Knowing When Almaraz/Guzman Sticks and When it Doesn’t

Presented by

Richard M. Jacobsmeyer, Esq.
SHAW, JACOBSMEYER, CRAIN & CLAFFEY PC

&

Negar Matian, Esq.
MATIAN LAW GROUP
In a Nutshell . . . .

The PDRS is rebuttable as long as:

• The physician stays within the four corners of the AMA Guides.

• The physician explains why the alternative rating reflects the disability more accurately than the strict rating.

• AND the report must constitute substantial evidence.
The whole spine divided into regions indicating the maximum Whole Person Impairment of one region of the spine.

Lumbar 90%,
Thoracic 40%
Cervical 80%
Case Law

- **Constantino v. Queenscare** (2016)
  - Dr. Fedder’s criticism is directed at **AMA Guides** as a whole, not the specific impairment applicable in this case.

- **Davis v. Walt Disney Company** (2014)
  - **AME** fails to provide sufficient explanation as to why an A/G analysis is more appropriate than ROM or DRE method. Also, Dr. Sohn did not utilize any chapter, table or method in the **AMA Guides**.

- **Hobbs v. County of Los Angeles** (2015)
  - Court rejected A/G analysis, but afforded **AME** Dr. Silbert opportunity to provide alternative A/G analysis.

- **Laury v. R&W Concrete** (2-1) (2011)
  - The **WCAB** notes that Figure 15-19 is within the four corners of the **Guides** and we defer to the clinical judgement of the **AME**. Applicant did have 5 failed back surgeries.
What do the Authors of the AMA Guides say ...

Criteria for Converting Whole Person Impairment to Regional Spine Impairment Using the AMA Guides, Fifth
Christopher R. Brigham, MD, Gunther Anderson, MD,
Manjula Sathy-Aryabhatt, MD, JD, James B. Tihansy, MD,
and Craig Uchio, MD, MPH

Question: Recently, California appellate attorneys are encouraging physicians to use Figure 15-10, Side View of Spinal Column (5th ed, 427) in Section 15.13, Criteria for Converting Whole Person Impairment to Regional Impairment (5th ed, 427) to convert a physician’s estimate of loss of function of the spine into a whole person rating. A February 7, 2011, California Workers’ Compensation Appeals Board panel decision in the case of Laury v. R&W Concrete Contractors (Case No. A090003878) based impairment on a physician’s clinical estimate of a 50% loss of use of the lumbar spine. This estimated impairment loss was multiplied by 50% (the relationship with the Flanges of Motion [FOM] method that a whole person estimate is converted into a regional impairment should occur by dividing 0.00 for the lumbar spinal joint to determine a 54% whole person permanent impairment. Is this approach appropriate?

Answer: No. Such approaches are markedly inconsistent with the methodology in the Guides and are fraught with problems. A primary goal of the Guides is that “two physicians, following the methods of the Guides to evaluate the same patient, should report similar results and reach similar conclusions.” (5th ed, 17.) Physicians lack the ability to independently define current incapacity for body parts, and there is no reasonable basis to define a precise level.

It has been clearly demonstrated that self-reported history in the context of litigation is unreliable. Therefore, the individual’s statements or the physician’s opinion of function in pre-injury capacity are speculative. Katz showed that the typical patient with pain syndrome from thoracic spinal cord injury rates as 55%–60% whole person impairment for the multiple consequences of devastating spinal injury, so a 54%-60% rating for back pain alone is ludicrous, and clearly a misuse of the Guides.

In this case, there was no reasonable basis to support the physician’s conclusion that there was 60% loss of the lumbar spine. The resulting value of 54% is nearly twice the maximum value assigned in the Diagnoses-Related Estimates (DRE) approach, the maximum for a DRE Lumbar Category V is 28% whole person permanent impairment. It is also higher than the maximum value assigned in the Sixth Edition: the maximum specified in Table 17-4, Lumbar Spine Regional Guides: Spinal Impairments (6th ed, 576-574) 33% whole person permanent impairment.

The reason for Section 15.13, Criteria for Converting Whole Person Impairment to Regional Spine Impairment (5th ed, 427) is that certain jurisdictions (Connecticut, for example) may need to convert spinal impairments from whole person to impairment of the spine. The conversion factors differ depending on whether the impairment was obtained from the DRE method or from the ROM method. Since neither approach was used to obtain the estimated 60% lumbar impairment, application of Figure 15-19 is moot.

