

# Designated Doctor Case-Based Webinar Module 4

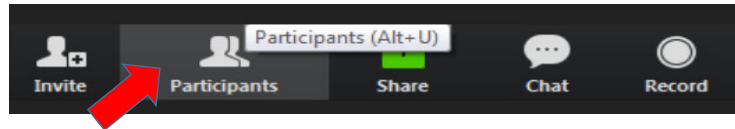
## Lower Extremity MMI IR

## Disclaimer

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# Housekeeping

At the bottom of your screen, click to turn on the participant list:



Ensure your name (not phone # or initials) is shown on the Participant List for CME and attendance purposes. If not, do the following to rename:

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Type in your first and last name

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## Asking questions

Please mute your phone/VOIP audio connection

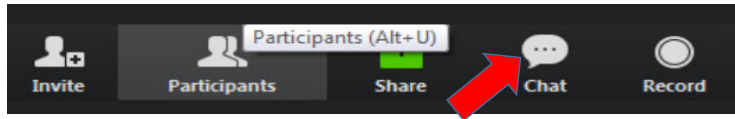
All attendees will be muted during the presentation and submit questions via Chat

Attendees may be unmuted at the request of the monitor or instructor for clarification or further discussion

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## Asking questions

You will find the Chat feature to the right of the participants list.



As the instructor goes through the course they will ask for questions via chat at the end of a case, or after a concept has been explained.

You may type your questions into Chat. The Chat monitor may answer your question in Chat, or have the instructor answer the question verbally.

## **Conflict between DWC Statutes/Rules and *AMA Guides***

**Be aware of when the DWC  
Statutes/Rules  
take precedence**

## Combining Values in the Lower Extremity

- If the patient has several impairments of the same lower extremity part, such as the leg or impairments of different parts, such as the ankle and a toe, the whole-person estimates for the impairments are combined.
- New APD 211091-s, when using two ranges of motion in the same joint, they should also be combined (not added).
- APD 132734 - the DD has discretion to use both ranges of motion within a joint, or the most severe.
- If both extremities are impaired, the impairment of each should be evaluated and expressed in terms of the whole person, and the two percents should be combined

New APD 211091-s states that ranges of motion within a joint are to be combined, not added. (September, 2021)

## Combining 3 or More

- “If three or more impairment values are to be combined, select any two and find their combined value as above. Then use that value and the third value to locate the combined value of all. This process can be repeated indefinitely, the final value in each instance being the combination of all the previous values. In each step of this process, the larger impairment value must be identified at the **side** of the chart.” (page 322)

## **Combining 3 or More Impairment Values**

- **Best practice - combine the largest % with the second largest %, then combine with third largest %, etc.**



## Lower Extremity MMI/IR Case 1

52-year-old warehouse supervisor sustained undisplaced right femoral intercondylar fracture falling down several steps, landing on right knee

Initial X-rays showed undisplaced right femoral intercondylar fracture and no osteoarthritis

Casted, healed without displacement

16 visits of PT with increased ROM but knee pain and weight bearing limitation persisted

RTW using an off-loading brace

Developed post-traumatic arthritis as part of injury

Think of what the original structural injury is so that you can be thinking if table 64 (or other tables) in 3.2 apply.

Is INTERCONDYLAR the same as SUPRACONDYLAR? NO. What are the implications for IR for both? We will see later in this case.

Defining the injury also helps with applying the ODG for consideration of MMI, and Appendix D.

## Lower Extremity MMI/IR Case 1

At MMI

Standing x-rays reveal 2 mm joint space  
(2mm loss)

Knee ROM

Flexion 110° and Extension 0°

Femoral –Tibial angle was 5° valgus

What do Guides say as to how to do x-rays for measuring arthritis? Page 82 – section 3.2g And Table 64.

The knee MUST be in neutral position – No flexion contracture.

For ROMs, think Table 41.

Deformity of varus or valgus are measured as per Table 41 by the femoral-tibial angle; 3 to 10 degrees of valgus is normal.

## Lower Extremity MMI/IR Case 1

On date of MMI, what is  
whole person IR?

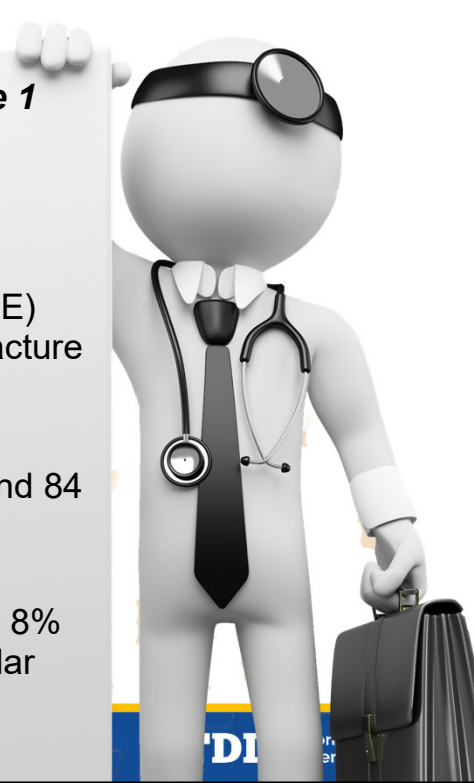
- A. 10%
- B. 8%
- C. 4%
- D. 2%



13

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CORRECT IS A. 10 %



**Lower Extremity MMI/IR Case 1**

**10% WP**

Arthritis (2 mm) = 8% WP

- Table 62, page 83)

Diagnosis Based Estimates (DBE)  
undisplaced intercondylar fracture  
= 2% WP

- Table 64, page 85

See instructions pages 82, 83 and 84  
re: combining arthritis and intra-  
articular fractures (DBE)

Combine post-traumatic arthritis 8%  
WP and undisplaced intercondylar  
fracture 2% = 10% WP

Let's break it down in detail with the relevant tables to see how we got there.

See Page 82 for instructions on how to do x-rays – If you are ordering.

**Lower Extremity MMI/IR Case 1**  
**Table 62, Page 83**



**Table 62.** Arthritis Impairments Based on Roentgenographically Determined Cartilage Intervals.

Joint	Whole-person (lower extremity) [foot] impairment (%)			
	Cartilage interval			
	3 mm	2 mm	1 mm	0 mm
Sacroiliac (3 mm)*	—	1 (2)	3 (7)	3 (7)
Hip (4 mm)	3 (7)	8 (20)	10 (25)	20 (50)
Knee (4 mm)	3 (7)	8 (20)	10 (25)	20 (50)
Patellofemoral†	—	4 (10)	6 (15)	8 (20)
Ankle (4 mm)	2 (5) [7]	6 (15) [21]	8 (20) [28]	12 (30) [43]
Subtalar (3 mm)	—	2 (5) [7]	6 (15) [21]	10 (25) [35]
Talonavicular (2 - 3 mm)	—	—	4 (10) [14]	8 (20) [28]
Calcaneocuboid	—	—	4 (10) [14]	8 (20) [28]
First metatarsophalangeal	—	—	2 (5) [7]	5 (12) [17]
Other metatarsophalangeal	—	—	1 (2) [3]	3 (7) [10]

\*Normal cartilage intervals are given in parentheses.

†In a patient with a history of direct trauma, a complaint of patellofemoral pain, and crepitation on physical examination, but without joint space narrowing on roentgenograms, a 2% whole-person or 5% lower-extremity impairment is given.

**Lower Extremity MMI/IR Case 1**  
**Table 64, Page 85**



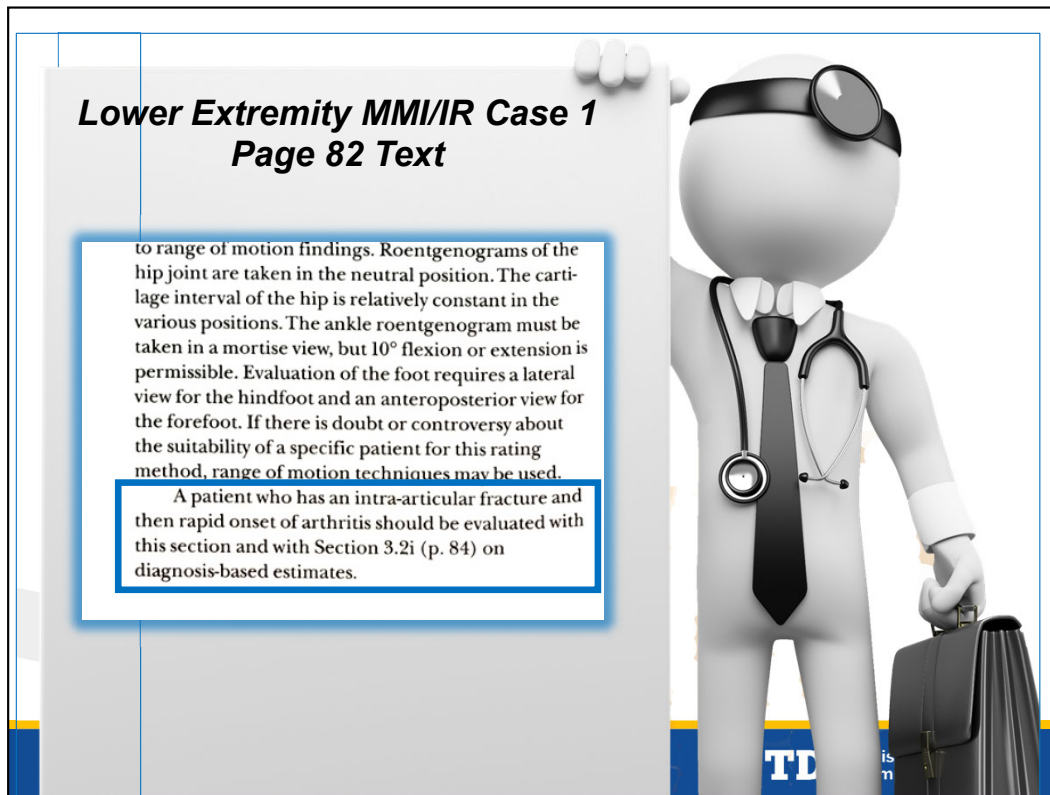
Or estimate according to examination findings; use the greater estimate		10°-19° angulation	10 (25)
Trochanteric bursitis (chronic) with abnormal gait	3 (7)	20°+ angulation	+1 (2) per degree up to 20 (50)
<b>Femoral shaft fracture</b>		<b>Supracondylar or intercondylar fracture</b>	
Healed with 10°-14° angulation or malrotation	10 (25)	Undisplaced fracture	2 (5)
15°-19°	18 (45)	Displaced fracture	
20°+	+1 (2) per degree up to 25 (62)	5°-9° angulation	5 (12)
		10°-19° angulation	10 (25)
		20°+ angulation	+1 (2) per degree up to 20% (50%)
		Total knee replacement including unicondylar replacement	
		Good result, 85-100 points*	15 (37)
		Fair result, 50-84 points*	20 (50)
		Poor result, less than 50 points*	30 (75)

Know your anatomy.

