Medical Examiners' Handbook
July 2024 Update

Impairment Ratings and Independent Medical Examinations in Washington State Workers' Compensation

For IME Examiners, Attending Doctors and Consultants

Free 3 Hours Category 1 CME Credit

The Washington State Department of Labor and Industries (L&I) is accredited by the PacWest to provide continuing medical education for physicians.

L&I designates this Enduring Material activity for a maximum of three AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

L&I certifies that non-physician participants have participated in the Enduring Material titled Medical Examiners Handbook (MEH). This activity was designated for three AMA PRA Category 1 Credit(s)™.

Accreditation: Original Activity Date — July 1, 2018
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This publication contains guidelines, sample reports, and billing procedures for preparing and conducting impairment ratings and independent medical exams (IME) in Washington's Workers' Compensation system. The activity was planned and produced in accordance with the WSMA Essential Elements, Criteria, and Standards of Accreditation of Continuing Medical Education.

Disclosure: None of the faculty involved with developing this handbook or self assessment test online has any financial relationship to disclose nor do they financially benefit from this product.

Washington State Department of Labor & Industries

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About the July 2024 Updated *Medical Examiners' Handbook*

The July 2024 updated edition of the *Medical Examiners' Handbook* contains selected updates to the July 2023 edition. New or updated information is listed in the table below.

Updates and Additions to the *Medical Examiners' Handbook*, July 2024

Chapter	Page	Title	Comments
3	21	Interpreter Services	Updated with new vendor information.
3	22	Who is Allowed to Attend an IME	Updated – WAC 296-23-362
3	26 – 27	Telehealth/Telemedicine	Added telehealth WAC language - WAC 296-23-359
3	27	Telehealth/Telemedicine	Updated special note to include in the report if whether the exam was recorded
4	33	When Examiners Disagree	Clarification given regarding what to do when examiners disagree.
4	33	Addendum Report	Added clarification regarding addendum requests.
4	35	Treatment Guidelines	No updates
6	44 – 45	The Occupational Disease Report	Clarify which billing codes IME providers, and which codes attending providers and consultants use.
9	72 – 75	Providing Testimony	Updated WAC language – WAC 263-12-117(2) Minor clarifications
Appendix C	174 – 182	Relevant Laws and Regulations	Updated RCW 51.04.050 – Health services provider's testimony not privileged. Updated RCW 51.08.142 – "Occupational disease"—Exclusion of mental conditions caused by stress, except for certain firefighters. (Effective January 1, 2024.) Updated RCW 51.32.055 (4) – Determination of permanent disabilities—Closure of claims by self-insurers. Updated RCW 51.36.060 – Duties of attending provider—Medical information. Updated RCW 51.36.070 – Medical examination—Reports—Costs—Worker's rights.
Appendix C	183 – 193	Relevant Laws and Regulations	Updated WAC 296-14-300 – Mental condition/mental disabilities Updated WAC 296-21-270 – Mental Health Services
Appendix C	207 – 209	Relevant Laws and Regulations	New WAC 296-23-358 – What happens when there is no approved independent medical exam (IME) provider in the specialty needed available in a reasonably convenient location for the worker? New WAC 296-23-359 – When is telemedicine appropriate for an independent medical exam (IME)? New WAC 296-23-362 – Independent medical examination (IME)—Accompanying person. New WAC 296-23-364 – Definition of notification process required for workers to record independent medical examinations (IME). New WAC 296-23-366 – Independent medical examination (IME)—Recording notification time frame.

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Preface

Dear Examiner,

We are excited to partner with you in providing independent medical examinations (IMEs) and impairment ratings for our workers.

You play a crucial role in the Washington State workers' compensation system, and our injured workers depend on you to help us administer claims effectively and fairly. We know that you follow evidence-based guidelines in formulating your opinions, and we rely on your unbiased, objective examinations as we collaborate together throughout the claims administration process.

The Revised Code of Washington (RCW) states that L&I must develop appropriate standards for performing IMEs. The intent of the Medical Examiner's Handbook (MEH) is to provide you with clear, usable information and to answer your questions about these medical standards and regulations.

Once you have reviewed the MEH, a test is available online at Lni.wa.gov/imes. This test is designed to help IME examiners and consultants fulfill the WAC regulations which specify that examiners be familiar with the handbook; passing the test is also a requirement for applying for or renewing your IME provider number. You will receive 3 hours of Category 1 Continuing Medical Education (CME) credit for passing the test.

We hope our electronic format helps you find the information you need quickly and efficiently; the hyperlinks will help you navigate the MEH with ease. If you have ideas for improvement, please let us know and we will consider them for the next edition. Please send suggestions to:

Special Programs Manager
Health Services Analysis, Washington Department of Labor and Industries
PO Box 44322
Olympia, WA 98504-4322

Throughout this book we refer to other helpful L&I reference materials, such as our Medical Treatment Guidelines. For more information about L&I, the Office of the Medical Director and Health Services Analysis, visit L&I's Internet: www.LNI.wa.gov.

Thank you for your services and interest.

Sincerely,

Gary Franklin, MD, MPH, Medical Director

Azadeh Farokhi, MD, MPH, MOH, Associate Medical Director

CHAPTER 1

Workers' Compensation in Washington State

Background

Washington's Department of Labor & Industries is one of the largest and oldest providers of workers' compensation in the United States. Industrial insurance laws were enacted in 1911 as a measure to protect both workers and employers by creating a "no-fault" insurance program. The law states employers cannot be sued as the result of an injury or incident. At the same time, workers are guaranteed medical benefits and compensation to offset lost wages during recovery.

Over 150,000 claims are filed with the department each year. Approximately 72% of the claims accepted are administered through the State Fund Program. Both workers and employers pay into the medical aid fund established to pay for medical benefits and time loss.

Twenty eight percent (28%) of the claims accepted are administered through a unique Self-Insured Program in which certain employers meeting department standards are certified to manage claims and distribute benefits to the worker. A small number of self-insured employers administer their own claims, however, the majority of self-insured employers contract with a third party administrator (TPA) to administer claims for them. Self-insured employers fund the payment of benefits. Workers do not pay into the employer's account.

Oversight of self-insured employers and/ or their TPA decisions and actions is provided by the department's Self-Insurance Program. The same laws, rules, and fee schedules apply to both the State Fund and self-insured employers unless self-insured employers are specifically exempt. Self-insured employers follow the same coverage decisions and Office of the Medical Director Guidelines. However, there may be differences in claim management procedures and the scheduling process of independent medical examinations (IME) between the two programs.

You may hear about a third program administered by the department that schedules IMEs. The Crime Victims Compensation Program (CVCP) was created by the legislature in 1974 to manage claims for victims of violent crime. In 2017, CVCP received 5,600 claims and paid for examinations on 4,200 sexual assault victims. CVCP has different laws, rules, and fees than Industrial Insurance. CVCP is funded by appropriations from the state legislature and grants from the federal government.

Legislative Intent & Department Role

The IME program was created by the legislature. It was the intent of the 1988 legislature that medical examinations for determining permanent disabilities be conducted fairly and objectively by qualified examiners and with respect for the dignity of the injured worker. The legislature charged the department with:

- Developing standards for conducting special medical examinations (IME and rating exams);
- Determining the qualifications of the persons conducting the examinations;
- Establishing a standard for the content of reports;
- Monitoring the quality and objectivity of examinations and reports.

The definition of an IME is a medical examination requested by the department or self-insured employer to answer medical and legal questions about the claim.

Performing independent medical examinations (IME) or ratings requires considerable judgment and understanding of specialized terms and a mastery of skills that may not be part of your original training. Washington Administrative Code (WAC) states that you must be familiar with the contents of this handbook. (WAC 296-23-347) This handbook was developed as a source of information to help you to become an examiner who not only treats the worker respectfully but writes reports that are fair, unbiased, objective, and stands up to scrutiny. Also, you can earn 3 Continuing Medical Education category 1 credits by completing the assessment test online. (see IME websites on page 216)

It is the department's expectation that IMEs and rating examinations be conducted using an open, transparent process. All IME and addendum requests should be in writing to avoid accusations of an influenced medical opinion. All reports received by the department or self-insurer are considered final reports. To correct errors it is best to submit an addendum citing the reason for the change, the date of the change, and who made the change, rather than send a corrected report where the reader must identify the difference between the documents.

Keep in mind other systems (personal injury, private, federal, and other state agencies) may use different definitions and rules for determining impairment and disability. Learning the standards for Washington will establish the foundation you need to conduct high quality IMEs. The questions you answer about the injured worker's medical status make it possible for Claim Managers to adjudicate claims fairly and effectively. A high quality IME report or rating saves time and money for all parties because fewer addendums or letters of clarification are needed.

Legislative Changes in 2020
The legislature amended RCW 51.32.110 and RCW 51.36.070 and added a new section to RCW 51.08. The updated RCWs are included in Appendix C of this Handbook.

Reasons Why IMEs are Requested

Over 38,000 pieces of mail are imaged daily by the State Fund program. It is impossible to guess how many documents are received by self-insured employers and TPAs since those documents are not received by the department. Claim Managers in both programs are encouraged to regularly review their assigned claims to ensure the worker receives medically appropriate care and appropriate adjudicative decisions are administered. Claim Managers are encouraged to request information when it is needed to adjudicate the claim, if it has not been received.

Note: Self-insured employers and TPAs retain the original files on claims they administer. The department only receives copies of information in the claim file when it is required to address an issue with the claim or if a department order is required to close the claim.

Since some treating providers are unwilling or not qualified to answer some medical questions or to rate a disability, the Claim Manager is encouraged to request a referral with a consultant for these services. When all attempts fail an IME is requested.

The reasons an IME can be requested are:

- **Claim allowance.** To determine if the condition is related to the industrial injury or occupational disease
- **Reopening.** Evaluate whether the injury or disease/illness has worsened and whether the worker would benefit from additional treatment
- **New Medical Issue.** Evaluate what conditions are related to the injury or disease/illness; determine whether an industrial injury or occupational disease/illness has worsened a preexisting condition and the extent of that worsening
- **Case progress.** Outline a treatment program when treatment or progress is controversial or when treatment occurs over an extended period of time with no change in objective findings; determine whether an injured worker meets OMD surgical guidelines; establish when the injury or disease/illness has reached maximum medical improvement (see WAC 296-23-308(1)(a)(b))
- **Appeal.** To resolve a protest or appeal
- **Permanent Partial Disability.** Determine the extent of total body impairment (category rating) or loss of bodily function when maximum medical improvement has been reached
- **Work Restrictions.** Determine the worker's ability to return to work; review job analyses in light of the medical condition

Additional Types of Examinations

Agreed examination: An agreed exam is an IME in which involved parties draft questions, select the examiner, and agree to abide by the findings, conclusions, and recommendations of the examiner. Agreed exams, however, are not always binding. According to state law a worker cannot agree to relinquish any rights (RCW 51.04.060). In addition, the department is not bound by any agreement when L&I has not been a party to the agreement.

Claim Managers in State Fund do not use agreed exams. Claim Consultants and Pension Adjudicators in both the State Fund and Self-Insurance Programs may use an agreed exam to settle a dispute about the claim. Self-insured employers and TPAs may find an agreed exam helpful in resolving treatment issues.

Forensic examinations or record reviews: Forensic examinations are requested when the worker is not available for the physical examination portion of an IME.

CR 35 examination: Infrequently, the Board of Industrial Insurance Appeals orders a CR (Court Rule) 35 examination. This legal examination is requested by the claimant or department to answer legal questions about the claim. If the Board finds there is good cause, the Board will order the exam. The time, place, manner, conditions, scope of the examination and the name of person conducting the examination are part of the order.

Worker requested examination: A worker's representative will sometimes request an approved examiner conduct an IME or rating. The worker's representative drafts the questions and pays for the service. The department or self-insured employer is not bound by the findings of a worker requested examination or rating. It is a common practice for the worker's attorney to request a draft report.

Confidential Information

Medical Records: Workers sign a medical release when submitting a claim with the department or self-insurer. The statement authorizes any physician, hospital, agency, or organization to release any medical records or other information regarding any treatment to the department, employer, or employer's representative.

When an IME is ordered, relevant claimant medical information received by the department or self-insurer is provided so the examiner may conduct a thorough review, conduct a physical examination, and write a report. Records provided for an IME must be protected and stored in a secure area and not released to other parties. Providers must have a fully documented chain of custody from point of initial transport to receipt by the examiner or examiner designee* for all medical claim files mailed or transported. Files must be mailed/delivered in a secure manner and never left unattended, even temporarily. Faxed records must include a cover sheet indicating restricted confidential information. Secure file transfer, secure email or encrypted file attachments must be used for emailed records and email communications containing two or more worker identifiers, which may include a worker's full name, date of birth, claim number, phone number, address, social security number, photo, or date of IME. **Electronic copies (CDs, USB drives, etc.) of transported records must be encrypted (secured with a password) with the password mailed or provided separately.**

Acceptable methods of transport include:

- Mail/Shipping service with traceable delivery (traceable delivery includes signature of receipt by the provider, at the provider's home or office, an individual covered by federal regulations [such as a post office or postal annex], or lock box delivery)
- Vehicle transport (using a lock box for paper copies)

Immediate notification to the department is required regarding any breach of security, or potential breach of security. *For additional requirements regarding notice/disclosure of security breaches see: RCW 42.56.590 and RCW 19.255.010*. Dispose of hard copies by shredding or use of certified, marked and locked bins for shredding.

*** An examiner designee is any individual designated by the examiner to accept claimant medical information on their behalf, including an individual at the examiner's home or office, or an IME firm location or staff.**

HIPAA: The complexity of the Health Insurance Portability and Accountability Act (HIPAA) makes examiners uncertain about their responsibilities to the workers they examine. **All workers' compensation programs are exempt from HIPAA Privacy Rule regulations**. You may disclose personal health information identified during an IME to the department or self-insurer without an additional signed authorization from the worker.

The department has voluntarily elected to participate in the HIPAA Privacy Rule sections about Electronic Protected Health Information, Security Rule, and Unique Identifier Rule (National Provider Identifier) to the extent possible. The State Fund billing system is compliant with HIPAA so you may bill State Fund electronically. More information about HIPAA and workers' compensation is located on the website at https://lni.wa.gov/claims/for-medical-providers/hipaa-and- lni.

Prudent privacy practices: In addition to the above, the department has adopted prudent privacy practices. The department requests you do not send claim numbers and worker names over the Internet. Recent changes to our Claims and Account Center (CAC) make it possible for secure messaging communication for State Fund claims. If you are granted access to the claim file through CAC, you may send messages including worker names and claim numbers over this system.

Information faxed to designated department or self-insured employer/TPA numbers can include names and claim numbers. Statute RCW 51.04.050 allows you to waive the patient-physician privilege in industrial insurance cases.

Sensitive medical information: The department has strict confidential safeguards for the release of sensitive medical information such as Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Virus (AIDS), sexually transmitted diseases (STD) and behavioral/mental health status. When an IME report contains sensitive information the report may not be released to the worker's attorney, ancillary health care providers, or employer/employer's staff not involved in handling the claim or determining bill payment. For that reason, follow the guidelines listed below:

- Information about a worker's drug use history and behavioral/mental health status that is relevant to the claim should be included.
- Do not include worker disclosed preexisting physical or mental health conditions not related to the claim.
- Do not include sensitive medical information in the report if the claim is not related to a possible work exposure to those diseases.

If in your professional opinion, the information disclosed during the IME is critical to support your conclusions, contact the Claim Manager and explain the situation. The Claim Manager may request the information in an addendum rather than in the main IME report. You should label each page of the addendum "**CONFIDENTIAL**" in an obvious spot on the page. The top right corner is recommended.

The Claim Manager will take steps to ensure the addendum is not accidentally disclosed to unauthorized parties. In compliance with Washington State Law, a general authorization to release claim information may not be adequate for the release of the medically sensitive information. A specific medical release from the worker may be required. If you have questions about the confidentiality of any information, contact the Claim Manager for guidance.

Claim Manager Role

The Claim Manager in all department programs is responsible for determining when an IME or rating exam is requested. Sometimes the attending provider requests an IME or rating exam but more frequently the Claim Manager identifies one of the reasons listed, earlier in this chapter. The Claim Manager:

- Determines the purpose of the examination.
- Selects the specialty or specialties required.
- Decides whether a single examiner or multiple examiners is required. Most IMEs only require a single examiner.
- Provides a brief summary of the claim.
- Identifies the issues and questions that need to be answered by the examiner.

- Provides either access to the imaged claim file, CD, or hard copies of relevant records.
- Determines whether the worker requires special accommodations to attend the IME.
- Conducts a timely review of the report.

IMPORTANT NOTE: Only examiners listed in the Find A Medical Examiner (FAME) search tool in "approved" status can accept or conduct exams, addendums, and/or JAs for State Fund, Self-Insured, or Crime Victims. However, participating in depositions and testimonies related to exams already completed is still required of examiners while in any status.

The Find A Medical Examiner (FAME) search tool can be found here,

Scheduling IMEs

State Fund Claims

Requests: At this time, we generally schedule state fund IME referrals with firms able to arrange an exam with multiple examiners. If interested, examiners who wish to schedule exams apart from the IME firm may ask to be added to our wait list.

Examination requests are made by the worker's Claim Manager and offered to firms via our on-line IME scheduling system. The system manages IME appointment scheduling between L&I and IME firms.

The system uses firm location and specialty information to determine where to schedule the appointments. RCW 51.36.070 directs the department to schedule appointments in reasonably convenient locations. Firms are notified that a referral is available via email and must respond via the IME scheduling system within a specified timeframe. The timeframe is generally three hours but it may be more in certain circumstances involving complex multi-specialty exam requests.

Each offer specifies the location, specialties, and date range available for each exam. The IME firm may accept the offer by submitting appointment information that meets the scheduling criteria. Firms may also decline an offer if they are unable to arrange the exam within the date range or they may suggest alternate scheduling options. If a firm schedules an exam on an offer they declined, the Department may not pay for the exam. Requests that are not acted upon within the indicated timeframe are offered to another IME firm.

Unless a specialty specific exception is requested, IME firms that wish to receive IME referrals must:

- Agree to use L&I's scheduling system.
- Maintain current specialty and contact information with L&I.
- Access claim files utilizing the following methods:
    - Secure File Transfer (SFT) - PDF versions of file documents are provided once an offer is accepted and scheduled. A SFT site for obtaining these documents is available to firms. If a firm does not have a SFT site set up, please contact the department for assistance. Web Support 360-902-5999
    - The Claim and Account Center (CAC). Firms must create their own SecureAccess Washington user ID and password to use CAC.

- Firms must contact and inform the claimant of the date, time, and location of the exam prior to the exam per WAC 296-23-347 (1)(c). Specific instructions related to the exam, such as fasting, perfume restrictions, etc., must also be communicated to the claimant.

When rescheduling an IME, L&I's general practice is to reschedule with the currently scheduled firm. We may reschedule with a different firm in certain circumstances. The circumstance include, but are not limited to the following:

- When the CM requires an additional specialty and the firm cannot accommodate the updated request.
- Late canceling due to issues within the panel's control.
    - Examiner conflict of interest
    - Double booking an examiner
- Recording a different exam location in our scheduling application than where the exam was actually scheduled.
- Unannounced location move or scheduling in a location that was closed on the date of the exam.
- Scheduling with an examiner who does not meet the cover letter's requirements.
- There is no attempt to notify the worker of an appointment.

Questions: The panel/examiner may direct clarifying questions to the department via the IME Scheduling Unit's email: LNIIME@lni.wa.gov. The question will be routed to either the department scheduler or the Claim Manager, depending on the question asked.

Reports: Submit reports, addendums, and testing results related to the IME to L&I via the IME scheduling system. The department requires a single report per IME referral. This includes referrals which request multiple examiners and may require multiple IME appointments.

Self-Insured Claims

Self-insured claim numbers are preceded by one of the following letters: S, T, or W. Newer claims are assigned double letters: SA, SB, etc.

On occasion the self-insured employer or TPA will give you a company assigned number for billing or other internal company purposes. WAC 296-15-350 (7) states that all communications with the department or self-insurer must show the worker's full name and claim number. Be sure to record the S, T, or W number on the report.

Requests: Examination requests are scheduled directly by the self-insured employer, or the contracted third party administrator (TPA). The actual person requesting the IME may be a Claim Manager, a Nurse Case Manager, or a self-insured employer's legal representative. Some employers elect to designate attorney oversight of complex claims. If an IME is requested by any employer's representative, it is an IME and subject to the rules and fee schedule. Examiners must be approved by the department. See the Find a Medical Examiner (FAME) online approved list. RCW 51.36.070 directs the department or self-insurer to schedule appointments in reasonably convenient locations.

Copies of relevant medical records are provided by the requester. Records should be provided at least 10 days before the exam so that the provider can prepare for the exam. The department does not manage the claim so any information imaged on the department's Claim and Account Center may be incomplete. The only exception occurs when a self-insured employer defaults. Default claims are managed by the Self-Insurance Program. IMEs requested by the SI program will be scheduled by the CSU and follow the same process as State Fund claims.

Interpreters are scheduled by the requester on self-insured claims. Interpreters are scheduled by the IME firm or examiner on default claims.

Questions: Contact the requester if records are not received 10 days prior to the examination or if there is a need to clarify the IME purpose, accepted conditions, or IME questions. Examiners are not expected to conduct examinations when records or questions have not been received.

Reports and bills: Mail reports and bills directly to the requester or as instructed in the referral letter or cover letter.

Crime Victims Compensation Program Claims

Crime Victims Compensation claim numbers begin with a V.

The CVCP uses a wide range of specialists to provide IMEs. These evaluations assist the Claim Manager in managing controversial or complex issues. The program prefers specialists, especially those providing mental health or psychological opinions, who have training and clinical experience in treating crime-related trauma victims. Because the needs of the victim may be greater than the average worker, special consideration and sensitivity is required. The exam may take longer to complete. The report may require more detail than a standard IME format. Forensic examinations or record reviews may be requested to avoid the psychological stress created by an independent medical examination. A large number of the claimants are victims of assault and sexual assault.

Requests: Examination requests are made by the Claim Manager and sent to the Central Scheduling Unit (CSU). The CSU schedules the examination, notifies the claimant of the appointment, communicates interpretation needs to the IME firm or examiner, and makes travel arrangements when requested. The CSU mails a CD containing the medical records to the IME firm or examiner. All cancellations and rescheduling requests should be directed to the CSU's email: LNIIME@lni.wa.gov.

Questions: Contact the requester if records are not received 10 days prior to the examination or if there is a need to clarify the purpose, conditions, or questions.

Reports and bills: Mail reports and bills to the address listed on the examination referral letter.

CHAPTER 2

The Independent Medical Examination Provider

Types of Examiners

Only doctors who have been approved by the department and have active IME provider numbers can perform IMEs for Self-Insurance, the State Fund, or Crime Victims Compensation Program. An IME provider number is NOT the same as a provider number that allows the provider to treat injured workers.

To ensure that independent medical examinations are of the highest quality and propriety, examiners and firms (partnerships, corporations, or other legal entities) that derive income from independent medical exams must apply and meet certain requirements for department approval. WAC 296-23-317

Only providers in the following specialties will be considered:

Doctor is licensed to practice:	Medicine & Surgery	Osteopathic Medicine & Surgery	Podiatric Medicine & Surgery	Chiropractic	Dentistry
In Washington	Yes	Yes	Yes	Yes	Yes
Not in Washington	Yes	Yes	Yes	No	Yes

Limited license providers (for example, dentists, podiatrists, and chiropractors) may only provide ratings for body regions (areas) or conditions within their scopes of practice.

The Department considers the examination of patients in IMEs to involve clinical medicine. IME providers must not have limitations on their ability to practice clinical medicine.

IMEs and impairment ratings are not the same. See Chapters 11 and 12 for information on rating impairment. **See Chapter 13 for the differences in billing.**

The department or self-insurer may order an examination by a single approved IME chiropractor under the following circumstances per RCW 51.32.112

- When the worker has been clinically managed by a chiropractor.
- The care provided is within the scope of their practice.

Application Process

The Washington State Department of Labor & Industries (L&I) is responsible for assuring that only qualified and approved examiners conduct examinations for the State Fund, Self-Insured and Crime Victims' programs. Only doctors who are licensed in medicine and surgery, osteopathic medicine and surgery, chiropractic, podiatric medicine and surgery, and dentistry are eligible to apply to become approved examiners.

To apply for approval as an independent medical examiner, providers must complete and sign the IME Provider Account Application and Agreement. The examiner information on the application allows schedulers to match the specialist's expertise with the worker's injury. The examiner's mailing address is listed on the Find A Medical Examiner (FAME) website at www.Lni.wa.gov/imelookup/. The department will not accept an IME firm address as the 'provider's mailing address'. Examiners may use a PO Box address in lieu of their physical mailing address, if they prefer.

See the web site for the application process and additional instructions: www.Lni.wa.gov/imes

Examiner Credentialing Requirements

To ensure that independent medical examinations are of the highest quality and propriety, examiners and firms (partnerships, corporations, or other legal entities) that derive income from independent medical exams must apply and meet the following requirements for department approval. WAC 296-23-317

Examiners must:

- Submit an accurate and complete IME provider application, including any required supporting documentation and sign without modification, an IME provider agreement with the department.
- Be currently licensed, certified, accredited or registered according to Washington state laws and rules or in any other jurisdiction where the applicant would conduct an examination. The license, registration or certification must be free of any restrictions, limitations, or conditions relating to the provider's acts, omissions, or conduct.
- The applicant must not have surrendered, voluntarily or involuntarily his or her professional state license or Drug Enforcement Administration (DEA) registration in any state while under investigation or due to findings resulting from the provider's acts, omissions, or conduct.
- The applicant must not have had clinical admitting and management privileges denied, limited, or terminated for quality of care issues.
- Have no final action by the department to suspend or revoke a previously assigned provider number as a treating provider or independent medical examiner.
- Have no pending civil or administrative action in any jurisdiction that affects the ability or fitness to practice medicine. The department will not process the application until the matter has been resolved.
- Have not been excluded, expelled, terminated, or suspended from any federally or state funded health care programs including, but not limited to, medicare or medicaid programs based on cause or quality of care issues.

- Have no significant malpractice claims or professional liability claims (based on severity, recency, frequency, or repetition)
- Have not been denied approval, or removed, from the provider network as defined in WAC 296-20-01010.
- Attest that all information submitted on the application or credentialing materials is true and accurate and must sign under penalty of perjury.
- Comply with all federal, state, and local laws, regulations, and other requirements with regard to business operations, including specific requirements for the provision of medical services.
- Exhibit appropriate professional and behavioral conduct at all times, and adhere to all other laws, rules, and policies. These include but are not limited to the following:
    - Provider application agreement;
    - Medical Aid Rules and Fee Schedules (MARFS);
    - Payment policies; and
    - Medical Examiners' Handbook.
- Review and sign the IME report and attest to its accuracy.
- Agree to conduct exams in a facility primarily designated as a professional office for medical, dental, podiatric, chiropractic or mental health exams where the primary use of the facility is for medical services.
- Have telephone answering capabilities during regular business hours.
- Agree that either they or the department may inactivate their IME provider number(s).
- Agree to keep the department informed and updated with any new information regarding changes or actions that may affect their status as an IME examiner.
- Reapply every three years or when requirements change.
- Achieve a passing score on the *Medical Examiners' Handbook* test prior to initial application and when renewing.

In addition all examiners must meet one of the following two criteria:

- Document a minimum of 768 hours of patient related services (excluding independent medical examinations) per calendar year; or
- Submit documentation showing fulfillment of continuing medical education (CME) hours as required for their respective state licensure. This training must focus on improving the provider's skills in completing IMEs or staying current in their specialty.

Additional Requirements for Specific Examiner Specialties:

Medicine and Surgery (MD), Osteopathic Medicine and Surgery (DO), Podiatric Medicine and Surgery (DPM)

- Applicants must hold a current board certification in their specialty; or have completed a residency and become board certified within five years of completing the residency.
- Residency must be in a program approved by:
    - American College of Graduate Medical Education (ACGME) or;

- American Osteopathic Association (AOA) or;
- American Podiatric Medical Association (APMA)

Chiropractic (DC)

- Be an approved chiropractic consultant for L&I for at least two years; and
- Attend the department's chiropractic IME seminar during the 24 months prior to initial application.

In order to become a chiropractic consultant for L&I, refer to https://www.lni.wa.gov/patient-care/provider-accounts/become-a-provider/become-a-chiropractic-consultant#becoming-a-consultant.

After completing two years as a chiropractic consultant, you may apply to become an independent medical examiner.

Dentistry (DDS/DMD)

- Applicants must have a minimum of two years of clinical experience after licensure; **and**
- Hold a current certification in their specialty; **or**
- Have one year of post-doctoral training in a program approved by the American Dental Association Commission on Dental Accreditation (CODA); **or**
- Be a general dentist.

The department accepts certifications from boards recognized by the following as meeting the board certification requirements in WAC 296-23-317:

- American Board of Medical Specialties;
- American Osteopathic Association (AOA)Bureau of Osteopathic Specialties;
- American Podiatric Medical Association; or
- American Dental Association.

Examiner Training Requirements and Opportunities

You must stay current with the new regulations and policies of the department in order to remain a department-approved IME provider. Failure to stay current in your specialized area and in the areas of impairment rating, performance of IMEs, industrial injury and occupational disease/illness, industrial insurance statutes, regulations and policies can mean possible suspension or termination of your IME provider number. WAC 296-23-337 (3)(d)

Training courses are available from other sources. The department does not endorse any specific training course. Training on the use of the *American Medical Association Guides to the Evaluation of Permanent Impairment* (*AMA Guides*) is available through several sources (including, but not limited to):

- The American College of Occupational and Environmental Medicine (ACOEM), 25 Northwest Point Blvd. Ste 700, Elk Grove Village, Illinois 60007-1030; 847-818-1800
- International Academy of Independent Medical Examiners (IAIME), 1061 E. Main Street, Suite 300, Est Dundee, Illinois 60118 1-312-663-1171
- SEAK, Inc., PO Box 729, Falmouth, MA 02541; 508-457-1111

These courses do not include information about the Category Rating System.

Site Standards and Business Requirements

You must provide your medical examinations only in a professional office suitable for medical, podiatric, chiropractic or mental health exams where the primary use of the exam space/room is for medical services—not for residential, recreational, commercial, educational or retail purposes.

Make sure that the site either in your office or at the IME firm contains adequate:

- Access,
- Climate control,
- Light,
- Space,
- Equipment for comfort and safety of the worker,
- Privacy for discussion of medical needs,
- Private disrobing area,
- Provision of examination gowns,
- Have telephone answering capability during regular business hours, Monday through Friday, in order to schedule independent medical examinations and communicate with workers about scheduled examinations. If an exam site is open on Saturday, telephone access must be available, and
- Compliance with all federal, state and local laws, and regulations, with regard to business operations. WAC 296-23-317 (1) and (4)

Exam site checklist form can be found on the IME webpage at: www.Lni.wa.gov/imes . The department may inspect locations for compliance.

Independent Medical Examination Firms

IME firms or medical groups (panels) are organizations that have scheduling and billing relationships with multiple approved examiners who conduct IMEs. L&I currently schedules state fund IME requests through these firms. Examiners must have a unique IME provider number for each firm with which they are affiliated. Examiners work directly with each firm to submit an application to the department in order to obtain the provider number. Firms must also apply for approval to provide IMEs. To receive approval, the IME firm, partnership, or corporation must have a medical director and meet other requirements. The medical director must be a licensed provider and approved examiner who provides oversight on the quality of IMEs, impairment ratings and reports. WAC 296-23-317 (4)(a)

IME firms or medical groups (panels) are organizations that have scheduling and billing relationships with multiple providers who provide examinations. Department policy, however, states that **examiners must have a separate provider number for each firm they are affiliated with.** If you work for a firm, it is your responsibility to submit your application containing accurate information, including the firm's information.

Firms must also apply for approval to provide IMEs.

To receive approval, the IME firm, partnership, or corporation must have a medical director. The director must be a licensed provider and approved examiner who provides oversight on the quality of IMEs, impairment ratings and reports. WAC 296-23-317 (4)(a)

Approved IME Firms can be found on the Find A Medical Examiner (FAME) search tool here, https://secure.lni.wa.gov/imelookup/.

Requirements for IME Firm Providers

IME firms (panels) are organizations that provide examinations by one or more examiners. To ensure that independent medical exams are of the highest quality and propriety, examiners and firms (partnerships, corporations or other legal entities) that derive income from independent medical exams must apply and meet requirements for department approval. Questions on starting an IME firm should be directed to L&I's Provider Quality and Compliance Unit. WAC 296-23-317

The department must have approved and issued a unique provider number to an IME firm so that it can bill for IME services. WAC 296-23-312

IME firms (partnerships, corporations or other legal entities) that derive income from independent medical examinations must:

- Have a medical director. The medical director must be a licensed medical physician and surgeon (MD) or osteopathic physician and surgeon (DO).
- The medical director's responsibilities include:
    - Oversight of the quality of independent medical examinations, impairment ratings and reports conducted by examiners through the IME firm, and
    - Availability to resolve any issue that department staff may bring to the medical director's attention.
    - The medical director must have a Washington state medical license and be a department approved independent medical examiner.
- Have no previous business or audit action by the department to suspend or revoke an assigned provider number.
- Have no previous action taken by any federal or state agency for any business previously owned or operated.
- Facilitate scheduling of providers for both the exam and for any required follow up, including amendments to the report, subsequent reports, or for any testimony required.
- Attest that all information on the application is true and accurate and must sign under penalty of perjury.
- Comply with all federal, state, and local laws, regulations, and other requirements with regard to business operations including specific requirements for any business operations for the provision of medical services.
- Adhere to independent medical examination standards of conduct, and all other laws, rules, and policies. These include, but are not limited to, the following:

    - IME provider application agreement;
    - Medical Aid Rules and Fee Schedules (MARFS);
    - Payment policies;
    - *Medical Examiners' Handbook*.
- Ensure that examinations are conducted in a facility primarily designated as a professional office suitable for medical, dental, podiatric, chiropractic or mental health exams where the primary use of the facility is for medical services. The facility must not be residential, commercial, educational, or retail in nature. The facility must be clean, sanitary and provide adequate access, climate control, light, space, and equipment. The facility must provide for the comfort and safety of the worker and for the privacy necessary to conduct exams and discuss medical issues. Providers must have a private disrobing area and adequate provision of examination gowns if disrobing is required.
- Have telephone answering capability during regular business hours, Monday through Friday, in order to schedule independent medical examinations and communicate with workers about scheduled examinations. If an exam site is open on Saturday, telephone access must be available.
- Agree that either the firm or the department may inactivate their IME provider number or numbers.
- Agree to keep the department informed and updated with any new information such as exam site or administrative office locations, phone numbers or contact information.
- Reapply every three years in order to maintain an active IME provider number.
- Have their medical director and a representative from their quality assurance (QA) staff achieve a passing score on the *Medical Examiners' Handbook* test prior to initial application and when renewal is due or required. WAC 296-23-317 (4)

IME firms may send copies of professional licenses and signed IME Provider Account Applications for the doctors who work for them to the Provider Quality and Compliance Unit.

IME firms must maintain billing records and reports with supporting documentation for a minimum of five years for audit purposes. WAC 296-20-02005

Review of Applications

If the department approves your application, we will enter the information you provide into the approved examiner database (IMETS). See "Find a Medical Examiner" (FAME). If we need more information, we may return your application with a letter, describing the areas that you need to complete. When we approve or deny your application, the Provider Quality and Compliance Unit will notify you by letter.

The department's Medical Director or designee considers many factors in disapproving an application. In addition to the requirements above, the department may consider:

- Any action against provider's license;
- Complaints about the provider;
- Quality of reports;
- Late reports;

- Lost or modified privileges;
- Charges regarding any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court or board; and/or
- Convictions of any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court or board.

If you have questions about the Approved Examiner Application, contact the Provider Quality and Compliance Unit at 360-902-5131.

Reporting Changes to L&I

Immediately notify L&I in writing of any change in your status that might affect your qualifications to hold an IME provider number. If applicable, providers must include a copy of any charges or final orders. Changes in status may include any of the following:

- Changes in amount of time spent in direct patient care, excluding IMEs;
- Loss or restriction of hospital admitting or practice privileges;
- Changes affecting business requirements;
- Loss of board certification;
- Charges regarding any criminal actions;
- Convictions of any criminal actions; or
- Temporary or permanent probation, suspension, revocation, or limitation on license to practice or Drug Enforcement Administration (DEA) registration in any state or foreign land.

Important to Know
The department does not guarantee referrals to any specific IME approved providers and providers are not obligated to accept any IME assignments.

All IME providers must maintain the requirements for approval as an IME Examiner and notify L&I's Provider Quality and Compliance Unit of any changes in their qualifications, practice status, board certification, licensure, as well as other information, such as address, contact information, exam sites, etc.

To make sure our information is current, you can query and view your information using the department's IME approved examiner search tool at "Find a Medical Examiner." (FAME)

If you are unwilling or unable to testify or make yourself reasonably available, you must decline to perform examinations.

If your information or availability has changed or is not correct, please contact:

Department of Labor & Industries
Provider Quality and Compliance Unit
PO Box 44322
Olympia, WA 98504-4322

Fax 360-902-4249

Or

Call the IME Specialist at 360-902-5131

CHAPTER 3

The Independent Medical Exam

Preparing for the Examination / Scheduling

The claim manager will send you an assignment letter or request for an IME. The assignment states the purpose of the IME, information about the condition to be addressed, and questions for you to answer. If you receive questions or correspondence from other parties, such as attorneys or vocational counselors, you should forward them to the claim manager.

- Contact the worker prior to the exam to confirm appointment date, time and location. (The IME firm/panel may perform this service if you work for a firm.)
- Review the purpose of the exam, the accepted and contended conditions, and the questions you will answer in the exam report.
- Provide sufficient time to fully evaluate the provided records.
- Be aware of the contents in the State Fund brochure entitled Your Independent Medical Exam that the worker receives in the mail before the visit so that you may answer questions, if necessary. You may find this brochure at this web site address: www.Lni.wa.gov/imes (follow the forms and publications link).
- Claim managers may approve a telehealth appointment for a particular specialty. Refer to applicable department policies and/or rules.
- When a worker notifies the firm/IME provider of their intent to record the exam, the firm/provider must inform the worker or their representative of any co-recording requirement or policy. **If a worker informs the IME firm of the intent to record, the firm must immediately respond to the worker if the examiner wants to co-record.**
    - • Any form asking the worker to consent to co-recording must not contain conditions that may be perceived as coercive to the worker. Worker consent to co-recording should be given freely and willingly. If the worker declines co-recording, the examination must proceed without it or the examination canceled without cost to the worker so that it can be rescheduled.

It is the department's expectation that IMEs be conducted by the most appropriately qualified examiner. Occasionally, an IME is scheduled with an examiner of the wrong specialty or field of practice. Check with the requester if you think the specialties were requested inappropriately. After scheduling the referral you may suggest a change through the IME scheduling system. The assigned Claim Manager will approve or deny your request within 48 hours. The IME may need to be rescheduled. At other times the correct examiner is selected but is asked to comment on medical issues that are outside their area of expertise. In this case, simply record in the report it is outside your area of expertise and decline to comment. **You must decline any referral for non-approved examiners including examiners in 'temporarily unavailable' status. This includes referrals and/or requests for exams, addendums, and job analyses.** Unapproved and temporarily unavailable examiners can and should be available to testify on exams conducted while they were in approved status. (see Find A Medical Examiner (FAME) for current status)

Missing Documents or Records

You must review and be familiar with all claim documents provided to you. If some **materials are missing or seem incomplete**, contact your referral source before the IME. The referral source will try to obtain them for you before the appointment with the worker.

Interpreter Services

Workers may not bring their own Language Access Providers (LAPs) to the exam. If the worker needs an LAP to communicate because of limited English-speaking ability, the department, Crime Victims Compensation Program, or the self-insurer will cover the cost of interpretation services arranged through and complying with applicable interpretation services policies. Family members or friends of the worker may not act as LAPs. WAC 296-23-362

L&I entered into a contract with SOS International LLC (SOSi) for all on-demand and scheduled spoken language interpretation services; in-person (IPI), video remote (VRI), and over-the-phone (OPI). Effective June 17, 2024, you must submit all interpreter requests through SOSi's scheduling system, **WordBridge**.

If SOSi is unable to fill a request for an LAP 24 hours before the scheduled appointment time, the request will be escalated. Every effort will be made to fill the appointment using the requested method (in-person, over-the-phone, or video remote); however, if the request for the desired method can't be filled, SOSi will offer other methods, if available.

Please see L&I's public website for interpretation services for more information.
https://lni.wa.gov/patient-care/treating-patients/interpreter-services/

IMPORTANT NOTE: Sign language interpretation or touch interpretation is not available through the in-person scheduling system. For those services, you may find the list of LAPs registered with L&I on our website: https://secure.lni.wa.gov/interpreters/

All sign language LAPs registered with L&I can now provide video interpretation services. Discuss this option with the LAPs when you reach out to arrange services.

For instructions of how to secure a sign language LAP visit our new Sign Language Interpreter page: https://lni.wa.gov/patient-care/treating-patients/interpreter-services/sign-language-interpreter-services

For questions or comments about arranging interpretation services, please contact:

Phone: (360) 902-6329
L&I interpretation mailbox: Interpretation@Lni.wa.gov

Who is Allowed to Attend an IME?

Per RCW 51.36.070, a worker has the right to have one person, who is at least the age of majority and who is of the workers choosing, to be present to observe all examinations, subject to the following conditions:

- Person attending cannot be a paid legal representative or legal representative staff member for the worker;
- The observer must be unobtrusive and not interfere with the examination:
- Person attending cannot be compensated for attending the examination by anyone in any manner; and
- Person attending cannot be the worker's attending provider, or an employee of the worker's attending provider
- The worker cannot bring an interpreter to the examination. If an interpreter is needed, the department or self-insurer will provide one.

The worker cannot bring an interpreter to the examination. If an interpreter is needed, the department or self-insurer will provide one.

May the Worker Record the IME?

Yes, workers have the right to audio and video record the exam. The worker Or their representative must provide notice of the intent to record the examination no less than seven calendar days prior to the exam. The worker is responsible for paying any costs associated with recording. The worker may not hold the recording equipment while the examination is occurring. Additionally, they must take steps to ensure the recording equipment does not interfere with the exam. The worker cannot post recordings to social media. See RCW 51.36.070

See Scheduling above.

Examiner Responsibilities

Beginning the examination

- Conduct the exam with dignity and respect for the worker.
- Provide a setting for an IME in a professional setting (office) suitable for medical, podiatric, chiropractic or mental health exams. (See Chapter 2 for more details on "Site Standards.")
- Introduce yourself to the worker. A name tag may be helpful, especially if there is a language problem. The worker has a right to know your name and specialty.
- Verify the identity of the worker by asking for a name and/or identifying picture.
- Tell the worker that you have received and reviewed the claims documents from L&I or the self-insurer.
- Explain the examination process, purpose of the exam and how an IME and personal doctor's visit differ.
- If the worker has brought x-rays or MRIs to the exam, acknowledge receipt of them in your report.
- Explain the examination procedure.

- Answer the worker's questions about the examination process. (Refer the worker to the claim manager for questions about the claim and to the attending provider for medical advice outside the scope of your examination.)
- Advise the worker that he/she should not perform any activities beyond the worker's physical capabilities. Ask the worker to inform you should pain occur.
- The worker must be fully dressed while you take the history.
- Allow an adult friend or adult family member to attend all portions of the examination. (See "Who is allowed to attend an IME?" earlier in this chapter.)

During the examination

- Provide adequate draping and privacy if the worker needs to remove clothing for the examination.
- Refrain from comments about the care the worker has received. While we may ask for your opinions later, please don't express opinions during the exam process.
- Refrain from expressing personal opinions about the worker, the employer, the attending provider or L&I.
- Conduct an exam that is unbiased, appropriate to the condition being evaluated, and sufficient to answer the Claim Manager's questions.
- Respond to questions asked by the worker about the exam process in an objective and professional manner.

Closing the examination

- Close the exam by telling the worker that the exam is over and ask the worker if they have any questions about the exam.
- Inform the worker that you will send the report directly to the Claim Manager.
- If needed, explain that you feel the necessity of ordering further diagnostic tests for the worker.
- Tell the worker to contact the Claim Manager for questions about their claim or if they would like a copy of the exam report. (1-800-LISTENS). WAC 296-23-347

Discussing the Examination Results with the Worker

You may briefly discuss the results of the exam with the worker if you choose. Record in your report that you have provided some summary comments to the worker's concerns. Remember that an attending provider may discuss with the worker the IME report and any appropriate treatment, if needed.

Do not advise the worker on benefits (such as time-loss compensation or vocational services). Refer the worker to the Claim Manager. (See Chapter 4 "What to Avoid in the Exam and Report" for examples.)

May I Offer to Provide Ongoing Treatment?

No. The rules state that you should not offer to provide ongoing treatment. However, if a worker voluntarily approaches an IME provider who has previously examined the worker and asks to be treated by that provider, the provider can treat the worker. The provider must document that the worker was aware of other treatment options.

L&I or the self-insured employer must approve any transfer of care. With only a few exceptions, the patient has free choice of a treating doctor. WAC 296-20-065 (Beginning in 2013, workers must see a provider in the Provider Network.)

Ordering Diagnostic Tests

All tests must be proper, medically necessary and related to the industrial injury. Order any non-invasive testing required to complete your examination or to supplement your finding. You should **arrange for the needed routine test(s) (laboratory or x-rays).** Complete and submit the IME report **within l4 calendar days** of receipt of the test results.

Invasive tests (e.g. myelogram, biopsies, studies with contract, etc.) require Claim Manager authorization. The Claim Manager may have provided this in the cover letter. Otherwise, send **requests for invasive testing** to the Claim Manager.

For State Fund exams, record the type of tests ordered, the testing date, and the date the results are received in L&I's IME Scheduling application. Include your recommendation for additional testing in the exam report. An addendum report may be requested after the results are received. See chapter 4 for information about deadlines.

Unable to Complete Examination

If you were unable to complete an examination due to the worker's condition or behavior, contact the Claim Manager immediately, and then write a report to the Claim Manager who requested the examination.

Additional Examiner Needed

If you need an additional specialist to complete the exam, include your reasons why in your report. The Claim Manager will decide whether another specialist is needed after reviewing your report and recommendation.

No Show or Late Cancel

If the worker calls to cancel the appointment, explain that only the Claim Manager may cancel an exam and encourage the worker to follow up with the assigned CM. If the worker prefers to reschedule on a future date, you may submit a reschedule request via the IME Scheduling application.

If a State Fund worker fails to show, record the no-show in the IME Scheduling application. This action notifies the Claim Manager of the missed exam and he or she will request a reschedule if necessary. If a self-insured worker fails to show for an exam, contact the person who scheduled the exam. Retain the worker's file and examination assignment (or IME referral letter) until this matter has been resolved.

In some circumstances a cancellation or no-show fee is appropriate. See the Medical Aid Rules and Fee Schedules, published on the Internet: https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/

Releasing Information to Other Parties

Before your exam and before you have completed your report:

If you receive correspondence or phone calls from parties other than the claims staff or the attending provider before the examination and completion of the exam report, direct these communications to the worker's Claim Manager.

Questions from other parties about your report:

If you are contacted by attorneys or any other parties with questions or comments about your report, refer them to the Claim Manager or self-insured employer.

Sending reports to other parties:

After you complete the examination, submit the report to the party that requested the exam. When other parties express interest in obtaining a copy of the exam report, advise them to contact the department or self-insured employer to obtain a copy. Per RCW 51.36.070 the department or self-insured employer are required to send a copy of this report to the attending provider, the worker, and the worker's legal representative. In addition, these reports are available to the employer assigned to the claim via the claim and account center (CAC).

If you are unsure about the validity of a request, it is always appropriate to check with the worker's Claim Manager. For State Fund claims you may call the Provider Hotline at 1-800-848-0811. (The number to call from outside Washington is 1-800-547-8367.) Be sure to reference the claim number and the worker's name to receive claim status information. For self-insured and crime victims claims call the referral source.

Medical Records - Maintenance and Disposal

For audit purposes you must maintain all medical records that show the extent of services you provided the worker. Document the level and type of service for which you seek payment. **You must maintain these documents for a minimum of five years.** [WAC 296-20-02005]

Then discard the worker files in the manner you dispose of other medical records that you have in your office.

Remember to return x-rays and other imaging studies to the worker, hospital or the office that provided them, unless they have directed you not to return them.

Worker's Questions About Their Claims

Refer the worker to their Claim Manager if they have questions about the claim or workers' compensation benefits. The L&I toll-free number for workers is 1-800-547-8367 (1-800-LISTENS) or 1-800-831-5227.

Telehealth/Telemedicine

The terms telehealth and telemedicine are used interchangeably and refer to face-to-face services delivered by a qualified and approved medical examiner through a real-time, two-way, audio video connection.

Examiners are responsible for ensuring telehealth services are approved by the Department for each specific IME exam type prior to scheduling the exam via telehealth. Examiners must comply with all applicable IME telehealth rules and policies, and document agreement from the Claims Manager, worker, worker representative, employer, or any other party to the claim that a telehealth IME is appropriate. Examiners are also responsible for ensuring complete confidentiality during the telehealth exam and that the privacy of the worker is protected at all times. Pursuant to WAC 296-23-317 (1)(b) and (1)(j) for examiners, (4)(d) and (4)(f) for IME firms; providers are responsible for complying with all federal, state, and local laws and regulations related to telemedicine services. The IME report must document that the exam was conducted via telemedicine.

