16-7kv 16-7kw 16-7kx 16-7ky 16-7kz 16-7la 16-7lb 16-7lc 16-7ld 16-7le 16-7lf 16-7lg 16-7lh 16-7li 16-7lj 16-7lk 16-7ll 16-7lm 16-7ln 16-7lo 16-7lp 16-7lq 16-7lr 16-7ls 16-7lt 16-7lu 16-7lv 16-7lw 16-7lx 16-7ly 16-7lz 16-7ma 16-7mb 16-7mc 16-7md 16-7me 16-7mf 16-7mg 16-7mh 16-7mi 16-7mj 16-7mk 16-7ml 16-7mm 16-7mn 16-7mo 16-7mp 16-7mq 16-7mr 16-7ms 16-7mt 16-7mu 16-7mv 16-7mw 16-7mx 16-7my 16-7mz 16-7na 16-7nb 16-7nc 16-7nd 16-7ne 16-7nf 16-7ng 16-7nh 16-7ni 16-7nj 16-7nk 16-7nl 16-7nm 16-7nn 16-7no 16-7np 16-7nq 16-7nr 16-7ns 16-7nt 16-7nu 16-7nv 16-7nw 16-7nx 16-7ny 16-7nz 16-7oa 16-7ob 16-7oc 16-7od 16-7oe 16-7of 16-7og 16-7oh 16-7oi 16-7oj 16-7ok 16-7ol 16-7om 16-7on 16-7oo 16-7op 16-7oq 16-7or 16-7os 16-7ot 16-7ou 16-7ov 16-7ow 16-7ox 16-7oy 16-7oz 16-7pa 16-7pb 16-7pc 16-7pd 16-7pe 16-7pf 16-7pg 16-7ph 16-7pi 16-7pj 16-7pk 16-7pl 16-7pm 16-7pn 16-7po 16-7pp 16-7pq 16-7pr 16-7ps 16-7pt 16-7pu 16-7pv 16-7pw 16-7px 16-7py 16-7pz 16-7qa 16-7qb 16-7qc 16-7qd 16-7qe 16-7qf 16-7qg 16-7qh 16-7qi 16-7qj 16-7qk 16-7ql 16-7qm 16-7qn 16-7qo 16-7qp 16-7qq 16-7qr 16-7qs 16-7qt 16-7qu 16-7qv 16-7qw 16-7qx 16-7qy 16-7qz 16-7ra 16-7rb 16-7rc 16-7rd 16-7re 16-7rf 16-7rg 16-7rh 16-7ri 16-7rj 16-7rk 16-7rl 16-7rm 16-7rn 16-7ro 16-7rp 16-7rq 16-7rr 16-7rs 16-7rt 16-7ru 16-7rv 16-7rw 16-7rx 16-7ry 16-7rz 16-7sa 16-7sb 16-7sc 16-7sd 16-7se 16-7sf 16-7sg 16-7sh 16-7si 16-7sj 16-7sk 16-7sl 16-7sm 16-7sn 16-7so 16-7sp 16-7sq 16-7sr 16-7ss 16-7st 16-7su 16-7sv 16-7sw 16-7sx 16-7sy 16-7sz 16-7ta 16-7tb 16-7tc 16-7td 16-7te 16-7tf 16-7tg 16-7th 16-7ti 16-7tj 16-7tk 16-7tl 16-7tm 16-7tn 16-7to 16-7tp 16-7tq 16-7tr 16-7ts 16-7tt 16-7tu 16-7tv 16-7tw 16-7tx 16-7ty 16-7tz 16-7ua 16-7ub 16-7uc 16-7ud 16-7ue 16-7uf 16-7ug 16-7uh 16-7ui 16-7uj 16-7uk 16-7ul 16-7um 16-7un 16-7uo 16-7up 16-7uq 16-7ur 16-7us 16-7ut 16-7uu 16-7uv 16-7uw 16-7ux 16-7uy 16-7uz 16-7va 16-7vb 16-7vc 16-7vd 16-7ve 16-7vf 16-7vg 16-7vh 16-7vi 16-7vj 16-7vk 16-7vl 16-7vm 16-7vn 16-7vo 16-7vp 16-7vq 16-7vr 16-7vs 16-7vt 16-7vu 16-7vv 16-7vw 16-7vx 16-7vy 16-7vz 16-7wa 16-7wb 16-7wc 16-7wd 16-7we 16-7wf 16-7wg 16-7wh 16-7wi 16-7wj 16-7wk 16-7wl 16-7wm 16-7wn 16-7wo 16-7wp 16-7wq 16-7wr 16-7ws 16-7wt 16-7wu 16-7wv 16-7ww 16-7wx 16-7wy 16-7wz 16-7xa 16-7xb 16-7xc 16-7xd 16-7xe 16-7xf 16-7xg 16-7xh 16-7xi 16-7xj 16-7xk 16-7xl 16-7xm 16-7xn 16-7xo 16-7xp 16-7xq 16-7xr 16-7xs 16-7xt 16-7xu 16-7xv 16-7xw 16-7xx 16-7xy 16-7xz 16-7ya 16-7yb 16-7yc 16-7yd 16-7ye 16-7yf 16-7yg 16-7yh 16-7yi 16-7yj 16-7yk 16-7yl 16-7ym 16-7yn 16-7yo 16-7yp 16-7yq 16-7yr 16-7ys 16-7yt 16-7yu 16-7yv 16-7yw 16-7yx 16-7yy 16-7yz 16-7za 16-7zb 16-7zc 16-7zd 16-7ze 16-7zf 16-7zg 16-7zh 16-7zi 16-7zj 16-7zk 16-7zl 16-7zm 16-7zn 16-7zo 16-7zp 16-7zq 16-7zr 16-7zs 16-7zt 16-7zu 16-7zv 16-7zw 16-7zx 16-7zy 16-7zz</small>
Tendonitis 16-7d (507) <i>Use Utah's Painful Upper Extremity Painful Disorders</i>

Manual Muscle Testing 16-8c (509) ⁶ <i>Must have true neurological weakness and use 16-10, 16-11</i>
Criteria for Rating Impairment of One Upper Extremity 13-16 (338)
Criteria for Rating Impairments Related to Chronic Pain in One Upper Extremity Table 13-22 (343)

4.1b. Peripheral Nerve Tables to be Used – Sensory Deficits

SENSORY DEFICITS* CLASSIFICATION FOR DETERMINING IMPAIRMENT DUE TO NERVE ROOT DISORDERS (Severity Multiplier)		
The following tables are to be used in the calculation of neurological impairments. They have been adapted and modified from the 5th edition of the AMA Guides, Table 15-15, page 424 and from tables 13-23 & 13-24 and are to be used		
Class	Description of sensory loss or pain	% Sensory
5	No loss of sensibility, abnormal sensation, or pain	0
4	Diminished light touch with or without minimal abnormal sensations or pain, forgotten during activity	20
3	Diminished light touch with some abnormal sensations or pain, interfering with activity	40
2	Decreased protective sensation (sharp dull discrimination) with abnormal sensations or moderate pain that may prevent some activity	60
1	Deep pain present, but no protective sensation (no sharp dull discrimination), severe pain or that prevents most activity	80
0	Absent sensibility, abnormal sensations or severe pain that prevents all activity	100

4.1c. Motor Deficits

MOTOR DEFICITS* CLASSIFICATION FOR DETERMINING IMPAIRMENT DUE TO LOSS OF FUNCTION RESULTING FROM NERVE DISORDERS (Upper or Lower Extremity Value)		
Class	Description of Muscle Function	% Motor Deficit
5	Active movement against gravity with full resistance	0
4	Active movement against gravity with some resistance	20
3	Active movement against gravity only without resistance	40
2	Active movement with gravity eliminated	60
1	Slight contraction and no movement	80
0	No contractions	100

* Adapted from the 5th edition of the AMA Guides, Table 15-16

⁶ Strength evaluation: voluntary muscles strength testing remains subjective that therefore inconsistent. Until a precise way of measuring muscle contraction is developed, manual muscle testing is not to be used. It should also be noted that the correlation of strength with performance of activities of daily living is poor and that increased strength does not necessarily equate with increased function.

4.2 Utah's Chronic Regional Pain Syndromes Type 1 or 2 for Upper Extremities

Methodology for the calculation of CRPS for the upper extremity is found on page 86.

The Rater is to first use the amputation values as found on page 440 table 16-4 that identifies the portion of the upper extremity that is involved. This % is then multiplied by the % of sensory deficits and pain as described on page 495.

4.3 Upper Extremity Ratings for Shoulder Conditions

The following schedule is to be used for individuals who incur shoulder injuries related to work. These are to be combined with other ratings as indicated in the FAD worksheet.

