MEDICAL ARBITER SURVEY RESULTS

SUMMARY

September – October 2013

25 medical arbiters responded out of 50 who were contacted
Of the 25 medical arbiters who responded, 22 are currently in practice, 3 are retired

Question 1: Are there areas of Oregon’s current impairment rating standards that primarily use range of motion (ROM) measurements that:
  a. Result in problems with reliability or accuracy of measuring a worker’s impairment? Are those problems for specific areas, body parts, or conditions?
  b. Result in a lot of variation in range of motion measurements between workers with similar conditions or injuries?

<table>
<thead>
<tr>
<th>Number of physician comments</th>
<th>Comments about difficulty using range of motion (ROM)</th>
<th>Physician numbers in appendix</th>
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</thead>
<tbody>
<tr>
<td>14</td>
<td>ROM is difficult to measure in the spine</td>
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<tr>
<td>5</td>
<td>ROM is difficult to measure in the lumbar spine</td>
<td>9, 10, 15, 19, 21</td>
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<tr>
<td>3</td>
<td>ROM is difficult to measure in the thoracic spine</td>
<td>11, 12, 13</td>
</tr>
<tr>
<td>2</td>
<td>ROM is difficult to measure in the cervical spine</td>
<td>9, 10</td>
</tr>
<tr>
<td>4</td>
<td>ROM is difficult to measure in the spine (not specific)</td>
<td>14, 19, 23, 25</td>
</tr>
<tr>
<td>1</td>
<td>ROM is difficult to measure in the shoulder</td>
<td>15</td>
</tr>
<tr>
<td>9</td>
<td>ROM is a good/valid method with no insurmountable concerns</td>
<td>1, 2, 5, 7, 16, 18, 22, 23, 24</td>
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<table>
<thead>
<tr>
<th>Number of physician comments</th>
<th>Comments about validity of ROM measurements</th>
<th>Physician numbers in appendix</th>
</tr>
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<tbody>
<tr>
<td>8</td>
<td>Less than full worker effort can invalidate the measurements</td>
<td>3, 4, 6, 8, 9, 12, 17, 21</td>
</tr>
<tr>
<td>6</td>
<td>ROM is impacted by body habitus</td>
<td>1, 2, 6, 8, 9, 20</td>
</tr>
<tr>
<td>4</td>
<td>Measurements vary from examiner to examiner</td>
<td>8, 10, 13, 17</td>
</tr>
<tr>
<td>2</td>
<td>ROM is impacted by pre-existing conditions</td>
<td>8, 20</td>
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Question 2: If there are problems with range of motion measurement, are there alternative ways to measure the impairment?

<table>
<thead>
<tr>
<th>Number of physician comments</th>
<th>Alternative ways to measure impairment</th>
<th>Physician numbers in appendix</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Know of no better way of calculating impairment (some recommend also considering the worker’s “whole picture” – past records, strength, imaging)</td>
<td>5, 6, 7, 8, 11, 12, 16, 18, 20, 22, 23, 24, 25</td>
</tr>
<tr>
<td>7</td>
<td>Consider using some version of a diagnosis-related estimate (DRE) system, limited to the spine, or other state system. Two of the comments mention utilization of the AMA 6th Edition as a possibility. (Note: this is a major policy issue)</td>
<td>3, 4, 9, 10, 14, 19, 21</td>
</tr>
<tr>
<td>1</td>
<td>The AMA 6th Edition is too complex and physicians should not be asked to rate impairment. (Note: in the current system, physicians take measurements and make findings of impairment, while insurers rate impairment)</td>
<td>10</td>
</tr>
<tr>
<td>6</td>
<td>Other comments about this question</td>
<td>1, 2, 10, 13, 15, 17</td>
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</tbody>
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Question 3: Are there areas of impairment rating that are not adequate under the rules? For example, we have been provided feedback that loss of strength measurement is subjective and there may be better ways to measure it.

