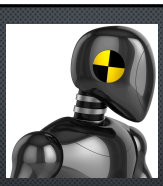
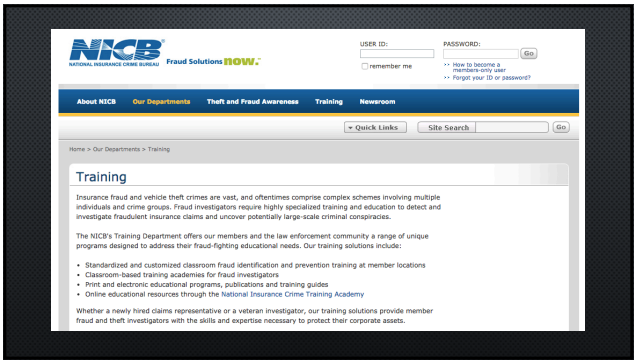


HOW TO INCREASE THE SETTLEMENT VALUE OF PERSONAL INJURY CASES

NEVER GIVE AWAY FREE EXAMS

- SAME DAY APPOINTMENTS AVAILABLE
- NO MONEY REQUIRED ON THE FIRST VISIT
- NO CHARGE TO COMPLETE INSURANCE PAPERS
- ATTORNEY REFERRALS AVAILABLE UPON REQUEST
- WE WAIT TO GET PAID UNTIL SETTLEMENT



3:00-4:30pm	**ICD-10 Codes & Classifications** **Dr. Lawrence Stolar, BS DC MCS-P, Medical Compliance & Insurance Consultants Grapevine, TX**
5:30 – 7:30pm	**Welcome Reception –**

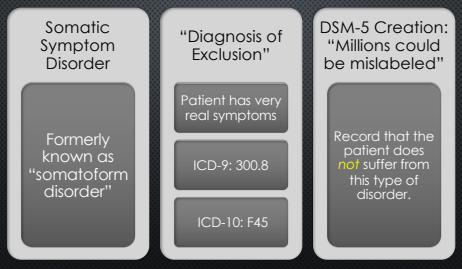
Tuesday, June 2

8:00am	**Medical Bill Review** **Kymberly McGhee, Special Agent, MFTF, Edison, NJ** **James Keith, Special Agent, MFTF, Chicago, IL**
10:00am	**BREAK**
10:15am	**Forensic & Compliance Case Review** **Dr. Lawrence Stolar, BS DC MCS-P, Medical Compliance & Insurance Consultants Grapevine, TX**

Thursday, June 4

8:00am	**Chiropractic Made Simple** **Dr. Matt Kuschner, DC, Medical Investigator, Travelers, Melville, NY**
	Break as necessary
12:00pm	**Lunch**
1:00pm	**Chiropractic Made Simple (continued)**

UNIVERSAL BOGUS DEFENSES



DEFENSE MYTH #1

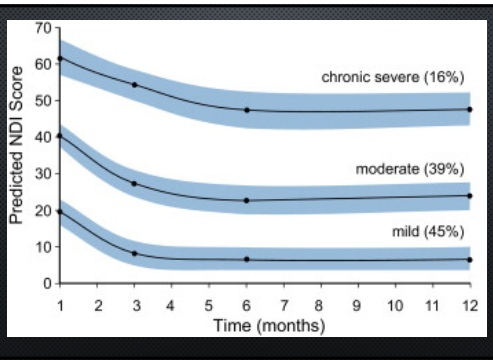
MYTH: THE FORCE OF THE IMPACT IS THE SAME AS SITTING IN A CHAIR, WAKING OFF A CURB OR A SNEEZE. (MURRAY ALLEN, MD ET AL – ACCELERATION PERTURBATIONS OF ACTIVITIES OF DAILY LIVING

TRUTH: SITTING IN A CHAIR DOES NOT TAKE INTO ACCOUNT THE EXCHANGE OF ENERGY FROM THE BULLET VEHICLE TO THE TARGET VEHICLE.

DEFENSE MYTH #2

MYTH: ALL SOFT TISSUE INJURIES RESOLVE IN 6-12 WEEKS.

TRUTH: THERE IS NO CREDIBLE STUDY TO SUPPORT THIS ASSERTION.



DEFENSE MYTH #3

MYTH: THE ACCIDENT RECONSTRUCTIONIST SAID THAT THERE IT IS IMPOSSIBLE TO BE INJURED IN A LOW SPEED CRASH.

TRUTH: ONLY THE TREATING DOCTOR CAN STATE WHETHER A PATIENT HAS BEEN HURT TO A REASONABLE DEGREE OF CERTAINTY.

DEFENSE MYTH #4

MYTH: AN ACCELERATION CHANGE OF 5 MPH IS NOT ENOUGH TO CAUSE INJURY.

TRUTH: A DELTA V OF 5 MPH IS MORE THAN ENOUGH TO CAUSE PERMANENT INJURY.

ONE CAN NOT RETROSPECTIVELY REVIEW AN INJURY.

DEFENSE MYTH #5

MYTH: 50% OF THE POPULATION OVER THE AGE OF 40 HAVE A HERNIATED DISC.

TRUTH: EVEN IF THIS WERE TRUE, HALF OF THE POPULATION OVER 40 DOES NOT WALK AROUND WITH CHRONIC BACK PAIN AND RADICULAR COMPLAINTS EVERY DAY.

DEFENSE MYTH #6

MYTH: THE INJURIES WERE PRE-EXISTING.

TRUTH: THE MAJORITY OF PEOPLE WHO HAVE DEGENERATION AND DISC BULGES DO NOT HAVE SYMPTOMS OF DECREASE IN STRENGTH AND SENSATION.

FACT: TRIAL ATTORNEY'S LOVE PATIENTS WITH DEGENERATION WHO WERE INJURED IN LOW SPEED CRASHES.

DEFENSE MYTH #7

MYTH: POSITIVE WADDELL'S SIGNS INDICATE MALINGERING.

TRUTH: WADDELL'S SIGNS ARE USED TO DETERMINE WHETHER A DISC HERNIATION IS CENTRALIZED OR LATERAL. THESE SIGNS ARE USED AS A PREDICTOR TO DETERMINE WHETHER SURGERY WILL HELP AN INDIVIDUAL OR NOT.

DEFENSE MYTH #8

MYTH: IT WAS AN ACCIDENT.

TRUTH: THE DEFENDANT WAS NEGLIGENT AND CAUSED AN INCIDENT CALLED A COLLISION. THE INCIDENT WAS COMPLETELY AVOIDABLE AND THEREFORE NOT AN ACCIDENT.

DEFENSE MYTH #9

MYTH: THERE WAS NO DAMAGE DONE TO THE VEHICLE SO THE OCCUPANT(S) COULD NOT HAVE BEEN INJURED.

TRUTH: THERE IS NO DIRECT CORRELATION BETWEEN THE DAMAGE OF THE VEHICLE AND THE INJURIES SUSTAINED BY THE OCCUPANT(S). SEE THE SAE STUDY.

DEFENSE MYTH #10

MYTH: PLAINTIFF'S AND DOCTORS AND LAWYERS ARE JUST TRYING TO RIP OFF THE SYSTEM.

TRUTH: 4 OUT 5 PROPERTY DAMAGE CASES DO NOT INVOLVE ANY BODILY INJURY. PEOPLE PAY INSURANCE TO INDEMNIFY THEM IN THE EVENT OF AN ACCIDENT. MORE THAN 9 OUT OF 10 CASES DO NOT INVOLVE ANY FRAUD.

DEFENSE MYTH #11

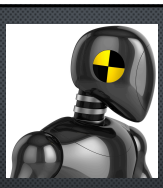
MYTH: THE PLAINTIFF WAITED FOR __ WEEKS TO GO TO THE DOCTOR.

TRUTH: HONEST PEOPLE THINK THAT SYMPTOMS ARE GOING TO GO AWAY AND WHEN THEY DO NOT THEY SEEK OUT MEDICAL CARE.

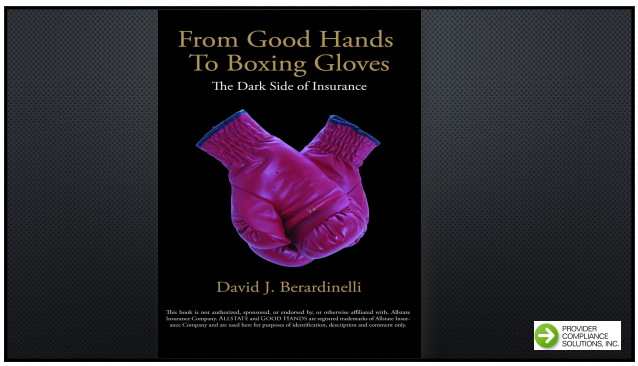
DEFENSE MYTH #12

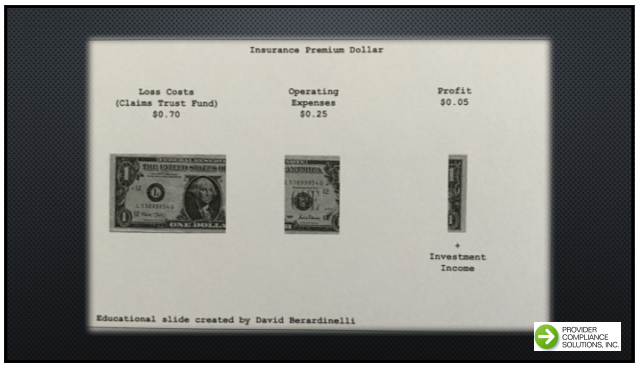
MYTH: THE LITHUANIAN STUDY SHOWED THAT THE SAME NUMBER OF PEOPLE WHO HAD NECK PAIN AND HEADACHES WAS THE SAME FOR PEOPLE WHO DID AND -- DID NOT -- HAVE A CAR ACCIDENT.

TRUTH: ARTHUR CROFT, DC AND MICHAEL FREEMEN, DC, PH.D. SAID THE STUDY WAS "FATALLY FLAWED".



LESSON 1:
FROM GOOD HANDS TO BOXING GLOVES


From Good Hands
To Boxing Gloves
The Dark Side of Insurance
David J. Berardinelli
This book is not authorized, sponsored, or endorsed by, or otherwise affiliated with, Allstate Insurance Company. ALLSTATE and GOOD HANDS are registered trademarks of Allstate Insurance Company and are used here for purposes of identification, description and comment only.
PROVIDER COMPLIANCE SOLUTIONS, INC.


Insurance Premium Dollar
Loss Costs
(Claims Trust Fund)
$0.70
Operating
Expenses
$0.25
Profit
$0.05
+
Investment
Income
Educational slide created by David Berardinelli
PROVIDER COMPLIANCE SOLUTIONS, INC.

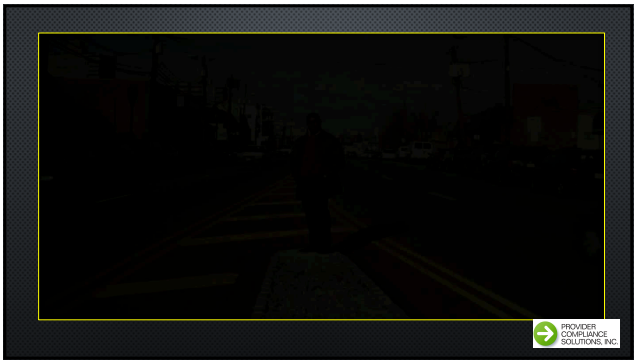

CHICAGO
WORLD'S FAIR
MAY 27TH
NOV. 1ST
1833 A CENTURY OF PROGRESS 1933
PROVIDER COMPLIANCE SOLUTIONS, INC.

ALLSTATE

- First tire sold by Sears in 1925
- April 17th, 1931 – Allstate Insurance Co.
- 1933 – Booth at World's Fair and catalogs
- 1934 – First Allstate desk appears in Sears
- 1985 – Agents were moved out to offices
- 1993 – Spun off 19.3% of shares
- 1995 – Sold the remaining 80.7%
- Largest publicly held insurance company

"YOU'RE IN GOOD HANDS…"

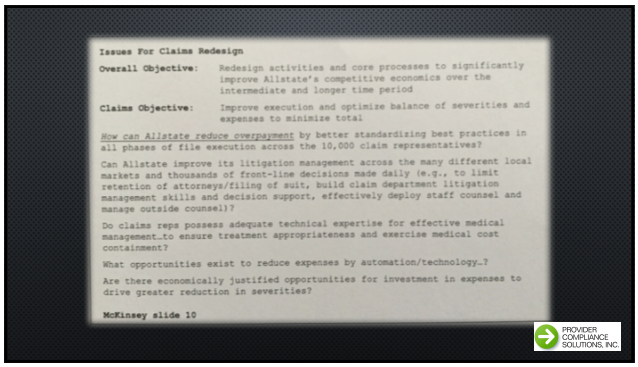
- The phrase was used by a family physician of the general sales manager.
- As of 2000, it is the most recognizable phrase in the United States.
- In 2003, policy growth slowed so they came up with a new advertising campaign.
- The goal was separate their image from GEICO and Progressive.

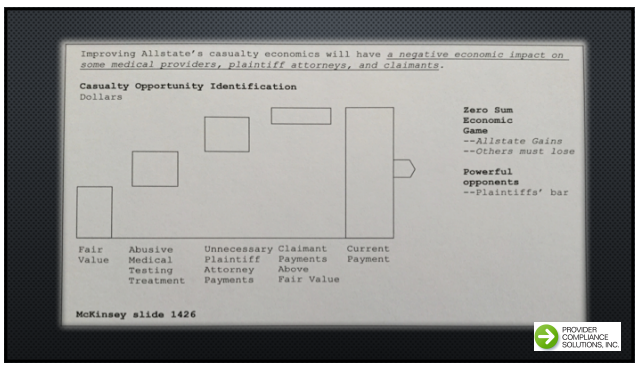


Bud Fox: Tell me Gordon, how much is enough?

Gordon Gekko: It's not a question of enough, pal. It's a zero sum game, somebody wins, somebody loses.


Zero-Sum Game
My Interests
"I Win"
Your Interests
"You Lose"
We are opponents - when I win, you lose
PROVIDER COMPLIANCE SOLUTIONS, INC.


Issues For Claims Redesign
Overall Objective: Redesign activities and core processes to significantly improve Allstate's competitive economics over the intermediate and longer time period
Claims Objective: Improve execution and optimize balance of severities and expenses to minimize total
How can Allstate reduce overpayment by better standardizing best practices in all phases of file execution across the 10,000 claim representatives?
Can Allstate improve its litigation management across the many different local markets and thousands of front-line decisions made daily (e.g., to limit retention of attorneys/filing of suit, build claim department litigation management skills and decision support, effectively deploy staff counsel and manage outside counsel)?
Do claims reps possess adequate technical expertise for effective medical management…to ensure treatment appropriateness and exercise medical cost containment?
What opportunities exist to reduce expenses by automation/technology…?
Are there economically justified opportunities for investment in expenses to drive greater reduction in severities?
McKinsey slide 10
PROVIDER COMPLIANCE SOLUTIONS, INC.


Improving Allstate's casualty economics will have a negative economic impact on some medical providers, plaintiff attorneys, and claimants.
Casualty Opportunity Identification
Dollars
Zero Sum Economic Game
--Allstate Gains
--Others must lose
Powerful opponents
--Plaintiffs' bar
Fair Value
Abusive Medical Testing Treatment
Unnecessary Plaintiff Attorney Payments
Claimant Payments Above Fair Value
Current Payment
McKinsey slide 1426
PROVIDER COMPLIANCE SOLUTIONS, INC.

CCPR Quiz

Question 2: In a "zero sum" game everybody wins.

Answer: False.

Competing in today's environment is a "zero sum" game - meaning someone must lose if we're to win

McKinsey Slide 2994

PROVIDER COMPLIANCE SOLUTIONS, INC.

We Will Win the Economics Game

Senior management is highly committed to capturing the opportunity

Winning will be a zero sum game

We will win the game in two phases

- Phase 1: Consistent execution of "better plays" and **"new game plans"**
- Phase 2: **"Change the rules"** and play a **"new game"**

McKinsey slide 8077 February 11, 1994 - PP&C Update

PROVIDER COMPLIANCE SOLUTIONS, INC.

By increasing the number of early unrepresented settlements while "holding the line" on represented cases, a new distribution of settlement times will likely emerge.

DISTRIBUTION OF SETTLEMENT TIMES
BI SUBJECTIVE CASES

CURRENT GAME

BI subjective cases

0 250 500 750 1000 1250 1500

NEW GAME

BI subjective cases

90% "Good Hands"

10% "Boxing Gloves"

0 250 500 750 1000 1250 1500

Source: Closed File Survey

McKinsey slide 3372

PROVIDER COMPLIANCE SOLUTIONS, INC.

CCPR Quiz

Question 12: We currently take over 10% of cases to verdict.

Answer: False

Comments:

- Because we are good at litigation, it may be easy to assume that we do it a lot; we don't
- Only about 4% of our represented files go to verdict
- Because **verdicts appear to lead to better results than negotiating with plaintiff attorneys, we should consider enhancing our litigation strategies**

McKinsey slide 3010

PROVIDER COMPLIANCE SOLUTIONS, INC.

In addition, Allstate does not *aggressively use litigation to maintain fair settlement values* in the market

Pie chart showing 75% of cases are represented with side bar graph showing 55% with no case filed, 41% filed a case, only 4% of 517 represented cases went to verdict]

Plaintiff Attorney quotes:

"State Farm is *terrible to deal with*; they are not afraid to go to trial."

"State Farm has driven values down in this market by going to court and winning some cases."

"State Farm has a *clear strategy to drive down market values through going to trial...* I don't like it and it will hurt them in the long run."

Source: Closed File Survey-13 MCOs, team analysis

McKinsey slide 1607

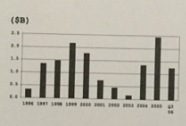
PROVIDER COMPLIANCE SOLUTIONS, INC.

