Slide One
I am Dr. Elaine Sobel Berger, the Associate Medical Director and Senior Policy Advisor for the New York State Workers’ Compensation Board. Our topic today will be the 2012 Guidelines for determining permanent impairment and loss-of-wage-earning capacity.

Slide Two
This training will help physicians apply the New York State 2012 Guidelines for determining permanent impairment and loss-of-wage-earning capacity, to assess medical and functional impairment for a worker with a non-scheduled permanent partial disability.

Slide Three
Why learn about the new 2012 Guidelines? These new guidelines, implemented on January 2012, represent a significant change in how impairment and function are evaluated and how loss-of-wage-earning capacity is determined for injured workers. It is important for physicians to understand the new guidelines, processes, procedures, and forms in order to ensure timely and appropriate disability awards for their patients.

Slide Four
Upon completing this training you will:
- understand the history of the 2012 Guidelines,
- understand the three-part analysis for determining loss-of-wage-earning capacity, also known as LWEC;
- describe the physician’s role in the medical evaluation of impairment and function. And perhaps there is a subset to this particular objective which is for the physician to understand the interrelationship between the medical and legal
aspects for determining LWEC;

- learn and apply the 2012 Guidelines general principles;
- perform a medical evaluation using objective criteria from the 2012 Guidelines with case studies to demonstrate this evaluation;
- learn the components of a functional assessment evaluation of residual functional ability or loss based on the 2012 Guidelines.

**Slide Five**

This course is approximately 71 pages with an estimated study time of approximately 1 ¼ hours to complete.

This activity has been planned and implemented in accordance with the essential areas and policies of the Medical Society of the State of New York through the joint sponsorship of MSSNY and the New York State Workers’ Compensation Board.

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I have no financial disclosures to make.

**Slide Seven**

In 1996 the Workers’ Compensation Board issued medical guidelines for the evaluation of schedule-loss-of-use awards which included permanent impairment of extremities, loss of vision, loss of hearing and facial disfigurement, and non-scheduled permanent partial disability evaluations which addressed those impairments that were not covered by a schedule and include spine, pelvis, respiratory, cardiovascular, skin and brain.
In 2007 Workers’ Compensation Reform Legislation resulted in a major overhaul of the Workers’ Compensation System.

Among the significant changes, the reform set duration limitation or caps on non-schedule PPD Awards based on an injured worker’s loss-of-wage-earning capacity. I think it is important to understand the legal foundation for the 2012 Guidelines. Prior to 2007, an injured worker who was eligible for indemnity benefits would receive them for life. The 2007 Reform Legislation set a maximum number of weeks (duration limits or caps) for the payment of indemnity PPD benefits. The caps are divided into 12 categories based on loss-of-wage-earning capacity ranging from 225 weeks for loss-of-wage-earning capacity of less than 15%, to a maximum of 525 weeks for loss-of-wage-earning capacity greater than 95%. On this slide I’ve provided a sample of 4 of the 12 categories, and as you will note, the maximum is 525 weeks for loss-of-wage-earning capacity greater than 95% and the minimum again is 225 weeks for loss-of-wage-earning capacity less than or equal to 15%. The 2007 legislation, however, does not provide definition or criteria for determining loss-of-wage-earning capacity.

In 2008, the Workers’ Compensation Reform Task Force at the New York State Insurance Department began to develop guidelines for criteria to determine the loss-of-wage-earning capacity.

In 2010, the Task Force issued proposed guidelines to the Workers’ Compensation Board for the evaluation of medical impairment for non-scheduled permanent partial disability and functional ability or loss across a range of work-related functions.
Slide Twelve
In 2011, the Workers’ Compensation Board published proposed 2012 Guidelines and sought shareholder comments.

Slide Thirteen
And finally, on January 1, 2012, the 2012 Guidelines were implemented. Keep in mind that the 1996 Guidelines addressed the medical evaluation of both scheduled loss of use and non-scheduled permanent partial disability. The 2012 Guidelines that were implemented keep the 1996 Guidelines for evaluating scheduled loss of use but replace the sections for evaluations of non-scheduled permanent partial disability. Of note, for claims that have at least one medical opinion with a permanent impairment rating based on the 1996 Guidelines on or before the implementation day of January 1, the Workers’ Compensation Board will determine the worker’s degree of permanent disability using the 1996 Guidelines. So if the claim is initiated using the 1996 Guidelines then those guidelines will continue to be used for the permanent medical, permanent impairment rating.