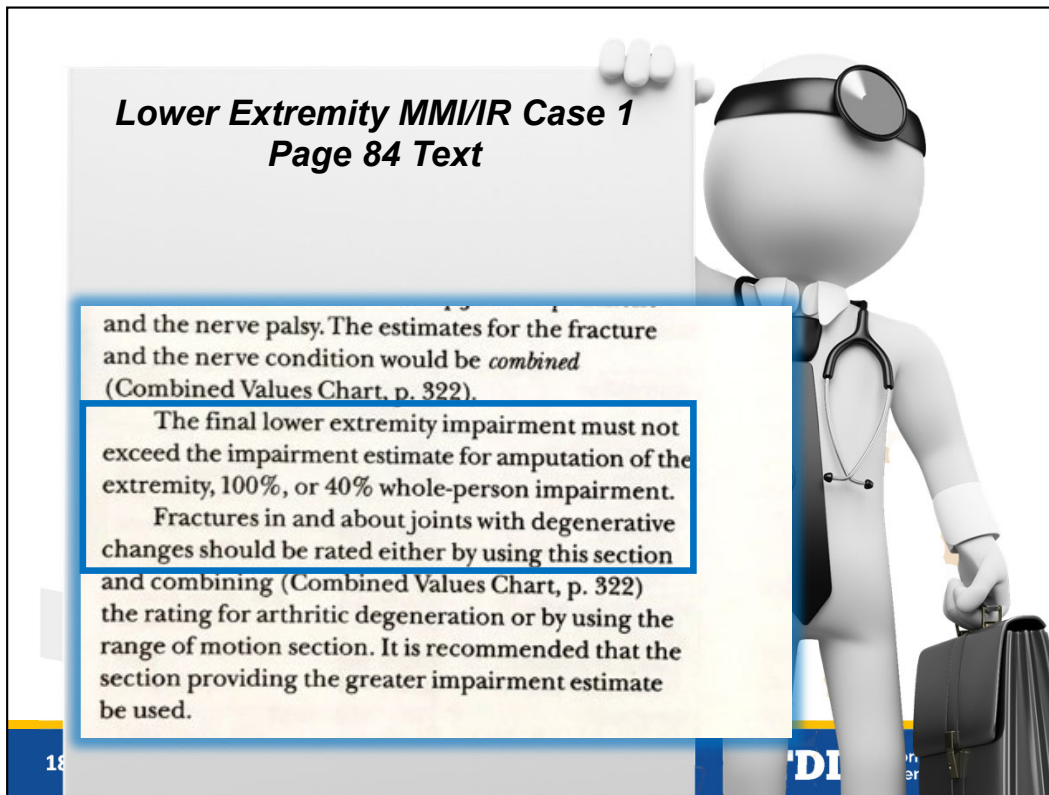
INTERCONDYLAR is an INTRA-ARTICULAR fracture.

This is NOT the same as a SUPRA-condylar.

A subcondylar fracture may disrupt the articular surface. In that case cannot use Table 64 , but you can use Table 62 if it provides the greatest IR.



An exception to combining items with Table 64. Remember this!



**What if we change the case...** What if it is SUPRACONDYLAR? NO Table 62.

Rate condition at MMI by either Table 64, ROM, atrophy, or other relevant sections in 3.2.

## Questions About Lower Extremity MMI/IR Case1?



19

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**PEARLS:** If there is Flexion contracture or LOSS of extension – you cannot use RCL. Use ROM instead.

There are other **EXCEPTIONS**. Look to case examples in Guides and read text for each of the sections!

## Lower Extremity MMI/IR Case 2

32-year-old male custodian sustained severe inversion injury to left ankle with a non-displaced spiral fracture of left lateral malleolus; casted and fracture healed with no angulation

What would this be in Table 64?

What does the ODG say?

## Lower Extremity MMI/IR Case 2

### At MMI

- Dysesthesia over dorsal ankle and foot that made it difficult to wear lace-up shoes, with positive Tinel's sign over anterolateral distal fibula
- No motor or sensory deficit
- Range of motion of left ankle and hindfoot
  - plantar flexion 30°, extension 5°
  - inversion 10°, eversion 15°

What is the sensory distribution? Does it conform to a specific nerve distribution (See Figure 59 on page 93) or is it dermatomal?

Sensory loss alone? Dysesthesias alone? Or both?

ROM – Table 42 and 43

## Lower Extremity MMI/IR Case 2

On date of MMI, what is  
whole person IR?

- A. 4%
- B. 5%
- C. 6%
- D. 7%



22

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Correct answer is C. 6 %.

**Lower Extremity MMI/IR Case 2**

**6% WP**

**Range of motion**

Left ankle

- Plantar flexion: 30° = 0% WP
- Extension: 5° = 3% WP

Ankle ROM = 3% WP

Left Hindfoot

- Inversion: 10° = 1% WP
- Eversion: 15° = 0% WP

Hindfoot ROM = 1% WP

ROM 3% WP cw 1% WP = 4% WP

Superficial Peroneal Nerve = 2% WP

ROM 4% WP cw dysethesia 2% WP

**= 6% WP**

Let's break it down in detail with the relevant tables to see how we got there.

Any concern for combining sensory and ROM? These are two different body systems. See TWO places on page 84.

You can also combine vascular (

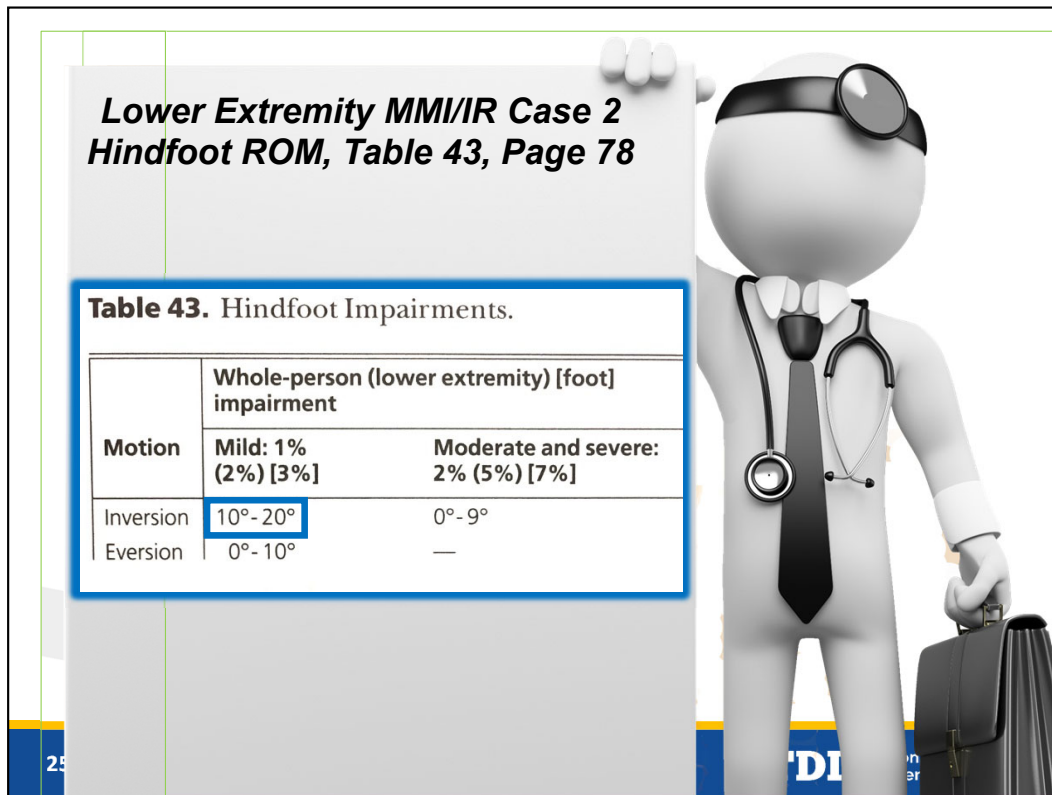
Be sure vascular injuries are within your DWC qualification table, or have exam redesignated if not)

**Lower Extremity MMI/IR Case 2  
Ankle ROM, Table 42, Page 78**

**Table 42.** Ankle Motion Impairments.

Motion	Whole-person (lower extremity) [foot] impairment		
	Mild: 3% (7%) [10%]	Moderate: 6% (15%) [21%]	Severe: 12% (30%) [43%]
Plantar flexion capability	11°-20°	1°-10°	None
Flexion contracture	—	10°	20°
Extension	10°- 0° (neutral)	—	—

Flexion Contracture....Loss of extension LESS than 0 degrees.



