Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region

The American Association of Oral and Maxillofacial Surgeons (AAOMS) recognizes the need to establish a specific method of evaluating permanent impairments of the maxillofacial region. The AAOMS Committee on Healthcare and Advocacy has established a methodology of measuring and assigning values for permanent impairment of this area. Using the methods described in this document and the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, Sixth Edition, the practitioner will be able to assign an impairment value for the patient's maxillofacial region.

Objectives

• Provide a permanent impairment rating for a patient's maxillofacial region.
• Define the various terms associated with impairments.
• Recognize the different purposes for providing an impairment rating, ie, worker's compensation, Social Security administration, personal injury litigation and medical indemnity insurance.
• Understand applicable state regulations for conducting such examinations.

Acknowledgement

The “Report of Medical Evaluation (Permanent Medical Impairment)” on pages 11-13 and the combined injury ratings on page 3 are taken from the Guides to the Evaluation of Permanent Impairment, sixth edition.

This document does not constitute endorsement by the American Medical Association of the methods and procedures described by the AAOMS in the Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region.

I. Definitions

Clarification of the following terms as they relate to impairment is important:

Impairment: “a significant deviation, loss, or loss of use of any body structure or body function in an individual with a health condition, disorder, or disease.” (p. 5)

Disability: “activity limitations and/or participation restrictions in an individual with a health condition, disorder, or disease.” (p. 5)

Example: Impairment: Loss of index finger
For a person who is a singer, this in fact would be impairment, but not a disability. For an individual who is a typist, this could represent significant disability in their work.

Handicap: The Federal Rehabilitation Act of 1973 identifies a “handicapped” individual as one who has an impairment that substantially limits one or more life activities including work, has a record of such impairment, and this impairment can be overcome only by compensation, ie, artificial limb.

Impairment Rating: consensus derived percentage estimate of loss of activity reflecting severity for a given health condition and the degree of associated limitations in terms of activities of daily living (ADL). (p. 5)

II. How to Perform an Impairment Examination

1. History and review of pertinent medical records.
2. Physical exam or physical findings.
3. Clinical studies or objective test results.
4. Consider permanency of impairment. If impairment is resolving, changing, unstable or expected to change significantly within 12 months, do not give a rating. If condition is not fixed and stable, or if one is making a recommendation for curative (not palliative) treatment, do not give a rating.
5. Consider type of impairment:
   • Range of motion
   • Neurologic
**TABLE 1-5** Generic Template for Impairment Classification Grids

<table>
<thead>
<tr>
<th>CLASS</th>
<th>CLASS 0</th>
<th>CLASS 1</th>
<th>CLASS 2</th>
<th>CLASS 3</th>
<th>CLASS 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPAIRMENT RATING (%)</td>
<td>0</td>
<td>Minimal %</td>
<td>Moderate %</td>
<td>Severe %</td>
<td>Very Severe %</td>
</tr>
<tr>
<td>SEVERITY GRADE (%)</td>
<td>(ABCDE)</td>
<td>(ABCDE)</td>
<td>(ABCDE)</td>
<td>(ABCDE)</td>
<td>(ABCDE)</td>
</tr>
<tr>
<td>HISTORY OF CLINICAL PRESENTATION*</td>
<td>No current symptoms and/or intermittent symptoms that do not require treatment</td>
<td>Symptoms controlled with continuous treatment or intermittent, mild symptoms despite continuous treatment</td>
<td>Constant mild symptoms despite continuous treatment or intermittent, moderate symptoms despite continuous treatment</td>
<td>Constant moderate symptoms despite continuous treatment or intermittent, severe symptoms despite continuous treatment</td>
<td>Constant severe symptoms despite continuous treatment or intermittent extreme symptoms despite continuous treatment</td>
</tr>
<tr>
<td>PHYSICAL EXAMINATION OR PHYSICAL FINDINGSb</td>
<td>No current signs of disease</td>
<td>Physical findings not present with continuous treatment or intermittent, mild physical findings</td>
<td>Constant mild physical findings despite continuous treatment or intermittent moderate findings</td>
<td>Constant moderate physical findings despite continuous treatment or intermittent severe findings</td>
<td>Constant severe physical findings despite continuous treatment or intermittent extreme findings</td>
</tr>
<tr>
<td>CLINICAL STUDIES OR OBJECTIVE TEST RESULTsc</td>
<td>Testing currently normal</td>
<td>Consistently normal with continuous treatment or intermittent mild abnormalities</td>
<td>Persistent mild abnormalities despite continuous treatment or intermittent moderate abnormalities</td>
<td>Persistent moderate abnormalities despite continuous treatment or intermittent severe abnormalities</td>
<td>Persistent severe, abnormalities despite continuous treatment or intermittent extreme abnormalities</td>
</tr>
</tbody>
</table>

