

ALMARAZ – GUZMAN II

EXAMPLES

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ALMARAZ – GUZMAN II

- September 3rd 2009
 - PD Rating rebuttable
 - may use any method within the “Guides of the Evaluation of Permanent Impairment 5th Edition” that most accurately reflects the injured workers impairment.
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WHAT TO DO?

- Evaluate per strict interpretation of the “Guides to the Evaluation of Permanent Impairment 5th Edition”.
 - Consider whether or not the rating accurately reflects the injured workers impairment. (Taking into account: subjective complaints, objective findings, and activities of daily living).
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EXAMPLE: LUMBAR SPINE

- A 44 year old plumber sustains a lifting injury at work.
- Subjective complaints: severe low back pain with radiation posteriorly to the right foot. Could lift 100 lbs pre injury, now can lift 50 lbs. Unable to work after doi.
- Examination: palpable low back spasm, painful asymmetrical restricted lumbar spine motion, restricted SLR on the right.

EXAMPLE: LUMBAR SPINE

- MRI two months after injury: L₅ - S₁ 5mm right sided disc herniation, no contact or compression of any neural structure.
 - No improvement after 6 months conservative treatment.
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EXAMPLE: LUMBAR SPINE

- Strict AMA Guides: table 15-3 page 384, DRE II or III (+ up to 3%WPI for “pain”)
 - Increase DRE Category
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Table 15-3 Criteria for Rating Impairment Due to Lumbar Spine Injury

DRE Lumbar Category I 0% Impairment of the Whole Person	DRE Lumbar Category II 5%- 8% Impairment of the Whole Person	DRE Lumbar Category III 10%-13% Impairment of the Whole Person	DRE Lumbar Category IV 20%-23% Impairment of the Whole Person	DRE Lumbar Category V 25%-28% Impairment of the Whole Person
<p>No significant clinical findings, no observed muscle guarding or spasm, no documentable neurologic impairment, no documented alteration in structural integrity, and no other indication of impairment related to injury or illness; no fractures</p>	<p>Clinical history and examination findings are compatible with a specific injury; findings may include significant muscle guarding or spasm observed at the time of the examination, asymmetric loss of range of motion, or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity and no significant radiculopathy</p> <p>or</p> <p>individual had a clinically significant radiculopathy and has an imaging study that demonstrates a herniated disk at the level and on the side that would be expected based on the previous radiculopathy, but no longer has the radiculopathy following conservative treatment</p> <p>or</p> <p>fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation (not developmental spondylolysis) that has healed without alteration of motion segment integrity; (3) a spinous or transverse process fracture with displacement without a vertebral body fracture, which does not disrupt the spinal canal</p>	<p>Significant signs of radiculopathy, such as dermatomal pain and/or in a dermatomal distribution, sensory loss, loss of relevant reflex(es), loss of muscle strength or measured unilateral atrophy above or below the knee compared to measurements on the contralateral side at the same location; impairment may be verified by electrodiagnostic findings</p> <p>or</p> <p>history of a herniated disk at the level and on the side that would be expected from objective clinical findings, associated with radiculopathy, or individuals who had surgery for radiculopathy but are now asymptomatic</p> <p>or</p> <p>fractures: (1) 25% to 50% compression of one vertebral body; (2) posterior element fracture with displacement disrupting the spinal canal; in both cases, the fracture has healed without alteration of structural integrity</p>	<p>Loss of motion segment integrity defined from flexion and extension radiographs as at least 4.5 mm of translation of one vertebra on another or angular motion greater than 15° at L1-2, L2-3, and L3-4, greater than 20° at L4-5, and greater than 25° at L5-S1 (Figure 15-3); may have complete or near complete loss of motion of a motion segment due to developmental fusion, or successful or unsuccessful attempt at surgical arthrodesis</p> <p>or</p> <p>fractures: (1) greater than 50% compression of one vertebral body without residual neurologic compromise</p>	<p>Meets the criteria of DRE lumbosacral categories III and IV; that is, both radiculopathy and alteration of motion segment integrity are present; significant lower extremity impairment is present as indicated by atrophy or loss of reflex(es), pain, and/or sensory changes within an anatomic distribution (dermatomal), or electromyographic findings as stated in lumbosacral category III and alteration of spine motion segment integrity as defined in lumbosacral category IV</p> <p>or</p> <p>fractures: (1) greater than 50% compression of one vertebral body with unilateral neurologic compromise</p>