<table>
<thead>
<tr>
<th>Number of physician comments</th>
<th>Areas of inadequate impairment rating under the rules (these are rules issues)</th>
<th>Physician numbers in appendix</th>
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<tbody>
<tr>
<td>14</td>
<td>Comments about loss of strength measurement</td>
<td>3, 4, 14, 22</td>
</tr>
<tr>
<td>4</td>
<td>The physician can tell when weakness is being feigned by the injured worker or can determine validity</td>
<td>1, 2, 5</td>
</tr>
<tr>
<td>3</td>
<td>A 5/5 strength measurement may be misleading because the worker may have had greater than 5/5 strength at the time of injury. Also, with repeated testing the measurement could deteriorate with usage and fatigue</td>
<td>6, 16, 17</td>
</tr>
<tr>
<td>3</td>
<td>Use a formal work capacity evaluation to determine loss of strength as part of a worker’s closing evaluation</td>
<td>23</td>
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<tr>
<td>1</td>
<td>Include circumference to determine atrophy as part of the strength loss impairment assessment</td>
<td>15, 16, 21</td>
</tr>
<tr>
<td>3</td>
<td>Other comments about loss of strength</td>
<td>9, 10, 20</td>
</tr>
<tr>
<td>3</td>
<td>After hernia repair, there may not be a palpable defect. The 1st class discusses a “palpable defect” as the means for rating impairment, but the worker may have permanent disability due to residual pain that limits their function</td>
<td>7, 8</td>
</tr>
<tr>
<td>2</td>
<td>For loss of sensation, 2-point discrimination should be broadened to include additional testing, and does not work for the hands/palms</td>
<td>9, 10</td>
</tr>
<tr>
<td>2</td>
<td>Chronic pain is not adequately rated. Workers who have no ratable impairment, but who experience pain and/or have work restrictions, should get an award</td>
<td>11</td>
</tr>
<tr>
<td>1</td>
<td>The “grade IV chondromalacia…” question that is posed</td>
<td>11</td>
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with some knee conditions is not really a diagnosis that can be made with exam and chart review alone

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<tr>
<td><strong>Cold intolerance</strong> classifications need work and should move toward a category where you do not have to piece out impairment</td>
<td>19</td>
</tr>
<tr>
<td><strong>Carpal tunnel syndrome, SI joint strain, and piriformis syndrome</strong> are not covered adequately</td>
<td>9</td>
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Question 4: Are there areas of impairment rating standards that have incongruous outcomes? For example, a worker may have no impairment under the rules, but has a loss of use or function; or a worker has ratable impairment when there is no measurable loss of use or function; or a worker has no impairment of a body part, area, or system, but still has restrictions or limitations on their return to work abilities.

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<thead>
<tr>
<th>Number of physician comments</th>
<th>Areas of incongruous outcomes</th>
<th>Physician numbers in appendix</th>
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<tbody>
<tr>
<td>11 A worker has no ratable impairment but should be rated because worker still has limitations on return to work abilities or significant pain</td>
<td>5, 7, 8, 9, 10, 11, 12, 14, 17, 19, 25</td>
<td></td>
</tr>
<tr>
<td>6 A worker has ratable impairment under the rules, but has no loss of use or function</td>
<td>5, 10, 11, 13, 14, 24</td>
<td></td>
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<tr>
<td>3 Standards should define “significant” for question about whether worker is significantly limited in repetitive use of a body part or joint</td>
<td>6, 7, 12</td>
<td></td>
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<tr>
<td>3 The accepted condition is not always the worker’s actual condition or correct diagnosis</td>
<td>1, 2, 18</td>
<td></td>
</tr>
<tr>
<td>2 Apportionment as allowed in the standards helps physicians capture the real impairment and validity.</td>
<td>10, 21</td>
<td></td>
</tr>
<tr>
<td>2 Vascular impairment and cold intolerance rating is inadequate, subjective, difficult to measure, and/or may result in too-large awards</td>
<td>10, 15</td>
<td></td>
</tr>
<tr>
<td>1 If everyone had a functional capacity examination by a physical therapist, there would be a much better assessment of impairment</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>7 The current standards are not problematic, or are workable if not perfect</td>
<td>3, 4, 16, 20, 21, 22, 23</td>
<td></td>
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</tbody>
</table>
Appendix

MEDICAL ARBITER SURVEY RESULTS
(All responses)

1. Are there areas of Oregon’s current impairment rating standards that primarily use range of motion (ROM) measurements that:
   a. Result in problems with reliability or accuracy of measuring a worker’s impairment? Are those problems for specific areas, body parts, or conditions?
   b. Result in a lot of variation in range of motion measurements between workers with similar conditions or injuries?

Physicians 1 and 2
- ROM is fairly consistent and reliable.
- Extremity ROM is more reliable than spinal ROM, which has more variability.
- Extremity ROM would be even more reliable if an inclinometer was used to measure versus using the required goniometer, especially on larger body types, which are harder to perform using a goniometer.
- Thoracic spinal ROM is the hardest measurement(s) to obtain.