Disciplined Capital Manager

Share Repurchases

10+ Year Total = $13.5 B

($B)



Dividends Per Share

11 Year CAGR = 12.3%

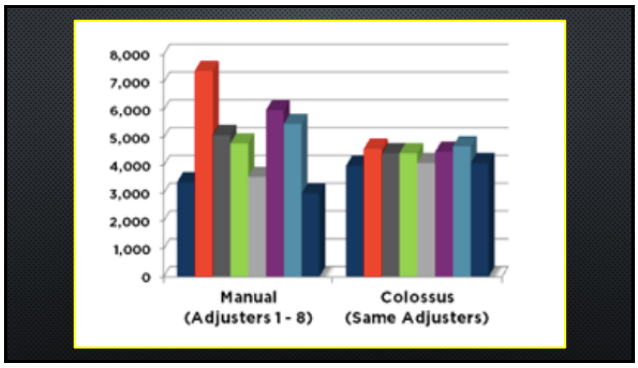
($)

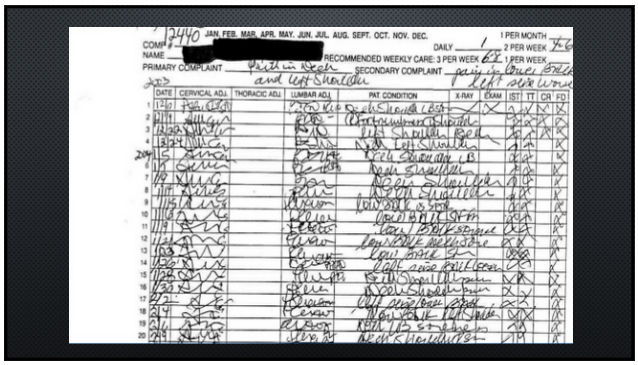
Returned 75% of net income to shareholders since 1995

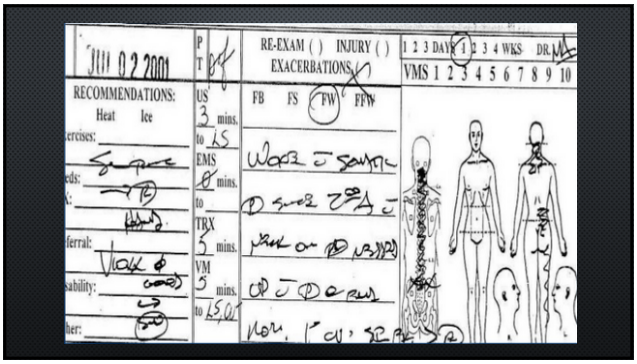
ArgusVision 2007 - November 13, 2006

PROVIDER COMPLIANCE SOLUTIONS, INC.


Claim Segmentation
SIU/SID
Quick Settle
MIST
Policy Limits
Colossus
Fraud
NICB
FBI
$200+
Board Complaints
Minor Damage
Lowball Offers
<60 Days
Severe Injury
Clear Case of Liability
60% of all claims
Computer Generated
"Value Drivers"


8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
Manual
(Adjusters 1 - 8)
Colossus
(Same Adjusters)


JAN. FEB. MAR. APR. MAY. JUN. JUL. AUG. SEPT. OCT. NOV. DEC.
1 PER MONTH
DAILY
2 PER WEEK
RECOMMENDED WEEKLY CARE: 3 PER WEEK
1 PER WEEK
SECONDARY COMPLAINT
PRIMARY COMPLAINT
and Left Shoulder
DATE
CERVICAL ADJ.
THORACIC ADJ.
LUMBAR ADJ.
PAT CONDITION
X-RAY
EXAM
IST
TT
CR
FO


JUL 02 2001

RECOMMENDATIONS: Heat Ice

exercises:

aids:

X:

referral:

stability:

other:

P T

US 3 mins. to 15

EMS 8 mins. to

TRX 5 mins.

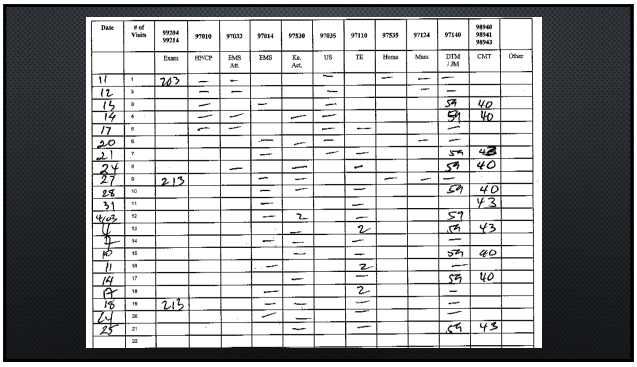
VM 5 mins. to 15.01

RE-EXAM ( ) INJURY ( ) EXACERBATIONS

FB FS FW FFW

1 2 3 DAYS 1 2 3 4 WKS DR

VMS 1 2 3 4 5 6 7 8 9 10



Date	# of Visits	99204 99214	97010	97032	97014	97530	97035	97110	97535	97124	97140	98940 98941 98943	
		Exam	HP/CP	EMS Att.	EMS	Ex. Act.	US	TE	Home	Mass	DTM / JM	CMT	Other
11	1	203	—	—			—		—	—	—		
12	2		—	—			—			—	—		
14	3		—		—		—				59	40	
14	4		—	—		—	—				59	40	
17	5		—	—			—	—			—		
20	6				—	—	—			—	—		
21	7				—			—			59	40	
24	8			—		—		—			59	40	
27	9	213			—	—			—	—	—		
28	10				—	—		—			59	40	
31	11				—			—				43	
4/03	12				—	2		—			59		
4	13							2			59	43	
7	14				—	—		—			—		
10	15					—		—			59	40	
11	16				—			2			—		
14	17					—		—			59	40	
17	18				—			2			—		
18	19	213			—	—		—			—		
21	20				—			—			—		
25	21					—		—			59	43	
	22												

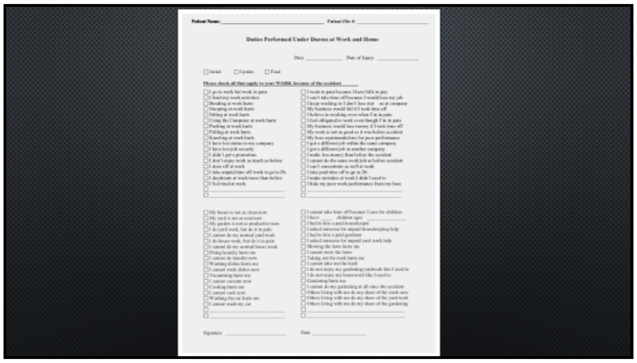
05/12/02

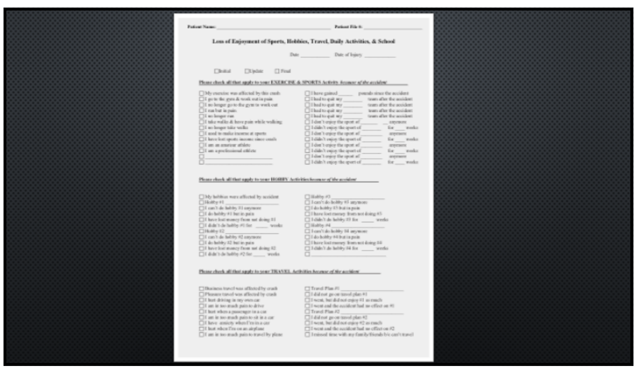
Subjective: Today, the patient indicated that his pain in the right region of the neck which is increased by rotating the head left has not noticeably changed since his last visit. The patient also indicated his pain across the right shoulder remains unchanged since his prior visit. Additionally, Mr. . stated his dull headaches located in the temples is feeling about the same as his last visit. Furthermore, the patient reported his pain in the bilateral mid back has not noticeably changed since his previous visit.

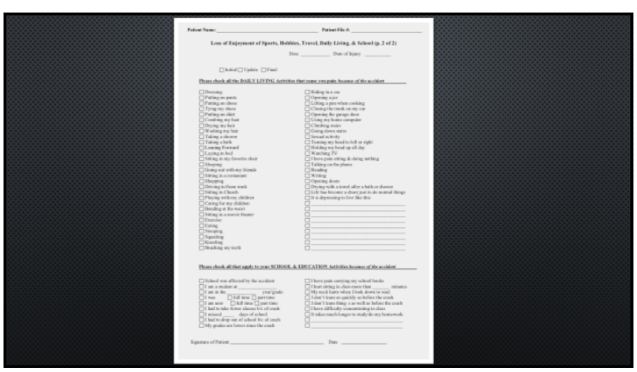
Objective: The cervical region was found to have a mild-moderate level of discomfort when evaluated by palpation. The thoracic region was revealed to have a mild-moderate level of tenderness when evaluated by palpation. Examination of muscle tenderness and spasm revealed the following: Levator scapulae revealed moderate tenderness. Posterior cervical revealed mild-moderate tenderness. A trigger point was found with active pain in the posterior cervical muscle area with radiation to the upper back region. Evaluation of the levator scapulae muscle area revealed a trigger point with active pain with radiation to the head region. A posterior subluxation was found at the thoracic region.

Assessment: Today, the patient seems to be accepting the treatment well, but has shown little progress since the prior visit.

Plan: The cervical spinal levels through the thoracic spinal levels showed minimal segmental motion during today's technique. Therapy on the cervical,thoracic,lumbar and upper extremity regions will continue as planned with kinetic therapy to restore normal spinal biomechanics. To increase the effectiveness of Mr. treatment, he will continue to perform specific stretches and use alternate heat and cold. Mr. is a prolific smoker and this is impeding his ability to heal.


Patient Name:
Patient File #:
Duties Performed Under Duress at Work and Home
Date
Date of Injury
Initial
Update
Final
Please check all that apply to your WORK because of the accident


Patient Name:
Patient File #:
Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School
Date
Date of Injury
Initial
Update
Final


Patient Name:
Patient File #:
Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)
Date
Date of Injury
Initial
Update
Final

Spine (Phila Pa 1976). 1994 Jun 1;19(11):1285-90.

Acceleration perturbations of daily living. A comparison to 'whiplash'.

Allen ME[1], Weir-Jones I, Motluk DR, Flewin KR, Goring RD, Kobeitich R, Broadhurst A.

Author information

Abstract

STUDY DESIGN: This study measured repeated human head accelerations (g) during daily activities.

OBJECTIVES: Perturbations of daily living were compared to similar data from low velocity rear-end motor vehicle accidents.

SUMMARY OF BACKGROUND DATA: Past assumptions suggest that motor vehicle accident severity does not correlate with the degree of sustained injury. Early engineering studies indicated that occupant disturbance in a low velocity motor vehicle accident is minor.

METHODS: Eight volunteers were perturbed with 13 daily activities. Helmets on the heads of volunteers were instrumented with tri-planar accelerometers with output sampling of 500 Hz, sensitivity of 0.02 g, and a range of +/- 20 g.

RESULTS: There was wide inter-subject response for various perturbations. Plopping backward into a chair caused maximum peak acceleration horizontally at 5.6 g and vertically at 8.5 g, with force vector of 10.1 g at 54.9 degrees. Mean impulse duration was 0.19 sec. There was no hint of injury in any subject.

CONCLUSIONS: Perturbations of daily living compared similarly to the jostling expected in low velocity "whiplash"-type motor vehicle accidents.

PROVIDER COMPLIANCE SOLUTIONS, INC.

iPad 9:33 AM hyperlexibook.com

	Jenny Hua	Matthew Grabczynski	Stephanie Ma	Average
Sneeze	2.189	1.800	0.957	1.649
Cough	1.790	0.899	0.957	1.215
Slap on Back	1.287	1.956	1.524	1.589
Hop off step	6.902	4.796	4.715	5.471
Plop down on chair	5.888	4.377	4.610	4.958
Crowd jostle	N/A	N/A	N/A	N/A

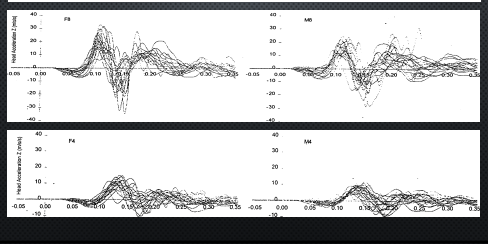
Compare to Dr. Allen's we have:

	Dr. Allen's	Our Average Value	% of our value to Dr. Allen's
Sneeze	2.9	1.649	57%
Cough	3.5	1.215	35%
Slap on back	4.1	1.589	39%
Hop off step	8.1	5.471	68%
Plop down on chair	10.1	4.958	49%

Head/Neck Kinematic Response of Human Subjects in Low-Speed Rear-End Collisions

Gunter P. Siegmund, David J. King, and Jonathan M. Lawrence
MacInnis Engineering Associates

Jeffrey B. Wheeler, John R. Brault, and Terry A. Smith
Biomechanics Research & Consulting, Inc.



Evaluating the Uncertainty in Various Measurement Tasks Common to Accident Reconstruction

2002-01-0546

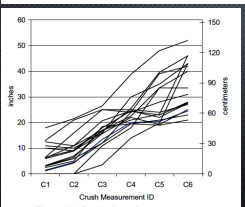


Figure 18: Residual crush measurement profiles recorded by 17 participants.

Figure 19: Single photograph used for speed/crush estimate.

EBS, mph (kph)	# of responses
6 – 10 (9.7-16.1)	2
11 – 15 (17.7-24.2)	12
16 - 20 (25.8-32.2)	16
21 - 25 (33.8-40.3)	14
26 - 30 (41.9-48.3)	5

Table 6: Crush estimates from a single photograph.

Evaluating the Uncertainty in Various Measurement Tasks Common to Accident Reconstruction

2002-01-0546

Figures 20a and 20b: Two photographs used together for one crush estimation exercise.

In the two-photograph exercise, 52 participants provided 8 crush estimates and 51 EBS estimates. The average estimated crush was 13.1 inches with a standard deviation of 3.3 inches. The EBS results are given in Table 7.

EBS, mph (kph)	# of responses
11 – 15 (17.7 - 24.2)	5
16 - 20 (25.8 - 32.2)	12
21 - 25 (33.8 - 40.3)	18
26 - 30 (41.9 - 48.3)	12
31 – 35 (49.9 - 56.4)	3
36 – 40 (58.0 - 64.4)	0
41 - 45 (66.0 - 72.5)	1

Table 7: Crush depth estimates from two photographs.

Evaluating the Uncertainty in Various Measurement Tasks Common to Accident Reconstruction

2002-01-0546

MEASURING VEHICLE CRUSH

The amount of deformation a vehicle sustains is often of interest to a reconstructionist conducting an energy-based accident analysis. While the vehicle itself is sometimes available for measurement, reconstruction-ists are occasionally asked to determine deformation depths from one or more photographs. Experiments examining the variation involved in each of these methods of crush measurement and estimation are described below.

Most of the participants in this exercise reported that they would not attempt to use information generated in this fashion in a reconstruction without additional details and analysis.

NEWTON'S FIRST LAW OF MOTION

I. EVERY OBJECT AT REST TENDS TO REMAIN AT REST AND EVERY OBJECT IN A STATE OF MOTION TENDS TO REMAIN IN THAT STATE OF MOTION UNLESS AN EXTERNAL FORCE IS APPLIED TO IT.

GALILEO'S *LAW OF INERTIA*

WE TREAT "INERTIAL INJURIES"

NEWTON'S SECOND LAW OF MOTION

II. THE RELATIONSHIP BETWEEN AN OBJECTS MASS (*M*), IT'S ACCELERATION (*A*) AND THE APPLIED FORCE (F) CAN BE STATED AS $F = MA$ $(N = KG \times M/S^2)$

ARISTOTLE STATED $F = MV$, MEANING THERE IS ONLY VELOCITY IF THERE IS FORCE. *THIS IS CONVENTIONAL WISDOM, HOWEVER, IT IS WRONG.*

ESTIMATE *F* OF COLLISION IN YOUR FINAL REPORT

NEWTON'S THIRD LAW OF MOTION

III. FOR EVERY ACTION, THERE IS AN EQUAL AND OPPOSITE REACTION.

WHEN TWO VEHICLES COLLIDE, ALL VEHICLES ABSORB THE IMPACT OF THE COLLISION. THEREFORE, YOU NEED TO GET PICTURES OF THE OTHER VEHICLE(S) INVOLVED IN THE COLLISION. THIS IS NOT PROPORTIONAL.

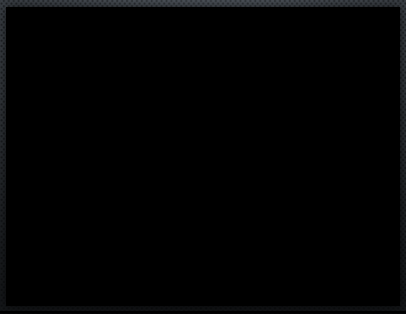
CONSERVATION OF ENERGY

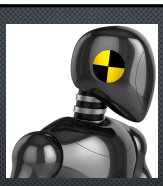
ENERGY CAN BE NEITHER CREATED NOR DESTROYED; RATHER, IT TRANSFORMS FROM ONE FORM TO ANOTHER.

THEREFORE, WHEN A COLLISION OCCURS, THERE IS A TRANSFER OF FORCE BETWEEN TWO VEHICLES EVEN WHEN THERE IS NO PROPERTY DAMAGE.

"CRUSHING CAN BE GOOD"

CONSERVATION OF ENERGY

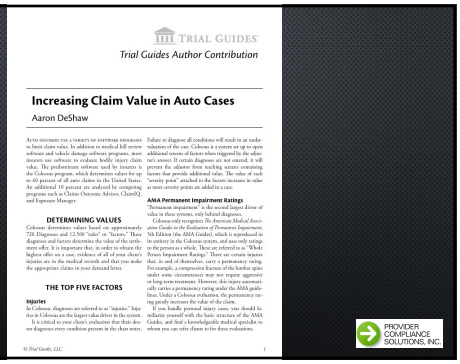




LESSON 2: DOCUMENTATION REQUIRED BEFORE THE FIRST VISIT

VALUE DRIVERS IN COLOSSUS

1. INJURIES (DIAGNOSIS)
2. DUTIES UNDER DURESS
3. LOSS OF ENJOYMENT OF LIFE
4. PROGNOSIS
5. FUTURE MEDICAL TREATMENT
6. IMPAIRMENT RATING – PLACE AT STATIC MMI



TRIAL GUIDES

Trial Guides Author Contribution

Increasing Claim Value in Auto Cases

Aaron DeShaw

Auto insurers use a variety of software programs to limit claim value. In addition to medical bill review software and vehicle damage software programs, most insurers use software to evaluate bodily injury claim value. The predominant software used by insurers is the Colossus program, which determines values for up to 60 percent of all auto claims in the United States. An additional 10 percent are analyzed by competing programs such as Claims Outcome Advisor, ClaimIQ, and Exposure Manager.

