NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

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2018 Impairment Guidelines for Determining Schedule Loss of Use (SLU)

Background

History of the Impairment Guidelines

1996

- The Medical Guidelines were first issued by the Board in 1996 for the evaluation of permanent impairment for both schedule and non-schedule injuries.
- These were in effect through 2011.

Background

2012

- In 2012, the Board issued the New York State Guidelines for Determining Permanent Impairment and Loss of Wage Earning Capacity, also known as the 2012 Guidelines.
- These guidelines addressed both schedule and non-schedule awards, and contained new criteria for evaluating non-schedule impairment.

Background

2017

- In 2017, workers' compensation legislation directed the Board to adopt revised guidelines for SLU injuries.

Background

2018

- The revised SLU Guidelines were developed and implemented on January 1, 2018.
- These 2018 Guidelines reflect advances in modern medicine that enhance healing and result in better outcomes.

Background

Summary

- Chapters two through eight for evaluation of SLU are **no longer in effect** as of January 1, 2018.
- Chapters nine through 17 for the evaluation of non-schedule injuries **remain in effect** and are unchanged.

Legal Framework

Health Care Providers Should Know That:

- New York State medical providers **must** be Board-authorized.
  - Board-authorized means approved by the New York State Workers' Compensation Board to treat and/or perform independent medical examinations.

Legal Framework

- Permanency evaluations performed outside of New York State must be consistent with the Impairment Guidelines.
- There are also revised Board forms that must be used to document impairment. This will be covered in the last section of this training module.

Legal Framework

2012 or 2018 Guidelines?

- When the first SLU medical evaluation was performed **before January 1, 2018, the 2012 Guidelines should be used** to determine the worker's degree of permanent disability.
- When the first SLU medical evaluation **occurs on or after January 1, 2018, the 2018 Guidelines should be used** to determine degree of permanent disability.

Organization: 2018 SLU Guidelines

- The table of contents identifies the location of each body part and/or condition that is amenable to an SLU evaluation.
- The introductory chapter contains key concepts and terms that are important in SLU evaluations.
- Each chapter discusses the SLU evaluation of an individual body part or condition.

Organization: 2018 SLU Guidelines

Number	Title
Chapter 1	Introduction
Chapter 2	Upper Extremities – Thumb and Fingers
Chapter 3	Upper Extremities – Hand and Wrist
Chapter 4	Upper Extremities – Elbow
Chapter 5	Upper Extremities – Shoulder
Chapter 6	Hip and Femur
Chapter 7	Knee and Tibia
Chapter 8	Lower Extremities – Ankle and Foot
Chapter 9	Lower Extremities – Greater and Lesser Toes
Chapter 10	Central Nervous System Conditions, Peripheral Nerve Injuries and Entrapment Compression Neuropathies
Chapter 11	Visual System/Auditory System, Facial Scars and Disfigurement

Chapter 1: Key Concepts & Terms

Impairment vs. Disability

Term	What is it?	Who makes the determination?
Impairment	A purely medical determination defined as any anatomic or functional abnormality or loss. Residual impairment is considered permanent at maximum medical improvement.	A medical professional determines impairment based on a complete examination and an accurate objective assessment.
Disability	A legal determination that reflects the impact of a workplace injury on a worker's ability to work.	A Workers' Compensation Law Judge establishes a level of disability based on the available medical evidence and other relevant information.

Chapter 1: Key Concepts & Terms

Maximum Medical Improvement (MMI) is defined as the assessed condition of a worker based on a medical judgment that:

- The worker has recovered to the greatest extent expected; and
- No further improvement in his or her condition is reasonably expected.

Chapter 1: Key Concepts & Terms

- The need for palliative or symptomatic treatment does not preclude a finding of maximum medical improvement.
- In cases that do not involve surgery or fractures, maximum medical improvement cannot be determined before six months from the date of injury or disablement, unless otherwise agreed to by the parties.

SLU Chapters 2-9

The first section of each chapter contains *Objectives for Determining Impairment.*

- This section provides an overview of the function of the involved joint and what is required to accurately assess the permanent residual physical deficit resulting from the work injury.
- The assessment should be based on objective findings determined by history, exam, and results of any appropriate diagnostic testing.