RATE BOTH ANKLE / TALAR joint AND “Hindfoot” / SUBTALAR joint.

These are different FUNCTIONAL UNITS, so combine (although numbers low enough that adding and combining will yield the same #).

Lower Extremity MMI/IR Case 2

Table 68, Page 89

**Dysesthesia Superficial Peroneal Nerve = 2% WP**

**Table 68.** Impairments from Nerve Deficits.

Nerve	Whole-person (lower extremity) [foot] impairment (%)		
	Motor	Sensory	Dysesthesia
Femoral	15 (37)	1 (2)	3 (7)
Obturator	3 (7)	0	0
Superior gluteal	25 (62)	0	0
Inferior gluteal	15 (37)	0	0
Lateral femoral cutaneous	0	1 (2)	3 (7)
Sciatic	30 (75)	7 (17)	5 (12)
Common peroneal	15 (42)	2 (5)	2 (5)
Superficial peroneal	0	2 (5)	2 (5)
Sural	0	1 (2)	2 (5)
Medial plantar	2 (5) [7]	2 (5) [7]	2 (5) [7]
Lateral plantar	2 (5) [7]	2 (5) [7]	2 (5) [7]



This is a tricky table.

Several nerves are

**missing from the table:**

Deep Peroneal (sensory AND motor)

Tibial (sensory AND motor) after it splits from the sciatic nerve

Saphenous sensory.

**Errors in the table:**

Omits motor portion of the superficial peroneal (Peroneal muscles).

Omits motor portion of obturator (Adductors).

Refer to the DD Certification course Lower Extremity presentation for more details.

## Questions About Lower Extremity MMI/IR Case 2?



27

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What if there was sensory loss and dysesthesia? See page 88

What if there was global loss of sensation of the foot? Does this make anatomic sense with the injury? If not, do not include.

What if there was partial loss? Table 68 is complete loss. If there is partial loss – review the certification course materials.

## Lower Extremity MMI/IR Case 3

Injured employee involved in motor vehicle accident, injuring right hip, knee and ankle; underwent extensive treatment including ORIF for a femoral neck fracture, a TKR and a pantalar fusion.  
He uses wheelchair for mobility

This case will be fun!

3 different regions in the lower extremity

We can use different methodology for each region then combine.

## Lower Extremity MMI/IR Case 3

### At MMI

- Knee replacement with poor result
- Healed femoral neck fracture in good position
- Hip ROM
  - flexion 80°, flexion contracture 10°
  - internal rotation 10°, external rotation 30°
  - abduction 20°, adduction 15°
- Pantalar **ankylosis** in neutral position (fusion of talus to all bones articulating with it: distal tibia, calcaneus, navicular and cuboid)

TKA – Tables 66 then 64.

HIP fracture = see table 64 – Instructs us to use ROM.

Pantalar Ankylosis.

## Lower Extremity MMI/IR Case 3

On date of MMI, what is  
whole person IR?

- A. 44%
- B. 40%
- C. 38%
- D. 30%



30


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Answer is B. 40%

*Lower Extremity MMI/IR Case 3*

**40% WP**

- Gait – use other methods whenever possible
- Knee replacement with poor result = 30%
  - (Table 64, page 85)
- Hip ROM
  - flexion of 80° = 2%
  - extension (10° flexion contracture) = 2%
  - internal rotation of 10° = 2%
  - external rotation of 30° = 2%
  - abduction of 20° = 2%
  - adduction of 15° = 2%
  - may combine more than one ROM in a joint (APD) 211091-s
  - Total = 12%



Never exceed the amputation value. Page 84

Let's break it down in detail with the relevant tables to see how we got there.

All ROMs in a joint can be used, per APD 211091-s. But ROMs should be relevant / Consistent / and make sense with the injury.

Don't just blindly accept ROMs. Passive vs. Active. Your measures compared to medical records. Your ROM compared to functional abilities.

**Lower Extremity MMI/IR Case 3**

Pantalar ankylosis = 10%  
(page 81)

30% cw 12% = 38%  
38% cw 10% = 44% WP

Don't exceed amputation value  
(page 84)

Correct answer = 40%

How did we get to the value for Pantalar? See example at the bottom of page 81.

Look for optimum measurement and base% for optimum; then regardless of joint, add deviation for optimum in 1<sup>st</sup> plane of motion.

Combine any deviation in the 2<sup>nd</sup> (or greater) plane of motion. In the case of Pantalar, The Guides tell you the % of optimum = 10%

(see upper right on page 81)

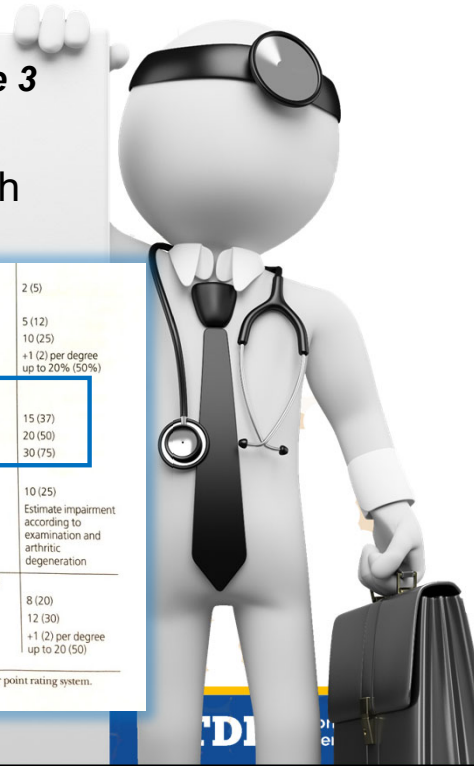
## Lower Extremity MMI/IR Case 3 Table 64, Page 85

### Total knee replacement with poor results

with abnormal gait		Supracondylar or intercondylar fracture	
<b>Femoral shaft fracture</b>		Undisplaced fracture	2 (5)
Healed with 10°-14° angulation or malrotation	10 (25)	Displaced fracture	5 (12)
15°-19°	18 (45)	5°-9° angulation	10 (25)
20°+	+1 (2) per degree up to 25 (62)	10°-19° angulation	+1 (2) per degree up to 20% (50%)
		20°+ angulation	
		<b>Total knee replacement including unicondylar replacement</b>	
		Good result, 85-100 points*	15 (37)
		Fair result, 50-84 points*	20 (50)
		Poor result, less than 50 points*	30 (75)
		Proximal tibial osteotomy	
		Good result	10 (25)
		Poor result	Estimate impairment according to examination and arthritic degeneration
		<b>Tibial shaft fracture, malalignment of</b>	
		10°-14°	8 (20)
		15°-19°	12 (30)
		20°+	+1 (2) per degree up to 20 (50)

\*See Table 65 (p. 87) or Table 66 (p. 88) for point rating system.

\*\*Refer also to section 3.4, p. 131.



Lower Extremity MMI/IR Case 3

Table 64, Page 85

## Healed femoral neck fracture in good position

<b>Hip</b>	
Total hip replacement; includes endoprosthesis, unipolar or bipolar	
Good result, 85-100 points*	15 (37)
Fair result, 50-84 points*	20 (50)
Poor result, less than 50 points*	30 (75)
Femoral neck fracture, healed in Good position	Evaluate according to examination findings
Malunion	12 (30) plus range of motion criteria
Nonunion	15 (37) plus range of motion criteria
Girdlestone arthroplasty Or estimate according to examination findings; use the greater estimate	20 (50)
Trochanteric bursitis (chronic) with abnormal gait	3 (7)

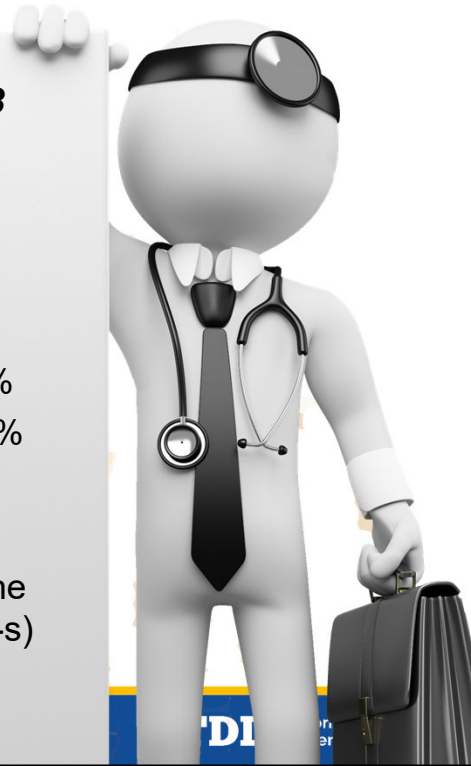


### ***Lower Extremity MMI/IR Case 3***

#### **Hip ROM**

- flexion of 80° = 2%
- extension (10° flexion contracture) = 2%
- internal rotation of 10° = 2%
- external rotation of 30° = 2%
- abduction of 20° = 2%
- adduction of 15° = 2%
- may combine more than one ROM in joint (APD 211091-s)