DETERMINING VALUES

Colossus determines values based on approximately 720 Diagnoses and 12,500 "Codes" or "factors." These diagnoses and factors determine the value of the settlement offer. It is important that, in order to obtain the highest offer on a case, evidence of all of your client's injuries are in the medical records and that you make the appropriate claims in your demand letter.

THE TOP FIVE FACTORS

Injuries

In Colossus, diagnoses are referred to as "injuries." Injuries in Colossus are the largest value driver in the system.

It is critical to your client's evaluation that their doctor diagnoses every condition present in the client soon. Failure to diagnose all conditions will result in an undervaluation of the case. Colossus is a system set up to open additional screens of factors when triggered by the adjuster's answer. If certain diagnoses are not entered, it will prevent the adjuster from reaching screens containing factors that provide additional value. The value of each "severity point" attached to the factors increases in value as more severity points are added in a case.

AMA Permanent Impairment Ratings

"Permanent impairment" is the second largest driver of value in these systems, only behind diagnoses.

Colossus only recognizes *The American Medical Association Guides to the Evaluation of Permanent Impairment*, 5th Edition (the AMA Guides), which is reproduced in its entirety in the Colossus system, and uses only ratings to the person as a whole. These are referred to as "Whole Person Impairment Ratings." There are certain injuries that, in and of themselves, carry a permanency rating. For example, a compression fracture of the lumbar spine under some circumstances may not require aggressive or long-term treatment. However, this injury automatically carries a permanency rating under the AMA guidelines. Under a Colossus evaluation, the permanency rating greatly increases the value of the claim.

If you handle personal injury cases, you should familiarize yourself with the basic structure of the AMA Guides, and find a knowledgeable medical specialist to whom you can refer clients to for these evaluations.

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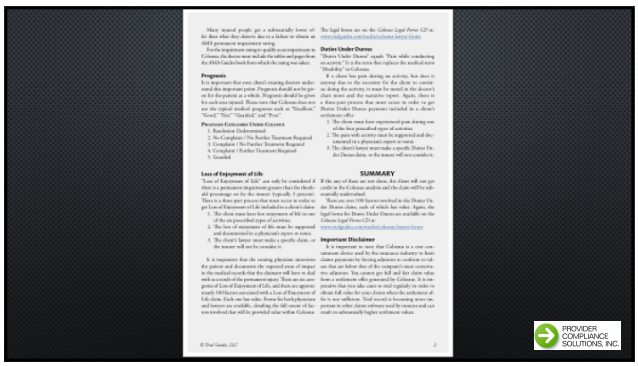
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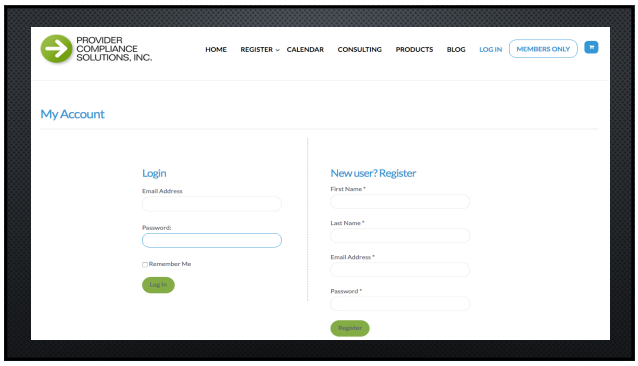
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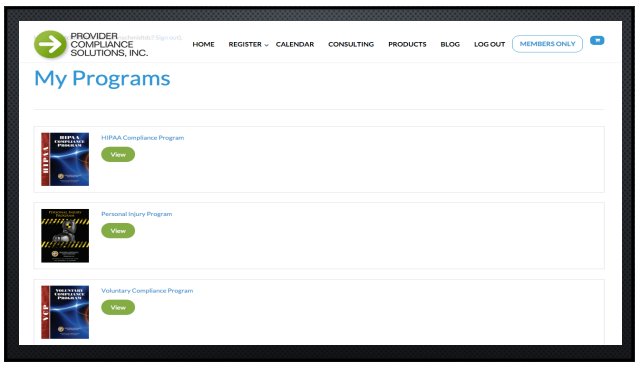
Log In
New user? Register
First Name *
Last Name *
Email Address *
Password *
Register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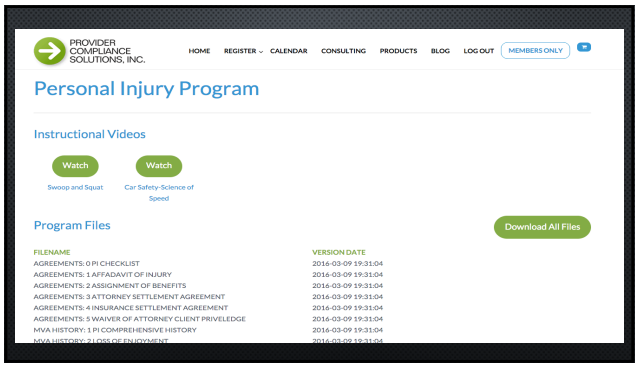
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Instructional Videos
Watch
Swoop and Squat
Watch
Car Safety-Science of Speed
Program Files
Download All Files
FILENAME
VERSION DATE
AGREEMENTS: 0 PI CHECKLIST
2016-03-09 19:31:04
AGREEMENTS: 1 AFFADAVIT OF INJURY
2016-03-09 19:31:04
AGREEMENTS: 2 ASSIGNMENT OF BENEFITS
2016-03-09 19:31:04
AGREEMENTS: 3 ATTORNEY SETTLEMENT AGREEMENT
2016-03-09 19:31:04
AGREEMENTS: 4 INSURANCE SETTLEMENT AGREEMENT
2016-03-09 19:31:04
AGREEMENTS: 5 WAIVER OF ATTORNEY CLIENT PRIVELEDGE
2016-03-09 19:31:04
MVA HISTORY: 1 PI COMPREHENSIVE HISTORY
2016-03-09 19:31:04


[NAME OF CLINIC]
[Address]
[Address]
[Phone]
[Fax]
AFFIDAVIT OF INJURY
I hereby affirm that I sustained injuries as a result of an incident on _____.
No one has offered or given me any money, incentive, remuneration, anything of value, or any other form of inducement for the purposes of treating at this clinic.
No one has made any promises or guarantees with regard to my medical treatment or any other aspect of my case. I understand that I have a choice regarding where I seek treatment for my injuries, and I have chosen, of my own free will, to seek treatment at this clinic.
Signature of patient and/or responsible parties
Signature on behalf of Provider
NOTARIZED BEFORE ME
Sworn to and subscribed before me by _____ on
Notary Public in and for:
The State of:
My commission expires:

OFFICE NAME
Address 1
Address 2
City, State Zip
Phone
Fax
Email

WAIVER OF ATTORNEY/CLIENT PRIVELEDGE

In the event that my attorney asks to reduce the final medical bills of [DR. NAME] and [DOCTORS OFFICE] for injuries sustained on ____________________, I hereby authorize my attorney to release a true and complete copy of the financial disbursement sheet that shows the full amount offered or agreed upon at settlement as well as a listing of all attorney fees, lost wages, medical expenses and/or any other payee and amount payable relating to my case.

THIS ASSIGNMENT AND CONTRACTUAL LIEN IS IRREVOCABLE UNLESS BOTH THE PROVIDER AND I AGREE TO REVOKE IT IN WRITING.

By my signature, I acknowledge that I have carefully read and fully understand the above document and acknowledge that it is a valid and irrevocable Waiver of Attorney/Client Privilege.

____
Signature of patient and/or responsible parties

____
Signature on behalf of Provider

NOTARIZED BEFORE ME

Sworn to and subscribed before me by ______________________ on

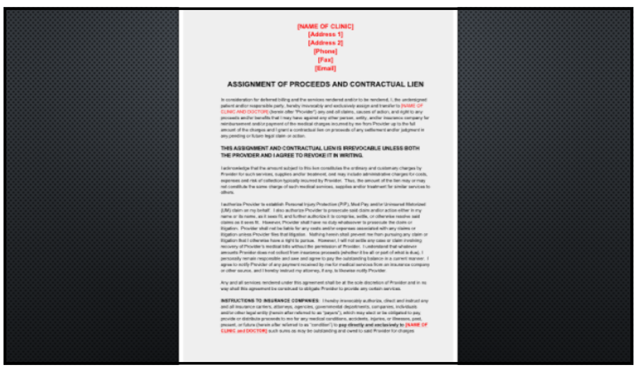
______________________________, 20___.

____

☐ Notary Public in and for:

☐ The State of:

☐ My commission expires:

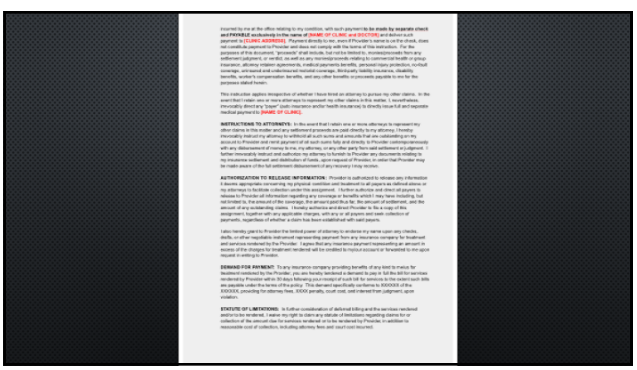


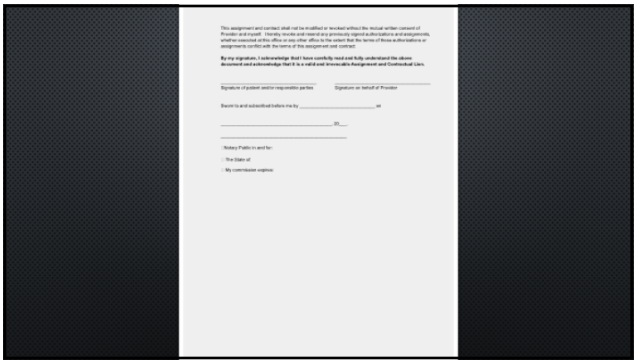
[NAME OF CLINIC]
[Address 1]
[Address 2]
[Phone]
[Fax]
[Email]

ASSIGNMENT OF PROCEEDS AND CONTRACTUAL LIEN

THIS ASSIGNMENT AND CONTRACTUAL LIEN IS IRREVOCABLE UNLESS BOTH THE PROVIDER AND I AGREE TO REVOKE IT IN WRITING.

INSTRUCTIONS TO INSURANCE COMPANIES:





This assignment and contract shall not be modified or revoked without the mutual written consent of Provider and myself. I hereby revoke and rescind any previously signed authorizations and assignments, whether executed at this office or any other office to the extent that the terms of those authorizations or assignments conflict with the terms of this assignment and contract.

By my signature, I acknowledge that I have carefully read and fully understand the above document and acknowledge that it is a valid and irrevocable Assignment and Contractual Lien.

Signature of patient and/or responsible parties Signature on behalf of Provider

Sworn to and subscribed before me by _____ on

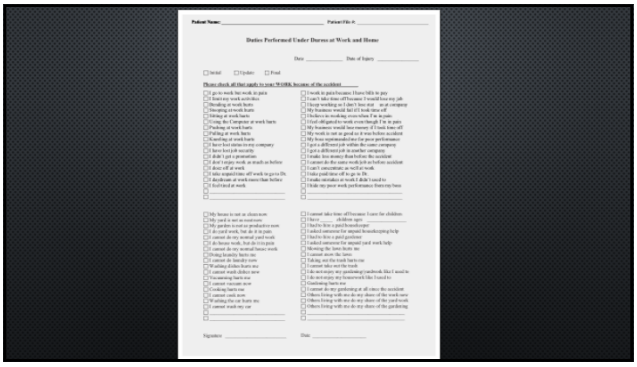
_____, 20__.

_____

Notary Public in and for:

The State of

My commission expires:



Patient Name: _____ **Patient File #:** _____

Duties Performed Under Duress at Work and Home

Date _____ Date of Injury _____

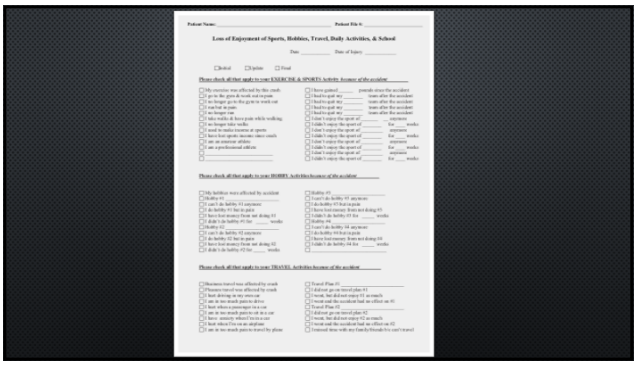
☐ Initial ☐ Update ☐ Final

Please check all that apply to your WORK become of the accident _____

- ☐ I go to work but work in pain
- ☐ I lost my work activities
- ☐ Bending at work hurts
- ☐ Sleeping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the Computer at work hurts
- ☐ Lifting at work hurts
- ☐ Pulling at work hurts
- ☐ Standing at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I have lost responsibility
- ☐ I don't enjoy work as much as before
- ☐ I keep off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ _____
- ☐ _____
- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working as I don't love my at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ I have been reprimanded since the accident
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I was demoted since the accident
- ☐ I cannot do the same work job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't used to
- ☐ I think my poor work performance from my boss
- ☐ _____
- ☐ _____

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ I cannot do my normal indoor work
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ I cannot do laundry
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot wash dishes now
- ☐ Vacuuming hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ _____
- ☐ _____
- ☐ I cannot take time off because I care for children
- ☐ I have _____ children ages _____
- ☐ I cannot afford a housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ I cannot do my gardening as much as I did before
- ☐ Others living with me do my share of the yard work
- ☐ Others living with me do my share of the gardening
- ☐ _____
- ☐ _____

Signature _____ Date _____



Patient Name: _____ **Patient File #:** _____

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School

Date _____ Date of Injury _____

☐ Initial ☐ Update ☐ Final

Please check all that apply to your EXERCISE & SPORTS Activity become of the accident _____

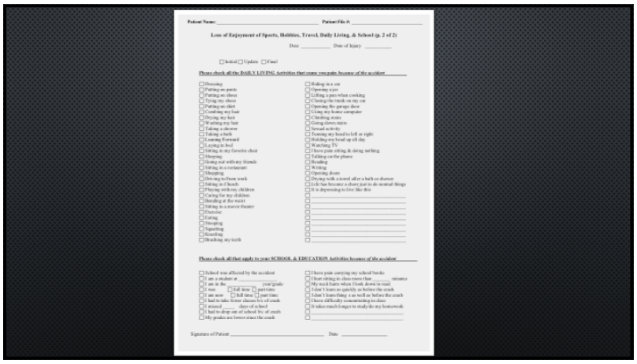
- ☐ My exercise was affected by this crash
- ☐ I go to the gym & work out regular
- ☐ I no longer go to the gym to work out
- ☐ I run long & runs
- ☐ I run short runs
- ☐ I take walks & have pain while walking
- ☐ I no longer take walks
- ☐ I used to make income at sports
- ☐ I have lost sports income since crash
- ☐ I am an amateur athlete
- ☐ I am a professional athlete
- ☐ _____
- ☐ _____
- ☐ I have quitted _____ pounds since the accident
- ☐ I had to quit my _____ years after the accident
- ☐ I had to quit my _____ years after the accident
- ☐ I had to quit my _____ years after the accident
- ☐ I had to quit my _____ years after the accident
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for _____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for _____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for _____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for _____ weeks

Please check all that apply to your HOBBY Activities become of the accident _____

- ☐ My hobbies were affected by accident
- ☐ Hobby #1
- ☐ I can't do hobby #1 anymore
- ☐ I do hobby #1 but in pain
- ☐ I have lost money from not doing #1
- ☐ I didn't do hobby #1 for _____ weeks
- ☐ Hobby #2
- ☐ I can't do hobby #2 anymore
- ☐ I do hobby #2 but in pain
- ☐ I have lost money from not doing #2
- ☐ I didn't do hobby #2 for _____ weeks
- ☐ Hobby #3
- ☐ I can't do hobby #3 anymore
- ☐ I do hobby #3 but in pain
- ☐ I have lost money from not doing #3
- ☐ I didn't do hobby #3 for _____ weeks
- ☐ Hobby #4
- ☐ I can't do hobby #4 anymore
- ☐ I do hobby #4 but in pain
- ☐ I have lost money from not doing #4
- ☐ I didn't do hobby #4 for _____ weeks

Please check all that apply to your TRAVEL Activities become of the accident _____

- ☐ Business travel was affected by crash
- ☐ Pleasure travel was affected by crash
- ☐ I feel driving in my own car
- ☐ I feel driving in my own truck
- ☐ I feel when a passenger in a car
- ☐ I am in too much pain to sit in a car
- ☐ I have anxiety when I'm in a car
- ☐ I feel when I'm on an airplane
- ☐ I am in too much pain to travel by plane
- ☐ Travel Plan #1
- ☐ I did/not go on travel plan #1
- ☐ I went, but did not enjoy #1 as much
- ☐ I went and the accident had no effect on #1
- ☐ Travel Plan #2
- ☐ I did/not go on travel plan #2
- ☐ I went, but did not enjoy #2 as much
- ☐ I went and the accident had no effect on #2
- ☐ I missed time with my family/friends b/c can't travel



Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)

Date _____ Date of Injury _____

☐ Initial ☐ Update ☐ Final

Please check all the DAILY LIVING Activities that cause you pain because of the accident _____

☐ Showering	☐ Making tea a cup
☐ Putting on pants	☐ Opening a jar
☐ Putting on shoes	☐ Lifting a pan when cooking
☐ Tying my shoes	☐ Closing the trunk on my car
☐ Combing my hair	☐ Opening the car door
☐ Washing my hair	☐ Using my home computer
☐ Drying my hair	☐ Climbing stairs
☐ Washing my hair	☐ Going down stairs
☐ Taking a shower	☐ Sexual activity
☐ Sitting in a chair	☐ Turning my head to left or right
☐ Leaning Forward	☐ Holding my head up all day
☐ Laying in bed	☐ Watching TV
☐ Sitting in my favorite chair	☐ I have pain sitting & doing nothing
☐ Shopping	☐ Talking on the phone
☐ Visiting with my friends	☐ Reading
☐ Sitting in a restaurant	☐ Writing
☐ Shopping	☐ Opening door
☐ Driving to/from work	☐ Drying with a towel after a bath or shower
☐ Sitting in Church	☐ Life has become a chore just to do normal things
☐ Playing with my children	☐ It is depressing to live like this
☐ Caring for my children	☐ _____
☐ Bending at the waist	☐ _____
☐ Sitting in a movie theater	☐ _____
☐ Exercise	☐ _____
☐ Sleeping	☐ _____
☐ Sleeping	☐ _____
☐ Squatting	☐ _____
☐ Kneeling	☐ _____
☐ Brushing my teeth	☐ _____

Please check all that apply to your SCHOOL & EDUCATION Activities because of the accident _____

☐ School was affected by the accident	☐ I have pain carrying my school books
☐ I am a student at _____	☐ I have sitting in class more than _____ minutes
☐ I am in the _____ year/grade	☐ My neck hurts when I look down to read
☐ I am a ☐ full-time ☐ part-time student	☐ I have difficulty writing for long periods
☐ I am now ☐ full-time ☐ part-time	☐ I don't learn/play a as well as before the crash
☐ I had to take home classes b/c of crash	☐ I have difficulty concentrating in class
☐ I missed _____ days of school	☐ It takes much longer to study/do my homework
☐ I had to drop out of school b/c of crash	☐ _____
☐ My grades are lower since the crash	☐ _____

Signature of Patient _____ Date: _____

OFFICE NAME

Patient: _____ Date: _____

Date of Injury: _____

PROGNOSIS

☐ The future prognosis for this patient is undetermined.