Slide Fourteen
What’s new in the 2012 Guidelines? These guidelines provide a standard framework and methodology to evaluate and document a worker’s medical condition, degree of impairment, and functional ability and loss, and in addition, have a guidance on how to determine loss-of-wage-earning capacity.

Slide Fifteen
Before proceeding to the rest of the training, I think it’s important to review key terms and concepts which will permit better insight into the interrelationship between the medical and legal components of a loss-of-wage-earning capacity determination. The first term, “impairment”, is purely a medical determination made by a physician. It is defined as an anatomic or functional abnormality or loss. An impairment will be considered permanent when MMI has been reached and there is a remaining impairment. MMI or maximum medical improvement is defined in the 2012 Guidelines. The definition will be
revisited again later on the general principles, so for now, let’s just focus on little a and little b. MMI is a finding based on medical judgment that the worker has recovered from the work injury to the greatest extent that is expected and no further improvement in his or her condition is reasonably expected. This definition will be revisited and put into a broader context as we proceed.

*Slide Sixteen*

The second important term is “disability“. Disability is a legal determination that reflects the impact of a workplace injury on the worker’s ability to work. The loss-of-wage-earning capacity is the reduction in an injured worker’s earning power due to a work-related injury or disease and the determination of loss-of-wage-earning capacity or disability, or the level of disability is within the purview of the Workers' Compensation Law judge. The law judge makes a determination based on the available medical evidence and other relevant information including vocational factors.

*Slide Seventeen*

The determination of loss-of-wage-earning capacity is a three-part analysis. Step number one is the evaluation and ranking of medical impairment at maximum medical improvement. Step two is a medical evaluation and determination of functional ability or loss called, for short, “functional assessment“. And finally, step number three is the LWEC determination that is based on impairment, functional and vocational factors.

*Slide Eighteen*

A physician assesses the worker’s impairment, which is step number one, and functional ability or loss and related medical issues, step number two. The Workers' Compensation Law judge determines loss-of-wage-earning capacity or step number three.

*Slide Nineteen*

Let’s dig a little deeper into each of the steps of the three-part analysis. The first step, medical impairment, again is a physician determination. The physician makes a determination that the medical impairment is permanent and if so, the severity of that
medical impairment. In order to qualify for benefits under the Worker’s Compensation Law the impairment must be permanent and not subject to a schedule loss of use award. As mentioned earlier, the determination of permanency is made when the worker has reached MMI. The physician has to assess the severity of the permanent impairment, and the physician does this by objectively assigning the impairment category and associated severity ranking, A through Z, that best fits the worker’s medical condition at the time of MMI. This severity assessment comes out of the impairment assessment in the 2012 Guidelines. Of note, it is not uncommon for workers to have an impairment of more than one body part but the 2012 Guidelines do not provide a mathematical formula for combining medical impairments. The common pathway for evaluating the cumulative impact of multiple permanent impairments is the functional assessment.

**Slide Twenty**
The second step of the three-part analysis is the functional assessment which includes a medical evaluation of residual functional ability and losses. Again, at MMI, the physician performs a functional assessment along with the medical impairment evaluation. The treating physician measures and documents the worker’s ability to perform work-related activities such as sitting, standing, walking, and overhead reaching, whether there are restrictions as to how long or how frequently these activities may be performed. In addition, the physician measures and documents the worker’s residual exertional capacity such as the ability to lift or carry weights based on a standard classification of physical demand requirements, and finally, any other limitations, such as environmental restrictions, that may preclude work in a particular occupation or certain work environments. These measurements and documentation are derived from the 2012 Guidelines criteria.