WAC 296-23-359 When is telemedicine appropriate for an independent medical exam (IME)?

1. The following exams may be conducted via telehealth:

   (a) Mental health;

   (b) Dermatology;

   (c) Speech when there is no documented hearing loss;

   (d) Kidney function;

   (e) Hematopoietic system;

   (f) Endocrine.

2. The terms telehealth and telemedicine are used interchangeably and have the same requirements as in-person visits. Telemedicine may be appropriate to effectively conduct an independent medical exam when:

   (a) Face-to-face services by a qualified medical provider can be delivered through a real-time, two-way, audio video connection, and complies with all federal, state, and local rules and laws; and

   (b) A worker is able and willing to participate in an exam via telemedicine; and

   (c) The department or self-insured employer, and worker, have agreed a telemedicine IME is appropriate; these individuals should also agree to the location of the worker during the exam; and

   (d) The agreement is documented in the claim file; and

   (e) A physical or hands-on exam is not required.

3. Upon request of the department or self-insured employer and with the agreement of the worker, a telemedicine IME may be approved on a case-by-case basis for additional specialties not listed under subsection (1) of this section.

IMPORTANT NOTE: Include in the introduction of your IME report, the following details:

- If an interpreter was used, be sure to include the name of the interpreter
- If the exam was conducted using telemedicine, state that all parties agreed and consented
- If the worker recorded the exam, state whether the recording was audio, video, or both

CHAPTER 4

The IME Report

Unbiased, Accurate IME Reports Contribute to Equitable Treatment of Workers

Your IME reports will make a difference—a significant difference—for the workers, the employers, the Claim Managers, the attorneys, the vocational counselors and others. Your report will help to determine whether the workers will receive the correct, lawful benefits due to them when Claim Managers make decisions or when someone disputes a decision. Your report must contain unbiased, accurate, sound, and comprehensive information, obtained through a high-quality examination that respects the dignity of the worker.

An IME is often ordered because a Claim Manager needs a specific piece of information or language in order to move a claim along, or because a Claim Manager is uncertain about a conclusion previously made by another person involved in the claim. Therefore, think of your IME report as a communications tool to educate the reader. Your report needs to be credible, impartial, thorough, and correct; in addition, it should "connect the dots" between the key facts from the medical record and the current status of the worker, so that the reader can understand the situation and the rationale you used to come to your conclusions.

Due Date for IME Reports

The IME report must be sent within 14 calendar days of the exam or within 14 days of receiving any test results. Failure to provide reports within this period may result in adjustment of payment amount or other penalties. **Do not submit the bill before you submit the report.**

In a case of multi-specialty requests, where at least one appointment resulted with a no-show and you have not received a request to reschedule it, please submit the report for the completed exams within 14 days of the most recent appointment date.

Late Reports

Special circumstances may exist when the Claim Manager must have the report in order to meet statutory deadlines. The exam assignment letter will indicate the date you must submit the exam report. If you are unable to meet this deadline, notify the Claim Manager immediately.

What to Include in an IME Report

WAC 296-23-382

The rules state that an IME report must:

- Contain objective, sound and sufficient medical information;
- Document the review of the claim documents provided by the department or the self-insurer;
- Document the worker's history and the clinical findings;
- Answer all the written questions posed by the department or self-insurer or include a description of what would be needed to address the questions;

- Include objective conclusions and recommendations supported by underlying rationale that links the medical history and clinical findings;
- Be in compliance with current department reporting policies; and
- Be signed by the IME provider performing the examination.

Failure to provide reports with these contents may result in non-payment, recoupment (holding monies from future payments) or other penalties.

IME reports are different from the traditional office notes or history & physical performed in a clinical setting:

- First, the area(s) of focus in the IME report will depend on the circumstances which gave rise to the need for the IME. For example, if there is a concern regarding pre-existing conditions, the worker's past medical history should be explored in detail and thoroughly documented. Or, if causation is in dispute, the circumstances surrounding the injury should be explored in depth, and a detailed occupational history (including current duties, past job activities, and hobbies) should be performed.
- Furthermore, the IME report needs to include a thorough review of the worker's medical records. This separate section should outline the key facts in each medical document which the IME examiner has reviewed or relied upon when formulating the conclusion(s). While the number of documents can sometimes seem daunting, a thorough review of pertinent medical records and other requested documents is critical because IME reports must withstand scrutiny and cross-examination. However, multiple progress notes with recurring similar documentation (e.g. physical therapy, medication management, etc.) do not need to be individually detailed, since relevant functional changes may not be seen at a single visit; instead, notes of this type may be grouped together and summarized for presence or absence of functional improvement, escalating opioid dose requirements, or other pertinent observations, as in the following example:

"Mr. Smith underwent multiple chiropractic treatments from June 1 through December 26, 2012. Initial complaints included a headache and neck 'tightness' which were affecting his work. By the end of this timeframe, headaches had increased in frequency, and Mr. Smith continued to report stiffness of the neck, with limited range of motion."

The goal is to document the records so that the reader can clearly see what documents you reviewed, and the information you gathered from them.

- In addition, the physical examination portion of the IME report should include a detailed explanation of special maneuvers or tests to investigate adequacy of effort, and/or gather data as needed for evaluating impairment if asked.
- Finally, the IME report's discussion section should individually list the questions posed by the claim manager, and provide full responses to each. The response must include an explanation of the basis for your response, supported by objective evidence (imaging studies, medical records, scientific research, etc.) and in terms that are understandable to a lay person. Since the questions have been precisely worded and are designed to elicit responses which can be used in the management of claims, "see above" is rarely a sufficient response to a question.

IMPORTANT NOTE: In your report, do not express opinions on causation or work-relatedness for any injury or occupational disease unless specifically requested by the Claim Manager. In many cases, once a condition is accepted, the Claim Manager no longer needs an opinion on causation, and receiving such opinions may create unnecessary confusion. If a diagnosis has been accepted on a claim and your opinion is that the condition is not work-related, you may state in your report that the diagnosis was "administratively accepted."

Appendix A includes sample reports to illustrate content expectations of an IME report.

We do not require that you use the format and template shown in Sample Report # 1, but we strongly recommend it. **We require that IME reports contain all the report elements except those marked by an asterisk (*).** You should only include those marked by an asterisk if the Claim Manager has specifically requested you to do so. Review your report to see that it is complete. The department will look for these elements when reviewing the quality of your documents.

Please make **each examination report unique** to reflect your individual consideration.

IMPORTANT NOTE: Include in the introduction of your IME report, the following details:

- If an interpreter was used, be sure to include the name of the interpreter
- If the exam was conducted using telemedicine, state that all parties agreed and consented
- If the worker recorded the exam, state whether the recording was audio, video, or both

Details to Include in the Report

Other health care professionals often scrutinize your IMEs. Remember that your duty is to reduce conflict by being objective and including data that will allow reviewers to understand your conclusions. The detailed record review must provide a detailed chronology of the accepted injury(ies) or condition(s). This record review would include: (a) the mechanism of injury or exposure, (b) diagnostic studies and results, (c) surgical interventions, (d) treatments and outcomes.

Multiple progress notes with recurring similar documentation (such as physical therapy, chiropractic, etc.) do not need to be individually detailed, since relevant functional changes may not be seen at a single visit; instead, notes of this type may be batched together and summarized for presence or absence of functional improvement, escalating opioid dose requirements, or other pertinent observations, as in the following example:

> *"Mr. Smith underwent multiple chiropractic treatments from June 1 through December 26, 2012. Initial complaints included a headache and neck 'tightness' which were affecting his work. By the end of this timeframe, headaches had increased in frequency, and Mr. Smith continued to report stiffness of the neck, with limited range of motion."*

The expectation would be that the statement gives a realistic and adequate summary of the treatments and outcomes for the year. If a claim is closed and reopened, please note dates of closures and reopenings.

Areas of the history and physical exam in which detail is often lacking, include portions that deal with pain, swelling, range of motion and skin eruptions. When one or more of these are part of the history or physical exam, you should discuss the following points:

- **Pain**: nature and quality; radiation; severity (including scale); ameliorating/exacerbating factors; effect on activities etc.;
- **Swelling**: location; shape; dimensions; color etc.;
- **Range of motion**: joint (right or left); measurement, for example, with a goniometer (not required, but helpful);
- **Contralateral range of motion:** If a contralateral "normal" joint has a less than average mobility, the impairment value(s) corresponding to the uninvolved joint can serve as a baseline and are subtracted from the calculated impairment for the involved joint (Page 453, *AMA Guides to the Evaluation of Permanent Impairment, 5th Edition*).
- **Rash**: location/distribution; character (e.g., macular, papular, urticarial), etc.

Why are fair, unbiased reports so important?
Employers, the labor community, the legislature, L&I—all want IME examiners to make a special effort to provide fair, unbiased reports. Reports should neither overstate nor understate a worker's medical condition or impairment.

Biased reports may create significant problems for all parties involved. For example, biased reports may affect the health of the worker and the operation of the employer's business, not to mention that they may lead to litigation, resulting in costly delays and high legal expenses.

Radiology Reporting Requirements for IMEs

IME providers who read imaging studies that they order in relation to an IME, or reinterpret imaging studies previously performed, are required to document their findings within the IME report. Each imaging study must be separately documented in its own section and include all of the following:

Date the imaging study was performed, *and*

The anatomic location of the procedure and type of procedure (lumbar spine, abdominal CT, MRI, etc.) *and*

Specific views (AP, lateral, axial, weight-bearing, with or without contrast, etc, as applicable) *and*

When ordering imaging studies, a brief sentence describing the reason for the study such as:

- "Neck pain radiating to upper extremity, rule out disc protrusion", and Description of, or listing of, imaging findings:
- Advanced imaging reports should follow generally accepted standards to include relevant findings related to the particular type of study, and
- Radiology reports on plain films of skeletal structures should include evaluation of osseous density and contours, important postural/mechanical considerations, assessment of any joint space abnormalities, and assessment of any important abnormal soft tissue findings, and

- Radiology reports on chest plain films should include assessment of lung fields, cardiovascular contours, abnormalities below the diaphragm, assessment of any important osseous abnormalities shown incidentally, etc, and
- Imaging impressions which summarize and provide significance for the imaging findings described in the body of the of the IME report. If the same imaging study was performed on multiple dates of service, the provider must document a comparison between the studies, in sequential order, noting any significant changes that occurred.

In addition to the above information, when reinterpreting imaging studies, the IME provider must document whether they are or aren't in agreement with the original interpretation of the imaging study.

Please see the following example:

> *There is an x-ray of the claimant's left shoulder, performed March 3, 2019. Radiologist interpretation of this study notes no evidence of fracture. There is mild acromioclavicular and glenohumeral joint osteoarthritis with minimal calcific tendinopathy of the rotator cuff. I am in agreement with the radiologist's interpretation. There is evidence of mild osteoarthritis and narrowing of the AC region. There is a bit of calcification within the soft tissue. The acromion is Type I and flat. I do not see any evidence of bony injury and there is minimal degenerative change in the glenohumeral region.*

For a full description of the documentation and billing requirements see MARFS, Chapter 13.

Failure to provide reports with these requirements may result in non-payment, recoupment (holding monies from future payments) or other penalties.

Payment Limits

Reinterpretation of imaging studies may only be billed once per panel exam. The reinterpretation is only payable for studies related to the accepted or contended condition.

In addition, services must be billed with the correct CPT code for the specific imagining study reinterpreted, along with the **modifier -26** and **modifier -7N.**

When to Sign the IME Report

Sign the IME report after you have reviewed the report to be submitted. Your signature on the report indicates that you have reviewed and approved the content of the report. You will be held accountable for the content of your report.

Where to Send the IME Report

Submit reports, addendums, and testing results related to the IME to L&I via the IME scheduling system.

If you fax your report for State Fund, the report will go directly into the worker's claim file. The Fax number for State Fund IME reports is 360-902-4567.

If you mail your report, you must use different addresses for State Fund, Self-Insurance, and Crime Victims' Compensation Program reports.

For State Fund: Do not attach or staple your bills to your reports. Send bills and reports to different addresses. If you send medical reports to the billing address, the report may not reach the Claim Manager. A post office box number makes a big difference in our mail delivery.

When Examiners Disagree on IME Conclusions

It is important that examiners recognize that conflicts in their findings can hinder the ability to move the claim forward.

Multiple-examiner IMEs should be conducted at the same site on the same day whenever possible. If IME examiners have conflicting opinions, the panel must consult with each other to discuss and see if an agreement can be made. If an agreement cannot be reached, the medical director should be consulted to see if the panel can come to an agreed conclusion.

If, after consulting with the medical director, agreement still cannot be achieved, the IME report must discuss the reason(s) for the disagreement and provide objective findings that supports each panel member's opinion.

Addendum Report

L&I or the self-insurer may ask you to complete an addendum report after receiving your IME report. If the request asks you to respond to a question that you overlooked in the examination assignment or request letter, we expect you to send the addendum report promptly (within 14 calendar days of receipt of the request) for no additional payment.

If we ask you to answer new questions, then you may bill for the report and receive payment. **Return the addendum report within 14 calendar days of receipt of the request**. If you cannot address the new questions based on your record of examination, contact the Claim Manager to discuss the kind of information needed or identify the additional expertise needed.

Billable addendums should follow the guidelines below:

- Less than 6 months from when the original IME was conducted, and;
- Minimal amount of review required, an addendum may be appropriate to ask questions that were not asked at the time of the exam, or to request review of new information (Minimal pages)
- If the addendum does not meet the criteria listed above, The CM should consider if a new IME is needed or consider a consultation

If you are uncertain if the requested addendum is appropriate contact the Department.

IMPORTANT NOTE: Only examiners in Approved status can accept or conduct exams, addendums, and/or JAs unless prior written approval have been obtained. However participating in depositions and testimonies is still required while in any status.

What is Meant by 'more-probable-than-not' in an IME?

We may ask you to determine whether the worker's condition is caused by an industrial injury or exposure on a more probable than not basis. Under Washington law, a causal relationship exists if you find that a **greater than 50% chance** exists that the condition resulted from the industrial accident or

exposure. Multiple causes may exist in a condition, and the industrial injury or exposure does not need to be the sole cause.

Maximum Medical Improvement (MMI)

L&I considers the terms "MMI" and "fixed and stable" to be synonymous. ("Fixed and stable" is the legal term.) WAC 296-20-01002 gives a definition of MMI as follows:

> *Maximum medical improvement occurs when no fundamental or marked change in an accepted condition can be expected, with or without treatment. Maximum medical improvement may be present though there may be fluctuations in levels of pain and function. A worker's condition may have reached maximum medical improvement though it might be expected to improve or deteriorate with the passage of time. Once a worker's condition has reached maximum medical improvement, treatment that results only in temporary or transient changes is not proper and necessary. "Maximum medical improvement" is equivalent to "fixed and stable."*

An accepted condition has reached maximum medical improvement (that is, fixed and stable) when it is reasonably certain that further medical treatment will not improve the illness or medical condition.

"Fixed" does not necessarily mean "healed" or "static." Rather, it means the worker has reached a stable plateau from which further recovery is not expected, although the passage of time may produce some benefit.

Be sure to specify the condition for which you are determining MMI, and whether it is an accepted condition on the claim. For example: "With respect to the accepted condition, lumbar strain, Mr. Y has reached MMI. With respect to his left knee complaint, which is not an accepted condition on this claim, Mr. Y has not reached MMI, and he may need to follow up with his attending provider."

A worker may be at MMI and still require ongoing treatment. Asthma is one example. A worker may have work-related asthma that has reached a plateau from which further recovery is not expected - and at the same time may require ongoing treatment with medications.

Treatment Recommendations

Do not provide treatment recommendations unless the Claim Manager specifically asked you to do so in the IME assignment letter. If the Claim Manager asked you to provide treatment recommendations, please indicate which recommendations are for accepted conditions and which are for preexisting or unrelated conditions. The Claim Manager may also ask you to provide treatment recommendations for conditions that are retarding recovery (WAC 296-20-055). The department can only consider treatment of conditions that are retarding recovery if the accepted conditions are not at maximum medical improvement (MMI).

For example: "With respect to Mr. Y's accepted condition of lumbar strain, the worker is not at MMI, and may benefit from physical therapy. With respect to Mr. Y's left knee complaint, it is not an accepted condition, but it may retard recovery. Mr. Y would likely also benefit from limited physical therapy for the left knee."

Guidelines, Coverage Decisions, and Policies on Specific Medical Conditions and Treatment Recommendations

The Office of the Medical Director has developed evidence-based Medical Treatment Guidelines in collaboration with practicing physicians and advisors. Some of these guidelines are intended to be educational tools for medical providers, while others are intended to promote best practices and improve the health of injured workers. When providing treatment recommendations in your IME reports, your opinions should, as much as possible, be consistent with these Medical Treatment Guidelines. If your recommendation is not consistent with these guidelines, you must provide substantial justification for your recommendations, including supporting references from medical literature.

New Treatment Guidelines may be added at any time.
See the most current Medical Treatment Guidelines online about these topics at https://lni.wa.gov/patient-care/treating-patients/treatment-guidelines-and-resources/#treatment-guidelines

Below list as of: 05/20/2024

- Ankle and foot Surgical Guideline
- Beryllium – Clinical Guideline for the Diagnosis of Beryllium Sensitization and Chronic Beryllium Disease
- Carpal Tunnel Syndrome (CTS) Guideline
- Cervical Radiculopathy and Myelopathy
- Complex Regional Pain Syndrome (CRPS-2011)
- Facet Neurotomy
- Knee surgery (CME)
- Low Back Pain, Guideline for Hospitalization
- Lumbar Spine Surgery Guideline (effective Oct. 3, 2021)
- Prescribing Opioids to Treat Pain in Injured Workers
- Proximal Median Nerve Entrapment (PMNE)
- Radial Nerve Entrapment Diagnosis and Treatment
- Shoulder Conditions Diagnosis and Treatment Guideline
- Single Cervical Nerve Root
- Spinal Injections
- Thoracic Outlet Syndrome – Neurogenic
- Thoracic Outlet Syndrome – Vascular
- Ulnar Neuropathy at the Elbow (UNE) Diagnosis and Treatment
- Work Rehabilitation Best Practices Guideline

Coverage Decisions: In addition to the guidelines discussed above, IME providers must be familiar with the "coverage decisions" which L&I has issued on a number of topics. More information about coverage may be found in the Condition and Treatment Index at: https://lni.wa.gov/patient-care/treating-patients/conditions-and-treatments/. Some conditions NOT covered include autologous blood injections, fibromyalgia, kyphoplasty, sacroplasty, and vertibroplasty, percutaneous discectomy for disc herniation,

electrodiagnostic sensory nerve conduction threshold, extracorporeal shockwave therapy, percutaneous discetomy for disc herniation, percutaneous neuromodulation therapy (PNT), spinal cord stimulation, thermal shrinkage for instability.

Pain Management and Opioid Prescribing

IME providers may be asked to address questions about treatment of chronic pain, including the prescribing of opioids and other medications. They should be familiar with the Agency Medical Directors' Group's "Interagency Guideline on Long-Term Opioid Therapy" (AMDG Guideline) and L&I's "Guideline for Prescribing Opioids to Treat Pain in Injured Workers" (L&I Guideline). Also, IME providers should be knowledgeable about the Department of Health's pain management rules for each of the boards and commissions.

If the IME provider has a concern about opioid or other medication prescribing, please contact the Claims Manager. If the examiner feels that an injured worker's drug therapy has resulted in an adverse outcome (e.g., substance use disorder, driving impairment, vocational impairment, etc.), then they must verify (1) that the IW is truly taking the implicated drug therapy AND (2) that the drug therapy is prescribed for an accepted condition AND (3) the drug therapy is covered under the claim BEFORE attributing the adverse outcome to the claim.

FREE Category 1 CME is available to learn about the AMDG Guideline and L&I Guideline.

A free online Opioid Dose Calculator is available to help providers assess compliance with the AMDG Guideline and the DOH Rules. The calculator converts the dose of one or more opioids to a daily morphine equivalent dose (MED). The calculator is available at: www.agencymeddirectors.wa.gov.

For State Fund exams, the IME provider may request a drug summary, which shows all prescriptions which have been paid under a claim. However, this will not reveal opioids and other drug therapy, which are not covered under a claim, so providers should review the worker's intake form and medical records to create an accurate picture of drug therapy.

What to Avoid in the Examination or Report

Your IME report **must not** include the following types of items:

- **Statements about the claim status**: Please do not make statements such as "Keep the claim open. . . (or) deny reopening." L&I is responsible for administrative decisions. Your role is to answer only the questions asked by L&I.
- **Opinions on Administratively-Accepted Diagnoses and other decisions made the Department:** Administratively accepted diagnoses have already been adjudicated by the Department. Please do not comment on any decisions made by the Department. It is your responsibility to only answer and address those items requested by the Department.
- **Speculation about services**: Avoid such statements as, "This worker needs vocational retraining," or "The insurer should pay for this worker to get a high school diploma." Please do not comment on vocational issues unless the Claim Manager specifically asks you to address the worker's ability to work or to perform a specific job.

If you are asked to discuss the worker's ability or inability to work in a specific job, focus on the worker's physical abilities and provide complete information regarding any restrictions, including the basis for the restrictions.

- **Inconsistencies**: Make sure no inconsistencies exist in your report, for example, saying the worker has reached MMI but requires six more weeks of physical therapy.
- **Discussion of fault**: Since Washington is a "no-fault" state, avoid discussing fault (anyone's) with the worker. Coverage exists regardless of fault. Your examination report should not determine fault.
- **Discussion of finances**: Do not discuss financial need or assets.
- **Incidental findings**: If there are incidental findings during the course of your examination, please note this in the report, discuss with patient, and if necessary, contact the Claims Manager.

Important: Only answer the questions asked by the Claim Manager and required as described at the beginning of this chapter. Any questions that are received from other parties need to be sent to the Claims Manager for consideration. For example, if the Claim Manager has not asked for an impairment rating, do not rate impairment.

If the Injured Worker needs Treatment from a different provider

Under Washington law, workers may choose their attending provider who may hold licenses in many different areas. Workers may sometimes choose doctors who are not qualified to provide the care that the worker needs. So, in your report recommend the specific treatment and the type of specialist needed. The attending provider is the one to make the referral.

If you expect that further treatment, such as the type the worker has been receiving, will not be curative, then say this in the report. Avoid statements about the attending provider that are based on your objection to general principles of a profession or area of specialty.

Reopening a Closed Claim (worsening, objective findings)

If the accepted condition of a worker objectively worsens, a closed industrial insurance claim may be reopened. We may ask you, as an examiner, to perform reopening exams to answer specific questions. An administrative decision about claim status will be made based on your report. Do not tell the worker their claim will or will not be reopened.

L&I or the self-insurer may arrange for a reopening exam in order to do the following:

- Determine whether the accepted condition has worsened;
- Assess whether further treatment is needed;
- Document objective signs or findings and rate the increased permanent impairment, if requested by Claim Manager;
- Determine whether the current condition is causally related to the injury or exposure covered under the claim.

Important things for you to do at the reopening exam:

- Document the findings substantiating any worsening of the worker's condition and the reason for the worsening.
- Describe the activity, if any, that caused the change in objective findings. Examples: Did symptoms start after loading firewood? After bending over to tie a shoe? Where did the activity occur?
- Be sure to review the worker's medical records at the time of last claim closure or last denial of reopening. It is not necessary to review records before that time.

New injury versus worsening of previous injury:

- If you are unsure whether a condition is a new injury or worsening of a previous injury, please check with the Claim Manager.

When worsening (aggravation) has occurred, an injured worker may be entitled to further treatment or additional compensation, if:

The causal relationship between the injury and the worker's impairment is established by medical evidence on a "more-probable-than-not" basis; and

- The medical evidence, backed in part by objective findings, shows that the worker's condition worsened; and
- The medical evidence, backed in part by objective findings, shows that the worker's condition worsened since the last closing order. (Check with the Claim Manager if you are unsure of the closing date.)

Note: A condition need not worsen enough to increase the impairment rating. Re-opening depends on evidence of worsening, regardless of whether or not the impairment rating has increased. Do not rate impairment unless asked by the Claim Manager.

See Chapter 5 for further discussion on aggravation of preexisting conditions.

Definition of worsening (aggravation): In workers' compensation, these terms refer to a worsening of the industrial injury or occupational disease that results in the need for further treatment or a temporary or permanent increase in impairment. Industrial insurance cannot cover conditions when other factors cause the worsening, such as an intervening injury, natural progression of a preexisting condition, etc. The opinion that the condition has worsened must be based at least in part on **objective evidence** (Wilber v. Department of Labor and Industries, 1963).

CHAPTER 5

Preexisting Conditions, Lighting Up, and Segregation

Industrial insurance law recognizes that not all workers are in perfect physical condition before their injury or exposure. Sometimes an industrial injury or occupational exposure can exacerbate a preexisting medical problem. Sometimes a preexisting condition can change independently of an industrial injury or occupational exposure.

IMPORTANT NOTE: When L&I has accepted the full effects of a preexisting condition, the doctor should NOT make any determination regarding segregation of preexisting impairment when completing a rating examination. Similarly, unless explicitly requested by the Claim Manager, the doctor should NOT express any opinion on causation or work-relatedness for any conditions diagnosed by the IME examiner.

Aggravation (also referred to as "worsening" or "exacerbation"—the three terms are used synonymously in Washington workers' compensation) of a preexisting condition occurs when an injured worker has a preexisting condition, symptomatic or asymptomatic, which is made worse by the industrial incident or exposure.

Your role, as an examiner, is to provide documentation of clinical observations and conclusions, so that the law can be applied correctly. Here are four examples of situations you might face:

- A worker may have had a condition that was asymptomatic and non-disabling, and then the injury or occupational disease caused the condition to become a problem for the worker.
- A worker may have an injury or contract an occupational disease that accelerates a preexisting symptomatic or disabling condition, or causes it to become worse.
- A worker may have an underlying condition that was temporarily affected by an injury or occupational disease, and now has returned to pre-injury status.
- A worker may have a preexisting condition which is not affected by an injury or occupational disease.

The department and self-insured employers apply two legal concepts in cases of preexisting conditions: **lighting up and segregation**. When these legal concepts are applied, we know if we are to accept full responsibility for a preexisting condition, partial or limited responsibility for the preexisting condition, or to deny responsibility for the preexisting condition. Whether a condition has been "lighted up" or needs to be "segregated" is a legal determination made by the department. In order to make this determination, we need your best medical judgment of the worker's condition before and after the industrial injury, and whether the industrial injury "lighted up," aggravated (permanently or temporarily) the condition, or whether the condition is totally unrelated to the industrial injury.

When Does L&I Accept Full Responsibility for a Preexisting Condition? "Lighting Up"

If an injury activates a previously asymptomatic AND non-disabling condition, the entire resulting impairment is attributed to the injury rather than to the preexisting condition. The law allows compensation for preexisting asymptomatic conditions that became symptomatic and disabling, or "lit up," as a proximate result of the industrial injury. "Lighting up" occurs if 1) a preexisting condition was not symptomatic and did not result in any limitations on the worker's ability to function prior to the industrial injury, 2) the preexisting condition is now symptomatic and it imposes some functional limitations on the worker, and 3) the industrial injury proximately caused the preexisting condition to become symptomatic and a source of functional limitations. The "lighting up" principle was established by the legal case of *Miller v. the Department (1939).* When the department or self-insured employer has accepted the full effects of a preexisting condition, the doctor should NOT make any determination regarding segregation of preexisting impairment when completing a rating examination. (See Sample Report #4 in Appendix A.)

When Does L&I Accept Limited Responsibility for a Preexisting Condition? "Segregation"

When medical evidence discloses that a preexisting condition was disabling and symptomatic prior to the injury, our responsibility is limited to the increase in impairment due to the industrial injury. We must segregate (subtract) the prior impairment from the overall impairment. In these cases, the doctor needs to advise us both of the impairment due to the industrial injury and of the preexisting impairment. There are no hard and fast rules about how to determine prior impairment. In many cases the apportionment must rely on the doctor's best medical opinion, (for example, in cases where no x-rays were obtained prior to the injury.) In some cases, the doctor may have a long-standing relationship with the patient and may have detailed medical records which allow a fairly accurate estimate of prior impairment (see Sample Report #5, Appendix A). In some cases, the Claim Manager may be able to provide records to which the attending provider does not have easy access. In any case, the expectation of the examining doctor is simply to make the best determination possible, and to provide a brief explanation of the basis for that determination.

Temporary treatment of an unrelated condition may be allowed, upon prior approval by the department or self-insurer, provided these conditions directly retard recovery of the accepted condition. The department or self-insurer will not approve or pay for treatment for a known preexisting unrelated condition for which the claimant was receiving treatment prior to his industrial injury or occupational disease, which is not retarding recovery of his industrial condition.

When Does L&I Deny Responsibility for a Preexisting Condition?

When a condition is totally unrelated to the industrial injury or occupational exposure, or if the worker has a preexisting condition and medical evidence does not establish that the condition was aggravated by the industrial injury or exposure, L&I may deny responsibility for the preexisting condition. In addition, we are not responsible for the natural progression of the preexisting condition or for changes due to the natural aging process.

What Should I do to Address Preexisting Conditions?

To summarize, when L&I has accepted the full effects of a preexisting condition, the doctor should NOT make any determination regarding segregation of preexisting impairment when completing a rating examination. If asked by the Claim Manager, and if you find that the preexisting condition was symptomatic AND disabling prior to the worker's injury, you should:

1) Rate the impairment that existed prior to the worker's injury; and

2) Document the basis for your opinion. At a minimum this should include the following:

- A discussion concerning how often the condition was symptomatic prior to the injury;
- The last time the condition was symptomatic prior to the injury;
- Any treatment the worker received for the condition prior to the injury (including the use of over-the-counter medications);
- A synopsis of prior medical records and diagnostic studies;
- The effect, if any, of the preexisting condition on the worker's daily activities/lifestyle prior to the injury (for example, did the worker miss time from work, require bed rest, need to refrain from performing certain household activities, etc.); and
- Any prior impairment award which the worker received for the condition.

CHAPTER 6

Occupational Diseases

Occupational diseases are different from occupational injuries. Carpal tunnel syndrome, noise-induced hearing loss, dermatitis, and asthma, when work-related, are examples of conditions which L&I considers occupational diseases. The Revised Code of Washington (RCW) defines an occupational disease as an infection or disease that "arises naturally and proximately" out of employment (RCW 51.08.140).

Unlike other questions in medicine where 90% or 95% certainty may be preferred for clinical decisions, in the workers' compensation system a degree of certainty greater than 50% is what is required for you to conclude that a condition is work-related on a more-probable-than-not basis.

Claims based on mental conditions caused by stress are excluded by law from this definition (RCW 51.08.142), except for certain firefighters. See Chapter 7, "Mental Health IME Reports."

Why do claim managers need so much information about occupational disease claims?
Various laws and court decisions have created a legal standard different for occupational disease claims than that which pertains to industrial injuries. These legal aspects make it necessary for claim managers to gather detailed information from approved examiners on occupational disease claims to guide their legal decisions. This additional information is especially vital where several jobs with different employers may have contributed to the diagnosed condition. **In the legal process we may have to apportion or pro-rate the cost of benefits among the multiple employers whose employment contributed to the condition.**

An example of a court decision is *Dennis v. Department of Labor and Industries* (1987). For more detailed information on the criteria for allowance for occupational disease claims, see the box titled "Criteria for Allowance of an Occupational Disease." Since the legal standard is different in occupational diseases, we need additional information from you for occupational claims.

The Occupational Disease Report

IME examiners should ONLY provide this report if specifically requested by the claim manager.

Required content: This extra report MUST include all the content illustrated in Sample Report #6 in Appendix A. To complete this extra report you should review information provided by the worker on the work history form (sample in Appendix A.)

IMPORTANT NOTE: By following the specific format in Sample Report #6 and answering Questions 1 through 6 in that format, you will provide all the information needed by the Claim Manager. Even if you find that none of the jobs contributed to the contended occupational disease, completing this report will provide the necessary rationale to support your opinion. As you answer these 6 questions, you may find the definitions below helpful.

IME providers use billing code 1128M, attending providers and consultants use billing code 1055M. These special billing codes may be used to compensate IME examiners, attending providers and consultants for the work required to file the extra report called the Doctor's Assessment of Work-Relatedness for Occupational Diseases. Depending on the diagnosis, it may or may not be necessary or appropriate to file this report. Refer to the Medical Aid Rules and Fee Schedules for billing codes.

Criteria for allowance of an occupational disease

"Occupational disease" is a disease or infection that arises naturally* and proximately out of employment**. Criteria used by Claim Managers for allowance of an occupational disease, based on law and regulation, include the following:

a) A physician must present an opinion that work conditions, on a more-probable-than-not basis (a greater than 50% chance), are a cause of the disease or have aggravated or "lit up" a preexisting condition; **AND**

b) Objective medical findings support the diagnosis; **AND**

c) The disease must arise "naturally and proximately" out of employment [RCW51.08.140].

***"Naturally":** To meet the definition of arising "naturally" out of employment [*Dennis v. Department of L&I (1987)*], a disease must be regarded as a natural consequence of distinctive conditions of the work process, including one or more of the following:

- The disease is caused by distinctive conditions of the worker's employment. The disease or disease-based disability does not arise out of employment if it is caused by conditions of everyday life or all employments in general." **OR**
- The worker's occupation exposed the worker to the likelihood of contracting the disease or the disease-based disability. **OR**
- The disease is caused by continuous and specific activity required to perform the job.

****"Proximately":** To meet the definition of arising "proximately" out of employment, "the cause must be proximate in the sense that there existed no intervening independent and sufficient cause for the disease, so that the disease would not have been contracted **but for** the [distinctive] condition existing in the …employment." [*Simpson Timber Company v. Department of L&I* (1949)] It is not required that the industrial injury or exposure be the only proximate cause of the condition [*Hurwitz v. the Department of L&I* (1951)]. For example, asbestos exposure can be a proximate cause of lung cancer, even though the worker is also a smoker.

IMPORTANT NOTE: In Washington State Workers' Compensation, the legal standard for causation is "a proximate cause." This is different from the legal standard of "the proximate cause" used in some other states and jurisdictions. This means that if a work-related exposure contributes to the development or worsening of a condition, even to a very small degree, then the condition is deemed to be work-related.

Be sure that the opinion you give in your report is based on the "a proximate cause" standard, in accordance with Washington laws (RCW), regulations (WACs), court cases and other criteria for occupational disease (before relying on other resources about causation).

The questions you will generally be asked by Claim Managers regarding occupational disease include:

Work Relatedness for an Occupational Disease (Claim Not Allowed)

1) Have you discussed with the claimant the work activities of ALL jobs listed in the work history (including discussion of protective equipment and engineering controls)?

2) What conditions have you diagnosed?

3) For each condition in Question #2 that is considered a disease (rather than an injury), which jobs in the work history created a recognizable risk of contracting (or worsening) this work-related condition relative to the risks in everyday life, on a more-probable-than-not basis? Which jobs did NOT create such a risk?

4) For each job that did create a recognizable risk, answer BOTH of the following questions:

a. Describe the job. Be sure to include the work activities and/or exposures which contributed to (or protected the worker from) the disease (proximate causes). Describe any protective equipment or engineering controls (or lack thereof) that may have affected the exposure.

b. Describe the basis for your opinion that the workplace activities contributed to the disease. Please include:

- A description of the temporal relationship. In your description of the temporal relationship, be sure to mention, for each job, when the worker began to experience symptoms and how the onset and pattern of symptoms related to work activities.
- Any other information you deem relevant (such as supporting references from the medical literature).

5) Describe non-work activities or conditions that may have an effect on the disease.

6) If you believe the disease was caused SOLELY by non-work activities or conditions, describe the basis for your opinion. Please include, for example, a description of the temporal relationship, supporting references from the medical literature, and any other information you deem relevant.

Work Relatedness for *Claim Accepted* for Occupational Disease

This claim has been allowed for the occupational disease diagnosed above.

Please answer these required questions about work related activities that caused the accepted occupational disease on a more probable than not basis.

Please use billing code 1128M to be paid for these additional questions.

Work History is located in imaging (see above):

1) For each accepted condition allowed as an occupational disease on this claim, which jobs in the work history created a recognizable risk of contracting (or worsening) this work-related condition relative to the risks in everyday life, on a more-probable-than-not basis? Which jobs did NOT create such a risk?

2) For each job that did create a recognizable risk, answer BOTH of the following questions:

a. Describe the job. Be sure to include the work activities and/or exposures which contributed to (or protected the worker from) the disease (proximate causes). Describe any protective equipment or engineering controls (or lack thereof) that may have affected the exposure.

b. Describe the basis for your opinion that the workplace activities contributed to the disease. Please include:

- A description of the temporal relationship. In your description of the temporal relationship, be sure to mention, for each job, when the worker began to experience symptoms and how the onset and pattern of symptoms related to work activities.
- Any other information you deem relevant (such as supporting references from the medical literature).

CHAPTER 7

Mental Health IME reports

The department expects you to conduct a full mental health evaluation that should generally include the required report elements below. The format follows a general mental health interview, with some features and considerations unique to workers' compensation. You must become familiar with the definitions and guidelines in the second part of this chapter.

Please note that failure to properly document all items below could result in delays in moving the claim to resolution and could result in a request for a non-billable addendum. Repeated failure to include necessary elements will result in a referral for IME quality assessment.

Neuropsychologists: Neuropsychologists may be asked to provide testing for the IME examiner, especially for claims involving cognitive issues. They are not approved to perform IMEs. They should not answer any IME assignment questions from Claim Managers, including those regarding job analyses, etc. Those questions should be answered by the IME examiner.

Note: Neuropsychological testing may be approved only when requested by a neurologist or physiatrist in order to evaluate suspected cognitive impairment secondary to a brain injury or to evaluate treatment progress in brain rehabilitation. Neuropsychological instruments should not be used screening tools.

GENERAL INSTRUCTIONS AND KEY QUESTIONS FROM THE CLAIM MANAGER

Diagnosis and Baseline

Each person has a pattern of adjustment to life. The pattern of adjustment before the industrial injury or occupational disease serves as a base line for all assessments. After conducting an informational interview with the worker with regards to mental health pre- and post-industrial injury or occupational disease, you must characterize the pre-injury or occupational disease baseline that you established.

Provide all of the required elements noted in Table 7.1 below. When making diagnoses, follow the format of the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5).

1) List the accepted condition(s) (as stated on the assignment letter from the Claim Manager).
2) What are the current psychiatric diagnoses? What objective medical evidence, in the form of documentation and clinical findings, supports these diagnoses?
3) Are there preexisting diagnoses or psychiatric impairments (based on history and medical record review)?
4) Provide the DSM criteria for the proposed diagnoses.

Your report must state the DSM criteria which supports each diagnosis, including consideration of other diagnoses and other explanations of the presentation. Please note that all mental health conditions present

must be discussed, even personality disorders. Discuss your diagnoses for this case, including those findings that support your diagnoses. In a multi-examiner examination, review your diagnoses and recommendations with other examiners.

"Unspecified" diagnoses by definition do not depend on specific criteria, and also do not have published rating scales or evidence-based treatments. The absence of methods to determine the severity of such conditions across time may complicate administrative issues and claim resolution. Please carefully consider the context before applying "unspecified" diagnosis. If you do make such a diagnosis, you must explain both why a mental illness is present and why a more definite diagnosis would not apply.

Causation

If asked by the Claim Manager, answer questions about causation.

Consider WAC 296-14-300, relative to claims based on stress (cited below).

1) Please explain on what grounds the industrial injury/occupational disease was or was not a proximate cause of the mental health condition(s) that you diagnosed. Consider principles of causation relevant to mental health, such as what is known about the etiology of psychiatric diagnoses, and if the mental condition or disability was caused by stress.

2) Discuss if any pre-injury mental illness became worse after the injury, and explain if this was related to the injury. Consider if the differences in adjustment patterns before and after the industrial condition (on a more probable than not basis) were:

- ***a)*** The result of the industrial condition and its sequelae, in the sense they would not have occurred had there not been the industrial condition?
- ***b)*** More than the normal, self-correcting and expectable response to the stress of the industrial condition or its sequelae?

Ability to Work / Work Restrictions

If asked by the Claim Manager, answer:

Are there any restrictions related to the proposed diagnoses that prevent this worker from returning to work? If so, what are they and how do they prevent this worker from returning to work? Provide a rationale based on the functional capabilities of people with various forms of mental illness (e.g., if people with depression are able to work).

In addition, include your assessment of whether the worker can:

1) Maintain focus on work?
2) Understand and follow work rules and instructions?
3) Be aware of and follow safety precautions?
4) Work with or near other workers?
5) Keep emotions under control?
6) Interact with public and customers?
7) For any barriers listed above what interventions could assist the worker in a successful return to work?

You must comment on the worker's ability to work as it relates to the mental health condition being treated, rather than the mental condition generally. The use of specific examples of a worker's mood, behavior, cognitive function, energy levels, daily activities, as well as other limitations, are helpful to communicate the effects of a mental health condition, or the effects of treatment for such a condition, on work ability or work restrictions. For example, you must:

- Describe if and how the mental health condition interferes with specific job tasks, and
- Summarize which targeted specific symptoms must improve to allow a successful return to work status, including a plan to achieve the goal.

Examiners can find recommendations for simple accommodations related to mental health at the U.S. Department of Labor's Job Accommodation Network (JAN) website: www.askjan.org/links/atoz.htm . JAN documents address mental illness, in general, as well as specific conditions like depression, anxiety, post-traumatic stress disorder, and others.

Job Analysis

If asked by the Claim Manager, answer:

Please review the job analysis and indicate whether you approve one or more job analyses and/or suggest modifications. Your recommendation on the job analysis should be limited to the mental health conditions accepted on the claim.

Maximum Medical Improvement (MMI) or Treatment

If asked by the Claim Manager, answer questions about maximum medical improvement, considering definitions in WAC 296-20-01002(2)(b) and WAC 296-20-01002(3), given below. These standards may be considerably different than a clinical recommendation for more treatment. For instance, the clinical recommendation for additional care is usually based on the presence of symptoms and impairments, while "proper and necessary" treatment is defined by the likelihood of improvement. A worker with even severe mental health symptoms might in certain circumstances be considered at maximum medical improvement, such as if she or he had received extensive treatment without improvement.

Curative treatment produces permanent changes, which eliminate or lessen the clinical effects of an accepted condition. Rehabilitative treatment allows an injured or ill worker to regain functional activity in the presence of an interfering accepted condition. Maximum medical improvement (MMI) occurs when no fundamental or marked change in an accepted condition can be expected. Proper and necessarily treatment, per WAC 296-20-01002, must therefore produce marked or fundamental changes in an accepted condition. Care intended primarily to prevent worsening ("maintenance," "preventative", or "palliative" care) is generally antithetical to curative treatment.

Has the worker reached maximum medical improvement? If yes, please explain.

If no, and if you recommend treatment or additional treatment, explain the following completely:

1) If you recommend mental health treatment, would it be curative for a mental health condition, or would it be an aid to recovery from the injuries that have been accepted on the claim?
2) What specific improvements in mental health symptoms and impairments would be expected during treatment?

3) If there has been previous mental health treatment, how would additional treatment produce marked or fundamental changes in the condition?
4) How long will the mental health treatment take? (Do not write that it should last "at least" a certain amount of time, as this is not useful for administrative or clinical purposes.)
5) Do you recommend medication and/or other mental health treatment?
6) What barriers would prevent or delay successful treatment?

Impairment Rating

If asked by the Claim Manager, answer:

If the worker is not at maximum medical improvement (MMI) for the accepted mental health condition, do not provide an impairment rating (unless otherwise instructed by the Claim Manager).

You must be familiar with WAC 296-20-340, "Categories for evaluation of permanent impairments of mental health". Please note that the abnormalities (1) are almost all exclusively functional in nature, rather than related to subjective distress, and (2) are not necessarily tied to any DSM diagnoses. "Having" a mental illness would not place a worker in any particular category.

Provide the essential elements of all rating reports:

1) A statement of whether the condition is at MMI, based on the definition in WAC 296-20-01002(3).
2) The history and examination findings to support your conclusion.
3) Diagnostic studies, if symptom scales were tracked.
4) (If at MMI) Consideration of impairment relative to pre-existing psychiatric abnormalities.
    a) If this is a pre-existing mental health condition, are the differences in the adjustment pattern the result of the industrial injury and its sequelae, in the sense they would not have occurred had there not been the industrial condition?
    b) Are the differences in the adjustment pattern permanent?
5) (If at MMI) the proposed impairment rating per WAC 296-20-340.
6) (If at MMI) a rationale for the rating., including specific elements of the categories in WAC 296-20-340, and consideration of other impairment categories.

The worker has previously been rated with **(CM enters prior rating)**. Please take this rating into account when documenting impairment. Refer to the section on "Pre-existing Conditions and Segregation" of the most recent edition of the Medical Examiners' Handbook.

Preparing for Your Mental Health Report - Definitions, WACs, and Background

In preparing your IME report, you must familiarize yourself with important definitions and WACs relevant to Washington State workers' compensation. Definitions in administrative code may not match with those in standard mental health practice or in common usage. Independent medical examinations must follow the definitions in the administrative code. You should cite these WACs explicitly in your report. These include:

- **WAC 296-20-330 – Impairments of mental health.**

Relevance for mental health: This WAC defines mental illness as "malfunction of the psychic apparatus that significantly interferes with ordinary living". This administrative definition of mental health emphasizes impairment in ordinary living. It requires that there be a "malfunction", indicating that normal or predictable reactions to stress would not be considered mental illness.

- **WAC 296-14-300 – Mental condition mental disabilities.**

Claims based on mental conditions or mental disabilities caused by stress do not fall within the definition of an occupational disease in RCW 51.08.140.

This WAC includes examples of mental conditions or mental disabilities caused by stress that do not fall within an occupational disease (https://app.leg.wa.gov/WAC/default.aspx?cite=296-14-300). Examples include:

- Change of employment duties;
- Conflicts with a supervisor;
- Actual or perceived threat of loss of a job, demotion, or disciplinary action;
- Relationships with supervisors, coworkers, or the public;
- Specific or general job dissatisfaction;
- Work load pressures;
- Subjective perceptions of employment conditions or environment;
- Loss of job or demotion for whatever reason;
- Fear of exposure to chemicals, radiation biohazards, or other perceived hazards;
- Objective or subjective stresses of employment;
- Personnel decisions;

This WAC also excludes coverage of disabilities that specify pain primarily as a psychiatric symptom (e.g., somatic symptom disorder) as not related to occupational diseases. This does not apply to industrial injuries.

- **RCW 51.08.140 "Occupational disease"**

"Occupational disease" means such disease or infection as arises naturally and proximately out of employment under the mandatory or elective adoption provisions of this title.

Relevance for mental health: (See WAC 296-14-300)

- **RCW 51.08.100 "Injury"**

A sudden and tangible happening, of a traumatic nature, producing an immediate or prompt result, and occurring from without, and such physical conditions as result therefrom.

Relevance for mental health: This RCW defines what an injury is.

PTSD - Presumptive and Non-Presumptive Occupational Disease

As a general rule, stress related mental health conditions are not covered as occupational diseases. However, there are two different rules where certain occupations in which PTSD is presumptively assumed to be an occupational disease. Firefighters and law enforcement officers may qualify for PTSD

under the presumption statute, RCW 51.32.185 and RCW 51.08.142. Firefighters, and law enforcement officers, may qualify for PTSD as an occupational disease under RCW 51.08.142 if the presumption criteria are not met. Also, the occupation of public safety tele-communicators may qualify for PTSD as an occupational disease under RCW 51.08.142.

Note: These RCWs do not alter the **diagnostic requirements** for PTSD. To apply, they require that the worker "has" PTSD. The presumption of PTSD may be rebutted by a preponderance of evidence including, but not limited to, exposure from other employment or non-employment activities.

- **RCW 51.32.185 Occupational disease** – Presumption of occupational disease for firefighters and fire investigators – Limitations – Exception – Rules – Advisory committee on occupational disease presumptions.

Relevance for mental health: This RCW presumes PTSD to be an occupational disease in firefighters, and law enforcement officers if the presumption criteria are met.

This RCW applies to conditions which developed (manifested) on or after June 7, 2018 (the effective date of the legislation) and after the worker had served for at least 10 years. This may NOT include volunteer work. The worker must have had occupational exposure on or after June 7, 2018 for the presumption to apply.

- **RCW 51.08.142 "Occupational disease"** – Exclusion of mental conditions caused by stress, except for certain firefighters.
  https://app.leg.wa.gov/RCW/default.aspx?cite=51.08.142

Relevance for mental health: This RCW allows for the condition of PTSD as an occupational disease only for those in the occupation of firefighters, law enforcement officers, and public safety telecommunicators.

This RCW directs the Department to adopt a rule that claims based on mental health conditions caused by stress are not occupational diseases (WAC 296-14-300), except for PTSD clams for firefighters, law enforcement officers, and public safety telecommunicators. The statute creates an exception for PTSD directly attributable to disciplinary action, work evaluation, job transfer, layoff, demotion, termination or similar action taken in good faith by an employer.

