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Disability Evaluation Guidelines for California Permanent Disability Ratings For The 1988 and 1997 Schedules for Rating Permanent Disabilities

California Code of Regulations 8 CCR 46 & 8 CCR 9725
Measurable Physical Elements of Disability Appendix

- **It is the Evaluating Physician's Responsibility to:**

1. Include a relevant description of body habitus and any general observations such as a limp, obvious discomfort while sitting/standing, etc.

2. Evaluate each tissue system, beginning with the skin/integument, by describing any skin abnormalities, surgical scars, obvious muscle atrophy or skeletal deformities *(all injured areas shall be inspected for soft tissue swelling, joint effusions/enlargements, erythema, muscle spasms, tenderness, etc.).*

3. Comment regarding circulation [vascular examination] *including comments on temperature change, abrasions or lacerations, evidence of skin burn, amputation, etc..*

4. Report all spinal motion preclusions "in estimated percentages of normal" representing the voluntary arc of motion, or as a ratio of the observed compared to the anticipated normal:

   4.1. If restriction of motion is present, evaluating physician must comment on the reason why: pain, muscle spasm, voluntary restriction, etc. *Gentle passive range of motion may be performed in addition to active range of motion to determine whether the restriction is due to pain or mechanical block.*
   4.2. The examination of injured workers with spinal or spino-radicular difficulties, should also include:
      4.2.1. Examination of the balance of the neuromusculoskeletal system, 2) balance of physical examination [neurological exam] and 3) special neurological/provocative test as per L.C. 139.2

5. Evaluate all joints on an injured extremity *(if measurements or observations are normal physician should simply state "normal").*

6. When evaluating the upper extremities, state handedness *(the following factors are usually considered when determining the "dominance" of an upper extremity:* the dominant (major) hand is usually the "throwing / writing" hand and circumference may also help in the determination).

7. Include the voluntary active arc of motion of the injured over the un-injured and appropriate circumferential measurements of the involved muscle groups *(evaluating physician should also record abnormal, excessive or limited range of motion, including ankylosis).*

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8. Comment on the effort by the employee on the voluntary/active range of motion for any given joint, to include the soundness of grip measurements *(if there are unexplained discrepancies in formally measured versus casually observed range of motion, it should be noted).*

9. If restriction of motion is present, provide the inhibited arc of motion with comments on the reasons why: pain, muscle spasm, voluntary restriction, etc.

10. Use the estimated normal ranges of motion according to Packard Thurber (8 CCR 9725) when both extremities are abnormal.

11. State when the uninjured joints' opposite measurements are normal for the injured worker even though they are less than the "estimated normals" according to Packard Thurber" *(due to the injured worker's individual characteristics, such as age, stature, weight, range of motion of other body joints, musculature, etc.).*

12. Report grasping power estimated normals taking into consideration claimant's individual characteristics, general physical condition, age, stature, weight, and range of motion of other joints in the affected extremities, atrophy of pertinent musculature and anomalies or other abnormal conditions.
If there are signs or evidence that the injured worker is not exerting maximal effort, the grip strength measurements obtained from the dynamometer become invalid for estimating a level of impairment or residual permanent disability.

12.1. If the evaluating physician feels that the dynamometer readings do not reflect the actual grip loss, it should be so stated.

12.2. Then, the evaluating physician should provide an estimate, on a percentage basis, as to what the actual grip loss really is and the reasons for his opinion.

12.3. The evaluating physician should not provide estimated normals that are based on pounds or kilograms, based on the AMA Guidelines Tables or any other Tables or Guidelines if they do not take into consideration all the factors in this section. (See pages 11 & 12 of the Evaluation of Industrial Disability by Packard Thurber: 8 CCR 9725.)

13. When a physician refers to/uses tables or charts to determine estimated normals or other information needed to help in the evaluation of impairment due to an industrial injury, the physician must still adhere to the evaluating formats established by the California Code of Regulations. *Physician must identify name, source and other relevant information of the materials being used.*

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- When dynamometer measurements are taken, if maximum effort is exerted, the data obtained will follow a bell curve with maximum exertion/strength being greatest near the mid-point. *If upper extremity pain is present, overall strength may be decreased, but the bell curve pattern should be evident.*

- Is there any atrophy present including atrophy of the thenar, hypothenar or intrinsic areas? Is the overall weakness in muscle strength testing felt to be a result of deconditioning, pain, and/or unassertiveness?

- Normal range has to do with employee's occupation and whether or not the employee is a well-conditioned person. In another words, if one works on grip strength using various devices to increase grip strength, the grip strength will be strong despite what they are doing at work. *Most people do not use their grip actively or frequently, and that would fall into what is considered normal range for relatively inactive people.* There is a significant range among people depending on what they do: Women 30-60, men 70-100.

Neurological Elements

- **Labor Code Section § 139.2,** states that in order to produce a complete, accurate, uniform and replicable evaluation, the physician must support findings and opinions by medical findings [measurable physical elements] based on standardized examinations and testing techniques generally accepted by the medical community.

  - The Permanent & Stationary medical evaluation must include findings and the reasons for all of the evaluating physician's opinions. The report should be clear, concise, reasoned and objective. When an evaluating physician reviews previous medical records and/or other sources of information, a list of all records reviewed must be included within the body of the medical report. *The findings of performed or reviewed diagnostic tests must be included within the medical report.*

Diagnostic Testing

- **8 CCR 46** states that when describing diagnostic tests, the physician must describe the purpose of the clinical tests rather than just referring to the test only by name or only stating that a result is negative or positive, since the main function of the medical report is to enable people who are not physicians to assess the case. The physician must describe how findings support disabling symptoms and the reasons of the evaluating physician for the imposition for any index of work capacity functional loss.

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Neurological Examination includes the Assessment of:

1. **Motor Examination** that includes general muscle bulk with a description of the specific muscles or muscle group atrophied; muscle tone power with grading of muscle strength on a 0-5 scale as referenced in Walton's "Aids to the Examination Of Peripheral Nervous System", 1988.

   1.1. If muscle weakness is noted, the physician should state an opinion as to the cause, such as neurological deficit, pain, disuse atrophy or lack of effort.

   1.2. Muscle weakness due to neurological deficit should be documented by needle electromyographic testing.

2. **Sensory Examination** shall include a screening of light touch and pain sensation (pinprick) in pertinent dermatomal patterns, peripheral nerve distribution and of joint proprioception of any involved joints, with any abnormalities described and fully correlated with peripheral nerve or dermatomal pattern.

   2.1. Physician must note if the pattern of sensory impairment is nonphysiological.

   2.2. Pinprick examination of the perianal region and assessment of sphincter tone may be indicated in certain cases.

3. **Deep Tendon Reflexes** shall be outlined/graded on a 0 (absent) to 4+ (hyperactive), **with the normal grade being 2.**

   3.1. Testing with reinforcement may be indicated.

   3.2. Physician must note if clonus is present and whether any other abnormal reflexes were elicited.

4. **The clinical evaluation is not solely made of only one aspect of the aforementioned but it must always be a combination of the 3 individual tests.** ***It is of extreme importance that physicians compare one side to the other in order to determine if pathology exists.***

   4.1. Refer to 8 CCR 41 & 46, The IMC's Physicians Guide, 8 CCR WCAB 10606 and L.C. 4628, for further explanation of the duties of an evaluating physician when preparing and signing a medical-legal report or a comprehensive Permanent & Stationary report.

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