SLU Chapters 2-9

The second section, *Methods Available to Assess Permanent Impairment,* provides assessment principles.

- The determination of the degree of permanent residual physical deficits should be performed at maximum medical improvement when no further healing is expected.
- MMI should be determined based on the outcome of the clinical course of treatment, medical provider's expertise and any further treatment options available.

SLU Chapters 2-9

- The severity of a permanent impairment is not based on the mechanism of injury.
  - It reflects the permanent residual impairment that occurs at maximum medical improvement and may include damage to a variety of tissues, including bone, muscle, cartilage, tendons, etc.
- The duration of time for maximum medical improvement varies; and in most cases, is one year from injury or last surgery.

SLU Chapters 2-9

Subsequent sections in chapters 2-9 provide:

- Normal range of motion (ROM) tables,
- The method for calculating the overall SLU for the body part,
- Special considerations, and
- Percent loss of use for amputations at different levels of the involved body part.

Role of the Medical Provider

Critical role in the SLU evaluation process

- Provide the Board and all involved parties with their best professional medical opinion regarding a worker's SLU impairment.
- Utilize the detailed criteria in the Guidelines to determine the severity of the impairment.
- Look only to objective findings of the physical exam and the data contained in the patient's medical record.

Role of the Medical Provider

Preparing a Report

- Report the work-related diagnoses and specifically report the relevant history, examination and test result findings.
- Follow the recommendations in the Guidelines to establish an impairment level.
- The clinical information must support the SLU determination.

Examination

Range of Motion (ROM)

- ROM is a key factor in the SLU determination in the 2018 Impairment Guidelines.
- There are several new requirements that must be met when evaluating ROM.
- Generally, a goniometer should be used to measure active ROM

Examination

ROM

- Three repeat measurements should be taken of maximum active ROM.
- When evaluating residual impairment, **the contralateral side should be considered for comparison for expected/normal values**, when appropriate.
- Deficits should be compared to the baseline reading of the contralateral member, if appropriate.

Examination

ROM

- Using the contralateral side is not appropriate when the opposite side has been previously injured or is not otherwise available for comparison.
- When the contralateral side is not available or not appropriate, the normal ROM from the tables in the 2018 Guidelines should be used as the baseline comparison.

Enhancements to the SLU Guidelines

There have been some significant enhancements to the 2018 Guidelines that help to clarify important aspects of the SLU evaluation.

1. Clearly Defined ROM Values
2. Maximum ROM Values
3. Specific ROM Values for Mild, Moderate and Marked Deficits
4. Loading
5. Special Considerations
6. Joint Replacements

Clearly Defined ROM Values

- There are written instructions and visual aids for each body part to make it easier to properly measure all ROM deficits for each identified joint.
- **Example:** Chapter 5, Section 5.3 provides specific instructions and values for measuring shoulder flexion and extension ROM.

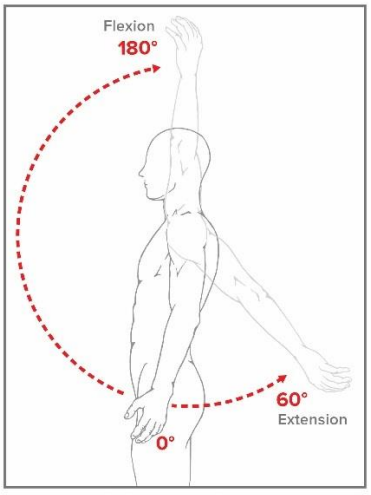
Chapter 5 Figure 5.3(1)

Shoulder Flexion and Extension Figure 5.3(1)

- **Flexion** (forward elevation):
  - ROM is in the sagittal plane rotating about an axis of an imaginary line through the glenoid fossae with the arm moving in front of and above the body.
  - The normal range of motion is to 180°.

Chapter 5 Figure 5.3(1)

- **Extension** – ROM that is in the sagittal plane rotating about an axis of an imaginary line through the glenoid fossae with the arm moving behind the body to 60 degrees.



Maximum ROM Values

- For all SLU determinations based on ROM, the total SLU value for several ROM deficits within a joint cannot exceed the value for ankylosis.
- When there are multiple ankylosed joints, the sum of the value of the SLU of the major member cannot exceed the value of an amputation of that member.
- An exception to these rules may occur when digits exceed these values due to loading.