Schedule VII Upper Extremity Ratings For Shoulder Conditions Only The Findings With The Highest Rating Is To Be Used These Are Combined With Other Conditions As Described In The FAD Work Sheet Findings must be present for >6 consecutive months despite non-surgical or surgical treatment Upper extremity impairment for these categories listed below are combined with ROM with the total not to exceed 18% Recommend MRI or arthroscopic pictures be available, confirming findings.		
Condition	Findings/Treatment	Upper Ext Rating
Shoulder bursitis/cuff tendinitis Pain consistent with impingement/ tendonitis confirmed by impingement signs on exam and/or increased signal in the rotator cuff on MRI	Non Surgical Treatment, Residual pain above 90 degrees of elevation (flexion or abduction)	2 %
	Surgical decompression with good result, residual pain with minimal reduction in activity	3 %
	Surgical decompression with a fair result, residual pain that prevents many activities	5 %
Rotator cuff tear Partial or full thickness	Confirmed by MRI, treated non-surgically with residual pain that limits activity	4 %
	Confirmed by MRI, treated surgically with residual pain that markedly limits activity	6 %
Global Tear	Non Repairable tears, latissimus dorsi transfer or scaffolding techniques	8 %
Acromioclavicular joint resection arthroplasty	Resection is primarily for chronic arthritic conditions and is curative. No impairment is indicated	0 %.
Complete acromionectomy (a rare occurrence)	No additional impairment for a partial acromionectomy, as this is removing "what shouldn't be there" (anomalous type II or type III acromion)	10 %

4.4 Utah's Upper Extremity Neuro-Muscular Impairments

Upper Extremity Impairments Due to Entrapment Neuropathies should be severity indexed according to table VII with impairment assigned. It should be noted that healed entrapment neuropathies may not have an impairment.

Utah's Upper Extremity Strength Evaluations

Upper extremity strength evaluations, (grip and pinch strength) should only be used as described in this section. The rater is not to award grip strength alone or in combination with other ratings.

4.4a. Constrictive Tenosynovitis

Constrictive tenosynovitis is a condition that is readily corrected by surgery, therefore table 16-29 only be applied to post-operative patients.

4.4b. Peripheral Nerve Entrapment

Carpal Tunnel Syndrome (CTS) and Ulnar Nerve Wrist (UNW)

Median nerve entrapment neuropathy (Carpal Tunnel Syndrome) and ulnar nerve entrapment neuropathy (in Guyon's canal) are rated when the patient is at MMI whether or not surgery has been performed. The symptoms of entrapment neuropathy are pain and/or numbness in the distal distribution of the involved nerve. There are no reliable objective physical exam signs with sufficient sensitivity and specificity to be useful in mild or moderate entrapment neuropathy. For this reason, to qualify for an impairment rating, nerve conduction testing (electrodiagnostic studies) is required to prove the diagnosis is correct. Unfortunately, NCS/EMG is not 100% sensitive or specific. A recent study found that measurement of a single, short-nerve segment tended to be superior to results obtained by either long-segment studies or differential subtraction between 2 segments of the same nerve in the electrodiagnosis of CTS yielding the highest sensitivity (75%).^{booxv} Needle examination (EMG) only records denervation changes which is only seen in severe, long standing entrapment.

The response to treatment is not an acceptable method of diagnosis for impairment rating purposes. Surgical relief of symptoms consistent with CTS in a person with normal nerve conduction studies may reflect true CTS with a false negative NCS, or may reflect a true negative NCS and a placebo response to treatment. Like other treatments for symptoms, surgery has a 40% placebo response rate.^{booxvi}

Post-operative nerve conduction testing is not necessary for impairment rating purposes. *A single clearly abnormal pre or post operative study (as defined below) is however necessary for any impairment rating other than zero.*

There is no national standard that defines how slow conduction should be, or how long distal latencies should be before a nerve conduction study is considered to be abnormal. Each professional society, laboratory and each electromyographer determines their own definitions. This unfortunately leads to some variability in the diagnosis of entrapment neuropathy. These studies should be interpreted by *physicians* qualified by training and experience to interpret the results. Limb temperature should be stated in the report, as normal nerves in cold limbs have slowed nerve conduction (hence prolonged latencies). Limb temperature should be > 31 degrees Celsius. Temperature strips can be purchased at <http://www.jarisupply.com>.

Very mild cases of entrapment neuropathy exist with "believable" symptoms, but normal nerve conduction studies. While a treating physician may chose to diagnose and treat based on believable symptoms with normal nerve conduction testing, these cases do not rise to the level of impairment. This is similar to tension headache, irritable bowel syndrome, and dysmenorrhea, in which believable symptoms are present with **no** impairment.

Grip strength is not used to rate impairment, as the post-operative palmar tenderness that limits grip can take up to 2 years to stop improving.^{booxvii} In symptomatic individuals pain limits grip and thus prevents the individual from exerting his/her true best effort.

The physical exam findings for impairment rating purposes are decreased sensation documented by 2 point discrimination testing (> 6 mm is abnormal), and thenar muscle atrophy and/or weakness of thumb opposition measured a pinch dynamometer as specified in the JAMA.^{booxviii} Symptoms also include nocturnal symptoms, paresthesias with activity, and symptoms within the appropriate nerve distribution.

4.4c. Nerve Entrapment: Near the Elbow

Median Nerve (Anterior Interossei or MNE), Ulnar Nerve Elbow (UNE), and Radial Nerve Elbow (RNE)

Median and ulnar nerve entrapment can be reliably confirmed, if moderate or severe, on nerve conduction testing and EMG. Radial nerve entrapment is rare and confirmation of entrapment can be problematic. Since these entrapments are more proximal, they affect the innervation of many more muscles than the entrapments at the wrist. Minimal entrapments may have more impairment than entrapment at the wrist. Surgical release of these entrapments (especially ulnar nerve entrapment) is more likely to leave residual problems than is entrapment surgical release at the wrist.

4.4d. Application of the Nerve Entrapment Tables

Cases that meet some of, but not all of, the criteria for one of the above categories should be rated using the adjacent category of lesser severity. For example, the extremely rare case of carpal tunnel syndrome with 2 point discrimination greater than 6 mm with delayed, but not with severely abnormal nerve conduction testing would be rated using category 3, not category 4.

Delayed nerve conduction means the distal motor latency and/or the distal sensory latency is prolonged according to established norms.

*Severely abnormal nerve conduction testing is defined as absent sensory latencies, or evidence of MOTOR axon loss manifest as decreased Compound Muscle Action Potential (CMAP) amplitude (usually < 5 millivolts) and/or with polyphasic motor action potentials, fibrillation potentials and positive waves on needle EMG of hand intrinsic muscles.

CRPS, Type 2 that follows carpal tunnel release surgery would be rated by use of the CRPS section (16-5e) (495) and not by use of the nerve entrapment section.

Severe entrapments that have severely abnormal nerve conduction testing (defined above) and total loss of sensibility and severe objective motor involvement, (2 point discrimination > 15 mm) would be rated according to methodology found in the *AMA Guides, 5th Edition*, Upper Extremity Chapter, Section 16.5, pages 480-490. This would include complications of carpal tunnel infection either from steroid injection or from surgical carpal tunnel release that results in major nerve damage and those that require major corrective tendon transfer surgery to restore some of hand intrinsic muscle function.

Abnormal sensory exam is defined as distorted superficial tactile sensibility (2-point discrimination >6 mm), with some abnormal sensations or slight pain, that interferes with some activities. Abnormal motor exam is defined as loss of >70% of strength of a normal contralateral extremity with acceptable effort being expended.

4.4e. Guidelines for Placement of Patients within Schedule VIII

Schedule VIII Residual Signs-Symptoms Grade	I	II	III	IV
Nocturnal paresthesia	+	+	+	+
Paresthesia with Activity	+	+	+	+
2 pt discrimination	< 6mm	6-8mm	9-15mm	>15mm
Symptoms are within the anatomical distribution of the involved nerve	+	+	+	+
Atrophy	0	0	+/-	+
% of Strength loss Index 1	<10	10-30	31-60	>61
Phalen's test positive	+	+	+	N/A
Tinel's test positive	+	+	+	+
Nerve Conduction Studies Positive 2	+	+	++	++
Electromyographic changes present	-	+/-	+	++

1. Normal Strength - Abnormal Strength $\frac{\quad}{\text{Normal Strength}}$ = % of Strength loss Index

These tests should be done with the methodology and validation of effort as described on page 508 of the AMA Guides 5th Edition. If there is bilateral involvement, use the normative data tables found in the AMA 5th Edition, Chapter 16, page 509.

2. For nerve conduction testing, the Impairment Committee recommends uniform adoption of the current AAEM Criteria.

4.4f. Utah's Specific Upper Extremity Impairments Due to Entrapment Neuropathy

Schedule VIII b. Utah's Specific Upper Extremity Impairments Due to Entrapment Neuropathy						
ENTRAPPED NERVE	ENTRAPMENT SITE	Grade I	Grade II	Grade III	Grade IV	Complete Motor and Sensory Loss
Median	Elbow	7	15	35	50	65
Median	Wrist	5	10	20	30	44
Ulnar	Elbow	3	10	30	40	50
Ulnar	Wrist	3	10	30	35	40

4.4g. Specific Upper Extremity Painful Organic Syndromes

Utah Specific Upper Extremity Painful Organic Syndromes is appropriate where there is the presence of a substantiated diagnosis and functional disability yet measurable impairment may be lacking. These are musculoskeletal conditions that are characterized by pain, weakness or diminished function with use of the affected member that is attributed to a lesion or condition in the soft tissue (capsule, ligament, tendon,

fascia, muscle). Documentation must support a specific ICD9 diagnosis that has been present for longer than six months, with consideration of the mechanism, history, duration of the injury, the initial presenting signs such as swelling and ecchymosis, changes on MRI, arthrogram, and/or intraoperative findings, swelling, pannus, or effusions). Maximum medical improvement (MMI) can occur with or without surgical treatment. If surgery is recommended but the patient elects not to proceed, MMI occurs on that day. The date the patient qualifies for an impairment rating or when the lesion or condition reaches medically stability may be different; however, both are required for the impairment.

