NEW YORK STATE OF OPPORTUNITY.

Workers' Compensation Board

May 23, 2018

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

Course Objectives

This training will help you apply the 2018 New York State Workers' Compensation Impairment Guidelines for Determining Schedule Loss of Use ("2018 Guidelines") to:

- Assess residual permanent physical and functional impairments for a worker with schedule, permanent-partial disability (PPD)
- Learn the history including changes from the 2012/1996 Guidelines

Course Objectives (continued)

- Describe the physician's role in the medical evaluation of permanent physical and functional impairment
- Learn and apply key terms, principles and approach to performing an SLU determination
- Perform a medical impairment evaluation using the Guidelines' objective criteria

History

History

1996

- Board issued *Medical Guidelines* for the evaluation of permanent impairment for schedule and non-schedule injuries
- These were in effect through 2011

.

History

2012

- Board issued 2012 *Medical Impairment and Loss of Wage Earning Capacity Guidelines* (2012 Guidelines)
- Chapters 2-8, Schedule Loss of Use Awards, were taken directly from the 1996 Guidelines
- Chapters 9-17 included new guidelines for evaluating non-schedule PPD

History

2018

- 2017 legislation directed the Board to adopt revised guidelines for the evaluation of injuries amenable to a schedule loss
- Revisions were to be “reflective of advances in modern medicine that enhance healing and result in better outcomes"
- Revised SLU Guidelines took effect January 1, 2018

History

2018

- Replaced Chapter 1 (Introduction)
- Replaced Chapters 2-8 from the 2012 Guidelines (SLU determination)
- Chapters 9-17 from the 2012 Guidelines (Evaluation of Non-Schedule PPD) remain in effect, unchanged

Legal Framework

NEW YORK STATE OF OPPORTUNITY.
Workers' Compensation Board

Legal Framework

- NYS medical providers must be Board authorized to treat and/or perform IMEs
- Permanency evaluations performed outside of NYS must comport with these Guidelines
- Revised Board forms* must be used to document SLU

*Forms will be discussed later in the presentation

Legal Framework

- When the first medical evaluation of SLU is performed before 1/1/18, the Board will determine the worker's degree of permanent disability using the 2012 Guidelines
- If the first SLU evaluation occurs on or after 1/1/18, the SLU will be determined using the 2018 Guidelines

Organization

Chapters (2018)

Chapter 1	Introduction
Chapter 2	Upper Extremities – Thumb and Fingers
Chapter 3	Upper Extremities – Hand and Wrist
Chapter 4	Upper Extremities – Elbow
Chapter 5	Upper Extremities – Shoulder
Chapter 6	Hip and Femur

Chapters

Chapter 7	Knee and Tibia
Chapter 8	Lower Extremities – Ankle and Foot
Chapter 9	Lower Extremities – Great and Lesser Toes
***Chapter 10**	Central Nervous System Conditions, Peripheral Nerve Injuries and Entrapment Compression Neuropathies
***Chapter 11**	Visual System/Auditory System, Facial Scars and Disfigurement

* The approach to SLU evaluations for the conditions covered in these two chapters is unchanged from the 2012 Guidelines.

Chapter 1: Key Concepts and Terms

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Impairment vs. Disability

- Impairment is a purely medical determination made by a medical professional
- Defined as any anatomic or functional abnormality or loss
- Requires a complete medical examination *and* accurate objective assessment
- Considered *permanent* when MMI has been reached and there is a remaining impairment

Impairment vs. Disability

- Disability is a legal determination that reflects the impact of a workplace injury on the worker's ability to work
- A Workers' Compensation Law Judge establishes a level of disability based on available medical evidence and other relevant information

Maximum Medical Improvement (MMI)

An assessed condition of a worker based on a medical judgement that the

- Worker has recovered from the work injury to the greatest extent that is expected, and
- No further improvement in his/her condition is reasonably expected

Maximum Medical Improvement (MMI)

- The need for palliative or symptomatic treatment does not preclude a finding of MMI
- In cases that do not involve surgery or fractures, MMI cannot be determined prior to 6 months from the date of injury or disablement, unless otherwise agreed to by the parties

SLU Chapters 2-9

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Chapters 2-9: Contents

- Objectives for Determining Impairment
- Methods Available to Assess Permanent Impairment
- Normal Range of Motion (ROM) for the Relevant Joint(s)
- Calculating Loss of Use
- Special Considerations
- Amputation

