

## When Should an Impairment Evaluation be Performed?

A discussion recently with a colleague surrounded the time frame at which a patient should be considered for permanent impairment evaluation. The AMA Guides don't give an absolute time frame but generally outline a clinical presentation which suggests that maximum medical improvement (MMI) has been achieved. In earlier editions there were suggestions that 6 months or 12 months post injury were ideal but that very much depends on factors that cannot be clearly quantified.

All physicians are familiar with the 3 phases of healing. These are the acute inflammatory phase (0-72hrs), the repair phase (48hrs to 6 months) and the remodeling phase (3 weeks to 12 months). As you can see there is some overlap and this has much to do with the different tissues involved, their degree of vascularity (for nutritional and chemical support), the extent of tissue damage, the patients overall health and co-morbidities and many other factors that are unique to each injury and patient.

For many conditions, the connective tissue components take the longest to repair completely, perhaps up to 12 months, but that does not mean that the condition will require 12 months before being determined to be at MMI. The completion of the tissue healing may not add any further measurable functional benefit or pain reduction. Typically, when a patient has demonstrated several months of stability in their clinical presentation with only a mild degree of waxing and waning it is reasonable to state, within a reasonable degree of medical probability, that the patient is at MMI. MMI is defined in the AMA Guides as *“The point at which a condition has stabilized and is unlikely to change (improve or worsen) substantially in the next year, with or without treatment. While symptoms and signs of the condition may wax and wane over time, further overall recovery or deterioration is not anticipated.”*

Considering the above, a typical and reasonable scenario may look like this. A patient with an uncomplicated whiplash injury to the neck seeks care the day of the injury. The doctor applies acute then sub-acute phase modalities and management techniques during a course of care ranging from 1-4 months at a decreasing frequency. During this window patients will either have complete resolution or show signs of developing residuals. Either way, as soon as tolerated, the patient is introduced to an exercise program to facilitate the healing and functional gains desired. By month 3 or 4 the majority of patients are resolved or having residuals that are unlikely to make further gains. They are ready to be transitioned to an independent home exercise program which is monitored monthly or bi-monthly for 3-6 months to continue the rehabilitation and to monitor the stability of the injury residuals, if any. After the monitoring period, in those patients with ongoing functional deficits and subjective residuals that are not flaring or remitting, it is reasonable to consider them to have met the definition of MMI, even if the healing process may not have fully completed. If they are stable for a reasonable

period of observation, without measurable improvement or worsening, they are considered at MMI. Therefore, a typical window during which a permanent partial impairment can be assessed would be between 6 and 12 months. Some considerations that may warrant waiting a longer period of time for observation would include continued significant flare-ups requiring episodic care, delayed return to normal social or occupational demands, co-morbid conditions which confound the healing process (i.e. metabolic conditions, obesity, osteoporosis, spinal deformities), intervening traumas.

Lets look at some outliers to this general philosophy. A patient sustains a long bone fracture that is reduced as much as possible but is left with a 30 degree angulation deformity after bone healing is completed in 3 months. That patient can be rated for the fracture at the point when the fracture healing is complete. Another outlier is a patient that has a compression fracture at L1 resulting in a 50% loss of vertebral body height. The fracture heals in several months and the spine specialist determines that the patients fracture is stable and would not benefit from a vertebroplasty or kyphoplasty. The compression fracture is ratable at that time strictly based upon the diagnosis. Of course, the long bone angulation may have gait and leg length impairments and the compression fracture may have neurological complications which may require a longer period to assess for permanency but those conditions could be rated for permanency earlier than the typical 3-6 months.

So, to summarize, impairment ratings should not be done until a patient is at MMI. That typically will be between 6 and 12 months post trauma but could, under certain defined circumstance be sooner or later. Ultimately, it is the doctors expertise that determines if a patient is at MMI and ready for a permanent impairment evaluation. The AMA Guides do not clearly define the timing criteria so a reasonable interpretation is defined in this newsletter for your consideration. It is important to recognize that not all patients with subjective complaints at MMI will meet the criteria for an assignment of impairment regardless of the time frame. That is an entirely different topic which may be discussed in a future newsletter, if requested.