Treatment

- **WAC 296-20-01002 – Definitions**

Proper and necessary: The department or self-insurer pays for proper and necessary health care services that are related to the diagnosis and treatment of an accepted condition.

Relevance for mental health: Mental health treatment may be clinically indicated by professional or community standards, but not considered proper and necessary by this administrative standard. For instance, significant mental health symptoms may be present, but treatment would be proper and necessary only if the treatment is (1) related to the diagnosis and treatment of an accepted condition, and (2) curative and rehabilitative per the definitions given below.

Curative or rehabilitative: Care must be of a type to cure the effects of a work-related injury or illness, or it must be rehabilitative. Curative treatment produces permanent changes, which eliminate or lessen the clinical effects of an accepted condition. Rehabilitative treatment allows an injured or ill worker to regain functional activity in the presence of an interfering accepted condition. Curative and

rehabilitative care produce long-term changes;

Relevance for mental health: Many mental health conditions involve residual symptoms, for which ongoing treatment may be partially effective, and never produce permanent improvement. For instance, treatment-resistant depression might persist despite multiple treatments, or might improve partially. It is important to consider whether the proposed treatment would produce either permanent curative changes or significant improvements in functioning.

Proper and necessary: (3) The department or self-insurer stops payment for health care services once a worker reaches a state of maximum medical improvement. Maximum medical improvement occurs when no fundamental or marked change in an accepted condition can be expected, with or without treatment. Maximum medical improvement may be present though there may be fluctuations in levels of pain and function. A worker's condition may have reached maximum medical improvement though it might be expected to improve or deteriorate with the passage of time. Once a worker's condition has reached maximum medical improvement, treatment that results only in temporary or transient changes is not proper and necessary. "Maximum medical improvement" is equivalent to "fixed and stable."

Relevance for mental health: Many mental health conditions have a fluctuating or relapsing course. This definition clarifies that maximum medical improvement does not mean either (1) that no more symptoms remain or (2) that no further improvements could be expected. The clinician will need to establish, given each mental health condition, whether permanent and fundamental or marked change would be likely with additional treatment.

- **WAC 296-20-01100(6) - Definitions**

Low quality care: Low quality care in the statewide workers' compensation network is defined as treatments or treatment regimens:

(f) That includes repetitive provision of care that is not curative or rehabilitative per WAC 296-20-01002 for extended periods that does not contribute to recovery, return to work, or claim resolution

Relevance for mental health: For many mental health conditions, ongoing treatment may be clinically indicated even if there are no significant improvements noted across time, and no particular goals besides stability. This would be considered “maintenance,” “preventative”, or “palliative” care. WAC 296-20-01100(6) clarifies that, for departmental purposes, care that is not curative or rehabilitative, and that does not promote functional outcomes, is considered of low quality.

If your examination includes an impairment rating, follow the instructions in the Mental Health Section of the Impairment Rating (chapter 12).

In your discussion with the worker, it is important to note the following guidelines:

- The evaluation report is **not confidential**.
- The purpose of the evaluation is to provide information regarding the worker’s medical/mental condition.
- You will **not** provide medical treatment or advice to the worker.

REQUIRED REPORT ELEMENTS	
1. Identifying Information	■ Name and address, etc. (See Sample Report #1 in Appendix A.)
2. Introduction, Purpose of this Examination and Statement of Non-Confidentiality	■ Explanations you give the worker about the purpose and procedures of the exam; ■ Statement about who accompanied the worker to the site (including name of interpreter, if any) ■ Other pertinent data (See Sample Report #1 in Appendix A.)
3. Record Review (This is a review separate from the worker history.)	Mental health and medical records: ■ Accident report (ROA) (Immediate clinical findings at time of injury). Helpful information includes: description of injury; area of body injured; length of employment; and length of time between the injury and filing of the claim. Review physician and employer portions of ROA. ■ Timing of mental health complaints. Include length of time between the injury and mental health complaints or treatments. (The presence of mental health findings or treatments immediately following the injury may suggest a preexisting condition.) ■ Past medical and mental health history (including mental health history before the date of injury – it may be necessary to request additional records from the Claim Manager. ■ If asked about vocational and physical therapy records, focus on attendance and compliance.
4. History from the Worker	**a) History of the present injury** (how did the injury occur, etc.) **b) Mental health complaint(s**) as related to injury in the worker's own words, including chronic pain ○ Current symptoms with specific examples and how examples affect functioning ○ Have symptoms changed over time? Describe. ○ Current and history of treatment and response **c) Pre-injury functioning** (life and "pattern of adjustment" before and at time of injury – self-care, social interaction, work, etc.) **d) Post-injury functioning** (impact of injury) including life "pattern of adjustment" changes **Other stressors** including medical conditions, psychosocial (relationships, financial, etc.) **e) Worker's Compensation/work history** ○ Brief history of employment ○ Worker's relationship with the employer since the injury ○ Plans for return to work ○ Prior vocational attempts ○ History of other claims **f) Past mental health history**

REQUIRED REPORT ELEMENTS	
	g) Family mental health history **h) Drug and alcohol history** **i) Legal history** **j) Trauma history** (physical and/or sexual abuse; life-changing events; etc.) **k) Medical history** (concurrent; past; relevant childhood history) **l) Social history** ○ Childhood (including physical and/or sexual abuse) ○ Education ○ Relationships, marital status (including abuse) ○ Impact of the injury on daily activities, finances, etc. ○ Has another family member had to assume additional responsibilities? ○ Occupation ○ Military experience ○ Current living situation ○ Other life events that have happened since the time of the injury
5. Mental Health Examination and Testing	**Exam:** General appearance; Demeanor; Eye contact; Psychomotor behavior; Gait; Speech; Mood; Affect; Thought Process; Thought Content; Cognition **Testing:** Interpret previous mental health test results from treating providers. Tests may include WHODAS 2.0, PROMIS 10, Short Form (SF) 36 or SF 12. Neuropsychological testing is not a standard part of a mental health IME. Neuropsychological testing is limited, and may be approved only when requested by a neurologist or physiatrist in order to evaluate the following: 1. Cognitive impairment secondary to a brain injury 2. Tracking progress of treatment in brain rehabilitation (with the exception of self-limited conditions) Additional requirements: 1. Involves specific questions that the testing should answer, focused on treatment planning. 2. Includes validity scales. 3. Administered by a trained neuropsychologist. NOTE: Neuropsychological instruments should not be used as screening tools.

REQUIRED REPORT ELEMENTS	
6. Diagnosis(es) and Findings	This report must contain data that support your diagnoses and conclusions. **Use of DSM-5 criteria is required (effective October 23, 2015)** Include detailed information about symptoms pertinent to the diagnostic criteria for your diagnoses. Also if you have ruled out other doctors' diagnoses, then include the detailed information as to why your opinion differs. Follow the format of the DSM-5 to report your diagnosis. The diagnosis needs to meet DSM-5 criteria for the specific disorder. Discuss your diagnoses for this case, including those findings that support your diagnoses. In a multi-examiner examination, review your diagnoses and recommendations with other examiners. **a)** Accepted conditions (as stated on the assignment letter from the Claim Manager); **b)** Current diagnoses **c)** Basis or rationale for above DSM diagnoses **d)** Pre-existing conditions (based on history and medical record review
7. Discussion, Including Assessment of Work-Relatedness and Pre-Existing Conditions	■ Is the condition diagnosed related to the injury? ■ Are there preexisting conditions? ■ Were the pre-existing conditions aggravated on a temporary basis? ■ Were the pre-existing conditions aggravated on a permanent basis?
As you answer these questions, be sure to apply the criteria that apply to all occupational diseases, as described earlier in Chapter 6. **Stress-related conditions are not allowed as an occupational disease under the Washington Industrial Insurance Act. See RCW and WAC on pages 53-56 of this chapter.**	
8. MMI or Treatment Recommendations	Has the worker reached maximum medical improvement? If yes, please explain. If no, and if you recommend treatment or additional treatment, explain the following completely: ■ If you recommend mental health treatment, would it be curative for a mental health condition, or would it be an aid to recovery from the injuries that have been accepted on the claim? ■ What specific improvements in mental health symptoms and impairments would be expected during treatment?

REQUIRED REPORT ELEMENTS	
	■ If there has been previous mental health treatment, how would additional treatment produce marked or fundamental changes in the condition? ■ How long will the mental health treatment take? (Do not write that it should last "at least" a certain amount of time, as this is not useful for administrative or clinical purposes.) ■ Do you recommend medication and/or other mental health treatment? ■ What barriers would prevent or delay successful treatment?
9. Impairment Rating	If asked to provide an impairment rating, first determine if the worker is at MMI with respect to the mental health condition which has been accepted on this claim. If the worker is not at MMI for the accepted mental health condition, do not provide an impairment rating (unless otherwise instructed by the Claim Manager). If the worker is at MMI, provide the 5 essential elements of all rating reports. **1) MMI** **2) Examination findings (describe your own observations of behavior and function, as well as symptoms reported by the worker – note discrepancies)** **3) Diagnostic studies (if any)** **4) Rating per WAC 296-20-340.** **5) Rationale** **Effects of preexisting mental health conditions** Answer the following 3 questions (WAC 296-20-330). Are the differences in adjustment patterns before and after the industrial condition (on a more-probable-than-not basis): **1)** The result of the industrial condition and its sequelae, in the sense they would not have occurred had there not been the industrial condition? **2)** Permanent? **3)** More than the normal, self-correcting and expectable response to the stress of the industrial condition?
10. Answers to Specific Questions from the Claim Manager	If the Claim Manager asks about any specific issues, please be sure to answer them in your report. In particular, if asked, address the issues below:

REQUIRED REPORT ELEMENTS	
	a) Ability to work: Are there any restrictions relating to the accepted mental health condition that prevent this worker from returning to work? If so, what are they? In addition, include your assessment of whether the worker can: 1) Maintain focus on work? 2) Understand and follow work rules and instructions? 3) Be aware of and follow safety precautions? 4) Work with or near other workers? 5) Keep emotions under control? 6) Interact with public and customers? **b) Job analyses**: You may be asked to approve one or more job analyses and/or suggest modifications. Your recommendation on the job analysis should be limited to the mental health conditions accepted on the claim.

CHAPTER 8

Vocational Issues & Physical Restrictions

Only address physical restrictions, job analyses (JA), and other vocational issues, if specifically requested by the claim manager in the IME assignment letter.

Clear information about the worker's current physical or mental capabilities is vital to include in your IME report. We need this information in order to decide the vocational issues of a claim. All providers participating on a panel examination must review or comment on JAs.

For administrative and legal reasons, we request that you not give opinions regarding transferable skills, education, or labor market, etc. A vocational professional does this assessment. We also request that you not make a direct statement that a person is totally and permanently disabled. Please objectively describe those limitations that may be barriers to returning to work.

Avoid using the word "retraining" in your recommendation. The term "retraining" has a specific legal and administrative meaning that limits which workers are eligible for these services. You and the claim manager may not be using the same definition. A worker who hears your recommendation for "retraining" may become frustrated or angry if the claim manager cannot meet the worker's expectations. **If you have questions about job requirements (e.g., workplace modification or job analyses), contact the claim manager.**

Job Analyses and/or Job Descriptions

Job analyses (JA) or job descriptions (JD) should be included with the IME assignment letter. If not, the JA or JD should be provided at least five working days before the examination. Claim managers may fax JAs or JDs to the panels. You will not be required to review documents received after five days. If the CM needs your comments after the examination, an addendum request will be made.

The JA or JD should provide detailed information regarding specific physical demands and environmental conditions required for a job.

IMPORTANTS NOTE: Only examiners in Approved status can accept or conduct exams, addendums, and/or review JAs and JDs unless prior written approval have been obtained. However participating in depositions and testimonies is still required while in any status.

Job Analysis

A registered vocational rehabilitation counselor specifically develops a job analysis. These job analyses appear similar to job descriptions and may be presented in a variety of formats. It is a detailed evaluation of a specific job or type of job per WAC 296-19A-170.

You will be asked to review a maximum of four job analyses, although more may be sent in complex cases if authorized by the claim manager. If you feel that you are being asked to review unnecessary job analyses, discuss your concerns with the claim manager who requested the IME.

Definition of allowed number of JAs and reimbursement to providers for review may be found in Chapter 27 Reports and Forms of the Medical Aid Rules and Fee Schedules.

Job Description

A job description is a written description of a job by the employer that is available to the worker.

- Employers use no standard format.
- Is typically for the worker's job of injury or an alternative job available to the worker
- May identify potential modifications to the job of injury
- Should include a summary of job duties/tasks, equipment and tools used, and a description of specific physical demands
- May be part of a Job Offer Letter

Reviewing a Job Analysis or Job Description

Review and report on job analysis (JA) and job descriptions in the same way.

During the review, please focus your attention only on the physical and/or mental demands of the job. Considering your specialty please answer the following question in your JA response: "Can the patient physically and/or mentally perform the tasks as described?" If not, state the objective evidence to support your conclusion.

Do not consider wages, personal issues, or employability.

When you approve the JA or job description, you are approving the maximum physical requirements of the job—not the minimum.

Your conclusions about the worker's ability to perform physical demands must be consistent with the JAs or job description, Doctor's Estimate of Physical Capacity form (PCE), and any physical restrictions contained in your IME report.

The job analysis(es) or job description(s) sent with the IME assignment letter must be completed and submitted with the IME report.

Addressing Current Physical Capabilities

In assessing physical restrictions, consider the effects of the injury and any restrictions due to preexisting conditions as those restrictions existed at the time of injury. You must clearly state in your report if the worker has:

- Unique limitations from the injury,
- A preexisting unrelated condition that has progressed since the date of injury,
- Restrictions due to post injury progression of a pre-existing condition.

For example, a worker may be able to perform work at the medium level, considering an accepted knee injury, but the worker's preexisting unrelated cervical degenerative disc disease has progressed post-injury and cervical spinal stenosis is now limiting the worker to sedentary work.

State what conditions cause the restrictions. These conditions can include the following:

- Accepted conditions,
- Preexisting conditions and/or
- Conditions that occurred after the industrial injury (post-injury).

For example, if a worker has an accepted back injury, he or she may be able to perform light work. The worker's cardiac condition, however, may prevent his or her return to work at this level.

Both temporary and permanent restrictions should:

- Have a reasonable medical basis with objective findings to support the restrictions
- Be based on diagnoses given in your report

Differentiating between "permanent" and "temporary": If physical restrictions are temporary or time limited, label clearly. Also give an estimate of how long the temporary restrictions will last. For example, you might state: "Avoid heavy lifting for three months"; or "Increase activity level over the next six weeks." Keep permanent restrictions consistent with your medical examination.

Completing your report

The IME report content described in Sample Report # 1 in Appendix A, includes one element called "Physical Restrictions" which relates to vocational issues.

Current physical capabilities can be addressed by:

- Review and comment on job analysis or job description,
- Review and comment on a Functional Capacity Evaluation (FCE), or
- Completion of the form "IME Doctor's Estimate of Physical Capacities (PCE) form. This form may be photocopied.

Sometimes you may not be able to address the work restrictions completely. If you can't, simply explain why or advise what information you need to help you address the restrictions. Here are some examples:

- You may not be able to predict the course of illness or recovery adequately.
- You may be evaluating the worker because of your special expertise in a particular body system. For example, an IME dentist may not have the expertise needed to give an opinion about ability to work.
- You are missing a specific medical document such as a functional capacity evaluation report

You should specify restrictions in your IME report, see sample report #1 in Appendix A. Also, see Appendix A for a description of physical demands and environmental conditions.

Time Definitions	
Seldom	1 – 10%, 0 – 1 Hour
Occasional	11 – 33%, 1 – 3 Hours
Frequent	34 – 66%, 3 – 6 Hours
Constant	67 – 100%, Not Restricted

DOSH Lifting Calculator: https://lni.wa.gov/safety-health/preventing-injuries-illnesses/sprains-strains/evaluation-tools

Washington State Department of
Labor & Industries
Workers' Compensation Services

Weights of Common Items

2 lbs. — Hammer

3 lbs. — Toaster

4 lbs. — Traffic cone

4.5 lbs. — Two quarts of juice

5 lbs. — Two liter bottle of pop

5 lbs. — Drill

5 lbs. — Ream of letter-size paper

7 lbs. — Grass trimmer

8 lbs. — Bag of charcoal

9 lbs. — One gallon of milk

9 lbs. — 2'x4' stud (8')

10 lbs. — Metal folding chair

10 lbs. — Blower (gas)

12 lbs. — Heavy electric guitar

16 lbs. — Five-gallon shrub (dry)

17 lbs. — Infant (4 months)

20 lbs. — Thanksgiving turkey

25 lbs. — Aluminum ladder

25 lbs. — Fertilizer

26–28 lbs. — Toddler (2 years)

30 lbs. — Kitty litter

30 lbs. — Metal hand cart

36 lbs. — Child (4 years)

47 lbs. — Water tank jug

50 lbs. — Dog food

65 lbs. — Five gallons of paint

Upon request, foreign language support and formats for persons with disabilities are available. Call 1-800-547-8367. TDD users, call 711. L&I is an equal opportunity employer.

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Washington State Department of Labor & Industries

Job Analysis

Physician Billing Codes
Summary included in JA Review:
1038M — Limit one per day
1028M — Additional review, up to 5 per worker per day

Vocational Firm:	Worker Name:
Address:	Claim Number:
	Job Title:
	DOT Number:
Phone Number:	Involved Body Part(s):
☐ Job of Injury ☐ Light Duty Position ☐ Direct/Transferable Skills Position ☐ Training Goal	

Job Title:	DOT Title:
SVP:	DOT Number:
SOC:	Type of Industry:

Analyst:	Source:
Assigned VRC:	Contact Name and Title:
Date:	Contact Phone Number:

Type of Analysis: ☐ On-Site ☐ Interview ☐ Representative
Essential Functions: 1. 2. 3. 4.
Job Qualifications and Skills:
Machines, Tools, Special Equipment, Personal Protective Equipment Used:

Worker Name:	Claim Number:	Job Title:

Physical Requirements		
Frequency Scale	**Strength**	**Work Pattern**
N = Never	☐ Sedentary	☐ Full-Time
S = Seldom (1% — 10%; up to 1 hour)	☐ Light	☐ Part-Time
O = Occasional (11% — 33%; 1 — 3 hours)	☐ Medium	☐ Seasonal
F = Frequent (34% — 66%; 3 — 6 hours)	☐ Heavy	Hours Per Day
C = Constant (67% — 100%; Not Restricted)	☐ Very Heavy	Days Per Week

Job Demand		**Frequency**					**Activity Description**
	% Time	**N**	**S**	**O**	**F**	**C**	
Sitting		☐	☐	☐	☐	☐	
Standing		☐	☐	☐	☐	☐	
Walking		☐	☐	☐	☐	☐	

Job Demand	**Frequency & Weight**					**Activity Description**
	N	**S**	**O**	**F**	**C**	
Lifting Floor — Waist	☐	lbs.	lbs.	lbs.	lbs.	
Lifting Waist — Shoulder	☐	lbs.	lbs.	lbs.	lbs.	
Lifting Shoulder — Overhead	☐	lbs.	lbs.	lbs.	lbs.	
Carry Distance/Surface	☐	lbs.	lbs.	lbs.	lbs.	
Pushing/Pulling Distance/Surface	☐	lbs.	lbs.	lbs.	lbs.	

Job Demand	**Frequency**					**Activity Description**
	N	**S**	**O**	**F**	**C**	
Perform Work on Ladders	☐	☐	☐	☐	☐	
Climb Stairs	☐	☐	☐	☐	☐	
Twisting at Neck	☐	☐	☐	☐	☐	
Twisting at Waist	☐	☐	☐	☐	☐	
Stooping/Bending	☐	☐	☐	☐	☐	
Squatting/Kneeling	☐	☐	☐	☐	☐	
Crawling	☐	☐	☐	☐	☐	

Job Demand (**L**eft/**R**ight/**B**oth)	**Frequency**					**Activity Description**
	N	**S**	**O**	**F**	**C**	
Reach Waist to Shoulder	☐					
Work Above Shoulder	☐					
Keyboarding	☐					
Wrist Flexion/Extension	☐					
Handle/Grasp	☐					
Forceful Grasp	☐					
Fine Finger Manipulation	☐					
Hand Controls	☐					
Foot Controls	☐					
Repetitive Motion	☐					
Vibratory Tasks — High	☐					
Vibratory Task — Low	☐					

Worker Name:	Claim Number:	Job Title:

Job Demand	Frequency					Activity Description
	N	S	O	F	C	
Talking	☐	☐	☐	☐	☐	
Hearing	☐	☐	☐	☐	☐	
Visual — Near Acuity	☐	☐	☐	☐	☐	
Visual — Far Acuity	☐	☐	☐	☐	☐	
Visual — Depth Perception	☐	☐	☐	☐	☐	
Visual — Color Discrimination	☐	☐	☐	☐	☐	
Visual — Accommodation	☐	☐	☐	☐	☐	
Visual — Field of Vision	☐	☐	☐	☐	☐	

Environmental Conditions	Frequency					Activity Description
	N	S	O	F	C	
Exposure to Weather	☐	☐	☐	☐	☐	
Extreme Cold	☐	☐	☐	☐	☐	
Extreme Hot	☐	☐	☐	☐	☐	
Wet and/or Humidity	☐	☐	☐	☐	☐	
Proximity to Moving Mechanical Parts	☐	☐	☐	☐	☐	
Exposure to Explosives	☐	☐	☐	☐	☐	
Noise Intensity (see scale below)						
1 = Very Quiet 2 = Quiet			3 = Moderate			4 = Loud 5 = Very Loud
Atmospheric Conditions	☐	☐	☐	☐	☐	
Exposed Heights	☐	☐	☐	☐	☐	
Exposure to Electricity	☐	☐	☐	☐	☐	
Exposure to Toxic/Caustic Chemicals	☐	☐	☐	☐	☐	
Exposure to Radiation	☐	☐	☐	☐	☐	
Other:						

Analyst's Comments:

Possible Employer Modifications:

Note:
The information for this job analysis was gathered by either on-site observation, interview, and/or is representative of the labor market as indicated on page one. Additional data may have been obtained from standardized industry resources such as the DOT, GOE, COJ, OOH, WOIS, and O-NET. On occasion, practicality and feasibility prevent direct observation and/or gathering of objective, quantifiable data. For this reason, a "best estimate" may have been used.

Analyst:		**Presenting VRC:**	
Vocational Consultant	Date	Vocational Consultant	Date
Employer Verification:		**Worker Verification:** (Optional) -	
Name	Date	Name	Date

Worker Name:	Claim Number:	Job Title:

Medical Provider

☐ I agree that the above named worker can perform the physical activities described in this job analysis and return to work.

State the date worker is released to return to work if different from today's date: _____

☐ I agree the above named worker can perform the described job but only with modifications as described below.

Comments:

Modifications noted above are needed on a:
☐ permanent basis.
☐ temporary basis.

☐ The above named worker ***temporarily*** can't perform this job based on the following physical limitations:

Anticipated release date: _____

Treatment plan: _____

☐ The above named worker is ***permanently*** restricted from performing the physical activities described in this job analysis based on the following physical limitation:

(State objective medical findings:)

☐ Restriction based on accepted conditions on claim.

☐ Restriction based on unaccepted conditions on claim.

Print Name	Signature	Date

☐ Attending Physician ☐ Consulting Physician ☐ Pain Program Physician
☐ IME Physician ☐ FCE Therapist ☐ OT/PT Therapist

CHAPTER 9

Providing Testimony

Providing testimony is an important part of the IME process. While you may not be asked to testify on each medical exam you perform, when you are asked to testify your testimony can be critical to the protest or appeal under consideration. When testimony is needed in a matter, an examiner is often one of the few doctors who have seen a worker and their examination of the patient, review of the patient's history, and expertise make them integral to the appeals process.

Examiner Responsibility

When you sign the application to become an IME provider, you agree to perform the exams as well as be reasonably available to testify, if needed. Your payment for an IME compensates you for the detailed nature of your examination and report, the complexity of the questions you must address, and your willingness to testify at some time in the future.

When performing the IME, you are determining clinical observations and conclusions in the claim at a point in time. All parties can then use this information. You may be called as a witness for L&I, State-Fund employer, Self-Insured employer or their representative, the worker, or by any combination of these.

Examiners who travel to conduct exams in Washington must be willing and able to return to testify in person if called to do so.

WAC 296-23-387

What are the responsibilities of an independent medical examination (IME) provider regarding testimony?

IME providers must make themselves reasonably available to testify at the board of industrial insurance appeals (board) or by deposition. Reasonably available to all parties means cooperating in the timely scheduling of the pretestimony conference and testimony and being available to testify during business hours (7:00 a.m. to 6:00 p.m.) as ordered by the judge and within the dates ordered by the board to complete testimony, unless a different time is needed and agreed upon by all parties. In signing the application to be an independent medical examination provider, the provider agrees to perform examinations and be available to testify and to answer questions about the medical facts of the case at rates established under the authority of Washington industrial insurance law. The department may fine the firm and/or examiner up to five hundred dollars per violation for failure to comply with these requirements, whether the failure was intentional or not.

In addition, failure to comply with these requirements may result in suspension or termination of the IME provider number.

If you are unwilling or unable to testify or make yourself reasonably available, you must decline to perform examinations. Realize that only a small portion of claims involving IMEs go before the Board

of Industrial Insurance Appeals (BIIA). Appearances before the BIIA are an important part of the services you provide to workers, employers and L&I.

Deposition or Live Testimony

The parties attend a scheduling conference that establishes important dates and rules for that case. These can include dates of hearings, whether depositions can be taken, dates by which depositions must be taken, and whether witnesses can appear by phone or video.

The ability to take testimony by telephone or video is in the discretion of the judge. Medical testimony is preferred to be taken in person and in-person testimony may be required.

WAC 263-12-117(2)

2. **Deposition format:** When testimony is taken by perpetuation deposition, a party or witness, representative, or other participant may participate, and testimony may be presented, in person or by contemporaneous transmission from a different location (telephone or video) if all parties agree. If there is no agreement, the industrial appeals judge may consider the following nonexclusive factors when determining the format by which participation occurs:

    • The need of a party to observe a witness's demeanor.

    • Difficulty in handling documents and exhibits.

    • The number of parties participating in the deposition.

    • Whether any of the testimony will need to be interpreted.

    • Ability of the witness to travel.

    • Availability of quality telecommunications equipment and service.

If a perpetuation deposition is taken by telephone or video, the court reporter transcribing the deposition is authorized to swear in the deponent, regardless of the deponent's location within or outside the state of Washington.

If all of the other parties are represented by attorneys, judges will generally allow experts to be deposed instead of having to appear in person at a hearing. Depositions differ from hearings because there is no judge presiding over the proceeding.

An IME examiner who has been contacted to testify should respond to all requests for testimony in a prompt manner. The BIIA has subpoena power to require your attendance if scheduling of testimony becomes too difficult. Generally, the party requesting testimony will send a copy of your IME report and additional documents they wish you to review. If you need additional information, documents, or need more time to complete your review, contact the party who requested your service.

Fee Schedule for Testimony

If you are required to testify, you will be paid separately for those services. You will need to discuss fees and billing requirements with the party requesting your testimony. Be aware that requests for a non-refundable amount will be denied and state agencies are prohibited from prepaying for any service. Any exceptions to the fee schedule will be considered on a case-by-case basis. The payment policy and fee schedule for providing testimony is contained in Chapter 15, Medical Testimony in the Medical Aid Rules and Fee Schedule. Please see the current fee schedule for any revisions or updates.

Appeal Process

The table below presents an overview of the appeal process, from the BIIA to the Washington State Supreme Court. The information is provided to help you understand the complexity of the legal processes affecting your work in the industrial insurance system. Your involvement is most likely to be at the BIIA level.

For more information about the BIIA call 360-753-6823 or visit their website at https://biia.wa.gov/.

L&I APPEAL PROCESS OVERVIEW

Level of Appeal	What Can be Appealed to this Tribunal?	What types of Information Are Considered on this Appeal?	What Are the Possible Outcomes?
Board of Industrial Insurance Appeals	All decisions, awards, and orders issued by the department can be appealed to the Board.	Both parties introduce evidence relevant to the appeal. This includes depositions or in-person testimony of medical and lay witnesses. The BIIA does not receive the department claim file, but parties may introduce information from the file as evidence.	The BIIA will issue an order accepting or denying the appeal. The appealing party may voluntarily dismiss the appeal, or the parties may settle the case. If the case proceeds to hearing, the Industrial Appeals Judge will issue a proposed order either affirming, reversing or modifying the department order. This order will become a final order if a party does not file a Petition for Review challenging the decision.

Level of Appeal	What Can be Appealed to this Tribunal?	What types of Information Are Considered on this Appeal?	What Are the Possible Outcomes?
			Any party may file a petition for review. In that case, the BIIA will review the proposed decision and order, and issue a final order which can be appealed.
Superior Court	Any party may appeal a Board order to the Superior Court; however, the department may only appeal board orders on disputed issues of law.	The record created at the Board, including transcripts of testimony, will be read to the court. No new testimony or exhibits are permitted.	The Superior Court will affirm or reverse the Board order.
Court of Appeals	Any party may appeal a superior court decision to the Court of Appeals.	The Court of Appeals defers to the fact finding at Superior Court but reviews the decision to make sure substantial evidence supports it.	The Court of Appeals may affirm, reverse, or modify the Superior Court order. A published decision (that is not appealed to the Supreme Court) creates case law that must be followed by Washington Superior Courts and administrative tribunals.
Supreme Court	The Supreme Court will consider appeals, generally from the Court of Appeals, and determine whether to take review.	The Supreme Court considers the same evidence as the Court of Appeals.	The Supreme Court may affirm, reverse or modify the Court of Appeals decision. Supreme Court decisions create case law that must be followed by all Washington courts and administrative tribunals.

CHAPTER 10

Complaints about the Independent Medical Exam

Complaints or Comments about an IME

Complaints about IMEs are received from different sources, such as the injured worker, their attorney, internal staff, providers, and others. Regardless of who sends the complaint or whether the complaint was about a state fund or self-insured IME, each complaint is reviewed and appropriate action is taken as necessary. The number and type of complaints are tracked and monitored by Provider Quality and Compliance (PQC). IME Complaints can be emailed to IMEcomplaints@lni.wa.gov.

Complaints about IMEs related to discrimination and/or denial of equitable access are referred to the Civil Rights Program at CivilRights@Lni.wa.gov for investigation and tracking. These complaints are based on race, national origin, skin color, language, sex, gender, religion, age, disability, or other protected class.

Types of Complaints

Worker complaints:
Worker complaints about an examiner's conduct during an IME may be sent to the examiner for review and response. Based on the nature of the complaint, we may refer a complaint to the Department of Health. (WAC 296-23-372) Complaints alleging physician malpractice, substance abuse, or sexually inappropriate conduct are forwarded to the appropriate section of the Department of Health.

Worker complaints about discrimination and/or denial of equitable access are referred to the Civil Rights Program at L&I for investigation. Civil Rights investigators may contact you for review and response of the complaint allegations filed against them.

Worker complaints about the outcome of the IME report are not sent to the doctor for response. Complaints of this nature are claim management issues. The claim manager may follow up for clarification or additional information.

Claim staff complaints:
If we receive complaints about poor report quality or late reports, the Department may review your reports and contact you for remedial action. The department bases its review on the quality of the examination and report, not on whether your recommendations are perceived as favorable or unfavorable to the parties involved.

Other types of complaints:
Other types of complaints are reviewed and evaluated based on their merit and whether appropriate action should be taken. This action could range from no action to suspension or termination of the IME provider number.

Possible Department Actions

The department could suspend or terminate your IME provider number if a consistent pattern of complaints develops, as illustrated in the following examples:

- Substantiated worker complaints or patterns of complaints, such as discrimination, denial of equitable access, language access, accessibility, rudeness, lack of respect, unprofessional behavior;
- Poor examination and substandard report quality;
- Untimely reports;
- Action taken by the Department of Health against your license to practice; or
- Unavailability or unwillingness to testify or inability to support your opinions in any legal proceeding as evidenced by board decisions finding the testimony less credible.

You can find a complete list of reasons for suspension or termination in WAC 296-23-337. The above list contains only a few of the reasons for termination as an approved IME examiner.

If the department suspends or terminates your IME provider number, you will receive no further IME referrals until you are returned to active status.

CHAPTER 11

Impairment Rating- General Information

The Difference Between "impairment" and "disability," and Why it is Important

"Impairment" is anatomic or functional abnormality or loss of function after maximum medical improvement has been achieved, as stated in WAC 296-20-200 (4) "Disability" means the inability to perform a specific task or job.

For example, if a classical pianist and a truck driver both lose the same finger, both have the same impairment and receive the same award amount. However, their disabilities may be different: the truck driver may be able to continue performing the job, while the pianist may not.

This distinction is important because state law requires that awards be based on impairment, not on disability.

Is an IME the Same as an Impairment Rating Examination?

No. IMEs and impairment rating exams are not synonymous. A rating exam may be part of an IME or a consultation. It may also be part of an office visit to the attending provider. The department or self-insurer may request an IME for various reasons. Most IMEs involve performing impairment ratings. See Chapter 13 for billing information and how to bill for an impairment rating by attending provider or consultant.

IMEs establish medical facts about an injured worker's physical and/or mental condition so that the department or self-insurer can give appropriate assistance to the worker and can make fair administrative decisions about the claim.

Who May Rate Impairment?

IME examiners: Any doctor who is an L&I-approved IME examiner may do rating exams as part of an IME if requested by the Claim Manager. Ratings by IME examiners must be accompanied by an IME report described in **Appendix A, Sample Report 1**. If you are asked to perform a "rating only IME," use **Sample Report 2**.

Attending providers: Attending providers may be asked by the Claim Manager to rate impairment for their own patients. Rating reports (see Appendix A, Sample Report 3) are shorter than IME reports, since ratings are just one of many elements in an IME. Be sure to use and include the rating worksheets with your report.

Doctors licensed in medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, and dentistry may conduct these exams on their own patients. Chiropractors who are approved IME examiners may also conduct these exams on their own patients if requested by a Claim Manager (WAC 296-20-2010).

If the attending provider does not wish to rate his/her own patient, the department encourages him/her to ask a consultant to perform the rating exam. (See "Consultants" below.) In the terminology of the department, consultations are different from IMEs. One difference is that the examiner in an IME is generally chosen by the department or self-insured employer, while a consultant is generally chosen by the attending provider.

If you need assistance in selecting a consulting doctor, names of approved IME examiners may be found on the web at https://secure.lni.wa.gov/imelookup/ (FAME). If more than one specialty is needed to evaluate the impairment, notify the Claim Manager so the option of an IME can be considered.

Consultants for rating impairment: Consultants must be familiar with the *Medical Examiners' Handbook* and follow its standards and guidelines and provide an impairment rating report as described in **Appendix A, Sample Report 2**. Be sure to include the rating worksheet. Doctors performing consultations involving a rating of permanent impairment may use the billing codes for consultant ratings. If you are a consultant and become an approved IME examiner, you do NOT need to be affiliated with an IME panel, and you are NOT obligated to accept referrals for IMEs.

Limited license providers: Limited license providers (for example, dentists, podiatrists, and chiropractors) may only provide ratings for regions or conditions within their scope of practice. Chiropractors must be approved IME examiners.

When to Rate Impairment

When the worker's industrial injury or disease has reached maximum medical improvement (fixed and stable), the Claim Manager may ask you to rate the accepted condition. If the worker's condition is not at MMI, the worker's impairment should not be rated unless you have special instructions from the Claim Manager. Please see Chapter 4 for the definition of MMI.

The Five Required Components of ALL Impairment Reports

Depending on the circumstances, an impairment rating may be performed by an attending provider, an IME examiner or a consultant. In the context of an IME, the rating is often just one of many elements of a full IME report. When performed by an attending provider, the rating report may be a stand-alone report or may be part of a chart note, a closing report or other types of reports.

Regardless of who performs it, reports on impairment rating MUST contain ALL of the following five sections:

1) **MMI**: A statement that the patient has reached maximum medical improvement (MMI) and that no further curative treatment is recommended for the accepted condition.
2) **Examination**: Pertinent details of the physical or mental health examination performed (both positive and negative findings)
3) **Diagnostic tests**: Pertinent results of any diagnostic tests performed (both positive and negative). Include copies of pertinent tests ordered as part of the exam.
4) **Rating**: An impairment rating consistent with the findings and a statement of the system on which the rating was based (Washington State Category Rating System, the *AMA Guides*, etc.)
5) **Rationale**: The rationale for the rating system is one of the most important parts of the rating report. The rationale must be supported by specific references to the clinical findings, especially

objective findings and supporting documentation, including the specific rating system, tables, figures and page numbers on which the rating was based. The rationale must restate all objective findings. (WAC 296-20-2010 & WAC 296-23-377)

IMPORTANT NOTE: Worksheets are required for rating impairment for the following:
Upper Extremities: Pages 436-437, *AMA Guides to the Evaluation of Permanent Impairment, 5th Edition* (pages 163-164 of Medical Examiners' Handbook).
Hearing: Page 111-112 of Medical Examiners' Handbook.

IMPORTANT NOTE: Even if you conclude that there is no impairment, it is still required that you document your rationale for arriving at that conclusion, including all 5 elements above. This is critical because Claim Managers need this information well-documented in the event workers request to re-open a closed claim.

Medical Judgment in the Rating Process

Most of the information in this handbook constitutes guidelines on how to rate impairment. Guidelines are NOT hard and fast rules. Sound medical judgment plays an important part in the process of rating impairment. Both the Category Rating System and the *American Medical Association Guides to the Evaluation of Permanent Impairment* (the two rating systems most commonly used in Washington state workers' compensation) emphasize the importance of medical judgment in this area.

At the same time, you should base your conclusions on objective findings, and you should state your rationale clearly.

For example, if your impairment rating is more or less than the rating specified in the *AMA Guides*, it is extremely important to explain in detail your rationale and methods for reaching your conclusion.

Objective Findings in the Rating Process for Physical and Mental Health Impairment

An impairment rating must be supported at least in part by objective findings (*Cooper v. Department, 1944*). Objective findings are those findings on examination that are "independent of voluntary action and can be seen, felt, or consistently measured by examiners" (WAC 296-20-220[i]).

Mental health impairments do not require the same extent of objective findings as do physical injuries (*Price v. Department, 1984*). You must document objective observations and other findings. See Chapter 7 for details on a mental health IME report.

What Rating Systems Should I Use?

Four rating systems are generally used to rate impairment in Washington State Workers' Compensation. The use of these four systems is restricted to certain conditions by law, as described below and summarized in Table 2 based on WAC 296-20-2015.

Injuries before 1974 and conditions not otherwise addressed are dealt with differently. You should also be aware of special considerations regarding impairment due to pain. (These topics are discussed further later in the chapter.)

Table 2: Overview of Systems for Rating Impairment

Rating System	Used for these Conditions	Form of the Rating
1. Category Rating System (Washington State)	Spine, neurologic system, mental health, respiratory, taste & smell, speech, skin, and disorders affecting other internal organs	Select the category that most accurately indicates overall impairment
2. *AMA Guides* *RCW 51.32.080* *RCW 51.36.020(2)*	Loss of function of extremities, partial loss of vision and hearing	Determine the percentage of loss of function, as compared to amputation value listed in RCW 51.32.080
3. RCW 51.32.080 (see next section)	Specified disabilities: loss by amputation, total loss of vision and hearing	Supply the level of amputation or total loss
4. Total Bodily Impairment (TBI)	Impairments not addressed by any of the rating systems above	Supply the percentage of TBI. (**Note: This is an unusual situation**.)

1. Washington State Category Rating System.

To rate impairment resulting from back disorders, mental health disorders, seizure disorders, respiratory disorders and other disorders affecting the internal organs, you **must use** the Washington State Category Rating System. The intent of the Category Rating System is to reduce litigation and to establish more uniformity in the rating of unspecified permanent partial impairment. The category rules do not allow you to express a rating as a percentage.

Chapter 12 presents details about the Category Rating System for the spine, respiratory system, and all other systems included. For most body systems, the Category Rating System is expected to be self-explanatory. Since the creation of the Category Rating System in 1974, doctors have been expected to read the statutes and regulations (RCWs and WACs) and figure out the rating on their own. Here are a few points that may help to understand how to use this system:

Flexibility of the Category Rating System: In many cases, there are bound to be reasonable differences in how clinicians interpret findings. Sound medical judgment will play an important role. Doctors should understand that there is considerable flexibility in the Category Rating System. It is not necessary for doctors to be unduly rigid in interpreting the regulations (WACs) or the guidelines presented in this guide.

If the worker seems to fit more than one category: The department recognizes there are situations where a patient's findings may be found in more than one category. Except for pelvis, taste and smell, the doctor should select the ONE category which most closely describes the patient's condition. The doctor SHOULD NOT "split" categories. For example, the doctor should NOT give a rating of Category 2.5 if the patient seems to be between a Category 2 and a Category 3. Medical judgment should be used to select the best category, as described above.

RCWs and WACs: Doctors who are interested in having a detailed understanding of the Category Rating System may wish to read the full text of the statutes and regulations pertaining to this topic (Appendix C).

2. *American Medical Association Guides to the Evaluation of Permanent Impairment* (*AMA Guides*).
If the injury or occupational disease is not included in the Category Rating System and is not an amputation or total loss of vision or hearing (as described in #3, "RCW 51.32.080" below), then you rate the impairment as a percentage, using the *American Medical Association Guides to the Evaluation of Permanent Impairment,* Fifth Edition.

Washington State has specific rules for Washington state workers' compensation regarding the use of *AMA Guides*. For example, you should be familiar with the WACs that deal with the question "To what extent is pain considered in an award for permanent partial disability?" This issue is addressed in WAC 296-20-19030. Similarly, you must be familiar with proper use of the *AMA Guides* for rating extremities, vision and hearing, and all parts of this handbook pertaining to impairment rating, including but not limited to chapter 12.

The *AMA Guides* is available from the Order Department, *American Medical Association*, PO Box 109050, Chicago, Illinois 60610-9050; 1-800-621-8335 or 312-464-5651.

3. RCW 51.32.080.
This system is used for disabilities specified in RCW 51.32.080, namely: loss by amputation; loss of one eye by enucleation; loss of central visual acuity in one eye; complete loss of hearing in both ears; complete loss of hearing in one ear. For these impairments, rate by indicating the disability specified in RCW 51.32.080 it most closely resembles or approximates in degree of disability. The term "specified disabilities" refers to disabilities that are listed in that RCW.

4. Rating other impairments.
There are unusual circumstances in which the rating may need to be stated as a percentage of total bodily impairment. The *AMA*'s *Guides*, Fifth Edition, should be used in making this determination.

Table 3: WHICH RATING SYSTEM TO USE

(for claims date of injury after October 1, 1974)

ORGAN SYSTEM, BODY PART OR TYPE OF INJURY	RATING SYSTEM	SEE PAGE IN THIS BOOK:
Amputation	Specified in RCW	103-107
Back (Cervical, Thoracic, Lumbo-Sacral)	Category Rating System	87-97
Cardiac	Category Rating System	99
Cognitive Impairment	*AMA Guides*	113
Convulsive Neurologic Disorders (Seizures, Epilepsy)	Category Rating System	99-100
Dental, tooth loss	Contact Claim Manager	100
Digestive Tract	Category Rating System	101-103
Extremities (upper and lower)	*AMA Guides*	103-107
Hearing * Total loss * Partial loss	Specified in RCW *AMA Guides*	108-112
Hernia, (Inguinal, Umbilical etc.)	*AMA Guides*	113
Mental Health	Category Rating System	113-118
Pelvis	Category Rating System	98
Respiratory * Air Passages ** Chronic Sinusitis	Category Rating System *Category Rating System ***AMA Guides*	118-125
Skin	Category Rating System	126-127
Speech	Category Rating System	128

ORGAN SYSTEM, BODY PART OR TYPE OF INJURY	RATING SYSTEM	SEE PAGE IN THIS BOOK:
Taste and Smell	Category Rating System	129
Urinary and Reproductive System Urinary System Upper Urinary Tract Urinary Diversion Bladder Male Reproductive Organs *Penis, Scrotum, Epididymides, Spermatic Cords, Prostate and Seminal Vesicles Testicular **Female Reproductive Organs	Category Rating System *AMA Guides* Category Rating System ***AMA Guides*	129-132
Vascular	*AMA Guides*	132
Visual System * Enucleation ** Total loss *** Partial loss	*Specified in RCW **Specified in RCW ****AMA Guides*	133-139
Others not listed above	Total bodily impairment	81-82

How are Injuries Prior to October 1974 Handled?

Injuries between 1971 and 1974: Injuries or exposure occurring on or after July 1, 1971, but before October 1, 1974, are rated as a percentage of total bodily impairment, but do not use the Category Rating System.

The percentage rating that you provide should reflect how the impairment affects the function of the person, as a whole, in the ordinary pursuits of life. This is described as a percentage of total bodily impairment. The edition of the *AMA Guides* designated by the department may be helpful in making this determination. (Currently the department has designated the Fifth Edition)

Injuries prior to 1971: For an injury or exposure that occurred prior to July 1, 1971, you should rate impairments to extremities, hearing loss and vision impairment in terms of percentage of loss of function of that area of the body. Use the edition of the *AMA Guides* designated by the department to rate theses impairments. (Currently the department has designated the Fifth Edition)

For all other impairments, rate by indicating the specified disability it most closely resembles or approximates in degree of disability. The term "specified disabilities" refers to disabilities that are listed in RCW 51.32.080. The Category Rating System should not be used, as it applies only to Washington claims on or after October 1, 1974. Again, please use the edition of the *AMA Guides* designated by the department to rate these impairments.

How is Pain Considered in an Impairment Rating?

WAC 296-20-19030
To what extent is pain considered in an award for permanent partial disability?
The categories used to rate unspecified disabilities incorporate the worker's subjective complaints. Similarly, the organ and body system ratings in the *AMA Guides to the Evaluation of Permanent Impairment* incorporate the worker's subjective complaints. A worker's subjective complaints or symptoms, such as a report of pain, cannot be objectively validated or measured. There is no valid, reliable or consistent means to segregate the worker's subjective complaints of pain from the pain already rated and compensated for in the conventional rating methods. When rating a worker's permanent partial disability, reliance is primarily placed on objective physical or clinical findings that are independent of voluntary action by the worker and can be seen, felt or consistently measured by examiners. No additional permanent partial disability award will be made beyond what is already allowed in the categories and in the organ and body system ratings in the *AMA guides*.

For example:

Chapter 18 of the 5th Edition of the *AMA Guides to the Evaluation of Permanent Impairment* attempts to rate impairment caused by a patient's pain complaints. The impairment caused by the worker's pain complaints is already taken into consideration in the categories and in the organ and body system ratings in the *AMA guides*. There is no reliable means to segregate the pain already rated and compensated from the pain impairment that Chapter 18 purports to rate. Chapter 18 of the 5th Edition of the *Guides to the Evaluation of Permanent Impairment* cannot be used to calculate awards for permanent partial disability under Washington's Industrial Insurance Act.

Does the Rating Process Include Consideration of the Worker's Financial Need?

Industrial insurance law determines disability payments to the worker on the basis of the amount of impairment. You are not asked to consider the worker's financial situation. For example, a worker with a knee injury who owns two homes and a boat will receive the same award as a worker with a similar knee injury who is in financial need. For conditions not accepted as work-related, Social Security Disability, a federal program, may be available to disabled workers who have contributed to the Social Security trust fund. The worker can be referred to the Social Security Administration at 1-800-772-1213.

CHAPTER 12

Impairment Rating - Detailed Instructions

Rating and Technical Assistance

If you have questions about which rating system to use or have other technical rating questions, contact the IME Nurse Consultant. (see Appendix D)

Detailed Instructions for Rating Various Body Systems

This chapter should be used in conjunction with Chapter 11, which gives general instructions on how to rate impairment. Also, please refer to Table 3 in Chapter 11, which summarizes where to look for the appropriate rating system for a given condition or diagnosis. Please note: The regulations (WACs) cited here are specific to the body systems. You can find other WACs relating to IMEs and rating impairment in Appendix C.

Body Systems

American Medical Association Guides - General Instructions

For conditions covered by the Washington State Category Rating System or RCW 51.32.080, do NOT use the *AMA Guides*.

When using the *AMA Guides*, you should follow these general principles:

- **IMPORTANT NOTE: You must give an exact percentage, NOT a range of percentages**. Several sections of the *AMA Guides* instruct the rating examiner to choose among several "Classes", each with a range of percentages. After you decide the appropriate Class, you must give your best estimate of a specific percentage (not a range). Without your estimate of the exact percentage the Claim Manager will not be able to calculate the impairment award.

  Examples of the concept above include chapters in the *AMA Guides* dealing with conditions involving cognition, hernias, vascular disease, vision and others.

- **WHOLE PERSON VERSUS EXTREMITY (or some other level):** Be sure to explicitly state whether the percentage from the *AMA Guides* is intended to be a percent of whole person or some other body part. For example, some tables in the *Guides* provide percentages of the upper or lower extremity; others are percentages of part of an extremity; others are for whole person. **In some situations, such as extremity ratings, you should NEVER state the rating as a percent of whole person. Follow instructions in the sections below**. If you do not clearly explain this, and be consistent with the tables in the *Guides*, the Claim Manager will not be able to calculate the impairment award.