Whole person permanent impairment ratings should never be based on Section 15.13, as this section is solely for converting a whole person value to a regional value. Impairment assessments must be performed in accordance with the procedures delineated in the Guides. Such creative misinterpretations are clearly not “within the four corners” of the Guides and thwart the purpose of having standards to define impairment.

Notes

Rating a Burn Victim Using the Skin Chapter in the AMA Guides, Sixth
Christopher R. Brigham, MD

Question: In Massachusetts, body parts are the acceptable ratings. I recently did an impairment on a burn victim and assessed a 56% whole person impairment (WPI). How do I convert this to an impairment of skin?

Answer: In the Sixth Edition, Section 2.2a, Regional vs. Whole Person Impairments (6th ed, 21) states “The Guides’ impairment ratings reflect the severity of the organ or body system impairment and the resulting functional limitations of the whole person. Impairments must be rated using the chapter most relevant to the organ or body system to which injury primarily occurs or where the greatest dysfunction is consistent with the obviously documented pathology remains. Most organ or body system chapters in the Guides provide impairment ratings based on whole person impairment. Some chapters, such as Chapters 15 to 17 (musculoskeletal) and Chapter 11 (hearing loss), provide regional impairment ratings (eg, percent impairment of upper or lower extremity) according to separate schedules. Those regional ratings may be convertible to whole person impairment ratings unless jurisdictional considerations exist or otherwise specifically requested by the referring source. For example, some jurisdictions (eg, Missouri and Hawaii) have separate schedules or monetary compensation based on regional vs whole person Impairments. It is possible however to develop an organ system impairment knowing the maximum whole person permanent impairment. In Chapter 8, The Skin, the maximum impairment for skin loss per Table 8-1, Criteria for Rating Permanent Impairment due to Skin Disorders (6th ed,
REALLY?
Heavy Lifting: ADL vs. Work Restrictions

- **Sarah Shipp v. Gottschalks (2010)**
  - Panel rejects Dr. Ovadia’s analogy of shoulder injury to hernia impairment based on lifting capacity, as it impermissibly resulted in PD rating based indirectly on 1997 PDRS (work restrictions).
  - “This approach runs afoul of *Almaraz II*’s prohibition that a physician may not utilize any chapter, table or method in the AMA Guides simply to achieve a desired result, e.g. a WPI that would result in a permanent disability rating based directly or indirectly on any Schedule in effect prior to 2005.”

- **Jose Oliveira v. Riverfront Apartments (2011)**
  - Panel affirms PQME Dr. Fujimoto’s analogy of shoulder injury to hernia impairment based on lifting capacity. “The schedule with respect to the hernias, in fact, described restrictions from heavy lifting, certainly an activity of daily living and not necessarily associated with work activity.”
Most Recent Cases

• **Rose Rockford v. Long Beach Unified School District (2012)**
  • The W.C.A.B. in this case rejected the PTP’s attempt to obtain a higher rating in order to achieve a desired result - that was less accurate.

• **Betoel Gomez v. United Pallet Service (2015)**
  • The W.C.A.B. rejected the PQME’s use of a FCE to support a hernia impairment for the wrist injury.
New, Complex, and Extraordinary

• In Guzman, the Court held "The Guides itself recognizes that it cannot anticipate and describe every impairment that may be experienced by injured employees. To accommodate those complex or extraordinary cases, it calls for a physician's exercise of clinical judgment to evaluate the impairment most accurately, even if that is possible only by resorting to comparable conditions described in the Guides."
BUT . . .

- In the Appellate Case of City of Sacramento v. WCAB (Cannon) (2013), there were no objective abnormalities identified other than some tenderness. The Court of Appeals held that subjective complaints alone, “in conjunction with a poorly understood condition” can be the basis for a “complex and extraordinary” case.
What does this mean?

• A/G analysis can be used for new conditions, poorly understood subj syndromes, and impairments not well described by the Guides such as the following:
  • Plantar fasciitis
  • Fibromyalgia
  • Epicondylitis (not operated)
  • Costrochondritis
  • Headaches
  • Recurrent DRE I lumbar, thoracic, or cervical spine “sprain”
  • Chronic pain syndromes with the absence of objective clinical data
Ronald Williams v. MV Transportation (2010) – The AME’s diagnosis of CRPS for the upper extremity did not fall within the requirements of Chapter 16: The Upper Extremity. The AME therefore found disability under Table 13-22 Chronic Pain, which provides impairment based on ADL limitations. The WCAB upheld 75% disability under this A/G analysis.