Objectives For Determining Impairment

- To accurately assess the permanent residual physical deficit resulting from the work injury
- Assessment should be based on objective findings determined by the history, examination and results of any appropriate diagnostic testing

Methods Available To Assess Permanent Impairment

- The determination of the degree of permanent residual physical deficit should be performed at MMI
- When evaluating the level of permanent residual physical deficit, the contralateral side should considered for comparison for expected/normal values (when appropriate)

Methods Available To Assess Permanent Impairment

- The severity of the permanent impairment is not based on the mechanism of injury

  It reflects the permanent residual physical deficit at MMI and may include physical damage to bone, muscles, cartilage, tendons, nerves, blood vessels and other tissues

- The duration of time from injury to MMI varies but in most cases is one year from the injury or last surgery

The Physician's Role

The Physician's Role

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

Preparing A Report

- Identify affected body part(s), including Chapter numbers(s) from the 2018 Guidelines and review applicable Guideline sections
- Review relevant medical records
- Perform thorough history and physical examination

Preparing A Report (continued)

- Report the work-related diagnosis(es) and examination findings including specific references to relevant history, exam and test results
- Follow the recommendations in the Guidelines to establish impairment level

ROM Examination Criteria

- Generally a goniometer should be used to measure active range of motion (ROM)
- To measure the maximum active ROM, three repeat measurements should be taken
- Deficits should be measured by comparing to the baseline reading of the contralateral member, if appropriate

ROM Examination Criteria

- Using the contralateral side is not appropriate where the opposite side has been previously injured or is not otherwise available for comparison
- When the contralateral side is not available for comparison, the designated normal ROM contained in the 2018 Guidelines should be used

Quiz #1

History

A provider documents that an injured worker can only achieve 150°of flexion in the healthy unaffected right shoulder due to body habitus.

The Guidelines state anterior flexion in a normal shoulder is 180°.

Question

In determining the SLU for the injured left shoulder, the starting point would be:

A. 150°

B. 180°

C. Neither

Answer

In determining the SLU for the injured left shoulder, the starting point would be:

A. **150°**

B. 180°

C. Neither

When evaluating the level of a permanent residual ROM deficit, the provider should compare the ROM to the contralateral unaffected side. When appropriate, the contralateral value should be the norm used to calculate the SLU percent

Ref. Section [1.3(3)(b)]- Role of the Examining Physician and Methods Available to Assess Permanent Impairment

Quiz #2

History

An injured worker’s right shoulder was normal prior to a work injury

- The unaffected left shoulder has a forward flexion of 140° due to body habitus
- According to the Guidelines, normal shoulder forward flexion is 180°
- The right injured shoulder attains forward flexion of 45°

Question

What is the right shoulder SLU?

A. 60%

B. 78%

C. 47%

Answer

What is the right shoulder SLU?

A. 60%

B. 78%

C. 47%

Flexion of the unaffected shoulder (140°) becomes the baseline and is used to calculate the shoulder SLU

140° / 180° (normal) x 100 = 78% (ratio of contralateral ROM to normal)

Answer

What is the right shoulder SLU?

A. 60%

B. 78%

C. 47%

Table 5.4 (a) Shoulder, Percent Loss of Use of Shoulder

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

Answer

What is the right shoulder SLU?

A. 60%

B. 78%

C. 47%

Worker's baseline shoulder ROM represents approximately 78% of the normal ROM

The worker's SLU = 60% from Table 5.4(a) (if the worker had normal ROM) x 78%= 47% SLU based upon worker's contralateral baseline ROM

*Section [1.3(3)(b)]- Role of the Examining Physician and Methods Available to Assess Permanent Impairment in the introduction to each chapter

Maximum ROM Deficits

Maximum ROM Deficits

- For all SLU determinations based on ROM, the total SLU value for several ROM deficits cannot exceed the value of full ankylosis of the joint
- In addition, when there are multiple ankylosed joints, the sum of the value of the SLU of a major member cannot exceed the value of an amputation of that member
- Exception: Digits may exceed these values due to loading*

