

## DEFINITIONS

### ***Impairment Rating Evaluations (MMI / IR Evaluations)***

An impairment rating in Texas, as [defined by statute](#), means the percentage of permanent impairment of the whole body resulting from a compensable injury. It is a measurement of the damage to your body resulting from your work injury. According to Texas workers' compensation law, impairment is any anatomic or functional abnormality or loss existing after maximum medical improvement. An impairment rating (IR) is expressed as a percentage that represents the permanency of the injury(s). For example, you might see a doctor issue a report showing that you have a 5%IR.

You are not supposed to get an impairment rating in Texas until you reach [maximum medical improvement](#). When you reach MMI, you no longer have any expectation of further recovery. So, at that point, the permanent damage to your body resulting from the injury can be determined. Pain is not a consideration when determining MMI and the date of MMI may be a date prior to the date of the evaluation. The determination of MMI is based on the conditions the insurance company has accepted as well as the progression of improvement based on the clinical findings throughout your case from your medical records as well as from the MMI/IR evaluation.

Once the MMI date has been determined, an impairment rating (IR) is then assigned and an IR is a measurement that represents the percent permanent damage to your whole body (whole person) caused by or resulting from your work injury. When MMI is reached, any [temporary income benefits](#) (TIBs) you are receiving for lost wages will end and you will be eligible for [impairment income benefits](#) (IIBs). Impairment income benefits are paid based on your impairment rating in Texas. You will get 3 weeks of income benefits for every percentage of impairment. So, if you get a 5% impairment rating, you will get 15 weeks of impairment income benefits.

A doctor has to be certified in order to performed impairment ratings in Texas. The doctor who assigns your impairment rating has to have special training to do this. The Division of Workers' Compensation requires them to pass a rigorous test and be qualified and authorized to perform and impairment rating evaluation and to issue an impairment rating. A doctor can be requested by perform impairment ratings by the Treating Doctor (TD), the Insurance Carrier (Required Medical Examination, or RME) or by the Texas Department of Insurance (TDI), Division of Workers Compensation (Designated Doctor).

When doctors assign an impairment rating, they must use the AMA's *Guidelines To The Evaluation Of Permanent Impairment*, 4<sup>th</sup> Edition. If they use any other book or method to determine the impairment rating, then the examination and impairment rating certification is not valid. The only way to properly use the *Guides* in order to issue an impairment rating is for the certifying doctor to perform a thorough examination. If the doctor did not examine you or did not perform a complete examination, then you may need to [dispute your impairment rating](#) and you have 90 days to dispute it.

### ***Designated Doctor Evaluations (DD Evals)***

From time to time during the life of a Texas Workers' Compensation case, a need may arise for a non-biased, authoritative doctor to answer specific question and make certain determinations about an injured worker's medical condition(s), their ability to work or other issues of medical fact that may need to be decided.

In these situations, it is not appropriate for an insurance adjuster, an attorney, or even a judge to make such medical determinations. The Texas Department of Insurance (TDI), Division of Workers' Compensation (DWC), therefore, has allowed for the introduction of state-appointed "Designated Doctors" to make these kinds of decisions. In theory, the Designated Doctor does not work for the insurance carrier or the injured worker (the Claimant) and is considered 'independent'. A Designated Doctor is appointed by the Division of Workers' Compensation to resolve such questions or disputes. Designated Doctors may be called upon to comment on or resolve questions such as:

- Has the employee reached MMI, and if so, what is the appropriate Impairment Rating?
- Is the employee's injury of a specific body part or condition (diagnosis) related to or aggravated by the Compensable Injury?
- To determine whether the injured worker is able to perform certain job functions and to what degree.

Determinations and opinions made by the Designated Doctor carry great weight when resolving disputes or presenting evidence at a Benefit Review Conference (BRC) or Contested Case Hearing (CCH). It is very difficult to overcome the determinations and findings of a Designated Doctor without sufficient and relevant evidence to do so.