4.4h Utah's Specific Upper Extremity Painful Organic Syndromes

SCHEDULE IX. UTAH'S SPECIFIC UPPER EXTREMITY PAINFUL ORGANIC SYNDROMES Post Operative Trigger Finger or Thumb, Intrinsic tightness post trauma, Bursitis, Chronic Tendonitis, de Quervain's tendonitis, Wrist intersection syndrome, Ganglions and masses, Epicondylitis, medial or lateral, Strains or Sprains of Fingers, Thumb, Hand, Wrist, Elbow, Shoulder. Crush injuries of the digits with cold intolerance (These Upper Extremity percentages are 60% whole person)				
Residual Symptoms Grade	I	II	III	IV
History of Mechanism of Injury	Minimal	Mild	Moderate	Severe
Initial presenting signs	Minimal	Mild Swelling	Moderate Swelling	Significant Swelling-ecchymosis
Image Findings X Ray, CT, MRI, Arthrogram	None	Minimal	Moderate	Significant
Intraoperative Findings	N/A	Minimal	Significant swelling, pannus, or effusions	Significant swelling, pannus, or effusions
Impact on Activities	Minimal impact	abnormal sensations or pain that does not prevent most activities	pain or abnormal sensations that interferes or prevents some activities	pain or abnormal sensations that interferes or prevents most activities
Ratings: Shoulder and or Elbow and or Wrist and or Hand	0%	2%	4%	6%

These are stand alone impairments that are otherwise not accounted for within these guides or the 5th Edition of the AMA guides. The rater is to place the findings into each category and then average the grades to establish the Impairment.

As with all conditions, the impairment maybe calculated using different methodologies, with the highest being reported.

4.5 Examples of Upper Extremity Impairment Ratings

Example #1 Rotator Cuff Repair

A 45-year-old postman is seen for shoulder pain after a fall at work 2 weeks earlier, where he slipped on some ice and landed on his outstretched arm. He was found to be unable to abduct his arm past 60 degrees with considerable pain. He was suspected of having a rotator cuff tear and was taken to surgery, where he was found to have a complete, full thickness (>5cm) tear of the rotator cuff. This was surgically repaired with an open procedure with a distal clavicle resection. He underwent a course of physical therapy and has been declared medically stable. He has been left with weakness and associated loss of motion in his shoulder.

His ROM findings are listed below:

ROM Shoulder Impairment (Upper Extremity) Figures 16-40, 43, 43, 46. (AMA Guides, p. 466)					
Flexion (180°)	Extension (50°)	Abduction (170°)	Adduct (40°)	Internal Rotation (80°)	External Rotation (60°)
100/5%	30/1%	100/4%	30/1%	60/2%	60/0%
Total Shoulder Range of Motion Impairment:					13%

His impairment for his rotator cuff:

Upper Extremity Ratings for Shoulder Conditions Findings must be present for >6 consecutive months despite non-surgical or surgical treatment upper extremity impairment for these categories listed below and combined with ROM is not to exceed 18% Recommend MRI or Arthroscopic Pictures be Available, Confirming Findings		
Condition	Findings/Treatment	Rating
Rotator cuff tear Partial or full thickness	Confirmed by MRI, treated non-surgically or surgically with residual pain that markedly limits activity.	6 %

His impairment is 6% for his rotator cuff repair. 6% combined with 13% is 18% upper extremity or 11% whole person.

2006 UTAH'S UPPER EXTREMITY RATING GUIDELINES WORKSHEET <i>Section/Page numbers correspond to 5th Edition of the AMA Guides unless stated to correspond to UTAH Guides</i>			
Schedules to use for a rating of the Upper Extremity per UTAH Guides		Section # (Page)	% Upper Ext Current ⁱ
Functional	Range of Motion including Ankylosis	16-4 (450)	13%
Diagnosis Based	Upper Extremity Rotator Cuff Impairments	Page *Utah's 2006 Guides	6%
Total Upper Extremity Impairment:			18%

Example #2: Shoulder Fracture

One year ago, a 58-year-old male incurred a fracture to his right shoulder after a fall at work. He has undergone therapy and has been left with a weak, stiff and painful upper extremity with associated numbness secondary to a partial neuropathy of the radial nerve. After undergoing physical therapy, he has been declared medically stable. (ROM are listed below.)

An impairment is calculated using the Utah's Impairment Guides and the AMA 5th Edition.

For his neurological loss, the radial nerve is weighted at 45% UE.

Table 16-16 Maximum Upper Extremity Impairment due to Unilateral Sensory or Motor Deficits <i>AMA Guides (p. 492)</i>			
Nerve	Sensory Deficits	Motor Deficits	Combined Motor and Sensory deficits
Radial (upper arm) with Loss of Triceps	5	42	45

He qualifies for 20% loss of the radial nerve.

Table 16-11 Determining Impairment Of The Upper Extremity Due To Motor And Loss Of Power Deficits Resulting From Peripheral Nerve Disorders Based On Individual Muscle Rating (Upper or Lower Extremity Value) Adapted and modified from the AMA Guides 5 th edition, Table 15-15, page 424		
Class	Description of Muscle Function	% Motor Deficit
3	Active movement against gravity only without resistance	20%

20% for the total value of the radial nerve x 45% equals 9% upper extremity for motor and sensory loss.

Loss of Motion

ROM Shoulder Impairment (Upper Extremity) Figures 40, 43, 44, 46 <i>AMA Guides</i> (p. 466)					
Flexion (180°)	Extension (50°)	Abduction (170°)	Adduct (40°)	Internal Rotation (80°)	External Rotation (60°)
130/3%	30/1%	120/3%	30/1%	40/3%	70/0%
Total Shoulder Range of Motion Impairment:					11%

For his loss of motion he would have 11% Upper extremity.

2006 UTAH'S UPPER EXTREMITY RATING GUIDELINES WORKSHEET <i>Section/Page numbers correspond to 5th Edition of the AMA Guides unless stated to correspond to UTAH Guides</i>			
Schedules to use for a rating of the Upper Extremity per UTAH Guides		Section # (Page)	% Upper Ext
			Recent
	Peripheral Nerve Damage	16-5 (480-495)	9%
Functional	Range of Motion including Ankylosis	16-4 (450)	11%
Total Upper Extremity Impairment:			19%

These combine to equal 19% upper extremity or 11% whole person.

Chapter Five: Lower Extremity

5.0 Introduction to Lower Extremity: AMA 5th Edition Chapter 17

The 5th Edition of the *American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides)* provides a number of methods that can be utilized in the calculation of the impairment rating in the lower extremity. To provide a rating methodology that facilitates consistency, the impairment committee has reviewed and simplified the lower extremity rating methodology as listed below. As with other sections of the *Utah Supplemental Guides for Rating Permanent Impairment (Utah Guides)*, the rater is reminded that the total rating of a part of an extremity should never be greater than that which is allowed for the whole extremity. This would mean that the maximum rating that a physician can award would be equal to 100% amputation of the lower extremity (hip disarticulation), which is awarded 40% whole person.

In that there are a number of different ways an extremity can be rated, the Utah has adopted the following worksheet. This worksheet not only facilitates the process for those doing complicated impairment ratings, but greatly helps those reading the rating to better understand the derivation of the final number.

Only those methods from the 5th Edition of the *AMA Guides* that are listed on the Lower Extremity Worksheet have been approved for rating impairments of the lower extremity. Physicians are reminded that these individual components of this lower extremity chapter are to be combined.

5.1 2006 Lower Extremity Rating Guidelines Worksheet

5.1 2006 UTAH LOWER EXTREMITTY RATING GUIDELINES WORKSHEET

Section/Page numbers correspond to 5th Edition of the AMA Guides unless stated to correspond to Utah Guides
100% Lower Extremity is 40% Whole Person

Name: _____ Age _____ Sex _____ Date _____

Side ☐ R ☐ L

Diagnosis: _____

Schedules to use for a rating of the Lower Extremity per UTAH Guides		Section # (Page)	% Lower Ext Current ⁱ	
Functional	Range of Motion including Ankylosis	17.2f (533)		
Anatomic	Limb Length Discrepancy	17.2b (528)		
	Amputation	17-2i (545)		
	Skin Loss	17-2k (550)		
	Peripheral Nerve Injury	17.2l (550)* 16-5 (480-495)		
	CRPS type 1 or 2	16-5e (495) Utah's		
	Vascular	17-38 (553)		
	These are Mutually Exclusive: Arthroscopic findings take Precedence	Arthritis of Joints (544) **Acute Arthroscopic Osteochondral Lesions:	17-2.h (544) UTAH's 2006 Guides	
	Diagnosis Based (545)	Fractures	17.2j (546)	
Ligament Injuries		17.2j (546)		
Partial Meniscectomies (2% L.E. Per Partial Meniscectomy, up to a max of 7% L.E. For each meniscus) Meniscal repair: Rate like partial meniscectomy Meniscal transplant, rate 50% of total meniscectomy		17.2j (546)		
Foot Deformities		17.2j (546)		
Hip and Bursitis		17.2j (546)		
Lower Extremity Joint Replacements		17.2j (546)		
Stand Alone: Lower Extremity Painful Organic Syndromes That Are Not Otherwise Accounted for Within These Guides or the AMA Guides - 5th Edition (Page #, Utah's 2006 Impairment Guides) Not to be Combined with Other Ratings		Utah's 2006 Guides		
Stand Alone: Patellofemoral pain and crepitation with a history of direct trauma	17-31 (544)			
Total Lower Extremity Impairment Value Without Apportionment:				
Final Impairment Related to the Last Event:				
Signature and Professional Title of Physician doing Rating:				