*See Chapter 2: Thumb and Fingers

Overview: Clearly Defined ROM Values

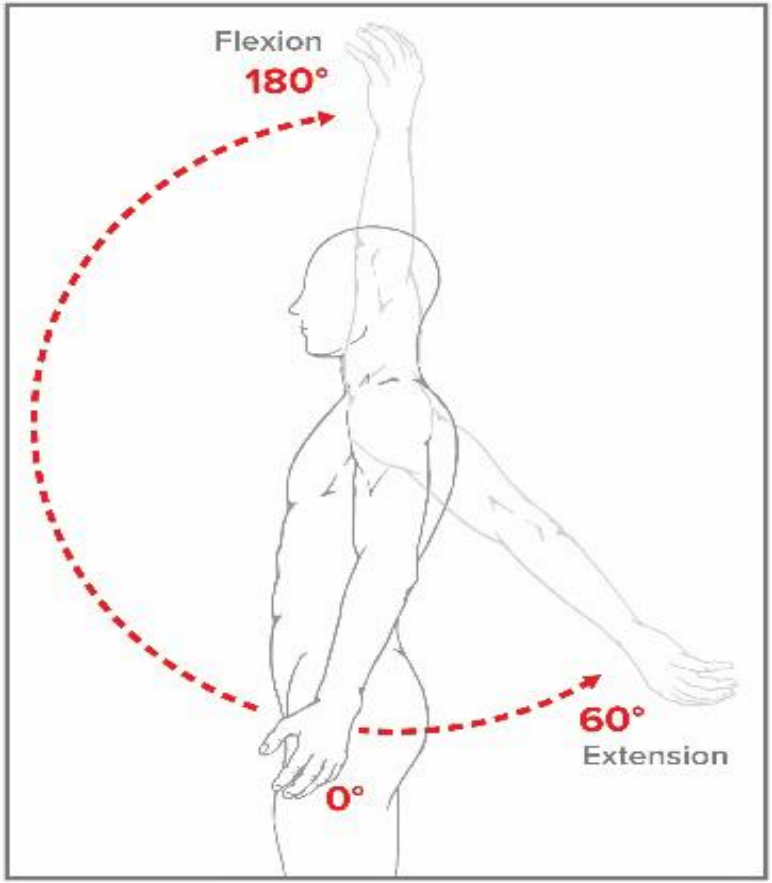
- There are written instructions and visual aids to properly measure all ROM deficits for each identified joint discussed in a Chapter
- Example: Chapter 5, Section 5.3 provides specific instructions and values for measuring shoulder flexion and extension ROM

Chapter 5
Figure 5.3(1)

Shoulder Flexion and Extension Figure 5.3(1)

Shoulder motions include:

1. Flexion (forward elevation) - ROM that is in the sagittal plane rotating about an axis of an imaginary line through the glenoid fossae with the arm moving in front of and above the body. The normal range of motion is to 180 degrees
2. Extension – ROM that is in the sagittal plane rotating about an axis of an imaginary line through the glenoid fossae with the arm moving behind the body to 60 degrees


Flexion
180°
60°
Extension
0°

Overview: Specific ROM Values and Mild, Moderate and Marked Defects

- Diagrams and tables clearly identify the specific ROM values that correlate with mild, moderate and marked defects (percent loss of use)
- Example: Chapter 3, Section 3.3 Wrist Dorsi and Palmar Flexion ROM values and associated defect (loss of use of the hand)