**Slide Twenty-one**
The third step in the three-part analysis is the actual determination of loss-of-wage-earning capacity. And let me reiterate at this point, the relationship between loss-of-wage-earning capacity and the number of benefit weeks that an injured worker would be eligible for. So once the loss-of-wage-earning capacity is established by the judge, this
will also establish the maximum number of benefit weeks available under the Workers' Compensation Reform Legislation. The Workers' Compensation Law judge must establish a reasonable loss-of-wage-earning capacity based on the facts of the case. And these facts would contain the medical evidence provided by the physician which would be the degree of the permanent impairment or mental impairment and the impact on function. The second prong would be vocational factors which would include education, training, skills, age, literacy, English proficiency, etcetera. The judge’s inquiry determines how much earning capacity an injured worker has lost due to his or her medical impairment, functional limitations, prior work history, education, skills and aptitudes. There is no simple formula to determine loss-of-wage-earning capacity. The judge evaluates the various components and makes the determination balancing the medical evidence and the vocational factors.

**Slide Twenty-two**
The physician’s role in the process, and this is kind of reiterating what we’ve said before, is to provide a medical opinion on the worker’s medical condition, degree of impairment and functional abilities or functional assessment. The physician submits the medical evidence to the Workers' Compensation Law judge who will consider the evidence together with non-medical evidence in making a legal determination regarding loss-of-wage-earning capacity.

**Slide Twenty-three**
The physician’s report should document the relevant medical history, exam findings, test results and work-related medical diagnosis based on the history, exam and test results. These four bullets represent standard medical practice for evaluating and documenting patient care. The last three bullets come from criteria in the 2012 Guidelines and the physician needs to identify the body part affected, from the appropriate chapter and table in the guidelines, the impairment ranking based on the 2012 Guidelines criteria and the impact of the impairments on the worker’s functional and exertional abilities. Please note that form C4.3, the doctor’s report of MMI or permanent impairment, has been modified to accommodate the new information from the 2012 Guidelines, including the medical
impairment and the functional assessment.

**Slide Twenty-four**
Next, we will explore the organization of the 2012 Guidelines and, in essence, the guidelines are organized by body systems. One of the most common systems that will be used will be Chapter 11, “spine and pelvis“. Chapter 13 is pending and will be developed shortly.

**Slide Twenty-five**
Some of the body systems are further divided into subcategories. So, for example, Chapter 11 would be spine and pelvis and that would be further divided into soft tissue spine conditions, non-surgically or surgically-treated vertebral fractures, spinal cord injury or pelvis injuries. Chapter 12 is another chapter that’s further divided and that’s respiratory, and that’s divided according to pneumoconiosis and other non-asthma respiratory conditions, asthma or lung cancer.

**Slide Twenty-six**
Each body system has tables associated with it and each table has two basic parts: the explanatory box which provides general instructions or concepts that apply to determining the medical impairment class and severity ranking. The second part of the table is the medical impairment class and the severity rankings. The medical impairment classes contain objective criteria for classifying the medical impairment and the associated severity ranking.

**Twenty-seven**
The following is an example of a severity ranking table for soft tissue spine conditions that have not been surgically treated. Note that additional tables are available for surgically treated conditions and for vertebral fractures. And here we have an explanatory box and this explanatory box lets us know that there will be other tables for surgically-treated spine conditions and vertebral fractures so it informs us of subsystem divisions. Number three gives us a very important concept, which is the need to have consistency
between symptoms, findings and the documented workplace injury. Number seven is another very important concept and resonates throughout the treatment guidelines and that is that the medical impairment ranking is not to be used as a direct translation loss-of-wage-earning capacity. This important concept has its origins in the history of Workers' Compensation Law. Prior to 2007, according to the 1996 Guidelines, a physician’s impairment rating and the percentage associated with it, in most circumstances, directly translated into that worker’s disability assessment. This is no longer the case and as we’ve said several times, the physician’s information or data is part of the information that the judge uses to determine loss-of-wage-earning capacity and is not a direct translation.

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On this slide we have an example of severity table for classes 1 through 3 for the soft tissue spine conditions that are non-surgically treated. And again, you will note that there are medical impairment classes that contain detailed criteria with progressively more severe symptoms and findings in subsequent classes. The severity ranking is also in increasing severity ranking order. Also note that not all letters A through Z will be used in each body system. So here, for example, we have class 1 where an injured worker has no symptoms and no clinical findings, the severity ranking for cervical would be none. There would be no impairment. However, as we progress to class 2 and class 3, there will be the persistence of symptoms and progression to objective findings or correlating imaging findings and an associated increase in the severity ranking letter.