☐ There are no ongoing complaints and no additional treatment is being prescribed.

☐ The patient continues to complain of _____, but no additional treatment is being prescribed.

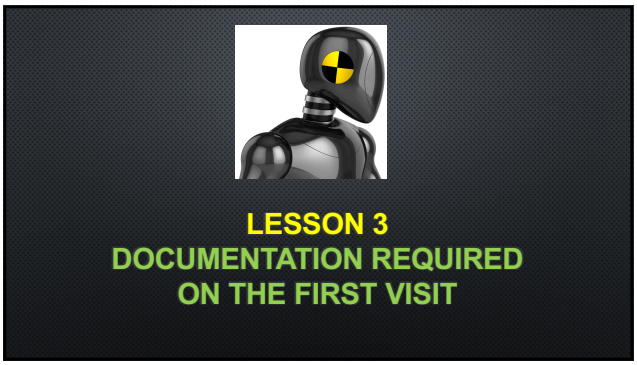
☐ The patient continues to complain of _____, and the following additional treatment has been

- ☐ Therapeutic Procedures (i.e. exercise, rehabilitation)
- ☐ Manipulation/ Manual Therapy
- ☐ Durable Medical Equipment
- ☐ Home Exercises
- ☐ Other _____

☐ The patient continues to complain of _____ and the future prognosis is guarded.

Doctor's Name (printed) _____

Doctor's Name (signature) _____



LESSON 3
DOCUMENTATION REQUIRED ON THE FIRST VISIT

EVALUATION & MANAGEMENT

New Patient:

- Someone that HAS NOT received professional services
- In an office, or
- By one of the providers
- In the previous THREE (3) YEARS.

EVALUATION & MANAGEMENT

Established Patient:

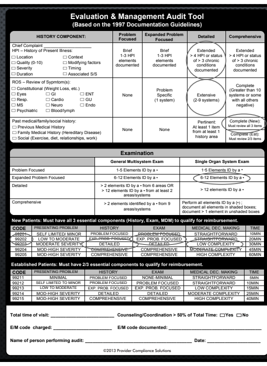
- Someone that HAS received professional services
- In an office, or
- By one of the providers
- In the previous THREE (3) YEARS.

EVALUATION & MANAGEMENT

- 99201
- 99202
- 99203
- 99204
- 99205
- 99211
- 99212
- 99213
- 99214
- 99215

TIME

- If the majority of time
- is spent coordinating care with another provider, or
- counseling the patient and/or immediate family member about the patients condition
- The total time of the visit is considered the key factor.



CODE	HISTORY	EXAM	MDM	TIME
99201	PF	PF	SF	10
99202	EPF	EPF	SF	20
99203	DET	DET	LOW	30
99204	COMP	COMP	MOD	45
99205	COMP	COMP	HIGH	60

CODE	HISTORY	EXAM	MDM	TIME
99201	PF	PF	SF	10
99202	EPF	EPF	SF	20
99203	DET	**DET**	LOW	30
99204	**COMP**	COMP	**MOD**	45
99205	COMP	COMP	HIGH	60

CODE	HISTORY	EXAM	MDM	TIME
99201	PF	PF	SF	10
99202	EPF	EPF	SF	20
99203	DET	**DET**	LOW	30
99204	**COMP**	COMP	**MOD**	45
99205	COMP	COMP	HIGH	60

CODE	HISTORY	EXAM	MDM	TIME
99201	PF	PF	SF	10
99202	EPF	EPF	SF	20
99203	DET	**DET**	LOW	30
99204	**COMP**	COMP	**MOD**	45
99205	COMP	COMP	HIGH	60

CODE	HISTORY	EXAM	MDM	TIME
99201	PF	PF	SF	10
99202	EPF	EPF	SF	20
99203	DET	DET	LOW	30
99204	COMP	COMP	MOD	45
99205	COMP	COMP	HIGH	60

CODE	HISTORY	EXAM	MDM	TIME
99201	PF	PF	SF	10
99202	EPF	EPF	SF	20
99203	DET	DET	LOW	30
99204	COMP	COMP	MOD	45
99205	COMP	COMP	HIGH	60

CODE	HISTORY	EXAM	MDM	TIME
99211	PF	PF	SF	5
99212	PF	PF	SF	10
99213	EPF	EPF	LOW	15
99214	DET	DET	MOD	25
99215	COMP	COMP	HIGH	40

CODE	HISTORY	EXAM	MDM	TIME
99211	PF	PF	SF	5
99212	PF	PF	SF	10
99213	EPF	EPF	LOW	15
99214	DET	DET	MOD	25
99215	COMP	COMP	HIGH	40

CODE	HISTORY	EXAM	MDM	TIME
99211	PF	PF	SF	5
99212	PF	PF	SF	10
99213	EPF	EPF	LOW	15
99214	DET	DET	MOD	25
99215	COMP	COMP	HIGH	40

HISTORY & EXAM

- PROPERTY DAMAGE – INDEPENDENT ESTIMATE, OEM PARTS
- AWARE OF THE ACCIDENT – #1 PREDICTOR OF LONG TERM PAIN
- POSITION IN VEHICLE, SEAT BELT, FOOT ON BRAKE, ETC.
- PRIOR TREATMENT – ER, HOSPITAL, MEDICATION, TENS, DME
- DOCUMENT ALL INJURIES – LOOK FOR TBI
- PAST TREATMENT IN YOUR OFFICE – WITHIN 3 YEARS?
- BILL THE ACCURATE E/M CODE – RARELY CAN BILL A 99204/99214

HISTORY & EXAM

- Range of Motion loss (this one is huge)
- Headaches (need duration and frequency)
- Dizziness (usually experienced right after accident; also big, linked to visual disturbance; can be recognized as form of Tinnitus)
- Anxiety (linked to depression and sleep disturbance)
- Radiating Pain – Must be validated

DIAGNOSIS

- #2 "value driver" in Colossus
- Use ICD-10 – Got to ICD10data.com
- Diagnose to the highest specificity – Revise if necessary
- Estimated that 40% of patients have ligamentous laxity
- Take AP and lateral first – Then flexion/extension
- Impairment potential – Dramatically increase the value
- Diagnostic Testing – MRI/CT, X-ray, sEMG, DMX, Digitizing

OUTCOME ASSESSMENTS

- Used to help determine treatment effectiveness
- Colossus outcome assessments – DUD, LOE
- Condition specific questionnaires – Oswestry, NDI, HDI
- Pain scales – McGill pain questionnaire
- Range of motion – Inclinometer and goniometers
- sEMG – DynaROM by MyoVision, p. 45 AMA Guides to ROM
- Computerized digitization

DUTIES UNDER DURESS AND LOSS OF ENJOYMENT OF LIFE

- Colossus questionnaires
- Significant "Value Drivers"
  - DUD: Over 100 questions. Each have a value
- Perform at a minimum every 30 days
- Give at beginning, during and end of treatment

SOAP NOTES & PROGNOSIS

- SOAP notes – Chief data source
  - Legible and complete; gaps in care
- Prognosis – Perform every 2 to 4 weeks
- Use regular terms as well as Colossus terminology
- Uncertain – let them know why
- Proposed treatment
- Expected outcome – Be detailed. Dictation is best

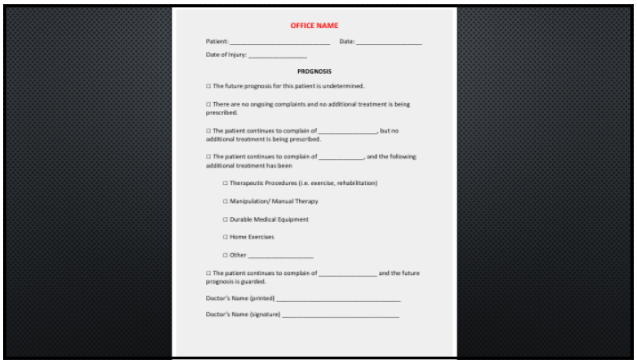
S: The patient presented today with continuing complaints of neck pain which she rated as 3/10. She stated that treatment in out office has improved her condition. She can sleep longer at night and is able to do more daily activities without as much pain. She still can not play tennis.

O: Fixations were noted at C2, C4 and C7. There was tenderness noted in the cervical at C5 on the left. Muscle spasms were noted in the cervical spine bilaterally. Range of motion was limited in the cervical spine on L lateral flexion and L and R rotation.

A: The patient is continuing to improve but still has some functional limitations and pain.

P: The patient received a diversified manipulation to the cervical. The patient tolerated the treatment well. This service was performed by the undersigned provider. This was billed as 98940.

She also received ice massage to the cervical spine for 30 minutes. The calculated time included the intra-service only. This was provided by a licensed massage therapist under the supervision of the undersigned licensee. The purpose of the massage was to decrease swelling and reduce muscle spasm rather than increase the extensibility of the muscle fibers, therefore, it was billed as 97124 rather than 97140.



OFFICE NAME

Patient: _____ Date: _____

Date of Injury: _____

PROGNOSIS

☐ The future prognosis for this patient is undetermined.

☐ There are no ongoing complaints and no additional treatment is being prescribed.

☐ The patient continues to complain of _____, but no additional treatment is being prescribed.

☐ The patient continues to complain of _____, and the following additional treatment has been

- ☐ Therapeutic Procedures (i.e. exercise, rehabilitation)
- ☐ Manipulation/ Manual Therapy
- ☐ Durable Medical Equipment
- ☐ Home Exercises
- ☐ Other _____

☐ The patient continues to complain of _____ and the future prognosis is guarded.

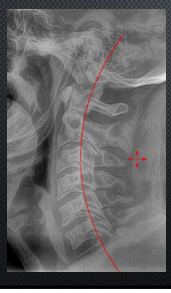
Doctor's Name (printed) _____

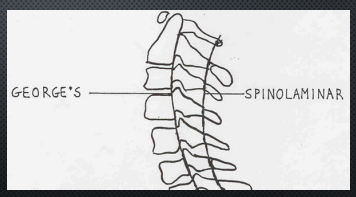
Doctor's Name (signature) _____

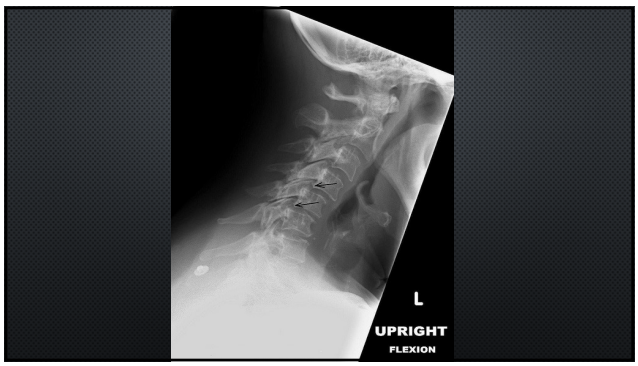
FUTURE MEDICAL TREATMENT

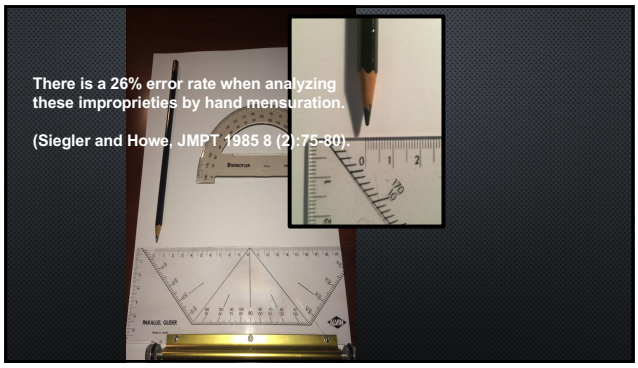
- PLACE PATIENT AT "STATIC MMI"
  - IF NOT, THERE WILL BE NO FUTURE MEDICAL ALLOWED
- BE SURE TO REFER TO AN MD/DO TO "BOOKEND" TREATMENT
- ESTIMATE ALL TREATMENT THAT THE PATIENT MAY LIKELY NEED
- THERAPY, COUNSELING FOR TBI, MANIPULATION, SURGERY
- MUST BE WITHIN 2 YEARS OF STATIC MMI DATE
- STATE "THIS IS TO A REASONABLE DEGREE OF MEDICAL CERTAINTY"

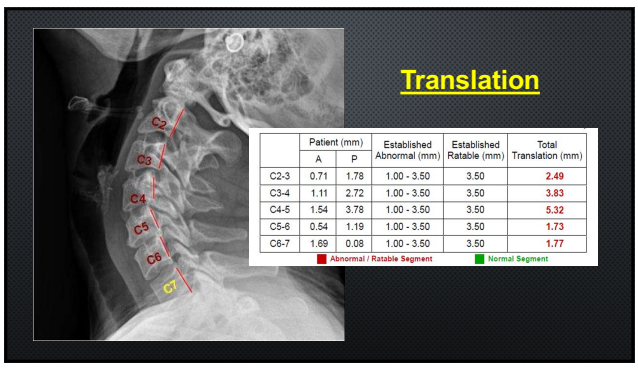
George's Line, since 1919, is relevant to ascertaining alignment in order to detect post-traumatic cervical injuries.





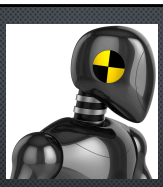

L
UPRIGHT
FLEXION


There is a 26% error rate when analyzing these improprieties by hand mensuration.
(Siegler and Howe, JMPT 1985 8 (2):75-80).

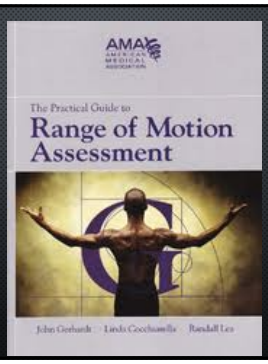

Translation
C2
C3
C4
C5
C6
C7
Patient (mm)
A
P
Established Abnormal (mm)
Established Ratable (mm)
Total Translation (mm)
C2-3 0.71 1.78 1.00 - 3.50 3.50 2.49
C3-4 1.11 2.72 1.00 - 3.50 3.50 3.83
C4-5 1.54 3.78 1.00 - 3.50 3.50 5.32
C5-6 0.54 1.19 1.00 - 3.50 3.50 1.73
C6-7 1.69 0.08 1.00 - 3.50 3.50 1.77
Abnormal / Ratable Segment
Normal Segment

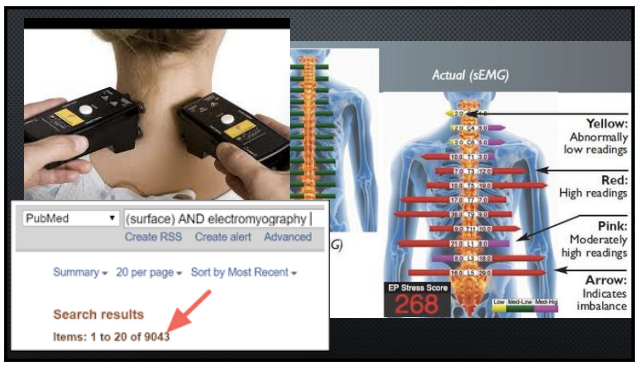
DRE CATEGORY IV

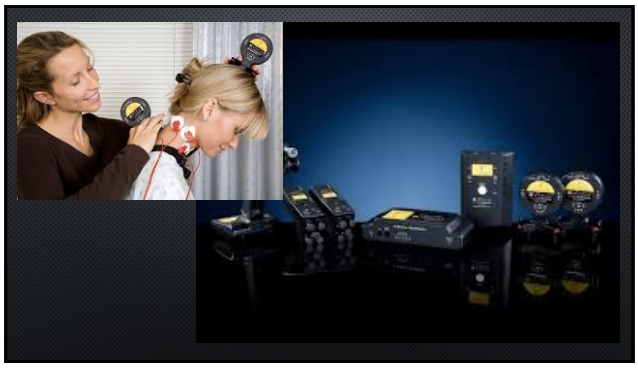
- 5TH EDITION OF AMA GUIDES
- CATEGORY IV 25-28%
- **AOMSI** EVIDENCE ABOVE THE THRESHOLD OF TRANSLATION GREATER THAN:
- CERVICAL: 3.5 MM OR ANGULATION > 11 DEGREES.
- THORACIC: > 2.5 (NO ANGULATION)
- LUMBAR: > 4.5 MM TRANSLATION (ANGULATION VARIES)