Chapter 3
Figure 3.3(a)
Table 3.4

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

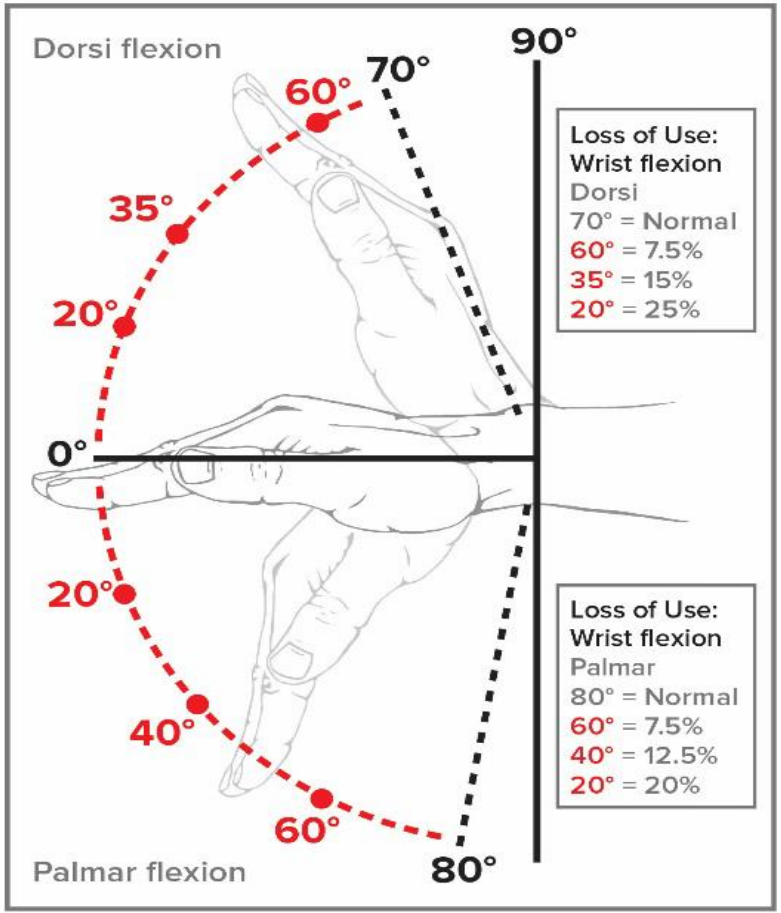

Dorsi flexion
90°
70°
60°
35°
20°
0°
20°
40°
60°
80°
Palmar flexion
Loss of Use:
Wrist flexion
Dorsi
70° = Normal
60° = 7.5%
35° = 15%
20° = 25%
Loss of Use:
Wrist flexion
Palmar
80° = Normal
60° = 7.5%
40° = 12.5%
20° = 20%

Table 3.4: Wrist ROM and Corresponding Defects

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

Overview: Loading

- 2018 Guidelines contain a step by step explanation to bring consistency to the application of loading criteria (Section 2.6)
- Loading involving fingers has been increased by 20% to address the increasing reliance on hand and finger function in the computer age

Overview: Special Considerations

- Instructions have clarified whether a condition that falls under a special consideration is evaluated as a stand alone or as a value that is added
- Special considerations for meniscal and rotator cuff tears with or without surgery have been removed

Overview: Joint Replacements

- Advances in medicine have improved many joint replacement outcomes
- The 2018 Guidelines joint replacement SLU determinations include the assessment of clinical outcomes such as overall assessment grade, ROM, position, atrophy and complications

Overview: Joint Replacements

- A 35% SLU is associated with a good joint replacement outcome
- When deficits exceed those described in Row A (Good Outcome), the value for any additional deficits are added to the base of 35% to calculate the total schedule loss of use award
- For additional deficits, add the value that most closely matches the deficit in the relevant column

Quiz #3

History

A worker is S/P hip replacement surgery. At MMI, the following clinical findings are noted:

- ROM more limited in flexion to 45°
- Leg length discrepancy of 0.8 inches
- Mal-rotation present at 20°

Question

The SLU determination for this worker is:

A. 35%

B. 55%

C. 45%

Answer

The SLU determination for this worker is:

A. 35%

B. 55%

C. 45%

The value of a hip replacement starts at 35%

Add 10% for flexion deficit (45°)

Add 10% for mal-rotation (20°)

Total SLU = 35 + 10 + 10 = 55%

Excerpt Table 6.5 Hip Replacement

Fair (B)	45° (add up to 10%)	Leg length discrepancy of ≤0.75 inches and/or 10-15 degrees rotation (add up to 5%)
Poor (C)	≤ 25° (add up to 35%)	Leg length discrepancy ≥ 1 inches and/or > 15-degrees rotation (add up to 10%)

Overview: Other Considerations

- When a percent loss of use is expressed as a range, the lower value is used when there is a deficit in only one ROM in a joint
- When two corresponding ROM values are affected (i.e., flexion/extension), the higher percent is used

Overview: Other Considerations

Example: Table 2.5(B) from Chapter 2, lists a percent range for the MCP joint

- In the moderate category, if only flexion were affected, the percent would be 30%; if flexion and extension were affected, the percent would be 40%

Table 2.5(B)
Percent Loss of Use of Finger

	ROM	Mild	Moderate	Marked	Ankylosis
A*	DIP (ROM 0-90°)	10-15% ROM 75°	20-25% ROM 45°	40-45% ROM 25°	Ankylosis of the DIP joint (loss of active flexion) is a 50% loss of use of the finger. Ankylosis of multiple joints cannot exceed 100%
B*	PIP (ROM 0-100°)	15-20% ROM 75°	25-30% ROM 45°	45-50% ROM 25°	
C*	MCP (ROM 0-90°)	20-25% ROM 75°	30-40% ROM 45°	50-90% ROM 25°	