Physicians 3 and 4
- “Range of motion problems. Over the years I have seen patients that have absolutely valid ranges of motion that are just impossible when you see them get in and out of their cars for instance. It is very easy and takes just a few attempts to duplicate an abnormal untrue range of motion that looks great on paper. Still, in the cooperative patient I don’t see any way to beat it. Another problem with range of motion is the aging population. Our standards seem to apply to the under thirty crowd.”

Physician 5
- There are no consistency or reliability problems with ROM.
- There are some subjective variations of ROM between different workers depending on the worker’s reported pain level, which can limit ROM.

Physician 6
- “ROM may be invalid, but not account for build or age.”

Physician 7
- ROM is not a problem.
- There is not a lot of variation in ROM between different workers.

Physician 8
- ROM in all body parts is objective, but dependent on the worker’s cooperation providing maximum effort.
- Different examiners may get different ROM measurements, but these are all still pretty close.
- Passive ROM is a better objective finding, but for every day life, it is more difficult to use passive ROM findings.
- Two people who are built the same have less ROM variations. ROM variations are highly dependent on the worker’s body habitus and pre-existing degenerative changes.

Physician 9
- With the exception of cervical extension, ROM measurements are reliable, accurate, and reproducible as long as the worker is giving valid effort.
• ROM findings are generally consistent unless there are body habitus issues or lack of worker effort.
• The SI joint does not move a lot, so measuring lumbar spine ROM for an SI joint strain or piriformis syndrome is not useful.

Physician 10
• ROM, in general, presents problems, but it is more appropriate for some body parts versus others.
• The cervical spine is the biggest problem. Lumbar spine is problematic as well. He has yet to see a worker who has “normal” cervical and/or lumbar spinal ROM per the standards. Some of these worker’s are impaired, some are not.
• There is a lot of variation in ROM findings between different workers and between different examiners.

Physician 11
• “None specifically; however I find spinal range of motion, esp. thoracic motion to be highly variable between similar workers.”

Physician 12
• With full valid effort on behalf of the worker, ROM is reproducible.
• Straight leg validity may not be good criteria for validation of findings.
• ROM is effort dependent.
• ROM is only one part of the impairment picture.
• Reproducible ROM is easier in the cervical spine.
• Thoracic ROM is difficult to measure and isolate and is “almost useless.”

Physician 13
• Thoracic spine ROM is difficult, as it is hard to explain to the worker how to move in a position to accurately measure this. Per the guides, if a doctor shows pictures to the worker of the movement, the results are more reliable.
• ROM can be variable depending on who is taking the measurements.

Physician 14
• ROM in the spine is a problem.
• ROM’s only value is to see if there is consistency in the worker for determination of validity.
• If a worker exercises, they should regain full ROM.

Physician 15
• ROM is most difficult to measure in the lumbar spine and shoulder.
• Validity/effort can cause a problem.

Physician 16
• The examiner is able to determine consistency pertaining to ROM.
• Physiatrist physicians have a better understanding of impairment and how to measure it.

Physician 17
• ROM can be variable between physicians. Not all doctors are interested in getting exact measurements.
• ROM is also variable dependent on the worker’s effort. It is difficult to test if the worker is not giving full effort.
• All findings are subjective.

Physician 18
• There are no problems with ROM. It is vulnerable to the worker’s effort, but the majority of workers put out good effort.

Physician 19
• ROM, specifically the inclinometer for the spine, is hard to read. See variations in readings.

Physician 20
• ROM is one way to measure impairment, but must be looked at in the global picture. It is reliable and accurate as one means of measuring impairment. Workers must give full valid effort when measuring.
• There can be variations in ROM findings between two workers, but this depends on pre-existing conditions or the worker’s body habitus.

Physician 21
• ROM works okay for cervical and thoracic regions, but not lumbar.
• There will be variation in ROM between workers. They do the best they can.
• Effort is a big determination in ROM findings.

Physician 22
• Do not typically have a problem with ROM. There are mild discrepancies between how doctors measure this.
• Variation between workers is because some have a complete recovery from an injury and some are left restricted.

Physician 23
• ROM is the least reliable in the spine, but does not know how you would do it any other way.
• There is variation in ROM’s between workers, but with additional diagnostics (e.g. x-rays), you can determine if the findings are objective.