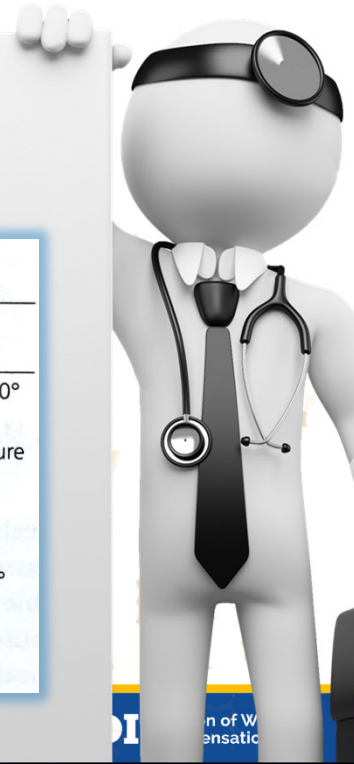
Total = 12%



Lower Extremity MMI/IR Case 3

Table 40, Page 78

Motion	Whole-person (lower extremity) impairment (%)		
	Mild: 2% (5%)	Moderate: 4% (10%)	Severe: 8% (20%)
Flexion	Less than 100°	Less than 80°	Less than 50°
Extension	10°- 19° flexion contracture	20°- 29° flexion contracture	30° flexion contracture
Internal rotation	10°- 20°	0°- 9°	
External rotation	20°- 30°	0°- 19°	
Abduction	15°- 25°	5°- 14°	Less than 5°
Adduction	0°- 15°	—	—
Abduction contracture*	0°- 5°	6°- 10°	11°- 20°



Lower Extremity MMI/IR Case 3  
Pantalar Ankylosis, Page 81

**Table 57.** Ankle Impairment\* from Ankylosis in Valgus Position.

Valgus Position (°)	Whole-person (lower extremity) [foot] impairment (%)		
10 - 19	10	(25)	[35]
20 - 30	15	(37)	[53]
30+	21	(52)	[74]

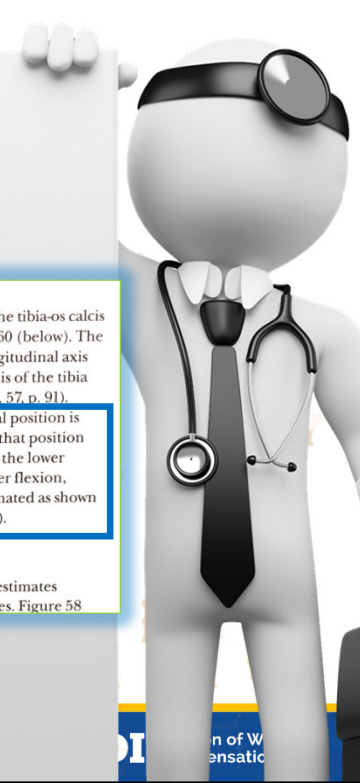
\*The appropriate ankylosis impairment percent is added to the impairment percent for ankylosis in the neutral position given in the text (p. 80).

**Table 58.** Ankle Impairment\* from Ankylosis in Internal Malrotation.

Ankylosis impairment for loss of the tibia-os calcis angle is estimated according to Table 60 (below). The tibia-os calcis angle is made by the longitudinal axis of the os calcis and the longitudinal axis of the tibia with the ankle in neutral position (Fig. 57, p. 91).

For pantalar ankylosis, the optimal position is neutral; the impairment estimates for that position are 10% for the whole person, 25% for the lower extremity, and 35% for the foot. Further flexion, varus, and valgus impairments are estimated as shown in Tables 55 through 60 (pp. 80 and 81).

**Toes**  
Table 61 (p. 82) indicates impairment estimates related to ankylosis of one or several toes. Figure 58



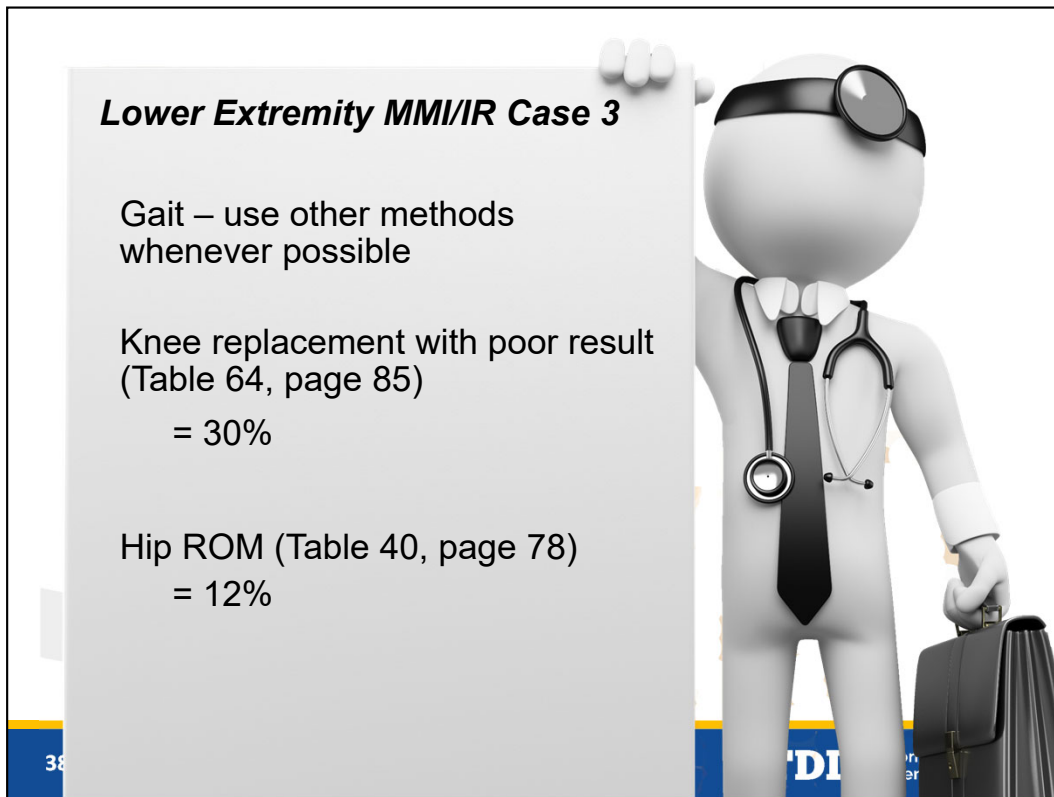
Once again...How did we get to the value for Pantalar? See example at the bottom of page 81.

Look for optimum measurement and base% for optimum; then regardless of joint, add deviation for optimum in 1<sup>st</sup> plane of motion.

Combine any deviation in the 2<sup>nd</sup> (or greater) plane of motion. In the case of Pantalar, The Guides tell you the % of optimum = 10%

(see upper right on page 81)

**NO example for the knee and hip, so look at the text and footnotes of the Tables for more information.**



**RE: GAIT.** See text on Page 75, Section 3.2b and Table 35 page 76.

**ARE THERE OTHER MORE SPECIFIC METHODS than Gait? YES**

IF USED Table 35, this would account for the IR for ALL of the 3 regional IR areas (hip, knee, ankle)

BUT ALSO: Look at the values that Table 35 gives you.

All in SEVERE category of Table 35 (j., and k. ) **exceed** the amputation value of ONE LE (40 %) AND exceed amputation value of TWO LEs (64 %).

**BEST PRACTICE is to use the most clinically specific methods:** Pantalar ANKYLOSIS of the ankle injury, KNEE REPLACEMENT for the knee injury and HIP ROM for the hip injury.

### **Lower Extremity MMI/IR Case 3**

Pantalar ankylosis (page 81)  
= 10%

30% (TKR) cw 12% (femoral  
neck fx healed in good  
position) = 38%

38% cw 10% (pantalar  
ankylosis in neutral position)  
= 44% WP, which exceeds  
amputation value



*Lower Extremity MMI/IR Case 3  
Cannot Exceed The Amputation  
Page 84*

estimates made for both the hip joint impairment and the nerve palsy. The estimates for the fracture and the nerve condition would be *combined* (Combined Values Chart, p. 322).

The final lower extremity impairment must not exceed the impairment estimate for amputation of the extremity, 100%, or 40% whole-person impairment.

Fractures in and about joints with degenerative changes should be rated either by using this section and combining (Combined Values Chart, p. 322) the rating for arthritic degeneration or by using the range of motion section. It is recommended that the section providing the greater impairment estimate be used.

**Therefore IR = 40% WP**



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# Documenting Hip ROM

**Table 40.** Hip Motion Impairments.

Motion	Whole-person (lower extremity) impairment (%)		
	Mild: 2% (5%)	Moderate: 4% (10%)	Severe: 8% (20%)
Flexion	Less than 100°	Less than 80°	Less than 50°
Extension	10°- 19° flexion contracture	20°- 29° flexion contracture	30° flexion contracture
Internal rotation	10°- 20°	0°- 9°	
External rotation	20°- 30°	0°- 19°	
Abduction	15°- 25°	5°- 14°	Less than 5°
Adduction	0°- 15°	—	—
Abduction contracture*	0°- 5°	6°- 10°	11°- 20°

\*An abduction contracture of greater than 20° is a 15% whole-person impairment.

The AMA Guides, Table 40, Hip Motion Impairments, can be confusing and lead to disputes.



Clear documentation can reduce LOCs and disputes.

# Documenting Hip ROM

**Table 40.** Hip Motion Impairments.

Motion	Whole-person (lower extremity) impairment (%)		
	Mild: 2% (5%)	Moderate: 4% (10%)	Severe: 8% (20%)
Flexion	Less than 100°	Less than 80°	Less than 50°
Extension	10°- 19° flexion contracture	20°- 29° flexion contracture	30° flexion contracture
Internal rotation	10°- 20°	0°- 9°	
External rotation	20°- 30°	0°- 19°	
Abduction	15°- 25°	5°- 14°	Less than 5°
Adduction	0°- 15°	—	—
Abduction contracture*	0°- 5°	6°- 10°	11°- 20°

\*An abduction contracture of greater than 20° is a 15% whole-person impairment.