Back Impairment

Cervical and Lumbo-Sacral Guidelines, Case Examples

For most organ systems, the Category Rating System is expected to be self-explanatory. Since the creation of the Category Rating System in 1974, doctors have been expected to read the statutes and regulations and figure out the rating on their own.

Cervical and Cervico-Dorsal Spine

General Principles
Several general principles should be followed when rating cervical and cervico-dorsal impairment. These include the following:

- **Bladder and/or bowel sphincter impairments**: Objectively demonstrated bladder and/or bowel sphincter impairments must be evaluated separately, using the Washington State Category Rating System. See "Urologic" and "Digestive Tract" sections.

- **Paraplegia and quadriplegia**: You may be asked to perform an examination on a worker with a severe spinal cord injury. The worker may be a complete or incomplete paraplegic or quadriplegic. After receipt of the examination request and before the examination takes place, please contact the assigned Pension Adjudicator. The Pension Adjudicator will provide guidance and answer any questions you may have regarding the evaluation. To contact a State Fund Pension Adjudicator, call 360-902-5119. To contact a Self-Insurance Pension Adjudicator, call 360-902-6911 or 360-902-6937.

Rules (WAC 296-20-230)

1) Rules for evaluation of cervical and cervico-dorsal impairments are as follows:

a) Muscle spasm or involuntary guarding, bony or fibrous fusion, any arthritic condition, internal fixation devices or other physical finding shall be considered in selecting the appropriate category, only insofar as productive of cervical or cervico-dorsal impairment.
b) Gradations of clinical findings of cervico-dorsal impairments in terms of "mild", "moderate" or "marked" shall be based on objective medical tests.
c) Categories 2, 3, 4 and 5 include the presence of complaints of whatever degree in the neck or extremities.
d) Bladder and/or bowel sphincter impairments deriving from cervical and cervico-dorsal impairment shall be evaluated separately.
e) Neck as used in these rules and categories shall include the cervical and adjacent areas.

Categories (WAC 296-20-240)

Choose the category below which best describes the patient's impairment:

Category 1. No objective clinical findings are present. Subjective complaints may be present or absent.

Category 2. Mild cervico-dorsal impairment, with objective clinical findings of such impairment with neck rigidity substantiated by x-ray findings of loss of anterior curve, without significant objective neurological findings.

- This and subsequent categories include the presence or absence of pain locally and/or radiating into an extremity or extremities.
- This and subsequent categories also include the presence or absence of reflex and/or sensory losses.
- This and subsequent categories also include objectively demonstrable herniation of a cervical intervertebral disc with or without discectomy and/or fusion, if present.

Category 3. Mild cervico-dorsal impairment, with objective clinical findings of such impairment, with neck rigidity substantiated by x-ray findings of loss of anterior curve, narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins, with significant objective findings of mild nerve root involvement.

- These and subsequent categories include the presence or absence of any other neurological deficits not otherwise specified in these categories with the exception of bladder and/or bowel sphincter impairments.

Category 4. Moderate cervico-dorsal impairment, with objective clinical findings of such impairment, with neck rigidity substantiated by x-ray findings of loss of anterior curve, narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins, with objective findings of moderate nerve root involvement with weakness and numbness in one or both upper extremities.

Category 5. Marked cervico-dorsal impairment, with marked objective clinical findings of such impairment, with neck rigidity substantiated by x-ray findings of loss of anterior curve, narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins, with objective findings of marked nerve root involvement with weakness and numbness in one or both upper extremities.

Guidelines For Cervical and Cervico-Dorsal Impairment

Use of these guidelines below is NOT required. You are encouraged to use them as you deem appropriate. They are intended to offer guidance. As always, sound medical judgment should be used in application of these materials.

This guideline attempts to give better definition and clarity to terms used in the Category Rating System, such as "mild but significant," "moderate," and "marked."

In all sections of these guidelines, examiners should only consider findings which are consistent with the clinical picture.

1) **Atrophy**
   For the arm or forearm, a difference in circumference of:

   - 1-1.9 cm. = mild
   - 2-2.9 cm = moderate
   - 3+ cm = marked

   Atrophy should not be considered in the rating if it can be explained by non-spine-related problems (for example, wrist fracture) or contralateral hypertrophy, as might occur with a dominant limb or greatly increased use of a limb.

2) **EMG Abnormalities**
   EMG abnormalities are considered significant if unequivocal electrodiagnostic evidence exists of acute nerve root compromise, such as multiple positive sharp waves or fibrillation potentials; or H-wave absence or delay greater than 3 mm/sec; or chronic changes such as polyphasic waves in peripheral muscles.

3) **Muscle Weakness**

   - Mild = 4/5 (Complete motion against gravity and less than full resistance);
   - Moderate = 3/5 (Barely complete motion against gravity);
   - Marked = 2/5 - 0/5 (Complete motion with gravity eliminated, to no evidence of contractility)

4) Reflex Loss

In general, only asymmetric reflex losses should be considered significant for the purposes of impairment rating.

5) X-ray or Imaging Findings

The categorization given below is NOT intended to be a comprehensive list of findings which may be described as mild, moderate or marked. Also, be sure to only include findings which are consistent with the clinical picture.

Mild	Moderate	Marked
Any of the following without hypermobility or radiculopathy: ■ spondylolysis ■ spondylolisthesis ■ vertebral body fracture with less than 25% compression of one vertebral body ■ post-surgical state	■ hypermobility or translation >3.5 mm at a single level ■ vertebral body fracture with 25-50% compression of one vertebral body	■ hypermobility or translation > 3.5 mm at multiple levels ■ vertebral body fracture with > 50% compression of one vertebral body
Other findings: ■ Disc bulge or degenerative changes in the absence of concurrent clinical presentation should be considered insignificant. ■ Disc narrowing, spurring, and arthrosis are part of the aging process and may be considered insignificant, depending on the circumstances of the individual patient. However, principles pertaining to preexisting conditions must be considered. For example, an industrial injury can light up degenerative changes in a 55-year-old worker which may result in the payment of an award for impairment. See Preexisting Conditions and Segregation in Chapter 5.		

6) Miscellaneous Findings

The chart below is NOT intended to be a comprehensive list of findings which may be considered for the purposes of impairment ratings. *Also, be sure to only include findings which are consistent with the clinical picture.*

These should not be considered in impairment rating:	These may be considered in an impairment rating:
■ Pain scales (for example, the Oswestry pain scale)	■ Dermatomal sensory loss ■ Muscle guarding ■ Asymmetric loss of active range-of-motion ■ Foraminal compression test, i.e., upper extremity symptoms in a radicular pattern (Spurling's maneuver)

IMPORTANT NOTE: Discectomy, and fusion: An individual who has undergone a discectomy and/or a fusion is NOT an automatic Category 2. **There are no automatic ratings**. Your rating should be based on the clinical outcome and objective findings.

- **For example**, a discectomy patient with:
  - an average outcome may be a Category 2
  - an excellent outcome may also be a Category 2
  - a poor outcome may be a Category 3 or above

- **Case Example**: An injured worker has had a discectomy with a poor outcome. Would he automatically be a Category 2 cervical impairment?

- **Answer**: No, it would not be automatic. Your rating should be based on the clinical outcome and objective findings.

Dorsal Spine

General Principles

Several general principles should be followed when rating impairment due to conditions involving ONLY the dorsal (thoracic) spine. These include the following:

- **Dorsal/cervical and dorsal/lumbar combinations**: For patients who have spinal pathology that involves the dorsal and lumbar regions (for example, involvement of T11-L2; or to give a second example, T5-T6 and L4-L5), impairment must be rated using ONLY the dorsolumbar and lumbosacral categories described in WAC 296-20-280 (NOT the categories for the dorsal spine). The same principle applies to pathology involving the cervical and dorsal regions.
- **Bladder and/or bowel sphincter impairments**: Objectively demonstrated bladder and/or bowel sphincter impairments must be evaluated separately, using the Washington State Category Rating System. See "Digestive Tract" and "Urologic" sections.
- **Paraplegia and quadriplegia**: You may be asked to perform an examination on a worker with a severe spinal cord injury. The worker may be a complete or incomplete paraplegic or quadriplegic. After receipt of the examination request and before the examination takes place, please contact the assigned Pension Adjudicator. The Pension Adjudicator will provide guidance and answer any questions you may have regarding the evaluation. To contact a State Fund Pension Adjudicator, call 360-902-5119. To contact a Self-Insurance Pension Adjudicator, call 360-902-6901.

Rules (WAC 296-20-250)

1. Rules for evaluation of permanent dorsal area impairments are as follows:

    a) Muscle spasm or involuntary guarding, bony or fibrous fusion, any arthritic condition, internal fixation devices or other physical finding shall be considered, in selection of the appropriate category, only insofar as productive of dorsal area impairment.
    b) Gradations of clinical findings of dorsal impairments in terms of "mild", "moderate" or "marked" shall be based on objective medical tests.
    c) Categories 2 and 3 include the presence of complaints of whatever degree.
    d) Bladder and/or bowel sphincter impairments deriving from impairments of the dorsal area shall be evaluated separately.
    e) Impairments which also involve the cervical or lumbar areas shall be evaluated only under the cervical and cervico-dorsal or dorsolumbar and lumbosacral categories.

Categories (WAC 296-20-260)

Choose the category below which best describes the patient's impairment:

Category 1. No objective clinical findings are present. Subjective complaints may be present or absent.

Category 2. Mild or moderate dorsal impairment, with objective clinical findings of such impairment, without significant objective neurological findings, with or without x-ray changes of narrowed intervertebral disc spaces and/or osteoarthritic lipping of intervertebral margins. Includes the presence or absence of reflex and/or sensory losses.

- This and the subsequent category include the presence or absence of pain, locally or radiating from the dorsal area.

Category 3. Marked dorsal impairment, with marked objective clinical findings, with marked x-ray findings of narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins, with significant objective neurological deficits, complaints and/or findings, deriving from dorsal impairment.

CASE EXAMPLE:

A 48 year old glazer fell 16' landing on his back approximately nine months ago. He sustained a 60% anterior compression fracture at T8. Since the injury he has had ongoing mid-back pain. His condition is aggravated by prolonged standing, bending and lifting. He has had conservative care and is now at maximum medical improvement. He had not been able to return to his job of injury and is on permanent light duty. He had no prior history of thoracic complaints. Objectively there is moderate to marked muscle guarding in the mid-thoracic area. There is increased tenderness to percussion of the T8 spinous process. Visually there is a hyperkyphosis with the apex at T8. X-rays show marked degenerative disc disease with anterior and lateral spurring from T4 to T10 with an anterior compression fracture at T8. The most appropriate rating in this case is Category 2. Rationale: There are no neurological deficits.

PLEASE NOTE: If both dorsal and lumbar (or dorsal and cervical) are accepted conditions on this case, you should NOT use WAC 296-20-260, but rather use the WACs for lumbo-sacral and/or cervical impairment.

Dorso-Lumbar and Lumbo-Sacral Spine Impairment

General Principles for Low Back Impairment

Several general principles should be followed when rating low back impairment. These include the following:

- **Bladder and/or bowel sphincter impairments**: Objectively demonstrated bladder and/or bowel sphincter impairments must be evaluated separately, using the Washington State Category Rating System. See "Digestive Tract" and "Urologic" sections.
- **Paraplegia and quadriplegia**: You may be asked to perform an examination on a worker with a severe spinal cord injury. The worker may be a complete or incomplete paraplegic or quadriplegic. After receipt of the examination request and before the examination takes place, please contact the assigned Pension Adjudicator. The Pension Adjudicator will provide guidance and answer any questions you may have regarding the evaluation. To contact a State Fund Pension Adjudicator, call 360-902-5119. To contact a Self-Insurance Pension Adjudicator, call 360-902-6901.

Rules (WAC 296-20-270)

1. Rules for evaluation of permanent dorso-lumbar and lumbo-sacral impairments are as follows:

   (a) Muscle spasm or involuntary guarding, bony or fibrous fusion, any arthritic condition, internal fixation devices or other physical finding shall be considered, in selecting the appropriate category, only insofar as productive of low back impairment.

   (b) Gradations of clinical findings of low back impairments in terms of "mild", "moderate" or "marked" shall be based on objective medical tests.

   (c) All of the low back categories include the presence of complaints of whatever degree.

   (d) Any and all neurological deficits, complaints, and/or findings in other bodily areas or systems which are the result of dorso-lumbar and lumbo-sacral impairments, except for objectively demonstrated bladder and/or bowel sphincter impairments, shall be evaluated by the descriptions contained in the categories of dorso-lumbar and lumbo-sacral impairments.

   (e) Bladder and/or bowel sphincter impairments deriving from dorso-lumbar and lumbo-sacral impairments shall be evaluated separately.

   (f) Low back as used in these rules and categories includes the lumbar and adjacent areas.

Categories (WAC 296-20-280)
Choose the category below which best describes the patient's impairment:

Category 1. No objective clinical findings. Subjective complaints and/or sensory losses may be present or absent.

Category 2. Mild low back impairment, with mild intermittent objective clinical findings of such impairment but no significant x-ray findings and no significant objective motor loss. Subjective complaints and/or sensory losses may be present.

Category 3. Mild low back impairment, with mild continuous or moderate intermittent objective clinical findings of such impairment but without significant x-ray findings or significant objective motor loss. This and subsequent categories include:

*the presence or absence of reflex and/or sensory losses;

*the presence or absence of pain locally and/or radiating into an extremity or extremities;

*the presence or absence of a laminectomy or discectomy with normally expected residuals.

Category 4. Mild low back impairment, with mild continuous or moderate intermittent objective clinical findings of such impairment, with mild but significant x-ray findings and with mild but significant motor loss objectively demonstrated by atrophy and weakness of a specific muscle or muscle group. This and subsequent categories include the presence or absence of a surgical fusion with normally expected residuals.

Category 5. Moderate low back impairment, with moderate continuous or marked intermittent objective clinical findings of such impairment, with moderate x-ray findings and with mild but significant motor loss objectively demonstrated by atrophy and weakness of a specific muscle or muscle group.

Category 6. Marked low back impairment, with marked intermittent objective clinical findings of such impairment, with moderate or marked x-ray findings and with moderate motor loss objectively demonstrated by atrophy and weakness of a specific muscle or muscle group.

Category 7. Marked low back impairment, with marked continuous objective clinical findings of such impairment, with marked x-ray findings and with marked motor loss objectively demonstrated by marked atrophy and weakness of a specific muscle or muscle group.

Category 8. Essentially total loss of low back functions, with marked x-ray findings and with marked motor loss.

Guidelines For Dorso-Lumbar and Lumbo-Sacral Impairment

Use of these guidelines is NOT required. You are encouraged to use them as you deem appropriate. They are intended to offer guidance. As always, sound medical judgment should be used in application of these materials.

The guidelines below attempts to give better definition and clarity to terms used in the Category Rating System, such as "mild but significant," "moderate," and "marked."

In all sections of these guidelines, examiners should only consider findings which are consistent with the clinical picture.

1) **Atrophy**

   For the calf or thigh, a difference in circumference of:

   - 1-1.9 cm. = mild
   - 2-2.9 cm = moderate
   - 3+ cm = marked.

Atrophy should not be considered in the rating if it can be explained by non-spine-related problems (for example, ankle fracture) or contralateral hypertrophy, as might occur with a dominant limb or greatly increased use of a limb.

2) **EMG Abnormalities**

EMG abnormalities are considered significant if unequivocal electrodiagnostic evidence exists of acute nerve root compromise, such as multiple positive sharp waves or fibrillation potentials; or H-wave absence or delay greater than 3 mm/sec; or chronic changes such as polyphasic waves in peripheral muscles.

3) **Muscle Weakness**

   - Mild = 4/5 (Complete motion against gravity and less than full resistance);
   - Moderate = 3/5 (Barely complete motion against gravity);
   - Marked = 2/5 - 0/5 (Complete motion with gravity eliminated, to no evidence of contractility)

4) **Reflex Loss**

   In general, only asymmetric reflex losses should be considered significant for the purposes of impairment rating.

5) **X-ray or Imaging Findings**

   The categorization given below is NOT intended to be a comprehensive list of findings which may be described as mild, moderate or marked. Also, be sure to only include findings which are consistent with the clinical picture.

Mild	Moderate	Marked
Any of the following without hypermobility or radiculopathy: ■ spondylolysis ■ spondylolisthesis ■ vertebral body fracture with less than 25% compression of one vertebral body ■ post-surgical state	■ hypermobility or translation >4.5 mm at a single level ■ vertebral body fracture with 25-50% compression of one vertebral body	■ hypermobility or translation > 4.5 mm at multiple levels ■ vertebral body fracture with > 50% compression of one vertebral body
Other findings: ■ Disc bulge or degenerative changes in the absence of concurrent clinical presentation should be considered insignificant. ■ Disc narrowing, spurring, and arthrosis are part of the aging process and may be considered insignificant, depending on the circumstances of the individual patient. However, principles pertaining to preexisting conditions must be considered. For example, an industrial injury can light up degenerative changes in a 55-year-old worker which may result in the payment of an award for impairment. See Preexisting Conditions and Segregation.		

6) Miscellaneous Findings

The chart below is NOT intended to be a comprehensive list of findings which may be considered for the purposes of impairment ratings. *Also, be sure to only include findings which are consistent with the clinical picture.*

These should not be considered in impairment rating:	These may be considered in an impairment rating:
■ Pain scales (for example, the Oswestry pain scale)	■ Dermatomal sensory loss ■ Positive straight-leg-raising with a radicular pattern ■ Muscle guarding ■ Asymmetric loss of active range-of-motion ■ Femoral nerve stretch ■ Foraminal compression test, i.e., lower extremity symptoms in a radicular pattern (Kemps sign) ■ Waddell's signs*
* *Waddell's signs are non-organic physical signs in low back pain (such as axial loading and cogwheel "give-way" weakness). They are distinguishable from the standard clinical signs of physical pathology and correlate with other psychological data. For more information, see Waddell, G., et al.: Non-organic physical signs in low back pain, Spine 5:117, 1980.*	

IMPORTANT NOTE: Laminectomy, discectomy, and fusion: An individual who has undergone a laminectomy or discectomy is NOT an automatic Category 3. An individual who has undergone a fusion is NOT an automatic Category 4. **There are no automatic ratings**. Your rating should be based on the clinical outcome and objective findings.

- **For example**, a laminectomy patient with:
  - an average outcome may be a Category 3
  - an excellent outcome may be a Category 2
  - a poor outcome may be a Category 4 or above

- **Case example**: An injured worker has had a laminectomy with a very good outcome, would they automatically be a Category 3 lumbar impairment?

- **Answer**: No, it would not be automatic. Your rating should be based on the clinical outcome and objective findings.

IMPORTANT NOTE: In cases where a worker incurs both dorsal impairment and a cervical or lumbar impairment, the overall impairment must be rated under either the cervical / cervicodorsal or dorsolumbar / lumbosacral category system (see WAC 296-20-250 and L&I v. DeLozier, March 2000)

IMPORTANT NOTE: If imaging studies demonstrate evidence of degenerative disease (DJD/DDD) in the spine, there must be objective evidence to support that it was caused by or made worse by the industrial injury. Given that DJD and DDD are present in virtually all of the working population, the mere presence of these conditions on imaging studies does not sufficiently support a causal relationship. Note that stair-stepping, or anterolisthesis of one vertebra over another, is most often a normal non-pathologic variant, or due to degenerative disease.

Pelvis

Rules (WAC 296-20-290)

1. Rules for impairment of the pelvis:

   (a) All of these categories include the presence of complaints of whatever degree.

   (b) Categories 2, 5, 6 and 7 describe separate entities and more than one may be selected when appropriate. Category 9 includes the findings described in Category 3, and Category 8 includes the findings described in Category 4.

Categories (WAC 296-20-300)

Choose the category(ies) below which best describes the patient's impairment (more than one category may be chosen):

Category 1.	Healed pelvic fractures without displacement, without residuals; healed fractures with displacement without residuals, of: Single ramus, bilateral rami, ilium, innominate or coccyx; or healed fracture of single rami with displacement with deformity and residuals.
Category 2.	Healed fractures with displacement with deformity and residuals of ilium.
Category 3.	Healed fractures of symphysis pubis, without separation with displacement without residuals.
Category 4.	Healed fractures of sacrum with displacement without residuals.
Category 5.	Healed fracture of bilateral rami with displacement with deformity and residuals.
Category 6.	Excision or nonunion of fractures of coccyx.
Category 7.	Healed fractures of innominate, displaced one inch or more, with deformity and residuals.
Category 8.	Healed fractures of sacrum extending into sacroiliac joint with deformity and residuals.
Category 9.	Healed fractures of symphysis, displaced or separated, with deformity and residuals.

IMPORTANT NOTE: More than one category may be selected in your impairment rating.

Case Example: A 39 year old worker received a crush injury to the pelvis when a 10 ton steel roller machine, used to roll out ribbons of steel, broke loose from its mounting and pinned him against a concrete wall. He sustained a fracture to the sacrum that extended into the right sacroiliac joint with widening of the joint. There was a small avulsion fracture in the posterior aspect of the right sacroiliac joint. He had a 3 cm. separation of the symphysis pubis. He had surgery where a plate with multiple screws and a large lag bolt was used to repair the right sacroiliac joint. He had a metal prosthesis installed to join the symphysis. He is now at MMI. He has no ongoing pain in the pelvic area. His physical examination is negative. Imaging shows a healed fracture at the sacrum and good alignment of the symphysis both with internal fixation remaining in place.

What is his rating? The correct rating would be a category 8 impairment and a category 9 impairment. Category 8 would address the healed fracture of the sacrum extending into the sacroiliac joint and category 9 would address the fracture with separation of the symphysis. If you said a category 3, this is included in the category 9 rating and if you said a category 4, this is included in the category 8 rating.

Cardiac

Rules (WAC 296-20-350)

1. Rule for evaluation of permanent cardiac impairments:

   (a) Classification of impairment using the following categories shall be based upon a carefully obtained history, thorough physical examination and the use of appropriate laboratory aids.

Categories (WAC 296-20-360)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings are present. Subjective complaints may be present or absent.

Category 2. Objective findings of mild organic heart disease but no signs of congestive heart failure. No medically appropriate symptoms produced by prolonged exertion or intensive effort or marked emotional stress.

Category 3. Objective findings of mild organic heart disease but no signs of congestive heart failure. Medically appropriate symptoms produced by prolonged exertion or intensive effort, or marked emotional stress but not by usual daily activities.

Category 4. Objective findings of moderate organic heart disease but no signs of congestive heart failure. Medically appropriate symptoms produced by prolonged exertion or intensive effort or marked emotional stress but not by usual daily activities.

Category 5. Objective findings of marked organic heart disease with minimal signs of congestive heart failure with therapy. Medically appropriate symptoms produced by usual daily activities.

Category 6. Objective findings of marked organic heart disease with mild to moderate signs of congestive heart failure despite therapy. Medically appropriate symptoms produced by usual daily activities.

Convulsive Neurologic Disorders (Seizure Disorders, Epilepsy)

Rules (WAC 296-20-310)

1. Rules for evaluation of convulsive neurological impairments:

   (a) The description of categories 2, 3 and 4 include the presence of complaints of whatever degree.

Categories (WAC 296-20-320)
Choose the category below which best describes the patient's impairment:

Category 1. No electroencephalogram findings of convulsive neurological disorder. Subjective complaints may be present or absent.

Category 2. Electroencephalogram findings of convulsive neurological disorder, but on appropriate medication there are no seizures.

Category 3. Electroencephalogram findings of convulsive neurological disorder, and on appropriate medication there are each year either one through four major seizures or one through twelve minor seizures.

Category 4. Electroencephalogram findings of convulsive neurological disorder, and on appropriate medication there are each year more than four major seizures or more than twelve minor seizures.

Dental, Tooth Loss

To rate impairment due to tooth loss, you will not need to use any rating system, but rather simply answer the following three questions in your impairment rating report:

1) Were any complete original teeth lost? If so, which ones? Identify each tooth by tooth number.
2) Were parts of teeth lost? Is so, which ones?
3) For each lost tooth, please state whether the tooth loss was caused by the industrial injury, on a more probable than not basis.

IMPORTANT NOTE: The department pays an impairment award only for complete loss of original teeth, whether or not the tooth is replaced by a bridge, denture or implant. The department does not pay impairment awards for loss of part of a tooth.

Other related impairments: To rate impairment due to temporomandibular joint (TMJ) injury, dislocated jaw, and other similar conditions, use the Ear, Nose and Throat chapter of the *AMA Guides*. For example, if mastication or deglutition is impaired, use the *AMA Guides*. Use the edition of the *AMA Guides* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition. Currently the department has designated the Fifth Edition.) If speech, taste or smell is impaired, you must use the Washington State Category Rating System, as presented elsewhere in this handbook.

Digestive Tract

Upper Digestive Tract

Rules (WAC 296-20-490)

1. Rule for evaluation of permanent impairments of the upper digestive tract, stomach, esophagus or pancreas.

   (a) Categories 2, 3, 4 and 5 include complaints of whatever degree.

Categories (WAC 296-20-500)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings are present. Subjective complaints may be present or absent.

Category 2. There are objective findings of digestive tract impairment but no anatomic loss or alteration, continuous treatment is not required and weight can be maintained at the medically appropriate level.

Category 3. There are objective findings of digestive tract impairment, or there is anatomic loss or alteration. Dietary restrictions and drugs control symptoms, signs and/or nutritional state, and weight can be maintained at least 90 percent of medically appropriate level.

Category 4. There are objective findings of digestive tract impairment, or there is anatomic loss or alteration. Dietary restrictions and drugs do not completely control symptoms, signs and/or nutritional state. Weight can be maintained at 80-90 percent of medically appropriate level.

Category 5. There are objective findings of digestive tract impairment, or there is anatomic loss or alteration. Dietary restrictions and drugs do not control symptoms, signs and/or nutritional state. Weight cannot be maintained as high at 80 percent of medically appropriate level.

Lower Digestive Tract

Rules (WAC 296-20-510)

1. Rule for evaluation of permanent lower digestive tract impairments.

   (a) Categories 2, 3 and 4 include the presence of complaints of whatever degree.

Categories (WAC 296-20-520)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings of impairment of lower digestive tract. Subjective complaints may be present or absent.

Category 2. The objective findings of lower digestive tract impairment are infrequent and of brief duration, and there is limitation of activities, but special diet or medication is not required, and there are neither systemic manifestations nor impairment of nutrition.

Category 3. There are objective findings of lower digestive tract impairment or anatomic loss or alteration and mild gastrointestinal symptoms with occasional disturbance of bowel function, accompanied by moderate pain and minimal restriction of diet; mild symptomatic therapy may be necessary; no impairment of nutrition.

Category 4. There are moderate to marked intermittent bowel disturbances with continual or periodic pain; there is restriction of activities and diet during exacerbations, there are constitutional manifestations such as fever, anemia or weight loss. Includes but is not limited to any permanent ileostomy or colostomy.

Anal Function

Rules (WAC 296-20-530)

1. Rule for evaluation of permanent impairment of anal function.

   (a) Categories 2, 3 and 4 include the presence of complaints of whatever degree.

Categories (WAC 296-20-540)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings of impairment of anal function. Subjective complaints may be present or absent.

Category 2. There are objective findings of mild organic disease, anatomic loss or alteration with loss of anal function and mild incontinence involving gas and/or liquid stool.

Category 3. There are objective findings of moderate anal disease, anatomic loss or alteration with loss of anal function and moderate incontinence requiring continual care.

Category 4. There are objective findings of marked anal disease, anatomic loss, alteration and/or complete fecal incontinence.

Liver and Biliary Tract

Rules (WAC 296-20-550)

1. Rule for evaluation of permanent liver and biliary tract impairments.

   (a) Categories 2, 3, 4 and 5 include complaints of whatever degree.

Categories (WAC 296-20-560)

Choose the category below which best describes the patient's impairment:

Category 1. There are no objective findings of impairment of the liver or biliary tract. Subjective complaints may be present or absent.

Category 2. There are objective findings on biochemical studies of minimal impairment of liver function with or without symptoms, or there are occasional episodes of loss of function of the biliary tract, but nutrition and strength are good.

Category 3. There are objective findings on biochemical studies of mild impairment of liver function without symptoms, or there is recurrent biliary tract impairment, but no ascites, jaundice or bleeding esophageal varices and nutrition and strength are good.

Category 4. There are objective findings on biochemical studies of moderate impairment of the liver function with jaundice, ascites, bleeding esophageal varices or gastric and nutrition and strength may be affected; or there is irreparable obstruction of the common bile duct with recurrent cholangitis.

Category 5. There are objective findings on biochemical studies of marked impairment of liver function and nutritional state is poor; or persistent jaundice, bleeding esophageal or gastric varices.

Extremity Ratings (Upper and Lower)

IMPORTANT NOTE FOR ALL UPPER EXTREMITY RATINGS (INCLUDING ALL AMPUTATIONS): You must complete the applicable rating worksheet(s) on pages 436-437 of the *AMA Guides*, Fifth Edition (Figure 16-1). If there are any digit amputations, in the amputation column, be sure to:

- Make reference to the worksheets in the body of your report
- Return the completed worksheets as an attachment to your report.

AMA Guides and RCW

General Principles:
Labor and Industries uses both RCW 51.32.080 and the *AMA Guides*, Fifth Edition, as resources when rating upper and lower extremity impairment. Examiners should be familiar with both resources when performing rating examinations of the upper and lower extremities. See Appendix C for the full text of RCW 51.32.080.

When rating an amputation, the examiner should first determine if the amputation falls within the types of amputations described in RCW 51.32.080(1)(a), and these generally include amputation through joints in the hand and feet and amputations through the long bones of the upper and lower extremities. For amputations not mentioned in RCW 51.32.080(1) (a), use the *AMA Guides* to rate impairment due to amputation. For upper and lower extremity impairment ratings that do not involve amputations, use the *AMA Guides* to rate these impairments. Most commonly, the *AMA Guides* is used to rate amputations that occurs through a phalanx instead of through a joint.

IMPORTANT NOTE: Be sure to attach worksheets used to formulate the rating so readers easily understand your methods. For example, the upper extremity worksheets on pages 436-437 of the *AMA Guides*, Fifth Edition are especially important. Follow the instructions for the worksheet carefully to determine when percentages are combined and when percentages are added.

IMPORTANT NOTE: Extremity ratings should NEVER be expressed as a percentage of whole person impairment (WPI, also known as Total Bodily Impairment or TBI). Impairment ratings should be expressed as a percentage of upper or lower extremity impairment when using the *AMA Guides*.

- If the *AMA Guides* provides a whole person rating, you must convert it to the level of the whole extremity using Table 16-3 on page 439 of the *AMA Guides*, Fifth Edition. Or, multiply ALL extremity impairments expressed as whole person impairments as follows:
  Whole Person Impairment % x 60% = Rating (rounded up)
- If both right and left extremities are involved, you must present separate ratings for each extremity – do NOT combine to whole person.

Amputations:
For purposes of rating impairment in Washington, "amputation" is defined as traumatic or surgical removal of an extremity, or part of an extremity when bone is involved. When there is no bony involvement and only soft tissue has been removed, this is defined as "avulsion." Avulsions are not rated using the amputation charts, but instead would be rated using the *AMA Guides*, Fifth Edition, for sensory loss (and range-of-motion loss, if applicable).

For amputations through a joint in the hand or foot, use RCW 51.32.080 to report the level of amputation. Also for amputations NOT through a joint but proximal to mid-metacarpals in the upper extremity or proximal to the mid-tarsals in the lower extremity, RCW 51.32.080 directs the examiner to indicate the level that best describes the amputation from the types of amputations listed. See Table 4 on page 106 for the levels of amputation defined by RCW 51.32.080(1) (a). If the amputation level is not listed in RCW 51.32.080(1) (a), use the *AMA Guides*, Fifth Edition, to assign an impairment rating for the amputation, and if appropriate, to document the impairment related to the amputation. The most common type of amputation not included in RCW 51.32.080(1) (a) is amputation through a proximal, middle, or distal phalanx where a joint is not involved.

If the worker has an amputation with or without additional impairment(s) in an extremity that resulted from the amputation:

1) Report the level of amputation.
   a. For amputations through a joint in the hand or foot, use RCW 51.32.080. For example, use RCW 51.32.080 for amputations through the distal interphalangeal joint (DIP), proximal interphalangeal joint (PIP), or metacarpophalangeal joint (MP).
   b. For amputations that did <u>not</u> occur through a joint but occurred through phalanges of the upper or lower extremity, use the *AMA Guides, Fifth Edition*. For example, use the *AMA Guides* for amputations through the proximal, middle, or distal phalanx.
      - For amputations in the hand through the phalanges, use Figure 16-6 for thumb amputation and Figure 16-7 for amputations of the digits to find digit impairment percentages. Both figures are on page 447 in the *AMA Guides*, *Fifth Edition*.
   c. For amputations through a joint proximal to the metacarpals in the upper extremity or through a joint proximal to the metatarsals in the lower extremities, use RCW 51.32.080. For example, use RCW 51.32.080 for amputations through the wrist or elbow in the upper extremity or the ankle or knee in the lower extremity.

d. For amputations through the metatarsals, tibia, fibula, or femur in the lower extremity; or through the metacarpals, radius, ulna, or humerus in the upper extremity: use RCW 51.32.080. Report the nearest site of amputation among the sites listed.

2) Rate additional extremity impairment (s), such as loss of sensation or range of motion, using the *AMA Guides*, Fifth edition, as described in section 16.2 d (Conditions Associated with Amputation). Rate additional impairments according to the appropriate section of the *AMA Guides*. Other sections to be familiar with include Section 16.2, Amputations (pages 441-445); Section 16.3 Sensory Impairments Due to Digital Nerve Lesion (pages 445-450); and Section 16.4e, Finger Motion Impairment (pages 461-466). Please note, in some circumstances both RCW 51.32.080 and the *AMA Guides* should be used to rate impairment. For example, in situations with both the amputation through a joint in the hand and foot (RCW 51.32.080) with accompanying loss of function (*AMA Guides*), both RCW 51.32.080 and *AMA Guides* should be used to rate impairment.

Important Note: Do not round up or round down to the nearest joint. Use RCW 51.32.080 where appropriate (see above) or *AMA Guides* where appropriate (see above). Do not use BOTH RCW 51.32.080 and the *AMA Guides* when reporting the site of an amputation; use the most appropriate source to define the amputation.

Table 4: AMPUTATION LEVELS ACCORDING TO RCW 51.32.080 Select the level which best describes the patient's amputation. See Appendix C for details.	
Leg ■ Of leg above the knee joint with short thigh stump (3" or less below the tuberosity of ischium) ■ Of leg at or above knee joint with functional stump ■ Of leg below knee joint ■ Of leg at ankle (Syme) ■ Of foot at mid-metatarsals ■ Of great toe with resection of metatarsal bone	■ Of great toe at metatarsophalangeal joint ■ Of great toe at interphalangeal joint ■ Of lesser toes (2nd to 5th) with resection of metatarsal bone ■ Of lesser toe at metatarsophalangeal joint ■ Of lesser toe at proximal interphalangeal joint ■ Of lesser toe at distal interphalangeal joint
Arm ■ Of arm at or above the deltoid insertion or by disarticulation at the shoulder ■ Of arm at any point from below the deltoid insertion to below the elbow joint at the insertion of the biceps tendon ■ Of arm at any point from below the elbow joint distal to the insertion of the biceps tendon to and including mid-metacarpal amputation of the hand with resection of carpometacarpal bone ■ Of thumb at interphalangeal joint ■ Of all fingers except the thumb at metacarpophalangeal joints ■ Of thumb at metacarpophalangeal joint or with resection of metacarpal bone ■ Of index finger at metacarpophalangeal joint or with resection of metacarpal bone ■ Of index finger at proximal interphalangeal joint	■ Of index finger at distal interphalangeal joint ■ Of middle finger at metacarpophalangeal joint or with resection of metacarpal bone ■ Of middle finger at proximal interphalangeal joint ■ Of middle finger at distal interphalangeal joint ■ Of ring finger at metacarpophalangeal joint or with resection of metacarpal bone ■ Of ring finger at proximal interphalangeal joint ■ Of ring finger at distal interphalangeal joint ■ Of little finger at metacarpophalangeal joint or with resection of metacarpal bone ■ Of little finger at proximal interphalangeal joint ■ Of little finger at distal interphalangeal joint

CASE EXAMPLE

Amputation
Mr. F. sustained an amputation of his right dominant thumb. Attempted replantation failed, and he underwent revision of the amputation to the level of the metacarpal head.

Rating: As listed in RCW 51.32.080, this amputation corresponds most closely to "amputation of thumb at metacarpophalangeal joint."

Rating Extremities Other Than Amputations

To rate impairment of the upper and lower extremities not involving amputation, use the *AMA Guides* Fifth Edition.

In rating extremities, please note the following important points:

- **Total joint replacement:** Impairment due to total joint replacement must be done using the *AMA Guides*, Fifth Edition,
- For impairment rating involving distal clavicle resection arthroplasty, follow the upper extremity impairment percentages in Table 16-27 on page 506 in the *AMA Guides*, Fifth Edition. The impairment rating for distal clavicle resection arthroplasty is 10% upper extremity impairment.
- **Grip strength, pinch strength and manual muscle testing:** In accordance with the *AMA Guides*, Fifth Edition, strength measurements does not play a large role in rating impairment, partly because it is subject to the individual's conscious or unconscious control. (This is covered in Section 16.8 on pages 507 through 511, for example.) Therefore you must follow the *AMA Guides* and choose a method other than strength measurements. In a rare case, if you feel strength measurement is appropriate, you must clearly and in detail explain the basis for your decision. If your rationale does not clearly explain your reasoning, then it may be difficult for the Claim Manager to use your rating.
- For Complex Regional Pain Syndrome, see Medical Treatment Guideline for Chronic Regional Pain Syndrome (CRPS), for diagnostic criteria. For rating impairment due to CRPS, see pages 496-497 (upper extremity CRPS) and pages 525-527 (lower extremity CRPS) of the *AMA Guides*, Fifth Edition.

Example: A worker had a left foot calcaneal fracture and an accepted diagnosis of Complex Regional Pain Syndrome (CRPS) of the left lower extremity. The combined impairment rating was 10% whole person (WPI). Using Table 17-3 on page 527 of the *AMA Guides*, Fifth Edition, the final impairment rating is 26% impairment of the left lower extremity.

Hearing Loss

AMA Guides and Worksheet

In the Washington State workers' compensation system, partial impairment of hearing is rated using the edition of the *American Medical Association Guides to the Evaluation of Permanent Impairment* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition.) To assist doctors in using the *Guides*, a two-page "Hearing Impairment Calculation Worksheet" is included later in this chapter. Doctors are encouraged to photocopy this worksheet and include the completed worksheet with the written report.

IMPORTANT NOTE: Per the worksheet, if there is hearing loss in only one ear, you should not use the "combined hearing loss formula" in the box at the bottom of the worksheet.

In addition to the worksheet, please provide the audiogram with your report. Also, indicate if you recommend a hearing aid or other intervention.

If hearing loss is complete, report it as: (1) Complete loss of hearing in both ears, or (2) Complete loss of hearing in one ear. See RCW 51.32.080, Permanent partial disability, miscellaneous, Appendix C.

Audiometric Testing

Audiometric testing should be performed at least 14 hours after the last exposure to noise. Prosthetic devices (e.g., hearing aids) must not be used during the evaluation of hearing sensitivity.

There are no laws or regulations under the industrial insurance statutes pertaining to standards for audiometric testing. However, there are several laws, regulations, and policies which may be pertinent in certain cases:

- Hearing aid establishments need to be licensed and need to employ at least one licensed fitter-dispenser at all times, and must annually submit proof that all audiometric equipment at that establishment has been properly calibrated (RCW 18.35.030). This statute is administered by the Washington State Department of Health.
- Employers must establish and maintain a mandatory audiometric testing program for all employees whose exposures equal or exceed an 8-hour time-weighted average of 85 dBA, as provided in Chapter 296-817 WAC, Hearing Loss Prevention (Noise). Audiometric tests must be performed by a licensed or certified audiologist, otolaryngologist, or other qualified physician, or by a technician who is certified by the Council of Accreditation in Occupational Hearing Conservation. A technician who performs audiometric tests must be responsible to an audiologist, otolaryngologist, or other qualified physician. The rule covers the audiometric testing requirements (for example, booth requirements, audiometer calibration, etc.). This rule is administered by the Department of Labor and Industries, Division of Occupational Safety and Health (DOSH). (Agriculture industry employers are covered under identical requirements in Chapter 296-307 WAC, Part Y-7, Hearing loss prevention (Noise).)

- The *American Medical Association Guides to the Evaluation of Permanent Impairment*, Fifth Edition, instructs doctors to use an audiometer that is calibrated according to American National Standards Institute (ANSI) audiometer specifications S3.6-1996 (or more recent ANSI specifications). The date of the most recent audiometer calibration should be specified in each audiometry report. Also, the same regulations that apply for mandatory audiometric testing programs apply to audiometric testing to determine impairment for hearing loss claims.

Presbycusis

In the Washington state workers' compensation system, partial impairment of hearing is rated using the edition of the *American Medical Association Guides to the Evaluation of Permanent Impairment* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition.) Rating of work-related hearing impairment due to noise exposure is not apportioned between age-related hearing impairment and work-related hearing impairment.

Because the effect of noise on hearing does not progress after the cessation of exposure, it is important to base impairment ratings on valid audiometric testing performed as close as possible to the last work-related exposure (whenever such tests are readily available). In some cases, a claim is filed and the sole valid audiogram was performed years after the claimant has ceased working with injurious noise.

Regardless of when the audiogram is performed, the award will be based on the schedule of benefits in effect at the time hearing loss became manifest, which is the earlier of when hearing loss required medical treatment or became disabling. "Disabling" could be demonstrated by a valid audiogram.

By way of example: An 85-year-old files a claim in 1996 for occupational hearing loss. Although his last exposure to injurious workplace noise was in 1976, the first valid audiogram was performed in 1996. The 1996 audiogram shows 10% bilateral hearing loss. Rather than pay the award according to the 1996 schedule of benefits, the department would look to the schedule in effect no later than the date of the last exposure in 1976. The department would not use a schedule of benefits later than the last date of injurious exposure. In this example, if that 85-year-old had a valid audiogram or received hearing aids in 1971 (and a hearing loss claim had not previously been filed), the department would look to the schedule in effect in 1971, as the audiogram/hearing aid would be documentation of the manifestation of the hearing loss condition.

As always, please refer to department publications and/or information on the web for the most current information on this topic.

Tinnitus

A physician may choose to rate (or not rate) tinnitus, according to his/her medical judgment and the specifics of each individual patient. When a physician chooses to rate tinnitus, he or she must use the edition of the *American Medical Association Guides to the Evaluation of Permanent Impairment* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition.) The physician may add up to 5% (depending on severity). (See the "Hearing Impairment Calculation Worksheet" later in this chapter to understand how the amount added to each ear is translated into a binaural value.) To assess severity, the physician may wish to consider such factors as: whether the tinnitus is constant or intermittent; the perceived loudness of the tinnitus; and whether the tinnitus interferes with the patient's ability to detect noises and/or interferes with perception or comprehension of speech.

According to department policy, physicians may rate tinnitus only in the presence of an otherwise compensable unilateral or bilateral hearing loss. If there is no otherwise compensable hearing loss, there is no award for tinnitus.

Tinnitus awards cannot exceed 5% during a worker's lifetime.

Hearing Impairment Calculation Worksheet

Department of Labor & Industries
Office of The Medical Director
PO Box 44321
Olympia WA 98504-4321

HEARING IMPAIRMENT CALCULATION WORKSHEET

Date	Date of audiogram	Claim number
10/1/05	7/5/05	A111111
Name: Joe Worker		Hours since last exposure to noise (must be more than 14): 48

Monaural Hearing Loss Formula: A.N.S.I. 1969

([([500 Hz + 1000 Hz + 2000 Hz + 3000 Hz] ÷ 4) - 25] x 1.5) = % of loss

LEFT EAR (X)		RIGHT EAR (0)	
Hz	dB level	Hz	dB level
500	35	500	35
1000	25	1000	25
2000	20	2000	20
3000	35	3000	25
Total	115		105
STOP here if total is 100 or less		STOP here if total is 100 or less	
Avg threshold for 4 frequencies ÷ 4 =	28.75	Avg threshold for 4 frequencies ÷ 4 =	26.25
Less threshold fence of 25 dB - 25 =	3.75	Less threshold fence of 25 dB - 25 =	1.27
Multiplied by 1.5 equals the % of monaural loss x 1.5 =	5.63	Multiplied by 1.5 equals the % of monaural loss x 1.5 =	1.88
Add rating for tinnitus of 0 through 5%	2.0	Add rating for tinnitus of 0 through 5%	2.0
Total percent monaural hearing loss	7.63	Total percent monaural hearing loss	3.88

STOP HERE IF EITHER OF THE MONAURAL HEARING LOSS %'s ARE ZERO!!!

****

Combined Hearing Loss Formula:

([% better ear x 5] + [% worse ear]) ÷ 6 = % of loss

% better ear	3.88	x 5 =	19.4
Plus % worse ear		+	7.63
		Sub-Total	27.03
Sub-Total divided by 6		÷ 6 =	4.51 % Binaural Hearing Loss

F252-007-000 hearing impairment calculation worksheet 9-00

Hearing Impairment Calculation Worksheet

Department of Labor & Industries
Office of The Medical Director
PO Box 44321
Olympia WA 98504-4321

HEARING IMPAIRMENT CALCULATION WORKSHEET

Date	Date of audiogram	Claim number
Name		Hours since last exposure to noise (must be more than 14)

A.N.S.I. 1969

Monaural Hearing Loss Formula:

([([500 Hz + 1000 Hz + 2000 Hz + 3000 Hz] ÷ 4) - 25] x 1.5) = % of loss

LEFT EAR (X)

Hz	dB level
500	
1000	
2000	
3000	
Total	

STOP here if total is 100 or less

Avg threshold for 4 frequencies	÷ 4 =
Less threshold fence of 25 dB	- 25 =
Multiplied by 1.5 equals the % of monaural loss	x 1.5 =
Add rating for tinnitus of 0 through 5%	
Total percent monaural hearing loss	

RIGHT EAR (0)

Hz	dB level
500	
1000	
2000	
3000	

STOP here if total is 100 or less

Avg threshold for 4 frequencies	÷ 4 =
Less threshold fence of 25 dB	- 25 =
Multiplied by 1.5 equals the % of monaural loss	x 1.5 =
Add rating for tinnitus of 0 through 5%	
Total percent monaural hearing loss	

STOP HERE IF EITHER OF THE MONAURAL HEARING LOSS %'s ARE ZERO!!!

****

Combined Hearing Loss Formula:

([% better ear x 5] + [% worse ear]) ÷ 6 = % of loss

% better ear	x 5 =	
Plus % worse ear	+	
	Sub-Total	
Sub-Total divided by 6	÷ 6 =	% Binaural Hearing Loss

F252-007-000 hearing impairment calculation worksheet 9-00

Hernia (Inguinal, Umbilical, etc.)

Impairment due to hernias (inguinal, umbilical, etc.) should be rated using the *AMA Guides*. **PLEASE NOTE: You must give an exact percentage, NOT a range of percentages.** This section of the *AMA Guides*, like several others, instructs the rating examiner to choose Class 1, 2 or 3, each with a range of percentages. After you decide the appropriate Class, you must give your best estimate of a specific percentage (not a range), based on your best clinical judgment. Without your estimate of the exact percentage the Claim Manager will not be able to calculate the impairment award. Per the *AMA Guides*, your percentage will be a percent of whole person impairment (WPI, or total bodily impairment, TBI). Whole person impairments are not appropriate for the vast majority of impairment ratings, but for hernias, you should state clearly in your report that your rating is a percent of whole person impairment.

Mental Health

The section below focuses on rating impairment from mental health conditions. Refer to Chapter 7, "Mental health IME Reports" for general information about mental health IME reports, including assessment of work-relatedness.

Use objective observations and/or findings to support your conclusions. For example, document observed behaviors, etc. – not only what the worker reports. Document discrepancies between your objective observations and what the worker reports, as well as inconsistencies in records and reporting across time.

Cognitive Impairment vs. Mental Health Impairment

If an injury or illness results in impairment which is primarily mental health in nature, the Category Rating System must be used (described below). If the impairment is primarily cognitive in nature or involves some other dysfunction of the central nervous system, use the *AMA Guides*. Use the edition of the *AMA Guides* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition. Currently the department has designated the Fifth Edition.)

If there are both significant cognitive impairment and mental health impairment, then they should be rated separately using both the Category Rating System and the *AMA Guides*.

Stress Not Covered

Stress-related conditions (such as, stress from financial difficulties, employment, claim management) are not compensable as an occupational disease under the Washington Industrial Insurance Act. See the RCW and WAC in Chapter 7, "Mental Health IME Reports." PTSD is a special consideration, also addressed in Chapter 7.