EXAMPLE: LUMBAR SPINE

- ROM Method, 3 parts: diagnosis, table 15-7 page 404; ROM loss, table 15-8 page 407, table 15-9 page 409; assess neurological loss resulting from lumbar spine per section 15-12 page 423.
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Table 15-7. Criteria for Rating Whole Person Impairment Percent Due to Specific Spine Disorders to Be Used as Part of the ROM Method*

Disorder	% Impairment of the Whole Person		
	Cervical	Thoracic	Lumbar
I. Fractures			
A. Compression of one vertebral body.			
0%-25%	4	2	5
26%-50%	6	3	7
> 50%	10	5	12
B. Fracture of posterior element (pedicle, lamina, articular process, transverse process).	4	2	5
<i>Note: An impairment due to compression of a vertebra and one due to fracture of a posterior element are combined using the Combined Values Chart (p. 604). Fractures or compressions of several vertebrae are combined using the Combined Values Chart.</i>			
C. Reduced dislocation of one vertebra.	5	3	6
If two or more vertebrae are dislocated and reduced, combine the estimates using the Combined Values Chart.			
An unreduced dislocation causes impairment until it is reduced; the physician should then evaluate the impairment on the basis of the individual's condition with the dislocation reduced.			
If no reduction is possible, the physician should evaluate the impairment on the basis of the range-of-motion and neurologic findings according to criteria in this chapter and Chapter 13, The Central and Peripheral Nervous System.			
II. Intervertebral disk or other soft-tissue lesion			
Diagnosis must be based on clinical symptoms and signs and imaging information.			
A. Unoperated on, with no residual signs or symptoms.	0	0	0
B. Unoperated on, with medically documented injury, pain, and rigidity* associated with none to minimal degenerative changes on structural tests.†	4	2	5
C. Unoperated on, stable, with medically documented injury, pain, and rigidity* associated with moderate to severe degenerative changes on structural tests;† includes herniated nucleus pulposus with or without radiculopathy.	6	3	7
D. Surgically treated disk lesion without residual signs or symptoms; includes disk injection.	7	4	8
E. Surgically treated disk lesion with residual, medically documented pain and rigidity.	9	5	10
F. Multiple levels, with or without operations and with or without residual signs or symptoms.	Add 1% per level		
G. Multiple operations with or without residual signs or symptoms	Add 2%		
1. Second operation	Add 1% per operation		
2. Third or subsequent operation			
III. Spondylolysis and spondylolisthesis, not operated on			
A. Spondylolysis or grade I (1%-25% slippage) or grade II (26%-50% slippage) spondylolisthesis, accompanied by medically documented injury that is stable, and medically documented pain and rigidity with or without muscle spasm.	6	3	7
B. Grade III (51%-75% slippage) or grade IV (76%-100% slippage) spondylolisthesis, accompanied by medically documented injury that is stable, and medically documented pain and rigidity with or without muscle spasm.	8	4	9
IV. Spinal stenosis, segmental instability, spondylolisthesis, fracture, or dislocation, operated on			
A. Single-level decompression without spinal fusion and without residual signs or symptoms	7	4	8
B. Single-level decompression without spinal fusion with residual signs or symptoms	9	5	10
C. Single-level spinal fusion with or without decompression without residual signs or symptoms	8	4	9
D. Single-level spinal fusion with or without decompression with residual signs and symptoms	10	5	12
E. Multiple levels, operated on, with residual, medically documented pain and rigidity.	Add 1% per level		
1. Second operation	Add 2%		
2. Third or subsequent operation	Add 1% per operation		

Table 15-8 Impairment Due to Abnormal Motion of the Lumbar Region: Flexion and Extension*

The proportion of flexion and extension of total lumbosacral motion is 75%.