Specific ROM Values for Mild, Moderate and Marked Deficits

- The new Guidelines contain diagrams and tables that clearly identify the specific ROM values that correlate with mild, moderate and marked deficits (percent loss of use).
- **Example**: Table 3.4: Percent Loss of Use of Wrist

Chapter 3 Figure 3.3(a)

Table 3.4: Wrist ROM and Percent Loss of Use

Letter	ROM	Mild	Moderate	Marked	Ankylosis
A	Palmer Flexion ROM 0-80°	7½% ROM 60°	12½% ROM 40°	20% ROM 20°	Position of function (mild dorsi flexion): 60% loss of the hand
B	Dorsi Flexion ROM 0-70°	7½% ROM 60°	15% ROM 35°	25% ROM 20°	In any other position (palmer, marked dorsi flexion or lateral deviation) 70 – 90% loss of the hand
C*	Pronation/Supination ROM 0-90°	7½ - 10% ROM 75°	17½ - 20% ROM 45°	25 – 30% ROM 25°	

Loading

- The 2018 Guidelines contain a step-by-step explanation to bring consistency to the application of loading criteria **(Section 2.6).**
- Values for loading that involve the fingers have been increased by 20 percent to address the increasing reliance on the hand and fingers in the computer age.

Special Considerations

- There are changes in the “Special Considerations” sections.
- An overarching change to take note of is that the instructions have been clarified regarding whether a condition that falls under a special consideration is evaluated as a stand-alone or as a value that is added.
- Considerations for meniscal and rotator cuff tears with or without surgery have been removed.

Joint Replacements

- The content for joint replacements has changed significantly.
- Advances in medicine have improved many joint replacement outcomes.
- The 2018 Guidelines provide an assessment of clinical outcomes to determine an SLU.

Joint Replacements

These clinical criteria include:

- Overall grade
- ROM
- Position
- Atrophy, and
- Complications

Joint Replacements

- The starting point for an SLU in a joint replacement with a good outcome is 35%.
- When deficits exceed those described in Row A (Good Outcome), the value for any additional deficits are added to the base of 35% to calculate the total SLU award.
- Any additional deficits, would be chosen from the relevant columns that have the closest matching deficit to the patient's deficits.

Step by Step: Applying the 2018 Guidelines

- First, determine whether a condition triggers a Special Consideration.
  - If so, perform the SLU determination consistent with the requirements noted in the relevant Special Consideration section.
  - If not, the SLU evaluation should conform to the Guidelines' general criteria for a given body part.

Applying the 2018 Guidelines

Documenting Loss

- ROM values for affected joints should be documented utilizing the Guidelines instructions.
- Once ROM value(s) have been determined, instructions in the appropriate Sections/Tables of the Guideline should be used to calculate the percent SLU.

Applying the 2018 Guidelines

Documenting Loss

- **Three repeat measurements of active ROM should be performed** using a goniometer and all three values recorded.
- **The highest of the three measured values** should be used in the SLU determination.
  - If a measurement other than the highest ROM is used, the physician must explain in detail why the highest range of motion was not appropriate.

Applying the 2018 Guidelines

Documenting Loss

- **As a baseline, ROM values for the unaffected contralateral joint**, if appropriate, should be documented.
- The contralateral side may not be appropriate when there has been a prior injury or is otherwise not available for comparison (example: body habitus, amputation).
- If the contralateral side is not appropriate, an explanation should be provided.

Applying the 2018 Guidelines

Documenting Loss

- Designated normal ROM values should be used when the contralateral healthy body part is not available as a result of a general or pre-existing (unrelated) inability to achieve full ROM.
- Generally, ROM defects correspond to SLU percentages as follows:
  - 25% loss = mild; 50% = moderate; 75% = marked

Case Study #1

History

A 53-year-old man has a work-related injury to the right shoulder, and is status post a right rotator cuff repair. His injury was caused by lifting a 40-pound box to shoulder height. He felt a sudden pop with pain and weakness in his right arm. Surgery was a year ago. He's at maximum medical improvement and working. Prior to surgery he had full range of motion in both shoulders.