Physician 24
• ROM is reliable and consistent. There is no problem.
• Do see variation in ROM between workers sometimes, but for the most part, the findings are similar.

Physician 25
• ROM in the spine can be difficult.
• Do see variations in ROM between workers.

2. If there are problems with range of motion measurements, are there alternative ways to measure the impairment?

Physicians 1 and 2
• No changes are needed regarding ROM impairment with the exception of changing the required goniometer tool for all extremities to allowance of the usage of the inclinometer tool for measuring all body parts.

Physicians 3 and 4
• “Alternative ways?? A possibility might be DREs like Washington State or the guides. At least for the spine. Range of motion of the extremities is also subjective and again hard to replace. ‘The downside is having doctor’s rate impairment, though the Washington way is not that tough. Even I can do it.”
Physician 5
- There are no problems with ROM, so there are no alternative ways to measure this impairment.

Physician 6
- Is not aware of any better alternative to ROM measurements.

Physician 7
- ROM is not a problem. There is not a better way to measure this impairment.

Physician 8
- Not aware of any better way to measure ROM impairment.
- Look at the whole picture, not just ROM, like looking at imaging studies to explain ROM loss, or ask about pain, etc.

Physician 9
- ROM is not useful with conditions of carpal tunnel syndrome, SI joint, or piriformis syndrome. In these cases, it would be possible to use the DRE method in the 6th edition for impairment, but isn’t sure the 6th edition even covers piriformis syndrome.
- Cervical extension ROM is not accurate, but not sure of a better way to measure it.

Physician 10
- Could use the 6th AMA edition, which is diagnosed based using adjustments. In theory, the 6th edition is okay, but it is too complex, so there is value in a simplified state system.
- Do not want to delegate the rating of impairment to the physicians. Physicians should be responsible for providing impairment findings and others should rate the loss.
- Could come up with user friendly forms or check the box letters for physicians to provide impairment findings for closing purposes (e.g. like SAIF Corporation), not using ROM, but other functional loss impairment.
- Could use L&I’s system, which has categorization similar to the 5th AMA edition.
- Could use Utah’s categories.

Physician 11
- “I think that impairment is more of a gestalt type concept. Not one measurement (strength, ROM, etc.) can adequately identify impairment by itself. I’m not sure of specific ways to measure the impairment otherwise though.”

Physician 12
- ROM is useful in terms of being relative to other factors. It is useful because it helps measure a worker’s motivation and helps with the whole picture when looking at impairment.
- The whole picture has to be looked at to determine impairment.
- ROM is good with full effort.

Physician 13
- No suggestions, aside from stated above.

Physician 14
- ROM does not matter. Impairment should be rated based on the diagnosis as opposed to ROM.
- The only advantage to measuring ROM is to determine if the worker is being truthful; if not, ROM findings are inconsistent.
Physician 15

- Not sure if there is a better way to rate impairment. Has no training on the 6th AMA edition.

Physician 16

- There is no better way to measure ROM impairment. If you try to gauge pain, effort, and motivation, you open the door to problems.
- The current system works adequately and physicians are able to apportion impairment.

Physician 17

- All ROM impairment should be based on three trails for all body parts, not just the spine.

Physician 18

- The current system using ROM probably provides the most objective data over any other methods.

Physician 19

- Recommend “spine only” categorization of impairment, like Washington’s L&I.

Physician 20

- For now, ROM is okay and works relatively well. Physicians and lawyers think about this differently.
- Apportionment as allowed in the standards helps physicians capture the real impairment and validity.

Physician 21

- Could go to the more current 4th or 5th AMA guide using diagnosed basis, but if so, this should only be for the spine, as the other areas are working well without problems.

Physician 22

- Likes ROM; states it is objective.
- Any other ways may not adequately determine the worker’s actual loss.

Physician 23

- No better way. Just make sure that the ROM measurements correlate to the past medical records and radiograph/x-ray findings.

Physician 24

- ROM is not a problem, so there are no recommended alternative ways to measure.

Physician 25

- Although ROM in the spine can be difficult, do not know of any better alternative to measuring this.

3. Are there areas of impairment rating that are not adequate under the rules? For example, we have been provided feedback that loss of strength measurement is subjective and there may be better ways to measure it.