\*Notice that the more severe impairment has a greater number.

This is only logical if it is a LOSS of extension



Extension is noted on the table however, hip extension does not accrue impairment. Impairment for extension loss is measured and rated based on the presence and degree of flexion contracture.

## Documenting Hip ROM

**You can help avoid letters of clarification by following these best practices for documenting hip flexion contracture and hip extension your narrative report:**

1. If there is **no flexion contracture**, explain that the absence of flexion contracture results in 0% impairment per Table 40.
2. If there is **flexion contracture**, provide the measurement finding, and explain the percent of impairment assigned per Table 40.
3. If you include any measurement finding of **extension**, clearly explain that any degree of extension is inconsistent with a flexion contracture and is not assigned an impairment rating per Table 40.

Figure 52, page 90 shows an incorrect method for measuring hip flexion contracture

For the correct method see the DD Certification Course Lower Extremity presentation; a corrected version of the figure is in the Pearls section.

Questions About  
Lower Extremity MMI/IR  
Case 3?



## Lower Extremity MMI/IR Case 4

- Injured employee sustained left distal fibula avulsion fracture
- Casted
- Healed without displacement

What is the anatomy telling you?

Tip of the fibula. Can be associated with ligament injury / instability.

Think of what Tables you will consider and which you can exclude.

## Lower Extremity MMI/IR Case 4

### At MMI

- 2 cm of left calf atrophy
- Ankle ROM
  - Dorsiflexion 5°
  - Plantarflexion 40°
- Hindfoot ROM
  - Inversion 15°
  - Eversion 15°
- 3 mm of excess opening on stress x-ray

Table 37 Atrophy.

Tables 42 and 43 for ROM

Table 64 for anatomic lesion.

X-ray testing relevant? Likely not for RCI, but maybe for instability.


## Lower Extremity MMI/IR Case 4

On date of MMI, what is  
whole person IR?

- A. 1%
- B. 2%
- C. 3%
- D. 4%



Answer is D. 4 %.



**Lower Extremity MMI/IR Case 4**

**4% WP**

- 2.6 cm of left calf atrophy  
= 3%-4% “moderate”
  - (Table 37, page 77)
- ROM
  - Ankle ROM = 3%
  - Hindfoot ROM = 1%
  - = **4% WP**
- 3 mm of opening on stress
- x-ray = 2% WP
  - (DBE Table 64, page 86)

Let's break it down detail with the relevant tables to see how we got there.

Lower Extremity MMI/IR Case 4

**Table 37.** Impairments from Leg Muscle Atrophy.

Difference in circumference (cm)	Impairment degree	Whole-person (lower extremity) impairment (%)
<b>a. Thigh:</b> The circumference is measured 10 cm above the patella with the knee fully extended and the muscles relaxed.		
0 - 0.9	None	0
1 - 1.9	Mild	1 - 2 (3 - 8)
2 - 2.9	Moderate	3 - 4 (8 - 13)
3+	Severe	5 (13)
<b>b. Calf:</b> The maximum circumference on the normal side is compared with the circumference at the same level on the affected side.		
0 - 0.9	None	0
1 - 1.9	Mild	1 - 2 (3 - 8)
2 - 2.9	Moderate	3 - 4 (8 - 13)
3+	Severe	5 (13)



The table lists impairments in ranges. Your chosen number should make sense. Explain it.

Document where you measured! Measure in the same place on each side. Look at the notes in the table.

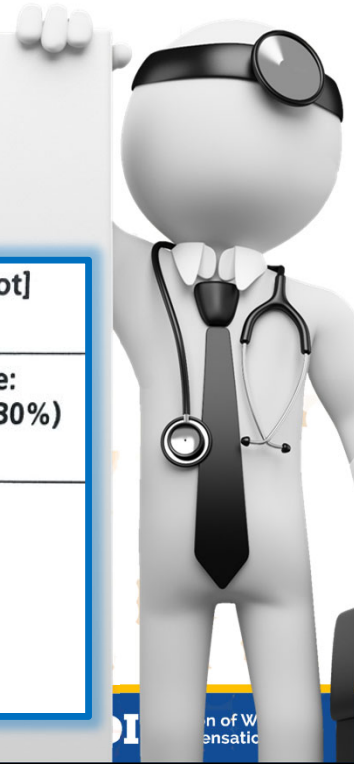
Lower Extremity MMI/IR Case 4

Table 42, Page 78

Dorsiflexion (Extension)  $5^\circ = 3\%$  WP

Plantar flexion  $40^\circ = 0\%$  WP

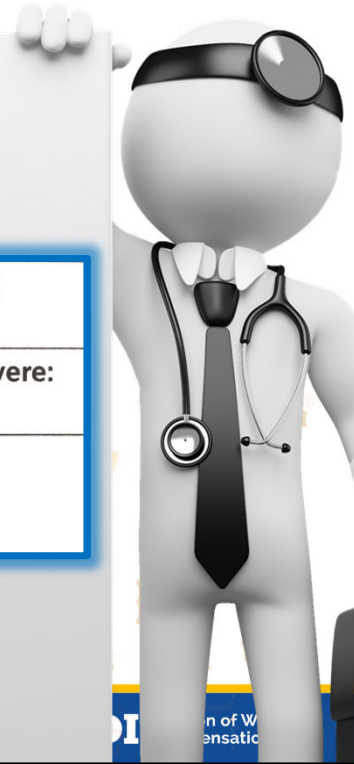
Motion	Whole-person (lower extremity) [foot] impairment		
	Mild: 3% (7%) [10%]	Moderate: 6% (15%) [21%]	Severe: 12% (30%) [43%]
Plantar flexion capability	$11^\circ - 20^\circ$	$1^\circ - 10^\circ$	None
Flexion contracture	—	$10^\circ$	$20^\circ$
Extension	$10^\circ - 0^\circ$ (neutral)	—	—



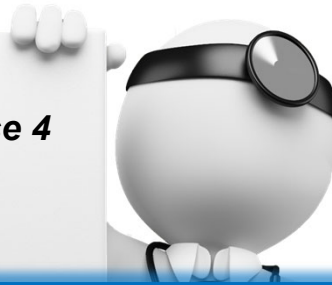
Lower Extremity MMI/IR Case 4

Table 43, Page 78

Motion	Whole-person (lower extremity) [foot] impairment	
	Mild: 1% (2%) [3%]	Moderate and severe: 2% (5%) [7%]
Inversion	10°-20°	0°-9°
Eversion	0°-10°	—



**Lower Extremity MMI/IR Case 4**  
**Table 64, Page 86**



Region and Condition	Whole-person (lower extremity) [foot] impairment (%)	Region and Condition	Whole-person (lower extremity) [foot] impairment (%)
<b>Ankle</b>		<b>Forefoot deformity</b>	
Ligamentous instability (based on stress roentgenograms*)		Metatarsal fracture with loss of weight transfer**	
Mild (2 - 3 mm excess opening)	2 (5) [7]	1st metatarsal	4 (10) [14]
Moderate (4 - 6 mm)	4 (10) [14]	5th metatarsal	2 (5) [7]
Severe (>6 mm)	6 (15) [21]	Other metatarsal	1 (2) [3]
Fracture		Metatarsal fracture with plantar angulation and metatarsalgia	
Extra-articular with angulation		1st metatarsal	4 (10) [14]
10° - 14°	6 (15) [21]	5th metatarsal	2 (5) [7]
15° - 19°	10 (25) [35]	Other metatarsal	1 (2) [3]
20°+	+1 (2) [3] per degree		

***Lower Extremity MMI/IR Case 4***

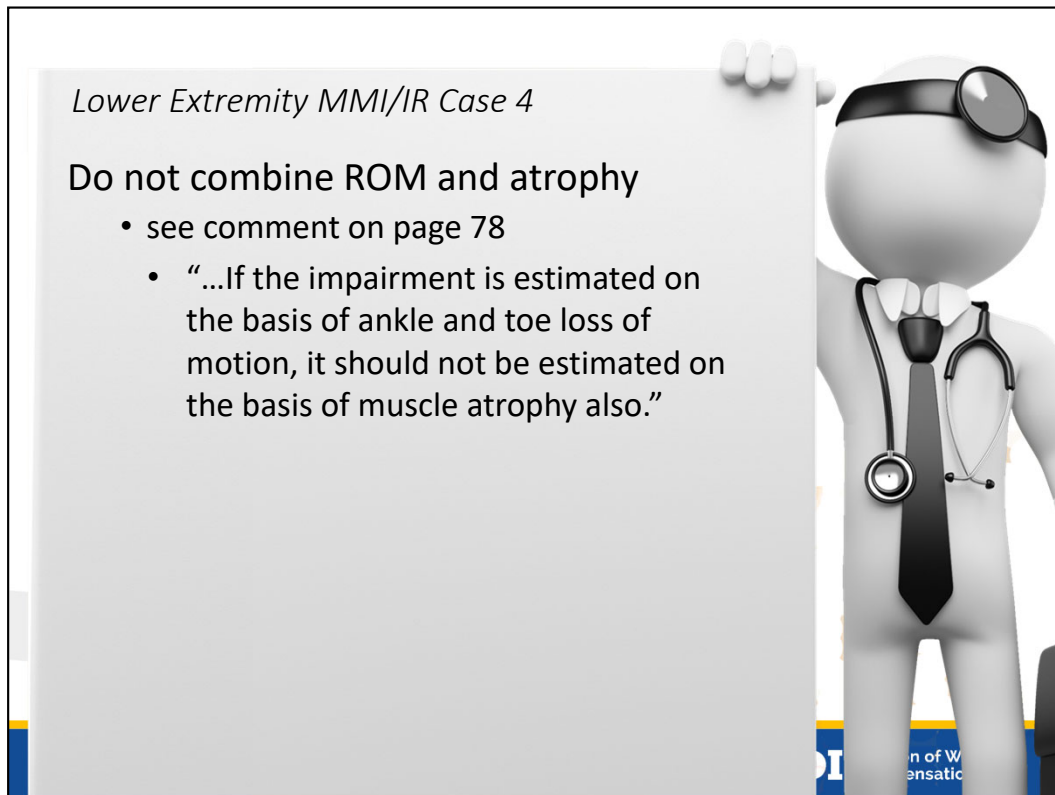
2.6 cm of left calf atrophy =  
3%-4% “moderate”  
(Table 37, page 77)

**ROM**

- Ankle ROM = 3%
- Hindfoot ROM = 1%  
= 4% WP

3 mm of opening on stress  
x-ray = 2% WP  
(DBE Table 64, page 86)





Make notes in the margins of your AMA Guides book.