Case Study #1

Physical Examination

Right shoulder exam reveals:

- Incision site is well-healed
- No atrophy
- Range of motion: forward flexion = 0° to 90°; abduction = 0 to 100°
- Mild defects in external and internal rotation
- The left shoulder has full range of motion

Case Study #1

Calculating the Shoulder SLU

- Utilizing the table from the 2018 guidelines, full range of motion for the left shoulder is 180°.
- The contralateral shoulder has full range of motion, which is 180°.

Case Study #1

Table 5.4(a) in the Guidelines contains additional instructions:

- If there are documented deficits in both flexion and abduction, the greater deficit must be used, not both.
  - In this case the greater deficit is flexion.
- A flexion deficit of 90° falls into a moderate category, a 40% loss of use.

Case Study #1

ROM	Mild	Moderate	Marked	Ankylosis
Flexion/Abduction ROM: 0-180° (use greater deficit)	20% ROM: 135%	40% ROM: 90°	60% ROM: 45°	Ankylosis at the scapulo-humeral joint at 0 degrees equals 80% loss of use of the arm

Case Study #1

- Next, if the deficits in both flexion and abduction are moderate or higher and within 10° of each other, an additional 10% can be added to the value of the SLU.
- Do not add mild deficits of internal and external rotation to avoid cumulative values. May add 10-15% for marked deficits of rotation and muscle atrophy, not to exceed ankylosis.

Case Study #1

- In summary, the flexion deficit (90 degrees) is greater than the abduction deficit (100 degrees) and falls into a moderate category of 40%
- Deficits in both ROMs (flexion and abduction) are in the moderate categories and within 10 degrees of each other, so an additional 10 percent may be added.
- The internal and external rotation deficits are mild, so they are not added

Case Study #1

- Note: there is no longer a Special Consideration for rotator cuff tears.
- Total SLU = 50% (40% + 10%)

Case Study #2

History

A 59-year-old woman with a knee injury is status post right total knee replacement. Her surgery took place over a year ago, and it's been determined that she is at maximum medical improvement. She has returned to full duty as a bus driver without restrictions.

Case Study #2

Physical Examination

- Right knee: incision is well-healed
- Range of motion: flexion = 125°; full extension to 0
- No instability or atrophy

Case Study #2

Table 7.5: Full or Partial Knee Replacement SLU

Clinical Findings following Full or Partial Knee Arthoplasty/Replacement and Corresponding SLU Ratings of the Leg					
Overall Assessment Grade	ROM: •Flexion (F) or Extension (E) Use whichever deficit is greater	Position: Measured by •Alignment (Varus or valgus deformity), or •stability (medical/lateral (ML) laxity) or •Anteroposterior (AP) motion •Leg Length (LL) Use whichever deficit is greater	Atrophy (measured at mid-thigh compared to the contralateral side)	Chronic complications requiring ongoing treatment e.g., chronic infection(s), revision, recurrent dislocation	SLU of leg
Good (A)	F: > 105° E: < 10°	• Malalignment < 10° • ML laxity < 10°, or • AP: < 5mm • LL < 0.5-inch shortening	< 1 inch	N/A	35%

Case Study #2

Calculating the TKR SLU

Utilizing the clinical indicators in Table 7.5

- ROM
  - Flexion > 105° (125° in this case)
  - Extension < 10° (0 in this case)
- No laxity

Case Study #2

Calculating the TKR SLU

- No atrophy <1 inch or < 2.5 cm (in this case 0.5 cm difference)
- No complications
- TKR Outcome Good = 35% SLU

Revised C- 4.3 Forms

The Doctor's Report of MMI/Permanent Impairment

- Form C-4.3 (pages 1-2) continues to be used for both Scheduled Loss of Use and Non-Schedule Loss of Use with minimal revisions.
- There are two new attachments for documenting permanent partial disability: C-4.3A and C-4.3B.