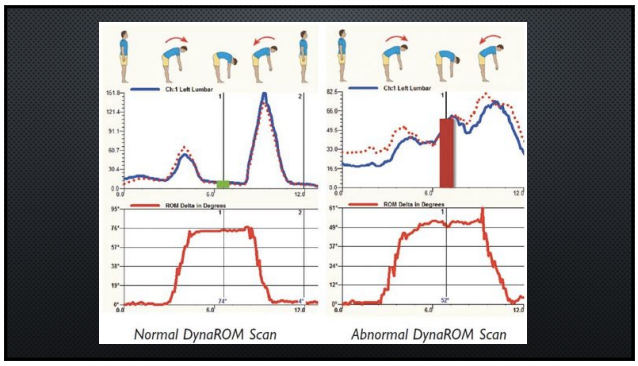


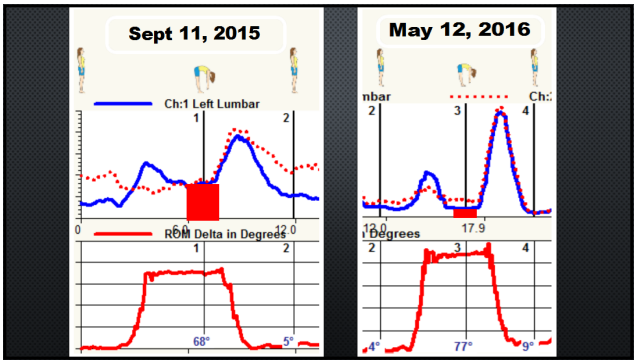
LESSON 4
MEASURING BASELINE FUNCTION UTILIZING OUTCOME ASSESSMENTS




PubMed
(surface) AND electromyography
Create RSS
Create alert
Advanced
Summary
20 per page
Sort by Most Recent
Search results
Items: 1 to 20 of 9043
Actual (sEMG)
Yellow:
Abnormally low readings
Red:
High readings
Pink:
Moderately high readings
Arrow:
Indicates imbalance
EP Stress Score
268




Normal DynaROM Scan
Abnormal DynaROM Scan



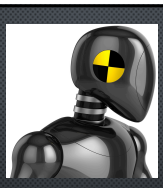
Date Of Service(s) From	Thru	Procedure/Revenue/NDC Code/Modifier	Description	Units	Billed Amount	Covered Amount
02/27/15	02/27/15	98940	Chiropractic manipulativ	1.00	$ 60.00	$ 60.00
02/27/15	02/27/15	96002	Dynamic surface electrom	1.00	$ 41.05	$ 41.05
02/27/15	02/27/15	96004	Review and interpretatio	1.00	$ 216.51	$ 216.51
Total:					$ 317.56	$ 317.56

FIRST VISIT

- LETTER OF PROTECTION (LIEN)
- ASSIGNMENT OF BENEFITS (PIP/MED PAY)
- ATTORNEY SETTLEMENT AGREEMENT
- AFFIDAVIT OF INJURY
- PATIENT HISTORY
- EXAM (NEUROMUSCULOSKELETAL)
- MDM
- EM CODES FOR EXAM, X-RAYS AND TREATMENT

SECOND VISIT
PHYSICAL PERFORMANCE TESTING

- Measure baseline function (97750 – each 15 min)
- Dynamic sEMG (96002 and 96004)
- Range of motion
- Muscle testing
- Duties under duress
- Loss of enjoyment of life
- Pain questionnaire
- Condition specific questionnaire



LESSON 5
MANIPULATION AND THERAPEUTIC PROCEDURES

Chiropractic Manipulative Treatment

Chiropractic manipulative treatment (CMT) is a form of manual treatment to influence joint and neurophysiological function. This treatment may be accomplished using a variety of techniques.

The chiropractic manipulative treatment codes include a pre-manipulation patient assessment. Additional Evaluation and Management services may be reported separately using modifier 25, if the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure. The E/M service may be caused or prompted by the same symptoms or

98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions *CPT Assistant* Jan 97:7, 11, Feb 99:10, Dec 00:15, Mar 06:15, Dec 07:16, 17, Oct 09:10
98941	spinal, 3-4 regions *CPT Assistant* Jan 97:7, 11, Mar 97:10, Feb 99:10, Dec 00:15, Mar 06:15, Dec 07:16, 17, Oct 09:10
98942	spinal, 5 regions *CPT Assistant* Jan 97:7, 11, Feb 99:10, Dec 00:15, Mar 06:15, Dec 07:16, 17, Oct 09:10
98943	extraspinal, 1 or more regions *CPT Assistant* Jan 97:7, 11, Mar 97:10, Feb 99:10, Dec 00:15, Mar 06:15, Dec 07:16, 17, Oct 09:10

In the January 1997 edition of the CPT Assistant on page 11 the following is included:

"Who can report the Osteopathic Manipulative Treatment codes (98925-98929) and the Chiropractic Manipulative Treatment codes (98940-98943)? Are the OMT codes restricted for use by osteopathic physicians and the CMT codes restricted for use by chiropractic physicians?

AMA Comment

It is important to recognize that the listing of a service or procedure and its code number in a specific section of the CPT code book does not restrict its use to a specific specialty group. Any procedure or service in any section of the CPT coding manual may be used to designate the services rendered by any qualified physician. Therefore, the osteopathic manipulative treatment codes and the chiropractic manipulative treatment codes can be reported by any physician who is qualified to perform these types of manipulation. No distinction is made concerning the physician's licensure or professional credential. Licensure and credentialing vary on a state-by-state and institutional basis."

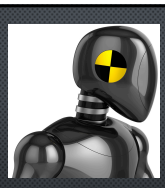
Osteopathic Manipulative Treatment

Osteopathic manipulative treatment (OMT) is a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.

thoracic region; lumbar region; sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.

CPT Assistant Nov 98:37-38

98925	Osteopathic manipulative treatment (OMT); 1-2 body regions involved *CPT Assistant* May 96:10, Jan 97:8, 10, Jul 98:10, Aug 00:11, Dec 00:15, Oct 09:10
98926	3-4 body regions involved *CPT Assistant* May 96:10, Jan 97:8, Aug 00:11, Dec 00:15, Oct 09:10
98927	5-6 body regions involved *CPT Assistant* May 96:10, Jan 97:8, Aug 00:11, Dec 00:15, Oct 09:10
98928	7-8 body regions involved *CPT Assistant* May 96:10, Jan 97:8, Aug 00:11, Dec 00:15, Oct 09:10
98929	9-10 body regions involved *CPT Assistant* May 96:10, Jan 97:8, 10, Aug 00:11, Oct 09:10



LESSON 5
MANIPULATION AND THERAPEUTIC PROCEDURES

CPT INTRODUCTION

- PROVIDERS ARE TO BILL THE SERVICE OR PROCEDURE THAT ~~MOST~~ ACCURATELY DESCRIBES THE LEVEL OF SERVICE PROVIDED.
- DO NOT APPROXIMATE
- USE UNLISTED CODE IN EACH SECTION
  - 97039 UNLISTED MODALITY

CPT USAGE IN PERSONAL INJURY

- USE THE CODES AS THEY ARE DEFINED IN THE CPT CODE BOOK.
- IF YOU ARE AN IN-NETWORK PROVIDER FOR ANY INSURANCE PLAN YOU MAY END UP TAKING A REDUCTION IN YOUR PIP AND MED-PAY BILLS.
- IF PATIENT USES COMMERCIAL INSURANCE OR MEDICARE YOU CAN NOT BALANCE BILL

"ONE ON ONE" DEFINITION

- THE PROVIDER MUST MAINTAIN:
  - VERBAL
  - VISUAL, AND OR
  - ACTUAL CONTACT
- WITH THE PATIENT THROUGHOUT THE PROCEDURE

THERAPEUTIC MODALITIES

SUPERVISED MODALITIES

- NO ONE-ON-ONE
- MUST BE ONSITE
- MAY BE DELEGATED
  - ICE/HEAT
  - UNATTENDED EMS
- CODES ARE NOT TIMED
- CAN ONLY BILL 1 UNIT

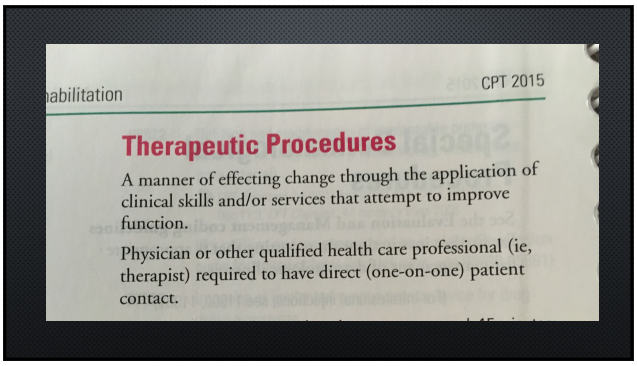
CONSTANT ATTENDANCE

- ONE-ON-ONE
- MUST BE ONSITE
- MAY BE DELEGATED
  - ULTRASOUND
  - ATTENDED EMS
- THESE CODES ARE TIMED
- ONE UNIT 8 PLUS MIN

Therapeutic Procedures

A manner of effecting change through the application of clinical skills and/or services that attempt to improve function.

Physician or therapist required to have direct (one-on-one) patient contact.



Identification of Users for the Physical Medicine and Rehabilitation Codes

As with other sections of CPT, the codes in the physical medicine section are designed to identify physical medicine services. These codes are not restricted to use by a specific specialty group. Instead, these codes may be used by any provider who is qualified to perform the service represented by the specific code. No distinction is made concerning the licensure or professional credentials of the provider. Licensure and credentialing vary on a state-by-state and institutional basis. Appropriate state and institutional authorities should be consulted regarding the appropriate provision of these services by health care professionals.

CALCULATING THE TIME OF THERAPEUTIC PROCEDURES

AS OF MARCH 2014, YOU CAN NO LONGER USE THE 52 MODIFIER WHEN BILLING FOR TIMED THERAPY SERVICES.

EXAMPLE: 20 MINUTES OF A THERAPEUTIC EXERCISE IS BILLED AS 97110 RATHER THAN 97110 – 52

TIMING THERAPEUTIC PROCEDURES

- MUST PERFORM 8 MINUTES OF EACH UNIT TO QUALIFY FOR THE UNIT OF THERAPY BILLED
  - I.E. ONE UNIT IS NOW 8 TO 22 MINUTES OF TOTAL TIME
- TIME INCLUDES THE PRE, INTRA AND POST SERVICE
- COMBINE TOTAL TIME WHEN BILLING >1 TIMED THERAPY
  - EX: 5 MIN OF ULTRASOUND AND 20 MIN OF THER EX = 2 UNITS

MUST PASS MID-POINT

1 UNIT - 8 TO 22 MINUTES
2 UNITS - 23 TO 37 MINUTES
3 UNITS - 38 TO 52 MINUTES
4 UNITS - 53 TO 60 MINUTES
INCLUDES PRE-, INTRA- AND POST- SERVICE

ATTENDED ELECTRIC STIM

- CPT CODE - 97032
  - CHANGE THE SETTINGS OF THE MACHINE AT PERIODIC INTERVALS.
- 97014 – ATTENDED E-STIM IS A FIXED POSITION FOR A FIXED AMOUNT OF TIME.

THERAPEUTIC EXERCISES

- CPT CODE 97110
- INCREASE STRENGTH, ENDURANCE AND/OR FLEXIBILITY
  - MUST HAVE MEASURABLE LOSS OF FUNCTION
  - CAN NOT COMPLETE WITHOUT ASSISTANCE
- MUST LIST A REASON WHY DONE IN OFFICE
  - COMORBIDITY
  - DO NOT STATE THE PATIENT DOESN'T HAVE REQUIRED EQUIPMENT

NEUROMUSCULAR RE-EDUCATION

- CPT CODE - 97112
- THERAPEUTIC EXERCISE TO REGAIN SOME FUNCTION OF A MUSCLE THAT HAS BEEN LOST
  - MUST HAVE SIGNIFICANT LOSS OF FUNCTION
- NOT JUST FOR STROKE VICTIMS

THERAPEUTIC ACTIVITIES

- CPT CODE - 97530
- THERAPEUTIC EXERCISES USING DYNAMIC ACTIVITIES TO INCREASE FUNCTION
- MULTIPLE PARAMETERS
  - BALANCE, STRENGTH, COORDINATION
  - WALKING, RUNNING, JUMPING, THROWING

MASSAGE THERAPY

- CPT CODE - 97124
- MASSAGE THAT ATTEMPTS TO INCREASE CIRCULATION AND PROMOTE TISSUE RELAXATION.
- THIS CODE CAN BE BILLED WITH CMT/OMT
- USE ICE MASSAGE IN ACUTE PHASE OF CARE

MANUAL THERAPY

- CPT CODE 97140
- MASSAGE THAT IS INTENDED TO INCREASE THE EXTENSIBILITY OF THE MUSCLE FIBERS OR BREAK UP ADHESIONS
- CAN NOT BILL IN THE SAME REGION OF A CMT
- MUST USE THE 59 MODIFIER WHEN DONE IN DIFFERENT REGION OF THE BODY THAN A CMT

98940	CERVICAL MANIPULATION
97140 52	LUMBAR MANUAL THERAPY

GROUP THERAPY

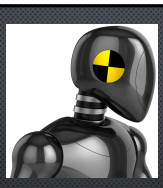
- CPT CODE 97150
- TWO OR MORE PEOPLE BEING SUPERVISED AT THE SAME TIME WITH SAME PROVIDER.
- DOES NOT REQUIRE DIRECT ONE-ON-ONE CONTACT

CODING MODIFIERS

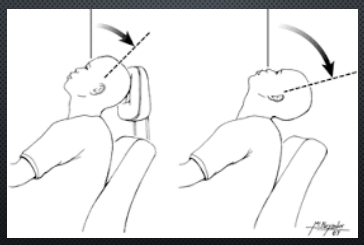
25 - APPENDED TO E/M SERVICE WHEN CMT/OMT IS PERFORMED ON SAME VISIT.

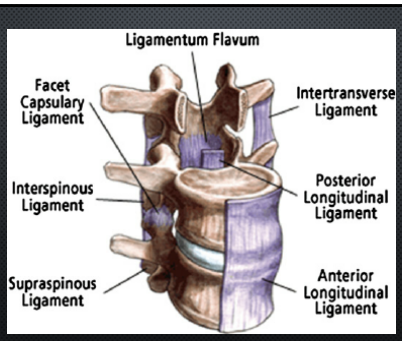
59 - APPENDED TO 97140 WHEN MANUAL THERAPY IS PERFORMED TO A DIFFERENT REGION OF THE BODY THAT A MANIPULATION.

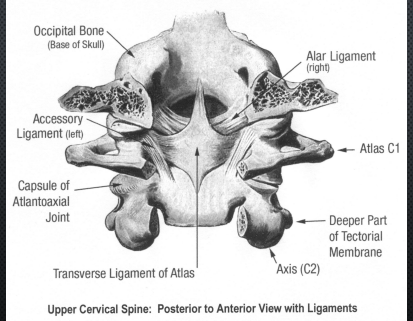
52 - CAN NO LONGER USE FOR TIMED THERAPY.

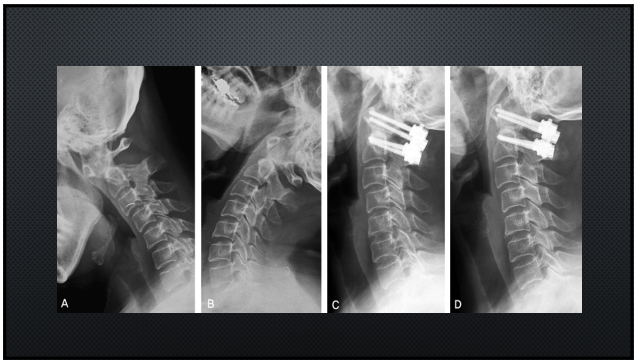


LESSON 6
DIAGNOSING LIGAMENT LAXITY AND TRAUMATIC BRAIN INJURY




Ligamentum Flavum
Facet Capsulary Ligament
Intertransverse Ligament
Interspinous Ligament
Posterior Longitudinal Ligament
Supraspinous Ligament
Anterior Longitudinal Ligament


Occipital Bone (Base of Skull)
Alar Ligament (right)
Accessory Ligament (left)
Atlas C1
Capsule of Atlantoaxial Joint
Deeper Part of Tectorial Membrane
Transverse Ligament of Atlas
Axis (C2)
Upper Cervical Spine: Posterior to Anterior View with Ligaments



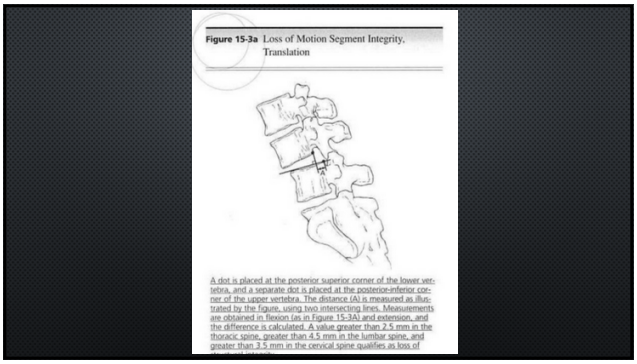
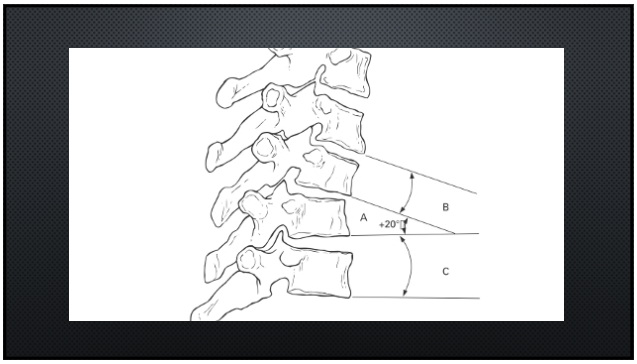
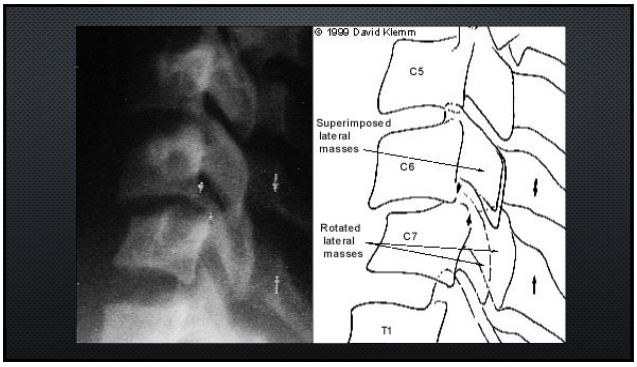
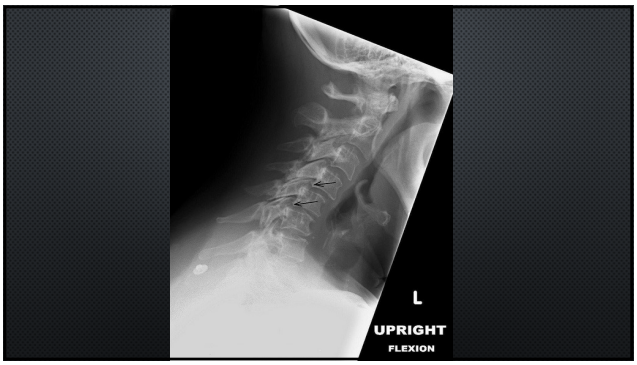