If more than one method can be used to calculate a rating, the physician should calculate the impairment rating using different alternatives and choose the method or combination of methods that gives the most clinically accurate and highest impairment rating.⁷

* Adapted and modified from the 5th Edition of the *AMA Guides*, Table 15-15, page 424

5.1a. Motor Deficits Worksheet

MOTOR DEFICITS* CLASSIFICATION FOR DETERMINING IMPAIRMENT DUE TO LOSS OF FUNCTION RESULTING FROM NERVE DISORDERS (Lower or Lower Extremity Value) Adapted and modified from the <i>AMA Guides</i> 5 th Edition, Table 15-15, page 424		
Class	Description of Muscle Function	% Motor Deficit
5	Active movement against gravity with full resistance	0
4	Active movement against gravity with some resistance	20
3	Active movement against gravity only without resistance	40
2	Active movement with gravity eliminated	60
1	Slight contraction and no movement	80
0	No contractions	100

* Adapted and modified from the 5th Edition of the *AMA Guides*, Table 15-16, page 424

Schedules in AMA 5th Not to be Used for Rating Impairments in the Lower Extremity

Atrophy 17.2d (530)
Causalgia/Reflex Sympathetic Dystrophy 17.2m (553) <i>Use methodology as found in the upper extremity section describing CRPS type 1 or 2, 16-5e (495)</i>
Gait derangement (336, 529)
Manual Muscle Testing 17-2e ⁸ except for severe compartment syndromes and other conditions where there has been major muscle mass loss for which an impairment cannot be extrapolated any other way. <i>For weakness due to true neurological weakness and use 16-10, 16-11</i>

5.1b. CRPS for Lower Extremities

Methodology for the calculation of CRPS in the lower extremity will be done as described on page 86.

The Rater is to first use the amputation values as found on page 440 table 16-4 that identifies the portion of the upper extremity that is involved. This % is then multiplied by the % of sensory deficits and pain as described on page 495.

⁷ The Guides to the Evaluation of Permanent Impairment, 5th Edition, Chicago, IL, American Medical Association; 2001. p. 526-27.

⁸ Strength evaluation: voluntary muscles strength testing remains somewhat subjective until a precise way of measuring muscle contraction is generally debatable. It should also be noted that the correlation of strength with performance of activities of daily living is poor and that increased strength does not necessarily equate with increased function. Page 507

5.2 Lower Extremity Arthroscopic Cartilaginous Impairments

It is readily recognized that arthroscopic findings are the most accurate in identifying a joint's current condition and prognosis, including findings expected from recent events compared to longstanding or degenerative conditions. Schedule X allows the impairment rater to outline what findings are present, the severity of the findings and why they are there, based on the arthroscopic findings. For cartilage implants, rate below as original lesion.

SCHEDULE X. ACUTE ARTHROSCOPIC OSTEOCHONDRAL LESIONS			
Impairments Lower Extremity			
(Chondromalacia is not considered an acute lesion)			
Recommend Pictures Be Taken, Confirming Findings			
Calculate the lower extremity impairment by adding Size% + Stage %+ Location = Total %LE			
Total Area of lesions	Stages of Acute Articular Cartilage Separation	Location	Current Event ⁱ
(Greatest Diameter of Lesion with sharp margins)	(No Award for Successful Re-implantation or Transplantation)	Weight Bearing Surface = 2% Non-weight bearing Surface = 0% (Patella femoral Joint is Considered a Weight Bearing Joint)	
< 1cm = 2% 1-1.5 cm = 4% >1.5 cm = 6%	Partial Thickness Cartilage Loss 3% Full Thickness Cartilage loss, Bone Exposed 6%	Hip	
		Knee	
		Medial	
		Lateral	
		Patella femoral	
		Ankle	
Lower Extremity Cartilage Impairment:			

5.2a. Specific Lower Extremity Painful Organic Syndromes

These are musculoskeletal conditions that are characterized by pain, weakness or diminished function with use of the affected member that is attributed to a lesion or condition in the soft tissue (capsule, ligament, tendon, fascia, muscle). Documentation must support a specific ICD9 diagnosis that has been present for longer than six months, with consideration of the mechanism, history, duration of the injury and the initial presenting signs such as swelling and ecchymosis. Maximum medical improvement (MMI) can occur with or without surgical treatment. If surgery is recommended but the patient elects not to proceed, MMI occurs on that day. The date the patient qualifies for an impairment rating or when the lesion or condition reaches medical stability may be different; however, both are required for the impairment.

5.2b. Utah's Specific Lower Extremity Painful Organic Syndromes

UTAH'S SPECIFIC LOWER EXTREMITY PAINFUL ORGANIC SYNDROMES Ganglions and masses, Chronic medial or lateral Strains or Sprains, Bursitis, tendonitis, Crush injuries of the digits with cold intolerance (Lower Extremity% is 40% whole person)				
Residual Symptoms Grade	I	II	III	IV
History of Mechanism of Injury	Minimal	Mild	Moderate	Severe
Initial presenting signs	Minimal	Mild Swelling	Moderate Swelling	Significant Swelling-ecchymosis
Image Findings X Ray, CT, MRI, Arthrogram	None	Minimal	Moderate	Significant
Intraoperative Findings	N/A	Minimal	Significant swelling, pannus, or effusions	Significant swelling, pannus, or effusions
Impact on Activities	Minimal impact	abnormal sensations or pain that does not prevent most activities	pain or abnormal sensations that interferes or prevents some activities	pain or abnormal sensations that interferes or prevents most activities
Ratings: Hip-Knee-Ankle and Foot (LE)	0%	2%	4%	6%

These are stand alone impairments that are otherwise not accounted for within these guides or the 5th Edition of the AMA guides. The rater is to place the findings into each category and then average the grades to establish the Impairment.

As with all conditions, the impairment maybe calculated using different methodologies, with the highest being reported.

5.3 Examples of Lower Extremity Impairment Rating

5.3a. Lower Extremity Example 1

8 months ago a 28 year old male severely injured his foot when a car ran over it. Fortunately there were no broken bones. Although initially he had significant swelling, it resolved over time with a residual painful foot. On physical examination, it was noted that he did not have vascularity, sweat, nail or hair pattern changes. He has been declared medically stable with normal ROM and residual pain that continues to interfere with high stress or loaded activities.

UTAH'S SPECIFIC LOWER EXTREMITY PAINFUL ORGANIC SYNDROMES Ganglions and masses, Chronic medial or lateral Strains or Sprains, Bursitis, tendonitis, Crush injuries of the digits with cold intolerance (Lower Extremity% is 40% whole person)				
Residual Symptoms Grade	I	II	III	IV
History of Mechanism of Injury	Minimal	Mild	<u>Moderate</u>	Severe
Initial presenting signs	Minimal	Mild Swelling	<u>Moderate Swelling</u>	Significant Swelling-ecchymosis
Image Findings X Ray, CT, MRI, Arthrogram	None	Minimal	Moderate	Significant
Intraoperative Findings	N/A	Minimal	<u>Significant swelling, pannus, or effusions</u>	Significant swelling, pannus, or effusions
Impact on Activities	Minimal impact	abnormal sensations or pain that does not prevent most activities	<u>pain or abnormal sensations that interferes or prevents some activities</u>	pain or abnormal sensations that interferes or prevents most activities
Ratings: Hip-Knee-Ankle and Foot (LE)	0%	2%	<u>4%</u>	6%

This impairment would best fit into a Grade III category or 4% LE or 2% whole person

5.3b. Lower Extremity Example 2

6 months ago, a 44 year old male twisted his knee with symptoms of swelling and locking. He was diagnosed with a medical meniscus tear and taken to surgery where he was found to have a bucket handle tear of the medical meniscus. This was débrided back to a stable rim. His postoperative course was unremarkable and he has been declared stable with minimal symptoms.