Sacral (Hip) Flexion Angle (°)	True Lumbar Spine Flexion Angle (°)	% Impairment of the Whole Person
45+	60+	0
	45	2
	30	4
	15	7
	0	10
30-45	40+	4
	20	7
	0	10
0-29	30+	5
	15	8
	0	11

True Lumbar Spine Extension From Neutral Position (0°) to:	Degrees of Lumbosacral Spine Motion		% Impairment of the Whole Person
	Lost	Retained	
0	25	0	7
10	15	10	5
15	10	15	3
20	5	20	2
25	0	25	0

Table 15-9 Impairment Due to Abnormal Motion and Ankylosis of the Lumbar Region: Lateral Bending

Abnormal Motion
Average range of left and right lateral bending is 50°; the proportion of total lumbosacral motion is 40% of the total spine.

a.	Left Lateral Bending From Neutral Position (0°) to:	Degrees of Lumbosacral Motion		% Impairment of the Whole Person
		Lost	Retained	
	0	25	0	5
	10	15	10	3
	15	10	15	2
	20	5	20	1
	25	0	25	0
b.	Right Lateral Bending From Neutral Position (°) to:	Degrees of Lumbosacral Motion		% Impairment of the Whole Person
		Lost	Retained	
	0	25	0	5
	10	15	10	3
	15	10	15	2
	20	5	20	1
	25	0	25	0
c.	Ankylosis Region Ankylosed at (°):			% Impairment of the Whole Person
	0 (neutral position)			
	30			
	45			
	60			
	75 (full flexion)			

EXAMPLE: LUMBAR SPINE

- ? Add gait abnormality (if present): table 17-5 page 529; or table 13-15 page 336.
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Table 17-5 Lower Limb Impairment Due to Gait Derangement

Severity	Individual's Signs	Whole Person Impairment
Mild	a. Antalgic limp with shortened stance phase and documented moderate to advanced arthritic changes of hip, knee, or ankle	7%
	b. Positive Trendelenburg sign and moderate to advanced osteoarthritis of hip	10%
	c. Same as category a or b above, but individual requires part-time use of cane or crutch for distance walking but not usually at home or in the workplace	15%
	d. Requires routine use of short leg brace (ankle-foot orthosis [AFO])	15%
Moderate	e. Requires routine use of cane, crutch, or long leg brace (knee-ankle-foot orthosis [KAFO])	20%
	f. Requires routine use of cane or crutch and a short leg brace (AFO)	30%
	g. Requires routine use of two canes or two crutches	40%
Severe	h. Requires routine use of two canes or two crutches and a short leg brace (AFO)	50%
	i. Requires routine use of two canes or two crutches and a long leg brace (KAFO)	60%
	j. Requires routine use of two canes or two crutches and two lower-extremity braces (either AFOs or KAFOs)	70%
	k. Wheelchair dependent	80%

Table 13-15 Criteria for Rating Impairments Due to Station and Gait Disorders

Class 1 1%-9% Impairment of the Whole Person	Class 2 10%-19% Impairment of the Whole Person	Class 3 20%-39% Impairment of the Whole Person	Class 4 40%-60% Impairment of the Whole Person
Rises to standing position; walks, but has difficulty with elevations, grades, stairs, deep chairs, and long distances	Rises to standing position; walks some distance with difficulty and without assistance, but is limited to level surfaces	Rises and maintains standing position with difficulty; cannot walk without assistance	Cannot stand without help, mechanical support, and/or an assistive device

EXAMPLE: LUMBAR SPINE

- Use ADL's. Maximum lumbar spine impairment = 90% WPI (cervical spine 80%, thoracic spine 40%). Table 1-2, page 4; table 1-3, pages 6 and 7.
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Table 1-2 Activities of Daily Living Commonly Measured in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Scales ^{6,7}

Activity	Example
Self-care, personal hygiene	Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating
Communication	Writing, typing, seeing, hearing, speaking
Physical activity	Standing, sitting, reclining, walking, climbing stairs
Sensory function	Hearing, seeing, tactile feeling, tasting, smelling
Nonspecialized hand activities	Grasping, lifting, tactile discrimination
Travel	Riding, driving, flying
Sexual function	Orgasm, ejaculation, lubrication, erection
Sleep	Restful, nocturnal sleep pattern

EXAMPLE: KNEE

- A 32 year old electrician sustains a twisting injury to his left knee while descending from a ladder.
 - Subjective complaints: pain medial aspect left knee, buckling and giving way left knee.
 - MRI shows bucket handle tear medial meniscus left knee.
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EXAMPLE: KNEE