Figure 15-3a Loss of Motion Segment Integrity, Translation

A dot is placed at the posterior superior corner of the lower vertebra, and a separate dot is placed at the posterior-inferior corner of the upper vertebra. The distance (A) is measured as illustrated by the figure, using two intersecting lines. Measurements are obtained in flexion (as in Figure 15-3A) and extension, and the difference is calculated. A value greater than 2.5 mm in the thoracic spine, greater than 4.5 mm in the lumbar spine, and greater than 3.5 mm in the cervical spine qualifies as loss of


A
B
C
+20°


© 1999 David Klemm
C5
Superimposed lateral masses
C6
Rotated lateral masses
C7
T1


L
UPRIGHT
FLEXION

LIGAMENT LAXITY

ESSENTIALS OF SKELETAL RADIOLOGY, 2ND ED. YOKUM AND ROWE (1996)

GEORGE'S LINE - P. 149

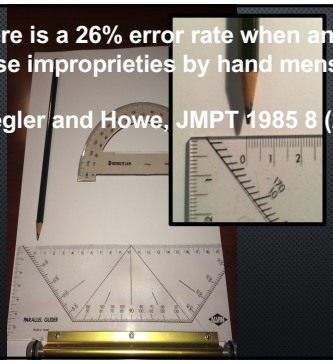
"…MAY BE RADIOLOGIC SIGN OF INSTABILITY DUE TO FRACTURE, DISLOCATION, LIGAMENTOUS LAXITY, OR DJD"

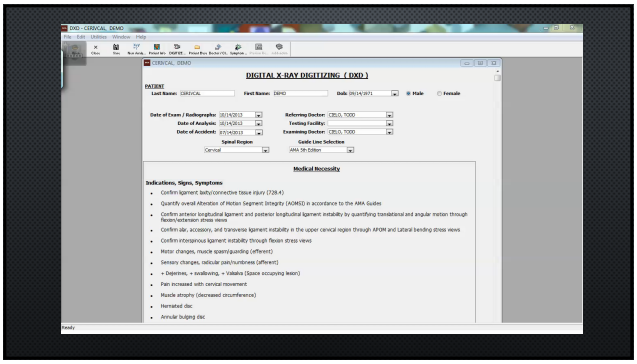
DRE category IV impairment #			
	Cervical	**Thoracic**	**Lumbar**
Translation *	3.5mm	>2.5mm	4.5mm
Angular change	More than 11° greater range of motion than that of adjacent spinal levels	not applicable	15° or more at L1, L2 and L3 20° or more at L4 25° or more at L5
DRE category IV Whole person impairment +	25 to 28%	20 to 23%	20 to 23%
Tables #	15-5	15-4	15-3

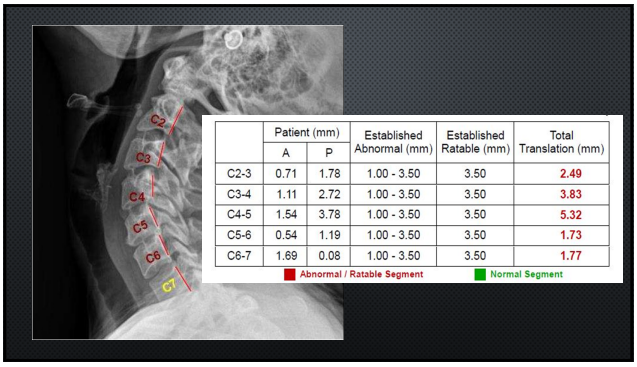
* Translation is a gliding motion where one bone of a joint glides over its neighbour.
+ If multiple levels are involved, these are NOT simply added together. Leave this task to a trained health care professional.
# AMA Guides to the Evaluation of Permanent Impairment 5th edition

There is a 26% error rate when analyzing these improprieties by hand mensuration.

(Siegler and Howe, JMPT 1985 8 (2):75-80).





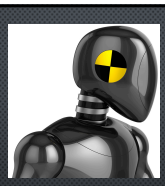


	Patient (mm)		Established Abnormal (mm)	Established Ratable (mm)	Total Translation (mm)
	A	P			
C2-3	0.71	1.78	1.00 - 3.50	3.50	2.49
C3-4	1.11	2.72	1.00 - 3.50	3.50	3.83
C4-5	1.54	3.78	1.00 - 3.50	3.50	5.32
C5-6	0.54	1.19	1.00 - 3.50	3.50	1.73
C6-7	1.69	0.08	1.00 - 3.50	3.50	1.77

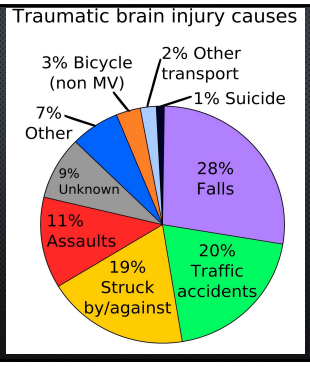
Abnormal / Ratable Segment Normal Segment

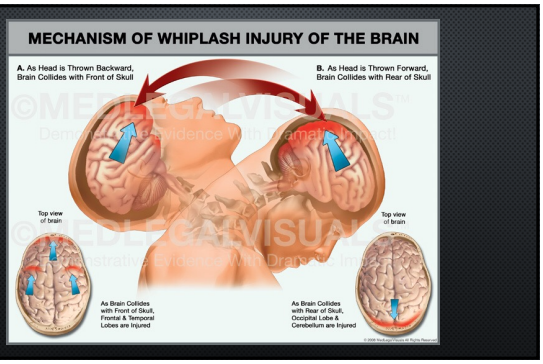
LIGAMENTOUS LAXITY

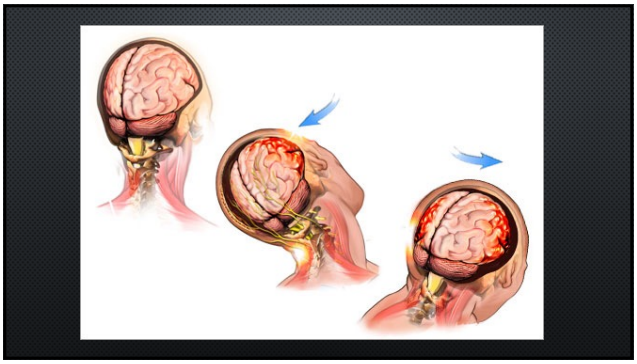
- LMSI IS HUGE IMPAIRMENT RATING FOR CERVICAL AND LUMBAR SPINE
- 25% IN CERVICAL
- 20% IN LUMBAR
- THIS IS WHY FLEX/EXT. X-RAYS ARE ALWAYS NECESSARY FOR EVERY WHIPLASH INJURY!
- EVERY PI CLAIM SHOULD ASSUME POSSIBLE LMSI AS A MATTER OF PRACTICE!



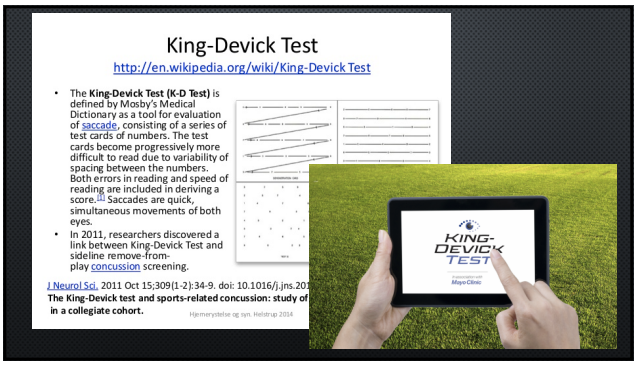
LESSON 6
DIAGNOSING LIGAMENT LAXITY AND TRAUMATIC BRAIN INJURY

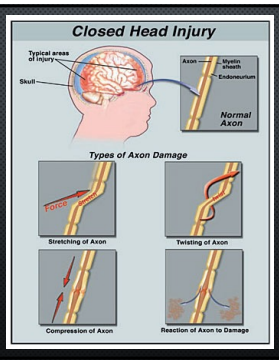


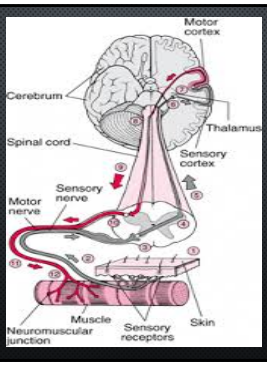





Confused, dazed, or disoriented state
Losing consciousness for a few seconds or minutes
Headache
Loss of balance or dizziness
Drowsiness or fatigue
Nausea or vomiting
Trouble sleeping
Sleeping more than usual
Light or sound sensitivity
Ringing in the ears
Blurred vision
Bad taste in the mouth
Changes in sense of smell
Mood swings or changes

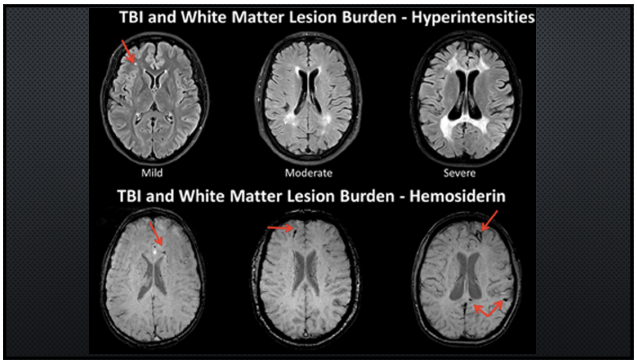

King-Devick Test
http://en.wikipedia.org/wiki/King-Devick Test
The King-Devick Test (K-D Test) is defined by Mosby's Medical Dictionary as a tool for evaluation of saccade, consisting of a series of test cards of numbers. The test cards become progressively more difficult to read due to variability of spacing between the numbers. Both errors in reading and speed of reading are included in deriving a score.[1] Saccades are quick, simultaneous movements of both eyes.
In 2011, researchers discovered a link between King-Devick Test and sideline remove-from-play concussion screening.
J Neurol Sci. 2011 Oct 15;309(1-2):34-9. doi: 10.1016/j.jns.201
The King-Devick test and sports-related concussion: study of in a collegiate cohort.
Hjernerystelse og syn. Helstrup 2014
KING-DEVICK TEST

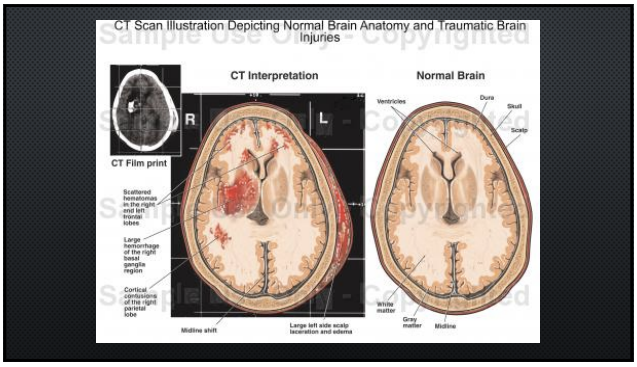


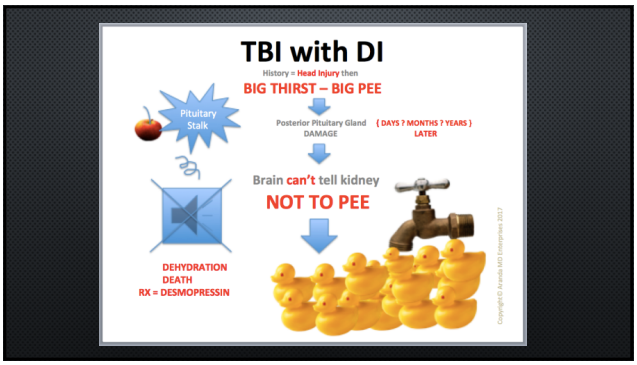


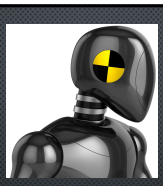
TRAUMATIC BRAIN INJURY

1. MRI OF THE BRAIN – 3T
2. CT OF THE BRAIN
3. EEG OF THE BRAIN
4. FUNCTIONAL IMAGING OF THE BRAIN
5. NEUROPSYCHIATRIC TESTING


TBI and White Matter Lesion Burden - Hyperintensities
Mild
Moderate
Severe
TBI and White Matter Lesion Burden - Hemosiderin


CT Scan Illustration Depicting Normal Brain Anatomy and Traumatic Brain Injuries
CT Interpretation
Normal Brain
CT Film print
R
L
Ventricles
Dura
Skull
Scalp
White matter
Gray matter
Midline
Midline shift
Large left side scalp laceration and edema


TBI with DI
History = Head Injury then
BIG THIRST – BIG PEE
Pituitary Stalk
Posterior Pituitary Gland DAMAGE
(DAYS ? MONTHS ? YEARS) LATER
Brain can't tell kidney
NOT TO PEE
DEHYDRATION
DEATH
RX = DESMOPRESSIN

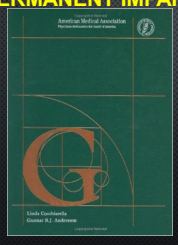


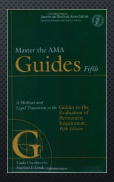
LESSON 7
IMPAIRMENT RATING TERMINOLOGY

VII. IMPAIRMENT RATING

- PERFORM WHEN PATIENT REACHES MMI
- USE THE 5TH EDITION OF THE AMA GUIDES – REGARDLESS OF WC
- SPINE – DRE AND ROM MODEL
  - DRE: ONE LEVEL, NO PRIOR INJURIES
  - ROM: MULTIPLE LEVELS OF IMPAIRMENT, RE-INJURY TO SAME AREA
    - SPECIFIC DISORDERS, ROM , MOTOR AND SENSORY
- EXTREMITIES – ROM, SENSORY AND MOTOR
- USED COMBINED VALUE CHART – PAGE 604 - 606

PERMANENT IMPAIRMENT RATING





IMPAIRMENT RATING

2nd Biggest Value Driver in COLOSSUS

- Patient must be at Maximum Medical Improvement (MMI) – medically stable
- 2% awarded if there is no impairment rating issued

Two (2) Methods:

- Diagnostic Related Estimate (DRE) Method
- Range of Motion (ROM) Method – Multiple injuries in same region of the spine
- If both can be used: Award higher impairment

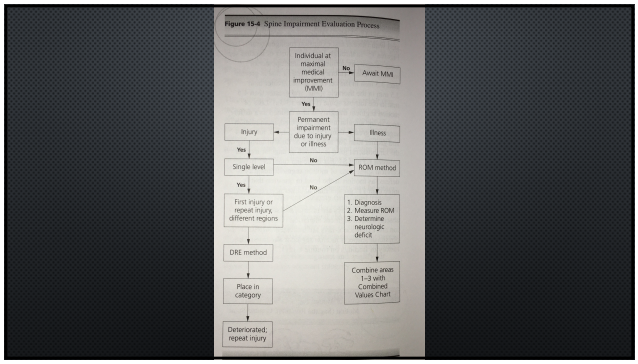
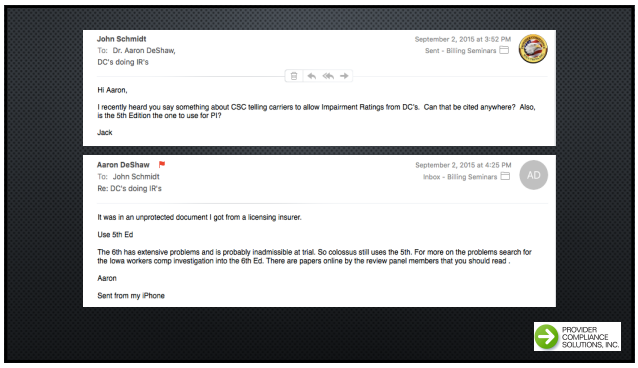
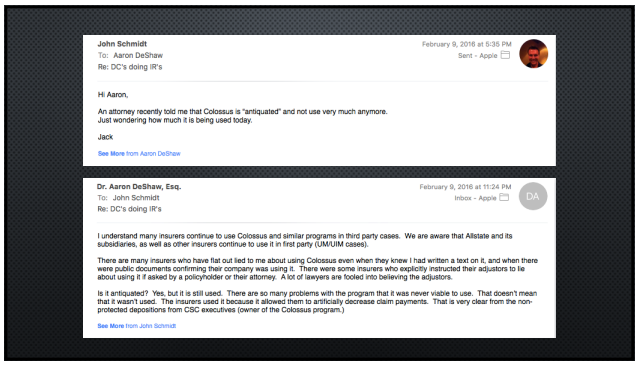
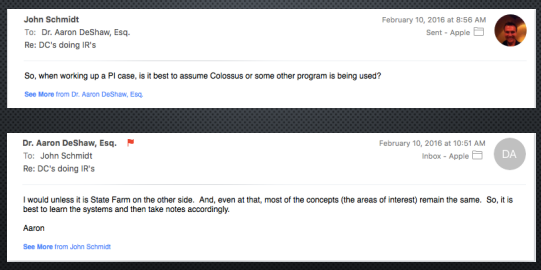


Figure 15-4 Spine Impairment Evaluation Process
Individual at maximal medical improvement (MMI)
No
Await MMI
Yes
Injury
Permanent impairment due to injury or illness
Illness
Yes
Single level
No
ROM method
Yes
First injury or repeat injury, different regions
No
1. Diagnosis
2. Measure ROM
3. Determine neurologic deficit
DRE method
Combine areas 1-3 with Combined Values Chart
Place in category
Deteriorated; repeat injury


John Schmidt
To: Dr. Aaron DeShaw,
DC's doing IR's
September 2, 2015 at 3:52 PM
Sent - Billing Seminars
Hi Aaron,
I recently heard you say something about CSC telling carriers to allow Impairment Ratings from DC's. Can that be cited anywhere? Also, is the 5th Edition the one to use for PI?
Jack
Aaron DeShaw
To: John Schmidt
Re: DC's doing IR's
September 2, 2015 at 4:25 PM
Inbox - Billing Seminars
AD
It was in an unprotected document I got from a licensing insurer.
Use 5th Ed
The 6th has extensive problems and is probably inadmissible at trial. So colossus still uses the 5th. For more on the problems search for the Iowa workers comp investigation into the 6th Ed. There are papers online by the review panel members that you should read .
Aaron
Sent from my iPhone
PROVIDER COMPLIANCE SOLUTIONS, INC.