* Descriptors will be disease-specific; mild, moderate, severe, and extreme need to be defined.

b Descriptors will be disease-specific and based on the number of abnormalities found.

c Descriptors will be disease-specific and based on the number of abnormalities found.

The following is used as a grade modifier in the musculoskeletal chapters:

<table>
<thead>
<tr>
<th>FUNCTIONAL HISTORYd</th>
<th>Asymptomatic</th>
<th>Pain/symptoms with strenuous/vigorous activity; Able to perform self-care activities independently</th>
<th>Pain/symptoms with normal activity; Able to perform self-care activities with modification but unassisted</th>
<th>Pain/symptoms with less than normal activity (minimal); Requires assistance to perform self-care activities</th>
<th>Pain/symptoms at rest; Unable to perform self-care activities</th>
</tr>
</thead>
</table>

d Based on self-report or scores from the PDQ, QuickDASH, Lower Limb Outcomes Questionnaire, or other self-report tool.

e Based on information in Appendix B; depending on the score, the examiner can opt to add 1 to 3 percentage points.

The following will be added in selected chapters when compliance with treatment minimizes objective evidence of organ dysfunction but results in a significant compromise in ADLs:

<table>
<thead>
<tr>
<th>BURDEN OF TREATMENT COMPLIANCEe</th>
<th>None</th>
<th>Will be based on factors such as number and route of medications taken or the need to regularly undergo diagnostic tests or invasive procedures if not already considered in the preliminary rating</th>
</tr>
</thead>
</table>
e Based on information in Appendix B, depending on the score, the examiner can opt to add 1 to 3 percentage points.
III. Evaluation of the Oral and Maxillofacial Region for Permanent Impairment

A. Masticatory Dysfunction:

Eating involves the function of the teeth, jaws, muscles of mastication, muscles of deglutition, and temporomandibular joint. In addition, it requires the ability of a person through lip, tongue and muscle function to be able to swallow food. Loss or change in the functional relationship of any of these anatomic-physiologic components of the system will result in a functional change for the individual.

Loss of teeth and/or dentoalveolar structure (underlying osseous or soft tissue structure) may be due to trauma, developmental condition, or associated disease, eg, extractions indicated for radiation therapy in the treatment of primary or metastatic cancers of the head and neck.

There is a distinct and measurable variation between forces generated by natural dentition versus patients with prostheses (full removable dentures). Maximal bite forces appear to be five to six times less for complete denture wearers. In addition, many prosthetic patients select foods that require reduced masticatory capability.

Patients may also develop adverse sequelae with tooth loss, including speech difficulties and associated psychosocial problems secondary to cosmetic changes.

The following recommendations are made for determining the impairment rating of the individual loss based on the contribution of each component to the masticatory system.

**Table 11-7**

<table>
<thead>
<tr>
<th>Impairments of Mastication and Deglutition: Relationship of Dietary Restrictions to Permanent Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Restriction</strong></td>
</tr>
<tr>
<td>Diet is limited to semisolid or soft foods*</td>
</tr>
<tr>
<td>Diet is limited to liquid foods*</td>
</tr>
<tr>
<td>Ingestion of food requires tube feeding or gastrostomy</td>
</tr>
</tbody>
</table>

*The choice of these discrete numbers depends on the range of foods that can be consumed by the individual within the category.

Rondinelli, Robert D, ed. *Guides to the Evaluation of Permanent Impairment*, Chicago, IL, American Medical Association, 2008; 269

Dietary Modifications: Many conditions require modifications in diet. The degree to which this is necessary varies from patient to patient, as does the degree to which patients comply with these restrictions. This will add 1-2% impairment to account for the “Burden of Treatment Compliance” (BOTC).