Physicians 1 and 2

- Strength can be a problem. The worker can have 5/5 strength, but still have lost strength due to the compensable condition, given the worker may have had greater than 5/5 strength at the time of injury.
- Strength can initially test as 5/5, but with repeated testing could deteriorate with usage and fatigue.
Physicians 3 and 4
- “Strength? The competent examiner can easily tell when weakness is being feigned by the claimant. It is not as easy to reduplicate as are range of motion impairments.”

Physician 5
- She uses 5/5 strength normally, but may require additional diagnostic nerve testing to verify if strength loss is measured.

Physician 6
- Believes a formal work capacity evaluation would be helpful as part of a worker’s closing evaluation.

Physician 7
- Loss of sensation testing is performed only by measuring 2-point discrimination. This should be broadened to include additional testing of “light touch, reflexes, proprioception, etc.”

Physician 8
- Standards require 2-point discrimination findings in the hands/palms, but people truly only have good 2-point discrimination in the fingertips. However, believes Grade 3 to 4 sensory loss requirement to have ratable impairment in the hands/palms makes this issue benign.
- Strength loss depends on maximal effort, as it is subjective.

Physician 9
- Specific conditions in the rules are not covered adequately. Specifically, in addition to carpal tunnel syndrome, SI joint strain, and piriformis syndrome, the hernia classifications of impairment are problematic. A worker can have surgery, with resultant chronic pain, but not have a palpable defect or a lifting restriction, which should be ratable impairment.
- Hernia classification 1 should be an “either/or” to make it clearer.
- Chronic pain should be included as impairment on a limited case-by-case basis.

Physician 10
- Hernia classifications are a problem. The 1st class discusses a “palpable defect” as the means for rating impairment. The hernia has been repaired, so there may not be a defect, but the worker may still have PPD due to residual pain that limits their function.
- Pain which limits function should be included as an impairment finding for all body parts.

Physician 11
- “I generally agree that loss of strength measurements can be subjective. I also have a tough time with the "…grade IV chondromalacia…” question that is posed with some knee conditions, as this is not really a diagnosis I can make with exam and chart review alone. Altogether though I feel the system is fair and good to all parties.”

Physician 12
- The current standards are not inadequate. Physicians must look at the whole picture and correlate the findings with everything else.

Physician 13
- There may be other ways to measure, but she has not looked into it.

Physician 14
- Strength is not subjective; requires the physician to know the difference.
Physician 15
- Strength loss can be difficult to measure, but it coincides with ROM.
- Not sure there is any better valid way to measure strength loss.

Physician 16
- Some physicians are better than others when measuring strength.
- Physical therapists over read strength findings, but can be better than many physicians.
- Best to provide a good video example to physicians on how to properly take strength measurements.

Physician 17
- There is really no highly objective way to measure strength. The best way would be to obtain a work capacity evaluation for this information.
- Range of motion, strength, and sensation are all subjective.

Physician 18
- No.
- The current strength scale is probably as good as any.

Physician 19
- Strength is not a problem.
- Cold intolerance classifications need work and should move towards a category where you do not have to piece out impairment.

Physician 20
- Hernia classifications should be revised, as the classes can be interpreted in multiple ways. If there is scar tissue and this interferes with function, this should be included as an impairment value.

Physician 21
- Manual muscle testing (e.g. strength) can be a problem. If he had to fix one thing, this would be it.

Physician 22
- We have a good system. If used consistently, it is not a problem. As long as the physician determines the validity of the findings.

Physician 23
- 5/5 strength is subjective based on the physician performing the examination. Must look at other factors. For example, if the worker has atrophy, there may be strength loss. However, if the worker has no atrophy, he would question the validity of the strength loss.
- Might include circumference as part of the strength loss impairment assessment.

Physician 24
- No suggestions, as there is not a problem.

Physician 25
- Strength can be subjective.
4. Are there areas of impairment rating standards that have incongruous outcomes? For example, a worker may have no impairment under the rules, but has a loss of use or function; or a worker has ratable impairment when there is no measurable loss of use or function; or a worker has no impairment of a body part, area, or system, but still has restrictions or limitations on their return to work abilities.

Physicians 1 and 2
- Biggest issue pertains to rating impairment only for the “accepted condition” versus rating impairment for the “work injury.”
- Worker may have impairment from the “work injury,” but not due to the accepted condition, but not all conditions stemming from the “work injury” have been formally accepted.

Physicians 3 and 4
- “I have not seen any examples. We like to think that we catch all impairments.”

Physician 5
- Sees cases where the worker has ratable impairment under the rules, but does not truly have a loss of use or function.
- Occasionally sees a worker who has no impairment, but still has limitations on return to work abilities.