John Schmidt
To: Aaron DeShaw
Re: DC's doing IR's
February 9, 2016 at 5:35 PM
Sent - Apple
Hi Aaron,
An attorney recently told me that Colossus is "antiquated" and not use very much anymore.
Just wondering how much it is being used today.
Jack
See More from Aaron DeShaw
Dr. Aaron DeShaw, Esq.
To: John Schmidt
Re: DC's doing IR's
February 9, 2016 at 11:24 PM
Inbox - Apple
DA
I understand many insurers continue to use Colossus and similar programs in third party cases. We are aware that Allstate and its subsidiaries, as well as other insurers continue to use it in first party (UM/UIM cases).
There are many insurers who have flat out lied to me about using Colossus even when they knew I had written a text on it, and when there were public documents confirming their company was using it. There were some insurers who explicitly instructed their adjustors to lie about using it if asked by a policyholder or their attorney. A lot of lawyers are fooled into believing the adjustors.
Is it antiquated? Yes, but it is still used. There are so many problems with the program that it was never viable to use. That doesn't mean that it wasn't used. The insurers used it because it allowed them to artificially decrease claim payments. That is very clear from the non-protected depositions from CSC executives (owner of the Colossus program.)
See More from John Schmidt



John Schmidt
To: Dr. Aaron DeShaw, Esq.
Re: DC's doing IR's
February 10, 2016 at 8:56 AM
Sent - Apple

So, when working up a PI case, is it best to assume Colossus or some other program is being used?

See More from Dr. Aaron DeShaw, Esq.

Dr. Aaron DeShaw, Esq.
To: John Schmidt
Re: DC's doing IR's
February 10, 2016 at 10:51 AM
Inbox - Apple

I would unless it is State Farm on the other side. And, even at that, most of the concepts (the areas of interest) remain the same. So, it is best to learn the systems and then take notes accordingly.

Aaron

See More from John Schmidt

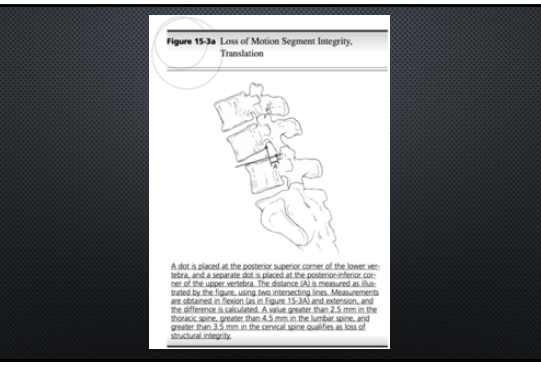
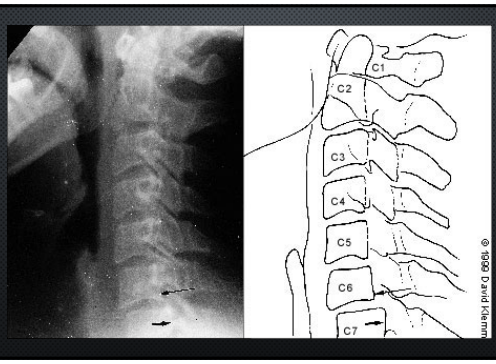


Figure 15-3a Loss of Motion Segment Integrity, Translation

A dot is placed at the posterior superior corner of the lower vertebra, and a separate dot is placed at the posterior-inferior corner of the upper vertebra. The distance (A) is measured as illustrated by the figure, using two intersecting lines. Measurements are obtained in flexion (as in Figure 15-3A) and extension, and the difference is calculated. A value greater than 2.5 mm in the thoracic spine, greater than 4.5 mm in the lumbar spine, and greater than 3.5 mm in the cervical spine qualifies as loss of structural integrity.

QUICK REVIEW OF LIGAMENT LAXITY RELATED INFO FROM CHIRO TEXTS

- ESSENTIALS OF SKELETAL RADIOLOGY, 2ND ED.; YOKUM AND ROWE (1996)
  - GEORGE'S LINE: P. 149 "…MAY BE RADIOLOGIC SIGN OF INSTABILITY DUE TO FRACTURE, DISLOCATION, LIGAMENTOUS LAXITY, OR DJD"



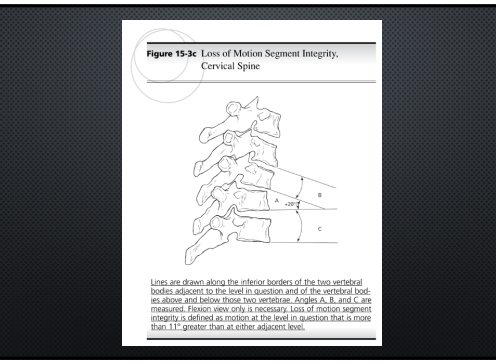
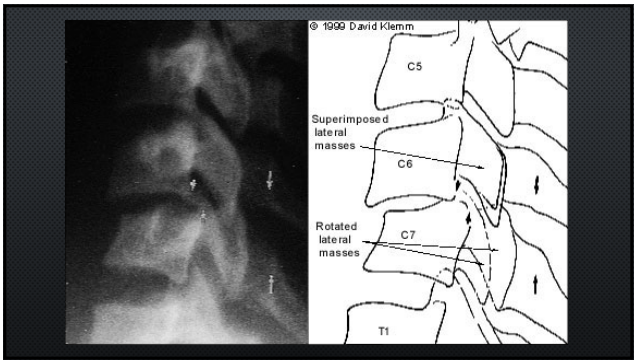


Figure 15-3c Loss of Motion Segment Integrity, Cervical Spine

Lines are drawn along the inferior borders of the two vertebral bodies adjacent to the level in question and of the vertebral bodies above and below those two vertebrae. Angles A, B, and C are measured. Flexion view only is necessary. Loss of motion segment integrity is defined as motion at the level in question that is more than 11° greater than at either adjacent level.



DRE category IV impairment #			
	Cervical	**Thoracic**	**Lumbar**
Translation *	3.5mm	>2.5mm	4.5mm
Angular change	More than 11° greater range of motion than that of adjacent spinal levels	not applicable	15° or more at L1, L2 and L3 20° or more at L4 25° or more at L5
DRE category IV Whole person impairment +	25 to 28%	20 to 23%	20 to 23%
Tables #	15-5	15-4	15-3

* Translation is a gliding motion where one bone of a joint glides over its neighbour.
+ If multiple levels are involved, these are NOT simply added together. Leave this task to a trained health care professional.
# AMA Guides to the Evaluation of Permanent Impairment 5th edition

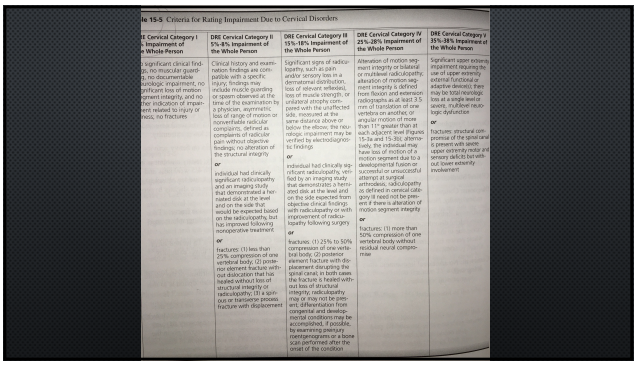
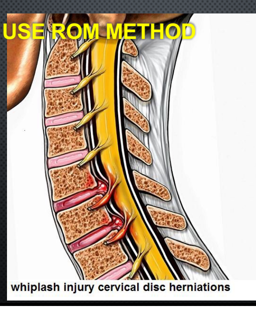


Table 15-3 Criteria for Rating Impairment Due to Lumbar Spine Injury

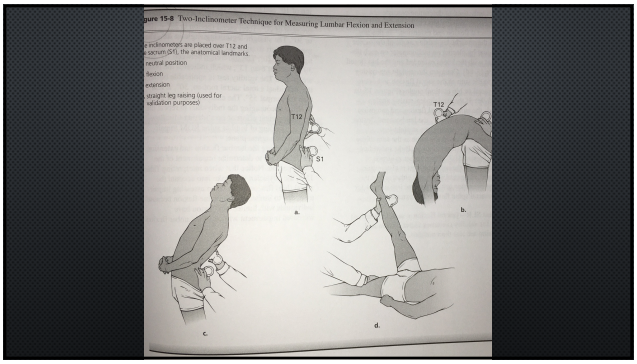
DRE Lumbar Category I 0% Impairment of the Whole Person	DRE Lumbar Category II 5%- 8% Impairment of the Whole Person	DRE Lumbar Category III 10%-13% Impairment of the Whole Person	DRE Lumbar Category IV 20%-23% Impairment of the Whole Person	DRE Lumbar Category V 25%-28% Impairment of the Whole Person
No significant clinical findings, no observed muscle guarding or spasm, no documentable neurologic impairment, no documented alteration in structural integrity, and no other indication of impairment related to injury or illness; no fractures	Clinical history and examination findings are compatible with a specific injury; findings may include significant muscle guarding or spasm observed at the time of the examination, asymmetric loss of range of motion, or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity and no significant radiculopathy *or* individual had a clinically significant radiculopathy and has an imaging study that demonstrates a herniated disk at the level and on the side that would be expected based on the previous radiculopathy, but no longer has the radiculopathy following conservative treatment *or* fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation (not developmental spondylolysis) that has healed without alteration of motion segment integrity; (3) a spinous or transverse process fracture with displacement without a vertebral body fracture, which does not disrupt the spinal canal	Significant signs of radiculopathy, such as dermatomal pain and/or in a dermatomal distribution, sensory loss, loss of relevant reflex(es), loss of muscle strength or measured unilateral atrophy above or below the knee compared to measurements on the contralateral side at the same location; impairment may be verified by electrodiagnostic findings *or* history of a herniated disk at the level and on the side that would be expected from objective clinical findings, associated with radiculopathy, or individuals who had surgery for radiculopathy but are now asymptomatic *or* fractures: (1) 25% to 50% compression of one vertebral body; (2) posterior element fracture with displacement disrupting the spinal canal; in both cases, the fracture has healed without alteration of structural integrity	Loss of motion segment integrity defined from flexion and extension radiographs as at least 4.5 mm of translation of one vertebra on another or angular motion greater than 15° at L1-2, L2-3, and L3-4, greater than 20° at L4-5, and greater than 25° at L5-S1 (Figure 15-3); may have complete or near complete loss of motion of a motion segment due to developmental fusion, or successful or unsuccessful attempt at surgical arthrodesis *or* fractures: (1) greater than 50% compression of one vertebral body without residual neurologic compromise	Meets the criteria of DRE lumbosacral categories III and IV; that is, both radiculopathy and alteration of motion segment integrity are present; significant lower extremity impairment is present as indicated by atrophy or loss of reflex(es), pain, and/or sensory changes within an anatomic distribution (dermatomal), or electromyographic findings as stated in lumbosacral category III and alteration of spine motion segment integrity as defined in lumbosacral category IV *or* fractures: (1) greater than 50% compression of one vertebral body with unilateral neurologic compromise

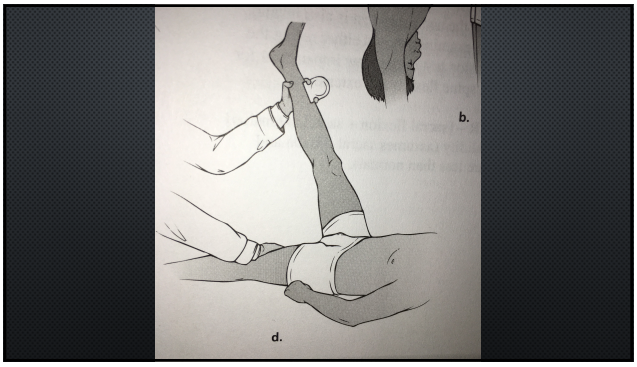
WHEN TO USE ROM METHOD



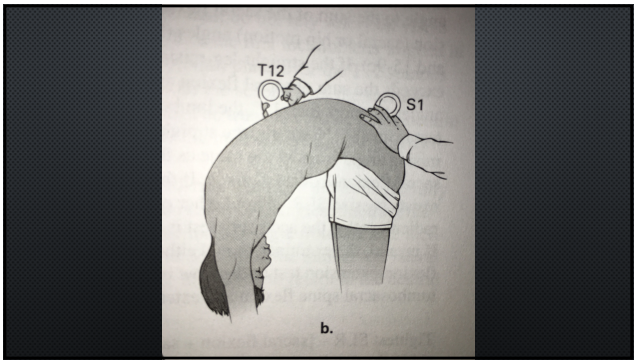
able 15-7 Criteria for Rating Whole Person Impairment Percent Due to Specific Spine Disorders to Be Used as Part of the ROM Method*

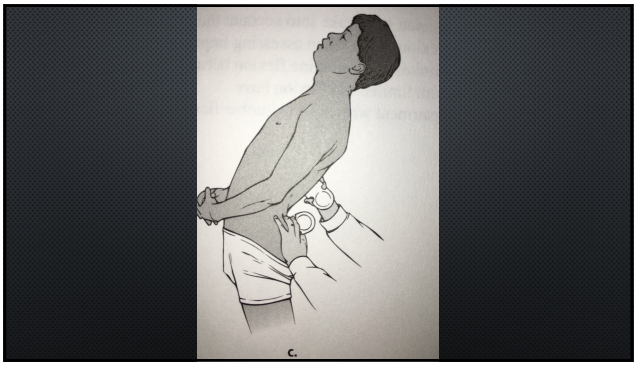
Disorder	% Impairment of the Whole Person Cervical	Thoracic	Lumbar
I. Fractures			
A. Compression of one vertebral body.			
0%-25%	4	2	5
26%-50%	6	3	7
> 50%	10	5	12
B. Fracture of posterior element (pedicle, lamina, articular process, transverse process).	4	2	5
Note: An impairment due to compression of a vertebra and one due to fracture of a posterior element are combined using the Combined Values Chart (p. 604). Fractures or compressions of several vertebrae are combined using the Combined Values Chart.			
C. Reduced dislocation of one vertebra.	5	3	6
If two or more vertebrae are dislocated and reduced, combine the estimates using the Combined Values Chart.			
An unreduced dislocation causes impairment until it is reduced; the physician should then evaluate the impairment on the basis of the individual's condition with the dislocation reduced.			
If no reduction is possible, the physician should evaluate the impairment on the basis of the range-of-motion and neurologic findings according to criteria in this chapter and Chapter 13, The Central and Peripheral Nervous System.			
II. Intervertebral disk or other soft-tissue lesion			
Diagnosis must be based on clinical symptoms and signs and imaging information.			
A. Unoperated on, with no residual signs or symptoms.	0	0	0
B. Unoperated on, with medically documented injury, pain, and rigidity* associated with none to minimal degenerative changes on structural tests.†	4	2	5
C. Unoperated on, stable, with medically documented injury, pain, and rigidity* associated with moderate to severe degenerative changes on structural tests;† includes herniated nucleus pulposus with or without radiculopathy.	6	3	7
D. Surgically treated disk lesion without residual signs or symptoms; includes disk injection.	7	4	8
E. Surgically treated disk lesion with residual, medically documented pain and rigidity.	9	5	10
F. Multiple levels, with or without operations and with or without residual signs or symptoms.	Add 1% per level		
G. Multiple operations *with* or without residual signs or symptoms			
1. Second operation	Add 2%		
2. Third or subsequent operation	Add 1% per operation		
III. Spondylolysis and spondylolisthesis, not operated on			
A. Spondylolysis or grade I (1%-25% slippage) or grade II (26%-50% slippage) spondylolisthesis, accompanied by medically documented injury that is stable, and medically documented pain and rigidity with or without muscle spasm.	6	3	7
B. Grade III (51%-75% slippage) or grade IV (76%-100% slippage) spondylolisthesis, accompanied by medically documented injury that is stable, and medically documented pain and rigidity with or without muscle spasm.	8	4	9
IV. Spinal stenosis, segmental instability, spondylolisthesis, fracture, or dislocation, operated on			
A. Single-level decompression without spinal fusion and without residual signs or symptoms	7	4	8
B. Single-level decompression without spinal fusion with residual signs or symptoms	9	5	10
C. Single-level spinal fusion with or without decompression without residual signs or symptoms	8	4	9
D. Single-level spinal fusion with or without decompression with residual signs and symptoms	10	5	12
E. Multiple levels, operated on, with residual, medically documented pain and rigidity.	Add 1% per level		
1. Second operation	Add 2%		
2. Third or subsequent operation	Add 1% per operation		


T12
S1
a.
T12
b.
c.
d.


b.
d.