- Arthroscopic partial medial menisectomy 3 months post injury. Findings at surgery include grade II to III chondromalacia medial compartment left knee.
 - Examination 6 months post surgery: limp left lower extremity, decreased ROM left knee 5° to 125° , 1.0 cm thigh atrophy.
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EXAMPLE: KNEE

- Strict AMA Guides: diagnosis, table 17-33 pages 546 and 547 = 1% WPI; range of motion, table 17-10 page 537 = 4% WPI; atrophy, table 17-6 page 530 = 1 to 2% WPI; muscle weakness, table 17-8, page 532.
 - Use combinations of the above.
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Table 17-10 Knee Impairment

Motion	Whole Person (Lower Extremity) Impairment (%)		
	Mild 4% (10%)	Moderate 8% (20%)	Severe 14% (35%)
Flexion	Less than 110°	Less than 80°	Less than 60° + 1% (2%) per 10° less than 60°
Flexion contracture	5°-9°	10°-19°	20°+
Deformity measured by femoral-tibial angle; 3° to 10° valgus is considered normal			
Varus	2° valgus-0° (neutral)	1°-7° varus	8°-12° varus; add 1% (2%) per 2° over 12°
Valgus	10°-12°	13°-15°	16°-20°; add 1% (2%) per 2° over 20°

Table 17-6 Impairment Due to Unilateral Leg Muscle Atrophy

Difference in Circumference (cm)	Impairment Degree	Whole Person (Lower Extremity) Impairment (%)
a. Thigh: The circumference is measured 10 cm above the patella with the knee fully extended and the muscles relaxed.		
0-0.9	None	0
1-1.9	Mild	1-2 (3-8)
2-2.9	Moderate	3-4 (8-13)
3+	Severe	5 (13)
b. Calf: The maximum circumference on the normal side is compared with the circumference at the same level on the affected side.		
0-0.9	None	0
1-1.9	Mild	1-2 (3-8)
2-2.9	Moderate	3-4 (8-13)
3+	Severe	5 (13)

Table 17-8 Impairment Due to Lower Extremity Muscle Weakness

Muscle Group		Whole Person (Lower Extremity) [Foot] Impairment (%)														
		Grade 0		Grade 1		Grade 2		Grade 3		Grade 4						
Hip	Flexion	6	(15)	6	(15)	6	(15)	4	(10)	2	(5)					
	Extension	15	(37)	15	(37)	15	(37)	15	(37)	7	(17)					
	Abduction*	25	(62)	25	(62)	25	(62)	15	(27)	10	(25)					
Knee	Flexion	10	(25)	10	(25)	10	(25)	7	(17)	5	(12)					
	Extension	10	(25)	10	(25)	10	(25)	7	(17)	5	(12)					
Ankle	Flexion (plantar flexion)	15	(37)	[53]	15	(37)	[53]	15	(37)	[53]	10	(25)	[35]	7	(17)	[24]
	Extension (dorsiflexion)	10	(25)	[35]	10	(25)	[35]	10	(25)	[35]	10	(25)	[35]	5	(12)	[17]
	Inversion	5	(12)	[17]	5	(12)	[17]	5	(12)	[17]	5	(12)	[17]	2	(5)	[7]
	Eversion	5	(12)	[17]	5	(12)	[17]	5	(12)	[17]	5	(12)	[17]	2	(5)	[7]
Great toe	Extension	3	(7)	[10]	3	(7)	[10]	3	(7)	[10]	3	(7)	[10]	1	(2)	[3]
	Flexion			[17]		(12)	[17]	5	(12)	[17]	5	(12)	[17]	2	(5)	[7]

EXAMPLE: KNEE

- Use gait abnormality: table 17-5 page 529; or table 13-15 page 336
- Evaluate as per total knee replacement: table 17-35, page 549 “Rating Knee Replacement Results”; then table 17-33 pages 546 and 547 “Impairment Estimates for Certain Lower Extremity Impairments”.
- Use ADL’s. Maximum lower extremity WPI = 40%

EXAMPLE: HAND

- A 54 year old female court recorder presents with a six month history of pain, numbness and tingling affecting the palmar aspects of the thumb, index, middle and ring fingers bilaterally. Despite non operative treatment measures, her symptoms increase, and she is unable to continue working. Electro diagnostic studies confirm the diagnosis of moderately severe bilateral carpal tunnel syndrome.
- Bilateral open carpal tunnel releases are performed.