General Requirements for Rating Mental Health Impairment

IMPORTANT NOTES

- **Only rate impairment that is due to the accepted industrial injury or occupational disease. WAC 296-20-330 (2).**
- **Do not rate impairment when the quality of daily life does not differ substantially from the pre-injury pattern. WAC 296-20-330 (6).**

The five following components are required of all rating reports:	
1) **MMI**	**Do not rate impairment unless it is medically probable that the emotional reactions are permanent**. WAC 296-20-330 (4)(b). If the worker is at maximum medical improvement (MMI), include a statement that the patient has reached MMI and that no further curative treatment is recommended.
2) **Examination**	Details of the physical or mental health examination performed (both positive and negative findings). Your report must include your assessment of pre-injury (baseline) and post- injury pattern of "adjustment to life" and the impact of the accepted mental condition on "ordinary living." Include assessment of: a. Activities of daily living b. Social functioning c. Thinking, concentration and judgment d. Adaptation to work and non-work obligations. State whether the differences in "adjustment patterns" after the industrial condition are more than the "normal, self-correcting and expectable response to the stress of the industrial condition." WAC 296-20-330(4)(c).
3) **Diagnostic tests**	Results of any diagnostic tests performed (both positive and negative). Include copies of pertinent tests ordered as part of the exam.
4) **Rating**	An impairment rating consistent with the findings and a statement of the system on which the rating was based (e.g., Washington State Category Rating System, or the *AMA Guides* for cognitive or other dysfunction of the central nervous system). **Only rate impairment due to the accepted industrial injury or occupational disease.** WAC 296-20-330(2).

5) Rationale	The rationale for the rating in your report is one of the most important elements in the IME. Your rationale must restate objective observations and findings and give your supporting documentation. WAC 296-20-2010 & WAC 296-23-377 **Do not rate impairment when the quality of daily life does not differ substantially from the pre-injury pattern**. WAC 296-20-330(6). **Consider whether the findings meet the definition of mental illness in WAC 296-20-330:** "malfunction of the psychic apparatus that significantly interferes with ordinary living." If your rationale does not clearly explain whether and how the worker's quality of daily life differs from the pre-injury pattern, and how the definition of mental illness is met, then it may be difficult for the Claim Manager to use your rating. Identify why you selected a specific impairment category rather than another.

Rules (WAC 296-20-330)

Rules for evaluation of permanent impairment of mental health:

1. Mental illness means malfunction of the psychic apparatus that significantly interferes with ordinary living.

2. Each person has a pattern of adjustment to life. The pattern of adjustment before the industrial injury or occupational disease serves as a base line for all assessments of whether there has been a permanent impairment due to the industrial injury or occupational disease.

3. To determine the preinjury pattern of adjustment, all evaluations of mental health shall contain a complete preinjury history including, but not necessarily limited to: Family background and the relationships with parents or other nurturing figures; extent of education and reaction to it; military experience, if any; problems with civil authorities; any history of prolonged illness, and difficulty with recovery; any history of drug abuse or alcoholism; employment history, the extent of and reaction to responsibility, and relationships with others at work; capacity to make and retain friends; relationships with spouses and children; nature of daily activities, including recreation and hobbies; and lastly, some summary statement about the sources of the patient's self-esteem and sense of identity. Both strengths and vulnerabilities of the person shall be included.

4. Differences in adjustment patterns before and after the industrial injury or occupational disease shall be described, and the report shall contain the examining physician's opinion as to whether any differences:

   (a) Are the result of the industrial injury or occupational disease and its sequelae, in the sense they would not have occurred had there not been the industrial injury or occupational disease;

   (b) Are permanent or temporary;

(c) Are more than the normal, self-correcting and expectable response to the stress of the industrial injury or occupational disease;

(d) Constitute an impairment psychosocially or physiologically; and

(e) Are susceptible to treatment, and, if so, what kind. The presence of any unrelated or coincidental mental impairment shall always be mentioned.

5. All reports of mental health evaluations shall use the diagnostic terminology listed in the edition of the *Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5).*

6. No classification of impairment shall be made for complaints where the quality of daily life does not differ substantially from the preinjury pattern. A patient not currently employed may not engage in the same activities as when working, but the level and variety of his activities and zest for them shall distinguish the purely situational difference from cases of regression and withdrawal. In cases where some loss of use of body member is claimed, no category or impairment shall be assigned unless there are objective findings of physiologic regression or consistent evidence of altered adaptability.

7. The physician shall identify the personality disorders as defined in the fifth edition of the DSM. Patients with these longstanding character disorders may show problem behavior that seems more related to current stress than it is, sometimes unconsciously insinuating themselves into difficult situations of which they then complain. Emotional reactions to an injury and subsequent events must be carefully evaluated in these patients. It must be medically probable that such reactions are permanent before a category of impairment can be attributed to the injury; temporary reactions or preexisting psychopathology must be differentiated.

Categories (WAC 296-20-340)

Choose the category below which best describes the patient's impairment:

Category 1 Nervousness, irritability, worry or lack of motivation following an injury and commensurate with it and/or other situational responses to injury that do not alter significantly the life adjustment of the patient may be present.

Category 2

- Any and all permanent worsening of preexisting personality traits or character disorders where aggravation of preexisting personality trait or character disorder is the major diagnosis;
- mild loss of insight, mildly deficient judgment, or rare difficulty in controlling behavior;
- anxiety with feelings of tension that occasionally limit activity;
- lack of energy or mild apathy with malaise;
- brief phobic reactions under usually avoidable conditions;
- mildly unusual and overly rigid responses that cause mild disturbance in personal or social adjustment;

- rare and usually self-limiting psycho-physiological reactions;
- episodic hysterical or conversion reactions with occasional self limiting losses of physical functions;
- a history of misinterpreted conversations or events, which is not a preoccupation;
- is aware of being absentminded, forgetful, thinking slowly occasionally or recognizes some unusual thoughts;
- mild behavior deviations not particularly disturbing to other;
- shows mild over-activity or depression;
- personal appearance is mildly unkempt.

Despite such features, productive activity is possible most of the time. If organicity is present, some difficulty may exist with orientation; language skills, comprehension, memory; judgment; capacity to make decisions; insight; or unusual social behavior; but the patient is able to carry out usual work day activities unassisted.

Category 3

- Episodic loss of self-control with risk of causing damage to the community or self;
- moments of morbid apprehension;
- periodic depression that disturbs sleep and eating habits or causes loss of interest in usual daily activities but self-care is not a problem;
- fear motivated behavior causing mild interference with daily life;
- frequent emotogenic organ dysfunctions requiring treatment;
- obsessive-compulsive reactions which limit usual activity;
- periodic losses of physical function from hysterical or conversion reactions;
- disturbed perception in that patient does not always distinguish daydreams from reality;
- recognizes his/her fantasies about power and money are unusual and tends to keep them secret;
- thought disturbances cause patient to fear the presence of serious mental trouble;
- deviant social behavior can be controlled on request;
- exhibits periodic lack of appropriate emotional control;
- mild disturbance from organic brain disease such that a few work day activities require supervision.

Category 4

- Very poor judgment, marked apprehension with startle reactions, foreboding leading to indecision, fear of being alone and/or insomnia;
- some psychomotor retardation or suicidal preoccupation;
- fear-motivated behavior causing moderate interference with daily life;
- frequently recurrent and disruptive organ dysfunction with pathology of organ or tissues;
- obsessive-compulsive reactions causing inability to work with others or adapt;
- episodic losses of physical function from hysterical or conversion reactions lasting longer than several weeks;

- misperceptions including sense of persecution or grandiosity which may cause domineering, irritable or suspicious behavior;
- thought disturbance causing memory loss that interferes with work or recreation;
- periods of confusion or vivid daydreams that cause withdrawal or reverie;
- deviations in social behavior which cause concern to others;
- lack of emotional control that is a nuisance to family and associates;
- moderate disturbance from organic brain disease such as to require a moderate amount of supervision and direction of work day activities.

Category 5

- Marked apprehension so as to interfere with memory and concentration and/or to disturb markedly personal relationships;
- depression causing marked loss of interest in daily activities, loss of weight, unkempt appearance, marked psychomotor retardation, suicidal preoccupation or disruptive behavior;
- psychophysiological reactions resulting in lasting organ or tissue damage;
- obsessive-compulsive reactions that preclude patient's usual activity;
- frequent or persistent loss of function from conversion or hysterical reactions with regressive tissue or organ change;
- defects in perception including frank illusions or hallucinations occupying much of the patient's time;
- behavior deviations so marked as to interfere seriously with the physical or mental well-being or activities of others;
- lack of emotional control including marked irritability or over activity.

Respiratory and Air Passages

Respiratory

Rules–For claims with a date of injury before March 1, 1994 (WAC 296-20-370)

1. Rules for evaluation of permanent respiratory impairments:

   (a) All reports of physical examination of persons for respiratory impairment shall include: Date of examination, name, sex, address, birth date, marital status, and occupation of the person being examined; height, weight, temperature, pulse rate, blood pressure and respiratory rate and physical findings on inspection, palpation, percussion, and auscultation, vital capacity tests including one-second forced expiratory volume, forced vital capacity and maximum voluntary ventilation; all symptoms such as wheeze, cough, orthopnea, chest pain, paroxysmal nocturnal dyspnea, expectoration, hemoptysis, as to date of onset, course with descriptions, variation, whether influenced by bodily activity, emotional stress, posture, allergens, immediate environmental factors, medications, frequency and duration, and how they are affected by respiratory infections; the history of the particular exposure, a history of any previous chest x-

rays, any allergies, cardiac symptoms or diagnosis, chest surgery or deformities, trauma, or other conditions such as pneumothorax, pulmonary infarct or chemical bronchitis; all pertinent personal history of habits such as smoking, weight gain or loss, fatigability, appetite; use of medications such as steroids, digitalis, antibiotics, bronchodilators, expectorants, etc., and occupational history.

(b) Categories 2 through 6 in WAC 296-20-380 include the presence of complaints of whatever degree.

(c) Dyspnea is the major complaint of respiratory impairment, and can usually be explained by the presence of abnormal lung ventilation, perfusion, or diffusion, measured either at rest or exercise. Since mechanisms of respiratory tract damage may differ widely, individual lung functions tests may not wholly correspond to the following categories of impairment, but the examining physician should be able to categorize the vast majority of persons, using a ”best fit” method for the following respiratory impairment Categories I through VI.

(d) Persisting variable respiratory impairment due to allergic or irritative disorders or the respiratory tract, such as bronchial asthma or reactive airway disease, caused or substantially aggravated by factors in the work place, shall be evaluated by detailed narrative report, including rationale for the work relationship, relative importance of nonwork-related co-factors, such as preexisting asthma, tobacco usage, or other personal habits, the need for regular medication to substantially improve or control the respiratory condition, and the prognosis. If tests of ventilatory function, done when the person is in clinical remission, are nearly normal (1) second forced expiratory volume 80 percent or greater of predicted, (2) an appropriate provocative bronchial challenge test should be done to demonstrate the presence of unusual respiratory sensitivity. When the respiratory condition (asthma or reactive airway disease) is thought to be permanent, but the degree of respiratory impairment varies, then the examining physician shall give an estimate of percentage of total bodily impairment, as per Rule 15 or WAC 296-20-220.

Rules—For claims with a date of injury on or after March 1, 1994 (WAC 296-20-370)

1. Rules for evaluation of permanent respiratory impairments:

(a) Definitions.

i. “FEV1” means the forced expiratory volume in 1 second as measured by a spirometric test performed as described in the most current *American Thoracic Society Statement on Standardization of Spirometry*, and using equipment, methods of calibration, and techniques that meet American Thoracic Society (ATS) criteria including reproducibility. The measurement used must be taken from a spirogram which is technically acceptable and represents the patient’s best effort. The measurement is to be expressed as both an absolute value and as a percentage of the predicted value. The predicted values are those listed in the most current edition of the *American Medical Association (AMA) Guidelines* for rating permanent respiratory impairment.

ii. “FVC” means the forced vital capacity as measured by a spirometric test in accordance with criteria described in (a)(i) of this subsection.

iii. "FEV1/FVC" is a ratio calculated based on the ATS Guides criteria as described in the most current American Thoracic Society Statement on Standardization of Spirometry.
iv. "Significant improvement" means a fifteen percent or greater improvement in FEV1 (volume) after a post-bronchodilator pulmonary function test.
v. "DLCO" means the diffusion capacity of carbon monoxide as measured by a test based on predicted values demonstrated to be appropriate to the techniques and equipment of the laboratory performing the test according to current ATS standards. DLCO may be considered for impairment rating only if accompanied by evidence of impaired gas exchange based on exercise testing.
vi. "VO2 Max" means the directly measured oxygen consumption at maximum exercise capacity of an individual as measured by exercise testing and oxygen consumption expressed in ml/kilo/min corrected for lean body-weight. Estimated values from treadmill or other exercise tests without direct measurement are not acceptable. The factor limiting the exercise must be identified.
vii. "Preexisting impairment" shall be reported as described in WAC 296-20-220 (l)(h).
viii. "Coexisting" is a disease or injury not due to or causally related to the work-related condition that impacts the overall respiratory disability.
ix. "Apportionment" is an estimate of the degree of impairment due to the occupational injury/exposure when preexisting or coexisting conditions are present.
x. "Dyspnea" is the subjective complaint of shortness of breath. Dyspnea alone must not be used to determine the level of respiratory impairment. Dyspnea unexplained by objective signs of impairment of spirometry requires more extensive testing (i.e., VO2 Max).
xi. Copies of the *American Thoracic Society Statement on Standardization of Spirometry* and ATS standards for measuring DLCO can be obtained by ordering *Pulmonary Function Testing* from The American Thoracic Society, 17640 Broadway, New York, NY 10019-4374, Attn: ATS Statements. Copies of this document are available for review in the section of the Office of the Medical Director, Department of Labor & Industries, Tumwater building.

These standards are also available through the following references: "American Thoracic Society of Committee on Proficiency Standards for Pulmonary Function Laboratories: Standardization of Spirometry-1987 update." *Am Rev Respir Dis* 1987; 136:1285-1298. "American Thoracic Society DLCO Standardization Conference: Single breath carbon monoxide diffusing capacity (transfer factor): Recommendations for a standard technique." *Am Rev Respir Dis* 1987; 136:1299-13707.

(b) Evaluation procedures. Each report of examination must include the following, at a minimum:

i. Identification data: Worker's name, claim number, gender, age, and race.
ii. Detailed occupational history: Job titles of all jobs held since employment began. A detailed description of typical job duties, protective equipment worn, engineering controls present (e.g., ventilation) as well as the specific exposures and intensity (frequency and duration) of exposures. More detail is required for jobs involving potential exposure to known respiratory hazards.

iii. History of the present illness: Chief complaint and description of all respiratory symptoms present (e.g., wheezing, cough, phlegm, chest pain, paroxysmal nocturnal dyspnea, dyspnea at rest and on exertion) as well as the approximate date of onset, and duration of each symptom, and aggravating and relieving factors.
iv. Past medical history: Past history of childhood or adult respiratory illness, hay fever, asthma, bronchitis, chest injury, chest surgery, respiratory infections, cardiac problems, hospitalizations for chest or breathing problems and current medications.
v. Lifestyle and environmental exposures: Descriptive history of exposures clinically related to respiratory disease including, but not limited to, tobacco use with type and years smoked. Use of wood as a primary heat source at home or hobbies that involve potential exposure to known respiratory tract hazards, and other environmental exposures.
vi. Family history: Family history of respiratory or cardiac disease.
vii. Physical examination findings: Vital signs including a measured height without shoes, weight, and blood pressure. Chest exam shall include a description of the shape, breathing, breath sounds, cardiac exam, and condition of extremities (e.g., cyanosis, clubbing, or edema).
viii. Diagnostic tests: A chest x-ray shall be obtained in all cases. When available, the x-ray should be obtained using International Labor Organization (ILO) standard techniques and interpreted using the ILO classification system. The presence or absence of pleural thickening or interstitial abnormalities shall be noted. Also include pulmonary function reports including a description of equipment used, method of calibration, and the predicted values used. A hard copy of all pulmonary functions tracings must be available for review. The report must contain a minimum FEV1 and FVC and a narrative summary of an interpretation of the test results and their validity.
ix. The rating of respiratory impairment. The rating of respiratory impairment shall be based on the pulmonary function test most appropriate to the respiratory condition. A prebronchodilator and postbronchodilator test must be performed on and results reported for all patients with demonstrated airway obstruction. The largest FEV1 or FVC, on either the prebronchodilator or postbronchodilator trial must be used for the rating impairment. If the FEV1 and FEV1/FVC result in different categories of impairment, the value resulting in a higher category on impairment will be used.
x. The rating of persisting variable respiratory impairment with abnormal baseline function. If resting FEV1 is “abnormal” (below eighty percent predicted) and shows significant bronchodilator improvement (a greater than or equal to fifteen percent improvement in FEV1) one category of impairment must be added to the given category rating, but only when the work-related disease being rated is obstructive in nature. If there is substantial variability from test to test (and good effort) the severity of impairment may be rated, using the best fit into the category system, as described in WAC 296-20-380.
xi. The rating of persisting variable respiratory impairment with normal baseline spirometry. Variable respiratory impairment due to allergic or irritative disorder of the respiratory tract, such as bronchial asthma or reactive airway disease, caused or permanently aggravated by factors in the work place, shall be evaluated by detailed narrative report, including the causal relationship to work factors, a discussion of the relative importance

of nonwork related cofactors, such as preexisting asthma, tobacco usage, or other personal habits, the need for regular medication to substantially improve or control the respiratory condition, and the prognosis. When tests of ventilatory function, done when the patient is in a clinical steady state, are normal (one second forced expiratory volume eighty percent or greater if predicted), an appropriate provocative bronchial challenge test (i.e., methacholine or histamine) shall be done to demonstrate the presence of unusual respiratory sensitivity.

xii. At the time of the rating, the patient shall be off theophylline for at least twenty-four hours, beta agonists for at least twelve hours, and oral and/or inhaled steroids or cromolyn for at least two weeks, in order to determine severity of air-flow obstruction, unattenuated by therapy. If withdrawal of medication would produce a hazardous or life threatening condition, then the impairment cannot be rated at this time, and the physician must provide a statement describing the patient's condition and the effect of medication withdrawal.

xiii. The method for standardizing provocative bronchial challenge testing, using either histamine or methacholine, shall be used. The test drug may be given either by continuous tidal volume inhalation of known concentrations, using an updraft nebulizer, for two minutes, or by the technique of intermittent deep breaths of increasing test drug strengths either via a Rosenthal dosimeter or updraft nebulizer, and the results shall be expressed either as the mg/ml concentration of test drug, or the cumulative breath units (1 breath of a 1 mg/ml solution equals one breath unit) which result in a prompt and sustained (at least three minute) fall in the FEV1, greater than twenty percent below baseline FEV1. Medications that can blunt the effect of bronchoprovocation testing shall be withheld prior to testing. Once testing is complete, the results shall be expressed in terms of normal, mild, moderate, or marked bronchial reactivity, as described in WAC 296-20-385.

    If multiple bronchoprocative inhalation challenge tests have been done, the examining physician shall select the one category (normal, mild, moderate, or marked) which most accurately indicates the overall degree of permanent impairment at the time of rating. If the results of serial pulmonary function testing are extremely variable and the clinical course and use of medication also indicate major impairment, then the physician must make a statement in the formulation and medical evaluation containing, at a minimum: Diagnosis and whether work-related or nonwork-related; nature and frequency of treatment; stability of condition and work limitations; impairment.

xiv. Further treatment needs. In all cases, the examining physician shall indicate whether further treatment is indicated and the nature, type, frequency, and duration of treatment recommended.

Categories of permanent respiratory impairments – For Claims with a date of injury before March 1, 1994 (WAC 296-20-380)

Category 1. Tests of ventilatory functions are not less than 85 percent of predicted normal for the person's age, sex and height. Arterial oxygen saturation at rest and after exercise is 93 percent or greater. Subjective complaints may be present or absent.

Category 2. Tests of ventilatory function range from 70 to 85 percent of predicted normal for the person's age, sex and height. Arterial oxygen saturation at rest and after exercise is 93 percent or greater. Dyspnea consistent with ventilatory function and arterial oxygen saturation.

Category 3. Tests of ventilatory function range from 60 to 70 percent of predicted normal for the person's age, sex and height and/or arterial oxygen saturation at rest is normal but after exercise is 88 to 93 percent. Dyspnea consistent with ventilatory function and arterial oxygen saturation.

Category 4. Tests of ventilatory function range from 50 to 60 percent of predicted normal for the person's age, sex and height. Arterial oxygen saturation at rest and after exercise is 88 to 93 percent. The single breath diffusing capacity (if performed) is greater than 50 percent predicted. Dyspnea consistent with ventilatory function and arterial oxygen saturation.

Category 5. Tests of ventilatory function range from 40 to 50 percent of predicted normal for the person's age, sex and height. Arterial oxygen saturation at rest and after exercise is less than 88 percent. The single breath diffusing capacity is greater than 40 percent predicted. Dyspnea consistent with ventilatory function and arterial oxygen saturation.

Category 6. Tests of ventilatory function are below 40 percent of predicted normal for the person's age, sex and height. Arterial oxygen saturation at either rest or exercise is less 83 percent or less. The single breath diffusing capacity is 40 percent or less of predicted. Grade III or IV dyspnea is present, measured on a scale of 0 to 4.

Categories of permanent respiratory impairments – For claims with a date of injury on or after March 1, 1994 (WAC 296-20-380)

Choose the category below which best describes the patient's impairment:

Category 1. The FVC and FEV1 are greater than or equal to eighty percent of predicted normal for the person's age, sex and height. The FEV1/FVC ratio is greater than or equal to .70. Subjective complaints may be present or absent. If exercise testing is done, the maximum oxygen consumption is greater than 25cc/kilo/min.

Category 2. The FVC or FEV1 is from seventy to seventy-nine percent of predicted, and if obstruction is present, the FEV1/FVC ratio is .60-.69. If exercise testing is done, the maximum oxygen consumption is 22.5-25cc/kilo/min.

Category 3. The FVC or FEV1 is from sixty to sixty-nine percent of predicted, and if obstruction is present, the FEV1/FVC ratio is .60-.69. If exercise testing is done, the maximum oxygen consumption is 20-22.4cc/kilo/min.

Category 4. The FVC or FEV1 is from fifty-one to fifty-nine percent of predicted. The FEV1/FVC ratio is .51-.59. If exercise testing is done, the maximum oxygen consumption is 17.5-19.9cc/kilo/min.

Category 5. FVC from fifty-one to fifty-nine percent of predicted, or the FEV1 from forty-one to fifty percent of predicted, and if obstruction is present, the FEV1/FVC ratio is .41-.50. If exercise testing is done, the maximum oxygen consumption is 15-17.4cc/kilo/min.

Category 6. The FVC is equal to or less than fifty percent of predicted or the FEV1 is equal to or less than forty percent of predicted. The FEV1/FVC ratio is equal to or less than .40. If exercise testing is done, the maximum oxygen consumption is less than 15cc/kilo/min.

Categories of persisting variable respiratory impairment with normal baseline spirometry–for claims with a date of injury on or after March 1, 1994 (WAC 296-20-385)
Choose the category below which best describes the patient's impairment:

Category 1. "Normal" bronchial reactivity is demonstrated by an insignificant (less than twenty percent) fall from baseline FEV1 at test doses of histamine or methacholine, up to 16mg/ml (continuous inhalation method) or up to 160 breath units (cumulative, repeated deep breath technique).

Category 2. "Mild" bronchial hyperactivity (BHR) is a significant (equal to or greater than twenty percent) fall in the FEV1 at test doses of 2.1-16-mg/ml, or 21-160 breath units.

Category 3. "Moderate" BHR is a significant (equal to or greater than twenty percent) fall in the FEV1 at test doses of 0.26-2-mg/ml, or 2.6-20 breath units.

Category 4. "Marked" BHR is a significant (equal to or greater than twenty percent) fall in FEV1 at test doses equal to or less than .25 mg/ml, or 2.5 breath units.

Air Passages

Rules (WAC 296-20-390)
1. Rule for evaluation of permanent air passage impairments:

   (a) Categories 2, 3, 4 and 5 include the presence of complaints of whatever degree.

Categories (WAC 296-20-400)
Choose the category below which best describes the patient's impairment:

Category 1. No objective findings are present. Subjective complaints may be present or absent.

Category 2. Objective findings of one or more of the following air passage defects: partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, complete obstruction of nasopharynx or of nasal passages bilaterally. No dyspnea caused by the air passage defect even on activity requiring prolonged exertion or intensive effort.

Category 3. Objective findings of one or more of the following air passage defects: partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, complete obstruction of nasopharynx or of nasal passages bilaterally, dyspnea caused by the air passage defect produced only by prolonged exertion or intensive effort.

Category 4. Objective findings of one or more of the following air passage defects: partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, complete obstruction of nasopharynx or of nasal passages bilaterally, with permanent tracheostomy or stoma, dyspnea caused by the air passage defect produced only by prolonged exertion or intensive effort.

Category 5. Objective findings of one or more of the following air passage defects: partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, with or without permanent tracheostomy or stoma if dyspnea is produced by moderate exertion.

Category 6. Objective findings of one or more of the following air passage defects: partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, with or without permanent tracheostomy or stoma if dyspnea is produced by mild exertion.

Nasal Septum Perforations

Rules (WAC 296-20-410)

1. Rules for evaluation of permanent air passage impairments due to nasal septum perforation.

   (a) These categories, if appropriate, are to be used in addition to the Categories of Permanent Air Passage Impairment.

   (b) Categories 1 and 2 include complaints of whatever degree.

Categories (WAC 296-20-420)

Choose the category below which best describes the patient's impairment:

Category 1. Perforation or perforations posterior to the cartilaginous septum.

Category2. Perforation or perforations through or anterior to the cartilaginous septum.

Chronic Sinusitis

The *AMA Guides* should be used for rating of impairment from chronic sinusitis.

Skin

Rules (WAC 296-20-470)

1. Rules for evaluation of permanent skin impairments.

   (a) Evaluation of permanent impairment of the skin shall be based upon actual loss of function and cosmetic factors shall not be considered.

   (b) Categories 2, 3, 4, 5 and 6 include the presence of complaints of whatever degree.

Categories (WAC 296-20-480)

Choose the category below which best describes the patient's impairment:

Category 1. Objective findings of skin disorder may be present or absent but there is no, or minimal limitation in daily activities. Subjective complaints may be present or absent.

Category 2. Objective findings of skin disorder are present and there is discomfort and minimal limitation in the performance of daily activities.

Category 3. Objective findings of skin disorder are present and there is limitation in some daily activities, including avoidance of and protective measures against certain chemical or physical agents. Intermittent symptomatic treatment is required.

Category 4. Objective findings of skin disorders are present and there is limitation in many daily activities, including avoidance of and protective measures against certain chemical or physical agents. Continuous symptomatic treatment is required.

Category 5. Objective findings of skin disorder are present and there is limitation in most daily activities, including avoidance of and protective measures against certain chemical or physical agents. Continuous symptomatic treatment is required.

Category 6. Objective findings of skin disorder are present and there is limitation in all daily activities, including avoidance of and protective measures against certain chemical or physical agents. Continuous symptomatic treatment is required.

IMPORTANT NOTE: "Skin" is viewed as an organ system under the WAC rules. In using these WACs on skin impairment, be aware of the following points:

1) If a body part has been amputated and significant skin grafting is required (for example, after a de-gloving accident), it may be appropriate to rate skin impairment in addition to the impairment from the amputation itself. Also, it may be appropriate to rate impairment from the donor site for the skin grafts. In all cases, the impairment must be based on the factors included in WAC 296-20-470 and 296-20-480. For example, the impairment must be based in part on the effects on daily activities, and those effects must be clearly documented and included in the rationale section of your impairment rating report.

2) If more than one part of the body is affected by skin conditions (for example, burns of the right arm, left leg and neck; or skin allergies affecting more than one part of the body; or skin grafts from multiple sites), you must provide a single skin impairment rating that reflects the effects on all involved parts of the skin. If some parts of the skin are affected more than others, you must choose the category that best describes the "totality" of the effect, with special attention to the overall impact on daily activities. Under no circumstance should you give more than a single skin impairment rating. (For example, consider a situation where one arm is severely burned, and one leg is only slightly burned, and a skin graft from another part of the body results in moderate effects. In this example, you must rate the impairment from all the skin conditions taken together, giving a single category rating that considers the factors in WAC 296-20-470 and WAC 296-20-480, including impact on daily activities. If there are other diagnoses, such as bone fracture, etc., it may be appropriate to rate impairment from these conditions separately, using the appropriate rating system. You should not "combine" or "add" ratings for other diagnoses to your rating for the skin condition - simply state them separately.)

3) For chronic osteomyelitis with active drainage involving the lower extremity, do NOT use these categories. Instead, use the *AMA Guides*. Use the edition of the *American Medical Association* Guides to the Evaluation of Permanent Impairment designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition. Currently the department has designated the Fifth Edition.) For example, on page 550 of the Fifth Edition, Table 17-36 provides a method for rating such conditions.

4) WAC 296-20-470 specifies that impairment rating for the skin should be based upon actual loss of function, and cosmetic factors are not considered. This is illustrated by the Edwards Case, where the department had closed the claim with an award for 5% loss of function of the left arm at the elbow, but the employer appealed, arguing that the award was made for cosmetic residuals alone. However, the rating physician had based his opinion on functional loss – i.e. scar tissue did not withstand the normal wear and tear as normal skin, was more likely to "break down" with temperature changes, and resulted in bothersome itching for the worker. The Board found that the rating was "amply supported by other than cosmetic considerations," and affirmed the award

Speech

Rules (WAC 296-20-450)

1. Rules for evaluation of permanent speech impairments.

   (a) The physician making an examination for evaluation of permanent speech impairment should have normal hearing and the examination should be conducted in a reasonably quiet office which approximates the noise level conditions of everyday living.

   (b) Selection of the appropriate category of permanent speech impairment shall be based on direct observation of the speech of the person being examined, including, but not limited to: response to interview, oral reading, and counting aloud. The observation shall be made with the physician about eight feet from the person being examined both when he faces the physician and with his back to the physician.

Categories (WAC 296-20-460)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings of significant speech impairments are present. Subjective complaints may be present or absent.

Category 2. Can produce speech of sufficient audibility, intelligibility and functional efficiency for most everyday needs, although this may require effort and occasionally exceed capacity; listeners may occasionally ask for repetition and it may be difficult to produce some elements of speech, and there may be slow speaking and hesitation.

Category 3. Can produce speech of sufficient audibility, intelligibility and functional efficiency for many everyday needs, is usually heard under average conditions but may have difficulty in automobiles, busses, trains, or enclosed areas; can give name, address, and be understood by a stranger, but may have numerous inaccuracies and have difficulty articulating; speech may be interrupted, hesitant or slow.

Category 4. Can produce speech of sufficient audibility, intelligibility and functional efficiency for some everyday needs such as close conversation, conversation with family and friends, but has considerable difficulty in noisy places; voice tires rapidly and tends to become inaudible in a few seconds, strangers may find patient difficult to understand; patient may be asked to repeat often, and often can only sustain consecutive speech for brief periods.

Category 5. Can produce speech of sufficient audibility, intelligibility and functional efficiency for few everyday needs; can barely be heard by a close listener or over the telephone; may be able to whisper audibly but has no voice; can produce some speech elements; may have approximation of a few words such as names of family members which are, however, unintelligible out of context; cannot maintain uninterrupted speech flow, speech is labored, and its rate is impractically slow.

Category 6. Is unable to produce speech of sufficient audibility, intelligibility and functional efficiency for any everyday needs.

Taste and Smell

Rules (WAC 296-20-430)

1. Rule for evaluation of permanent loss of taste and smell.

   (a) If the person being examined can detect any odor or taste, even though it cannot be named, no category shall be assigned.

Categories (WAC 296-20-440)

Choose the category below which best describes the patient's impairment:

Category 1. Loss of sense of taste.

Category 2. Loss of sense of smell.

IMPORTANT NOTE: If the worker has both loss of sense of taste AND loss of sense of smell, provide an impairment rating using both Category I and Category II.

Urinary and Reproductive Systems

Spleen, Loss of One Kidney and Surgical Removal of Bladder with Urinary Diversion

Rules (WAC 296-20-570)

1. Rule for evaluation of permanent impairments of the spleen, loss of one kidney, and surgical removal of bladder with urinary diversion.

   (a) Categories 1, 2 and 3 include complaints of whatever degree.

Categories (WAC 296-20-580)

Choose the category below which best describes the patient's impairment (more than one category may be chosen):

Category 1. Loss of spleen by splenectomy after age eight.

Category 2. Loss of one kidney by surgery or complete loss of function of one kidney.

Category 3. Surgical removal of bladder with urinary diversion.

IMPORTANT NOTE: More than one category may be selected in your impairment rating.

Upper Urinary Tract

Rules (WAC 296-20-590)

1. Rule for evaluation of permanent impairment of upper urinary tract.

   (a) Categories 2, 3, 4 and 5 include the presence of complaints of whatever nature.

Categories (WAC 296-20-600)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings of impairment of the upper urinary tract. Subjective complaints may be present or absent.

Category 2. Loss of upper urinary function as evidenced by creatinine clearance of 75 to 90 liters/24 hr (52 to 62.5 ml/min) and PSP excretion of 15 percent to 20 percent in 15 minutes; or if there are intermittent objective findings of upper urinary tract disease or dysfunction not requiring continuous treatment or surveillance.

Category 3. Loss of upper urinary tract function as evidenced by creatinine clearance of 60 to 75 liters/24 hr (42 to 52 ml/min) and PSP excretion of 10 percent to 15 percent in 15 minutes; or although function is greater than test levels, there are objective findings of upper urinary tract disease or dysfunction requiring continuous surveillance and frequent symptomatic treatment.

Category 4. Loss of upper urinary tract function as evidenced by creatinine clearance of 40 to 60 liters/24 hr (28 to 42 ml/min) and PSP excretion of 5 percent to 10 percent in 15 minutes; or although function is greater than these levels, there are objective findings of mild or moderate upper urinary tract disease or dysfunction which can be only partially controlled.

Category 5. Loss of upper urinary tract function as evidenced by creatinine clearance below 40 liters/24 hr (28 ml/min) and PSP excretion below 5 percent in 15 minutes; or although function is greater than these levels there are objective findings of severe upper urinary tract disease or dysfunction which persists despite continuous treatment.

Upper Urinary Tract (due to surgical diversion)

Rules (WAC 296-20-610)

1. Rule for evaluation of additional permanent impairments of upper urinary tract due to surgical diversion.

   (a) These categories include the presence of complaints of whatever degree.

Categories (WAC 296-20-620)

Choose the category below which best describes the patient's impairment:

Category 1. Uretero-intestinal diversion of cutaneous ureterostomy without intubation.

Category 2. Nephrostomy or intubated ureterostomy.

Bladder

Rules (WAC 296-20-630)

1. Rules for evaluation of permanent impairment of bladder function.

   (a) In making examinations for evaluation of impairments of bladder function, physicians shall use objective techniques including, but not limited to, cystoscopy, cystography, voiding cystourethrography, cystometry, uroflometry, urinalysis and urine culture.

   (b) Categories 2, 3, 4 and 5 include the presence of complaints of whatever degree.

Categories (WAC 296-20-640)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings are present. Subjective complaints may be present or absent.

Category 2. Objective findings of bladder dysfunction, intermittent treatment required, but there is no dysfunction between such intermittent attacks.

Category 3. Objective findings of bladder dysfunction, continuous treatment required or there is good bladder reflex activity but no voluntary control.

Category 4. Objective findings of bladder dysfunction, there is poor reflex activity with intermittent dribbling and no voluntary control.

Category 5. Objective findings of bladder dysfunction, there is no reflex or voluntary control and there is continuous dribbling.

Male Reproductive Organs

Testicular

Rules (296-20-650)

1. Rule for evaluation of permanent anatomical or functional loss of testes.

   (a) Categories 2, 3, 4 and 5 include the presence of whatever complaints.

Categories (WAC 296-20-660)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings. Subjective complaints may be present or absent.

Category 2. Anatomical or functional loss of one testicle.

Category 3. Anatomical or functional loss of both testes after the age of 65.

Category 4. Anatomical or functional loss of both testes between the ages of 40 and 65.

Category 5. Anatomical or functional loss of both testes before the age of 40.

The AMA Guides should be used for rating of impairment for all other male reproductive organs, including the penis (erectile dysfunction), scrotum, epididymides, spermatic cords, prostate, and seminal vesicle.

Female Reproductive Organs

The AMA Guides should be used for rating of impairment for all female reproductive organs.

Vascular Conditions

Impairment due to vascular conditions should be rated using the *AMA Guides*. Use the edition of the *American Medical Association Guides to the Evaluation of Permanent Impairment* designated by the department. (See the Independent Medical Exams page on the L&I website for details about the designated edition. Currently the department has designated the Fifth Edition.)

IMPORTANT NOTE: You must give an exact percentage, NOT a range of percentages. This section of the *AMA Guides*, like several others, instructs the rating examiner to choose Class 1, 2, 3, etc., each with a range of percentages. After you decide the appropriate Class, you must give your best estimate of a specific percentage (not a range). Without your estimate of the exact percentage the Claim Manager will not be able to calculate the impairment award.

Vision

A. How Rating Impairment of the Visual System for L&I Differs from Rating with the *AMA Guides*

There are several key reasons why you must not simply rate using the *AMA Guides*. Instead, you must rate as described in this section, taking into account unique aspects under Washington statute. Briefly, these include:

- **Complete loss of vision:** Loss of central visual acuity of 20/200 or greater by Snellen notation (without correction) is considered to be equal to 100% loss of central visual acuity - sometimes called "industrial blindness". (See details below.)
- **Uncorrected versus corrected vision:** The law requires doctors to base impairment ratings on uncorrected vision. (See details below.)
- **Monocular versus binocular**: In general, when the only abnormality is loss of visual acuity and only one eye is affected, DO NOT rate impairment of the visual system as a whole. (See details below.)
- **Pre-injury status:** To help you assess pre-injury acuity, etc., the Claim Manager will often but not always obtain pre-injury records. When records are not available, you will need to use your best medical judgment to estimate pre-injury status. See Sample Reports #1 and #2.

The table below summarizes how to rate various conditions using parts of this section:

Worker's condition	Rate using	Brief Notes (see details on following pages):
Complete loss of vision (in one or both eyes)	Part B	Includes loss of central visual acuity of 20/200 or greater (without correction)
Partial loss of visual acuity (in one or both eyes)	Part C	Use *AMA Guides*. Base rating on uncorrected acuity. Rate each eye individually (not binocular).
Loss of visual fields in one or both eyes, **without** loss of visual acuity	Part D	Use *AMA Guides*. Calculate FFS and give a specific percent - see Part D for details.
Loss of visual fields and/or diplopia, **with** loss of visual acuity	Part E	Use *AMA Guides*. Calculate VSI – see Part E for details.

B. Complete Loss of Vision

To rate complete loss of vision in an eye, do NOT use the *AMA Guides*. Instead, as illustrated in Sample Rating Report #1 below, cite RCW 51.32.080 and simply report the impairment as either one of the following: (1) Loss of one eye by enucleation, or (2) Loss of central visual acuity in one eye, per the following statute:

RCW 51.32.080 Permanent partial disability— Injury after permanent partial disability.

- Loss of one eye by enucleation
- Loss of central visual acuity in one eye

IMPORTANT NOTE: The Department has a longstanding policy that any industrially caused loss of central visual acuity of 20/200 or greater by Snellen notation is considered to be industrial blindness and entitles the claimant to receive the full statutory amount allowed for loss of central visual acuity in the affected eye. In this situation, in your report, simply give the Snellen notation for each eye separately. Do not use the *AMA Guides* to rate loss of acuity in this case.

- **Monocular versus binocular:** In general, when the only abnormality is loss of visual acuity and only one eye is affected, DO NOT rate impairment of the visual system as a whole. (See details below.) The reason for this is that the PPD calculation by the Claim Manager is based on the statutory loss of vision in each eye.

SAMPLE RATING REPORT #1 – COMPLETE LOSS OF CENTRAL VISUAL ACUITY (excerpt: the 4th and 5th of the five essential elements of all rating reports):

4. IMPAIRMENT RATING: Mr. Jones' impairment resulting from the accepted condition is 100% of the value of complete loss of central visual acuity in the right eye, as provided in RCW 51.32.080.

5. RATIONALE: Mr. Jones' injury has resulted in loss of visual acuity in his right eye.

Current condition: The visual acuity in his right eye and left eye (respectively) without correction, are currently 20/300 and 20/20 by Snellen notation. His binocular visual acuity without correction is currently 20/20 by Snellen notation.

Pre-injury condition: No records have been provided documenting pre-injury acuities. Based on my history from the worker, my examination of the worker, and my best medical judgment, it is my opinion on a more-probable-than-not basis that Mr. Jones' pre-injury right, left, and binocular acuities were all 20/20 by Snellen notation.

Rating: According to the Medical Examiners' Handbook, by department policy 20/200 is considered to be industrial blindness. Therefore, under RCW 51.32.080, there is impairment of 100% of the value of complete loss of central visual acuity in the right eye.

C. Partial Loss of Visual Acuity (without visual field loss or other abnormalities)

Partial loss of visual acuity is rated as a percentage of complete loss of central visual acuity in each eye. When evaluating vision, provide central visual acuity data in your report.

1) **20/200 – defined as blindness:** The Department has a longstanding policy that any industrially caused loss of central visual acuity of 20/200 or greater by Snellen notation is considered to be industrial blindness and entitles the claimant to receive the full statutory amount allowed for loss of central visual acuity in the affected eye. In this situation, in your report, simply give the Snellen notation for each eye separately. Do not use the *AMA Guides* to rate loss of acuity in this case. (See Part B above, "Complete Loss of Vision.")

2) **Use uncorrected vision:** To rate loss of uncorrected visual acuity, use the edition of the *AMA Guides* designated by the department (currently the Fifth Edition). Describe the worker's condition without correction, without the aid of glasses. (Disregard *AMA Guides* instructions to use best-corrected visual acuity as described on page 282, Section 12.2b.3.)
PLEASE NOTE: Although the *AMA Guides* has instructed examiners to use corrected visual acuities for the rating, RCW 51.36.020 requires that the rating of visual impairment be based on the loss of sight before correction. Therefore, examiners should use uncorrected visual acuities for the rating.

   RCW 51.36.020 (2) indicates:
   "Every worker whose injury results in the loss of one or more limbs or eyes shall be provided with proper artificial substitutes and every worker, who suffers an injury to an eye producing an error of refraction, shall be once provided proper and properly equipped lenses to correct such error or refraction **and his or her disability rating shall be based upon the loss of sight before correction."**

3) **IMPORTANT NOTE - Rate each eye separately.**
   In general, when the only abnormality is loss of visual acuity:
   - DO NOT rate impairment of the visual system as a whole.
   - DO NOT STATE THE RATING AS AN IMPAIRMENT OF THE WHOLE PERSON. Instead, give the impairment as a percent of "the value of complete loss of central visual acuity in the right or left eye, as provided in RCW 51.32.080." (See "Complete loss of vision" above)

4) **Use Snellen notation and Table 12-2:** Provide uncorrected monocular measurements for both eyes (even if only one eye has been injured). Use Table 12-2 on page 284 of the *AMA Guides*, Fifth Edition to calculate the Visual Acuity Impairment % based on Snellen notation for each eye. For example, Table 12-2 shows that a visual acuity of 20/80 corresponds to a Visual Acuity Impairment Rating of 30%. (No need to use Table 12-3, etc. to evaluate the visual system as a whole.) Your rating report simply states "x% impairment of the eye" using language demonstrated in Sample Report #2.

5) **Pre-injury status:** If the Claim Manager requests that you compare post-injury and pre-injury vision, provide this data in your report. The Claim Manager may pay the difference between the two ratings, depending on the circumstances. You should not calculate the difference - simply state the pre- and post-injury acuity impairment percentages. If pre-injury data are not available, notify the Claim Manager to see if the data can be obtained. If the data cannot be obtained, use your best medical judgment to estimate pre-injury, uncorrected visual acuity. If the worker had a symptomatic pre-existing condition, the department is only responsible for the increase in impairment. See Chapter 5 for more information on pre-existing conditions.

6) **Rationale:** In your report, cite all the page numbers and table numbers you use (along with the complete title of the *AMA Guides*, including the edition of the *AMA Guides* designated by the department (currently the Fifth Edition). Make it easy for readers to understand how you reached your conclusions.

7) **Treatment recommendations:** Give treatment recommendations, if requested by the Claim Manager.

SAMPLE RATING REPORT #2 – PARTIAL LOSS OF VISUAL ACUITY (excerpt: the 4th and 5th of the five essential elements of all rating reports):

4. IMPAIRMENT RATING: Mr. Jones' impairment resulting from the accepted condition is 35% of the value of complete loss of central visual acuity in the right eye, as provided in RCW 51.32.080.

5. RATIONALE: Mr. Jones' injury has resulted in loss of visual acuity in his right eye.

Current condition: The visual acuities without correction are currently 20/100 in the right eye and 20/20 in the left eye by Snellen notation. His binocular visual acuity without correction is currently 20/20 by Snellen notation.

Pre-injury condition: Records have been provided documenting pre-injury acuities. A medical record dated May 17, 2014 – 3 months prior to the date of injury on this claim - gives measurements of uncorrected vision of 20/40 in the right eye and 20/20 in the left eye. Based on my history from the worker, my examination of the worker, and my best medical judgment, it my opinion on a more-probable-than-not basis that Mr. Jones' pre-injury right and left acuities were 20/40 and 20/20, respectively, by Snellen notation.

Rating: According to Table 12-2 on page 284 of the *AMA Guides*, Fifth Edition, his Visual Acuity Impairment Rating in the right eye is 35% of the value of complete loss of central visual acuity in the right eye, as provided in RCW 51.32.080. [If the Claim Manager asks about pre-existing acuities, you may add: "Prior to the industrial injury, his acuity of 20/40 without correction equates to 15% loss of central visual acuity in the right eye."]

D. Loss of Visual Fields in One or Both Eyes, without Loss of Visual Acuity

When there is visual field loss in one or both eyes, follow the *AMA* instructions carefully. Begin on page 298, Table 12-10 and refer to the part of the table titled "Both eyes have normal visual acuity and…" Decide whether the patient best fits under "visual fields better than 50 degrees," "visual fields better than 30 degrees" etc. To make this determination, use the *AMA Guides* Fifth Edition, Section 12.3b, pages 288 to 295. In your report, state the Class that corresponds. **Then select the exact percent of Whole Person impairment within that class, based on your best medical judgment.**

- **IMPORTANT NOTE: You must give an exact percentage, NOT a range of percentages.** Several sections of the *AMA Guides* instruct the rating examiner to choose among several "Classes", each with a range of percentages. After you decide the appropriate Class, you must give your best estimate of a specific percentage (not a range). Without your estimate of the exact percentage the Claim Manager will not be able to calculate the impairment award.

  Example: In the context of visual field loss, Table 12-10 on page 298 gives 6 Classes of impairment. If the worker fits best under "visual fields better than 30 degrees", that places the worker in Class 2, which has a range of 10% to 29% impairment of the visual field. **For your impairment rating, you will need to choose a specific percent from within that range (for example 20%), based on your professional judgment, and state it clearly in your report.**
- **Rationale:** Cite the pages and tables you use. Make it easy for readers to understand how you reached your conclusions. For example, be sure to state which method you have used to measure visual fields, as described on page 287. Be specific. For example, when Goldmann visual field equipment is used, the III4e isopter should be plotted.
- **Medical judgment:** Some visual fields, by position of the loss or the binocularity of the loss, create greater impairment than is reflected in the *AMA Guides*. For example, temporal loss in one eye is a greater impairment than nasal loss in one eye, even though by the *Guides* they would come out as the same impairment. In such circumstances, you may use your best judgment to estimate an additional percent impairment (generally not to exceed an additional 10%). **It is imperative that your report describe your rationale for making this adjustment.**

Need help? For assistance with ratings involving loss of visual fields, feel free to contact a rating specialist at L&I. You may contact the Claim Manager and they will put you in touch with the appropriate individual.

E. Diplopia and Loss of Visual Fields, with Loss of Visual Acuity

The following method to rate impairment should be used in the two circumstances below.

1) Any condition affecting both eyes (including, for example, diplopia), except when the only abnormality is loss of visual acuity (see Part C);
2) Any condition affecting one or both eyes with changes in BOTH visual acuity and visual fields

Step 1: Calculate Visual System Impairment (VSI):

Use the *AMA Guides* Fifth Edition, pages 296-300 to calculate the "Visual System Impairment Rating," or VSI, for the whole visual system (in other words, for binocular vision, assessing function of both eyes). (Assess the worker's condition without correction, without the aid of glasses – see above.) The VSI is described on page 296 and 298 and is equal to 100 minus the FVS (Functional Vision Score). As required by RCW, the rating must be for uncorrected vision.

Diplopia, etc.: Please note that Section 14.b "Individual Adjustments" on page 297 for diplopia, glare sensitivity, etc. allows for a limited increase in the impairment rating of the visual system by, at most, 15 points.

- If the worker has diplopia which can be minimized and/or eliminated by prisms in glasses, provide data on the diplopia both with and without prism correction. You must base your impairment rating on the extent of diplopia without prism correction.
- Pre-existing diplopia: When requested by the Claim Manager, give your assessment of the worker's diplopia prior to the injury. See Part C above.

Step 2: Calculate Whole Person Impairment (WPI):

As described in the footnote in Table 12-10 on page 298, WPI is calculated as follows:

- If VSI is less than or equal to 50%, WPI=VSI.
- If VSI is greater than 50%, WPI = 50 + 0.7 x (VSI-50).