*Use lower figure for one deficit and higher figure when both are affected

Overview: Other Considerations

- In the shoulder, if there is documentation of a deficit in both flexion (forward elevation) and abduction, the greater of the two deficits must be used, not both (Table 5.4(a))*

*Case Study #1

Applying the 2018 Guidelines

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Applying the 2018 Guidelines: Special Considerations

- First, determine whether a condition triggers a Special Consideration
- If so, perform the SLU determination consistent with the requirements noted in the relevant Special Consideration section

Applying the 2018 Guidelines: Special Considerations

- If the condition is not addressed as a Special Consideration, the SLU evaluation should conform to the Guidelines' general criteria for a body part

Applying the 2018 Guidelines: Documenting Loss

- ROM values for affected joints should be documented utilizing Guideline instructions
- Once ROM value(s) have been determined, instructions in the appropriate Sections/Tables of the Guideline should be used to calculate the percent SLU
- Three repeat measurements of active ROM should be performed using a goniometer

Applying the 2018 Guidelines: Documenting Loss

- Record all three measurements in the narrative report
- The highest of the three measured values should be used in the SLU determination
- If a measurement other than the highest ROM is used, the physician should explain in detail why the highest ROM was not appropriate

Applying the 2018 Guidelines: Documenting Loss

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

Applying the 2018 Guidelines: Documenting Loss

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

Case Study #1

History

- 53 y/o man with a work-related injury to the right shoulder, S/P right rotator cuff repair
- Lifted a 40 lb. box to shoulder height and felt a sudden “pop” with pain and weakness in his right arm
- Surgery was a year ago
- At MMI and working
- Prior to surgery, he had full ROM in both shoulders

Physical Examination

Right shoulder:

- Incision: well healed
- No atrophy

ROM

- Forward flexion = 0-90°
- Abduction = 0-100°
- ER and IR = mild defects

Left shoulder → Full ROM

Calculating the Shoulder SLU

- The contralateral shoulder has full ROM, so forward flexion and abduction = 180°
- The Guideline tables can be used as the baseline without the need for contralateral modification

Table 5.4(a): Percent Loss of Use of Shoulder

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

Table 5.4(a): Notes

- If a deficit of both flexion (forward elevation) and abduction are documented, the greater of the two deficits must be utilized, not both. If the deficit in both ranges of motion are moderate or higher, and the measures are within 10° of each other, up to 10% may be added to the overall schedule loss of use, not to exceed ankylosis
- Do not add mild deficits of internal and external rotation to avoid cumulative values. May add 10-15% for marked deficits of rotation and muscle atrophy, not to exceed ankylosis

Calculating the Shoulder SLU

- The flexion deficit (90°) is greater than the abduction deficit (100°) and falls into a moderate category of 40%
- Deficits in both ROMs (Flexion and Abduction) are in the moderate categories and within 10° of each other, so up to 10% may be added

Calculating the Shoulder SLU

- Mild deficits of IR and ER are not added
- There is no longer a Special Consideration for Rotator Cuff Tears

Total SLU = 40% + 10% = 50%

Case Study #2

History

- 59 y/o woman
- S/P Right Total Knee Replacement
- Surgery over a year ago
- At MMI
- Returned to full duty as a bus driver without restrictions

Physical Examination

Right knee:

- Incision: healed

ROM

- Flexion = 125° (near full)
- Full Extension: 0°
- No Varus/Valgus instability

No atrophy → (R → 44.5 cm; L → 44cm)

Table 7.5: Full or Partial Knee Replacement SLU

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

Calculating the TKR SLU

Utilizing the clinical indicators in Table 7.5

- ROM: Flexion ≥ 105° (125° in this case);

  Extension < 10° (0° in this case)
- No laxity
- No atrophy ≤ I inch or ≤ 2.5 cm (in this case .05 cm difference)
- No complications

TKR Outcome Good = 35% SLU

Revised Forms

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Form Changes: Treating and IME

Doctor's Report

- Revised Doctor's Report of MMI/Permanent Impairment (Form C-4.3)
- Two new attachments (Forms C-4.3A and C-4.3B)