Revised C- 4.3 Forms

Attachments

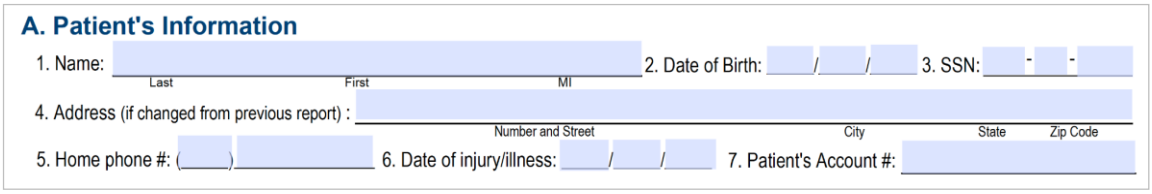
- C-4.3A, Attachment A, is used to document an SLU evaluation and **reflects the 2018 Guidelines' criteria for documenting SLU determinations.**
- C-4.3B, Attachment B, is used to document non-schedule permanent partial disability assessments and **reflects the non-schedule PPD criteria in the 2012 Guidelines.**

Revised IME Report Forms

IME Report

- Revised Form IME-4 Cover Sheet for Report of Independent Medical Examination (IME).
- Two new attachments
  - IME 4.3A to document the SLU evaluation
  - IME 4.3B to document Non-Schedule PPD evaluation

Revised Forms



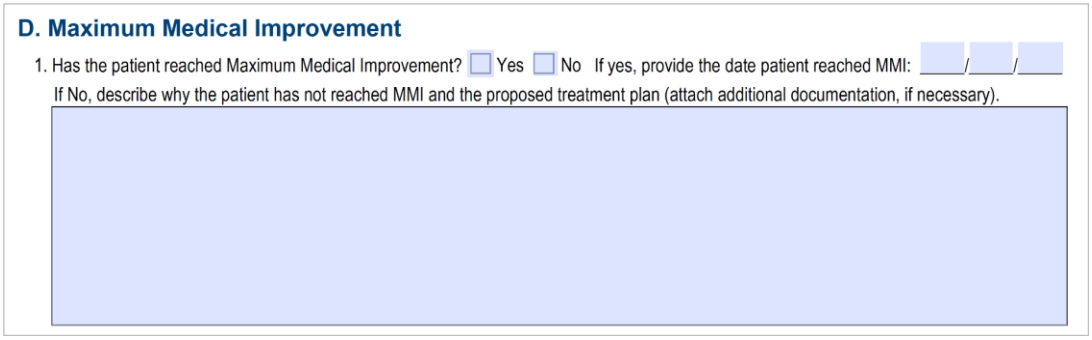
A. Patient's Information

1. Name: _____ (Last / First / MI) 2. Date of Birth: ____/____/____ 3. SSN: ___-___-____

4. Address (if changed from previous report) : _____ (Number and Street / City / State / Zip Code)

5. Home phone #: (____)_____ 6. Date of injury/illness: ____/____/____ 7. Patient's Account #: _____

Revised Forms

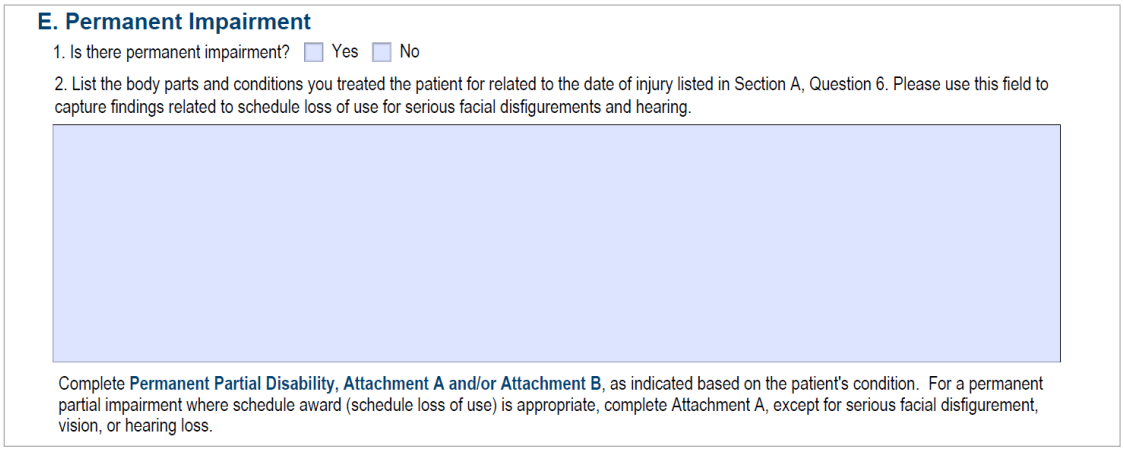


D. Maximum Medical Improvement

1. Has the patient reached Maximum Medical Improvement? ☐ Yes ☐ No If yes, provide the date patient reached MMI: ____/____/____

If No, describe why the patient has not reached MMI and the proposed treatment plan (attach additional documentation, if necessary).