SAMPLE RATING REPORT #3 for visual field loss with loss of visual acuity – VSI less than or equal to 50%:
In your report, state something like the following:

> "Per my findings above and using the *AMA Guides*, Fifth Edition, pages 296 to 300, the Visual System Impairment Rating (VSI) for Mr. Jones' visual field loss and loss of visual acuity is 40%. Per Table 12-10 on page 298, this VSI corresponds to a Whole Person Impairment (WPI) of 40%. "

SAMPLE RATING REPORT #4 for visual field loss with loss of visual acuity – VSI greater than 50%:
In your report, state something like the following:

> "Per my findings above and using the *AMA Guides*, Fifth Edition, pages 296 to 300, the Visual System Impairment Rating (VSI) for Mr. Jones' visual field loss and loss of visual acuity is 60%. Per Table 12-10 on page 298, this VSI corresponds to a Whole Person Impairment (WPI) of 57%. "

Need help? For assistance with ratings involving loss of visual fields, feel free to contact a rating specialist at L&I. You may contact the Claim Manager and they will put you in touch with the appropriate individual.

CHAPTER 13

Billing Information

Department rules, coverage decisions, treatment guidelines and payment policies apply to all claims administered by State Fund and Self-Insured Employers unless otherwise noted.

All providers must follow:

- Department laws and administrative rules.
- Department condition and treatment index. For more information please refer to: https://lni.wa.gov/patient-care/treating-patients/conditions-and-treatments/.
- Medical Aid Rules and Fee Schedules (MARFS) including payment policies. For more information, please refer to: https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/.
- Other related information such as treatment guidelines and utilization review. For more information, please refer to: https://lni.wa.gov/patient-care/treating-patients/treatment-guidelines-and-resources/#treatment-guidelines.

The Crime Victims Compensation Program follows the Medicaid fee schedules for most services rather than MARFS. The fee schedule for IMEs, lab or other tests for the Crime Victims Compensation Program can vary significantly from the fees listed in the MARFS. To determine the appropriate reimbursement rate for the Crime Victims Compensation Program, go to https://lni.wa.gov/claims/crime-victim-claims/crime-victim-and-provider-resources#fee-schedule-information.

Department rules and policies take precedence (WAC 296-20-010) if there are any services, procedures or text contained in the Current Procedural Terminology (CPT®), or the federal Healthcare Common Procedure Coding System (HCPCS) coding books that are in conflict with MARFS.

MARFS is typically published in July of each calendar year. L&I's Fee Schedules can be found at: https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/. Questions concerning coverage and reimbursement may be directed to:

- State Fund the Provider Hotline at 1-800-848-0811
- Crime Victims Compensation Program at 1-800-762-3716
- Self-insured employer or their third party administrator. For contact information see the list of self-insured employers at https://lni.wa.gov/insurance/self-insurance/look-up-self-insured-employers-tpas/find-a-third-party-administrator.

Medical Aid Rules and Fee Schedules (MARFS)

The reimbursement for services performed by medical providers, including IME medical examiners, is clearly referenced in the RCWs and WACs. **Reimbursement laws, rules and policies apply equally whether the provider is billing the State Fund or a self-insured employer.**

RCW 51.04.030(2) directs the establishment of a fee schedule by the director for the maximum charges to be paid to any medical provider. It states that "no service covered under this title, including services provided to injured workers, […], shall be charged or paid at a rate or rates exceeding those specified in such fee schedule, and no contract providing for greater fees shall be valid as to the excess."

WAC 296-20-020 identifies who is governed by the department's fee schedule. This WAC states "the filing of an accident report or the rendering of treatment to a worker who comes under the department's or self-insurer's jurisdiction, as the case may be, constitutes acceptance of the department's medical aid rules and compliance with its rules and fees."

WAC 296-20-125 explains the department's billing procedures. It states that "all services rendered must be in accordance with the medical aid rules, fee schedules, and department policy. The department or self-insurer may reject bills for services rendered in violation of these rules. Workers may not be billed for services rendered in violation of these rules."

The provider is required to bill their usual and customary fee for the service(s) provided. If the usual and customary fee is greater than the department's fee schedule, the payment will be adjusted to the amount shown in the fee schedule. If the usual and customary fee for service(s) is less than the department's fee schedule, then the usual and customary fee is paid. This applies to IMEs performed for state fund or self-insured claims.

Billing for an IME and/or Impairment Rating

Firms and examiners:
IME Providers must use Chapter 13 of the Medical Aid Rules and Fee Schedules (MARFS), Billing & Payment Policies, when billing for any IME service and/or test. Link to MARFS Chapter 13:

https://lni.wa.gov/patient-care/billing-payments/marfsdocs/2023/2023MarfsChapter13.pdf

Attending Providers and Consultants:
Attending providers and consultants must use Chapter 12 of the MARFS Billing & Payment Policies, when billing for impairment ratings. Link to MARFS Chapter 12:

https://lni.wa.gov/patient-care/billing-payments/marfsdocs/2023/2023MarfsChapter12.pdf

Note: IMEs and impairment rating exams are not synonymous. See Chapter 11 for more clarification. Appendix A contains sample reports for both IMEs and Impairment Ratings. IMEs must be requested and scheduled by the Department or Self-Insured Employer.

Impairment ratings may be conducted by the attending provider or a consultant. When it is determined that a worker is at or near maximum medical improvement, the claim manager or self-insured employer typically asks the attending provider if they will conduct an impairment rating or arrange for a consultant to rate impairment. If the attending provider declines, the claim manager will likely request an IME.

It is important to identify your report accurately whether it is an IME report or an Impairment Rating report so that it is indexed and paid appropriately by the Department.

Billing for an Impairment Rating – For Non-IME Providers

Codes used to bill rating examinations by the attending providers and consultants are found in MARFS Chapter 12: Impairment Rating Services:

https://lni.wa.gov/patient-care/billing-payments/marfsdocs/2023/2023MarfsChapter12.pdf

Doctors who may rate impairment must be currently licensed in medicine and surgery (including osteopathic and podiatric) or dentistry, and department approved chiropractors (WAC 296-20-2010).

APPENDIX A

Sample Reports and Forms

This appendix presents templates of reports you should follow to make sure your report includes all required information.

Please be sure to refer to other portions of this handbook for more information. In particular, please note that Chapter 12 includes a worksheet for rating hearing loss impairment.

** Note regarding consultants: The referral source is the attending provider who has been asked by the Claim Manager to perform an impairment rating. Attending provider may not wish to perform the rating, but prefer to select a consultant.*

Forms	Use this format if you are:	Page
Job Analysis F252-072-000	All - attending providers, IME examiners, consultants*	68-71
Hearing Impairment Calculation Worksheet F252-007-000	All - attending providers, IME examiners, consultants*	111-112
Occupational Disease Work History Form F242-071-000	Worker fills out this form. Examining doctor reviews it with worker to complete Doctor's Assessment of Work-Relatedness for Occupational Diseases	160-161
IME Doctor's Estimate of Physical Capacities Form F242-387-000	IME examiners, if requested	162
***AMA Guides* Worksheet for Upper Extremity Ratings** F252-115-000 F252-116-000	All - attending providers, IME examiners, consultants*	163-164

Sample Report #1: Required Content of IME Reports in Washington State Workers' Compensation

All elements are required in all IME reports except those marked by an asterisk. (*) Elements marked by an asterisk should be included ONLY if specifically requested by the claim manager.

Please use this Sample Report as a "template" when you dictate your reports so you remember to include all the information required. Your transcriptionist may download the template from the L&I web page . See L&I websites on Page 204.

A. INTRODUCTION
The introduction should include explanations given to the worker about the purpose and procedures of the exam, a statement about who accompanied the claimant, and other general information about the exam.

B. HISTORY OF PRESENT INJURY
A history from the worker describing both the course of injury or treatment and his or her present status (to be reported separately and distinctly from the record review). The report should distinguish when events described are based on the worker's history alone.

C. CURRENT SYMPTOMS
When the worker describes pain, swelling or rash, be sure to elicit and report details such as location, distribution, effect on activities, etc. See Chapter 4.

IDENTIFYING INFORMATION

Name:	John Smith	**Claim #:**	N100000
Address:	2424 Poplar Drive	**Date of injury:**	July 7, 2003
	Seattle, WA 98100	**Date of birth:**	June 2, 1948

Employer at time of injury: ABC Lumber, Inc.
Date of examination: March 2, 2005
Location of examination: Seattle Clinic
Examiners: Tim Jones, M.D., Hand Surgeon (dictating)
Susan Barnes, M.D., Neurologist

INTRODUCTION

The opinions expressed in this report are those of the physicians and reflect agreement by both examining physicians on all conclusions, except where otherwise specified. The opinions do not reflect the opinions of XYZ Panel, Inc. Mr. Smith was informed that this examination was at the request of the Washington State Department of Labor and Industries (L&I). He was also informed that a written report would be sent to L&I and to his attending doctor, Dr. X, as requested in the assignment letter from the claim manager. Mr. Smith was also informed that the examination was for evaluative purposes only, intended to address specific injuries or conditions as outlined by L&I, and was not intended as a general medical examination.

Mr. Smith was asked at the time of the examination not to engage in any physical maneuvers beyond what he could tolerate, or which he felt were beyond his limits, or which could cause harm or injury.

Mr. Smith was an excellent historian. The historical portion of this report is being dictated in the presence of the claimant so that additions or corrections can be made if necessary.

Mr. Smith was accompanied by his friend, Sally Rogers, during the entire examination.

HISTORY FROM THE WORKER

Chief complaints:

1) Decreased strength in the dominant right hand
2) Tingling and numbness in the both hands.

History of present injury:

Mr. Smith is a 56-year-old greenchain puller at ABC Lumber. He has held this job for 20 years. He...

Current symptoms

At the time of today's exam, Mr. Smith reports moderate tingling and numbness in both hands, right greater than left. The distribution of the tingling is …. In the last few days the sensation has been getting worse, which he associates with …. He also reports decreased strength in his right hand. He denies pain in any part of either upper extremity ….

Sample Report #1: Required Content of IME Reports in Washington State Workers' Compensation

D. OCCUPATIONAL HISTORY

See "Occupational Diseases," Chapter 6 for the additional information required for occupational carpal tunnel syndrome, occupational hearing loss, and other work-related diseases. For occupational injuries, a brief occupational history will suffice.

E. CURRENT WORK STATUS

This is a statement from the worker about whether he or she is employed at the time of the examination, and if unemployed, why.

F. PAST MEDICAL HISTORY

This should include a medication history that documents a worker's current medications, past and present illicit drug use, if any, and pattern of alcohol and tobacco intake. A negative or positive history must be recorded. Confounding conditions (diabetes, etc.) should be addressed.

G. SOCIOECONOMIC HISTORY

This should include education, marital status and military experience.

H. REVIEW OF SYSTEMS

A review of systems is needed to determine if other illnesses or conditions are present.

I. RECORD REVIEW

The record review must provide a detailed chronology of the injury or condition including:

- Mechanism of injury or exposure.
- Diagnostic studies or results.
- Treatments and outcomes, including names of all practitioners involved in treatment.

As always, put the claim number in the top right corner of every page.

March 2, 2005
John Smith, Claim # N100000
Page 2 of 5

Occupational history:
Since the diagnoses include an occupational disease (carpal tunnel syndrome), and because we have been requested by the claim manager to provide the Doctor's Assessment of Work-Relatedness for Occupational Diseases, we are attaching the requested report as an addendum.

Current work status:
Mr. Smith states he is not working at present because....

Past medical history:
Injuries: Lumbar strain, 1985
Illnesses: Pneumonia, 1982
Operations: Hernia repair, 1990
Hospitalizations: None
Allergies: No known allergies
Medications: None
Substance use:
- **Tobacco:** One pack per day for the last 20 years
- **Alcohol:** One beer per week; no history of DWIs or black-outs
- **Illicit drugs:** History of marijuana use over 25 years ago

Family history: Father with diabetes….

Socioeconomic history:
Marital status and dependents: Single; no dependents
Education: Finished 10th grade; GED.
Military: Served 4 years in the army 1966-70, honorable discharge with no service-connected disability.
Non-work activities, hobbies:

Review of systems:
Non-contributory except mild depression for the last two months, without suicidal ideation, weight loss, insomnia or other....

RECORD REVIEW

The chart has been reviewed in detail. Records reviewed and pertinent data from those records include the following:

- Chart notes of Brian Johnson, M.D., Family Practice, from 7/28/02 through 3/3/04.
  7/28/02: Dr. Johnson saw Mr. Smith for the first time. Chief complaint at that visit was low back pain. Examination revealed normal neurologic exam, ...Lumbo-sacral spine x-rays revealed....

  8/7/02: Mr. Smith reported substantial improvement in his symptoms with conservative care.....
- Chart notes of Mary Miller, D.O., Neurologist, from 9/5/00 through 11/4/01.
  9/5/00: Dr. Miller saw Mr. Smith for the first time. She reported a normal neurologic exam....
- Electrodiagnostic report of William Jones, M.D., Neurologist, performed on 1/3/05.
  EMG revealed.....

Significant missing records included those of the most recent clinical visits and an electrodiagnostic report referenced in the chart notes of Dr. Johnson on 11/3/03.

Sample Report #1: Required Content of IME Reports in Washington State Workers' Compensation

J. PHYSICAL EXAMINATION

Please give sufficient detail of both positive and negative findings to support examination conclusions. This will establish a record that you may be asked to discuss in the future. Non-organic signs (such as Waddell's signs) should be reported when appropriate. When swelling, rash, or abnormal range of motion are observed, be sure to report details such as location, distribution, character, etc. Goniometric measurement of ROM is not required but may be helpful.

K. MULTIPLE EXAMINATIONS

For IMEs with multiple examiners, each specialty should report physical exam findings separately (orthopedic exam, neurologic exam, etc.).

L. DIAGNOSTIC STUDIES

If diagnostic testing is needed to complete the examination, please arrange for the needed test, then complete the report. Invasive testing (myelogram, biopsies, etc.) should be referred back to the attending doctor. Opinions on testing should, as much as possible, be consistent with guidelines established by the department.

March 2, 2005
John Smith, Claim # N100000
Page 3 of 5

PHYSICAL EXAMINATION

Vital signs: Height: 6' 1". Weight: 240 pounds. Blood pressure: 130/76. Pulse: 88 and regular. Temperature: 98.6. Dominant hand: right.

ORTHOPEDIC EXAM:

Mr. Smith is a well-developed, well-nourished male who appears his stated age. He is alert, oriented, and cooperative. He is appropriately attired.....Range of motion of the wrist reveals dorsiflexion to .....Non-organic signs are not present.....

NEUROLOGIC EXAM:

Neurologic exam shows strength to be 5/5 in all the major muscle groups. Reflexes are +2 and equal bilaterally. Sensation is ....

[*Complete orthopedic, neurologic, psychiatric exams are expected when the IME is performed by specialists in these fields.*]

DIAGNOSTIC STUDIES

Studies performed prior to this IME are summarized in Record Review above. No new studies are indicated for the purpose of this IME....

PAIN STATUS INVENTORIES

Please see the attached pain diagram.... We interpret the pain diagram to indicate....

CONCLUSIONS

Accepted conditions (as stated on the assignment letter from the claims manager):

#1: Right carpal tunnel syndrome

Diagnoses and assessment of work-relatedness:

Diagnoses:
#1: Right carpal tunnel syndrome
#2: Epicondylitis, right upper extremity, resolved

Pre-existing conditions:
None.

M. PAIN STATUS INVENTORIES

Optional: Include pain status inventories if you deem them appropriate for the worker's condition.

N. ACCEPTED CONDITIONS

You should simply repeat exactly the accepted conditions in the assignment letter. This is for administrative purposes, since the accepted conditions may differ from your diagnoses.

O. DIAGNOSES AND WORK-RELATEDNESS

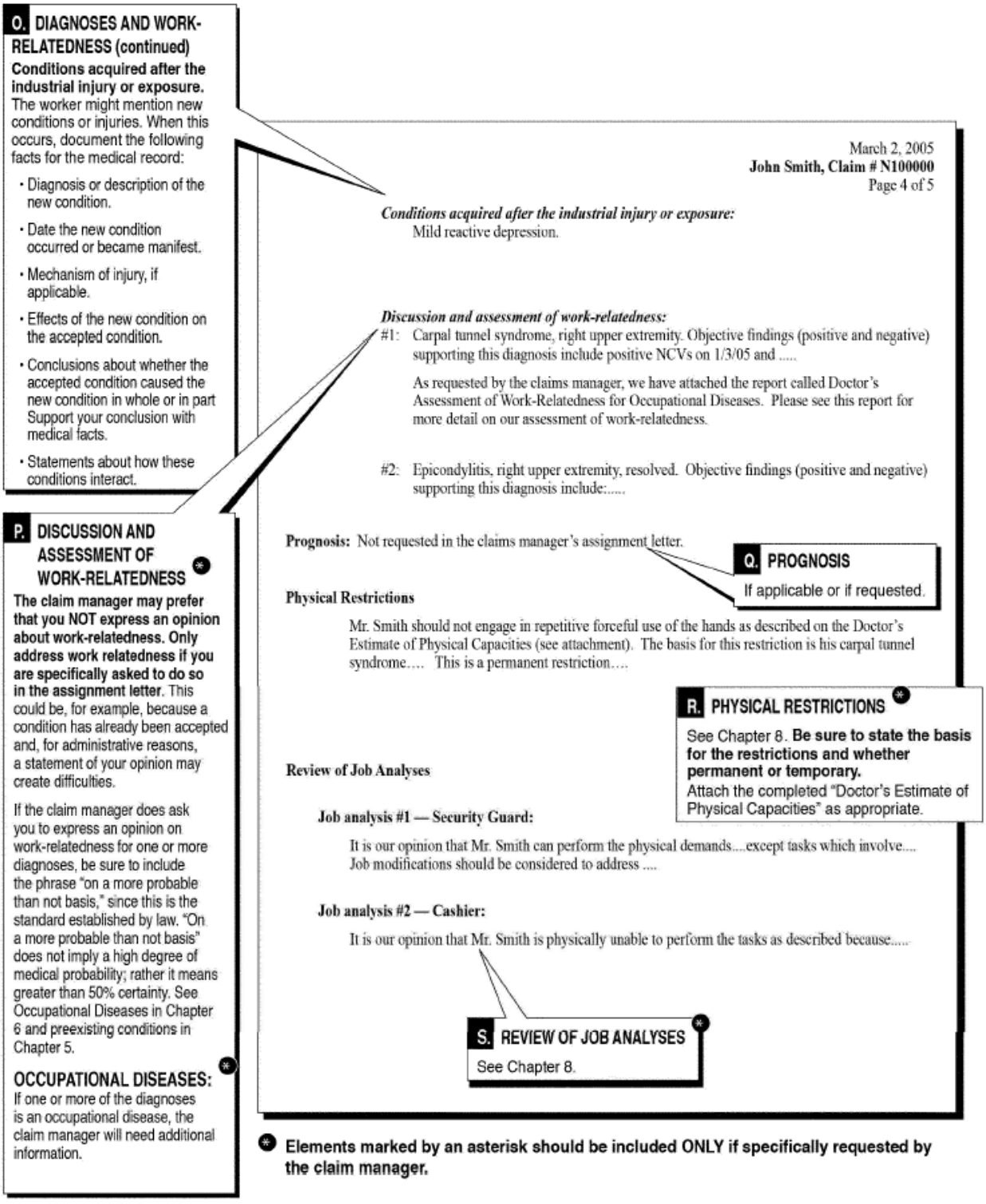
Specific diagnoses must be presented in the way listed below.

Diagnoses. Give a brief, one-line statement of each diagnosis.

Pre-existing conditions. State whether they are worsening on their own or as a result of the accepted condition.

(See Pre-existing Conditions, and Lighting Up, Chapter 5.)

Sample Report #1: Required Content of IME Reports in Washington State Workers' Compensation



Sample Report #1: Required Content of IME Reports in Washington State Workers' Compensation

T. RECOMMENDATIONS *

Your recommendations may address both conditions related to the injury, as well as conditions unrelated but hindering recovery.

TREATMENT *

- Clearly state the goal of further treatment. Is it curative or palliative in nature?
- Clearly indicate if treatment is likely to restore function and/or reduce impairment. If the treatment might make a permanent improvement, even if the impairment rating remains the same, the injury is not yet stable and rating is premature.
- How long should it continue and what is the result expected?
- Guidelines. Opinions should, as much as possible, be consistent with department guidelines.

See Pages 33-34

U. REFERRAL FOR FINDINGS UNRELATED TO THE ACCEPTED CONDITION

Findings not related to the industrial injury may come to light during the examination. For example, you may note an elevated blood pressure while examining an injured ankle. Write a paragraph separate from your findings about the industrial injury. State that a finding, unrelated to the injury, was made and requires follow-up by the attending doctor. Comments on these conditions should be directed to the attending doctor. In some instances, it may be a good idea to phone the attending doctor to communicate your concerns directly.

V. IMPAIRMENT RATINGS *

The rating content described in Chapter 11 is REQUIRED for all IMEs (and for ratings by attending doctors and consultants). Do NOT rate impairment if the worker is not at maximum medical improvement or if further treatment is likely to restore function. See Sample Reports #4 and #5 for rating with Pre-existing Conditions and Lighting Up.

March 2, 2005
John Smith, Claim # N100000
Page 5 of 5

Recommendations:

Diagnostic: No further testing is indicated.

Therapeutic: Mr. Smith may benefit from.... Such treatment would be palliative.... This treatment is not likely to restore function, but it could achieve.... A 3-month period of treatment would probably be sufficient to ....

Follow-up care: The treatment described above could probably be provided by Mr. Smith's current attending doctor, Dr. X. If Dr. X prefers not to provide this treatment, it may be appropriate to refer Mr. Smith to a neurologist or a specialist in ....

Findings unrelated to the accepted condition: Our exam revealed a skin condition over the posterolateral portion of the .... It appears to be .... We recommend that Mr. Smith follow-up with his attending doctor, Dr. X, as soon as possible....

Impairment Rating Report

MMI: Mr. Smith has (or has not) reached maximum medical improvement....

Physical exam: Examination reveals....

Diagnostic tests: Electrodiagnostic studies show....

Rating: According to the *AMA Guides to the Evaluation of Permanent Impairment,* 5th edition,...

Rationale: The rationale for this rating is that, according to Table....

ANSWERS TO SPECIFIC QUESTIONS FROM THE CLAIM MANAGER

The information under "Conclusions" above gives complete answers to questions #1, 2, 3, 5, 6, 7 and 8 in the referral letter from L&I. Answers to remaining questions are given below:

Question #4: How does your physical assessment differ or concur with prior medical information regarding the patient's physical limitations? Please explain.

Answer: The physical assessment appears to concur with prior medical information.

Signed: _____ _____

Tim Jones, MD
Hand Surgery
Today's date: _____

Susan Barnes, MD
Neurology
Today's date: _____

W. ANSWERS TO CLAIM MANAGER'S QUESTIONS

If you cannot answer a question, please explain requirements for addressing it.

X. ISSUES NOT TO ADDRESS

In your recommendations and throughout your report avoid statements about the claim status such as, "The worker's claim should remain open," or "The worker's claim should be closed." Also avoid speculation about services that may be covered by industrial insurance, like, "The employer should retrain this worker." For more about this, see Chapter 4.

* **Elements marked by an asterisk should be included ONLY if specifically requested by the claim manager.**

Sample Report #2: Impairment Rating Only for Consultants and IME Examiners

(For brevity, the sample report below presents only key elements, omitting many details that would be expected in an actual report. Please see WAC 296-23-377 and Chapter 11 of this handbook for report requirements.)

Impairment Rating Report

Identifying Information

Name:	John Smith	Claim #:	Y100000
Address:	2424 Poplar Drive	Date of injury:	July 7, 2002
	Seattle, WA 98100	Date of birth:	June 2, 1953

Employer at time of injury:	ABC Lumber, Inc.
Date of examination:	March 2, 2003
Location of examination:	Seattle Clinic
Examiners:	Tim Jones, MD, Orthopedic Surgery, Hand Surgery

Introduction

The opinions expressed in this report are those of the examiner. Mr. Smith was informed that this examination was at the request of the Washington State Department of Labor and Industries (L&I) and a written report would be sent to L&I and to his attending doctor, Dr. X. Mr. Smith was also informed that the examination was for evaluative purposes only, intended to address specific injuries or conditions as outlined by L&I, rather than to constitute a general medical examination.

Mr. Smith was asked at the time of the examination not to engage in any physical maneuvers beyond what he could tolerate, or which he felt were beyond his limits, or which could cause harm or injury.

The historical portion of this report is being dictated in the presence of the claimant so that additions or corrections can be made if necessary. His friend, Sally Rogers, accompanied Mr. Smith to the exam.

History From the Worker

Chief complaints (current symptoms):

1) Decreased strength in the right hand, dominant extremity
2) Tingling in the right hand and palm with intermittent tingling and numbness in the left hand.

History of present injury:

Mr. Smith is a 49-year-old greenchain puller at ABC Lumber. He has held this job for 13 years. He...

Record Review

The chart has been reviewed in detail. Records reviewed and pertinent data from those records include the following:

- Chart notes of Brian Johnson, M.D., Family Practice, from 3/2/02 through 1/3/03. 7/7/02: Dr. Johnson saw Mr. Smith for complains about his right hand....1/3/03: Mr. Smith reported substantial improvement in his symptoms with conservative care....
- Chart notes of Mary Miller, D.O., Neurologist, from 9/5/02 through 11/4/02. 9/5/02: Dr. Miller saw Mr. Smith for the first time. She reported a normal neurologic exam....
- Electrodiagnostic report of William Jones, M.D., Neurologist, performed on 10/3/02. EMG revealed.....

Physical examination

Neurologic exam shows strength to be 5/5 in all the major muscle groups, except in the hand, as described below. Reflexes are...

[Complete physical examination is expected as appropriate for the issues involved in the case.]

Diagnosis

#1: Carpal tunnel syndrome, right upper extremity

#2: Epicondylitis, right upper extremity, resolved

Impairment Rating

1. MMI: I concur with the January 3, 2003 report from Dr. Johnson, the attending physician, that Mr. Smith has reached maximum medical improvement.

2. Physical exam: Positive and negative examination finding relevant to the impairment rating include the following: atrophy of the thenar muscles; presence of Phalen's sign; moderate weakness of thumb abduction: ....

3. Diagnostic tests: On October 3, 2002 electrodiagnostic studies revealed... No new studies are indicated for the purpose of this IME ...

4. Rating: According to the American Medical Association *Guides to the Evaluation of Permanent Impairment*, 5th Edition, it is my opinion that the findings correspond most closely to a rating of ...

5. Rationale: The rationale for this rating is that, using Section 16.5d on pages 491 through 495 of the 5th edition of the AMA *Guides to the Evaluation of Permanent Impairment* ...

Signed: _____

Tim Jones, MD
Orthopedic Surgery, Hand Surgery

Sample Rating Report #3: Required Content of an Attending Provider Rating Report

This sample report illustrates the five required components of an Attending Provider rating report.

For a patient with this clinical data:

Mr. A., a 28-year-old male, was injured lifting a 50-pound container out of a van. He developed sharp low back pain radiating down the left lower extremity into the foot. The patient received non-operative treatment, including physical therapy and non-steroidal medications. At the time of the impairment rating examination, Mr. A. reported moderate intermittent pain. Physical examination was remarkable for decreased sensation to pinprick over the lateral left leg and foot; positive SLR on the left at 30 degrees with increased radicular pain on ankle dorsiflexion; and tenderness at L5-S1 with deep pressure. X-rays showed 25% loss of disc height at L5-S1 disc.

The Rating Report should read as follows:
MMI: Mr. A. has reached maximum medical improvement. No further curative treatment is recommended.

Physical exam: Examination does not reveal any muscle weakness, , or reflex loss. There is decreased sensation to pinprick over the lateral left leg and foot; positive SLR at 30 degrees with increased radicular pain on ankle dorsiflexion; and tenderness at L5-S1 with deep pressure.

Diagnostic tests: X-rays show 25% loss of disc height at L5-S1 disc.

Rating: According to the Washington State Category Rating System, it is my opinion that these findings correspond most closely to an impairment rating of Category 2.

Rationale: The rationale for this rating is that I consider the 25% loss of disc height at the L5-S1 disc to be "mild but significant." I consider his findings of decreased sensation in a dermatomal distribution and positive SLR to be "moderate intermittent." He has no atrophy, muscle weakness, reflex loss or other significant findings.

Sample Rating Report #4: Previously Asymptomatic Worker, With Preexisting X-ray Findings ("Lighting Up" & the Miller decision)

This sample report illustrates the "lighting up" principle described in the Miller decision. (Please see Chapter 5 for details about dealing with preexisting conditions, segregation, and "lighting up.")

As illustrated in this sample rating report, in cases of "lighting up" the doctor should NOT segregate preexisting impairment or express any opinion about the significance of preexisting findings. (Please compare this with sample rating report #5.)

For a patient with this clinical data:

Mr. B. is a 50-year-old truck driver with no history of back symptoms or disabling back condition. He sustains an injury lifting a 50-pound crate. After conservative treatment, he reaches a plateau at which he

continues to experience moderate, intermittent radicular pain. Physical examination was remarkable for decreased sensation to pinprick over the lateral left leg and foot; positive SLR on the left at 30 degrees with increased radicular pain on ankle dorsiflexion; tenderness at L5-S1 with deep pressure. X-rays reveal mild-to-moderate degenerative changes at L5-S1.

The report could read something like this:

MMI: Mr. B. has reached maximum medical improvement. No further curative treatment is recommended.

Physical exam: Examination does not reveal any muscle weakness, atrophy, or reflex loss. Examination was remarkable for decreased sensation to pinprick over the lateral left leg and foot; positive SLR on the left at 30 degrees with increased radicular pain on ankle dorsiflexion; tenderness at L5-S1 with deep pressure.

Diagnostic tests: On x-ray he has degenerative changes at L5-S1.

Rating: According to the Washington State Category Rating System, it is my opinion that these findings indicate an impairment of Category 2.

Rationale: The rationale for this rating is that I consider the degenerative changes at L5-S1 to be "mild but significant," and consistent with the pain Mr. B describes. I consider his findings of decreased sensation in a dermatomal distribution and positive SLR to be "moderate intermittent." He lacks other significant findings.

Sample Rating Report # 5: Patient With Symptomatic Preexisting Condition, Whose Medical Records Include Data on Which to Base a Rating of Preexisting Impairment, and the Claim Manager Explicitly Asked the Examiner to Segregate

Patient with symptomatic preexisting condition, whose medical records include data on which to base a rating of preexisting impairment, and the Claim Manager explicitly asked the examiner to segregate

This sample report illustrates a patient with a symptomatic preexisting condition, where the "lighting up" principle described in the Miller decision does NOT apply. (Please see Chapter 5 for details about dealing with preexisting conditions, segregation, and "lighting up.")

As illustrated in this sample rating report, in cases where the "lighting up" principle does not apply, the doctor should rate the impairment that existed prior to the worker's injury, and provide documentation. (Please compare this with sample rating report #4.)

Report:

MMI: Mr. C. has reached maximum medical improvement. No further curative treatment is recommended.

Physical exam: Examination reveals 2 cm. of calf atrophy on the right and diminished Achilles reflex on the right. There is mild muscle weakness and mild decrease in sensation to pinprick over the lateral right leg and foot. There are no other significant findings.

Diagnostic tests: He has x-ray changes from his fusion at L5-S1.

Rating: According to the Washington State Category Rating System, it is my opinion that the most appropriate impairment rating for Mr. C.'s current condition is Category 5.

Rationale: The rationale for this rating is that Mr. E. has pseudoarthrosis of the lumbar fusion with 30% loss of disc height at L5-S1, which I would categorize as marked. He has 2 cm. of calf atrophy on the right and diminished Achilles reflex on the right. There is mild muscle weakness and mild decrease in sensation to pinprick over the lateral right leg and foot. There were no other significant findings.

Preexisting conditions: Mr. C. had a previous non-industrial back injury on July 15, 1988. I have been seeing him periodically for this injury since January, 1991. I examined Mr. C. three months prior to the industrial injury. At that time, examination did not reveal any muscle weakness, atrophy, reflex loss, sensory loss, or other significant findings. He did have a bulging disc at L5-S1, which I considered insignificant. According to the Washington State Category Rating System, it is my opinion that these findings indicate a preexisting impairment rating of Category 1.

Sample Report #6: Required Content of the Doctor's Assessment of Work Relatedness for Occupational Diseases

On the following pages are the Doctor's Assessment of Work Relatedness for Occupational Diseases and a blank copy of the Occupational Disease Work History form. The form is filled out and signed by the worker at the request of the Claim Manager. The information is used to determine which jobs, if any, contributed to the alleged occupational disease.

What do you need to do?

The Occupational Disease Work History form, already completed by the worker, should be provided to you by the Claim Manager prior to the IME with the rest of the medical records.

Review the completed work history form with the worker to gather additional detail about each job's activities. Use the detail to support your conclusions.

Sample Report #6: Required Content of Occupational Disease Reports in Washington State Workers' Compensation

Please use this Sample Report as a "template" when you dictate your reports so you remember to include all the information required.

B. SOURCE OF INFORMATION FOR THIS REPORT

When IME examiners are requested to submit this report, the claim manager should provide you with a copy of the "Occupational Disease Work History Form" already filled out by the worker. Attending doctors and consultants may request it from the claim manager. **The doctor must review the form with the worker to gather information necessary to provide the occupational history described below.**

See i). below

C. ANSWERS TO THE FOUR REQUIRED QUESTIONS ABOUT WORK ACTIVITIES

For legal reasons, you MUST re-state each of the four questions in your report, EXACTLY as written below.

C.1 The answer to this question should almost always be "yes."

C.2 Briefly (in one line or so) state your diagnosis or diagnoses. Number each diagnosis for later reference.

DOCTOR'S ASSESSMENT OF WORK-RELATEDNESS FOR OCCUPATIONAL DISEASES

A. IDENTIFYING INFORMATION

Name:	Mary Johnson	**Claim #:**	P200000
Address:	9898 Tulip Street, Anywhere, WA 98100	**Date of Injury:**	December 1, 1992
		Date of Birth:	April 1, 1958

Employer at Time of the Claim: Chicken Industries, Inc.

Date of Examination: June 12, 2002

Location of Examination: XYZ Clinic, Seattle, WA

Examiners: Joanne Taylor, M.D., Neurology

B. SOURCE OF INFORMATION FOR THIS REPORT

The Occupational Disease Work History Form was provided to us by the claims manager prior to the examination. It had been completed by Ms. Johnson at home. I have discussed the information on the form with Ms. Johnson and gathered additional details, which form the basis for the opinions presented below. In addition, a job analysis for job #1 was provided by the claims manager and is discussed in the next section. Also, an industrial hygiene report was available for job #2 and is described below. No documentation was available for jobs #3 through #10, so opinions are based solely on the patient's history.

For the record, I am attaching a copy of the Occupational Disease Work History Form which Ms. Johnson filled out. I have numbered the jobs for easy reference in this report. Numbers start with #1 (Poultry worker at Chicken Industries, Inc. from 1994-2000) and go in reverse chronological order through #10 (Cashier at ABC Food Stop from 1979-1980).

C. ANSWERS TO THE FOUR REQUIRED QUESTIONS ABOUT WORK ACTIVITIES

Question #1: **Have you discussed with the claimant the work activities of ALL jobs listed in the work history (including discussion of protective equipment and engineering controls)?**

Yes.

Question #2: **What conditions have you diagnosed?**

Diagnosis #1: Carpal tunnel syndrome, right upper extremity

i). If the claim manager has not provided the Occupational Disease and Employment History form to you, you may request it from the Claim Manager, or you may ask the worker to complete the form (or a form of equivalent content). This form may be downloaded at www.Lni.wa.gov/Forms/pdf/F242-071-000.pdf .

As much as possible, the claim manager will provide industrial hygiene reports, Material Safety Data Sheets, job analyses, or any other material that may be helpful to you for your assessment of work-relatedness.

Sample Report #6: Required Content of Occupational Disease Reports in Washington State Workers' Compensation

C.3 Certain jobs are known to create a recognizable risk of contracting work-related conditions relative to everyday life.

See ii). below.

C.4a This information is needed to establish the legal requirement of proximate cause. Please reference industrial hygiene reports, information from the employer and/or coworkers, Material Safety Data Sheets (MSDSs), or any other documentation that supports your opinion that the activity/exposure occurred.

C.4a Personal protective equipment is used or worn by the worker to reduce personal exposures and include such things as ear plugs, gloves, hard hats, safety glasses and respirators. Engineering controls are designed as part of the work process or environment to reduce personal and/or general area exposures, examples of which include ventilation hoods, machine guards or enclosures, mechanical lifts and vibration or sound-absorbing materials and mats.

As always, put the claim number in the top right corner of every page.

June 15, 2002
Mary Johnson, Claim #P200000
Page 2 of 4

Question #3: **For each condition in Question #2 which is considered a disease (rather than an injury), which jobs in the work history created a recognizable risk of contracting (or worsening) this work-related condition *relative to the risks in everyday life*, on a more-probable-than-not basis? Which jobs did NOT create such a risk?**

Diagnosis # 1: Carpal Tunnel Syndrome, Right Upper Extremity

On a more-probable-than-not basis, jobs #1 and #2 created a recognizable risk of contracting this condition, relative to the risks in everyday life.

Jobs #3-10 did not create such a risk, on a more-probable-than-not basis.

Question #4: **For each job that did create a recognizable risk, answer BOTH of the following questions:**

a) Describe the job. Be sure to include the work activities and/or exposures which contributed to (or protected the worker from) the disease (proximate causes). Describe any protective equipment or engineering controls (or lack thereof) that may have affected the exposure.

b) Describe the basis for your opinion that the workplace activities contributed to the disease. Please include:

- **A description of the temporal relationship. In your description of the temporal relationship, be sure to mention, for each job, when the worker began to experience symptoms and how the onset and pattern of symptoms related to work activities.**
- **Any other information you deem relevant (such as supporting references from the medical literature).**

JOB #1

Job title:	Poultry worker
Employer:	Chicken Industries, Inc.
Employer's city and state:	Tacoma, WA
Approximate dates of employment:	September 1994-December 2000

a) Job description: Ms. Johnson reports that her job includes cutting up chicken parts with a hand-held knife to remove bones from the meat. The job involves a significant amount of repetition and force. Ms. Johnson estimates that she spends at least 6.5 hours a day at this task. The work rate is 90 chickens an hour. The claims manager provided a job analysis from the employer which confirms the nature and duration of the task and adds that they are in the process of trying to reduce the "repetitiveness" of the task by incorporating job rotation into their work practices policy.

Be sure to include information requested in part a) of this question (see C.4a above).

ii). Examples include:
- Health care workers and the development of latex sensitivity.
- Meat packers or poultry plant workers and the development of carpal tunnel syndrome.
- Bakers and the development of asthma.

Other jobs may not have such a well-established association, but may nevertheless contribute, on a more-probable-than-not basis. In all cases, your answer to Question #4 should adequately support your answer to Question #3.

Sample Report #6: Required Content of Occupational Disease Reports in Washington State Workers' Compensation

C.4b Describe the basis for your opinion that the workplace activities contributed to the disease. **Be sure to include information requested in part (b) of this question.**

See previous page and See iii). below

Repeat the steps above for each job that created a recognizable risk.

June 15, 2002
Mary Johnson, Claim #P200000
Page 3 of 4

b) Basis for my opinions: The repetitive, forceful work of cutting up chicken parts is likely to have contributed to Ms. Johnson's carpal tunnel syndrome. It is well documented in the medical literature that repetitive tasks which require force are associated with the development of carpal tunnel syndrome. This disorder is common among workers from other industries and occupations that are also associated with repetitive, forceful work. Furthermore, there is a clear temporal relationship between the onset and pattern of her symptoms and her work activities. Her symptoms began approximately six months after... In August 1992 Ms. Johnson took a week-long vacation during which her symptoms...

JOB #2

Job title:	Laborer
Employer:	ABC Wallboard International
Employer's city and state:	Tacoma, WA
Approximate dates of employment:	April 1991-June 1991

a) Job description: This job involved the installation of wallboard in both residential and non-residential buildings. Ms. Johnson described the job to be very demanding. The tasks associated with installing wallboard include repetitive and forceful motions, specifically with the use of a pneumatic nail gun, which was so heavy it required the use of both arms to operate. The nature of the work often required that the nail gun be used in awkward postures. The employer's description of the job was consistent with that of Ms. Johnson. An industrial hygiene report was also available. It documented....

b) Basis for my opinions: The repetitive, forceful work of installing wallboard is likely to have contributed to Ms. Johnson's carpal tunnel syndrome. I have observed this condition in laborers before. Just as in Job #1, it is well documented in the medical literature that repetitive tasks which require force are associated with the development carpal tunnel syndrome. The types of motions known to be associated with carpal tunnel syndrome were demonstrated by Ms. Johnson in her description of operating the nail gun as well as in other tasks necessary to perform her job such as handling the wallboard. Also, there is a clear temporal relationship between the onset and pattern of her symptoms and her work activities. Although her symptoms in this job were not as severe as in Job #1, ...

iii). In many cases only limited information on the work exposures will be available. The claim manager understands that it may be difficult to assess work-relatedness without complete information. Therefore, the expectation is that you will make as accurate a determination as possible, based on whatever information is available at the time of the examination.

Sample Report #6: Required Content of Occupational Disease Reports in Washington State Workers' Compensation

D. ANSWERS TO THE TWO REQUIRED QUESTIONS ABOUT NON-WORK ACTIVITIES

For legal reasons, you MUST re-state each of the two questions in your report, exactly as written below.

D.5 Does the worker report any non-work activities or exposures that may have an effect on the diagnosed condition? An example is a receptionist who has bilateral carpal tunnel syndrome which may be a result of crocheting projects done on non-work time.

D.6 Give a clear statement of the association (or lack of association) between the exposure and the condition, on a more-probable-than-not basis. Please include, for example, a description of the temporal relationship, supporting references from the medical literature, and any other information you deem relevant.

D. ANSWERS TO THE TWO REQUIRED QUESTIONS ABOUT NON-WORK ACTIVITIES

Question #5: **Describe non-work activities or conditions that may have an effect on the disease.**

Ms. Johnson's hobbies include body work on her car and the cars of friends and relatives. She reports doing body work roughly 2 hours per week over the last two years....

Question #6: **If you believe the disease was caused SOLELY by non-work activities or conditions, describe the basis for your opinion. Please include, for example, a description of the temporal relationship, supporting references from the medical literature, and any other information you deem relevant.**

Not applicable.

Signed: _____

Joanne Taylor, M.D., Attending Doctor Neurology

Today's Date: _____

D.6 You should not answer this question if you indicated in Question #3 that any of the jobs the worker has performed created a recognizable risk of contracting the condition relative to the risks in everyday life.

Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

Occupational Disease & Employment History

Name	Claim Number

Occupational Disease History

What is the medical condition for which you are filing this claim?	What symptoms do you have?	When did you first notice you had these symptoms? Month / Year
When were you first told by a doctor that your symptoms were caused by your job? Month / Year	Have you ever seen any other doctor for these symptoms? ❒ Yes ❒ No	
	Have you ever had any medical tests for these symptoms? ❒ Yes ❒ No	
Name of doctor who told you that your symptoms are related to your job: (print or type)		
Address City State ZIP+4		
Please complete the attached medical records release forms so that we can obtain your records. Is your **completed** release attached? ❒ Yes ❒ No	**If the release is not completed, your claim for benefits will be delayed or may be rejected.**	
Type of work you perform that you believe caused your symptoms:	Start date of employment at the first job you think caused your symptoms. Month / Year	

What activity did you perform at work that you believe caused your symptoms? (Please check all that apply)

❒ Gripping or Pinching ❒ Pulling ❒ Kneeling ❒ Tools used _____

❒ Forceful activity ❒ Pushing ❒ Reaching overhead ❒ Twisting with my _____

❒ Repetitive tasks (describe) _____

❒ Other (describe)

Employment History

Please start with your most RECENT job and work BACKWARDS ***Include all current and past employment.***
All dates should be your best estimate. You must list any breaks or interruptions in your work history.

Employer's business name	Your job title	**Employment Dates:** From (mo/yr) To (mo/yr)
Employer's address	Employer's phone number	
City State ZIP+4	How many hours per week did you perform the activity you believe caused your symptoms? hours	
Describe the job duties, tool use or repetitive activities done on a regular basis. Include approximately how much time per day you spent doing each activity		
Indicate any break or interruption in your work history during this job or between this job and the next. From (mo/yr) To (mo/yr) Reason for interruption:		

Employer's business name	Your job title	**Employment Dates:** From (mo/yr) To (mo/yr)
Employer's address	Employer's phone number	
City State ZIP+4	How many hours per week did you perform the activity you believe caused your symptoms? hours	
Describe the job duties, tool use or repetitive activities done on a regular basis. Include approximately how much time per day you spent doing each activity		
Indicate any break or interruption in your work history during this job or between this job and the next. From (mo/yr) To (mo/yr) Reason for interruption:		

I certify that the information is true and correct to the best of my knowledge.

Page 1 of _____ Date: _____ Signature: _____

F242-071-000 Occupational Disease Work History 10-2005

Occupational Disease and Employment History (Continuation)

Page of	Name (please print)	Claim Number

This is a continuation sheet. You must complete the first page of this form. If additional space is needed you may make copies of this form.

Please continue with your most **Recent** job and work **Backwards**

Employer's business name		Your job title	**Employment Dates:** From (mo/yr) To (mo/yr)
Employer's address		Employer's phone number	
City State	ZIP+4	How many hours per week did you perform the activity you believe caused your symptoms? hours	
Describe the job duties, tool use or repetitive activities done on a regular basis. Include approximately how much time per day you spent doing each activity			
Indicate any break or interruption in your work history during this job or between this job and the next.			From (mo/yr) To (mo/yr)
Reason for interruption:			

Employer's business name		Your job title	**Employment Dates:** From (mo/yr) To (mo/yr)
Employer's address		Employer's phone number	
City State	ZIP+4	How many hours per week did you perform the activity you believe caused your symptoms? hours	
Describe the job duties, tool use or repetitive activities done on a regular basis. Include approximately how much time per day you spent doing each activity			
Indicate any break or interruption in your work history during this job or between this job and the next.			From (mo/yr) To (mo/yr)
Reason for interruption:			

Employer's business name		Your job title	**Employment Dates:** From (mo/yr) To (mo/yr)
Employer's address		Employer's phone number	
City State	ZIP+4	How many hours per week did you perform the activity you believe caused your symptoms? hours	
Describe the job duties, tool use or repetitive activities done on a regular basis. Include approximately how much time per day you spent doing each activity			
Indicate any break or interruption in your work history during this job or between this job and the next.			From (mo/yr) To (mo/yr)
Reason for interruption:			

Employer's business name		Your job title	**Employment Dates:** From (mo/yr) To (mo/yr)
Employer's address		Employer's phone number	
City State	ZIP+4	How many hours per week did you perform the activity you believe caused your symptoms? hours	
Describe the job duties, tool use or repetitive activities done on a regular basis. Include approximately how much time per day you spent doing each activity			
Indicate any break or interruption in your work history during this job or between this job and the next.			From (mo/yr) To (mo/yr)
Reason for interruption:			

Dept of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

I certify that the information is true and correct to the best of my knowledge.

Date: ____________ Signature: ______________________________

F242-071-111 Occupational Disease Work History Continuation 10-2005

Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

IME DOCTOR'S ESTIMATE OF PHYSICAL CAPACITIES

Name of Claimant

Claim Number

Important: Please complete the following items based on your clinical evaluation of the claimant and other testing results. Any item that you do not believe you can answer should be marked N/A. Percentages refer to a workday.

I. In an 8 hour workday, worker can: (Circle full capacity for each activity)

		Total at one time (hours)										Total during entire 8 hour day (hours)									
A)	Sit	0	1/2	1	2	3	4	5	6	7	8	A)	Sit	0	1/2	1	2	3	4	5	6	7	8
B)	Stand	0	1/2	1	2	3	4	5	6	7	8	B)	Stand	0	1/2	1	2	3	4	5	6	7	8
C)	Walk	0	1/2	1	2	3	4	5	6	7	8	C)	Walk	0	1/2	1	2	3	4	5	6	7	8

II. Worker can lift: *(Address any restrictions in lifting from the floor or to overhead in "Remarks" section)*

III. Worker can carry:

	Not at all		Seldom (1 - 10%)		Occasionally (11 - 33%)		Frequently (34 - 66%)		Continuously (67 - 100%)	
	Lift	**Carry**	**Lift**	**Carry**	**Lift**	**Carry**	**Lift**	**Carry**	**Lift**	**Carry**
A) Up to 5 lbs										
B) 6 - 10 lbs										
C) 11 - 20 lbs										
D) 21 - 25 lbs										
E) 26 - 50 lbs										
F) 51 - 100 lbs										

IV. Worker can use hands for repetitive tasks such as:

	Simple grasping		Pushing & pulling		Fine manipulating	
A) Right	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
B) Left	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

V. Worker can use feet for repetitive movements as in operating foot controls:

Right ☐ Yes ☐ No Left ☐ Yes ☐ No

VI. Worker is able to:

	Not at all	Seldom (1-10%)	Occasionally (11 - 33%)	Frequently (34 - 66%)	Continuously (67 - 100%)
A) Bend					
B) Squat					
C) Kneel					
D) Crawl					
E) Climb					
F) Reach above shoulder level					

VII. Restriction on activities involving:

	Yes	No	If "Yes," explain:
A) Unprotected heights	☐	☐	
B) Being around moving machinery	☐	☐	
C) Exposure to marked changes in temp & humidity	☐	☐	
D) Driving automotive equipment	☐	☐	

E) Exposure to dust, fumes and gasses (Restrictions): _____

Remarks (on above, on other functional limitations):

If a performance-based physical capabilities evaluation is requested, may the worker be tested to tolerance? If not, what are the restrictions?