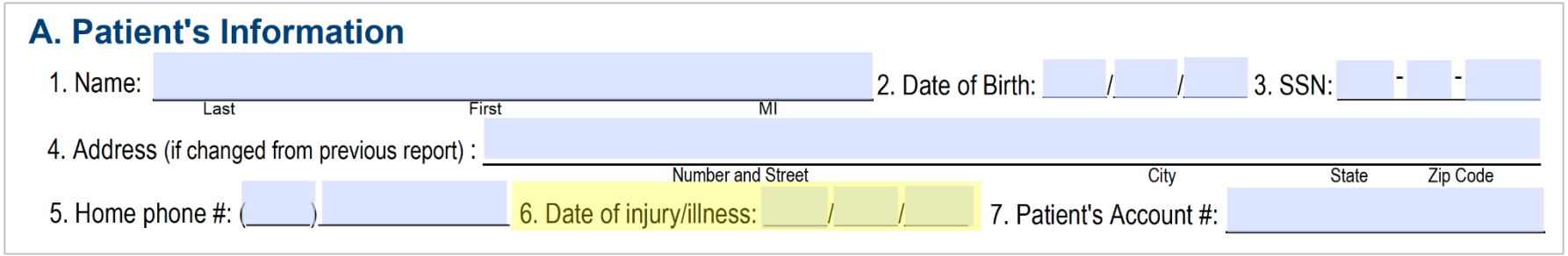
IME Report

- Revised Form IME-4 Cover Sheet for Report of Independent Medical Examination (IME) Scheduled Loss of Use
- Two new attachments - Report of IME for SLU (Form IME-4.3A) and Non-Scheduled Disability (Form IME-4.3B)

Doctor's Report of MMI/Permanent Impairment (C-4.3)

- C-4.3 form (pages 1-2) continues to be used for both Scheduled Loss of Use and Non-Scheduled Loss of Use with minimal revisions
- New attachments for documenting permanent partial disability
  - Attachment A for documenting Scheduled Loss of Use
  - Attachment B for Non-Scheduled Loss of Use

Doctor's Report of MMI/Permanent Impairment (C-4.3)



A. Patient's Information

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

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

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

Doctor's Report of MMI/Permanent Impairment (C-4.3)

D. Maximum Medical Improvement

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

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

Doctor's Report of MMI/Permanent Impairment (C-4.3)

E. Permanent Impairment

1. Is there permanent impairment? ☐ Yes ☐ No

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

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

Doctor's Report of MMI/Permanent Impairment (C-4.3)

- Hearing Loss:
  - Occupational Loss of Hearing: C-72.1 should be utilized
  - Traumatic Hearing Loss: C-4.3 with an attached narrative

- Vision Loss:
  - Attending Ophthalmologist's Report (Form C-5), or
  - C-4.3 with an attached narrative

- Serious Facial Disfigurement:
  - C-4.3 with an attached narrative

For a non-schedule award (classification), complete **Attachment B. Attachment A** and/or **Attachment B** must be completed for each body part and/or condition which you treated the patient for on the date of injury listed in Section A, Question 6

Practitioner's Report C-4.3A (SLU)

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

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

Practitioner's Report C-4.3A

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

Body Part

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

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

Practitioner's Report C-4.3A

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

Details:

Independent Medical Examination

IME 4

PO Box 5205
Binghamton, NY 13902-5205

Customer Service Toll-Free Line: 877-632-4996
Statewide Fax Line: 877-533-0337
www.wcb.ny.gov

COVER SHEET FOR REPORT OF INDEPENDENT MEDICAL EXAMINATION

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

CHECK ONE: ☐ PHYSICIAN ☐ PODIATRIST ☐ CHIROPRACTOR ☐ PSYCHOLOGIST

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

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

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

Authorization No.	Date of Report of Independent Medical Examination

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

Independent Medical Examination IME 4 Cover Sheet

Attach Report of Independent Medical Examination

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

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

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

Independent Medical Examination IME-4.3A SLU

- IME 4.3A mirrors changes in C-4.3A

ATTACHMENT FOR REPORT OF INDEPENDENT MEDICAL EXAMINATION SCHEDULED LOSS OF USE

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

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

Social Security No.: _____

WCB Case No.: _____

Date of Injury/Illness: _____

Date of Examination: _____

A. Permanent Partial Disability

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

A1. Schedule Loss of Use of Member:

Body Part

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

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

Independent Medical Examination IME-4.3A SLU

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

Details:

Resources

- Workers' Compensation Guidelines for Determining Impairment at: wcb.ny.gov/2018-Impairment-Guidelines.pdf
- Subject Number 046-1011 at: wcb.ny.gov/content/main/SubjectNos/sn046_1011.jsp

Contact

Customer Service
(877) 632-4996

Monday - Friday
8:30 AM to 4:30 PM

Questions