Revised Forms



E. Permanent Impairment

1. Is there permanent impairment? ☐ Yes ☐ No

2. List the body parts and conditions you treated the patient for related to the date of injury listed in Section A, Question 6. Please use this field to capture findings related to schedule loss of use for serious facial disfigurements and hearing.

Complete **Permanent Partial Disability, Attachment A and/or Attachment B**, as indicated based on the patient's condition. For a permanent partial impairment where schedule award (schedule loss of use) is appropriate, complete Attachment A, except for serious facial disfigurement, vision, or hearing loss.

Exceptions

Hearing Loss:

- Occupational loss of hearing can be documented using *Form C-72.1*.
- Traumatic loss of hearing can be documented using *Form C-4.3* with an attached narrative.

Exceptions

Vision Loss:

- Can be documented on the attending Ophthalmologist Report using *Form C-5*.
- As an alternative, can also be documented using *Form C-4.3* with an attached narrative.

Exceptions

Serious Facial Disfigurement:

- Serious Facial Disfigurement can be documented using *Form C-4.3* with an attached narrative.

Revised Forms

Practitioner's Report C-4.3A (SLU)

Permanent Partial Disability - Attachment A
Schedule Loss of Use of Member

If the patient has a permanent partial impairment, complete **Attachment A** for all body parts and conditions for which a schedule award is appropriate (schedule loss of use). You must complete this attachment for all body parts and conditions for which you treated the patient for the date of injury listed in Section A, Question 6. Attach additional sheets if needed.

Revised Forms

To capture information on SLU consistent with the new 2018 SLU Guidelines, the following must be documented:

Body Part

Please include all the information in the bullet points below in the table on this page or attach a medical narrative with your report. The medical narrative should include the following information:

- Affected body part (include left or right side) and identify Guideline chapter and applicable table or chart
- Measured Active Range of Motion (ROM) (3 measurements for injured body part, and use the greatest ROM. If not, please explain why.
- Measurement of contralateral body part ROM, or explain why inapplicable
- Previously received scheduled losses of use to same body part(s), if known
- Special considerations
- Loading for Digits and Toes

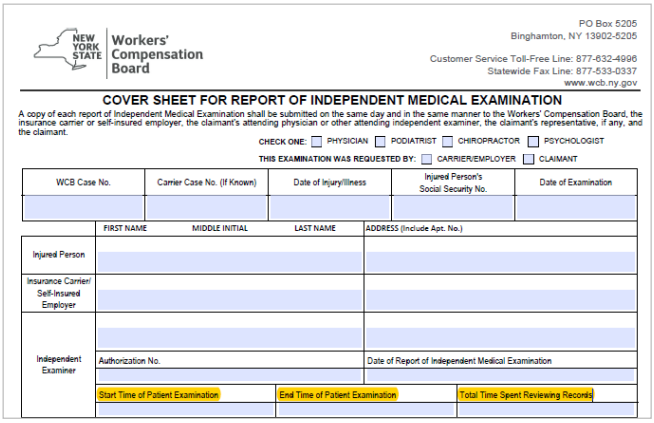
Revised Forms

	Body Part/Measurement 1		Body Part/Measurement 2		Body Part/Measurement 3		Body Part/Measurement 4		Body Part/Measurement 5		Body Part/Measurement 6	
	☐ Left	☐ Right	☐ Left	☐ Right	☐ Left	☐ Right	☐ Left	☐ Right	☐ Left	☐ Right	☐ Left	☐ Right
Range of Motion (3 measures)												
Contralateral ROM												
Contralateral Applicable Y/N If No, please explain below												
Special Considerations (Chapter)												
Impairment %												

Details:

Revised Forms

Independent Medical Examination (IME-4)



NEW YORK STATE Workers' Compensation Board

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COVER SHEET FOR REPORT OF INDEPENDENT MEDICAL EXAMINATION

A copy of each report of Independent Medical Examination shall be submitted on the same day and in the same manner to the Workers' Compensation Board, the insurance carrier or self-insured employer, the claimant's attending physician or other attending independent examiner, the claimant's representative, if any, and the claimant.