Page Twenty-nine
There are supplemental tables, noted by an S in the table number, that are used in conjunction with the primary tables to make the determination of medical impairment and the associated severity ranking. Some examples of the supplemental tables are provided on this slide and let me draw your attention to the first three bullets which are supplemental tables that we will be using in case studies later in this training. And again, these tables cannot be used alone but must be used in conjunction with other tables for making the medical impairment assessment.
Slide Thirty
On this slide there is another excerpt from table 11.1, soft tissue spine conditions, non-surgically treated. Class 4 is the most severe class within this system. A key point is that there is a requirement that there be consistency between symptoms, exam findings and diagnostic imaging and tests. In addition, objective clinical findings, which has an *, is defined at the bottom of the table. Objective clinical findings are atrophy or reflex changes. So when the term “objective clinical findings” is used the criteria are specific: atrophy or reflex changes. Finally, class 4 has a range of severity rankings and supplemental tables are identified to assist with identifying a rank within a range.

Slide Thirty-one
Using “cervical” as our model for this discussion at this point, there is a severity range of C through H. To determine the specific ranking within that range, supplemental tables will be used and these have been identified as 11.4, 11.5, and 11.7. Again, noting the S in front of the table indicating that it’s a supplementary table to be used in conjunction with 11.1 and other tables.

Slide Thirty-two
On the next page we have an excerpt from supplemental table S11.4. This table assigns points for radiculopathy criteria. And we will be using these tables in subsequent case studies so you’ll get a flavor for how they are to be utilized.

Slide Thirty-three
Supplemental table 11.5 takes us a step further in the analysis and provides points for the nerve root that’s impaired or affected by the the radiculopathy criteria.

Slide Thirty-four
And finally, in supplemental table 11.7 we are able to, according to the number of points accumulated in the other tables, assign a specific rank in a range that will now be used as the severity ranking for this particular body part.
Slide Thirty-five

Before we move on to the case studies, let’s take a moment to look at the general principles. And this will be an overview. Take the time when performing an impairment evaluation and a functional assessment to review the general principles and to understand them. Chapter 10 of the 2012 Guidelines contains the general principles that govern the approach to the evaluation of non-scheduled PPD and include principles that talk about maximum medical improvement, reclassification, objective tests, the impact of medical impairment and severity ranking and assistive devices.

Slide Thirty-six

Once more, we’ll just talk briefly about maximum medical improvement and again, because this is such an important concept, before an impairment rating is considered, the injured worker must reach maximum medical improvement. And as we said earlier, that is defined on a medical judgment, that the worker has recovered from the work injury to the greatest extent that is expected and no further improvement in his or her condition is reasonably expected. Classification should not occur until MMI has been reached. And finally, MMI cannot be determined prior to six months from the date of injury or disablement unless otherwise agreed to by the parties. The Guidelines are not intended in any shape or form to prevent an application for reclassification in the event that the worker’s medical condition worsens.

Slide Thirty-seven

The Guidelines were not intended to prevent an application for reclassification in the event that a worker’s medical condition worsened.

General principle regarding objective tests

Objective tests are weighted more heavily than subjective symptoms and this concept is a framework for the criteria in the medical impairment classes. The next two bullets are corollaries and basically, just because an objective test is identified in the 2012 Guidelines does not mean that the test must or should be performed. Rather, the performance of objective tests should be determined by the patient’s clinical condition.
**Slide Thirty-eight**

**General principle regarding medical impairment, functional loss and loss-of-wage-earning capacity**

Generally speaking, medical impairment is generally predictive of residual functional ability or losses. The severity ranking within a specific impairment table is also generally predictive of the expected functional loss, based on the medical impairment. And finally, medical impairment cannot be directly translated to loss-of-wage-earning capacity, keeping in mind that the loss-of-wage-earning capacity is a judge-determined concept and depends upon medical evidence that is provided to the judge, and additional factors that the judge takes into consideration. Assistive devices such as canes, crutches, wheelchairs etc. are not taken into account when determining medical impairment but may be considered in the functional analysis.

**Slide Thirty-nine**

Next we will go through a series of 4 case studies which will demonstrate the various concepts and data that I’ve provided in the earlier part of the training. For each of the case studies, assume that MMI has been reached and also recognize that the histories, the symptoms and the diagnostic imaging studies have been abbreviated for purposes of this demonstration.