EXAMPLE: HAND

- 9 months after the last CTR she reports improvement in her subjective complaints, but is unable to return to work. Examination shows mild decrease in sensory acuity to monofilament testing in the median sensory distribution bilaterally. Grip strengths using a Jamar Dynamometer are right dominant 11, 10, 11 kg. and left 10, 10, 9 kg. Electro diagnostic testing 6 months post surgery shows mild residual slowing of median sensory conduction across the wrist. Motor conduction is normal.

EXAMPLE: HAND

- Strict AMA Guides: table 16-15, page 492 maximum upper extremity impairment = 36% for each side, modified by the severity of the sensory loss, per table 16-10, page 482; in this case grade 4 = 1 to 25% sensory deficit. 25% of 36% = 9% UE impairment for each side. Per table 16-3, 9% UE impairment = 5% WPI. Combining 5% and 5% per the combined values chart page 604 and 605 the result is 10% WPI. (?+ up to 3% WPI for “pain”)
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Table 16-15 Maximum Upper Extremity Impairment Due to Unilateral Sensory or Motor Deficits or to *Combined* 100% Deficits of the Major Peripheral Nerves

Nerve	Maximum % Upper Extremity Impairment Due to:		
	Sensory Deficit or Pain *	Motor Deficit†	Combined Motor and Sensory Deficits
Pectorals (medial and lateral)	0	5	5
Axillary	5	35	38
Dorsal scapular	0	5	5
Long thoracic	0	15	15
Medial antebrachial cutaneous	5	0	5
Medial brachial cutaneous	5	0	5
Median (above midforearm)	39	44	66
Median (anterior interosseous branch)	0	15	15
Median (below midforearm)	39	10	45
Radial palmar digital of thumb	7	0	7
Ulnar palmar digital of thumb	11	0	11
Radial palmar digital of index finger	5	0	5
Ulnar palmar digital of index finger	4	0	4
Radial palmar digital of middle finger	5	0	5
Ulnar palmar digital of middle finger	4	0	4
Radial palmar digital of ring finger	3	0	3
Musculocutaneous	5	25	29
Radial (upper arm with loss of triceps)	5	42	45
Radial (elbow with sparing of triceps)	5	35	38
Subscapulars (upper and lower)	0	5	5
Suprascapular	5	16	20
Thoracodorsal	0	10	10
Ulnar (above midforearm)	7	46	50
Ulnar (below midforearm)	7	35	40
Ulnar palmar digital of ring finger	2	0	2
Radial palmar digital of little finger	2	0	2
Ulnar palmar digital of little finger	3	0	3

* See Table 16-10a to grade sensory deficits or pain.

† See Table 16-11a to grade motor deficits.

* From Swanson AB, de Groot Swanson G. Evaluation of permanent impairment in the hand and upper extremity. In: Doegge TC, ed. *Guides to the Evaluation of Permanent Impairment*. Fourth ed. Chicago, Ill: American Medical Association; 1993.

Table 16-10 Determining Impairment of the Upper Extremity Due to Sensory Deficits or Pain Resulting From Peripheral Nerve Disorders

a. Classification

Grade	Description of Sensory Deficit or Pain	% Sensory Deficit
5	No loss of sensibility, abnormal sensation, or pain	0
4	Distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations or pain, that is forgotten during activity	1-25
3	Distorted superficial tactile sensibility (diminished light touch and two-point discrimination), with some abnormal sensations or slight pain, that interferes with some activities	26-60
2	Decreased superficial cutaneous pain and tactile sensibility (decreased protective sensibility), with abnormal sensations or moderate pain, that may prevent some activities	61-80
1	Deep cutaneous pain sensibility present; absent superficial pain and tactile sensibility (absent protective sensibility), with abnormal sensations or severe pain, that prevents most activity	81-99
0	Absent sensibility, abnormal sensations, or severe pain that prevents all activity	100

b. Procedure

- 1 Identify the area of involvement using the cutaneous innervation chart (Figure 16-48) or the dermatome chart (Figure 16-49).
- 2 Identify the nerve structure(s) that innervate the area(s) (Table 16-12 and Figures 16-48, 16-49, and 16-50).
- 3 Grade the severity of the sensory deficit or pain according to the classification given above (a). Use clinical judgment to select the appropriate percentage from the range of values shown for each severity grade.
- 4 Find the maximum upper extremity impairment value due to sensory deficit or pain for each nerve structure involved: spinal nerves (Table 16-13), brachial plexus (Table 16-14), and major peripheral nerves (Table 16-15).
- 5 *Multiply* the severity of the sensory deficit by the maximum upper extremity impairment value to obtain the upper extremity impairment for each nerve structure involved.