Write notecards for studying for test.

It is okay to memorize the exceptions.

## Do not combine ROM and atrophy

Motion	Whole-person (lower extremity) [foot] impairment		
	Mild: 3% (7%) [10%]	Moderate: 6% (15%) [21%]	Severe: 12% (30%) [43%]
Plantar flexion capability	11°-20°	1°-10°	None
Flexion contracture	—	10°	20°
Extension	10°- 0° (neutral)	—	—

Combined Values Chart (p. 322).

The whole-person impairment was 8%.

*Comment:* Comparing Tables 42 and 45 with Table 37 (p. 77), one can see that estimated impairment for loss of motion of the ankle and toes would exceed any estimated impairment for weakness or atrophy

of the leg muscles. If the impairment is estimated on the basis of ankle and toe loss of motion, it should not be estimated on the basis of muscle atrophy also. Manual muscle testing is difficult to assess because of the lower leg muscles' limited range of motion of the ankle and toes.

*Lower Extremity MMI/IR Case 4*

**Do not combine DBE and atrophy**

- see comment on page 84
  - “...The expected muscle weakness or atrophy is included in the diagnosis related estimates...”



## Lower Extremity MMI/IR Case 4

### Page 84

*Do not combine ROM and atrophy*

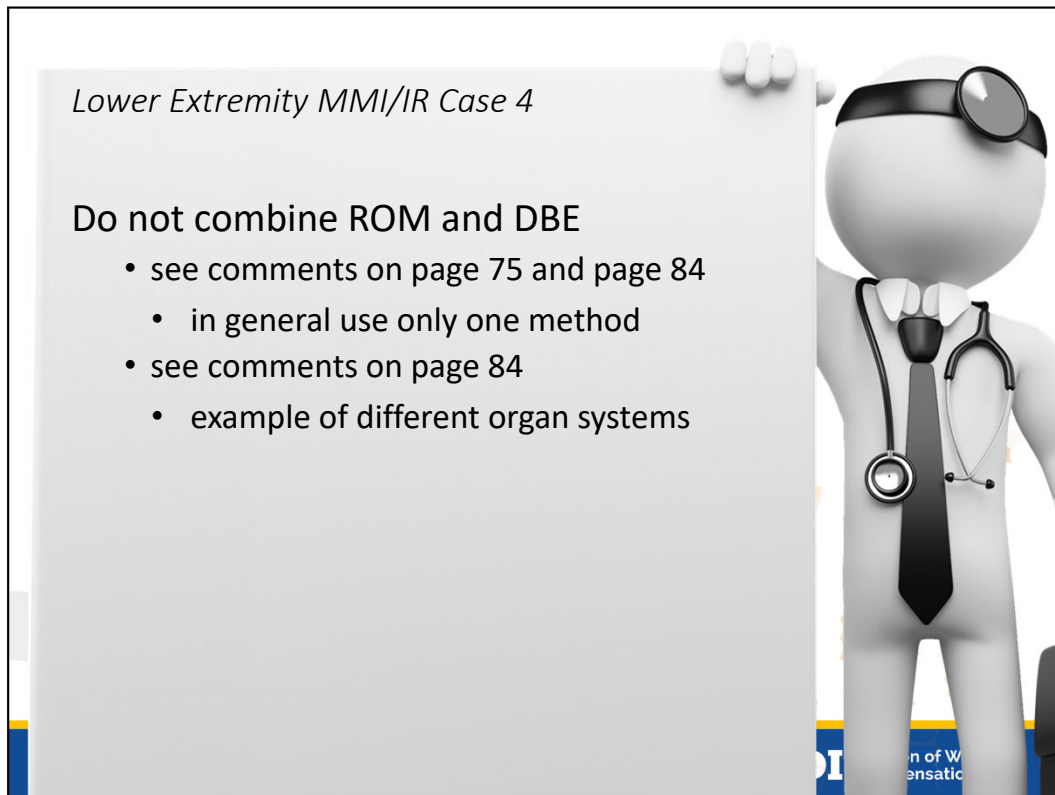
whether diagnostic or examination criteria best describe the impairment of a specific patient. *The physician, in general, should decide which estimate best describes the situation and should use only one approach for each anatomic part.* For instance, a patient with a femoral neck fracture with nonunion, who requires one crutch, should be rated either for use of the crutch or for the nonunion plus the range of motion restriction, whichever is greater.

There may be instances in which elements from both diagnostic and examination approaches will apply to a specific situation. A patient with an acetabular fracture and a sciatic nerve palsy should have

**Comment:** Impairment due to malunion of a fracture should be estimated according to the diagnosis. The expected muscle weakness or atrophy is included in the diagnosis-related estimates, but shortening is a different impairment.

If there were an associated nerve palsy, which usually does not occur with a fracture, the fracture and nerve palsy impairment percents reflecting impairments of different organ systems, would be *combined* (Combined Values Chart, p. 322), because they involve different organ systems.

DI n of W ensatic



In general – don't combine. Know the exceptions

It is okay to combine different organ systems, such as MSK with nerve/vascular/skin

Table 67 in section 3.2j

DCs – remember to watch for possible conditions outside of your qualification table during review of records prior to exam, etc.

If there are, contact DWC to redesignated.

## Lower Extremity MMI/IR Case 4 Page 75

Do not combine ROM and DBE



### 3.2 The Lower Extremity

Anatomic, diagnostic, and functional methods are used in evaluating permanent impairments of the lower extremity. While some impairments may be evaluated appropriately by determining the range of motion of the extremity, others are better evaluated by the use of diagnostic categories or according to test criteria.

In general, only one evaluation method should be used to evaluate a specific impairment. In some instances, however, as with the example on p. 77, a combination of two or three methods may be required.

This section includes information on using some

**Table 35.** Impairment from Limb Length Discrepancy.

Discrepancy (cm)	Whole-person (lower extremity) impairment (%)
0-1.9	0
2-2.9	2-3 (5-9)
3-3.9	4-5 (10-14)
4-4.9	6-7 (15-19)
5+	8 (20)

### 3.2b Gait Derangement

TD

## Lower Extremity MMI/IR Case 4 Page 84

### Do not combine ROM and DBE



and the estimate will depend on the clinical manifestations.

The evaluating physician must determine whether diagnostic or examination criteria best describe the impairment of a specific patient. *The physician, in general, should decide which estimate best describes the situation and should use only one approach for each anatomic part.* For instance, a patient with a femoral neck fracture with nonunion, who requires one crutch, should be rated either for use of the crutch or for the nonunion plus the range of motion restriction, whichever is greater.

There may be instances in which elements from

combined Values Chart (p. 322). The lower extremity impairment is 31%, which is a 12% whole-person impairment.

*Comment:* Impairment due to malunion of a fracture should be estimated according to the diagnosis. The expected muscle weakness or atrophy is included in the diagnosis-related estimates, but shortening is a different impairment.

If there were an associated nerve palsy, which usually does not occur with a fracture, the fracture and nerve palsy impairment percents reflecting impairments of different organ systems, would be

TD

## Lower Extremity MMI/IR Case 4 Page 84

### Do not combine ROM and DBE

crutch, should be rated either for use of the crutch or for the nonunion plus the range of motion restriction, whichever is greater.

There may be instances in which elements from both diagnostic and examination approaches will apply to a specific situation. A patient with an acetabular fracture and a sciatic nerve palsy should have estimates made for both the hip joint impairment and the nerve palsy. The estimates for the fracture and the nerve condition would be *combined* (Combined Values Chart, p. 322).

The final lower extremity impairment must not

If there were an associated nerve palsy, which usually does not occur with a fracture, the fracture and nerve palsy impairment percents reflecting impairments of different organ systems, would be *combined* (Combined Values Chart, p. 322), because they involve different organ systems.

## Lower Extremity MMI/IR Case 4 Page 84

### Do not combine ROM and DBE



whether diagnostic or examination criteria best describe the impairment of a specific patient. *The physician, in general, should decide which estimate best describes the situation and should use only one approach for each anatomic part.* For instance, a patient with a femoral neck fracture with nonunion, who requires one crutch, should be rated either for use of the crutch or for the nonunion plus the range of motion restriction, whichever is greater.

There may be instances in which elements from both diagnostic and examination approaches will apply to a specific situation. A patient with an acetabular fracture and a sciatic nerve palsy should have

*Comment:* Impairment due to malunion of a fracture should be estimated according to the diagnosis. The expected muscle weakness or atrophy is included in the diagnosis-related estimates, but shortening is a different impairment.

If there were an associated nerve palsy, which usually does not occur with a fracture, the fracture and nerve palsy impairment percents reflecting impairments of different organ systems, would be *combined* (Combined Values Chart, p. 322), because they involve different organ systems.