Speech should not be evaluated by an oral and maxillofacial surgeon. The patient should be referred to a speech pathologist, who will evaluate speech and/or voice impairments together and the whole person impairment can range from 0% to 35% depending on audibility, intelligibility, and functional efficiency.²

B. Temporomandibular Joint (TMJ)

Range of motion is used to assess impairment in the maxillofacial region involving the TMJ.

The craniomandibular articulation is composed of the temporomandibular joints bilaterally and the masticatory musculature. These two joints function as a unit.

Total loss of motion, or ankylosis, renders the patient unable to chew or speak in a normal manner.

The following are not correlated to the AMA Guides, but are suggestions of the AAOMS Committee on Healthcare and Advocacy:

**Summary of Steps in Evaluation of Impairment of Craniomandibular Articulation**

1. Identify the area of involvement.

2. Measure the voluntary, non-painful interincisal opening between maxillary and mandibular central incisors (interincisal range of motion).

Measure the lateral excursive distance of the mandible, using the dental midlines from maximum dental intercuspation.

3. Add the impairment values for loss of interincisal opening and lateral excursive distance to obtain the craniomandibular articulation impairment value.
### Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region

**Clinical Paper**

#### INTERINCISAL RANGE OF MOTION

<table>
<thead>
<tr>
<th>Hypomobile</th>
<th>% OF NORMAL WHOLE PERSON</th>
<th>% IMPAIRMENT WHOLE PERSON</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-10 mm</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>10-20 mm</td>
<td>40</td>
<td>8</td>
</tr>
<tr>
<td>21-29 mm</td>
<td>50</td>
<td>5-7</td>
</tr>
<tr>
<td>30-35 mm</td>
<td>70</td>
<td>3-4</td>
</tr>
<tr>
<td>35-39 mm</td>
<td>95</td>
<td>3-5</td>
</tr>
<tr>
<td>Normal</td>
<td>100</td>
<td>0</td>
</tr>
</tbody>
</table>

*35 mm is an acceptable range of jaw opening according to the AAOMS Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial (AAOMS ParCare 2013).*

#### LATERAL EXCURSION RANGE OF MOTION

<table>
<thead>
<tr>
<th>Hypomobile</th>
<th>% OF NORMAL</th>
<th>% IMPAIRMENT OF WHOLE PERSON</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 mm</td>
<td>60</td>
<td>4</td>
</tr>
<tr>
<td>4-7 mm</td>
<td>70</td>
<td>3</td>
</tr>
<tr>
<td>8-10 mm</td>
<td>90</td>
<td>1</td>
</tr>
<tr>
<td>Normal</td>
<td>100</td>
<td>0</td>
</tr>
</tbody>
</table>

**Example:** A patient has a noted disc derangement with an incisal opening of 25 mm and lateral excursive movements of 6 mm.

**Ratable Criteria:**

Interincisal opening 6% impairment  
Lateral excursive movement 3% impairment

The two range of motion values are combined together: 6% + 3% = 9% impairment of whole person.*

**Example:** A patient has an ankylosis of the temporomandibular joint with a maximum opening of 5 mm and lateral excursive movements of 2 mm. Diet is restricted to liquid foods.
**Ratable Criteria:**

- Interincisal opening: 10% impairment
- Lateral excursive movement: 4% impairment
- Diet restriction: 30% impairment

*To calculate, use equation A+B (1-A) where A>B, so for this last example it would calculate as follows:

First combining the range of motion values:
\[ 0.10 + 0.04 \times (1 - 0.10) = 0.136 \approx 14\% \]

Then combine 14% with the diet restriction:
\[ 0.30 + 0.14 \times (1 - 0.30) = 0.398 \approx 40\% \]

This gives a whole person impairment of 40% for these three combined criteria.

Impairments secondary to other derangement such as resection, implant arthroplasty, or musculoskeletal disorders are usually rated according to the above criteria. It is left up to the individual examiner whether to consider these disorders separately. The evaluator must use judgment and avoid duplication of impairments.

Hypermobility generally does not impair function and is not ratable. If it appears to cause impairment, it should be treated as a muscle weakness.

**C. Skeletal Facial Deformities and Facial Disfigurement**

Skeletal-facial deformities of the maxilla and/or mandible can produce abnormal function and appearance. These deformities may arise from multiple genetic factors, environmental influences, acquired defects, neoplastic processes, degenerative disease and trauma.