2006 UTAH LOWER EXTREMITY RATING GUIDELINES WORKSHEET <i>Section/Page numbers correspond to 5th Edition of the AMA Guides unless stated to correspond to Utah Guides</i> <i>100% Lower Extremity is 40% Whole Person</i>		
Schedules to use for a rating of the Lower Extremity per UTAH Guides	Section # (Page)	% Lower Ext
		Current ⁱ
Partial Meniscectomies (2% L.E. Per Partial Meniscectomy, up to a max of 7% L.E. for each meniscus) Meniscal repair: Rate like partial meniscectomy Meniscal transplant, rate 50% of total meniscectomy	17.2j (546)	2%
Total Lower Extremity Impairment Value Without Apportionment:		2%
Final Impairment Related to the Last Event:		2%

5.3c. Lower Extremity Example 3

A 33 year-old male is seen for an impairment rating for the residual loss that he has of his left knee. He states that he was in his usual state of health until February 5, 1999. At that time he was driving freight and in the process of doing his job, he slipped off the freight truck trailer approximately four feet straight down, putting full weight on the left knee and as a result it buckled underneath him. He eventually had an MRI that showed an ACL tear and a partial lateral meniscus tear. He was taken into surgery, where he was found to have a complete tear of the anterior cruciate ligament of the left knee and a longitudinal tear of the posterior horn of the lateral meniscus of his left knee. He was also found to have an acute osteochondral defect, with its greatest diameter of 1.6 cm, full thickness to bone on the weight bearing surface of the lateral femoral condyle left knee. His rehabilitation was completed with ROM, and moderate ACL laxity (17-33)

Schedule X and the Lower Extremity Worksheet are used below in rating the impairment:

ACUTE ARTHROSCOPIC OSTEOCHONDRAL LESIONS			
Impairments Lower Extremity			
Recommend Pictures Be Taken, Confirming Findings			
Calculate the lower extremity impairment by adding Size% + Stage % + Location = Total %LE			
Total Area of lesions (Greatest Diameter of Lesion)	Stages of Acute Articular Cartilage Separation (No Award for Successful Re-implantation or Transplantation)	Location Weight Bearing Surface = 2% Non-weight bearing Surface = 0% (Patella femoral Joint is Considered a Weight Bearing Joint)	Current Event ⁱ
< 1cm = 2% 1-1.5 cm = 4% <u>>1.5 cm = 6%</u>	Partial Thickness Cartilage Loss 3% <u>Full Thickness Cartilage loss,</u> <u>Bone Exposed 6%</u>	Knee	
		Medial	
		<u>Lateral</u>	14%
		Patella femoral	
		Subtalar	
Lower Extremity Cartilage Impairment:			14%

2006 UTAH LOWER EXTREMITY RATING GUIDELINES WORKSHEET			
Section/Page numbers correspond to 5 th Edition of the AMA Guides unless stated to correspond to UTAH Guides			
Schedules to use for a rating of the Lower Extremity in UTAH		Section No# (Page)	% Lower Ext
			Current ⁱ
Functional	Range of Motion including Ankylosis	17.2f (533) 17-10	20
Anatomic	Limb Length Discrepancy	17.2b (528)	
	Amputation	17-2i (545)	
	Skin Loss	17-2k (550)	
	Peripheral Nerve Injury	17.2l (550)	
	CRPS type 1 or 2	16-5 (480-495)	
	Vascular	17-38 (553)	
	These are Mutually Exclusive: Arthroscopic findings take Precedence	Arthritis of Joints (544) **Acute Arthroscopic Osteochondral Lesions: Schedule IX	17-2.h (544) Page * Utah's 2006 Guides 14
Diagnosis Based (545)	Fractures	17.2j (546)	
	Ligament Injuries	17.2j (546)	17
	Partial Meniscectomies (2% L.E. Per Partial Meniscectomy, up to a max of 7% L.E. For each meniscus)	17.2j (546)	2
	Foot Deformities	17.2j (546)	
	Hip and Bursitis	17.2j (546)	
	Lower Extremity Joint Replacements	17.2j (546)	
Stand Alone: Lower Extremity Painful Organic Syndromes That Are Not Otherwise Accounted for Within These Guides or the AMA Guides - 5th Edition (Page #, Utah's 2006 Impairment Guides) Not to be Combined with Other Ratings		Utah's 2006 Guides	
Stand Alone: Patellofemoral pain and crepitation with a history of direct trauma		17-31 (544)	
Combined Value Final Impairment Related to the Last Event:			44% LE 18% WP

ⁱThat which precipitated the need for care as compared to those findings that are present, absent the new findings from the current event

5.3d. Lower Extremity Example 4

A 22 year old male slipped off the second rung of a ladder, falling backwards. His right ankle sustained an inversion injury as he landed on a rock. Due to persistent symptoms, he eventually underwent an ankle reconstruction surgery. Post-operatively, he developed progressive allodynia initially over the dorsal foot, and later over the entire foot up to the ankle. Symptoms persisted despite treatment. He is able to ambulate without a cane, but his gait is antalgic. A triple phase bone scan confirmed asymmetric delayed pooling in the affected limb, and x-rays demonstrated localized osteoporosis. Edema, allodynia and mottling were noted on exam. The affected foot was 2 degrees C cooler than the left foot. Nail appearance in the right foot showed curved, "talon-like" nails, which were different than the left foot. The skin appearance was smooth, and non-elastic, and there was a lack of hair on the dorsal right foot when compared with the left. Joint stiffness, with decreased passive motion was noted. Ankle plantarflexion

was to 15 degrees, with extension to 5 degrees. He has been declared medically stable and an impairment rating is calculated.

Rating:

From Table 16-10, on page 482 of the 5th Edition, the severity index is graded as 40% (grade 3, with pain that interferes with some activities). This is multiplied by the maximal impairment for an amputation at the level of the ankle (Syme), which is 100% foot (62% lower extremity, or 25% whole person, as noted in Table 17-32, on page 545), yielding a 40% foot impairment (25% lower limb or 10% whole person) $40\% \times 62\% = 25\% \text{ LE}$

For CRPS, the patient would receive a 40% foot (25% lower limb or 10% whole person) impairment.

The patient would receive a 10% foot (7% lower extremity or 3% whole person impairment) for decreased plantar flexion, and another 10% foot (7% lower extremity or 3% whole person impairment) for decreased extension.

2006 UTAH LOWER EXTREMITY RATING GUIDELINES WORKSHEET <i>Section/Page numbers correspond to 5th Edition of the AMA Guides unless stated to correspond to UTAH Guides</i>			
Schedules to use for a rating of the Lower Extremity in UTAH		Section No# (Page)	% Lower Ext Current ⁱ
Functional	Range of Motion including Ankylosis		17.2f (533) 17-10
Anatomic	Limb Length Discrepancy		17.2b (528)
	Amputation		17-2i (545)
	Skin Loss		17-2k (550)
	Peripheral Nerve Injury		17.2l (550) 16-5 (480-495)
	CRPS type 1 or 2		16-5e (495)
	Vascular		17-38 (553)
	These are Mutually Exclusive: Arthroscopic findings take Precedence	Arthritis of Joints (544) **Acute Arthroscopic Osteochondral Lesions: Schedule IX	17-2.h (544) Page * Utah's 2006 Guides
Diagnosis Based (545)	Fractures		17.2j (546)
	Ligament Injuries		17.2j (546)
	Partial Meniscectomies (2% L.E. Per Partial Meniscectomy, up to a max of 7% L.E. For each meniscus)		17.2j (546)
	Foot Deformities		17.2j (546)
	Hip and Bursitis		17.2j (546)
	Lower Extremity Joint Replacements		17.2j (546)
Stand Alone: Lower Extremity Painful Organic Syndromes That Are Not Otherwise Accounted for Within These Guides or the AMA Guides - 5th Edition (Page #, Utah's 2006 Impairment Guides) Not to be Combined with Other Ratings		Utah's 2006 Guides	
Stand Alone: Patellofemoral pain and crepitation with a history of direct trauma		17-31 (544)	
Combined Value Final Impairment Related to the Last Event:			36% LE 14% WP

This results in a 36% lower extremity or 14% whole person.

Miscellaneous Impairments and Clarification Statements for the AMA 5th Edition Impairment Guides®

Part 6 of the Supplemental Impairment Rating Guides

Loss of Teeth Secondary to an Industrial Event

Maximum of 10% WP to Be Awarded

Impairment in Whole Person

Upper Incisors.....1% (Each)
All other Teeth.....1/2% (Each)

TEMPOROMANDIBULAR JOINT

Impairment in Whole Person

The temporomandibular joint is unique in that it is a bilateral joint, but functions in relationship to only a single bone, the mandible, which moves as a unit with complex motions. This joint is not comparable to the situation of bilateral joints of the extremities that are independent from each other. The following schedule should be used in reporting impairment related to the temporomandibular joint.

Schedule XI. Temporomandibular Joint Impairment (Whole Person)	
Use either the <u>Range of Motion</u> or the <u>Structural Change</u> Model, <i>Whichever is Greater*</i>	
Range of Motion Model	Structural Change Model
Range of Motion in Millimeters (Only the vertical opening from incisal edge of maxillary teeth to incisal edge of mandibular teeth measured in mm) 0 -10....(Traumatic Microstomia)..... 10% 11-20..... 8% 21-30..... 6% 31-40 ⁸⁹ 3%	Recurrent Subluxating or dislocating disc Unilateral.....1% Bilateral.....2% Recurrent Subluxating or dislocating joint Unilateral.....3% Bilateral.....4% Meniscal Repair or Meniscectomy Unilateral..... 3% Bilateral.....4% Meniscectomy and implant alloplastic or soft tissue Unilateral.....7% Bilateral.....10% Arthroplasty (Total Joint) reconstruction, resection Unilateral.....7% Bilateral.....10% Arthroscopic surgical debridement/synovectomy Unilateral.....2% Bilateral.....3%

* In severe cases, the range of motion model or the structural change model may be combined with weight loss,⁹⁰ speech impediment,⁹¹ or disfigurement⁹² as defined in the *AMA Guides, 5th Edition*.