*Case study number 1:* We have a 44-year old woman who sustained a low back injury when a three-foot bar stool collapsed under her at work and she landed on her buttocks. After physical therapy and medications her symptoms improved significantly. She has occasional, intermittent pain across her low back with radiation into the back of her legs but not into her feet. The neurological exam is normal. *Using the 2012 Guidelines, what is the worker’s severity ranking?*

**Slide Forty**

The first step in identifying the medical impairment class is to recognize the body system. And in this case the body system is the spine/lower back. No surgery has been performed. So we would be looking at table 11.1 soft tissue spine conditions, non-surgically treated. In this case, we have occasional symptoms but no objective findings and no correlative
imaging findings. So the medical impairment class would be class 2 and we go across to the severity ranking under the lumbar spine and the severity ranking would be the letter A.

**Slide Forty-one**

In the next case study, *Case study 2*, we have a 53-year-old man who sustained a work-related, low back injury when he lifted an 80-pound concrete slab. He initially had pain into his right leg down to the ball of the foot associated with numbness, tingling and weakness. An MRI demonstrated an L4 to L5 herniated disc with right L5 nerve-root displacement. He failed conservative treatment which included physical therapy, medications and epidural steroid injections. A surgical discectomy was performed at L4/L5. Exam findings: there is an absent right ankle jerk, a positive straight leg raise at 30° which produces the radicular pain in an L5 pattern and leg atrophy of 2cm when comparing right to left. *Using the 2012 Guidelines, what is the worker’s severity ranking?*

**Slide Forty-two**

Once again, we would identify the particular body system or subsystem that is applicable in this case. We have the spine/low back but surgery was performed. So instead of using table 11.1, we would use 11.2, surgically-treated spine conditions. And here we would come to class 4 because we would have objective findings: absent ankle jerk and atrophy, and we would have a positive tension compression sign. So we would then be in class 4. We would go across to the lumbar severity ranking column and, where number 3 is, the severity ranking would be a range of D through J. In order to determine the ranking between D through J, we are referred to supplemental tables to assist in that placement determination.

**Slide Forty-three**

In the case at hand, we have muscle involvement demonstrated by muscle atrophy where we get 6 points. We have reflex changes where the ankle reflex is absent so that would be 6 points and we have a positive tension compression sign which gives us 4 points.
So, from the radiculopathy criteria we have a total of 16 points.

**Slide Forty-four**
We then go to table 11.7 and we will now determine what these total radiculopathy points will mean in terms of a severity ranking within the range. We go to table S11.7B, lumbar radiculopathy, and we look for 16 points which is going to be a severity ranking of E.

**Slide Forty-five**
And returning to table 11.2, our starting table, our particular severity ranking within the range of D through J is equal to E.

**Slide Forty-six**
Let’s take the same 53-year-old man from *Case study number 2* who sustained a work-related low back injury when he lifted an 80-pound concrete slab. He initially had pain in his right leg down to the ball of the foot associated with numbness, tingling and weakness. An MRI demonstrated an L4/L5 herniated disc with right L5 nerve-root displacement. He failed conservative treatment, physical therapy, medications and epidural steroid injections. A surgical discectomy was performed at L4/L5. He has episodic pain responsive to Tylenol. His exam findings are as follows. He is unable to dorsiflect his right foot against gravity. Leg atrophy with the right being 2cm, smaller than the left, decreased light-touch perception and decreased sharp/dull recognition in the L5 distribution. So to summarize, he has some motor weakness, atrophy and sensory changes. *Using the 2012 Guidelines, what is the worker’s severity ranking?*

**Slide Forty-seven**
Once more, we look at the body system involved or in this case subsystems and surgery was performed so once more we’re looking at table 11.2 for surgically-treated spine conditions. And the patient’s medical impairment class will be class 4. And if we go across to the severity ranking under the lumbar spine, the severity, range is D through J. We are referred to tables S11.4, S11.6 and S11.7 to determine the severity ranking within the range.
Slide Forty-eight
We go to S, table S11.4A for points that relate to the right, radiculopathy criteria. Here we have muscle involvement and a range for the muscle weakness between 6 to 20. The muscle weakness is represented by the inability to dorsiflect the right foot against gravity. We have a second component of muscle involvement, muscle atrophy, and here we have a definitive number of points, 6. And then we also have sensory involvement and a range of points for the sensory involvement of 4 to 6. In order to determine where we are or what the actual number of points is for muscle weakness and for the sensory involvement, we are referred to additional supplemental tables.