TD

Do not combine ROM and DBE

The final lower extremity impairment must not exceed the impairment estimate for amputation of the extremity, 100%, or 40% whole person impairment.

Fractures in and about joints with degenerative changes should be rated either by using this section and combining (Combined Values Chart, p. 322) the rating for arthritic degeneration **or by using the range of motion section**. It is recommended that the section providing the greater impairment estimate be used.

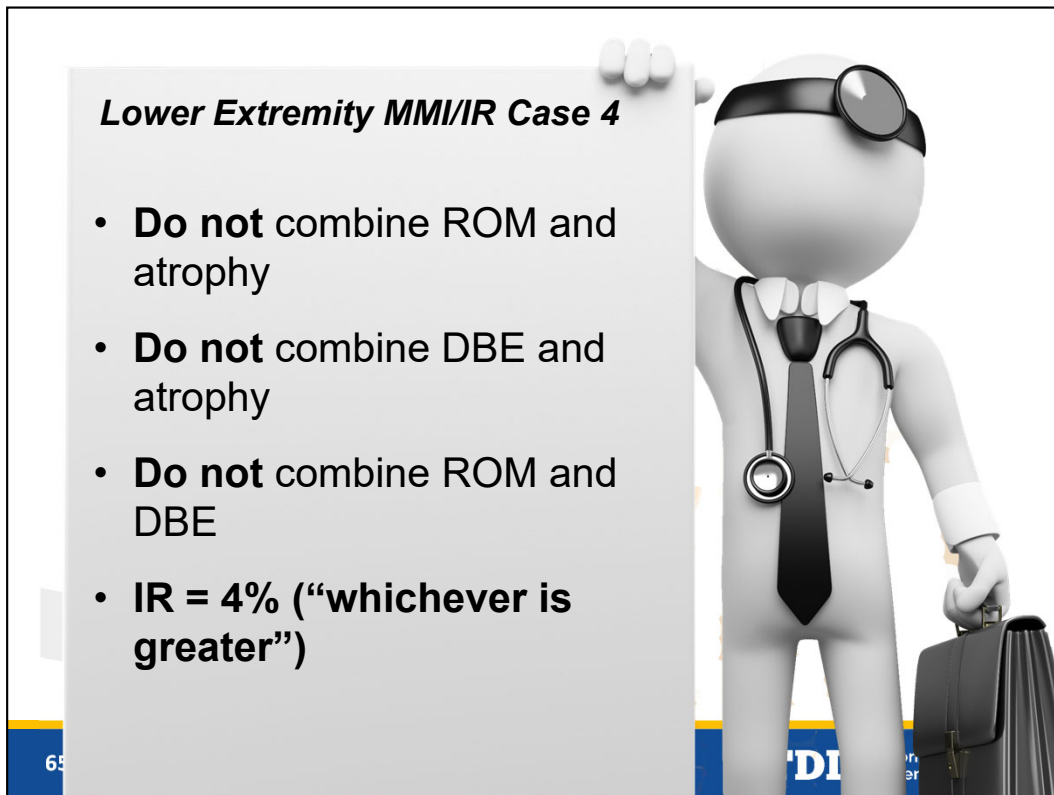


*Lower Extremity MMI/IR Case 4*  
*Table 64, Page 85*

**DBE exceptions that are combined  
with ROM**

<b>Hip</b>	
Total hip replacement; includes endoprosthesis, unipolar or bipolar	
Good result, 85-100 points*	15 (37)
Fair result, 50-84 points*	20 (50)
Poor result, less than 50 points*	30 (75)
Femoral neck fracture, healed in Good position	Evaluate according to examination findings
Malunion	12 (30) plus range of motion criteria
Nonunion	15 (37) plus range of motion criteria





**Learn this!**

These are the most common errors on reports and testing

## Questions About Lower Extremity MMI/IR Case 4?



66

**TDI** | Division of  
Tenneco

In this case, how would IR change for MODERATE joint line opening? 4 %.  
What if SEVERE joint line opening? 6 %.  
Greater than the other potential IRs.

# Questions About Lower Extremity MMI/IR?



Nerve deficits in the Lower  
Extremity create some  
concerns and questions



# LE Peripheral Nerve Injuries

## Chapter 3 Method – Section 3.2k.

- pages 88 and 89 and TABLE 68.
- Three categories of nerve impairment in the LE
  - motor deficits
  - sensory deficits
  - dysesthesia
- All estimates listed in Table 68 are for COMPLETE motor or sensory loss for named peripheral nerves
- Also, see APD 101481

Please refer to Table 68. Several ERRORS or DEFICIENCIES.  
See next slide...

# LE Peripheral Nerve Injuries

## Chapter 3 Method – Section 3.2k.

- Motor, sensory and dysesthesia estimates should be **combined** (text page 88)
- Not all nerve lesions are COMPLETE.
- What to do when there is an incomplete lesion?  
A couple of options
- ALSO, are there problems with Table 68?

Please refer to Table 68. Several ERRORS or DEFICIENCIES.  
See next slide...

# Peripheral Nerve Injuries

**Table 68.** Impairments from Nerve Deficits.

Nerve	Whole-person (lower extremity) [foot] impairment (%)		
	Motor	Sensory	Dysesthesia
Femoral	15 (37)	1 (2)	3 (7)
Obturator	3 (7)	0	0
Superior gluteal	25 (62)	0	0
Inferior gluteal	15 (37)	0	0
Lateral femoral cutaneous	0	1 (2)	3 (7)
Sciatic	30 (75)	7 (17)	5 (12)
Common peroneal	15 (42)	2 (5)	2 (5)
Superficial peroneal	0	2 (5)	2 (5)
Sural	0	1 (2)	2 (5)
Medial plantar	2 (5) [7]	2 (5) [7]	2 (5) [7]
Lateral plantar	2 (5) [7]	2 (5) [7]	2 (5) [7]

## MISSING SEVERAL NERVES WHAT DO YOU SEE AS MISSING?

Several nerves are

### missing from the table:

Deep Peroneal (sensory AND motor)

Tibial (sensory AND motor) after it splits from the sciatic nerve

Saphenous sensory.

### Errors in the table:

Omits motor portion of the superficial peroneal (Peroneal muscles).

Omits motor portion of obturator (Adductors).

Refer to the DD Certification course Lower Extremity presentation for more details.

## LE Peripheral Nerve Injuries

- TABLE 68 (page 89)
  - Errors of OMISSION
  - Errors based on INCORRECT data
- Refer to Figures 59 and 60 on Page 93
- DO NOT just make up a value!

### **PLEASE REFER TO TABLE 68.**

Several nerves are

#### **missing from the table:**

Deep Peroneal (sensory AND motor)

Tibial (sensory AND motor) after it splits from the sciatic nerve

Saphenous sensory.

#### **Errors in the table:**

Omits motor portion of the superficial peroneal (Peroneal muscles).

Omits motor portion of obturator (Adductors).

Refer to the DD Certification course Lower Extremity presentation for more details.

## LE Peripheral Nerve Injuries

- TABLE 68 (page 89)
  - Errors based on OMISSIONS
    - # **SAPHENOUS** extension of the FEMORAL (sensory)
  
    - # **TIBIAL** after splits from SCIATIC NERVE at the popliteal region (sensory AND motor)
  
    - # **DEEP PERONEAL** (sensory AND motor)
  - *There is a method for the determining MOTOR nerve without Table 68.*

### **PLEASE REFER TO TABLE 68.**

Several nerves are

#### **missing from the table:**

Deep Peroneal (sensory AND motor)

Tibial (sensory AND motor) after it splits from the sciatic nerve

Saphenous sensory.

#### **Errors in the table:**

Omits motor portion of the superficial peroneal (Peroneal muscles).

Omits motor portion of obturator (Adductors).

Refer to the DD Certification course Lower Extremity presentation for more details.

## Peripheral Nerve Injuries - OMISSIONS

**Table 68.** Impairments from Nerve Deficits.

Nerve	Whole-person (lower extremity) [foot] impairment (%)		
	Motor	Sensory	Dysesthesia
Femoral Saphenous (S)	15 (37)	1 (2)	3 (7)
Obturator	3 (7)	0	0
Superior gluteal	25 (62)	0	0
Inferior gluteal	15 (37)	0	0
Lateral femoral cutaneous	0	1 (2)	3 (7)
Sciatic Tibial (M&S)	30 (75)	7 (17)	5 (12)
Common peroneal	15 (42)	2 (5)	2 (5)
Superficial peroneal	0	2 (5)	2 (5)
Sural Deep Peroneal (M&S)	0	1 (2)	2 (5)
Medial plantar	2 (5) [7]	2 (5) [7]	2 (5) [7]
Lateral plantar	2 (5) [7]	2 (5) [7]	2 (5) [7]

The Saphenous is the sensory extension of the femoral nerve at the Medial knee. ALSO MISSING FROM Figure 60. but demonstrates its distribution on Figure 59.

# LE Peripheral Nerve Injuries

## Chapter 3 Method – Section 3.2k.

- TABLE 68 (page 89)
  - Errors based on INCORRECT DATA

# **SUPERFICIAL PERONEAL**  
(Motor to Peroneal muscles)

# **OBTURATOR**  
(Sensory innervation of the medial thigh).

### **PLEASE REFER TO TABLE 68.**

Several nerves are

#### **missing from the table:**

Deep Peroneal (sensory AND motor)

Tibial (sensory AND motor) after it splits from the sciatic nerve

Saphenous sensory.

#### **Errors in the table:**

Omits motor portion of the superficial peroneal (Peroneal muscles).

Omits motor portion of obturator (Adductors).

Refer to the DD Certification course Lower Extremity presentation for more details.