☐ Yes ☐ No

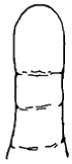
Date Signature of Physician

F242-387-000 IME Dr's est of physical capacities 09-2007

AMA Guides Worksheet for Upper Extremity Ratings – Part 1

Figure 16-1A. Upper Extremity Impairment Evaluation Record – Part 1 (Hand) Side ☐ R ☐ L

Name:	Age:	Sex: ☐ M ☐ F	Dominant Hand ☐ R ☐ L
Claim No:	Date of Injury:	Date of Exam	
Employer:	Diagnosis:		

Abnormal Motion						Amputation	Sensory Loss	Other Disorders	Hand Impairment %
Record motion or ankyloses angles and digit impairment %						Mark level & impairment %	Mark type, level & impairment %	List type & impairment %	• Combine digit imp % • Convert to hand imp %
			Flexion	Extension	Ankylosis / Imp %				
Thumb	IP	Angle°							
		Imp%							
	MP	Angle°							
		Imp%							
				Motion	Ankylosis	Imp %	[2]		
	CMC	Radial Abduction	Angle°						Abnormal motion [1]
			Imp %						Amputation [2]
		Adduction	Cm						Sensory loss [3]
			Imp %						Other disorders [4]
		Opposition	Cm						Total digit imp % •Combine 1, 2, 3, 4
			Imp %				‡UE [5] IMP % = _____		
Add Digit impairment % CMC + MP + IP = _____ [1]						**Digit** [2] **IMP % =** _____	**Digit** [3] **IMP % =** _____	**Digit** [4] **IMP % =** _____	**Hand impairment %** ***Convert above**
			Flexion	Extension	Ankylosis / Imp %				
Index	DIP	Angle°							Abnormal motion [1]
		Imp%							Amputation [2]
	PIP	Angle°							Sensory loss [3]
		Imp%							Other disorders [4]
	MP	Angle°							Total digit imp % •Combine 1, 2, 3, 4
		Imp%							
•Combine Digit impairment % MP+PIP+DIP = _____ [1]						**Digit** [2] **IMP % =** _____	**Digit** [3] **IMP % =** _____	**Digit** [4] **IMP % =** _____	**Hand impairment %** ***Convert above**
			Flexion	Extension	Ankylosis / Imp %				
Middle	DIP	Angle°							Abnormal motion [1]
		Imp%							Amputation [2]
	PIP	Angle°							Sensory loss [3]
		Imp%							Other disorders [4]
	MP	Angle°							Total digit imp % •Combine 1, 2, 3, 4
		Imp%							
•Combine Digit impairment % MP+PIP+DIP = _____ [1]						**Digit** [2] **IMP % =** _____	**Digit** [3] **IMP % =** _____	**Digit** [4] **IMP % =** _____	**Hand impairment %** ***Convert above**
			Flexion	Extension	Ankylosis / Imp %				
Ring	DIP	Angle°							Abnormal motion [1]
		Imp%							Amputation [2]
	PIP	Angle°							Sensory loss [3]
		Imp%							Other disorders [4]
	MP	Angle°							Total digit imp % •Combine 1, 2, 3, 4
		Imp%							
•Combine Digit impairment % MP+PIP+DIP = _____ [1]						**Digit** [2] **IMP % =** _____	**Digit** [3] **IMP % =** _____	**Digit** [4] **IMP % =** _____	**Hand impairment %** ***Convert above**
			Flexion	Extension	Ankylosis / Imp %				
Little	DIP	Angle°							Abnormal motion [1]
		Imp%							Amputation [2]
	PIP	Angle°							Sensory loss [3]
		Imp%							Other disorders [4]
	MP	Angle°							Total digit imp % •Combine 1, 2, 3, 4
		Imp%							
•Combine Digit impairment % MP+PIP+DIP = _____ [1]						**Digit** [2] **IMP % =** _____	**Digit** [3] **IMP % =** _____	**Digit** [4] **IMP % =** _____	**Hand impairment %** ***Convert above**

Total hand impairment: Add hand impairment % for thumb + index + middle + ring + little finger =		%
Convert total hand impairment to upper extremity impairment† (if thumb metacarpal intact, enter on Part 2 line II)		%
*Add thumb ray upper extremity amputation imp [5] _____% + hand upper extremity imp _____% =		%
If hand region impairment is only impairment, convert upper extremity impairment to whole person impairments§		%

• Combined Values Chart (pg 604) *Use Table 16-1 (digits to hand) †Use Table 16-2 (hand to upper extremity) §Use Table 16-3

Signature	Printed Name	Date Signed

AMA Guides Worksheet for Upper Extremity Ratings – Part 2

Figure 16-1b. Upper Extremity Impairment Evaluation Record – **Part 2 (Wrist, Elbow, and Shoulder)** Side ☐ R ☐ L

Name:	Age:	Sex: ☐ M ☐ F	Dominant Hand ☐ R ☐ L
Claim No:	Date of Injury:	Date of Exam	
Employer:	Diagnosis:		

Abnormal Motion	**Other Disorders**	**Regional Impairment %**	**Amputation**
Record motion or ankyloses angles and digit impairment %	List Type & Impairment %	•Combine [1] & [2]	Mark level & Impairment %

Wrist

	Flexion	Extension	Ankylosis	Imp %
Angle°				
Imp%				

	RD	UD	Ankylosis	Imp %
Angle°				
Imp%				

[1] **Add Imp % Flex/Ext + RD/UD =** _____

[2] **Imp %** _____

Elbow

	Flexion	Extension	Ankylosis	Imp %
Angle°				
Imp%				

	Pronation	Supination	Ankylosis	Imp %
Angle°				
Imp%				

[1] **Add Imp % Flex/Ext + Pro/Sup =** _____

[2] **Imp %** _____

Shoulder

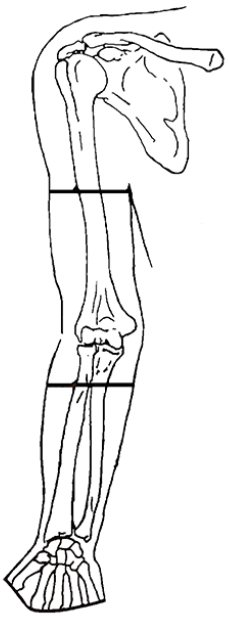
	Flexion	Extension	Ankylosis	Imp %
Angle°				
Imp%				

	Adduction	Abduction	Ankylosis	Imp %
Angle°				
Imp%				

	Int Rot	Ext Rot	Ankylosis	Imp %
Angle°				
Imp%				

[1] **Add Imp % Flex/Ext + Add/Abd + Int Rot/Ext Rot =** _____

[2] **Imp %** _____



Imp % _____

I. Amputation impairment (other than digits)	=	_____%
II. Regional impairment of upper extremity •(Combine hand _____% + wrist _____% + elbow _____% + shoulder _____%)	=	_____%
III. Peripheral nerve system impairment	=	_____%
IV. Peripheral vascular system impairment	=	_____%
V. Other disorders (not included in regional impairment)	=	_____%

Total upper extremity impairment (•Combine I, II, III, IV and V)	=	_____%
Impairment of the whole person (Use Table 16-3)	=	_____%

•Combined Values Chart (p. 604)
If both limbs are involved, calculate the whole person impairment for each on a separate chart and *combine* the percents (Combined Values Chart).

Signature	Printed Name	Date Signed

Physical Demand Definitions

U.S. Department of Labor Classification of Physical Demands and Environmental Conditions

Physical demands analysis is a systematic way of describing the physical activities that a job requires. It is concerned only with the physical demands of the job; it is not concerned with the physical capacity of the worker. Environmental conditions are the surroundings in which a job is performed. To be considered present, an environmental condition must be specific and related to the job.

The above information was taken from *The Revised Handbook for Analyzing Jobs, U.S. Department of Labor, 1991, Pages 12-1 to 12-13*.

Physical Demands

1. Strength

This factor is expressed by one of five terms: sedentary, light, medium, heavy and very heavy. In order to determine the overall rating, an evaluation is made of the worker's involvement in the following activities:

Position

Standing: Remaining on one's feet in an upright position at a workstation without moving about.

Walking: Moving about on foot.

Sitting: Remaining in a seated position.

Weight/Force

Lifting: Raising or lowering an object from one level to another (includes upward pulling).

Carrying: Transporting an object, usually holding it in the hands or arms or on the shoulder.

Pushing: Exerting force upon an object so that the object moves away from the force (includes slapping, striking, kicking and treadle actions).

Pulling: Exerting force upon an object so that the object moves toward the force (includes jerking).

Lifting, pushing and pulling are expressed in terms of both intensity and duration. Judgments regarding intensity involve consideration of the weight handled, position of the worker's body or the part of the worker's body used in handling weights, and the aid given by helpers or by mechanical equipment. Duration is the total time spent by the worker in carrying out these activities. Carrying most often is expressed in terms of duration, weight carried and distance carried.

Controls: Hand-Arm and Foot-Leg Controls entail use of one or both arms or hands (hand-arm) or one or both feet or legs (foot-leg) to move controls on machinery or equipment. Controls include but are not limited to buttons, pedals, levers and cranks.

Sedentary Work

Exerting up to 10 pounds of force occasionally or a negligible amount of force frequently to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

Light Work

Exerting up to 20 pounds of force occasionally, or up to 10 pounds of force frequently, or a negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for sedentary work. Even though the weight lifted may be only a negligible amount, a job should be rated light work: (1) when it requires walking and standing to a significant degree; (2) when it requires sitting most of the time but entails pushing and pulling of arm or leg controls; or (3) when the job requires working a production rate pace entailing the constant pushing or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.

Medium Work

Exerting 20 to 50 pounds of force occasionally, or 10 to 25 pounds of force frequently, or greater than negligible up to 10 pounds of force constantly to move objects.

Heavy Work

Exerting 50 to 100 pounds of force occasionally, or 25 to 50 pounds of force frequently, or 10 to 20 pounds of force constantly to move objects.

Very Heavy

Exerting in excess of 100 pounds of force occasionally, or in excess of 50 pounds of force frequently, or in excess of 20 pounds of force constantly to move objects.

2. Climbing: Ascending or descending ladders, stairs, scaffolding, ramps, poles and the like, using feet and legs or hands and arms. Body agility is emphasized.

3. Balancing: Maintaining body equilibrium to prevent falling when walking, standing, crouching, or running on narrow, slippery, or erratically moving surfaces; or maintaining body equilibrium when performing gymnastic feats.

4. Stooping: Bending the body downward and forward by bending the spine at the waist, requiring full use of the lower extremities and back muscles.

5. Kneeling: Bending the legs at the knees at come to rest on the knees or knees.

6. Crouching: Bending the body downward and forward by bending the legs and spine.

7. Crawling: Moving about on the hands and knees or hands and feet.

8. Reaching: Extending, the hand(s) and arm(s) in any direction.

9. Handling: Seizing, holding, grasping, turning or otherwise working with the hand or hands. Fingers are involved only to the extent that they are an extension of the hand, such as to turn a switch or shift automobile gears.

10. Fingering: Picking, pinching or otherwise working primarily with the fingers rather than with the whole hand or arm as in handling.

11. Feeling: Perceiving attributes of objects, such as size, shape, temperature or texture, by touching with skin, particularly that of fingertips.

12. Talking: Expressing or exchanging ideas by means of the spoken word to impart oral information to clients or to the public and to convey detailed spoken instructions to other workers accurately, loudly, or quickly.

13. Hearing: Perceiving nature of sounds by ear.

14. Tasting/Smelling: Distinguishing, with a degree of accuracy, differences or similarities in intensity or quality of flavors or odors, or recognizing particular flavors or odors, using tongue or nose.

15. Near Acuity: Clarity of vision at 20 inches or less.

16. Far Acuity: Clarity of vision at 20 feet or more.

17. Depth Perception: Three-dimensional vision. Ability to judge distances and spatial relationships in order to see objects where and as they actually are.

18. Accommodation: Adjustment of lens of eye to bring an object into sharp focus. This factor is required when doing near point work at varying distance from the eye.

19. Color Vision: Ability to identify and distinguish colors.

20. Field of Vision: Observing an area that can be seen up and down or to right or left while eyes are fixed on a given point.

Environmental Condition Factors

1. Exposure to Weather: Exposure to outside atmospheric conditions.

2. **Extreme Cold**: Exposure to non-weather-related cold temperatures.

3. Extreme Heat: Exposure to non-weather-related hot temperatures.

4. Wet and/or Humid: Contact with water or other liquids or exposure to non-weather-related humid conditions.

5. Noise Intensity Level: The noise intensity level to which the worker is exposed in the job environment. This factor is expressed by one of five levels. Consider all the benchmarks within a level as providing an insight into the nature of the specific level.

6. Vibrations: Exposure to a shaking object or surface.

7. Atmospheric Conditions: Exposure to conditions such as fumes, noxious odors, dusts, mists, gases and poor ventilation, that affect the respiratory system, eyes or skin.

8. Proximity to Moving Mechanical Parts: Exposure to possible bodily injury from moving mechanical parts of equipment, tools or machinery.

9. Exposure to Electrical Shock: Exposure to possible bodily injury from electrical shock.

10. Working in High, Exposed Places: Exposure to bodily injury from falling.

11. Exposure to Radiation: Exposure to possible bodily injury from radiation.

12. Working with Explosives: Exposure to possible injury from explosions.

13. Exposure to Toxic or Caustic Chemicals: Exposure to possible bodily injury from toxic or caustic chemicals.

14. Other Environmental Conditions: Explain other environmental conditions, not defined above, in Environmental Conditions Comments.

APPENDIX B

Safety for Examiners and Staff

The department values your safety and does not expect you to take unnecessary risks when doing an IME. Although rare, it is possible you could encounter a hostile or violent injured worker when you are conducting an IME. Awareness and preparation are important keys to remember before the encounter starts.

Should you encounter a worker who is using abusive or threatening language or behavior, you will need to make a decision on whether or not to terminate the exam. If this occurs, please notify the claim manager immediately so the claim file may be documented. See chapter 13 payment policies for how to bill a terminated exam.

Prevention is the key to your safety. If a hostile situation evolves on the day of the examination, follow the procedures established by the office where the exam is being conducted. For emergency assistance on the day of the exam, call 911. Whenever possible review the claim file a few days before the examination. If a potential situation is identified, follow the steps below before the exam date.

Options

- Request approval for an off-duty plain-clothed law enforcement agent to be present in the clinic during the exam.
- For State Fund claims call 1-360-902-6818
- For Self- Insured Employer claims contact the requester of the exam.

Contact the appropriate law enforcement agency for the clinic location and request an off-duty police officer. Each jurisdiction may have different procedures to obtain services.

This process may take several days, so do not wait until the last moment.

Personal Conduct to Minimize Violence

Follow these suggestions in your daily interactions with people to de-escalate potentially violent situations. If at any time a person's behavior starts to escalate beyond your comfort zone, disengage.

Do	Do Not
■ Project calmness, move and speak slowly, quietly and confidently. ■ Be an empathetic listener: Encourage the person to talk and listen patiently. ■ Focus your attention on the other person to let them know you are interested in what they have to say.	■ Use styles of communication which generate hostility such as apathy, brush off, coldness, condescension, robotism, going strictly by the rules or giving the runaround. ■ Reject all of a client's demands from the start. ■ Pose in challenging stances such as standing directly opposite someone, hands on hips or crossing your arms. Avoid any

Do	Do Not
■ Maintain a relaxed yet attentive posture and position yourself at a right angle rather than directly in front of the other person. ■ Acknowledge the person's feelings. Indicate that you can see he/she is upset. ■ Ask for small, specific favors such as asking the person to move to a quieter area. ■ Establish ground rules if unreasonable behavior persists. Calmly describe the consequences of any violent behavior. ■ Use delaying tactics which will give the person time to calm down. For example, offer a drink of water (in a disposable cup). ■ Be reassuring and point out choices. Break big problems into smaller, more manageable problems. ■ Accept criticism in a positive way. When a complaint might be true, use statements like "You are probably right" or "It was my fault." If the criticism seems unwarranted, ask clarifying questions. ■ Ask for his/her recommendations. Repeat back to him/her what you feel he/she is requesting of you. ■ Arrange yourself so that a visitor cannot block your access to an exit.	physical contact, finger pointing or long periods of fixed eye contact. ■ Make sudden movements which can be seen as threatening. Notice the tone, volume and rate of your speech. ■ Challenge, threaten, or dare the individual. Never belittle the person or make him/her feel foolish. ■ Criticize or act impatiently toward the agitated individual. ■ Attempt to bargain with a threatening individual. ■ Try to make the situation seem less serious than it is. ■ Make false statements or promises you cannot keep. ■ Try to impart a lot of technical or complicated information when emotions are high. ■ Take sides or agree with distortions. ■ Invade the individual's personal space. Make sure there is a space of three feet to six feet between you and the person.

**From Combating Workplace Violence: Guidelines for Employers and Law Enforcement. International Association of Chiefs of Police. 1996.*

Five Warning Signs of Escalating Behavior

Warning Signs	Possible Responses
Confusion	
Behavior characterized by bewilderment or distraction. Unsure or uncertain of the next course of action.	■ Listen to their concerns. ■ Ask clarifying questions. ■ Give them factual information.
Frustration	
Behavior characterized by reaction or resistance to information. Impatience. Feeling a sense of defeat in the attempt of accomplishment. May try to bait you.	■ See steps above. ■ Relocate to quiet location or setting. ■ Reassure them. ■ Make a sincere attempt to clarify concerns.
Blame	
Placing responsibility for problems on everyone else. Accusing or holding you responsible. Finding fault or error with the action of others. They may place blame directly on you. **Crossing over to potentially hazardous behavior.**	■ See steps above. ■ Disengage and bring second party into the discussion. ■ Use teamwork approach. ■ Draw client back to facts. ■ Use probing questions. ■ Create “Yes” momentum.
Anger - Judgment call required	
Characterized by a visible change in body posture and disposition. Actions include pounding fists, pointing fingers, shouting or screaming. This signals very risky behavior.	■ Utilize venting techniques. ■ Don’t offer solutions. ■ Don’t argue with comments made. ■ Prepare to evacuate or isolate. ■ Contact supervisor and/or security office.
Hostility - Judgment call required	
Physical actions or threats which appear imminent. Acts of physical harm or property damage. Out-of-control behavior signals they have crossed over the line.	■ Disengage and evacuate. ■ Attempt to isolate person if it can be done safely. ■ Alert supervisor and contact security office immediately.

Helpful Resources

- WAC 296-800-140, Accident Prevention Program Requires employers to conduct a workplace hazard assessment and address all identified hazards in writing. Violence is a recognized hazard in many healthcare workplaces as verified by the statements made by the IM group.
- In addition, any hospital or hospital owned clinic (along with other specific workplaces, e.g. home health) is required to have a workplace violence plan under RCW 49.19 http://apps.leg.wa.gov/rcw/default.aspx?cite=49.19.
- Firearms
    - Private property owners may limit individuals' right to carry on their property. If the property is clearly marked with very visible signs at all entrances that say no firearms allowed – then it is illegal to bring a firearm onto the property, with or without a CPL. The crime would be trespassing. RCW 9.41.270 http://app.leg.wa.gov/RCW/default.aspx?cite=9.41.270.

APPENDIX C

Relevant Laws and Regulations

Washington state laws (Revised Code of Washington – RCW) and regulations (Washington Administrative Code – WAC) relevant to independent medical exams are listed in this appendix.

Regulations (WACs) relevant to specific impairment ratings of body systems can be found in chapter 12.

Laws

RCW 51.04.050
Physician or licensed advanced registered nurse practitioner's testimony not privileged

In all hearings, actions or proceedings before the department or the board of industrial insurance appeals, or before any court on appeal from the board, any physician or licensed advanced registered nurse practitioner having theretofore examined or treated the claimant may be required to testify fully regarding such examination or treatment, and shall not be exempt from so testifying by reason of the relation of the physician or licensed advanced registered nurse practitioner to patient.

Health services provider's testimony not privileged. ***(Effective July 1, 2025.)***

In all hearings, actions or proceedings before the department or the board of industrial insurance appeals, or before any court on appeal from the board, any health services provider having theretofore examined or treated the claimant may be required to testify fully regarding such examination or treatment, and shall not be exempt from so testifying by reason of the relation of the health services provider to patient.

RCW 51.08.100
Injury

"Injury" means a sudden and tangible happening, of a traumatic nature, producing an immediate or prompt result, and occurring from without, and such physical conditions as result therefrom.

RCW 51.08.121
New medical issue

"New medical issue" means a medical issue not covered by a previous medical examination requested by the department or the self-insurer such as an issue regarding medical causation, medical treatment, work restrictions, or evaluating permanent partial disability.

RCW 51.08.140
Occupational disease

"Occupational disease" means such disease or infection as arises naturally and proximately out of employment under the mandatory or elective adoption provisions of this title.

RCW 51.08.142
"Occupational disease"—Exclusion of mental conditions caused by stress, except for certain firefighters. (Effective January 1, 2024.)

1. Except as provided in subsections (2) and (3) of this section, the department shall adopt a rule pursuant to chapter 34.05 RCW that claims based on mental conditions or mental disabilities caused by stress do not fall within the definition of occupational disease in RCW 51.08.140.

2. (a) Except as provided in (b) and (c) of this subsection, the rule adopted under subsection (1) of this section shall not apply to occupational disease claims resulting from posttraumatic stress disorders of firefighters as defined in RCW 41.26.030(17) (a), (b), (c), and (h) and firefighters, including supervisors, employed on a full-time, fully compensated basis as a firefighter of a private sector employer's fire department that includes over fifty such firefighters, and law enforcement officers as defined in RCW 41.26.030(19) (b), (c), and (e), and public safety telecommunicators who receive calls for assistance and dispatch emergency services.

   (b) For firefighters as defined in RCW 41.26.030(17) (a), (b), (c), and (h) and firefighters, including supervisors, employed on a full-time, fully compensated basis as a firefighter of a private sector employer's fire department that includes over fifty such firefighters, and law enforcement officers as defined in RCW 41.26.030(19) (b), (c), and (e) hired after June 7, 2018, and public safety telecommunicators hired after June 11, 2020, (a) of this subsection only applies if the firefighter or law enforcement officer or public safety telecommunicators, as a condition of employment, has submitted to a psychological examination administered by a psychiatrist licensed in the state of Washington under chapter 18.71 RCW or a psychologist licensed in the state of Washington under chapter 18.83 RCW that ruled out the presence of posttraumatic stress disorder from preemployment exposures. If the employer does not provide the psychological examination, (a) of this subsection applies.

   (c) Posttraumatic stress disorder for purposes of subsections (2) and (3) of this section is not considered an occupational disease if the disorder is directly attributed to disciplinary action, work evaluation, job transfer, layoff, demotion, termination, or similar action taken in good faith by an employer.

   (d) "Public safety telecommunicators" means individuals who receive and respond to telephone or other electronic requests for emergency assistance, such as law enforcement, fire, and medical services, and dispatch appropriate emergency responders.

3. (a) Except as provided in this subsection, the rule adopted under subsection (1) of this section shall not apply to occupational disease claims resulting from posttraumatic stress disorders of direct care registered nurses as defined in RCW 51.32.395.

   (b) The limitation in subsection (2)(c) of this section also applies to this subsection (3).

   (c) This subsection (3) applies only to a direct care registered nurse who has posttraumatic stress disorder that develops or manifests itself after the individual has been employed on a fully compensated basis as a direct care registered nurse in Washington state for at least 90 consecutive days.

RCW 51.32.055 (4)

Determination of permanent disabilities—Closure of claims by self-insurers. (Effective until July 1, 2025.)

The department or, in cases authorized in subsection (9) of this section, the self-insurer may require that the worker present himself or herself for a special medical examination by a physician or physicians selected by the department, and the department or, in cases authorized in subsection (9) of this section, the self-insurer may require that the worker present himself or herself for a personal interview. The costs of the examination or interview, including payment of any reasonable travel expenses, shall be paid by the department or self-insurer, as the case may be.

Determination of permanent disabilities—Closure of claims by self-insurers. (Effective July 1, 2025.)

The department or, in cases authorized in subsection (9) of this section, the self-insurer may require that the worker present himself or herself for a special medical examination by a physician or physicians selected by the department, and the department or, in cases authorized in subsection (9) of this section, the self-insurer may require that the worker present himself or herself for a personal interview. The costs of the examination or interview, including payment of any reasonable travel expenses, shall be paid by the department or self-insurer, as the case may be.

RCW 51.32.080

Permanent partial disability – Specified – Unspecified, rules for classification – Injury after permanent partial disability

1. (a) Until July 1, 1993, for the permanent partial disabilities here specifically described, the injured worker shall receive compensation as follows:

Loss By Amputation

Of leg above the knee joint with short thigh stump (3" or less below the tuberosity of ischium)	$54,000.00
Of leg at or above knee joint with functional stump	48,600.00
Of leg below knee joint	43,200.00
Of leg at ankle (Syme)	37,800.00
Of foot at mid-metatarsals	18,900.00
Of great toe with resection of metatarsal bone	11,340.00
Of great toe at metatarsophalangeal joint	6,804.00
Of great toe at interphalangeal joint	3,600.00
Of lesser toes (2nd to 5th) with resection of metatarsal bone	4,140.00
Of lesser toe at metatarsophalangeal joint	2,016.00
Of lesser toe at proximal interphalangeal joint	1,494.00
Of lesser toe at distal interphalangeal joint	378.00
Of arm at or above the deltoid insertion or by disarticulation at the shoulder	54,000.00
Of arm at any point from below the deltoid insertion to below the elbow joint at the insertion of the	51,300.00
Of arm at any point from below the elbow joint distal to the insertion of the biceps tendon to and	48,600.00
Of all fingers except the thumb at metacarpophalangeal joints	29,160.00
Of thumb at metacarpophalangeal joint or with resection of carpometacarpal bone	19,440.00
Of thumb at interphalangeal joint	9,720.00
Of index finger at metacarpophalangeal joint or with resection of metacarpal bone	12,150.00
Of index finger at proximal interphalangeal joint	9,720.00

Of index finger at distal interphalangeal joint	5,346.00
Of middle finger at metacarpophalangeal joint or with resection of metacarpal bone	9,720.00
Of middle finger at proximal interphalangeal joint	7,776.00
Of middle finger at distal interphalangeal joint	4,374.00
Of ring finger at metacarpophalangeal joint or with resection of metacarpal bone	4,860.00
Of ring finger at proximal interphalangeal joint	3,888.00
Of ring finger at distal interphalangeal joint	2,430.00
Of little finger at metacarpophalangeal joint or with resection of metacarpal bone	2,430.00
Of little finger at proximal interphalangeal joint	1,944.00
Of little finger at distal interphalangeal joint	972.00
Miscellaneous	
Loss of one eye by enucleation	21,600.00
Loss of central visual acuity in one eye	18,000.00
Complete loss of hearing in both ears	43,200.00
Complete loss of hearing in one ear	7,200.00

(d) Beginning on July 1, 1993, compensation under this subsection shall be computed as follows:

i. Beginning on July 1, 1993, the compensation amounts for the specified disabilities listed in (a) of this subsection shall be increased by thirty-two percent; and

ii. Beginning on July 1, 1994, and each July 1 thereafter, the compensation amounts for the specified disabilities listed in (a) of this subsection, as adjusted under (b) (i) of this subsection, shall be readjusted to reflect the percentage change in this consumer price index calculated as follows: The index for the calendar year preceding the year in which the July calculation is made, to be known as "calendar year A," is divided by the index for the calendar year preceding calendar year A, and the resulting ratio is multiplied by the compensation amount in effect on June 30 immediately preceding the July 1st on which the respective calculation is made. For the purposes of this subsection, "index" means the same as the definition in RCW 2.12.037(1).

2. Compensation for amputation of a member or part thereof at a site other than those specified in subsection (1) of this section, and for loss of central visual acuity and loss of hearing other than complete, shall be in proportion to that which such other amputation or partial loss of visual acuity or hearing most closely resembles and approximates. Compensation shall be calculated based on the adjusted schedule of compensation in effect for the respective time period as prescribed in subsection (1) of this section.

3. (a) Compensation for any other permanent partial disability not involving amputation shall be in the proportion which the extent of such other disability, called unspecified disability, shall bear to the disabilities specified in subsection (1) of this section, which most closely resembles and approximates in degree of disability such other disability, and compensation for any other unspecified permanent partial disability shall be in an amount as measured and compared to total bodily impairment. To reduce litigation and establish more certainty and uniformity in the rating of unspecified permanent partial disabilities, the department shall enact rules having the force of law classifying such disabilities in the proportion which the department shall determine such disabilities reasonably bear to total bodily impairment. In enacting such rules, the department shall give consideration to, but need

not necessarily adopt, any nationally recognized medical standards or *guides* for determining various bodily impairments.

(b) Until July 1, 1993, for purposes of calculating monetary benefits under (a) of this subsection, the amount payable for total bodily impairment shall be deemed to be ninety thousand dollars. Beginning on July 1, 1993, for the purposes of calculating monetary benefits under (a) of this subsection, the amount payable for total bodily impairment shall be adjusted as follows:

i. Beginning July 1, 1993, the amount payable for total bodily impairment under this section shall be increased to one hundred eighteen thousand eight hundred dollars; and
ii. Beginning July 1, 1994, and each July 1 thereafter, the amount payable for total bodily impairment prescribed in (b) (i) of this subsection shall be adjusted as provided in subsection (1) (b) (ii) of this section.

(c) Until July 1, 1993, the total compensation for all unspecified permanent partial disabilities resulting from the same injury shall not exceed the sum of ninety thousand dollars. Beginning on July 1, 1993, total compensation for all unspecified permanent partial disabilities resulting from the same injury shall not exceed a sum calculated as follows:

i. Beginning on July 1, 1993, the sum shall be increased to one hundred eighteen thousand eight hundred dollars; and
ii. Beginning on July 1, 1994, and each July 1 thereafter, the sum prescribed in (b)(i) of this subsection shall be adjusted as provided in subsection (1)(b)(ii) of this section.

4. If permanent partial disability compensation is followed by permanent total disability compensation, any portion of the permanent partial disability compensation which exceeds the amount that would have been paid the injured worker if permanent total disability compensation had been paid in the first instance, shall be deducted from the pension reserve of such injured worker and his or her monthly compensation payments shall be reduced accordingly.

5. Should a worker receive an injury to a member or part of his or her body already, from whatever cause, permanently partially disabled, resulting in the amputation thereof or in an aggravation or increase in such permanent partial disability but not resulting in the permanent total disability of such worker, his or her compensation for such partial disability shall be adjudged with regard to the previous disability of the injured member or part and the degree or extent of the aggravation or increase of disability thereof.

6. When the compensation provided for in subsections (1) through (3) of this section exceeds three times the average monthly wage in the state as computed under the provisions of RCW 51.08.018, payment shall be made in monthly payments in accordance with the schedule of temporary total disability payments set forth in RCW 51.32.090 until such compensation is paid to the injured worker in full, except that the first monthly payment shall be in an amount equal to three times the average monthly wage in the state as computed under the provisions of RCW 51.08.018, and interest shall be paid at the rate of eight percent on the unpaid balance of such compensation commencing with the second monthly payment. However, upon application of the injured worker or survivor the monthly payment may be converted, in whole or in part, into a lump sum payment, in which event the monthly payment

shall cease in whole or in part. Such conversion may be made only upon written application of the injured worker or survivor to the department and shall rest in the discretion of the department depending upon the merits of each individual application. Upon the death of a worker all unpaid installments accrued shall be paid according to the payment schedule established prior to the death of the worker to the widow or widower, or if there is no widow or widower surviving, to the dependent children of such claimant, and if there are no such dependent children, then to such other dependents as defined by this title.

7. Awards payable under this section are governed by the schedule in effect on the date of injury.

RCW 51.32.100
Preexisting disease.

If it is determined that an injured worker had, at the time of his or her injury, a preexisting disease and that such disease delays or prevents complete recovery from such injury, it shall be ascertained, as nearly as possible, the period over which the injury would have caused disability were it not for the diseased condition and the extent of permanent partial disability which the injury would have caused were it not for the disease, and compensation shall be awarded only therefor.

RCW 51.32.110
Medical examination – Refusal to submit – Traveling expenses – Pay for time lost.

1. As required under RCW 51.36.070, any worker entitled to receive any benefits or claiming such under this title shall, if requested by the department or self-insurer, submit himself or herself for medical examination, at a place reasonably convenient for the worker. An injured worker, whether an alien or other injured worker, who is not residing in the United States at the time that a medical examination is requested may be required to submit to an examination at any location in the United States determined by the department or self-insurer.

2. If the worker refuses to submit to medical examination, or obstructs the same, or, if any injured worker shall persist in unsanitary or injurious practices which tend to imperil or retard his or her recovery, or shall refuse to submit to such medical or surgical treatment as is reasonably essential to his or her recovery or refuse or obstruct evaluation or examination for the purpose of vocational rehabilitation or does not cooperate in reasonable efforts at such rehabilitation, the department or the self-insurer upon approval by the department, with notice to the worker may suspend any further action on any claim of such worker so long as such refusal, obstruction, noncooperation, or practice continues and reduce, suspend, or deny any compensation for such period: PROVIDED, That (a) the department or the self-insurer shall not suspend any further action on any claim of a worker or reduce, suspend, or deny any compensation if a worker has good cause for refusing to submit to or to obstruct any examination, evaluation, treatment or practice requested by the department or required under this section and (b) the department may not assess a no-show fee against the worker if the worker gives at least five business days' notice of the worker's intent not to attend the examination.

3. If the worker necessarily incurs traveling expenses in attending the examination pursuant to the request of the department, such traveling expenses shall be repaid to him or her out of the accident fund upon proper voucher and audit or shall be repaid by the self-insurer, as the case may be.

4. (a) If the medical examination required by this section causes the worker to be absent from his or her work without pay:

    i. In the case of a worker insured by the department, the worker shall be paid compensation out of the accident fund in an amount equal to his or her usual wages for the time lost from work while attending the medical examination; or
    ii. In the case of a worker of a self-insurer, the self-insurer shall pay the worker an amount equal to his or her usual wages for the time lost from work while attending the medical examination.

    (b) This subsection (4) shall apply prospectively to all claims regardless of the date of injury.

RCW 51.32.112
Medical examination – Standards and criteria –Special medical examinations by chiropractors – Compensation guidelines and reporting criteria.

1. The department shall develop standards for the conduct of special medical examinations to determine permanent disabilities, including, but not limited to:

    (a) The qualifications of persons conducting the examinations;

    (b) The criteria for conducting the examinations, including guidelines for the appropriate treatment of injured workers during the examination; and

    (c) The content of examination reports.

2. Within the appropriate scope of practice, chiropractors licensed under chapter 18.25 RCW may conduct special medical examinations to determine permanent disabilities in consultation with physicians licensed under chapter 18.57 or 18.71 RCW. The department, in its discretion, may request that a special medical examination be conducted by a single chiropractor if the department determines that the sole issues involved in the examination are within the scope of practice under chapter 18.25 RCW. However, nothing in this section authorizes the use as evidence before the board of a chiropractor's determination of the extent of a worker's permanent disability if the determination is not requested by the department.

3. The department shall investigate the amount of examination fees received by persons conducting special medical examinations to determine permanent disabilities, including total compensation received for examinations of department and self-insured claimants, and establish compensation guidelines and compensation reporting criteria.The department shall investigate the level of compliance of self-insurers with the requirement of full reporting of claims information to the department, particularly with respect to medical examinations, and develop effective enforcement procedures or recommendations for legislation if needed.

RCW 51.32.114
Medical examination – Department to monitor quality and objectivity.

The department shall examine the credentials of persons conducting special medical examinations and shall monitor the quality and objectivity of examinations and reports for the department and self-insured

claimants. The department shall adopt rules to ensure that examinations are performed only by qualified persons meeting department standards.

Intent -- 1988 c 114: “It is the intent of the legislature that medical examinations for determining permanent disabilities be conducted fairly and objectively by qualified examiners and with respect for the dignity of the injured worker.”

RCW 51.36.060
Duties of attending provider—Medical information. (Effective July 1, 2025.)

Attending providers under this title shall comply with rules and regulations adopted by the director, and shall make such reports as may be requested by the department or self-insurer upon the condition or treatment of any such worker, or upon any other matters concerning such workers in their care. Except under RCW 49.17.210 and 49.17.250, all medical information in the possession or control of any person and relevant to the particular injury in the opinion of the department pertaining to any worker whose injury or occupational disease is the basis of a claim under this title shall be made available at any stage of the proceedings to the employer, the claimant's representative, and the department upon request, and no person shall incur any legal liability by reason of releasing such information.

RCW 51.36.070
Medical examination—Reports—Costs—Worker's rights. (Effective July 1, 2025.)

1. (a) Whenever the department or the self-insurer deems it necessary in order to (i) make a decision regarding claim allowance or reopening, (ii) resolve a new medical issue, an appeal, or case progress, or (iii) evaluate the worker's permanent disability or work restriction, a worker shall submit to examination by a physician or physicians selected by the department, with the rendition of a report to the person ordering the examination, the attending provider, and the injured worker.

   (d) The examination must be at a place reasonably convenient to the injured worker, or alternatively utilize telemedicine if the department determines telemedicine is appropriate for the examination. For purposes of this subsection, "reasonably convenient" means at a place where residents in the injured worker's community would normally travel to seek medical care for the same specialty as the examiner. The department must address in rule how to accommodate the injured worker if no approved medical examiner in the specialty needed is available in that community.

2. The department or self-insurer shall provide the physician performing an examination with all relevant medical records from the worker's claim file. The director, in his or her discretion, may charge the cost of such examination or examinations to the self-insurer or to the medical aid fund as the case may be. The cost of said examination shall include payment to the worker of reasonable expenses connected therewith.

3. For purposes of this section, "examination" means a physical or mental examination by a medical care provider licensed to practice medicine, osteopathy, podiatry, chiropractic, dentistry, or psychiatry at the request of the department or self-insured employer.

4. (a) The worker has the right to record the audio, video, or both, of all examinations ordered under this section, RCW 51.32.110, or by the board of industrial insurance appeals.

   (b) The worker or the worker's representative must provide notice to the entity scheduling the examination that the examination will be recorded no less than seven calendar days before the date of the examination. The department must adopt rules to define the notification process.

   (c) The worker is responsible for paying the costs of recording.

   (d) Upon request, the worker must provide one copy of the recording to the department or self-insured employer within 14 days of receiving the request, but in no case prior to the issuance of a written report of the examination.

   (e) The worker must take reasonable steps to ensure the recording equipment does not interfere with the examination. The worker may not hold the recording equipment while the examination is occurring.

   (f) The worker may not materially alter the recording. Benefits received as a result of any material alteration of the recording by the worker or done on the worker's behalf may be subject to repayment pursuant to RCW 51.32.240.

   (g) The worker may not post the recording to social media.

   (h) Recordings made under this subsection are deemed confidential pursuant to RCW 51.28.070.

   (i) The worker has the right to have one person, who is at least the age of majority and who is of the worker's choosing, to be present to observe all examinations ordered under this section, RCW 51.32.110, or by the board of industrial insurance appeals. The observer must be unobtrusive and not interfere with the examination. The observer may not be the worker's legal representative, an employee of the legal representative, the worker's attending provider, or an employee of the worker's attending provider.

5. This section applies prospectively to all claims regardless of the date of injury.

Regulations (WACs)

In addition to the regulations presented next, refer to WACs 296-20-230 through 296-20-660 (Category Rating System for cervical, cardiac, urologic impairment, etc.) in Section V. These regulations are specific to impairment and, therefore, listed there, not below.

WAC 296-14-300
Mental condition/mental disabilities.

1. Claims based on mental conditions or mental disabilities caused by stress do not fall within the definition of an occupational disease.

Examples of mental conditions or mental disabilities caused by stress that do not fall within occupational disease shall include, but are not limited to, those conditions and disabilities resulting from:

(a) Change of employment duties;

(b) Conflicts with a supervisor;

(c) Actual or perceived threat of loss of a job, demotion, or disciplinary action;

(d) Relationships with supervisors, coworkers, or the public;

(e) Specific or general job dissatisfaction;

(f) Work load pressures;

(g) Subjective perceptions of employment conditions or environment;

(h) Loss of job or demotion for whatever reason;

(i) Fear of exposure to chemicals, radiation biohazards, or other perceived hazards;

(j) Objective or subjective stresses of employment;

(k) Personnel decisions;

(l) Actual, perceived, or anticipated financial reversals or difficulties occurring to the businesses of self-employed individuals or corporate officers.

2. (a) Stress resulting from exposure to a single traumatic event will be adjudicated as an industrial injury. See RCW 51.08.100.

(b) Examples of single traumatic events include: Actual or threatened death, actual or threatened physical assault, actual or threatened sexual assault, and life-threatening traumatic injury.

(c) These exposures must occur in one of the following ways:

i. Directly experiencing the traumatic event;
ii. Witnessing, in person, the event as it occurred to others; or
iii. Extreme exposure to aversive details of the traumatic event.

(d) Repeated exposure to traumatic events, none of which are a single traumatic event as defined in subsection (2)(b) and (c) of this section, is not an industrial injury (see RCW 51.08.100) or an occupational disease (see RCW 51.08.142). A single traumatic event as defined in subsection (2)(b) and (c) of this section that occurs within a series of exposures will be adjudicated as an industrial injury (see RCW 51.08.100).

3. For certain firefighters and law enforcement officers, there is a presumption that posttraumatic stress disorder (PTSD) is an occupational disease as provided by RCW 51.08.142 and 51.32.185.

4. For public safety telecommunicators, PTSD may be considered an occupational disease as provided by RCW 51.08.142.

5. Mental conditions or mental disabilities that specify pain primarily as a psychiatric symptom (e.g., somatic symptom disorder, with predominant pain), or that are characterized by excessive or abnormal thoughts, feelings, behaviors or neurological symptoms (e.g., conversion disorder, factitious disorder) are not clinically related to occupational exposure.

WAC 296-20-055
Limitation of treatment and temporary treatment of unrelated conditions when retarding recovery. Conditions preexisting the injury or occupational disease are not the responsibility of the department. When an unrelated condition is being treated concurrently with the industrial condition, the attending doctor must notify the department or self-insurer immediately and submit the following:

1. Diagnosis and/or nature of unrelated condition.

2. Treatment being rendered.

3. The effect, if any, on industrial condition.

Temporary treatment of an unrelated condition may be allowed, upon prior approval by the department or self-insurer, provided these conditions directly retard recovery of the accepted condition. The department or self-insurer will not approve or pay for treatment for a known preexisting unrelated condition for which the claimant was receiving treatment prior to his industrial injury or occupational disease, which is not retarding recovery of his industrial condition.

A thorough explanation of how the unrelated condition is affecting the industrial condition must be included with the request for authorization.

The department or self-insurer will not pay for treatment of an unrelated condition when it no longer exerts any influence upon the accepted industrial condition. When treatment of an unrelated condition is being rendered, reports must be submitted monthly outlining the effect of treatment on both the unrelated and the accepted industrial conditions.

The department or self-insurer will not pay for treatment for unrelated conditions unless specifically authorized. This includes prescription of drugs and medicines.

WAC 296-20-19000

What is a permanent partial disability award?

Permanent partial disability is any anatomic or functional abnormality or loss after maximum medical improvement (MMI) has been achieved. At MMI, the worker's condition is determined to be stable or nonprogressive at the time the evaluation is made. A permanent partial disability award is a monetary award designed to compensate the worker for the amputation or loss of function of a body part or organ system. Impairment is evaluated without reference to the nature of the injury or the treatment given. To ensure uniformity, consistency and fairness in rating permanent partial disability, it is essential that injured workers with comparable anatomic abnormalities and functional loss receive comparable disability awards. As such, the amount of the permanent partial disability award is not dependent upon or influenced by the economic impact of the occupational injury or disease on an individual worker. Rather, Washington's Industrial Insurance Act requires that permanent partial disability be established primarily by objective physical or clinical findings establishing a loss of function. Mental health impairments are evaluated under WAC 296-20-330 and 296-20-340.

WAC 296-20-19010

Are there different types of permanent partial disabilities?

Under Title 51 RCW, there are two types of permanent partial disabilities.

1. Specified disabilities are listed in RCW 51.32.080 (1) (a). They are limited to amputation or loss of function of extremities, loss of hearing or loss of vision.

2. Unspecified disabilities include, but are not limited to, internal injuries, back injuries, mental health conditions, respiratory disorders, and other disorders affecting the internal organs.

WAC 296-20-19020

How is it determined which impairment rating system is to be used to rate specified and unspecified disabilities?

1. Specified disabilities are rated in one of two ways:

   (a) Impairment due to amputation, total loss of hearing, and total loss of vision are rated according to RCW 51.32.080;

   (b) Impairment for the loss of function of extremities, as well as partial loss of hearing or vision, is rated using a nationally recognized impairment rating guide unless otherwise precluded by department rule.

2. Unspecified disabilities are rated in accordance with WAC 296-20-200 through 296-20-660.

WAC 296-20-19030

To what extent is pain considered in an award for permanent partial disability?

The categories used to rate unspecified disabilities incorporate the worker's subjective complaints. Similarly, the organ and body system ratings in the *AMA Guides to the Evaluation of Permanent*

Impairment incorporate the worker's subjective complaints. A worker's subjective complaints or symptoms, such as a report of pain, cannot be objectively validated or measured. There is no valid, reliable or consistent means to segregate the worker's subjective complaints of pain from the pain already rated and compensated for in the conventional rating methods. When rating a worker's permanent partial disability, reliance is primarily placed on objective physical or clinical findings that are independent of voluntary action by the worker and can be seen, felt or consistently measured by examiners. No additional permanent partial disability award will be made beyond what is already allowed in the categories and in the organ and body system ratings in the *AMA Guides*.

For example:

- Chapter 18 of the 5th Edition of the *AMA Guides to the Evaluation of Permanent Impairment* attempts to rate impairment caused by a patient's pain complaints. The impairment caused by the worker's pain complaints is already taken into consideration in the categories and in the organ and body system ratings in the *AMA Guides*. There is no reliable means to segregate the pain already rated and compensated from the pain impairment that Chapter 18 purports to rate. Chapter 18 of the 5th Edition of the *Guides to the Evaluation of Permanent Impairment* cannot be used to calculate awards for permanent partial disability under Washington's Industrial Insurance Act.

WAC 296-20-200
General information for impairment rating examinations by attending doctors, consultants or independent medical examination (IME) providers.

1. The department of labor and industries has promulgated the following rules and categories to provide a comprehensive system of classifying unspecified permanent partial disabilities in the proportion they reasonably bear to total bodily impairment. The department's objectives are to reduce litigation and establish more certainty and uniformity in the rating of unspecified permanent partial disabilities pursuant to RCW 51.32.080(2).

2. The following system of rules and categories directs the provider's attention to the actual conditions found and establishes a uniform system for conducting rating examinations and reporting findings and conclusions in accord with broadly accepted medical principles.

   The evaluation of bodily impairment must be made by experts authorized to perform rating examinations. After conducting the examination, the provider will choose the appropriate category for each bodily area or system involved in the particular claim and include this information in the report. The provider will, therefore, in addition to describing the worker's condition in the report, submit the conclusions as to the relative severity of the impairment by giving it in terms of a defined condition rather than a personal opinion as to a percentage figure. In the final section of this system of categories and rules are some rules for determining disabilities and the classification of disabilities in bodily impairment is listed for each category. These last provisions are for the department's administrative use in acting upon the expert opinions which have been submitted to it.

3. In preparing this system, the department has complied with its duty to enact rules classifying unspecified disabilities in light of statutory references to nationally recognized standards or guides for

determining various bodily impairments. Accordingly, the department has obtained and acted upon sound established medical opinion in thus classifying unspecified disabilities in the reasonable proportion they bear to total bodily impairment. In framing descriptive language of the categories and in assigning a percentage of disability, careful consideration has been given to nationally recognized medical standards and guides. Both are matters calling for the use of expert medical knowledge. For this reason, the meaning given the words used in this set of categories and accompanying rules, unless the text or context clearly indicates the contrary, is the meaning attached to the words in normal medical usage.

4. The categories describe levels of physical and mental impairment. Impairment is anatomic or functional abnormality or loss of function after maximum medical improvement has been achieved. This is the meaning of "impairment" as the word is used in the *guides* mentioned above. This standard applies to all persons equally, regardless of factors other than loss of physical or mental function. Impairment is evaluated without reference to the nature of injury or the treatment therefore, but is based on the functional loss due to the injury or occupational disease. The categories have been framed to include conditions in other bodily areas which derive from the primary impairment. The categories also include the presence of pain, tenderness and other complaints. Workers with comparable loss of function thus receive comparable awards.