Be aware that many Designated Doctors also have "side jobs" and perform peer reviews or independent medical evaluations for insurance carriers. In fact, there are some doctors who (by all appearances) primarily earn their living working for insurance companies, wherein they are paid to conduct examinations of injured workers that often lead to the employee's loss or reduction of benefits. It is a good idea to ask your Designated Doctor at the start of the examination if he or she performs work for the insurance company handling your case as this issue may arise in the future.

The Workers Compensation System is extremely complicated and legalistic and insurance companies frequently hire attorneys to represent them. If you have an upcoming appointment to see a Designated Doctor, it may be important to contact an experienced workers' compensation lawyer or contact an Ombudsman at the Office of Injured Employee Council (OIEC) to assist you through the many processes involved.

### ***Functional Capacity Evaluations (FCEs)***

According to the *American Occupational Therapy Association*, A functional capacity evaluation (FCE) evaluates an individual's capacity to perform work activities related to his or her participation in employment (Soer et al., 2008). The FCE process compares the individual's health status, and body functions and structures to the demands of the job and the work environment. In essence, an FCE's primary purpose is to evaluate a person's ability to participate in work, although other instrumental activities of daily living that support work performance may also be evaluated. Similar types of testing may also be called a functional capacity assessment (FCA), physical capacity assessment or evaluation (PCA or PCE), or work capacity assessment or evaluation (WCA or WCE). A well-designed FCE should consist of a battery of standardized assessments that offers results in performance-based measures and demonstrates predictive value about the individual's return to work (Kuijer et al., 2011; Soer, et al., 2008). Traditionally, FCEs measured an individual's ability to perform the physical demands of a job, but over the last decade many FCE batteries have begun to include evaluation of cognitive demands if such testing is warranted. The FCE must be administered with care for the client's safety and well-being.

**The purpose of an FCE is to:** 1) collect reliable information about current functional and vocational status and 2) estimate potential functional and vocational status. The components of the FCE will vary based on the purpose of the assessment. The FCE typically begins with a client interview,

medical record review, and musculoskeletal screening. Functional testing may include graded material-handling activities such as lifting, carrying, pushing, and pulling; and positional tolerance activities such as sitting, standing, walking, balancing, reaching, stooping, kneeling, crouching, crawling, object handling/manipulation, fingering, hand grasping, and hand manipulation. Pain monitoring is frequently performed during the FCE to document client-reported levels of pain during various activities as well as to manage pain. The FCE may also include evaluation of an individual's hand dexterity, hand coordination, endurance, and other job-specific functions.

The FCE report includes an overall physical demand level (U.S. Department of Labor, n.d.), a summary of job-specific physical abilities, a summary of performance consistency and overall voluntary effort, job match information, adaptations to enhance performance, and treatment recommendations, if requested. Some FCEs are designed to also report on the worker's ability to meet the cognitive demands of the job in question. FCEs are done on a one-on-one basis and may range in length from 4 to 6 hours. The FCE may take place over 2 consecutive days.

### ***Dynamic Motions Studies (DSM)***

Range of motions of a body area is well accepted for evaluating soft tissue injury and spinal function. Rated "Established" by the Mercy Guidelines range of motion is taught in the core curriculum as the part of every major healthcare curriculum in Physical Therapy, Chiropractic, and Medicine. A limitation exposed by John Gerhardt, author of the AMA's Text, *A Practical Guide to Range of Motion Assessment*, may have altered the usefulness of traditional endpoint range of motion measures due to the large number of false negatives exposed in the clinical setting. False negative range of motion (ROM) data may adversely impact a patient's ability to receive appropriate care, as insurers may utilize false negative data to prematurely terminate treatment and disrupt reimbursement prior to the patient returning to normal or improved function.