T12
S1





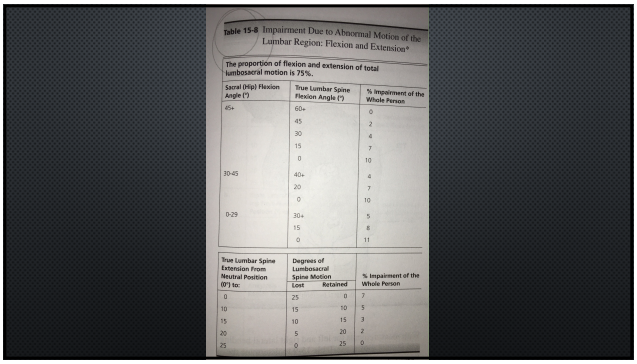


Table 15-8 Impairment Due to Abnormal Motion of the Lumbar Region: Flexion and Extension*

The proportion of flexion and extension of total lumbosacral motion is 75%.

Sacral (Hip) Flexion Angle (°)	True Lumbar Spine Flexion Angle (°)	% Impairment of the Whole Person
45+	60+	0
	45	2
	30	4
	15	7
	0	10
30-45	40+	4
	20	7
	0	10
0-29	30+	5
	15	8
	0	11

True Lumbar Spine Extension from Neutral Position (0°) to:	Degrees of Lumbosacral Spine Motion		% Impairment of the Whole Person
	Lost	Retained	
0	25	0	7
10	15	10	5
15	10	15	3
20	5	20	2
25	0	25	0

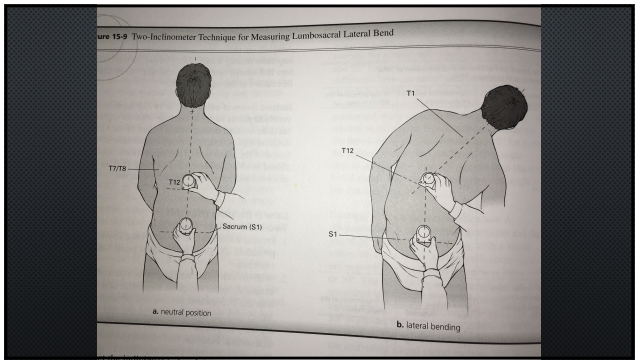


Figure 15-9 Two-Inclinometer Technique for Measuring Lumbosacral Lateral Bend

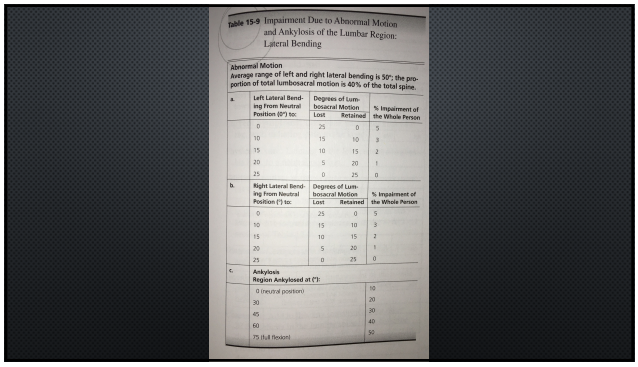


Table 15-9 Impairment Due to Abnormal Motion and Ankylosis of the Lumbar Region: Lateral Bending

Abnormal Motion
Average range of left and right lateral bending is 50°; the proportion of total lumbosacral motion is 40% of the total spine.

a.	Left Lateral Bending From Neutral Position (°) to:	Degrees of Lumbosacral Motion Lost	Retained	% Impairment of the Whole Person
	0	25	0	5
	10	15	10	3
	15	10	15	2
	20	5	20	1
	25	0	25	0

b.	Right Lateral Bending From Neutral Position (°) to:	Degrees of Lumbosacral Motion Lost	Retained	% Impairment of the Whole Person
	0	25	0	5
	10	15	10	3
	15	10	15	2
	20	5	20	1
	25	0	25	0

c.	Ankylosis Region Ankylosed at (°):	
	0 (neutral position)	10
	20	20
	45	30
	60	40
	75 (full flexion)	50

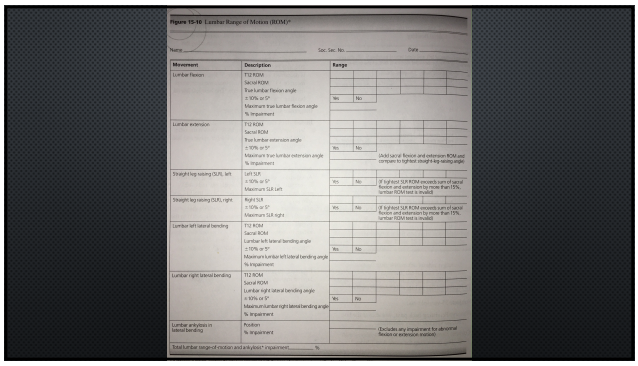


Figure 15-10 Lumbar Range of Motion (ROM)*

Name _____ Soc. Sec. No. _____ Date _____

Movement	Description	Range
Lumbar flexion	T12 ROM Sacral ROM True lumbar flexion angle ≥ 50% or 5° Maximum true lumbar flexion angle % impairment	Yes / No
Lumbar extension	T12 ROM Sacral ROM True lumbar extension angle ≥ 50% or 5° Maximum true lumbar extension angle % impairment	Yes / No (Add sacral flexion and extension ROM and compare to right/left straight-leg-raising angle)
Straight leg raising (SLR), left	Left SLR ≥ 50% or 5° Maximum SLR Left	Yes / No If right/left SLR ROM exceeds sum of sacral flexion and extension by more than 15%, lumbar ROM test is invalid.
Straight leg raising (SLR), right	Right SLR ≥ 50% or 5° Maximum SLR right	Yes / No If right/left SLR ROM exceeds sum of sacral flexion and extension by more than 15%, lumbar ROM test is invalid.
Lumbar left lateral bending	T12 ROM Sacral ROM Lumbar left lateral bending angle ≥ 50% or 5° Maximum lumbar left lateral bending angle % impairment	Yes / No
Lumbar right lateral bending	T12 ROM Sacral ROM Lumbar right lateral bending angle ≥ 50% or 5° Maximum lumbar right lateral bending angle % impairment	Yes / No
Lumbar ankylosis in lateral bending	Position % impairment	(Excludes any impairment for abnormal flexion or extension motion)

Total lumbar range-of-motion and ankylosis* impairment _____ %

Table 15-10 Impairment Due to Abnormal Motion (Flexion) and Ankylosis of the Thoracic Region

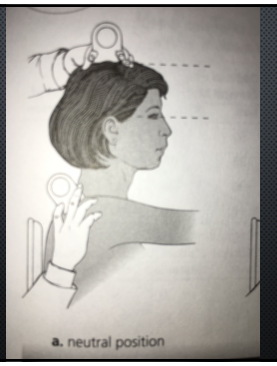
Average range of flexion and extension is 50°; the proportion of all thoracic motion is 60% of the total spine.

Abnormal Motion

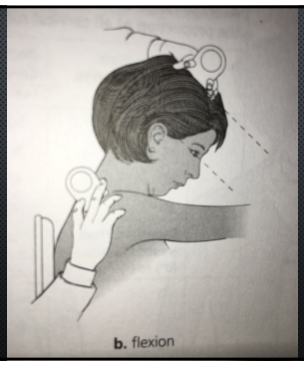
Flexion From Erect Position (Angle of Thoracic Flexion) to:	Degrees of Thoracic Motion		% Impairment of the Whole Person
	Lost	Retained	
0	50	0	4
15	35	15	2
30	20	30	1
60	0	50	0

Ankylosis
Angle of Minimum Kyphosis (°)

−30 (Extension thoracic lordosis)	20
0 (neutral)	0
60	5
80	20
100	40



a. neutral position



b. flexion

Table 15-12 Cervical Region Impairment From Abnormal Flexion or Extension or Ankylosis

Abnormal Motion
Average range of flexion and extension is 110°; the proportion of all cervical motions is 40%.

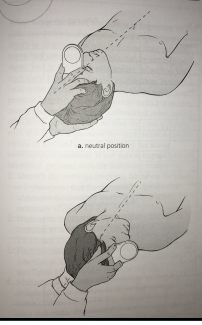
a. Flexion From Neutral Position (0°) to (°):	Degrees of Cervical Motion Lost	Retained	% Impairment of the Whole Person
0	50	0	5
15	35	15	4
30	30	20	2
50	0	50	0

b. Extension From Neutral Position (0°) to (°):	Degrees of Cervical Motion Lost	Retained	% Impairment of the Whole Person
0	60	0	6
20	40	20	4
40	20	40	2
60	0	60+	0

c. Region Ankylosed at (°):	
0 (neutral position)	12
15	20
30	30
50 (full flexion)	40

d. Region Ankylosed at (°):	
0 (neutral position)	12
20	20
40	30
60 (full extension)	40

Figure 15-17 Measuring Cervical Rotation



a. neutral position

Table 15-14 Impairment Due to Abnormal Motion and Ankylosis of the Cervical Region: Rotation

Abnormal Motion
Average range of rotation is 160°; the proportion of all cervical motion is 35%.

a. Left Rotation From Neutral Position (0°) to (°):	Degrees of Cervical Motion Lost	Retained	% Impairment of the Whole Person
0	80	0	6
20	60	20	4
40	40	40	2
60	20	60	1
80	0	80+	0

b. Right Rotation From Neutral Position (0°) to (°):	Degrees of Cervical Motion Lost	Retained	% Impairment of the Whole Person
0	80	0	6
20	60	20	4
40	40	40	2
60	20	60	1
80	0	80+	0

c. Ankylosis Region Ankylosed at (°):	
0 (neutral position)	12
20	20
40	30
60	40
80 (full right or left rotation)	50

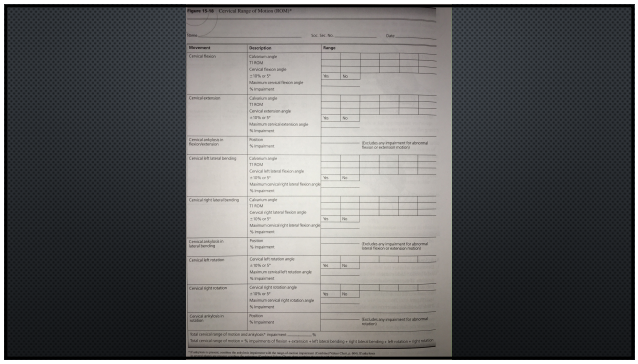


Figure 15-38 Cervical Ranges of Motion (ROM)*

Name _____ Soc. Sec. No. _____ Date _____

Movement	Description	Range
Cervical flexion	Cutaneous angle TT-ROM Cervical flexion angle ≥ 50% on 5° Maximum cervical flexion angle % impairment	Yes / No
Cervical extension	Cutaneous angle TT-ROM Cervical extension angle ≥ 50% on 5° Maximum cervical extension angle % impairment	Yes / No
Cervical ankylosis in flexion/extension	Position % impairment	Excludes any impairment for abnormal flexion or extension motion(s)
Cervical left lateral bending	Cutaneous angle TT-ROM Cervical left lateral flexion angle ≥ 50% on 5° Maximum cervical right lateral flexion angle % impairment	Yes / No
Cervical right lateral bending	Cutaneous angle TT-ROM Cervical right lateral flexion angle ≥ 50% on 5° Maximum cervical right lateral flexion angle % impairment	Yes / No
Cervical ankylosis in lateral bending	Position % impairment	Excludes any impairment for abnormal lateral flexion or extension motion(s)
Cervical left rotation	Cervical left rotation angle ≥ 50% on 5° Maximum cervical left rotation angle % impairment	Yes / No
Cervical right rotation	Cervical right rotation angle ≥ 50% on 5° Maximum cervical right rotation angle % impairment	Yes / No
Cervical ankylosis in rotation	Position % impairment	Excludes any impairment for abnormal rotation(s)

Total cervical range of motion and ankylosis* impairment _____ %

Total cervical range of motion = % impairment for flexion + extension + left lateral bending + right lateral bending + left rotation + right rotation

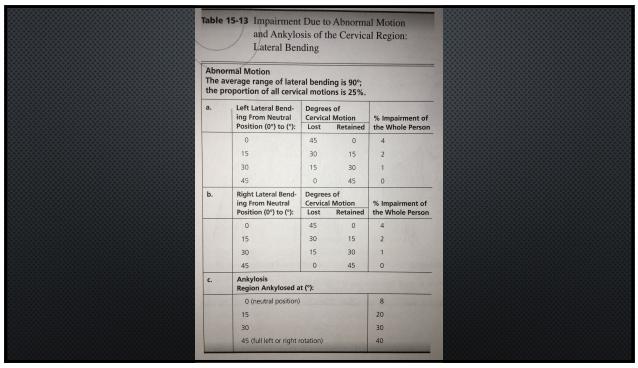


Table 15-13 Impairment Due to Abnormal Motion and Ankylosis of the Cervical Region: Lateral Bending

Abnormal Motion
The average range of lateral bending is 90°; the proportion of all cervical motions is 25%.

a.	Left Lateral Bending From Neutral Position (0°) to (°):	Degrees of Cervical Motion Lost	Degrees of Cervical Motion Retained	% Impairment of the Whole Person
	0	45	0	4
	15	30	15	2
	30	15	30	1
	45	0	45	0
b.	Right Lateral Bending From Neutral Position (0°) to (°):	Degrees of Cervical Motion Lost	Degrees of Cervical Motion Retained	% Impairment of the Whole Person
	0	45	0	4
	15	30	15	2
	30	15	30	1
	45	0	45	0

c.	Ankylosis Region Ankylosed at (°):	
	0 (neutral position)	8
	15	20
	30	30
	45 (full left or right rotation)	40

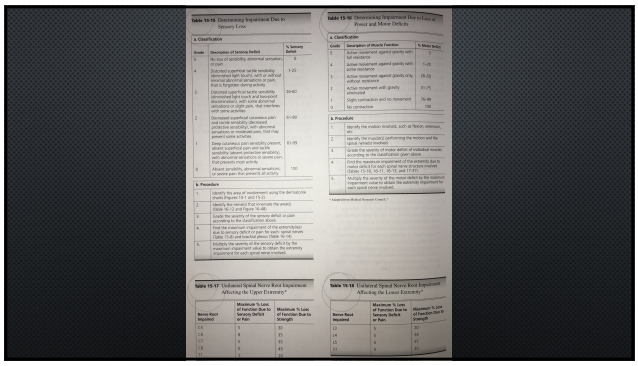


Table 15-15 Determining Impairment Due to Sensory Loss

a. Classification

Grade	Description of Sensory Deficit	% Sensory Deficit
5	No loss of sensibility; abnormal sensations, if present, do not interfere with normal activities	0
4	Decreased superficial tactile sensibility (decreased light touch, with or without abnormal sensations or pain, that is not gross; some pain)	1–20
3	Decreased superficial tactile sensibility (diminished light touch and function discriminators), with some abnormal sensations or pain, that interferes with some activities	26–60
2	Decreased superficial cutaneous pain and tactile sensibility (decreased protective sensibility), with abnormal sensations or pain (severe), that may prevent some activities	61–80
1	Deep cutaneous pain sensibility present, but superficial pain and tactile sensibility (absent protective sensibility), with abnormal sensations or severe pain, that prevents most activities	81–99
0	Absent sensibility; abnormal sensations or severe pain that prevents all activity	100

b. Procedure

1. Identify the area of involvement using the dermatome charts (Figures 15-1 and 15-2).
2. Identify the nerve root(s) to evaluate the area(s) (Table 15-12 and Figure 15-48).
3. Grade the severity of the sensory deficit or pain according to the classification above.
4. Find the maximum impairment of the extremity(ies) due to nerve root deficit for each spinal nerve (Table 15-16) and brachial plexus (Table 16-14).
5. Multiply the severity of the sensory deficit by the maximum impairment value to obtain the extremity impairment for each spinal nerve involved.

Table 15-16 Determining Impairment Due to Loss of Power and Motor Deficits

a. Classification

Grade	Description of Muscle Function	% Motor Deficit
5	Active movement against gravity with full resistance	0
4	Active movement against gravity with some resistance	1–25
3	Active movement against gravity only, without resistance	26–50
2	Active movement with gravity eliminated	51–75
1	Slight contraction and no movement	76–99
0	No contraction	100

b. Procedure

1. Identify the motion involved, such as flexion, extension, etc.
2. Identify the muscle(s) performing the motion and the spinal nerve(s) involved.
3. Grade the severity of motor deficit of individual muscles according to the classification above.
4. Find the maximum impairment of the extremity due to motor deficit for each spinal nerve involved (Tables 15-18, 15-17, 16-13, and 17-37).
5. Multiply the severity of the motor deficit by the maximum impairment to obtain the extremity impairment for each spinal nerve involved.

* Adapted from Medical Research Council.*

Table 15-17 Unilateral Spinal Nerve Root Impairment Affecting the Upper Extremity*

Nerve Root Impaired	Maximum % Loss of Function Due to Pain, Deficit or Paln	Maximum % Loss of Function Due to Strength
C5	5	30
C6	8	35
C7	5	35
C8	5	45
T1	5	40

Table 15-18 Unilateral Spinal Nerve Root Impairment Affecting the Lower Extremity*

Nerve Root Impaired	Maximum % Loss of Function Due to Pain, Deficit or Pain	Maximum % Loss of Function Due to Strength
L2	5	30
L4	5	65
L5	5	97
S1	5	97

BILLING FOR IMPAIRMENT RATINGS

99455 – Impairment Rating

Performed by Treating Doctor

History, Exam and Record Review

DRE Model: $500 First body part and $250 each additional body area

ROM Model: $750 First body part and $250 each additional part

BILLING FOR IMPAIRMENT RATINGS

99456 – Impairment Rating

Performed by Other Than Treating Doctor

History, Exam and Record Review

DRE Model: $750 First body part and $250 each additional body area

ROM Model: $1,000 First body part and $250 each additional part

BILLING FOR FINAL NARRATIVE

99080 – Special Report

$500 – First 4 pages

$150 - Each additional page

Review Entire Case

- Initial history: List all injuries
- Diagnosis: Initial and final
- Treatment: What and why
- Test Results: List positive results
- Prognosis and Future Medical
- Impairment Rating: 5th Edition of AMA Guides
- Causation: Reasonable degree of probability