CHECK ONE: ☐ PHYSICIAN ☐ PODIATRIST ☐ CHIROPRACTOR ☐ PSYCHOLOGIST

THIS EXAMINATION WAS REQUESTED BY: ☐ CARRIER/EMPLOYER ☐ CLAIMANT

WCB Case No.	Carrier Case No. (If Known)	Date of Injury/Illness	Injured Person's Social Security No.	Date of Examination

	FIRST NAME MIDDLE INITIAL LAST NAME	ADDRESS (Include Apt. No.)
Injured Person		
Insurance Carrier/ Self-Insured Employer		
Independent Examiner		

Authorization No.	Date of Report of Independent Medical Examination

Start Time of Patient Examination	End Time of Patient Examination	Total Time Spent Reviewing Records

Revised Forms

Attach Report of Independent Medical Examination

Report of Independent Medical Examination must include this cover sheet and a narrative report that includes the components listed below. If the examination concludes Schedule Loss of Use and/or Non-Schedule Permanent Partial Disability please include the IME-4.3A and/or IME-4.3B with the cover sheet and your medical narrative.

- A description of the examination;
- A list of all documents or information reviewed by the IME evaluator;
- The examiner's professional opinion; and
- A signed and dated certification at the end of the report of the independent medical examination as follows:
  - I hereby certify that this report is a full and truthful representation of my professional opinion with respect to the claimant's condition; that no person or entity has caused, directed or encouraged me to submit a report that differs substantially from my professional opinion; and I have reviewed the report and attest to its accuracy.
  - The signature and date must be below the required certification.

Any questionnaire or intake sheets completed by the claimant either before arriving or after arriving for the independent medical examination must be attached to this cover sheet with the report.

Revised Forms

IME 4.3A mirrors changes in C-4.3A

ATTACHMENT FOR REPORT OF INDEPENDENT MEDICAL EXAMINATION SCHEDULED LOSS OF USE

Please utilize this form as an attachment to the IME report, where there is an injury to a scheduled body part. These attachments will be considered part of the IME report, and must be served together with the IME-4.

Claimant's Name (LAST, FIRST, MI):

Social Security No.:

WCB Case No.:

Date of Injury/Illness:

Date of Examination:

A. Permanent Partial Disability

If the claimant has a permanent partial impairment, **complete A1** for all body parts and conditions for which a schedule award is appropriate (schedule loss of use). Use Form IME-4.3B for all body parts and conditions for which a non-schedule award (classification) is appropriate.

A1. Schedule Loss of Use of Member:

Body Part

Please include all the information in the bullet points below in the table on this page or attach a medical narrative with your report. The medical narrative should include the following information:

- Affected body part (include left or right side) and identify Guideline chapter and applicable table or chart
- Measured Active Range of Motion (ROM) (3 measurements for injured body part, and use the greatest ROM. If not, please explain why.
- Measurement of contralateral body part ROM, or explain why inapplicable
- Previously received scheduled losses of use to same body part(s), if known
- Special considerations
- Loading for Digits and Toes

Revised Forms

	Body Part/Measurement 1		Body Part/Measurement 2		Body Part/Measurement 3		Body Part/Measurement 4		Body Part/Measurement 5		Body Part/Measurement 6	
	☐ Left	☐ Right	☐ Left	☐ Right	☐ Left	☐ Right	☐ Left	☐ Right	☐ Left	☐ Right	☐ Left	☐ Right
Range of Motion (3 measures)												
Contralateral ROM												
Contralateral Applicable Y/N If No, please explain below												
Special Considerations (Chapter)												
Impairment %												

Details:

Resources

- **Workers' Compensation Guidelines for Determining Impairment: www.wcb.ny.gov/2018-Impairment-Guidelines.pdf**

- **Subject Number 046-1011: www.wcb.ny.gov/content/main/SubjectNos/sn046_1011.jsp**

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Thank you

Questions?