5. These rules and categories (WAC 296-20-200 through 296-20-690) shall only be applicable to compensable injuries occurring on or after the effective date of these rules and categories.

6. These rules and categories (WAC 296-20-200 through 296-20-690) shall be applicable only to cases of permanent partial disability. They have no applicability to determinations of permanent total disability.

WAC 296-20-2010
General rules for impairment rating examinations by attending doctors and consultants.
These general rules must be followed by doctors who perform examinations or evaluations of permanent bodily impairment.

1. Impairment rating examinations shall be performed only by doctors currently licensed in medicine and surgery (including osteopathic and podiatric) or dentistry, and department-approved chiropractors subject to RCW 51.32.112. The department or self-insurer may request the worker's attending doctor conduct the impairment rating when appropriate. If the attending doctor is unable or unwilling to perform the impairment rating examination, a consultant, at the attending doctor's request, may conduct a consultation examination and provide an impairment rating based on the findings. The department or self-insurer can also request an impairment rating examination from an independent medical examiner (IME) provider. A chiropractic impairment rating examination may be performed only when the worker has been clinically managed by a chiropractor.

2. Whenever an impairment rating examination is made, the attending doctor or consultant must complete a rating report that includes, at the minimum, the following:

(a) Statement that the patient has reached maximum medical improvement (MMI) and that no further curative treatment is recommended;

(b) Pertinent details of the physical examination performed (both positive and negative findings);

(c) Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of any pertinent tests or studies ordered as part of the exam;

(d) An impairment rating consistent with the findings and a statement of the system on which the rating was based (for example, the *AMA Guides to the Evaluation of Permanent Impairment* and edition used, or the Washington state category rating system—refer to WAC 296-20-19000 through 296-20-19030 and WAC 296-20-200 through 296-20-690); and

(e) The rationale for the rating, supported by specific references to the clinical findings, especially objective findings and supporting documentation including the specific rating system, tables, figures and page numbers on which the rating was based.

3. It is the responsibility of attending doctors and consultants to be familiar with the contents of the Medical Examiner Handbook section on how to rate impairment.

4. Attending doctors and consultants performing impairment ratings must be available and willing to testify on behalf of the department or self-insurer, worker or employer and accept the department fee schedule for testimony.

5. A complete impairment rating report must be sent to the department or self-insurer within fourteen calendar days of the examination date, or within fourteen calendar days of receipt of the results of any special tests or studies requested as a part of the examination. Job analyses (JAs) sent to the IME provider at the time of the impairment rating exam must be completed and submitted with the impairment rating report.

WAC 296-20-2015
What rating systems are used for determining an impairment rating conducted by the attending doctor or a consultant?
The following table provides guidance regarding the rating system generally used. These rating systems or others adopted through department policies should be used to conduct an impairment rating.

Overview of Systems for Rating Impairment

Rating System	Used for These Conditions	Form of the Rating
RCW 51.32.080	Specified disabilities: Loss by amputation, total loss of vision or hearing	Supply the level of amputation

Rating System	Used for These Conditions	Form of the Rating
AMA Guides to the Evaluation of Permanent Impairment	Loss of function of extremities, partial loss of vision or hearing	Determine the percentage of loss of function, as compared to amputation value listed in RCW 51.32.080
Category Rating System	Spine, neurologic system, mental health, respiratory, taste and smell, speech, skin, or disorders affecting other internal organs	Select the category that most accurately indicates overall impairment
Total Bodily Impairment (TBI)	Impairments not addressed by any of the rating systems above, and claims prior to 1971	Supply the percentage of TBI

WAC 296-20-2025

May a worker bring someone with them to an impairment rating examination conducted by the attending doctor or a consultant?

1. Workers can bring an adult friend or family member to the impairment rating examination to provide comfort and reassurance. The accompanying person may attend the physical examination but may not attend a psychiatric examination.

2. The accompanying person cannot be compensated for attending the examination by anyone in any manner.

3. The worker may not bring an interpreter to the examination. If interpretive services are needed, the department or self-insurer will provide an interpreter.

4. The purpose of the impairment rating examination is to provide information to assist in the determination of the level of any permanent impairment, not to conduct an adversarial procedure. Therefore, the accompanying person cannot be:

   (a) The worker's attorney, paralegal, any other legal representative, or any other personnel employed by the worker's attorney or legal representative; or

   (b) The worker's attending doctor, any other provider involved in the worker's care, or any other personnel employed by the attending doctor or other provider involved in the worker's care.

   (c) The department may designate other conditions under which the accompanying person is allowed to be present during the impairment rating examination.

WAC 296-20-2030

May the worker videotape or audiotape the impairment rating examination conducted by the attending doctor or a consultant?

The use of recording equipment of any kind by the worker or accompanying person is not allowed.

WAC 296-20-220

Special rules for evaluation of permanent bodily impairment

1. Evaluations of permanent bodily impairment using categories require uniformity in procedure and terminology. The following rules have been enacted to produce this uniformity and shall apply to all evaluations of permanent impairment of an unspecified nature.

   (a) Gradations of relative severity shall be expressed by the words "minimal," "mild," "moderate" and "marked" in an ascending scale. "Minimal" shall describe deviations from normal responses which are not medically significant. "Mild," "moderate" and "marked" shall describe ranges of medically significant deviations from normal responses. "Mild" shall describe the least severe third. "Moderate" shall describe the middle third. "Marked" shall describe the most severe third.

   (b) "Permanent" describes those conditions which are fixed, lasting and stable, and from which within the limits of medical probability, further recovery is not expected.

   (c) "Impairment" means a loss of physical or mental function.

   (d) "Total bodily impairment," as used in these rules, is the loss of physical or mental function which is essentially complete short of death.

   (e) The examiner shall not assign a percentage for permanent bodily impairment described in the categories established herein.

   (f) The method of evaluating impairment levels is by selection of the appropriate level of impairment. These descriptive levels are called "categories." Assessments of the level of impairment are to be made by comparing the condition of the injured workman with the conditions described in the categories and selecting the most appropriate category.

   These rules and categories for various bodily areas and systems provide a comprehensive system for the measurement of disabling conditions which are not already provided for in the list of specified permanent partial disabilities in RCW 51.32.080(1). Disabilities resulting from loss of central visual acuity, loss of an eye by enucleation, loss of hearing, amputation or loss of function of the extremities will continue to be evaluated as elsewhere provided in RCW 51.32.080.

   The categories have been classified in percentages in reasonable proportion to total bodily impairment for the purpose of determining the proper award. Provision has been made for correctly weighing the overall impairment due to particular injuries or occupational disease in cases in which there are preexisting impairments.

   (g) The categories of the various bodily areas and systems are listed in the order of increasing impairment except as otherwise specified. Where several categories are given for the evaluation

of the extent of permanent bodily impairment, the impairments in the higher numbered categories, unless otherwise specified, include the impairments in the lesser numbered categories. No category for a condition due to an injury shall be selected unless that condition is permanent as defined by these rules.

The examiner shall select the one category which most accurately indicates the overall degree of permanent impairment unless otherwise instructed. Where there is language in more than one category which may appear applicable, the category which most accurately reflects the overall impairment shall be selected.

The categories include appropriate subjective complaints in an ascending scale in keeping with the severity of objective findings, thus a higher or lower category is not to be selected purely on the basis of unusually great or minor complaints.

(h) When the examination discloses a preexisting permanent bodily impairment in the area of the injury, the examiner shall report the findings and any category or impairment appropriate to the worker's condition prior to the industrial injury in addition to the findings and the categories appropriate to the worker's condition after the injury.

(i) Objective physical or clinical findings are those findings on examination which are independent of voluntary action and can be seen, felt, or consistently measured by examiners.

(j) Subjective complaints or symptoms are those perceived only by the senses and feelings of the person being examined which cannot be independently proved or established.

(k) Muscle spasm as used in these rules is an involuntary contraction of a muscle or group of muscles of a more than momentary nature.

(l) An involuntary action is one performed independently of the will

(m) These special rules for evaluation of permanent bodily impairment shall apply to all examinations for the evaluation of impairment, in accordance with RCW 51.32.080, for the body areas or systems covered by or enumerated in WAC 296-20-230 through 296-20-660.

(n) The rules for evaluation of each body area or system are an integral part of the categories for that body area or system.

(o) In cases of injury or occupational disease of bodily areas and/or systems which are not included in these categories or rules and which do not involve loss of hearing, loss of central visual acuity, loss of an eye by enucleation or loss of the extremities or use thereof, examiners shall determine the impairment of such bodily areas and/or systems in terms of percentage of total bodily impairment.

(p) The words used in the categories of impairments, in the rules for evaluation of specific impairments, the general rules, and the special rules shall be deemed, unless the context indicates the contrary, to have their general and accepted medical meanings.

(q) The rating of impairment due to total joint replacement shall be in accordance with the limitation of motion guidelines as set forth in the *Guides to the Evaluation of Permanent Impairment* of *American Medical Association*, with department of labor and industries acknowledgement of responsibility for failure of prostheses beyond the seven year limitation.

WAC 296-21-270
Mental Health Services

1. The following rule supplements information contained in the fee schedules regarding coverage and reimbursement for mental health services.

2. Treatment of mental conditions to workers is to be goal directed, time limited, intensive, targeted on specific symptoms and functional status and limited to conditions caused or aggravated by the industrial condition. Specific functional goals of treatment must be identified and treatment must have an emphasis on functional, measurable improvement towards the specific goals.

3. Mental health services to workers are limited to those provided by psychiatrists, doctoral level psychologists, psychiatric advanced registered nurse practitioners, licensed independent clinical social workers, licensed marriage and family therapists, licensed mental health counselors, and according to department policy. Psychiatrists and psychiatric advanced registered nurse practitioners may prescribe medications while providing concurrent care. For purposes of this rule, the term "mental health services" refers to treatment by psychologists, psychiatric advanced registered nurse practitioners, psychiatrists, licensed independent clinical social workers, licensed marriage and family therapists, and licensed mental health counselors.

4. Initial evaluation, and subsequent treatment must be authorized by department staff or the self-insurer, as outlined by department policy. The report of initial evaluation, including test results, and treatment plan is to be sent to the worker's attending provider, as well as to the department or self-insurer. A copy of the 60-day narrative reports are to be sent to the department or self-insurer and to the attending provider.

5. (a) All providers are bound by the medical aid rules in chapter 296-20 WAC. Reporting requirements are defined in chapter 296-20 WAC. In addition, the following are required: Testing results with scores, scales, and profiles; report of raw data sufficient to allow reassessment by a panel or independent medical examiner. Explanation of the numerical scales is required.

   (b) Providers must use the edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association designated by the department in the initial evaluation, follow-up evaluations and 60-day narrative reports.

   (c) A report to the department or self-insurer will contain, at least, the following elements:

   (i) Subjective complaints;
   (ii) Objective observations;
   (iii) Identification and measurement of target symptoms and functional status;

(iv) Assessment of the worker's condition and goals accomplished in relation to the target symptoms and functional status; and
(v) Plan of care.

6. The codes, reimbursement levels, and other policies for mental health services are listed in the fee schedules.

7. When providing mental health services, providers must track and document the worker's functional status using validated instruments such as the World Health Organization Disability Assessment Schedule (WHODAS) or other substantially equivalent validated instruments recommended by the department. A copy of the completed functional assessment instrument must be sent to the attending provider and the department or self-insurer, as required by department policy or treatment guideline.

WAC 296-23-302
Definitions.
Approved Independent Medical Examination (IME) provider - A licensed doctor or firm whose credentials are approved to conduct an independent medical examination, rating evaluation, or provide IME associated services including but not limited to file preparation, scheduling of examinations and processing billing. An approved IME provider is assigned a unique provider number.

Case progress examination - An examination requested for an accepted condition because:

(a) A proper and necessary treatment plan, per the definition of "proper and necessary" found in WAC 296-20-01002, is not in place; or

(b) The treatment plan has stalled or been completed without resulting in objective or functional improvement for physical conditions, or clinically meaningful signs of improvement for mental health conditions.

Department – For the purpose of this rule, department means the Department of Labor and Industries industrial insurance workers' compensation State Fund and self-insured programs.

Direct patient care - For the purpose of meeting the qualifications of an independent medical examination (IME) provider, direct patient care means face-to-face contact with the patient for the purpose of evaluation and management of care that includes, but is not limited to:

- History taking and review of systems;
- Physical examination;
- Medical decision making;
- Coordination of care with other providers and agencies.

This does not include time spent in independent medical examinations.

Impairment rating examination - An examination to determine whether or not the injured/ill worker has any permanent impairment(s) as a result of the industrial injury or illness after the worker has reached maximum medical improvement. An impairment rating may be conducted by the attending provider, a medical consultant, or an approved examiner. An impairment rating may be a component of an IME.

Independent medical examination (IME) - An objective medical-legal examination requested to establish medical findings, opinions, and conclusions about a worker's physical condition. These examinations may only be conducted by department approved examiners.

Independent medical examination (IME) provider - A firm, partnership, corporation, or individual licensed doctor (examiner) who has been approved and given an independent medical examination (IME) provider number by the department to perform IMEs.

Medical director - A licensed doctor and approved IME examiner in the firm, partnership, corporation or other legal entity responsible to provide oversight on quality of independent medical examinations, impairment ratings and reports.

Medical Examiners' Handbook - A handbook developed by the department containing department policy and information to assist providers who perform independent medical examinations and impairment rating examinations.

Patient related services – Patient related services are defined as one or more of the following professional activities:

- Direct Patient Care
- Locum tenens
- Clinical consultations for treating/attending doctors
- Clinical instruction of medical, osteopathic, dental, podiatry, or chiropractic students and/or residents
- On-call emergency services
- Volunteer clinician providing patient care services in his or her specialty

Provider number - A unique number(s) assigned to a provider by the Department of Labor and Industries. The number identifies the provider and is linked to a tax identification number that has been designated by the provider for payment purposes. A provider may have more than one provider number assigned by the department.

Suspension – A department action during which the provider is approved by the department but not available to accept referrals.

Temporarily unavailable – Provider is approved by the department but is temporarily unavailable to accept referrals. Temporarily unavailable applies at the provider's request for personal reasons or by the department as part of an administrative action. Provider remains unavailable until the issue is resolved.

Termination – The permanent removal of a provider from the list of approved IME examiners. All IME provider numbers assigned to the examiner are inactivated.

WAC 296-23-308
Scheduling case progress examinations.

1. Unless a case progress examination is requested by the attending provider, no case progress examination may be scheduled until 120 days have passed since the later of:

   (a) The department or self-insurer's receipt of the claim; or

(b) The department or self-insurer's receipt of the last case progress examination report and additional treatment of the condition, if requested, has been authorized.

2. Subject to subsection (1) of this section, the department or self-insurer may schedule a case progress examination of an injured worker after:

   (a) Requesting an explanation from the attending provider regarding status of the treatment plan per WAC 296-23-302, definition of case progress examination, or a referral of the injured worker to a consultation with the appropriate specialty(ies) per WAC 296-20-051 within 15 business days of the request; and

   (b) The attending provider or consultant:

      i. Did not respond within 15 business days of the department or self-insured employer request or the consultation could not be completed within 90 days;
      ii. Omitted requested information;
      iii. Did not have further treatment recommendations;
      iv. Recommended a treatment plan that is not proper and necessary or does not meet the department's medical treatment guidelines; or
      v. Wrote a report that does not comply with the provisions of WAC 296-20-06101.

WAC 296-23-309
How many examinations may be requested?
Unless explicitly required by statute, the total number of examinations per claim is limited as follows:

1. One complete examination including report prior to an order under RCW 51.52.050 or 51.52.060 allowing or denying a new claim unless an additional examination is authorized by the department in state fund or self-insured cases;

2. One complete examination including report(s) from all appropriate specialty(ies) for an impairment rating unless the prior rating examination determined a rating was premature and/or further treatment was needed and is authorized by the self-insured employer or department;

3. One complete examination including report(s) from all appropriate specialty(ies) to adjudicate any application to reopen a claim under RCW 51.32.160 prior to a final order under RCW 51.52.050 or 51.52.060 allowing or denying reopening of the claim, unless the department authorizes an additional examination in state fund and self-insured cases. Additional impairment rating examinations are allowed following each time a claim is reopened under RCW 51.32.160;

4. One examination may be performed after any new medical issue is contended to resolve a new medical issue prior to a final order, under RCW 51.52.050 or 51.52.060, accepting or denying responsibility of the condition, unless the department authorizes an additional examination in state fund and self-insured cases; and

5. Additional examinations per case progress rules and to resolve appeals as outlined in WAC 296-23-308 and 296-23-401.

WAC 296-23-312

Can a provider conduct independent medical examinations (IMEs) for the department or self-insurer without an active IME provider number from the department?

No. Only doctors who possess an active IME provider number can provide independent medical examinations for the department or self-insurer. Providers must submit an IME provider application and be approved by the department to receive this number.

WAC 296-23-317

What qualifications must a provider meet to become an approved independent medical examination (IME) provider and be assigned an IME provider number?

To ensure that independent medical examinations are of the highest quality and propriety, examiners and firms (partnerships, corporations, or other legal entities) that derive income from independent medical exams must apply and meet the following requirements for department approval:

1. Examiners must:

   (a) Submit an accurate and complete IME provider application, including any required supporting documentation and sign without modification, an IME provider agreement with the department.

   (b) Be currently licensed, certified, accredited or registered according to Washington state laws and rules or in any other jurisdiction where the applicant would conduct an examination.

      i. The license, registration or certification must be free of any restrictions, limitations, or conditions relating to the provider's acts, omissions, or conduct.
      ii. The applicant must not have surrendered, voluntarily or involuntarily his or her professional state license or Drug Enforcement Administration (DEA) registration in any state while under investigation or due to findings resulting from the provider's acts, omissions, or conduct. The department may grant an exception for any restriction, limitation, or condition deemed by the department to be minor or clerical in nature or for a case where the restriction, limitation, or condition has been removed.
      iii. If any restriction once existed against the applicant's license, registration, or certification, the department must automatically deny the application if the applicant's record has not been clear for at least five years. If after five years the record has been cleared, then the department exclusively reserves the right to grant or deny the application based on the nature of the prior restriction.
      iv. Exception to the five-year limit may be granted for any restriction or offense deemed by the department to be of a minor or clerical nature.

   (c) Not have had clinical admitting and management privileges denied, limited, or terminated for quality of care issues.

      i. If an applicant has any pending action on their privilege to practice by any court, board, or administrative agency, or by any health care institution such as a hospital in any jurisdiction, the department exclusively reserves the right to grant or deny the application based upon the nature of the action.

ii. If the applicant has any criminal history, history of a violation of statutes or rules by any administrative agency, court or board in any jurisdiction, the department must automatically deny the application if such history exists within five years of the application. If such history exists but is older than five years, then the department exclusively reserves the right to grant or deny the application based upon the nature of the history.
iii. Exception to the five-year limit may be granted for any restriction or offense deemed by the department to be of a minor or clerical nature.

(d) Have no final action by the department to suspend or revoke a previously assigned provider number as a treating provider or independent medical examiner.

(e) Have no pending civil or administrative action in any jurisdiction that affects the ability or fitness to practice medicine. The department will not process the application until the matter has been resolved.

(f) Have not been excluded, expelled, terminated, or suspended from any federally or state funded health care programs including, but not limited to, medicare or medicaid programs based on cause or quality of care issues.

(g) Have no significant malpractice claims or professional liability claims (based on severity, recency, frequency, or repetition).

(h) Have not been denied approval, or removed, from the provider network as defined in WAC 296-20-01010.

(i) Attest that all information submitted on the application or credentialing materials is true and accurate and must sign under penalty of perjury.

(j) Comply with all federal, state, and local laws, regulations, and other requirements with regard to business operations, including specific requirements for the provision of medical services.

(k) Adhere to the independent medical examination standards of conduct, and all other laws, rules, and policies. These include but are not limited to the following:

- IME provider application agreement;
- *Medical Aid Rules and Fee Schedules* (MARFS);
- Payment policies;
- *Medical Examiners' Handbook*.

(l) Review and sign the IME report and attest to its accuracy.

(m) Conduct examinations in a facility primarily designated as a professional office for medical, dental, podiatric, chiropractic or psychiatric examinations where the primary use of the facility is for medical services. The facility must not be residential, commercial, educational or retail in nature. The facility must be clean, sanitary and provide adequate access, climate control, light, space, and equipment. The facility must provide for the comfort and safety of the worker and for

the privacy necessary to conduct examinations and discuss medical issues. Providers must have a private disrobing area and adequate provision of examination gowns if disrobing is required.

(n) Have telephone answering capability during regular business hours, Monday through Friday, in order to facilitate scheduling of independent examinations and means for workers to contact the provider regarding their scheduled examination. If the office is open on Saturday, telephone access must be available.

(o) Agree that either they or the department may inactivate their IME provider number or numbers. If an IME provider number has been inactivated and the examiner wishes to resume performing IMEs, they must reapply and meet current requirements.

(p) Agree to keep the department informed and updated with any new information regarding changes or actions that may affect their status as an IME examiner.

(q) Reapply every three years in order to maintain an active IME provider number.

i. In the first year of the new rule, effective March 1, 2013, all current examiners must reapply.
ii. Examiners may have until March 1, 2014, to comply with the new continuing education (CE) documentation requirement.
iii. Examiners will be notified by mail sixty days prior to their renewal application due date.

(r) Achieve a passing score on the Medical Examiners' Handbook test prior to initial application and when renewal is due or required.

2. Requirements for specific examiner specialties:

(a) Medical physician and surgeon (MD) or osteopathic physician and surgeon (DO) applicants must: Hold a current board certification in their specialty; or have completed a residency and become board certified within five years of completing the residency.

i. Residency must be in a program approved by the American College of Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) or equivalent approving body.
ii. Fellowships will not be accepted in lieu of accredited residency training though they may be used to determine examination specialty qualifications.

(b) Podiatric physician (DPM) applicants must: Have a current board certification in their specialty or have completed a residency and become board certified within five years of completing the residency.

i. Complete a residency program approved by the American Podiatric Medical Association (APMA).
ii. Fellowships will not be accepted in lieu of accredited residency training though they may be used to determine examination specialty qualifications.

(c) Chiropractic physician (DC) applicants must be a chiropractic consultant for the department for at least two years and attend the department's chiropractic IME seminar in the twenty-four months before initial application.

(d) Dentist (doctor of dental science/doctor of dental medicine) (DDS/DMD) applicants must have at least two years of clinical experience after licensure, and:

i. Hold current certification in their specialty; or
ii. Have one year of postdoctoral training in a program approved by the American Dental Association Commission on Dental Accreditation (CODA); or
iii. Be a general dentist.

3. All examiners must meet the continuing education (CE) requirement for their respective state licensure. Washington state CE requirements are shown in the table below.

Doctors licensed to practice:

	Medicine & surgery	Osteopathic medicine & surgery	Podiatric medicine & surgery	Chiropractic	Dentistry
Required continuing education hours:	50 hours per year or 200 hours in 4 years	50 hours per year or 150 hours in 3 years	25 hours per year or 50 hours every 2 years	25 hours per year	21 hours per year

Applicants must submit documentation of CE hours with their initial application and when renewal is due or required. This training must focus on subject areas relevant to the provider's specialty or skills required to complete IMEs.

Exception: The requirement to submit CE documentation will be waived for applicants who provide documentation of a minimum of seven hundred sixty-eight hours of patient related services (excluding independent medical examinations) per calendar year.

Only examiners in the following practice specialties who meet all other requirements may perform IMEs:

Doctors licensed to practice:

	Medicine & surgery	Osteopathic medicine & surgery	Podiatric medicine & surgery	Chiropractic	Dentistry
Examiner is: In Washington	Yes	Yes	Yes	Yes	Yes
Outside Washington	Yes	Yes	Yes	No	Yes

4. IME firms (partnerships, corporations or other legal entities) that derive income from independent medical examinations must:

   (a) Have a medical director. The medical director must be a licensed medical physician and surgeon (MD) or osteopathic physician and surgeon (DO), be responsible to provide oversight on the quality of independent medical examinations, impairment ratings and reports, and be available to resolve any issue that department staff may bring to the medical director's attention.

      i. IME firms conducting exams in Washington state must have a medical director who has a Washington state medical license.
      ii. The medical director must be an approved independent medical examiner.

   (b) Have no previous business or audit action by the department to suspend or revoke an assigned provider number.

   (c) Have no previous action taken by any federal or state agency for any business previously owned or operated.

   (d) Facilitate scheduling of providers both for the examination and for any required follow up, including amendments to the report, subsequent reports, or for any testimony required. If the provider fails to participate in scheduling or otherwise causes an undue expense to the department, whether intentionally or not, the department may fine the provider up to five hundred dollars per violation.

   (e) Attest that all information submitted on the application is true and accurate and must sign under penalty of perjury.

   (f) Comply with all federal, state, and local laws, regulations, and other requirements with regard to business operations including specific requirements for any business operations for the provision of medical services.

(g) Adhere to the independent medical examination standards of conduct, and all other laws, rules, and policies. These include, but are not limited to, the following:

- IME provider application agreement;
- *Medical Aid Rules and Fee Schedules* (MARFS);
- Payment policies;
- *Medical Examiners' Handbook.*

(h) Ensure that examinations are conducted in a facility primarily designated as a professional office for medical, dental, podiatric, chiropractic or psychiatric examinations where the primary use of the facility is for medical services. The facility must not be residential, commercial, educational or retail in nature. The facility must be clean, sanitary and provide adequate access, climate control, light, space, and equipment. The facility must provide for the comfort and safety of the worker and for the privacy necessary to conduct examinations and discuss medical issues. Providers must have a private disrobing area and adequate provision of examination gowns if disrobing is required.

(i) Have telephone answering capability during regular business hours, Monday through Friday, in order to schedule independent medical examinations and communicate with workers about scheduled examinations. If an exam site is open on Saturday, telephone access must be available.

(j) Agree that either the firm or the department may inactivate their IME provider number or numbers. If an IME provider number has been inactivated and the firm wishes to resume related services, they must reapply and meet current requirements.

(k) Agree to keep the department informed and updated with any new information such as exam site or administrative office locations, phone numbers or contact information.

(l) Reapply every three years in order to maintain an active IME provider number.

i. In the first year of the new rule, effective March 1, 2013, all IME firms must reapply.
ii. Firms will be notified by mail sixty days prior to their renewal application due date.

(m) Have their medical director and a representative from their quality assurance (QA) staff achieve a passing score on the *Medical Examiners' Handbook* test prior to initial application and when renewal is due or required.

WAC 296-23-322
What boards are recognized by the department for independent medical examination (IME) provider approval?
The department accepts certifications from boards recognized by the following as meeting the board certification requirements in WAC 296-23-317:

1. American Board of Medical Specialties;
2. American Osteopathic Association (AOA) Bureau of Osteopathic Specialties;
3. American Podiatric Medical Association;

4. American Dental Association.

WAC 296-23-327

What other factors may the department's medical director consider in approving or disapproving an application for an independent medical examination (IME) provider number?

The department's medical director considers other factors in approving or disapproving an IME application, including, but not limited to, the following:

1. Complaints about the provider;
2. Quality of reports;
3. Timeliness of reports;
4. Charges regarding any crime, gross misdemeanor, felony or violation of statutes or rules by any administration agency, court or board;
5. Convictions of any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court or board.

WAC 296-23-332

What are the requirements for notifying the department or self-insurer if an independent medical examination (IME) provider has a change in status?

Providers must immediately notify the department of any change in status that might affect their qualifications for an independent medical examination (IME) provider number. The notification must be in writing. Providers must include a copy of any charges or final orders if applicable. Changes in status include, but are not limited to:

1. Changes in time spent in direct patient care;
2. Loss or restriction of hospital admitting or practice privileges;
3. Changes affecting business requirements (WAC 296-23-317);
4. Loss of board certification;
5. Charges regarding any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court or board;
6. Convictions of any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court or board;
7. Temporary or permanent probation, suspension, revocation, or limitation placed on their license to practice by any court, board, or administrative agency in any state or foreign jurisdiction.

WAC 296-23-337

For what reasons shall the department's medical director or designee suspend or terminate approval of an independent medical examination (IME) examiner or firm?

To ensure high quality independent medical examinations (IMEs), the department's medical director or designee may, in the situations described below, terminate, suspend, or inactivate approval of examiners

or firms (partnerships, corporations, or other legal entities) that derive income from IMEs. IME providers must have an active provider account number to perform IMEs or provide IME related services.

FOR EXAMINERS:

1. AUTOMATIC TERMINATION. The department's medical director or designee may terminate approval of examiners in situations including, but not limited to, the following:

   (a) Their license has been revoked in any jurisdiction.

   (b) A final order or stipulation to informal disposition has been issued against the examiner by a state authority in any jurisdiction including, but not limited to, the Washington state department of health, when such charges involve conduct or behavior as defined in chapter 18.130 RCW, Uniform Disciplinary Act. These include, but are not limited to:

      i. Sexually inappropriate conduct, behavior or language.
      ii. Behavior that puts a patient's safety or well-being at risk.

   (c) The examiner has committed perjury or falsified documents provided to the department or insurer.

   (d) The examiner has a criminal felony history in any jurisdiction.

   (e) The examiner has failed to reapply every three years.

2. AUTOMATIC SUSPENSION. The department's medical director or designee may suspend approval of examiners in situations including, but not limited to, the following listed below. The department will initiate a review within ninety days of notification. The results of the review will determine if further action is necessary, which may include termination of approval status.

   (a) The examiner has failed to meet or maintain the requirements for approval as an IME examiner.

   (b) The examiner's license or Drug Enforcement Administration (DEA) registration has been restricted in any jurisdiction. Exceptions may be granted for any restriction or offense deemed by the department to be of a minor or clerical nature.

   (c) The examiner has lost hospital privileges for cause.

   (d) A statement of charges has been filed against the examiner by a state authority in any jurisdiction, including, but not limited to the Washington state department of health, when such charges involve conduct or behavior as defined in chapter 18.130 RCW, Uniform Disciplinary Act. These include, but are not limited to:

      i. Sexually inappropriate conduct, behavior or language.
      ii. Behavior that puts a patient's safety or well-being at risk.

   (e) The examiner has any pending or history of criminal charges or violation of statutes or rules by any administrative agency, court or board in any jurisdiction.

3. OTHER EXAMINER ACTIONS. In addition to automatic terminations and suspensions described in subsections (1) and (2) of this section, the department's medical director or designee may consider any of the following factors in determining a change in status for examiners. These status changes include temporarily unavailable, suspension or termination of the approval to conduct IMEs.

   These factors include, but are not limited to:

   (a) Substandard quality of reports, failure to comply with current department policy on report contents, or inability to effectively convey and substantiate medical findings, opinions, and conclusions, concerning workers.

   (b) Unavailable or unwilling to testify on behalf of the department, worker, or employer.

   (c) Failure to cooperate with attorneys representing a party in industrial insurance litigation at the board of industrial insurance appeals (board) by not cooperating in a timely manner to schedule preparatory activities and/or testimony during business hours and within the dates and locations ordered by the board to complete testimony.

   (d) Failure to stay current in the area of specialty and in the areas of impairment rating, performance of IMEs, industrial injury and occupational disease/illness, industrial insurance statutes, regulations and policies.

   (e) Substantiated complaints or pattern of complaints about the provider.

   (f) Other disciplinary proceedings or actions not listed in subsections (1) and (2) of this section.

   (g) Other proceedings in any court dealing with the provider's professional conduct, quality of care or criminal actions not listed in subsections (1) and (2) of this section.

   (h) Untimely reports.

   (i) Unavailable or unwilling to communicate with the department in a timely manner.

   (j) Misrepresentation of information provided to the department.

   (k) Failure to inform the department of changes or actions that may affect the approval status as an IME examiner.

   (l) Failure to comply with the department's orders, statutes, rules, or policies.

   (m) Failure to accept the department fee schedule rate for independent medical examinations, testimony, or other IME related services.

   (n) Any pending action in any jurisdiction.

FOR FIRMS:

4. AUTOMATIC TERMINATION. The department's medical director or designee may terminate approval of firms when they fail to reapply every three years.

5. AUTOMATIC SUSPENSION. The department's medical director or designee may suspend approval of firms in situations including, but not limited to, those listed below. The department will review the matter to determine if further action is necessary, which may include termination of approval status.

(a) The firm no longer meets requirements for approval as an IME provider.

(b) The firm's representative has committed perjury or falsified documents provided to the department or insurer.

(c) A firm representative's behavior has placed a patient's safety or well-being at risk.

6. OTHER FIRM ACTIONS. In addition to automatic terminations and suspensions described in subsections (4) and (5) of this section, the department's medical director or designee may consider any of the following factors in determining a change in status for firms. These status changes include temporarily unavailable, suspension or termination of the approval to provide IME related services.

   These factors include, but are not limited to:

   (a) Substantiated complaints or pattern of complaints about the firm.

   (b) Other disciplinary proceedings or actions not listed in subsections (4) and (5) of this section.

   (c) Other proceedings in any court dealing with the provider's professional conduct, quality of care or criminal actions not listed in subsections (4) and (5) of this section.

   (d) Untimely reports.

   (e) Unavailable or unwilling to communicate with the department in a timely manner.

   (f) Misrepresentation of information provided to the department.

   (g) Failure to inform the department of changes affecting the firm's status as an IME provider.

   (h) Failure to comply with the department's orders, statutes, rules, or policies.

   (i) Failure to accept the department fee schedule rate for independent medical examinations and services.

   (j) Any pending action in any jurisdiction.

WAC 296-23-342

Are providers entitled to referrals from the department or self-insurer?

No. The department or self-insured employer refers industrially injured or ill workers for independent medical examination (IME) services at their sole discretion. No provider is entitled to referrals from the referral source.

WAC 296-23-347

What are the independent medical examination (IME) provider's responsibilities in an examination?

1. The IME provider's responsibilities prior to the examination are to:

   (a) Be familiar with the contents of the medical examiner's handbook;

   (b) Review all claim documents provided by the department or self-insured employer;

(c) Contact the worker prior to the examination to confirm the appointment date, time and location; and

(d) Review the purpose of the examination and the questions to be answered in the examination report.

2. The IME provider's responsibilities during the examination are to:

(a) Introduce himself or herself to the worker;

(b) Verify the identity of the worker;

(c) Let the worker know that the claim documents from the department or self-insurer have been reviewed;

(d) Explain the examination process and answer the worker's questions about the examination process;

(e) Advise the worker that he/she should not perform any activities beyond their physical capabilities;

(f) Allow the worker to remain fully dressed while taking the history;

(g) Ensure adequate draping and privacy if the worker needs to remove clothing for the examination;

(h) Refrain from expressing personal opinions about the worker, the employer, the attending doctor, or the care the worker has received;

(i) Conduct an examination that is unbiased, sound and sufficient to achieve the purpose and reason the examination was requested;

(j) Conduct the examination with dignity and respect for the worker;

(k) Ask if there is any further information the worker would like to provide; and

(l) Close the examination by telling the worker that the examination is over.

3. The IME provider's responsibilities following the examination are to:

(a) Send a complete IME report to the department or self-insurer within fourteen calendar days of the examination date, or within fourteen calendar days of the receipt of the results of any special tests or studies requested as a part of the examination. Reports received after fourteen calendar days may be paid at a lower rate per the fee schedule. The report must meet the requirements of WAC 296-23-382; and

(b) The claim file information received from the department or self-insurer should be disposed of in a manner used for similar health records containing private information after completion of the IME or any follow-up test results are received. IME reports should be retained per WAC 296-20-02005.

WAC 296-23-352

Must the independent medical examination (IME) provider address job analyses (JAs) at the request of the department or self-insurer?

Job analyses (JAs) sent to the IME provider at the time of the IME referral must be completed and submitted with the IME report. JAs submitted within sixty calendar days after the IME must be completed and returned within fourteen days of receipt of the JAs.

WAC 296-23-357

May an independent medical examination (IME) provider offer to provide ongoing treatment to the worker?

No. However, if a worker voluntarily approaches an IME provider who has previously examined the worker and asks to be treated by that provider, the provider can treat the worker. The provider must document that the worker was aware of other treatment options.

WAC 296-23-358

What happens when there is no approved independent medical exam (IME) provider in the specialty needed available in a reasonably convenient location for the worker?

When there is no approved examiner in the worker's community or in a reasonably convenient location for the worker, the department or self-insurer may make alternate arrangements for the examination including, but not limited to:

1. Considering whether a consultation might be a sufficient alternative;

2. Using telemedicine where appropriate;

3. Notifying the worker or their representative before scheduling the IME in the nearest location available. In this case:

   (a) Travel must not exceed any travel restrictions imposed by the attending provider unless alternative methods of travel will overcome the travel limitations.

   (b) The department or self-insured employer will assist the worker with travel accommodations when requested by the worker.

   (c) Travel accommodations are paid by the department or self-insured employer as listed in the fee schedule.

WAC 296-23-359

When is telemedicine appropriate for an independent medical exam (IME)?

1. The following exams may be conducted via telehealth:

   (a) Mental health;

   (b) Dermatology;

(c) Speech when there is no documented hearing loss;

(d) Kidney function;

(e) Hematopoietic system;

(f) Endocrine.

2. The terms telehealth and telemedicine are used interchangeably and have the same requirements as in-person visits. Telemedicine may be appropriate to effectively conduct an independent medical exam when:

(a) Face-to-face services by a qualified medical provider can be delivered through a real-time, two-way, audio video connection, and complies with all federal, state, and local rules and laws; and

(b) A worker is able and willing to participate in an exam via telemedicine; and

(c) The department or self-insured employer, and worker, have agreed a telemedicine IME is appropriate; these individuals should also agree to the location of the worker during the exam; and

(d) The agreement is documented in the claim file; and

(e) A physical or hands-on exam is not required.

3. Upon request of the department or self-insured employer and with the agreement of the worker, a telemedicine IME may be approved on a case-by-case basis for additional specialties not listed under subsection (1) of this section..

WAC 296-23-362
Independent medical examination (IME)—Accompanying person.

1. Workers can bring an adult observer to the IME to provide comfort and reassurance.

The accompanying person will not be compensated for attending the examination by the department or self-insured employer. The accompanying person must be unobtrusive at all times. Obtrusive behavior includes, but is not limited to, verbally or physically interrupting, interfering, or obstructing the examination in any way.

2. The accompanying person cannot be:

(a) The worker's attorney, paralegal, any other legal representative, or any other personnel employed by the worker's attorney or legal representative; or

(b) The worker's attending provider, any other provider involved in the worker's care, or any other personnel employed by the attending provider or other provider involved in the worker's care.

The department may designate other conditions under which the accompanying person is allowed to be present during the IME.

3. The worker may not bring an interpreter to the examination. If interpretive services are needed, the department or self-insurer will provide an interpreter.

WAC 296-23-364
Definition of notification process required for workers to record independent medical examinations (IME).

1. After receipt of the IME appointment/assignment letter, but no less than seven calendar days before the date of the examination, the worker or their representative must provide written notice to the IME firm or an examiner not in a firm, as listed in the appointment/assignment letter, to inform of their intent to record the examination.

2. Written notification of the workers' intent to record must be given for each IME appointment.

WAC 296-23-366
Independent medical examination (IME)—Recording notification time frame.
If notice is received less than seven calendar days prior to the IME, a worker may record the examination only if the IME provider waives the seven calendar day notification requirement. If notification is received after 5:00 p.m., in the time zone of the examination location, the notification is considered received the next calendar day.

WAC 296-23-372
Can a worker file a complaint about a provider's conduct during an independent medical examination?
Workers can send written complaints about a provider's conduct during an independent medical examination to the self-insurer or department. Based on the nature of the complaint, the department may refer the complaint to the Department of Health.

WAC 296-23-377
If an independent medical examination (IME) provider is asked to do an impairment rating examination only, what information must be included in the report?
When doing an impairment rating examination, the IME provider must first review the determination by the attending doctor that the worker has reached maximum medical improvement (MMI).

1. If, after reviewing the records, taking a history from the worker and performing the examination, the IME provider concurs with the attending doctor's determination of MMI, the impairment rating report must, at a minimum, contain the following:

   (a) A statement of concurrence with the attending doctor's determination of MMI;

   (b) Pertinent details of the physical or psychiatric examination performed (both positive and negative findings);

(c) Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of pertinent tests with the report;

(d) An impairment rating consistent with the findings and a statement of the system on which the rating was based (for example, the *AMA Guides to the Evaluation of Permanent Impairment* and edition used, or the Washington state category rating system—refer to WAC 296-20-19000 through 296-20-19030 and WAC 296-20-200 through 296-20-690); and

(e) The rationale for the rating, supported by specific references to the clinical findings, especially objective findings and supporting documentation including the specific rating system, tables, figures and page numbers on which the rating was based.

2. If, after review of the records, a history from the worker and the examination, the IME provider does not concur with the attending doctor's determination of MMI, an IME report must be completed. (See WAC 296-23-382.)

WAC 296-23-381

What rating systems are used for determining an impairment rating conducted by an independent medical examination (IME) provider?

The following table provides guidance regarding the rating systems generally used. These rating systems or others adopted through department policies should be used to conduct an impairment rating.

Overview of Systems for Rating Impairment

Rating System	Used for These Conditions	Form of the Rating
RCW 51.32.080	Specified disabilities: Loss by amputation, total loss of vision or hearing	Supply the level of amputation
AMA Guides to the Evaluation of Permanent Impairment	Loss of function of extremities, partial loss of vision or hearing	Determine the percentage of loss of function, as compared to amputation value listed in RCW 51.32.080
Category Rating System	Spine, neurologic system, mental health, respiratory, taste and smell, speech, skin, or disorders affecting other internal organs	Select the category that most accurately indicates overall impairment
Total Bodily Impairment (TBI)	Impairments not addressed by any of the rating systems above, and claims prior to 1971	Supply the percentage of TBI

WAC 296-23-382

What information must be included in an independent medical examination (IME) report?

1. It is the department's intention to purchase objective examinations to ensure that sure and certain determinations are made of all benefits to which the worker might be entitled. The independent medical examination report must:

   (a) Contain objective, sound and sufficient medical information;

   (b) Document the review of the claim documents provided by the department or self-insurer;

   (c) Document the worker's history and the clinical findings;

   (d) Answer all the written questions posed by the department or self-insurer or include a description of what would be needed to address the questions;

   (e) Include objective conclusions and recommendations supported by underlying rationale that links the medical history and clinical findings;

   (f) Be in compliance with current department reporting policies; and

   (g) Be signed by the IME provider performing the examination.

2. An impairment rating report may be requested as a component of an IME. Impairment rating reports are to be done as specified in WAC 296-20-200 and 296-20-2010 (2) (a) through (e) and 296-23-377.

WAC 296-23-387

What are the responsibilities of an independent medical examination (IME) provider regarding testimony?

IME providers must make themselves reasonably available to testify at the Board of Industrial Insurance Appeals (Board) or by deposition. Reasonably available to all parties means cooperating in the timely scheduling of the pre-testimony conference and testimony and being available to testify during business hours (7am – 6pm) as ordered by the judge and within the dates ordered by the Board to complete testimony.

In signing the application to be an independent medical examination provider, the provider agrees to perform examinations and be available to testify and to answer questions about the medical facts of the case at rates established under the authority of Washington industrial insurance law.

The Department may fine the firm and or examiner up to $500 per violation for failure to comply with these requirements, whether the failure was intentional or not.

In addition, failure to comply with these requirements may result in suspension or termination of the IME provider number.

WAC 296-23-392

Is there a fee schedule for independent medical examinations (IMEs)?

The maximum fee schedule for performing independent medical examinations is published by the department in the Medical Aid Rules and Fee Schedules (MARFS) available from the department.

WAC 296-23-401

Can the department schedule an examination or order a self-insured employer to schedule an examination after receipt of an appeal to the board of industrial insurance appeals (BIIA)?

Following receipt of an appeal by any party, the department may reassume and schedule, or may order the self-insured employer to schedule, an examination.

The self-insured employer may also schedule an examination regarding an appeal if a request has been approved by the department.

WAC 296-23-403

Independent medical examinations—Department data reporting.

The department will regularly provide independent medical examination data to interested parties that includes emerging trends.

As much as possible, the data should include and differentiate between examinations for claims insured by the department and those covered by self-insured employers.

APPENDIX D

Useful Resources

Addresses and Phone Numbers	
IME reports for State Fund Department of Labor & Industries PO Box 44239 Olympia, WA 98504-4239 fax: 360-902-4567	**IME bills for State Fund** Department of Labor & Industries PO Box 44269 Olympia, WA 98504-4269
Questions about State Fund billing Provider Toll-Free Line: 1-800-848-0811 Online Claim and Account Center https://lni.wa.gov/claims/	**IME reports and bills for crime victims** Department of Labor & Industries Crime Victims Section PO Box 44520 Olympia, WA 98504-4520
IME reports and bills for self-insurers Use address on IME cover letter	**General information about self-insurers** Department of Labor & Industries Self-Insurance Section PO Box 44892 Olympia, WA 98504-4892
Application information, and updates Department of Labor & Industries Provider Quality and Compliance PO Box 44322 Olympia, WA 98504-4322 Phone: 360-902-6822	**Suggestions to improve this handbook** Special Programs Manager Health Services Analysis, Washington Department of Labor and Industries PO Box 44322 Olympia, WA 98504-4322

Assistance with IMEs and impairment ratings IME Occupational Nurse Consultant phone: 360-902-6818	**Order the *AMA Guides to the Evaluation of Permanent Impairment*** Order Department *American Medical Association* PO Box 109050 Chicago, Illinois 60610-9050 Phone: 1-800-621-8335
Order L&I publications (*Medical Examiners' Handbook* is available online only) Labor & Industries Warehouse PO Box 44843 Olympia, WA 98504-4843 OR Provider Toll Free Line: 1-800-848-0811	**Other IME Resources** **L&I Central Scheduling Unit**: Main Phone 1-800-468-7870 or fax 206-515-2791 E-mail address for exam comments: IMEcomplaints@lni.wa.gov To request pre-auth for MARFS Billing Code 1124M IMEbills@lni.wa.gov
Civil Rights Program at L&I CivilRights@Lni.wa.gov 1-855-682-0778	

Websites

L&I web sites:

L&I web site, main page
www.Lni.wa.gov

Web page for Independent Medical Examinations
including report template
Lni.wa.gov/imes

Find an Approved Medical Examiner
Lni.wa.gov/imes and click on "Find a Medical Examiner."
or
https://secure.lni.wa.gov/imelookup/

Main web page for providers
https://lni.wa.gov/patient-care/

Online Claim and Account Center
https://secure.lni.wa.gov/home/

Interpreter Services – Tips & FAQs
https://lni.wa.gov/patient-care/treating-patients/interpreter-services/
(or)
Lni.wa.gov/imes and click on "Find an Interpreter Service"

Direct link to treatment information
https://lni.wa.gov/patient-care/

Cultural Competency
Governor's Interagency Council on Health Disparities/Health Equity CLAS Standards Training and Resources
E-Learning Modules:
http://healthequity.wa.gov/clastrainingandresources

Reading Resource:
Cultural Competency in Health Services and Care; A Guide for Health Care Providers, June 2010
https://www.doh.wa.gov/Portals/1/Documents/Pubs/961-959-WorkingWithDiverseParticipants.pdf

Department of Health Resource for Healthcare Providers
https://doh.wa.gov/public-health-healthcare-providers

Glossary

L&I Industrial Insurance terms related to claims

Abeyance
This means a department decision has been stayed so the adjudicator can reevaluate or reexamine the information. Any order can be placed in abeyance but the department should only ask an IME provider to address medical conditions.

Accepted
Normally used to indicate the status of medical condition/s in a claim

Allowed
Normally used to indicate the status of a claim

Authorized
Normally used to indicate the status of a procedure or test

Denied
Normally used to indicate the status of medical condition/s in a claim

Impairment versus Disability

Impairment is anatomic or functional abnormality or loss of function after maximum medical improvement has been achieved. Disability means the inability to perform a specific task or job

Invasive Testing

Tests such as a myelogram, biopsies, studies with contrast

Lighting Up

Aggravation, worsening, or exacerbation of a preexisting condition caused by the industrial injury or occupational exposure

Maximum Medical Improvement (MMI)

Maximum medical improvement occurs when no fundamental or marked change in an accepted condition can be expected, with or without treatment. Equivalent to "fixed and stable".

More Probable than Not

Finding that a greater than 50% chance exists that the condition resulted from the industrial accident or exposure

Naturally
To meet the definition of arising "naturally" out of employment, disease must be regarded as a natural consequence of distinctive condition of the work process. *For more information refer to Chapter 6.*

New Medical Issue
A medical issue not covered by a previous medical examination requested by the department or the self-insurer such as an issue regarding medical causation, medical treatment, work restrictions, or evaluating permanent partial disability.

Non-Invasive Testing

Routine laboratory or x-rays that an examiner may order to complete the IME or to supplement the examiner's finding

Not Authorized
Normally used to indicate the status of a procedure or test

Occupational Disease

An infection or disease that arises naturally and proximately out of employment

Proximate Cause

In Washington State Workers' Compensation, the legal standard for causation is "**a** proximate cause". This means that if a work-related exposure contributes to the development or worsening of a condition, even to a small degree, then the condition is deemed to be work-related. This is different from the legal standard of "**the** proximate cause" used in some other states and jurisdictions. *For more information refer to Chapter 6.*

Rejected
Normally used to indicate the status of a claim

Segregated
Indicates a medical condition has been denied and an order should exist addressing the denied status of the medical condition.

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