Documentation of a skeletal-facial deformity should include:

- History to clearly indicate the source of the skeletal-facial deformity (congenital, developmental, or acquired);
- Imaging documentation, when feasible, of the deformity, eg, post-traumatic defects and/or lateral skull and facial bone x-rays for cephalometric analysis;
- Clinical photographs; and/or
- Facial moulage or dental models.

Impairment evaluation of an individual with a skeletal-facial deformity should be based on a combined value score using the AMA’s combined value table based on ratable symptoms that are deviations from normal function.

The following conditions (impairments) should be rated separately. Using the combined value table, whole person impairment may then be calculated.

**Masticatory Insufficiency:** Premature loss of teeth not in functional occlusion as a result of the underlying skeletal deformity.

All teeth missing or not in functional occlusion could be assigned an impairment value of 5% of the dental system for molars and 3% of the dental system for incisors. If the whole person impairment value based on premature loss of teeth or teeth not in functional occlusion is less than that of a total restriction to liquid diet, the greater value of a whole person impairment assigning 20-30% loss of whole person impairment based on a liquid diet should be used.

A person missing 30 teeth who wears a prosthesis is not usually on a liquid diet. Therefore, the impairment value would be 0% -8% for loss of teeth.

**Abnormal Respiratory (Airway) Problem:** Abnormal respiratory problems are related to the skeletal dental deformity that results in either obstruction, snoring, or sleep apnea. A referral for a laboratory sleep study is needed. Abnormal airway problems are usually rated by other examiners.

A patient with facial skeletal deformities such as vertical maxillary excess and mandibular retrognathia may have upper airway impairment. A sequela of this deformity may be multiple episodes of breathing cessation for at least 10 seconds during periods of sleep. Some signs and symptoms of this syndrome are snoring, abnormal behavior during sleep and interrupted sleep patterns, and excessive daytime somnolence.

**Facial Appearance (Disfigurement):** Facial appearance is extremely important for identification and self image. Disturbances in facial appearance or function may also have a major impact on social acceptance. Loss of structural integrity and soft tissue changes or injury can result in disfigurements that may cause not only physical, but social and functional problems as well.
In cases where skeletal facial defects, as a result of either congenital or developmental deformities, disease, trauma, or surgical intervention, result in a permanent disfigurement, the following impairments may be assigned and used with the combined values scale in determining a total value for skeletal facial deformities.

AAOMS supports the following classifications and rating impairment of whole person.

<table>
<thead>
<tr>
<th>TABLE 11-5 Criteria for Rating Impairment due to Facial Disorders and/or Disfigurement*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLASS</strong></td>
</tr>
<tr>
<td>WHOLE PERSON IMPAIRMENT RATING (%)</td>
</tr>
<tr>
<td>SEVERITY GRADE (%)</td>
</tr>
<tr>
<td>HISTORY*</td>
</tr>
<tr>
<td>PHYSICAL EXAM</td>
</tr>
<tr>
<td>DIAGNOSTIC OR OTHER OBJECTIVE FINDINGS</td>
</tr>
</tbody>
</table>

*Any vision loss or losses should be rated in those chapters. Breathing and eating disorders should be rated separately in this chapter and combined. The rater must use caution not to assess the activities of daily living (ADL) impairment in more than 1 section.

*Key factor.
Clinical Paper

**Cleft Palate Deformity**

Cleft palate deformity is a congenital deformity that is amenable to surgical correction and improvement from the time of birth through adolescence and adulthood. The cleft palate patient can be evaluated for impairment value based on skeletal deformity values of:

1. Mastication dysfunction/malocclusion
2. Articulation
3. Temporomandibular joint problems
4. Facial appearance
5. Psychosocial and/or behavioral problems
6. Sleep disorder

**Psychosocial:** If indicated, impairment values can be assigned for behavioral or psychosocial problems that are the result of a facial deformity, but it is suggested they be rated by other examiners.

**Pain:** There is disagreement by experts as to the validity of a pain-related impairment (PRI) and the relationship to whole person impairment (WPI). The 5th edition of the AMA Guides capped this at 3% WPI. In the sixth edition, the AMA Guides advises examiners to consider congruence with established conditions, consistency over time and situation, consistency with anatomy and physiology, agreement between observers and inappropriate illness behavior. The 6th edition also recommends that the patient fill out the Pain Disability Questionnaire (PDQ). The numerical total should then be related to whole person impairment.