## Peripheral Nerve Injuries - ERRORS

**Table 68.** Impairments from Nerve Deficits.

Nerve	Whole-person (lower extremity) [foot] impairment (%)		
	Motor	Sensory	Dysesthesia
Femoral	15 (37)	1 (2)	3 (7)
Obturator	3 (7)	0	0
Superior gluteal	25 (62)	0	0
Inferior gluteal	15 (37)	0	0
Lateral femoral cutaneous	0	1 (2)	3 (7)
Sciatic	30 (75)	7 (17)	5 (12)
Common peroneal	15 (42)	2 (5)	2 (5)
Superficial peroneal	0	2 (5)	2 (5)
Sural	0	1 (2)	2 (5)
Medial plantar	2 (5) [7]	2 (5) [7]	2 (5) [7]
Lateral plantar	2 (5) [7]	2 (5) [7]	2 (5) [7]

# LE Peripheral Nerve Injuries

## Chapter 3 Method

- Alternate: Partial motor loss MAY be rated on basis of manual muscle testing per Section 3.2d:
  - # Table 39, page 77
  - # Text on page 76
- **Motor findings MUST be reproducible and consistent\***
- Does not provide a method for partial sensory loss - would have to use another methodology.

To Presenter: stress the following - Motor findings MUST be reproducible and consistent.

AMA GUIDES Page 76 \**“PATIENTS WHOSE PERFORMANCE IS INHIBITED BY PAIN or the FEAR OF PAIN are NOT GOOD CANDIDATES for MMT”*. Also, *“Findings varying be more than one grade between observers or such findings made by the same observer on separate occasions, are NOT VALID”*

# Peripheral Nerve Injuries

**USE TABLE 39 WHEN TABLE 68 DOES NOT HAVE A MOTOR NERVE LISTED**

**Table 39.** Impairments from Lower Extremity Muscle Weakness.

Muscle group		Whole-person (lower extremity) [foot] impairment (%)				
		Grade 0	Grade 1	Grade 2	Grade 3	Grade 4
Hip	Flexion	6 (15)	6 (15)	6 (15)	4 (10)	2 (5)
	Extension	15 (37)	15 (37)	15 (37)	15 (37)	7 (17)
	Abduction*	25 (62)	25 (62)	25 (62)	15 (27)	10 (25)
Knee	Flexion	1 (25)	1 (25)	10 (25)	1 (17)	5 (12)
	Extension	10 (25)	10 (25)	10 (25)	7 (17)	5 (12)
Ankle	Flexion (plantar flexion)	15 (37) [53]	15 (37) [53]	15 (37) [53]	10 (25) [35]	7 (17) [24]
	Extension (dorsiflexion)	10 (25) [35]	10 (25) [35]	10 (25) [35]	10 (25) [35]	5 (12) [17]
	Inversion	5 (12) [17]	5 (12) [17]	5 (12) [17]	5 (12) [17]	2 (5) [7]
	Eversion	5 (12) [17]	5 (12) [17]	5 (12) [17]	5 (12) [17]	2 (5) [7]
Great toe	Extension	3 (7) [10]	3 (7) [10]	3 (7) [10]	3 (7) [10]	1 (2) [3]
	Flexion	5 (12) [17]	5 (12) [17]	5 (12) [17]	5 (12) [17]	2 (5) [7]

\*Hip adduction weakness is evaluated as an obturator nerve impairment (Table 68, p. 89).

This is ONE methodology to account for errors in TABLE 68. The table states that MOTOR for the Superficial Peroneal is 0 %. The SP motor branch innervates the PERONEAL MUSCLES in the lateral compartment. Everts the foot. ALSO allows for PARTIAL loss.

## Peripheral Nerve Injuries – Table 39

USE TABLE 39 WHEN TABLE 68 DOES NOT HAVE A MOTOR NERVE LISTED

Table 39. Impairments from Lower Extremity Muscle Weakness.

Muscle group		Whole-person (lower extremity) [foot] impairment (%)				
		Grade 0	Grade 1	Grade 2	Grade 3	Grade 4
Hip	Flexion	6 (15)	6 (15)	6 (15)	4 (10)	2 (5)
	Extension	15 (37)	15 (37)	15 (37)	15 (37)	7 (17)
	Abduction*	25 (62)	25 (62)	25 (62)	15 (27)	10 (25)
Knee	Flexion	10 (25)	10 (25)	10 (25)	7 (17)	5 (12)
	Extension	10 (25)	10 (25)	10 (25)	7 (17)	5 (12)
	Flexion (plantar flexion)	15 (37) [53]	15 (37) [53]	15 (37) [53]	10 (25) [35]	7 (17) [24]
	Extension (dorsiflexion)	10 (25) [35]	10 (25) [35]	10 (25) [35]	10 (25) [35]	5 (12) [17]
	Inversion	5 (12) [17]	5 (12) [17]	5 (12) [17]	5 (12) [17]	2 (5) [7]
Great toe	Eversion	5 (12) [17]	5 (12) [17]	5 (12) [17]	5 (12) [17]	2 (5) [7]
	Extension	3 (7) [10]	3 (7) [10]	3 (7) [10]	3 (7) [10]	1 (2) [3]
	Flexion	5 (12) [17]	5 (12) [17]	5 (12) [17]	5 (12) [17]	2 (5) [7]

SCIATIC NERVE INJURY WITH REINNERVATION AND INTACT HAMSTRINGS BUT WEAK IN POSTERIOR TIBIAL NERVE

While this is NOT in THIS case, this is a way to account for COMPLETE or PARTIAL loss of the TIBIAL branch of the SCIATIC nerve, when hamstrings are intact AND the LEVEL of the LESION is ABOVE the Medial & Lateral Plantar at the level of the ankle / foot.

# Peripheral Nerve Injuries

## ***Chapter 4 Method:***

- Alternate: The Nervous System - pages 150 and 151
- Similar to UE methodology
- Consider this section for partial motor **and/or** sensory nerve loss where applicable

You may use this when there is a motor nerve listed on Table 68, but it is an Incomplete lesion.

# Peripheral Nerve Injuries

## Chapter 4 Method

- Determine appropriate peripheral nerve involved
- Take WP value from Chapter 3, Table 68, page 89 for **complete** motor or sensory loss
- **Multiply value for complete motor loss** (Table 68) by the **grade of the partial loss for motor deficit**
  - Chapter 4, **Table 21**, page 151
- **Multiply value for complete sensory loss** (Table 68) by the **grade of the partial loss for sensory deficit**
  - Chapter 4, **Table 20**, page 151
- Combine partial motor % WP with partial sensory % WP
  - Combined Values Chart, page 322

Table 20 in Chapter 4 is the SAME as Tale 11 in Chapter 3  
Table 21 in Chapter 4 is the SAME as Tale 12 in Chapter 3

## Chapter 4, Tables 20 and 21 - Page 151

**Table 20.** Classification and Procedure for Determining Impairment Due to Pain or Sensory Deficit Resulting from Peripheral Nerve Disorders.

a. Classification		
Class	Description of sensory loss or pain	% Sensory impairment
1	No loss of sensation, abnormal sensation, or pain	
2	Normal sensation except for pain, or decreased sensation with or without pain, forgotten during activity	1 - 25
3	Decreased sensation with or without pain, interfering with activity	26 - 60
4	Decreased sensation with or without pain or minor causalgia that may prevent activity	61 - 80
5	Decreased sensation with severe pain or major causalgia that prevents activity	81 - 95

- b. Procedure**
1. Identify the area of involvement, using the dermatome charts in Chapter 3 (pp. 50 and 52).
  2. Identify the nerve, part of plexus, or root that innervates the area.
  3. Find the value for maximum loss of function of the specific nerve or root due to pain or loss of sensation, using the appropriate table in the *Guides* chapter on the musculoskeletal system (Chapter 3, p. 13).  
Use Table 13 (p. 51) for the cervical roots; Table 14 (p. 52) for the brachial plexus; Table 15 (p. 54) for upper extremity nerves; Table 83 (p. 130) for the lumbosacral roots; and Table 68 (p. 89) for the lower extremity nerves.
  4. Grade the degree of decreased sensation or pain according to the classification given above.
  5. Multiply the percentage associated with the nerve identified in procedure 3 (above) by the percentage associated with the decreased sensation.
  6. Determine other nerve impairments by the same procedure; combine the impairments using the Combined Values Chart (p. 322) to determine the whole-person impairment of the nervous system.

**Table 21.** Classification and Procedure for Determining Nervous System Impairment Due to Loss of Muscle Power and Motor Function Resulting from Peripheral Nerve Disorders.

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 or extension.
  2. Identify the muscle(s) performing the motion and the motor nerve(s) involved.
  3. Grade the severity of motor deficit of the individual muscles according to the classification given above.
  4. Find the maximum impairment due to the motor deficit for each nerve structure involved, as listed in Chapter 3: upper extremity (Table 15, p. 54); brachial plexus (Table 14, p. 52); lower extremity nerves (Table 68, p. 89); and lumbosacral nerves (Table 83, p. 130).
  5. Multiply the severity of the motor deficit by the percentage associated with the nerve(s) identified in procedure 4 (above) to obtain the estimated impairment from strength deficit for each structure involved.

Table 20 in Chapter 4 is the SAME as Tale 11 in Chapter 3  
 Table 21 in Chapter 4 is the SAME as Tale 12 in Chapter 3

# Peripheral Nerve Injuries

## Chapter 4 Method (cont'd)

- **What is missing from this CHAPTER 4 METHOD?**
- **Dysesthesia is either present or NOT; there is no partial.**
- **However, the higher levels of Table 20 include minor or major causalgia that interferes with activity – so IF assigning a higher value here, do not also rate dysesthesia.**

Thank you