Utah's Burn Impairment Methodology

The current methodology found in 5th Edition of the AMA Guides chapter 8, table 8-2 page 178 is vague as to how best be utilized in the calculation of the impairment ratings for burns. Burns can occur with significant diverse and different severity over any or all body surfaces and damage the integrity of the skin making the skin more sensitive to physical and chemical insult. The skin may become sensitive to the touch and breakdown more easily with friction, etc. Burns can cause scarring that limits function of other tissues or motion in affected joints. Burns can also cause disfigurement if in exposed surface areas (face, neck and hands).

To provide rating methodology that facilitates consistency and fairness, the Impairment Committee has reviewed and updated the burn rating process.

As with other sections of the Impairment Guides, the rater is reminded that the rating of a part should never be greater than that which is allowed for a whole amputation. This would mean that the maximum rating a physician could award for the upper extremity would be equal to 100% upper extremity or 60% whole person.

The extent of skin involvement should be documented. If the patient has burns or scars, describe the location, exact measurements (cm. x cm.), shape, depression, type of tissue loss (superficial, deep, full thickness, etc.), adherence to underlying tissue or free mobility, and tenderness. Note breakdown, ulceration, large keloid formation, and whether or not a graft is present and its effectiveness. For each burn scar, state if due to a 2nd or 3rd degree burn. Describe any limitation of activity or limitation of motion due to scarring or other skin lesions. **NOTE:** If there are disfiguring scars (of face, head, or neck), color photographs are extremely helpful of the affected area(s) to submit with the examination report. In rating burns, the following items should be described in the report.

A. Review of Medical Records

B. Medical History (Subjective Complaints)

1. Type of burn injury causing scar, its date, the treatment used and the response to such treatment.
2. Current symptoms.

C. Physical Examination (Objective Findings)

For every scar to be examined, address EACH of the following and fully describe the current findings. Note that, in addition to measuring the scar itself, measurements of areas with certain abnormal characteristics must also be provided. All measurements should be reported in inches or centimeters.

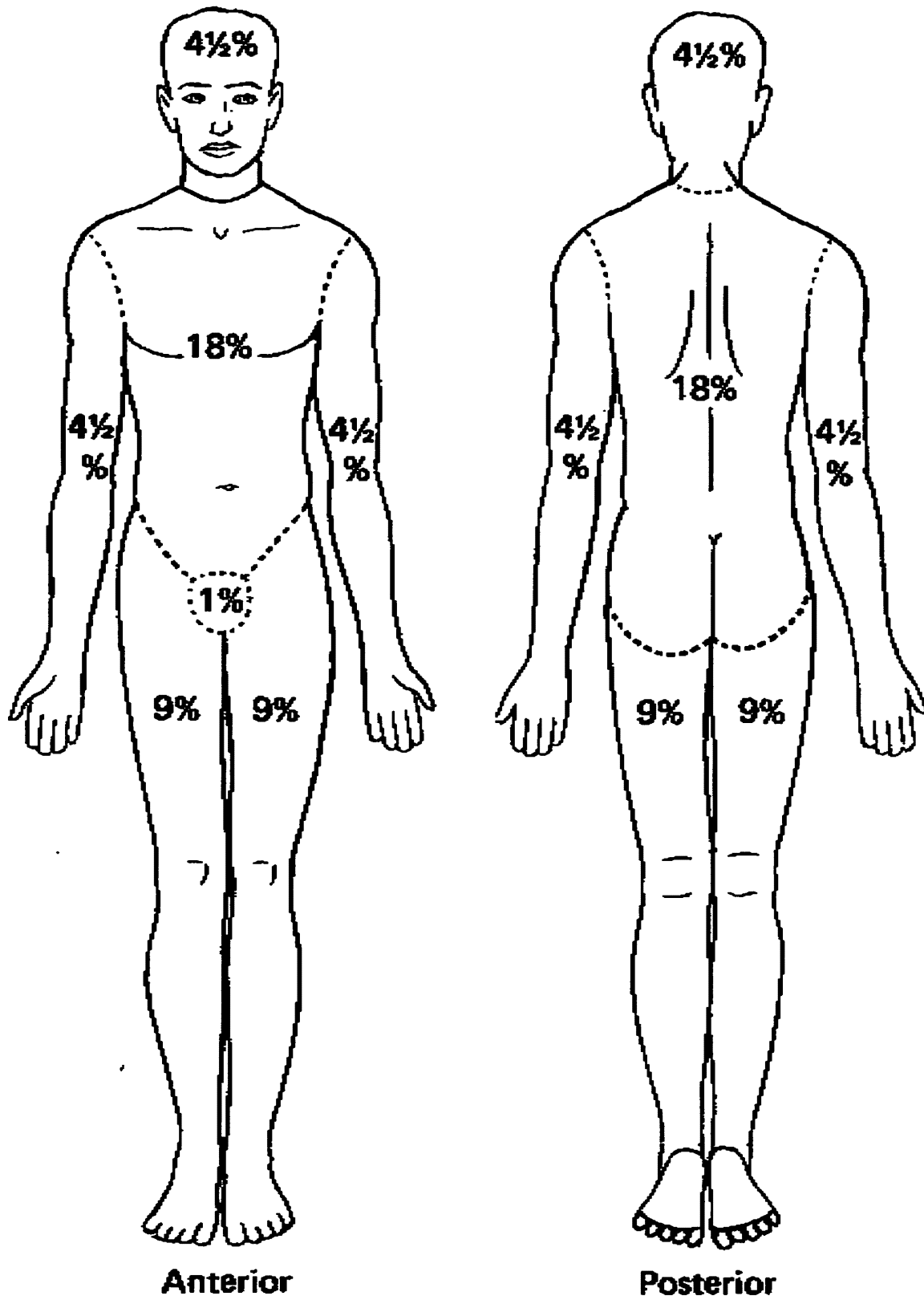
1. Describe precise location of each scar. Draw diagram if necessary.
2. Give MEASUREMENT of length and width (at its widest part) of each scar.
3. Is there pain in the scar on examination?
4. Is there adherence to underlying tissue?
5. Texture of skin. If irregular, atrophic, shiny, scaly, etc., give MEASUREMENT of length and width of area so affected.
6. Is the scar unstable, meaning is there frequent loss of covering of skin over the scar, such as from ulceration or breakdown of skin?
7. Is there elevation or depression of the surface contour of the scar on palpation?
8. Is the scar superficial (meaning there is no underlying soft tissue damage)?
9. Is the scar deep (meaning there is underlying soft tissue loss or damage)? If yes, give MEASUREMENT of length and width of underlying soft tissue damage.
10. Describe any inflammation, edema, or keloid formation.
11. Describe color of scar compared to normal areas of skin (give MEASUREMENT of length and width of any hypopigmentation or hyperpigmentation).

12. For face, discuss whether there is gross distortion or asymmetry of any feature or set of paired features (nose, chin, forehead, eyes ((including eyelids)), ears ((auricles)), cheeks, lips).
13. Is there an area of induration and inflexibility of skin in the area of the scar? If so, give MEASUREMENT of length and width of area of induration.
14. Describe any limitation of motion or other limitation of function caused by a scar.
15. With disfigurement or disfiguring scar of head, face, or neck, submit COLOR PHOTOGRAPHS.
16. Specify if any exposed areas (head, face, neck, and hands) are affected. Provide the percent affected of exposed areas. Provide the percent affected of the entire body.

Also, using the rule of nines, the skin surface area involved should be documented as a percent of total body surface area as well as a second recording for the percent of involved area (in terms of total surface area percentage) that is exposed surface area.

Rule of 9's:

The major body areas are divided such that each area is a multiple of nine. The head represents 9% of the body surface, and each arm is 9%. The front of each leg (to the groin) is 9%, and the back 9%. The front of the torso is 18%, and the back is 18%.





UTAH'S BURN SCHEDULE METHODOLOGY FOR CALCULATING IMPAIRMENT FOR BURNS (WHOLE PERSON) Loss of Motion, Amputation, Sexual Dysfunction and Neurological Loss Would Also Be Combined For Each Extremity. Each Extremity Is Then Converted To Whole Person And Combined With Any Other Areas Of The Body.			
Estimated % of Burn	Severity of Burn Multiplier	Location of burn add 5% WP	Disfigurement involves areas where scars are visible when fully clothed (face, neck, hand)
Rule of Nines	Partial-thickness x 1	Deep burns over flexion creases, hands, face, feet and/or Genital areas.	Extreme: likely to interfere with obtaining employment in any setting, including those without public contact: Add 10%
	Area of full-thickness keloid, adhesions to underlying tissue and frequent breakdown, x 2		Moderate: likely to impair some employment in jobs requiring frequent public contact. Add 5% Minimal: unlikely to significantly limit employment in public contact positions. Add 1%

Example: Burn

A 42 Year old male is severely burned on both upper extremities and the chest area from a thermal fire 15 months prior. His medical records indicated that he had an estimated 5% full thickness burn on his right upper forearm to include the palm of the hand. His left upper extremity had an estimated 3% partial thickness burn to his forearm only and he and 3% full thickness burn to his chest. He has required extensive therapy and now has been declared stable with a painful contractured right upper extremity.