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**Appendix 3-2 Pain Disability Questionnaire (PDQ)**

**Administering the Pain Disability Questionnaire**

Follow these instructions for administering and scoring the PDQ:

1. Reproduce the PDQ (Appendix 3-1) and ask the patient to complete all items on the questionnaire.
2. If necessary, the patient may complete the form with the assistance of a translator or reader. Be certain all 15 questions are answered. If the patient is unable to complete the PDQ, no functional assessment score will be given.
3. The evaluating doctor will score the PDQ by adding together the marked integer in each question.
4. If the patient fails to mark a question, the default score for that question is 0.
5. Apply the final score to Table 3-1 and consider this in the Steps of Assessment as described in Section 3.3d.

The PDQ scores can be divided into 5 distinct categories: no disability (score of 0); mild (scores of 1 to 70); moderate (scores of 71 to 100); severe (scores of 101 to 130); and extreme (scores of 131 to 150).
3.7 Appendixes

Appendix 3-1 Pain Disability Questionnaire

Patient Name: ___________________________ Date: ___________________________

Instructions: These questions ask for your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
   Work normally       Unable to work at all
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
   Take care of myself completely       Need help with all my personal care
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

3. Does your pain interfere with your traveling?
   Travel anywhere I like       Only travel to see doctors
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

4. Does your pain affect your ability to sit or stand?
   No problems       Cannot sit / stand at all
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
   No problems       Cannot do at all
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
   No problems       Cannot do at all
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

7. Does your pain affect your ability to walk or run?
   No problems       Cannot walk / run at all
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

8. Has your income declined since your pain began?
   No decline       Lost all income
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

9. Do you have to take pain medication every day to control your pain?
   No medication needed       On pain medication throughout the day
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

10. Does your pain force you to see doctors much more often than before your pain began?
    Never see doctors       See doctors weekly
    0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
    No problem       Never see them
    0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
    No interference       Total interference
    0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
    Never need help       Need help all the time
    0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
    No depression / tension       Severe depression / tension
    0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social, and / or work activities?
    No problems       Severe problems
    0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

Examiner


Rondinelli, Robert D, ed, Guides to the Evaluation of Permanent Impairment, Chicago, IL, American Medical Association, 2008; 43

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<table>
<thead>
<tr>
<th>Degree of Pain-Related Impairment</th>
<th>Pain Disability Questionnaire Score</th>
<th>Whole Person Impairment (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mild</td>
<td>1–70</td>
<td>0</td>
</tr>
<tr>
<td>Moderate</td>
<td>71–100</td>
<td>1</td>
</tr>
<tr>
<td>Severe</td>
<td>101–130</td>
<td>2</td>
</tr>
<tr>
<td>Extreme</td>
<td>131–150</td>
<td>3</td>
</tr>
</tbody>
</table>

**TABLE 13-18** Grading System for Rating Impairment due to Migraine Headache

Rondinelli, Robert D, ed, *Guides to the Evaluation of Permanent Impairment*, Chicago, IL, American Medical Association, 2008; 40

2. Cranial neuropathies or dysfunction: p. 343, Table 13-19.

<table>
<thead>
<tr>
<th>Class</th>
<th>Class 0</th>
<th>Class 1</th>
<th>Class 2</th>
<th>Class 3</th>
<th>Class 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of trigeminal or glossopharyngeal neuralgia with impairment despite optimal medical management. Headaches have reached a period of maximal medical improvement.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MIDAS SCORE (SEE TEXT)</td>
<td>0</td>
<td>1–5</td>
<td>6–10</td>
<td>11–20</td>
<td>21+</td>
</tr>
<tr>
<td>DESCRIPTION</td>
<td>No migraine headaches</td>
<td>Minimal or infrequent disability</td>
<td>Mild or infrequent disability</td>
<td>Moderate disability</td>
<td>Severe disability</td>
</tr>
<tr>
<td>WHOLE PERSON IMPAIRMENT RATING (%)</td>
<td>0%</td>
<td>2%</td>
<td>3%</td>
<td>4%</td>
<td>5%</td>
</tr>
</tbody>
</table>