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Table S11.4A provides points for muscle weakness. The greater the weakness the more points and in this case, the muscle weakness will fall into a grade 2. A grade 2 will equal 18 points for the motor deficit.

Slide Fifty
Table S11.4B allows us to determine the number of points for the degree of sensory deficit and here too, the more severe the deficit, the higher the number of points. In this case we are looking at the middle category where the sensory function is compromised. We have diminished or altered sensation and a sensory deficit with 4 points.

Slide Fifty-one
Next we go to table S11.6 and here we have points assigned for the nerve root that is impacted by the injury. In this case the nerve root impacted is L5 and since there is a sensory deficits, that sensory deficit has 4 points, and since there is associated motor weakness, that motor weakness is assigned 16 points.

Slide Fifty-two
And, putting all of the information together, we have radiculopathy with associated muscle involvement, including muscle weakness with 18 points from table S11.4, with
points for muscle atrophy from table 11.4, S11.4, we have sensory involvement from S11.4B of 4 points, and the nerve-root impairment associated with radiculopathy gives us another total of 20 points, and all together we have 48 points for the total radiculopathy value.

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Table S11.7 allows us to take the total points and now use them to identify a specific rank within the severity range. Table S11.7B, if we look at the lumbar points, 48 points puts us into the category G. So the severity ranking for this patient with the associated symptoms and findings would be a severity ranking of G.

*Slide Fifty-four*

We’re going to switch gears in case study 4 and look at a 62-year-old man who has worked as an insulator for 40 years. He mixed powdered asbestos with water and applied it to pipes for the first 20 years of work. His current symptoms include a 5-year history of increasing dyspnea and having to walk more slowly on level ground than others his age. The first item again is to identify the body system. We’re talking pulmonary and here we’re talking pulmonary asbestos or pulmonary pneumoconiosis, non-asthma related. We also will look initially at table S12.13 the dyspnea evaluation questionnaire and using this questionnaire we will find that the patient’s symptoms fit into the moderate category, and moderate is: do you have to walk more slowly on level ground than people of your age because of breathlessness? And this is exactly what the patient has complained of. So the severity, the severity component of his dyspnea will be moderate.

*Slide Fifty-five*

And his lung functions we’ll look at the ones that are in bold because those are the ones that are used for the pulmonary criteria. And we have an FEV1 of 60% of predicted and a diffusing capacity of 50% of predicted. **Using the 2012 Guidelines, what is the worker’s severity ranking?**
**Slide Fifty-six**

So in table 12.1, pneumoconiosis and other occupational respiratory diseases other than asthma, class 7 will meet the patient’s symptoms and lab results. So here we have to have a patient who has moderate dyspnea. The moderate dyspnea questionnaire is based on table S12.13, the dyspnea evaluation criteria, and then the abnormal function tests, the FEV1 of 60 to 69 (the patient is 60% and fits right into that category) or a diffusing capacity of greater than 40% of predicted but less than 80% (and here too, the patient’s diffusing capacity fits into that category) so with either of the function tests we would be squarely placed in class 7 and class 7 has an associated severity ranking of I. Of note, this particular worker should permanently avoid exposure to asbestosis and limit exposure to respiratory irritants and extremes of temperature and humidity. The environmental limitation should be addressed in the appropriate section of the C4.3 form.

**Slide Fifty-seven**

We will now enter the second phase of the two-part analysis: the functional assessment. And again, when the injured worker has reached MMI, the treating physician performs a functional assessment along with the medical impairment evaluation. The physician’s functional assessment is recorded on the doctor’s report of MMI or permanent impairment form C4.3 and should include or address the worker’s at-injury job activities, the worker’s functional abilities or losses, exertional capacity, psychiatric and other limitations.