His impairment rating at this time would be:

Burns:

Right Arm 5% for estimated burn area x 2 for severity =10% + 5% for inclusion of his palm = 15% WP

Left Arm	3% x 1 = 3% WP
Chest	3% x 2 = 6% WP

Total impairment for his burns is 22% WP (Combined)

For his contractured right hand with associated loss of sensation, he would have calculated 33% of his hand, or 30% upper extremity or 18% whole person.

22% for his burn and 18% for his loss of motion, sensation is combined to equal 36% whole person.

AMA 5th Edition Review
Utah's 2006 Clarification of the
AMA Guides to the Evaluation of Permanent Impairment 5th Edition

The relative scale of 0 to 100% is inconsistent through out the different chapters.
Definitions established in Chapters 1 and 13, establish the entire relative scale of the rating process.

Chapter 1

90 percent to 100 percent whole person impairment indicates a very severe organ or body system impairment requiring the individual to be fully dependent on others for self-care, approaching death. Page 5

Chapter 13

90 Percent, persistent vegetative state due to cerebral contusion and intracranial hemorrhage. 90 percent of the whole person. Persistent vegetative state is defined as a clinical condition of complete unawareness of the self and the environment. Page 311, Exp 13-4.

Location and Inconsistencies

These chapter's relative scale is inconsistent with the prior defined definitions.

Page 30, 3.2 a, table 3-5

Signs of physical examination valvular heart disease and symptoms at rest or in performance of less than ordinary activities **50 percent -100 percent impairment of the whole person.** Out of line with impairment relative scale.

Page 34, Ex. 3-8

Unable to do most activities of daily living without assistance. **90 to 100 percent impairment of the whole person.** Out of line with impairment relative scale

Page 46, 3-25 Ex. 3-25

Comfortable during exertion for short periods: weak and breathless on more moderate exertion. **80 to 90 percent impairment of the whole person.** Out of line with impairment relative scale

Page 46, Ex. 3-26

Recent activity markedly limited because of fatigue with minimal exertion. **95 to 100 percent of whole person.** Out of line with impairment relative scale

Page 51, Ex. 3-34

Dyspnea on exertion with one flight of stairs or ambulation over 25 feet. **80 to 89 percent of whole person.** Out of line with impairment relative scale

Page 54, Ex. 3-41

Able to walk on a little surface and do activities of living. **80 to 89 percent of whole person.** Out of line with impairment relative scale

Page 59, Ex. 3-49

70 to 90 percent impairment of the whole person. Out of line with impairment relative scale

Page 69, Ex. 4-8

Marked tiredness and breathlessness with ordinary activities. 80 percent whole person. Out of line with impairment relative scale

Page 110, Ex. 5-7

Increasing dyspnea for 5 years: difficulty keeping up with others the same age. Unable to walk upstairs past second flight. **26 to 50 percent whole person.** Out of line with impairment relative scale

Page 111, Ex. 5-10

Severe dyspnea: unable to perform activities of daily living, try pain to and from work, walking on little ground, said dress. **51 to 100 percent whole person.** Out of line with impairment relative scale

Page 344 Ex. 13-44

Routine venipuncture causing post traumatic neuralgia of the superficial radial nerve secondary to injury. **25 percent of the whole person.** Out of line with impairment relative scale

Utah Clarification

Utah will adopt the scale of 0% represents a complete and independent individual with 90 percent to 100 percent whole person impairment indicating a very severe organ or body system impairment requiring the individual to be fully dependent on others for self-care, approaching death. Page 5 Raters are to use this relative scale in interpreting all rating throughout the Guides in Utah.

Chapter 7 Gynecological Impairments are out of line with accepted scales.

Page 167, Ex. 7-46

A symptomatic female with radical hysterectomy and pelvic lymphadenectomy, ovaries conserved. **30 percent whole person.** Out of line with impairment relative scale

Page 168, Ex. 7-48

Pelvic pain secondary to recurrent endometriosis. **20 percent whole person.** Out of line with impairment relative scale

Page 169, Ex. 7-49

Bilateral salpingectomy. **30 percent whole person.** Out of line with impairment relative scale

Page 169, Ex. 7-50

Infertility due to primary ovarian failure. **30 percent whole person.** Out of line with impairment relative scale

Utah Clarification

Utah raters are to calculate their ratings as specific as possible with written justification of their derivations. Utah will maintain the methodology that, "In certain instances, the treatment of an illness may result in apparently total remission of the person's signs and symptoms. Examples include individuals with deep vein thrombosis with chronic anti-coagulants for more than a year. Yet it is debatable whether, with treatment, the patient has actually regained the previous status of normal good health. In these instances, the physician may choose to increase the impairment estimate by **three percent.**"

Inconsistencies exist for the defining, diagnosing and rating RSD, Causalgia and C.R.P.S. 1 & 2

The Guides states in Chapter 13, Page 343, 13.8, not to use the terminology C.R.P.S. 1 & 2, and to only use the terms RSD, Causalgia

Yet Chapter 16, states that RSD and Causalgia terms are not to be used, but a very comprehensive review is given for C.R.P.S. 1 & 2

Utah Clarification

Utah raters are to calculate their ratings for these conditions using the standard methodology found in Chapter 16.5e, page 495, for both the upper and lower extremity.

Dominate Extremity Inconsistencies

Controversy exists as to whether to allow an increase of 5-10% impairment for the dominant extremity.

Chapter 13 Table 13-22

Page 338, 13.6, table, 13-16 Chapter 15, Table 15-6, Page 396, awarded five to ten percent more for dominant upper extremity.

Chapter 16 16.1 B. page 435

Impairment ratings in this chapter have not been adjusted for hand dominance.

Utah Clarification

Utah raters are not to consider hand dominance, except as specified for corticospinal tract impairment (page 396).

Rating Subjective Complaints

Instructions for the ratings of subjective complaints of pain.

Utah Clarification

It is believed that the methodology found in the prior editions of the Guides adequately considered pain. Utah raters are **not to award additional percentages for pain under Chapters 13, 16, 17 and 18, of the AMA 5th Edition of the Guides**, until advances in diagnostic technology and clinical experience make pain related impairment ratings feasible.

Spinal Chapter 15

Remains very confusing. Two separate ways are described to calculate a rating, with little or no consideration for current published literature. How one selects which method to use remains unnecessarily complicated and confusing.

Utah Clarification

In Utah, Chapter 15 for spinal rating is not to be used, except as specified in the Utah 2006 Impairment Guides.

Strength Testing

Chapters 16 and 17

Strength evaluation: those who have contributed to the guides believe that further research is needed before loss of grip & strength is given a larger role in impairment evaluation page 507

Utah Clarification

In Utah, strength testing is not to be utilized, except at specified in these Guides.

Atrophy Chapter 16

Utah Clarification

In Utah, atrophy is not to be used.

Combining range of motion in upper extremities and lower extremities

Fifth Edition is confusing, allowing ROM to be combined in fingers with nerve loss and in lower extremity with nerve loss, but not in upper extremity.

Utah Clarification

In Utah, ROM may be combined with upper and lower extremities as specified.

Errors Identified in the Calculation Process of the 5th Edition

Error: In calculation of impairment for the same example found in two different chapters
Page 75, Ex. 4-19, Ex. is the same case that is found on page 498 16-62. The impairment of 49 percent of whole person is calculated wrong, the Ex. of page 498 calculates a rating of 44 percent whole person and appears correct.

Error: The Skin chapter. Impairment exceeds total amount that can be awarded (amputation)

Page 185, Ex. 8-17, post thrombophlebitis syndrome with stasis dermatitis and ulceration; scar formation secondary to chemical burn. Fifty-five percent whole person. The maximum award for complete leg amputation is 40 percent whole person.

Error: Award for whole person instead of upper extremity

Table 13-22: rating for chronic pain in one upper extremity.
Uses dominant and nondominant extremity with ranges of 5 to 10 percent whole person difference. Is awarded as the whole person, not upper extremity.

Error: Reference made that is not found

Page 346 a reference is made to a section 13.8 B. that does not appear to be in the book.

Error: Award for whole person instead of lower extremity

Page 348, Ex. 13-46 Ex. calculates the impairment as a whole person first and not as a lower extremity and then converting to a whole person.

Error: In calculation

Page 349, Ex. 13-47, Ex. is calculated entirely wrong, concluding with a 31% whole person rating. The correct calculation is 15 percent whole person. (Not only is the methodology incorrect, but the numbers utilized to calculate the rating are also incorrect.)

Error: Award for whole person instead of upper extremity

Page 424 to 15-17 and table 15-18 should be for upper extremity rather than whole person. Refer to page 346 and is inconsistent refer to page 489

Error: Award for whole person instead of lower extremity

Example 425 should be 1% and 5% lower extremity or 6% lower extremity, not whole person. (See page 489)

Error: Wrong calculations process

Page 438 wrong, to begin with the biggest number and combine

Error: Wrong calculation process

Page 346 nerve pain, the sensory and motor impairments are first combined to upper extremity and then converted to a whole person impairment page 347.

Error: Inconsistent: Ratings of conditions that become asymptomatic should be 3 percent
Page 218, Ex. 10-5, Hashimoto's thyroiditis. 5 % whole person. Inconsistent: Ratings of conditions that become asymptomatic should be 3%

Inconsistency: Vestibular system

Chart 11-4, p 253 demonstrates 95% WP for dysequilibrium where as table 13-13, p 334 is 70% for same condition. In Utah, Chapter 13 is to be used for dysequilibrium.