EXAMPLE: HAND

- Use grip strength: tables 16-34, 16-31, 16-32, all page 509 (50% loss of grip strength bilaterally = 20% UE impairment for each side. Per table 16-3, page 439, 20% UE impairment = 12% WPI. Combining 12% and 12% the result is 23% WPI.
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Table 16-31 Average Strength of Unsupported Grip by Occupation in 100 Subjects

Occupation	Grip Strength (kg)			
	Males		Females	
	Major Hand	Minor Hand	Major Hand	Minor Hand
Skilled	47.0	45.4	26.8	24.4
Sedentary	47.2	44.1	23.1	21.1
Manual	48.5	44.6	24.2	22.0
Average	47.6	45.0	24.6	22.4

Adapted with permission from Swanson AB, Matev IB, de Groot Swanson. The strength of the hand. *Bull Prosthet Res.* Fall 1970:145-153.

Table 16-33 Average Strength of Lateral Pinch by Occupation in 100 Subjects

Occupation	Lateral Pinch (kg)			
	Males		Females	
	Major Hand	Minor Hand	Major Hand	Minor Hand
Skilled	6.6	6.4	4.4	4.3
Sedentary	6.3	6.1	4.1	3.9
Manual	8.5	7.7	6.0	5.5
Average	7.5	7.1	4.9	4.7

Adapted with permission from Swanson, AB, Matev IB, de Groot Swanson. The strength of the hand. *Bull Prosthet Res.* Fall 1970:145-153.

Table 16-32 Average Strength of Grip by Age in 100 Subjects

Age Group (yrs)	Grip Strength (kg)			
	Males		Females	
	Major Hand	Minor Hand	Major Hand	Minor Hand
< 20	45.2	42.6	23.8	22.8
20-29	48.5	46.2	24.6	22.7
30-39	49.2	44.5	30.8	28.0
40-49	49.0	47.3	23.4	21.5
50-59	45.9	43.5	22.3	18.2

Adapted with permission from Swanson AB, Matev IB, de Groot Swanson. The strength of the hand. *Bull Prosthet Res.* Fall 1970:145-153.

Table 16-34 Upper Extremity Joint Impairment Due to Loss of Grip or Pinch Strength

% Strength Loss Index	% Upper Extremity Impairment
10- 30	10
31- 60	20
61-100	30

EXAMPLE: HAND

- Use table 13-22, page 343 “chronic pain” C&PNS
 - Use ADL’s. Maximum upper extremity impairment = 60%
WPI
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Table 13-22 Criteria for Rating Impairment Related to Chronic Pain in One Upper Extremity

Class 1		Class 2		Class 3		Class 4	
Dominant Extremity 1%-9%	Nondominant Extremity 1%-4%	Dominant Extremity 10%-24%	Nondominant Extremity 5%-14%	Dominant Extremity 25%-39%	Nondominant Extremity 15%-29%	Dominant Extremity 40%-60%	Nondominant Extremity 30%-45%
Impairment of the Whole Person	Impairment of the Whole Person	Impairment of the Whole Person	Impairment of the Whole Person	Impairment of the Whole Person	Impairment of the Whole Person	Impairment of the Whole Person	Impairment of the Whole Person
Individual can use the involved extremity for self-care, daily activities, and holding, but is limited in digital dexterity		Individual can use the involved extremity for self-care and can grasp and hold objects with difficulty, but has no digital dexterity		Individual can use the involved extremity but has difficulty with self-care activities		Individual cannot use the involved extremity for self-care or daily activities	

SUMMARY

- Evaluate per strict interpretation of the “Guides to the Evaluation of Permanent Impairment 5th Edition”.
 - Consider whether or not the rating accurately reflects the injured workers impairment. (Taking into account: subjective complaints, objective findings, and activities of daily living).
 - Some other methods of evaluating impairment within the “Guides to the Evaluation of Permanent Impairment 5th Edition” have been discussed.
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