* Per the AME, Chapter 16 of the AMA Guides was written in the early 1990s and is outdated. For CRPS, the AMA Guides allows use of Table 13-22 for the upper extremities and Table 13-15 for the lower extremities. The applicant clearly met the updated criteria for CRPS but did not meet the criteria using the older version of Chapter 16 criteria.
Speaking of Chronic Pain . . .

- **Matta v. Nummi** (2009)
  - There was no reference to Applicant's difficulty with self care. Panel rejected rating for Dr. Newman’s failure to explain why rating by analogy was necessary.

- **Lobdell v. California Department of Corrections & Rehabilitation** (2014)
  - Applicant’s elbow injury under a strict interpretation of the Guides would have rated at 0%. The AME noted that injury significantly impacted the Applicant's ability to perform ADLs such as self care, personal hygiene, and physical activity and provided a rating under Chronic Pain (Table 13-22) for the upper extremity and provided 9% WPI.
Substantial Medical Evidence

The report must still provide reasons to support its analysis.
Burden of Proof 101

LC §5705 states that the burden of proof rests upon the party holding the affirmative of the issue.

If you need to prove an issue in your case, it is your burden to prove it. Your opponent need not respond until you have carried your burden of proof.
Burden of Proof and A/G

Nickell v. PKB Investments (2013)

1. The strict AMA Guides rating must be provided.

2. If a party does not believe this rating is accurate; that party has the burden of rebuttal by a preponderance of the evidence.

3. Once Applicant has put forth evidence to rebut the rating, a Defendant may put forth evidence to show that the opinion of the medical provider is not substantial evidence.
Burden of Proof and A/G Cont.

• **Gomez v. Unified Pallet Services (2015)**
  • WCJ raises issue of Defendant’s failure to seek clarification from PQME regarding the alternative rating reached through analogy to hernia impairment.
  • Board rejects this, noting that APPLICANT carries the burden to justify a rebuttal of a strict rating. Applicant also declined to seek clarification from PQME.

• **Board puts burden on Applicant to seek clarification from PQME regarding the Almaraz/Guzman finding!**
In *Greene v. Central Parking Systems* (2015), both the PTP and PQME provided impairment “incorrectly” combining gait derangement and other lower extremity impairments with very little analysis to supporting a deviation from the AMA Guides.

The WCAB approved the increased impairment; stating that both doctors provided ratings under the AMA Guides, they just did not apply the Guides mechanically.
The Board pointed out the Defendants filed the DOR that eventually set this matter for Trial.

“Absent a showing of good cause, we are not inclined to allow Defendant further development of the record having declared itself ready for trial.”
The dissent in this case strongly opposed the decisions because neither doctor provided a proper rating under the A/G analysis set forth under Guzman.

(1) Provide a strict rating.
(2) Explain why the strict rating does not apply.
(3) Provide an A/G analysis.
(4) Explain why that applies.

Dissent also states that regardless of who filed the DOR, the Board had obligation to further develop the record.
A Flip Side to the Coin

**Gomez v. Castle & Cooke (2012)** The WCAB affirmed WCJ’s agreement with rating of Defense QME Dr. Sanders of a DRE III, even though a strict analysis may also find DRE IV appropriate. The Board appeared to be satisfied with Dr. Sanders’ analysis of why the strict rating was unreasonably high.

**Riley v. City of Pasadena (2011)** The WCAB agreed with AME, who found that though strict rating would yield WPI of 26%, lack of limitations on ADLs led to conclusion that no rating above 7% was warranted. WCJ’s increase to 15% was rejected by Board and found AME’s finding of 7% to be supported by evidence and well-reasoned.
It’s Important to Note . . .

These were not typical A/G cases, but still do suggest that the WCAB will consider a “reverse” A/G analysis.
Are We Done yet?
1 + 1 = 2

- **East Bay Mud v. W.C.A.B. (Kite) (2013)**
  - In this Writ Denied case, the PQME added PD for bilateral hips rather than combining impairments and the court upheld this, noting that the AMA Guides does not require a rigid of application of combining impairments.

  - W.C.A.B. rejected the WCJ adding versus combining impairments where the AME was silent on the issue. A medical opinion is required for this result.

  - W.C.A.B allowed adding versus combining rating based on the AME’s analysis.
Important Notes

WCAB commissioners rotate panels and many of the A/G panel decisions are from commissioners no longer on the WCAB or were written pre-\textit{Cannon}.

Whether a particular rebuttal method was allowed may depend on the quality of the physician’s analysis, so it is hard to conclude that a particular method is or is not OK.
Take Aways

Loss of Work Capacity
“New, Complex, or Extraordinary” Pain
Burden of Proof
Adding v. Combining