In the clinic setting it is common to see patients who present with normal ROM but are clearly experiencing muscle spasm, muscle guarding and reported pain. To combat false negative findings, a standard approach has been to document muscle spasms and muscle guarding through palpation. The AMA's *Guidelines to the Evaluation of Permanent Impairment*, fifth edition provides a method to clinically verify the presence or absence of muscle spasm or muscle guarding although this is not objectively accurate nor consistent even though this method is more accurate than solely relying on palpation, which, based on the Citation from the *AMA Guides to the Evaluation of Disease and Injury Causation*, second edition, on page 108,

*"The best disease status in epidemiological studies is likely a histologically confirmed cancer case in a cancer registry. Musculoskeletal disorders have much greater risks of bias. Disease status is susceptible to biases that include selection, information, recall, interviewer, and sampling. These biases are parallel with those for exposure measurement described previously. Measurement of disease status is ideally objectively measured and blinded from exposure. Objective is defined as a measurable commodity that may be reasonably duplicated (within 10%) by another equally trained examiner in the same time frame. A good example of a non-objective finding would be **spasm**, which has an extremely poor inter-rater and intra-rater reliability. Therefore, the conclusion must be reached that the spasm is merely a subjective issue. In addition, because there is much variability in diagnoses, an independent, standardized measurement is the ideal but rarely performed approach. It is also important to understand that the "objective" nature of some tests, specifically the EMG, is provider-driven in terms of accuracy and reliability."*

Although clinically valuable for the doctor, palpation and postural observations lack the objectivity necessary to overcome the negative objective findings of range of motion. Nederhand<sup>3</sup> points out that palpation has poor inter-examiner reliability and recommends utilizing an EKG-based

technology which more accurately and objectively replaces palpation findings by measuring the muscle guarding response in an objective manner.

The control group study published by Sihvonen et.al.<sup>8</sup> describes a solution to this problem. The researchers evaluated both range of motion and muscle guarding found no significant differences between control group and LBP group on range of motion measures, but statistically significant differences when both EKG-based muscle guarding measurement and needle EMG were used as objective measures. The needle EMG data and muscle guarding as measured with attached electrodes to measure dynamic motions of the spine surface (AEM-SEMG based upon EKG Technology) correlated so highly that Sihvonen concluded that the AEM-SEMG technique was preferable to needle EMG when evaluating for LBP as it is painless to perform and has excellent test-retest reliability. The result of his study provides solid evidence supporting the position of this paper.

The AMA's *Guidelines to the Evaluation of Permanent Impairment*, fourth and fifth editions described muscle pathologies as specific conditions that are criteria for permanent Criteria, namely in DRE category II. The AMA's *Guidelines to the Evaluation of Permanent Impairment*, fifth edition, specifically define the terms Asymmetry of Spinal Motion, Muscle Spasm and Muscle Guarding which is the body's natural defense mechanism to pain and spinal dysfunction in motion as well as procedures for their clinical assessment as these are specific criteria listed in the *Guides* as ratable for permanent impairment:

Dynamic Motion Studies can assist in evaluating various muscle dysfunctions including simple postural dysfunction, emotional (psychological or behavioral) dysfunction, muscle guarding, peripheral weakness or deconditioning (post-traumatic disuse atrophy), acute reflex muscle spasms/inhibition, direct compensation for abnormal joint movements, and chronic faulty motor [neuro-muscular] programs. The identification of these types of pathological conditions is extremely helpful in developing a proper diagnosis and specific treatment program to successfully treat a patient's condition(s). DMS can also be utilized as a form of neuro-muscular feedback during active, physical rehabilitation so that a specific muscle or group of muscles can be evaluated during a treatment session.

**Asymmetry of Spinal 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.

**Muscle Guarding** is a contraction of muscle to minimize motion or agitation of the injured or diseased tissue. It is not true muscle spasms because the contraction can be relaxed. In the cervical or lumbar spines, the contraction frequently results on loss of the normal cervical or lumbar lordosis, and it may be associated with reproducible loss of spinal motion.

**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).