**TABLE 13-19** Criteria for Rating Trigeminal or Glossopharyngeal Neuralgia

Rondinelli, Robert D, ed, *Guides to the Evaluation of Permanent Impairment*, Chicago, IL, American Medical Association, 2008; 343
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Miscellaneous Peripheral Nerves, (greater and lesser occipital nerves and greater and lesser auricular nerves), p. 344, Table 13-20

<table>
<thead>
<tr>
<th>Table 13-20</th>
<th>Criteria for Rating Miscellaneous Peripheral Nerves</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLASS</strong></td>
<td><strong>CLASS 0</strong></td>
</tr>
<tr>
<td><strong>WHOLE PERSON IMPAIRMENT RATING (%)</strong></td>
<td>0%</td>
</tr>
<tr>
<td><strong>GREATER OCCIPITAL NERVE</strong></td>
<td>No neuralgia</td>
</tr>
<tr>
<td><strong>LESSER OCCIPITAL NERVE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>GREATER AURICULAR NERVE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>INTERCOSTAL NERVE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>GENITOFEMORAL</strong></td>
<td></td>
</tr>
<tr>
<td><strong>ILIOINGUINAL</strong></td>
<td></td>
</tr>
<tr>
<td><strong>ILIOHYPOGASTRIC</strong></td>
<td></td>
</tr>
<tr>
<td><strong>PUDENDAL</strong></td>
<td></td>
</tr>
</tbody>
</table>

Rondinelli, Robert D, ed, *Guides to the Evaluation of Permanent Impairment*, Chicago, IL, American Medical Association, 2008; 344
Report of Medical Evaluation
Permanent Medical Impairment

To: ________________________________

Re: ________________________________

Case #: ________________________________

Date of Impairment: ________________________________

1. Past Medical History 
   | Yes / No
   | A. Medical Office Records  Reviewed  Enclosed
   | B. Hospital Record  Reviewed  Enclosed
   | C. From Patient
   | D. From Other Sources (Describe)

2. Clinical Evaluation 
   | Yes / No
   | A. Physical Examination  Report Enclosed
   | B. Laboratory Tests  Report Enclosed
   | C. Special Tests and Diagnostic Procedures  Report Enclosed
   | D. Specialty Evaluations  Report Enclosed

3. Diagnosis
   | ________________________________
   | B. ________________________________
   | C. ________________________________
   | D. ________________________________
4. Stability of Medical Condition

A. The clinical condition is stabilized and not likely to improve with surgical intervention or active medical treatment. Medical maintenance care is warranted.

Yes / No

B. The degree of whole body impairment is not likely to change by more than 3% within the next year.

Yes / No

C. Employment is not likely to improve with surgical intervention or active medical treatment

Yes / No

D. The patient is not likely to suffer sudden or subtle incapacitation

Yes / No

5. Other Analyses

A. Explain briefly the impact(s) of the medical condition(s) on the patient’s activities of daily living:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

B. Is there a medical reason to believe the patient is likely to suffer injury, harm, or further medical impairment by engaging in usual activities of daily living or other activities necessary to meet personal, social, or occupational demands? Explain briefly.

Yes / No

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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C. Is there a medical reason to believe other restrictions or accommodations are necessary to help the patient carry out usual activities of daily living or meet personal, social and occupational demands? If so, briefly explain their therapeutic, risk-avoidance, or other kind of value.

Yes / No

6. Important Evaluations (According to AMA Guides) – Attach a complete report of findings and narrative comments for each body part or system.

Bony Part or System:

A. (Report Enclosed)
B. (Report Enclosed)
C. (Report Enclosed)
D. (Report Enclosed)

☐ This patient has been under my care from ___/___/___ to ___/___/___

☐ I have not provided care for this patient. I have seen this patient ____ time(s) for the purpose of evaluating medical impairment. My evaluation occurred between ___/___/___ and ___/___/___

Signature

Please Print Name
REFERENCES


Parameters and Pathways: Clinical Practice Guidelines for Oral & Maxillofacial Surgery (AAOMS Parameters of Care, 2013)

Statements by the American Association of Oral and Maxillofacial Surgeons Concerning the Management of Selected Clinical Conditions and Associated Clinical Procedures – Temporomandibular Disorders.

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