Glossary of Terms

Definitions of clinical findings accepted by the Utah Glossary of Terms

Medical stability

Medical Stability sometimes referred to maximum medical improvement (MMI), or fixed state of recovery, ⁹³ refers to a date in which the period of healing has ended and the condition of the worker is not expected to materially improve or deteriorate by more than 3% Whole Person in the ensuing year. ^{94 95 96}
^{97 98} It is important to note that medical stability may not be used to terminate necessary medical care. The date of medical stability and the date when the worker qualifies for an impairment rating can be two separate dates.

Causation

Causation means an identifiable factor, e.g., accident or exposure to hazards of the disease that brought on and worsened a medically identifiable condition. Medical or scientifically based causation requires a detailed analysis of whether the factor, **based on a reasonable probability, greater than 50 percent likelihood**, could have caused the condition, or temporarily-permanently aggravated the condition, based upon scientific evidence and specifically experienced judgment as to whether the alleged factor in the existing environment did cause the permanent impairment. ⁹⁹

Apportionment of Permanent Impairment Ratings

Apportionment represents a distribution or allocation of causation among multiple factors that caused or significantly contributed to the injury or disease and resulting impairment. The factor could be a pre-existing injury, illness, or impairment. Before determining apportionment, the physician needs to verify that all the following information is true for an individual. No. 1, there is documentation of a prior factor. No. 2, the current permanent impairment is greater as a result of the prior factor, by impairment, the injury, or illness. No. 3, there is evidence indicating the prior factor caused or contributed to the impairment, based on a reasonable probability, greater than 50 percent likelihood. ¹⁰⁰

The apportionment analysis must consider the nature of the impairment and its possible relationship to each alleged factor and must provide an explanation of the medical basis for all conclusions and opinions. ¹⁰¹

Aggravation: Temporary

Temporary aggravation refers to a factor, e.g., physical, chemical, biological, or medical condition that temporarily alters the course or progression of the medical condition, without a new added dimension of medical impairment.

Aggravation: Permanent

Permanent aggravation refers to a factor, e.g., physical, chemical, biological, or medical condition that alters the course or progression of the medical condition, with a new added dimension of impairment expected. ¹⁰²

Muscle Spasm

Muscle spasm is a sudden, involuntary contraction of a muscle or group of muscles. Paravertebral muscle spasm is common after acute spinal injury but is rare in chronic back pain. It is occasionally visible as a contracted paraspinal muscle but is more often diagnosed by palpation (a hard muscle). To differentiate true muscle spasm from voluntary muscle contraction, the individual should not be able to relax the contractions. The spasm should be present standing as well as in the supine position and frequently causes a scoliosis. The physician can sometimes differentiate spasm from voluntary contraction by asking the individual to place all his or her weight first on one foot and then the other while the physician gently palpates the paraspinal muscles. With this maneuver, the individual normally relaxes the paraspinal muscles on the weight bearing side. If the examiner witnesses this relaxation, it usually means that true muscle spasm is not present.

Muscle Guarding

Guarding is a contraction of muscle to minimize motion or agitation of the injured or diseased tissue. It is not true muscle spasm because the contraction can be relaxed. In the lumbar spine, the contraction frequently results in loss of the normal lumbar lordosis and it may be associated with reproducible loss of spinal motion.

Asymmetry of Spinal Motion

Asymmetric motion of the spine in one of the three principal planes is sometimes caused by muscle spasm or guarding. That is, if an individual attempts to flex the spine, he or she is unable to do so moving symmetrically; rather, the head or trunk leans to one side. To qualify as true asymmetric motion, the finding must be reproducible and consistent and the examiner must be convinced that the individual is cooperative and giving full effort.

Non-verifiable Radicular Root Pain

Non-verifiable pain is pain that is in the distribution of a nerve root but has no identifiable origin; i.e., there are no objective physical, imaging, or electromyographic findings. For dermatomal distributions see Figures 15-1 and 15-2.

Reflexes

Reflexes may be normal, increased, reduced, or valid, the involved and normal limb(s) should show marked asymmetry between arms or legs repeated testing. Once lost because of previous radiculopathy, a reflex rarely returns. Abnormal reflexes such as Babinski signs or clonus may be signs of corticospinal tract involvement.

Weakness and Loss of Sensation

To be valid, the sensory findings must be in a strict anatomic distribution, i.e., follow dermatomal patterns (see Figures 15-1 and 15-2). Motor findings should also be consistent with the affected nerve structure(s). Significant, long-standing weakness is usually accompanied by atrophy.

Atrophy

Atrophy is measured with a tape measure at identical levels on both limbs.

Radiculopathy (As defined in the Radiculopathy Schedule, V)

Radiculopathy for the purposes of the Guides is defined as significant alteration in the function of a nerve root or nerve roots and is usually caused by pressure on one or several nerve roots. The diagnosis requires a dermatomal distribution of pain, numbness and/or paresthesias in a dermatomal distribution. A root tension sign is usually positive. The diagnosis of a nerve root compression must be substantiated by an appropriate finding on an imaging study. The presence of findings on an imaging study in and of itself does not make the diagnosis of radiculopathy. There must also be clinical evidence as described above.

Electrodiagnostic Verification of Radiculopathy

Unequivocal electrodiagnostic evidence of acute nerve root pathology includes the presence of multiple positive sharp waves or fibrillation potentials in muscles innervated by one nerve root. However, the skill of the person performing and interpreting the study is critical. Electromyography should be performed only by a licensed physician qualified by reason of education, training and experience in these procedures. Electromyography does not detect all compressive radiculopathies and cannot determine the cause of the nerve root pathology. On the other hand, electromyography can detect non-compressive radiculopathies, which are not identified by imaging studies.

Cauda Equina Syndrome

Cauda Equina Syndrome is manifested by bowel or bladder dysfunction, saddle anesthesia and variable loss of motor and sensory function in the lower extremities. Individuals with Cauda Equina Syndrome usually have loss of sphincter tone on rectal examination and diminished or absent bladder, bowel and lower limb reflexes.

Urodynamic Tests

Cystometrograms are useful in individuals where a Cauda Equina Syndrome is possible but not certain. A normal cystometrogram makes the presence of a nerve-related bladder dysfunction unlikely. Occasionally, more extensive urodynamic testing is necessary.

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IN THE FOURTH JUDICIAL DISTRICT COURT FOR UTAH COUNTY

STATE OF UTAH

GARTH GINES and CHRISTINE
FOUNTAIN, E

Plaintiff,

vs.

SEAN EDWARDS

Defendant.

**ORDER DENYING PLAINTIFFS'
MOTIONS FOR DIRECTED VERDICT,
JUDGMENT NOTWITHSTANDING
THE VERDICT, AND/OR MOTION
FOR NEW TRIAL ON DAMAGES AND
MOTION FOR ADDITUR
and
FINAL JUDGMENT**

Civil No. 120400620

Judge Derek P. Pullan

The above captioned matter came on for jury trial October 27, 2014 through October 30, 2014. The jury returned a verdict in favor of Plaintiff Garth Gines in the amount of \$17,500.00 and a verdict in favor of Plaintiff Christine Fontaine in the amount of \$62,668.00. Set offs were taken for PIP payments and interest was added to Christine Fontaine's unpaid medical bills. Following application of the set offs and interest Garth Gines' total award is reduced to \$7,500.00 and Christine Fontaine's total award is increased to \$66,322.31.

On November 13, 2014 Plaintiff Christine Fontaine filed a Motion for Additur and/or New Trial on Damages and Plaintiff Garth Gines filed a Motion for Directed Verdict, Judgment Notwithstanding the Verdict, and/or Motion for New Trial on Damages. Following the parties briefing on these motions Plaintiffs filed a Request/Notice to Submit for decision on January 8, 2015. The Court filed its Ruling and Order on the aforesaid motions January 20, 2015.

IT IS HEREBY ORDERED AND ADJUDGED that Plaintiff Garth Gines' Motion for a Directed Verdict, Judgment Notwithstanding the Verdict, and/or Motion for a New Trial on Damages is DENIED. The final

Judgment for Garth Gines is \$7,500.00.

IT IS HEREBY ORDERED AND ADJUDGED that Plaintiff Christine Fountaine's Motion for Additur and/or Motion for a New Trial on Damages is DENIED. The final Judgment for Christine Fountaine is \$66,322.31.

This is the final order and judgment of the Court. No further action is necessary.

SUBMITTED BY:

/s/ Warren F. Wadsworth
Warren F. Wadsworth
TEMPLE & ASSOCIATES
Attorney for Defendant

APPROVED AS TO FORM:

Leonard E. McGee
Peter R. Mifflin
ROBERT J. DEBRY & ASSOCIATES
Attorneys for Plaintiffs

CERTIFICATE OF MAILING

I certify that on this 28th day of January, 2015, I mailed a true and correct copy of the foregoing **ORDER DENYING PLAINTIFFS' MOTIONS FOR DIRECTED VERDICT, JUDGMENT NOTWITHSTANDING THE VERDICT, AND/OR MOTION FOR NEW TRIAL ON DAMAGES AND MOTION FOR ADDITUR** by United States mail, first class, postage prepaid, to the following parties:

Leonard E. McGee, Esq.
ROBERT J. DEBRY & ASSOCIATES

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