Physician 6
- Chronic condition impairment, which requires a “significant” limitation in repetitive use is subjective at times.

Physician 7
- Infrequently seen worker’s who have 5/5 strength, but still have lost strength compared to the contralateral side.
- Frequently has problem determining what is “significant” when asked if the worker is “significantly” limited in repetitive use of a body part or joint. Definition of “significant” should be provided.

Physician 8
- See shoulder cases, where the examination finds no impairment, but the worker reports “pain” after work hours, so the worker really is impaired.

Physician 9
- Occasionally see workers with a low back, thoracic, or cervical condition who have no body impairment, but a physical capacity evaluation (PCE) or a work hardening program indicate the worker should have work restrictions, which should be ratable impairment, but is not.

Physician 10
- Believes all in question #4 can be true.
- Specifically, cold intolerance classifications are problematic. Cold intolerance should be based on objective findings and easier to determine. Reporting the temperature at which the cold intolerance causes problems is hard. Recommend rewriting this rule, in addition to vascular impairment classifications.
- New cold intolerance/vascular classifications should be based on historical evidence reported by the worker (e.g. blanching, turning red, Raynaud’s like phenomenon).
- There should be an overarching model for vascular impairment (with cold intolerance not separated out) based on the “guides.”
• Looking at the 4th AMA edition, the classes of pain relating to cold intolerance/vascular impairment are similar to the current standards, but they also say “Raynaud’s phenomenon triggered at certain temperatures.” Cold intolerance would be an additional issue. 1st vascular impairment would be demonstrated and then if there is cold intolerance in addition, impairment is established.
• Seen cold intolerance cases where there is no loss of use or function, but the worker gets an award.
• Cold intolerance can jump into a huge/excessive award.
• Worker’s experiencing pain who have no physical impairment, but have work restrictions should get an award.
• In addition to allowing apportionment of impairment findings, physicians should be able to apportion the worker’s residual functional capacity.

Physician 11
• “I think that shoulder conditions can sometimes fall into this scenario. Also, impairment can be relative, unfortunately, based on the work required. I think we can all agree on impairment that affects ADLs, but affecting specific work tasks is sometimes harder.”

Physician 12
• The significant repetitive use limitation is vague and should be defined better.
• Once in a while a worker has pain, which cannot be objectively verified, but believes it is valid and due to the accepted condition and should be rated as this is a loss for the person.

Physician 13
• Workers have come to her who state they are having “no issues,” but have ratable impairment per the standards.
• Not always convinced by the worker that the restrictions or limitations are objective.

Physician 14
• Diagnosis based rating would be helpful. Spine diagnosis based impairment would be better to compensate workers who have no measurable impairment, but are unable to return to work.
• This can go both ways. Personal effort has a lot to do with it.

Physician 15
• Cold intolerance is a problem and is currently based on subjective complaints.
• Current description for cold intolerance can allow huge awards.
• Cold intolerance is out of date. The worker may have cold sensitivity versus having an actual loss of use or function.

Physician 16
• The current system is working. It is not broken. There is no need to fix it.

Physician 17
• There are cases where the worker is found not to have impairment, but still has restrictions on returning to work.

Physician 18
• The weakest part of the system is that the “accepted condition” is not always the worker’s “real” condition or correct diagnosis.
Physician 19
- “The latter.”
- Spine comes to mind. The worker has objective evidence of a disc herniation, but does not have ratable impairment in the standards, but has work restrictions.

Physician 20
- We make the best of an imperfect system, but do not know what would make the system better at this point. Nothing is a perfect system, but there is nothing better now.

Physician 21
- No issues with incongruous outcomes.
- Apportionment can be hard, but not much problems with other standards.
- There may be problems with moving the spine to a diagnosed based system.
- Working in Indiana, he used the 4th and 5th AMA guides.

Physician 22
- No problems on a normal occurrence.
- Any problems are only very specific individual situations.

Physician 23
- No real problems in determining impairment if you look at the overall past treatment and attending physician information. You must compare the physical findings upon your examination of the worker to the overall record and see if the other physician’s findings are drastically different then yours.

Physician 24
- It is more common that the worker has impairment per the rules, but are not really impaired.

Physician 25
- Sees workers that have full ROM, but continue to have pain and may not be sustainable.
- If everyone had a functional capacity examination by a physical therapist, there would be a much better assessment of impairment.