**Slide Fifty-eight**

The physician’s job is to first determine whether or not the injured worker can actually perform the work activities of the at-injury job. In order to understand the major work requirements, the physician should request a job description or other similar documentation from the employer and speak with the worker about job requirements. If the employer maintains that the injured worker is capable of performing the at-injury job, the employer must provide appropriate detail about the physical job requirements. The physician’s documentation on whether or not the worker can perform the at-injury job has to be based on the best information that is available to the physician about the job.
requirements at the time of the evaluation.

**Slide Fifty-nine**
When performing the functional assessment the physician must measure the injured worker’s performance and restrictions across a range of functional abilities, including dynamic abilities such as lifting, carrying and pushing, general tolerances, walking, sitting and standing, and specific tolerances for climbing, bending, stooping, kneeling, and so on. These abilities and restrictions, including specific weight and time limitations are recorded on the form C4.3. Alternatively, the physician may refer the injured worker to a physical or occupational therapist for completion of the functional measurements and functional assessment. After the physician’s review, the physician may incorporate them into the C4.3 form.

**Slide Sixty**
An important component of the physician’s assessment is rating the worker’s residual exertional capacity according to a standard classification system of sedentary to very heavy. The exertional capacity relates to activities that require lifting and pushing and/or pulling objects. The following definitions are derived from the dictionary of occupational titles and are also used by the Social Security system. I won’t read each of these individually but just note that as you move from sedentary to medium, to heavy, to very heavy, the injured worker is capable of increased physical demand requirements. And these categories reflect those increasing demands.

**Slide Sixty-one**
There is no audio on this slide.

**Slide Sixty-two**
For claims that involve an established permanent psychiatric impairment the physician must document the impact of the psychiatric impairment on the worker’s ability to function in the workplace, including relevant activities to obtaining, performing and maintaining employment. There are other limitations that the physician should document
and these are limitations that may be caused by the permanent impairment and that impact the worker’s ability to function in the workplace. These could include environmental limitations or prescription medication that impact the worker’s ability to work.

**Slide Sixty-three**
I just want to touch briefly on forms that have been revised in order to accommodate the 2012 Guidelines and a new form that has been developed to assist in capturing vocational data that will be used by the judge to make the determination of loss-of-wage-earning capacity. First, the C4.3 form which is the doctor’s report of MMI or permanent impairment. This is a form that is already in existence and was modified to capture medical impairment class, severity ranking and the functional analysis information. The physician completes the C4.3 when rendering an opinion on MMI and/or permanent impairment or in response to a request by the Workers’ Compensation Board to render a decision on MMI. Of importance, a physician who fully completes an evaluation of permanent impairment, including a full evaluation of functional limitations on the C4.3 form, is entitled to payment for a consultation code CPT 99245. The vocational data form or VDF-1 form is completed by the injured worker and is mentioned here for completion’s sake. The physician does not complete it and it is the worker who provides information about the work experience, education and language literacy.

**Slide Sixty-four**
On this slide is a copy of the revised C4.3 and a copy of the VDF-1 for informational purposes just to make you aware of what these forms look like and their availability.

**Slide Sixty-five**
In conclusion, let me review the key concepts for determining loss-of-wage-earning capacity under the 2012 Guidelines. The analysis is a three-part analysis. Step one is the evaluation and ranking of medical impairment at maximum medical improvement. Step two is the medical evaluation and determination of functional ability or loss. Step three is the actual loss-of-wage-earning capacity determination based on
impairment, functional and vocational factors.

*Slide Sixty-six*

The physician provides the medical evidence regarding the nature and severity of the work-related, non-scheduled permanent impairments and the associated functional assessment. The Workers’ Comp. law judge considers the medical evidence provided by the physician together with non-medical evidence, age and other related vocational factors to make a legal determination regarding loss-of-wage-earning capacity. The judge will review the VDF form that the patient has completed to obtain information on vocational-related factors.

Finally, I’d like to make you aware of resources that are available to assist in understanding and applying the 2012 Guidelines. The Board’s website contains a section dedicated to the Guidelines, along with frequently asked questions and additional free web-based, web-based training. Additionally, there is a phone number and an e-mail address for specific questions that you may wish to ask. And finally, the Medical Director’s office is always available to assist in answering questions and that contact information is on this last slide as well. Thank you for your attention.